**PROGRAM ANNOUNCEMENT**

**DEPARTMENT OF DEFENSE (DoD)**

**Defense Health Agency**

**Title:** Department of Defense HIV/AIDS Prevention Program

**Announcement Type:** Initial Announcement

Funding Opportunity Number: W81XWH-22-DHAPP

**Assistance Listing Number:** 12.350 -- Department of Defense HIV/AIDS Prevention Program

**Key Dates:** This announcement will be **open to receive applications continuously** until 5:00 p.m. Eastern Time (ET), 18 September 2027, at which point all applications must be received.

**Issued: September 2022**
**Revised: April 2026**

**Table of Contents**

## A. Program Description

**Background:** The United States Government has a long history and extensive network of international collaboration and partnerships in the fight against HIV/AIDS, providing funding, technical assistance, and program support. These collaborations increase the fundamental understanding of HIV transmission and provide an evaluative basis for prevention and intervention success. The HIV/AIDS epidemic is devastating and Militaries, in particular, have been identified as a high-risk population.

DoD HIV/AIDS Prevention Program (DHAPP) works as part of the U.S. Government's effort to save lives, prevent HIV infections, and accelerate progress toward achieving HIV/AIDS epidemic control in more than 50 countries around the world. DHAPP is positioned within the Defense Health Agency (DHA) and located at the Naval Health Research Center (NHRC) in San Diego, California.

DHAPP has successfully engaged over 80 countries in efforts to combat HIV/AIDS among its respective military services. DHAPP is the Department of Defense's (DOD, herein referred to using the secondary title Department of War, DOW – unless specifically referenced to the DHAPP program or active Department of Defense labeled directives) military to military implementing arm of the President's Emergency Plan for AIDS Relief (PEPFAR) collaborating with the U.S. State Department (DoS), U.S. Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), the U.S. Agency for International Development (USAID), the Peace Corps, and other federal agencies. Working closely with U.S. Department of War, U.S. Unified Combatant Commanders, Joint United Nations Program on HIV/AIDS (UNAIDS), university collaborators, and other non-governmental organizations, DHAPP assists countries in establishing HIV/AIDS prevention, care and treatment programs in strengthening their capabilities to combat HIV.

DHAPP continues to rely upon the vital support of various partners such as local and international non-governmental organizations (NGOs) including faith-based organizations to implement HIV prevention, care and treatment programs across the globe. A customized plan is needed to assist militaries as they implement HIV/AIDS programs capable of reaching our shared goals for HIV epidemic control.

Applicants for an award should be aware of the country specific military's HIV control activities and propose a plan that builds on the country specific military's activities without duplicating efforts, creating parallel systems, or conflicting activities. The overall program manager for PEPFAR is the Department of State's Office of the U.S. Global AIDS Coordinator (OGAC). DHAPP provides support for military-specific programs. Country HIV programs supported by PEPFAR funds can be found on the OGAC website: https://www.state.gov/where-we-work-pepfar

DHAPP provides technical assistance, management, and administrative support to the HIV/AIDS

prevention, care, and treatment for foreign militaries through support to implementing partners. In addition, DHAPP provides HIV program execution and monitors outcomes with staff that include country specific active duty military, civil service, and contractor personnel.

**Program Objective:** DHAPP's objective, through the PEPFAR program, is to save lives, prevent HIV infections, and accelerate progress toward achieving HIV/AIDS epidemic control and to support the development of interventions and programs in military health systems that address these issues. DHAPP works with militaries of foreign countries to devise plans based on the following process:

- Meet with key partners in country to determine provisional major program areas and other technical assistance needs.
- Adapt DHAPP support to a country's need for prevention, care and/or treatment of its HIV/AIDS situation based on an assessment of the country's epidemic, and more specifically, in that country's military.
- Strengthen the military capacity for ownership and behavioral changes over the long term.
- Consider program design by leveraging assets with other country partners who have/had successful prevention, care, and/or treatment efforts.
- Focus on prevention, care and/or treatment impact aligned with national implementation plans.
- Implement and monitor programs to ensure accountability and sustainability.

Countries and their militaries need strong evidenced based HIV programs with measurable courses of action that demonstrate the following specific attributes. Priorities for DHAPP include the following but are subject to change.

- Support and ownership from the military sector.
- Development of plans of action and support for military policies that further HIV epidemic control.
- Alignment with PEPFAR and national strategies and priorities.
- Testing and treatment expansion to meet 2020 goals of 90-90-90 and 2030 goals of 95-95-95 for people living with HIV. (The first goal is identifying 90/95 percent of all HIV-positive individuals in the population; the second goal is linking 90/95 percent of all those identified HIV positive people to consistent antiretroviral treatment; and the last goal is reaching 90/95 percent of all those on antiretroviral treatment to attain viral suppression.)
- Care and treatment plans should use the "Treat All" approach with differentiated models of care including tuberculosis (TB), hepatitis, cervical cancer in HIV positive women, other sexually transmitted infections (STI), other opportunistic infections, and care for those with advanced HIV disease.
- Reduction of mother-to-child transmission of HIV.
- Combination prevention using biomedical, behavioral and structural support for sexual transmission of HIV and other STI.
- Prevention packages for specific populations including a comprehensive package for Key Populations (KP), Priority Populations, and prevention interventions for young people.
- Stigma and discrimination reduction associated with HIV infection.

- Program monitoring to collect and report on PEPFAR indicators, ensure quality of service delivery using clinical and laboratory monitoring tools and to take rapid corrective action based on results.
- Strengthen HIV data collection systems for improved clinical decision making and program management.
- Promoting sustainability through capacity building of the military partner.

Transition to Local Partners: **Local 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.

## B. Federal Award Information

The following information applies to awards issued under this announcement:

- Funding Amount: For each country where funding is available, Attachment 1 (Country Specific Narrative) will contain a description of the work that is needed, along with the program areas and an approximation of the available funding. It should be noted that while dollar amounts are listed, this should be taken as an estimate of the funding for an effort whether a single amount or range is listed. Changes to Attachment 1 will be provided in the form of amendments to this announcement.
- Anticipated number of Federal awards: The anticipated number of awards for this program in FY23 will range from approximately 10 to 20, with the number of awards being determined based on the rigor and transformative potential of the proposals received, as well as the availability of funds. All funding decisions are final.
- The Period of Performance for these awards is 4 years.
- Information regarding program funding amounts as well as total cost limitations within the application can be found in the country specific narrative outlined in Attachment 1.
- Investigators on collaborative projects should each write and submit separate, unique proposals, and provide the name and title of their collaborator's proposal within the project narrative of the application.
- Awards will be made on an open continuous basis. Refer to your country specific narrative in Attachment 1 for more details. Cooperative agreements will be awarded under this announcement.

## C. Eligibility Information

**Eligible Applicants**: All responsible sources from academia, industry, and non-governmental organizations may submit proposals under this announcement. No grants, contracts or cooperative agreements may be awarded directly to foreign military establishments. **All respondents must demonstrate the active support of the in-country military and the DoW representative in the corresponding U.S. Embassy in the planning and submission of their proposals.**

**Other information:**

- The Federal Assistance Certifications Report (completed as part of the SAM registration) is a required attestation that the entity will abide by the requirements of the U.S. laws and regulations; therefore, as applicable, you are still required to submit any documentation, including the SF LLL Disclosure of Lobbying Activities (if applicable), and informing DoW of unpaid delinquent tax liability or a felony conviction under any Federal law. If applicable, the SF LLL should be submitted with the SF 424 form. See Section F. Federal Award Information for additional information.
- DoW required certifications: By checking "I agree" in block 17 of the SF 424 (see below) and signing the application as the authorizing official, you are certifying that your institution will be in compliance with these additional requirements:
    - Institutions of higher education must certify compliance with 10 U.S.C 983, *Institutions Of Higher Education That Prevent ROTC Access Or Military Recruiting On Campus: Denial Of Grants And Contracts From Department Of Defense, Department Of Education, And Certain Other Departments And Agencies*, and 32 C.F.R. 216 *Military Recruiting And Reserve Officer Training Corps Program Access To Institutions Of Higher Education.*
    - Recipient will not require any of its employees, contractors, or sub-recipients seeking to report fraud, waste, or abuse to sign or comply with internal confidentiality agreements or statements prohibiting or otherwise restricting those employees, contractors, sub-recipients from lawfully reporting that waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.

## D. Application and Submission Information

**Submitting a Proposal**: DoW will only accept proposals submitted through Grants.gov on or before the date specified in the country specific narrative provided in Attachment 1. Read the instructions below about registering to apply for DoW funds. Applicants should read the registration instructions carefully and prepare the information requested before beginning the registration process. Reviewing and assembling the required information before beginning the registration process will alleviate last-minute searches for required information.

Organizations must have a Unique Entity Identifier (UEI) Number, active System for Award Management (SAM) registration, and Grants.gov account to apply for grants. If individual applicants are eligible to apply for this funding opportunity, then you may begin with step 3, Create a Grants.gov Account, listed below.

Creating a Grants.gov account can be completed online in minutes, but UEI and SAM registrations may take several weeks. Therefore, an organization's registration should be done in sufficient time to ensure it does not impact the entity's ability to meet required application submission deadlines. Note: Failure to allow enough time for the systems to complete the registration is not considered a valid explanation for why grants.gov did not accept the proposals.

Complete organization instructions can be found on Grants.gov at: https://www.grants.gov/applicants/applicant-registration/

1) *Register with SAM*: The applicant organization must be registered as an entity in SAM (https://www.sam.gov/SAM/) and receive confirmation of an "Active" status before submitting an application through Grants.gov. As published in the Federal Register, July 10, 2019, (https://www.federalregister.gov/documents/2019/07/10/2019-14665/unique-entity-id-standard-for-awards-management), the UEI for awards management generated through SAM will be used instead of the Data Universal Numbering System (DUNS) number as of April 2022. All federal awards including, but not limited to, contracts, grants, and cooperative agreements will use the UEI. USAMRDC will transition to use of the UEI beginning with FY22 announcements and utilize the latest SF424, which includes the UEI. The DUNS will no longer be accepted. Applicant organizations will not go to a third-party website to obtain an identifier. During the transition, your SAM registration will automatically be assigned a new UEI displayed in SAM. Current SAM.gov registrants are assigned their UEI and can view it within SAM.gov.

2) *Create a Grants.gov Account*: The next step is to register an account with Grants.gov. Follow the on-screen instructions or refer to the detailed instructions at https://www.grants.gov/applicants/applicant-registration/

3) *Add a Profile to a Grants.gov Account*: A profile in Grants.gov corresponds to a single applicant organization the user represents (i.e., an applicant) or an individual applicant. If you work for or consult with multiple organizations and have a profile for each, you may log in to one Grants.gov account to access all your grant applications. To add an organizational profile to your Grants.gov account, enter the UEI Number for the organization in the UEI field while adding a profile. For more detailed instructions about creating a profile on Grants.gov, refer to: https://www.grants.gov/applicants/applicant-registration/

4) *EBiz POC Authorized Profile Roles*: After you register with Grants.gov and create an Organization Applicant Profile, the organization applicant's request for Grants.gov roles and access is sent to the EBiz POC. The EBiz POC will then log in to Grants.gov and authorize the appropriate roles, which may include the Authorized Organization Representative (AOR) role, thereby giving you permission to complete and submit applications on behalf of the organization. You will be able to submit your application online any time after you have been assigned the AOR role. For more detailed instructions about creating a profile on Grants.gov, refer to: https://www.grants.gov/web/grants/applicants/registration/authorize-roles.html

5) *Track Role Status*: To track your role request, refer to: https://www.grants.gov/applicants/applicant-registration/

*Electronic Signature*: When applications are submitted through Grants.gov, the name of the organization applicant with the AOR role that submitted the application is inserted into the signature line of the application, serving as the electronic signature. The EBiz POC **must** authorize people who are able to make legally binding commitments on behalf of the organization as a user with the AOR role; **this step is often missed, and it is crucial for valid and timely submissions.**

**Proposal Narrative: All proposals must be submitted in English or they will be rejected.**

**Formatting Requirements:**

- Font: Times New Roman, 12 point
- Margins: 1 inch on all sides
- Paper size: 8 ½ by 11"
- Single-spaced

**Required Documents:** All elements and forms listed below are required, except as stated, for a proposal to be determined complete and must be submitted in English.

**Technical Narrative (Not to exceed 45 pages):**

**Cover Page** - Should include the words "Technical Narrative" as well as the following:

1) Funding Opportunity number
2) Targeted Country
3) Title of Proposal
4) Identity of Prime Respondent and complete list of subcontractors, if applicable
5) Technical Contact (name, title, address, phone, fax and e-mail)
6) Administrative/Business Contact (name, title, address, phone, fax and e-mail)
7) Duration of effort
8) Table of Contents: Section, Title and page numbers are required

**Project Abstract** – Concise, single-spaced abstract, not to exceed 4000 characters, summarizing the proposed program effort, including the name of the Offeror institution/organization, anticipated public benefit, type of substantial involvement by the Government objectives, assessed need, and anticipated impact and results. ***Applications with abstracts exceeding 4000 characters will be withdrawn from consideration.***

The project abstract must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible, understandable to the technically literate lay reader. This abstract must not include any proprietary/confidential information.

**Section I: Technical Approach.** The following items shall be addressed:

**Executive Summary (Not to exceed two pages).** Brief description of proposed activities, goals, purposes, and anticipated results. Briefly describe technical and managerial resources of your organization. Describe how the overall program will be managed. State the bottom line funding request. The Executive Summary shall not copy the abstract.

**Background Information (Not to exceed two pages)**. Provide contextual information relevant to setting goals and technical approaches. Include general background information about the host country and its military, including conditions and issues that have relevance to HIV transmission and HIV prevention programs. This information should include data on HIV prevalence. Other possible information to include: population size, economic conditions, political conditions, conflicts and border disputes, country infrastructure, and host nation military HIV program accomplishments or priorities to date and other donors, resources leveraged, etc. Information provided in this section should demonstrate awareness of the conditions and needs within the country and it's military.

**Goal and Objectives (Not to exceed five pages).** Provide high level goals/aims of programming to include outcomes and impacts in target populations (including sub-populations and sub-national geographies), as well as strategies and approaches to achieve this (including theory of change). Describe (a) the overall program goal of the project, and (b) the specific objectives that are measurable and time phased, consistent with the objectives and numerical targets that are described in the program narrative. See DHAPP current Priority activities in Section II. A. Program Description for reference.

**Work Plan (Not to exceed six pages)**. Provide expanded detail on activities contributing to approach and sequencing. Clearly detail the scope and plan of the effort. Describe the specific methods (e.g., surveys, interviews, surveillance, etc.) you will use to accomplish the proposed objectives. All anticipated work must be aligned with the national guidelines of the host country. If the plan includes a training/education program or other intervention, please describe these in detail. Training should be aligned with national standards where possible. It is anticipated that the proposed plan will be incorporated as an attachment to the resultant award instrument. To this end, such proposals must include a severable self-standing plan without any proprietary restrictions that can be attached to the agreement award.

**Data Management Plan (Not to exceed two pages).** Data Management Plan should include:

a) The types of data, guidance, physical data collections, software, training materials, and other materials to be used or produced in the course of the project;
b) The standards to be used for data and metadata format and content (where existing standards are absent or deemed inadequate, this should be documented along with any proposed solutions or remedies);
c) Data governance policies for access and sharing including provisions for appropriate protection of privacy, confidentiality, security, intellectual property, or other rights or requirements; in cases where Personal Health Information is collected, identify appropriate national/international standard to be used for data protection. Data is considered property of the military partner.
d) Policies and provisions for re-use, re-distribution, and the production of derivatives; and
e) Plans for archiving data and other information products (reports), and for preservation of access to them.

f) A valid Data Management Plan may include only the statement that no detailed plan is needed, as long as the statement is accompanied by a clear justification.

**Monitoring and Evaluation (Not to exceed five pages, inclusive of table of indicators).** State how you will demonstrate that the proposed program will have an impact on military members and/or their families and state the specific PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators of performance that will be used. Indicators of performance and associated targets need to be specific and measurable (e.g., 100 military members will receive Voluntary Counseling and Testing (VCT) counseling, 2 laboratories will be established). Also, state how you will collect this information.

**Schedule and milestones (Not to exceed two pages).** Provide a schedule and description of major milestones or tasks to be accomplished in the proposed program by quarter (e.g., by 3-month period). No set number of milestones is required; the number and nature of the milestones will depend on your program and objectives. This section should include the sequencing of key activities.

**In-Country Participation (Not to exceed four pages).** Describe the involvement of the host country's military and its leadership in: (a) the development of the proposal (and/or the ideas presented in the proposal), and in (b) the planned execution of the proposed program bearing in mind the long term sustainability and host country military ownership of the program. Include how local/national institutions and stakeholders contributed to the development of goals, objectives and strategies proposed and what their roles will be in the program (*Letters of support from all stakeholders mentioned should be included as addendums to the proposal).

**Relevance of the Program (Not to exceed two pages).** (a) Describe the relevance of the proposed program to the needs, priorities and circumstances of the host country's military; (b) describe how the proposed program fits into the overall HIV strategy for the country and/or the country's military. If the respondent has previously performed and accomplished HIV prevention, treatment, or system strengthening efforts involving the host country's military, it should describe its past and current efforts.

## Section II: Management and Qualifications Approach

**Management Approach (Not to exceed fifteen pages).** The Management Plan will provide a clear description of how the cooperative agreement will be managed, including the approach to addressing potential problems. The plan shall outline, where applicable, which organization/sub-awardee will carry out the various tasks specified in the technical approach. The prime partner will be responsible for all technical activities regardless of the activities implemented by the sub-partner or other member of the team. The application team (including home office support and other sub-partners) needs to describe the role of each staff member named under key personnel, technical experience and expertise, and estimated amount of time he or she will devote to the program. Given the funding limit of the award and the broad scope, applicants may want to propose innovative ways to reduce managerial costs of sub-partners such as sharing office space, vehicles, etc. It is expected that sub-partners will not set up separate offices and separate managerial units, but instead offer specialized technical support under the prime partner.

The application shall discuss proposed technical, managerial and other personnel as deemed appropriate to implement the tasks described above, inclusive of a coordination plan for other partners working in the district or sub-district. Such staff should have played important technical and country-level support roles in the past and current health and HIV and AIDS programs. The staffing plan shall elaborate what and how long-term and short-term technical and management assistance will be provided to the program to accomplish tasks and objectives.

The application shall provide summary role descriptions, responsibilities and qualifications of all key personnel relevant to successful implementation of the proposed technical approach. The application may include CVs of key personnel as addendums to the proposal package.

In proposing the overall staffing plan, the applicant should ensure that experience in implementing similar programs of focus and scale in the country is represented. In particular, the application should consider:

g) Program Director: The applicant is required to appoint a Program Director. The Program Director should have demonstrated capabilities in management, institutional capacity building, high-level strategic visioning and leadership, and experience in working effectively with district, provincial and national government authorities. Prior experience in senior level management of similar programs is required. Demonstrated experience is required in coordination and collaboration with broad set of stakeholders, including multi-lateral and international donors and local and international Non-Governmental Organizations (NGO). The Program Director must have background and experience in more than one technical area of the program and experience or familiarity in management in an integrated, comprehensive, clinic-based program environment. Written and oral communications skills in English must be demonstrated.
h) Other Personnel: Applicant has the discretion to determine the proper number and mix of additional key personnel, short-term technical staff, and others to meet award requirements.
i) Consultants: Applicant may propose a mix of international and local advisors and specialists to cover the full range of objectives and activities. The management plan shall also demonstrate how the applicant will use in-country experts and resources. All personnel must demonstrate written and oral communications skills in English. Familiarity and demonstrated experience with the political, social, economic and cultural context of the country is required.

The application should support the organization's effectiveness and provide partnership arrangements. The applicant should propose how they will coordinate with the host country military as well as with other district partners and/or PEPFAR partners working across program areas. If the applicant intends to develop institutional partnerships/teaming arrangements for implementation of the cooperative agreement (sub-recipients or alliances), the application must specify the nature of organizational linkages. This includes their relationships between each other, lines of authority and accountability, and patterns for utilizing and sharing resources. Applicants that intend to utilize sub-awards should indicate the extent intended, the method of identifying sub-awardees, and the tasks/functions they will be performing. Applicants that plan to team up with other organizations, or government agencies for the implementation of the agreement should outline the services to be provided by each agency or organization and should discuss how the

collaboration with these partners fits into the Applicant's proposed management plan. Applicant should state whether or not they have any existing relationships with the proposed partners and, if so, should include the Memoranda of Understanding (MOUs) in the Attachment/Annex. It is not expected at this time that offerors should include host country military letters of support or MOUs as these will be negotiated after award once district and sub-district allocation are finalized.

**The Organization's Qualifications (Not to exceed five pages)** - In this section, the applicant should describe its organizational knowledge, capability and experience in managing similar programs. Include the organization's history, mission and structure of organization. This includes activities in institutional capacity building, HIV and AIDS policy development and implementation, delivery of integrated, comprehensive district-based HIV-related services for care and treatment and collaborations with donors, host country governments, and NGOs to strengthen health and HIV and AIDS systems. Offeror shall also describe its organizational capability in collaborating with the host country military, donors, and NGOs to strengthen health and HIV/AIDS systems, and to improve the quality and use of data for decision making and advance organizational capacity building. The Applicant should also describe the organizational knowledge, capability, and experience of the other proposed team members (sub-contractors and/or grantees) in successfully managing similar programs.

**Current and Pending Support (Not to exceed five pages)** – The applicant must provide information on all current and pending projects, including subsequent funding in the case of continuing contracts, grants and other assistance agreements and proposals that involve the proposed Technical Program Manager. All current project support from whatever source (e.g., Federal, State, local or foreign government agencies, public or private foundations, industrial or other commercial organizations) must be listed.

The information must also be provided for all pending proposals already submitted concurrently to other possible sponsors, including DHA. Concurrent submission of a proposal to other organizations will not prejudice its review by DHA. Provide a chart relaying the following information for all current and pending support:

- Title of award or project title;
- Source and amount of funding (annual direct costs; provide award numbers for all current awards);
- Percentage effort devoted to each project;
- Technical contact (name, address, phone, e-mail);
- Administrative/Business contact (name, address, phone, e-mail);
- Period of performance;
- The proposed project and all other projects or activities requiring a portion of time of the proposed Technical Program Manager and other proposed senior personnel must be included, even if they receive no salary support from the project(s); The total award amount for the entire award period covered (including indirect costs) must be shown as well as the number of person-months or labor hours per year to be devoted to the project, regardless of the source of support;
- Commitment proposed for the Technical Program Manager in terms of person-months per year for each year.

All submissions will be protected from unauthorized disclosure in accordance with applicable law and DoW regulations. You are expected to appropriately mark each page of the submission that contains proprietary information.

**Statement of Work (SOW) File:** Proposals must include a supplementary document for Statement of Work. In the Excel workbook provided by the program office, provide a summary of the planned activities for each program area or intervention requirement indicated in the Program Announcement for each year. A sample Statement of Work template for Year 1 and Years 2-4 is available on Grants.gov with this Program Announcement.

**The following SF 424 forms and attachments, as applicable are required for all applications:**

**SF-424 Research and Related, Application for Federal Assistance** - (included in the application package available on grants.gov posted with this Program Announcement). This form must be sent as the cover page for all proposals. Complete all required fields in accordance with the "pop-up" instructions on the form and the following instructions for specific fields. Please complete the SF-424 first, as some fields on the SF-424 are used to auto-populate fields on other forms.

**SF-424 Research and Related Budget -** included in the application package available on grants.gov posted with this Program Announcement. **Please ensure there is a submission for each budget year**.

**Budget Narrative Attachment Form –** Attach the Budget justification the SF424 R&R as required under Section L of the SF424 (R&R) form.

**SF-424B, Assurances -** Nonconstruction Programs - (included in the application package available on grants.gov posted with this Program Announcement).
The program described in Section I above includes non-construction elements. Therefore, the mandatory forms for non-construction programs must be completed. Non-construction activity costs should be included on the SF-424A.

**Project Abstract Form –** The project abstract must identify the problem and objectives, technical approaches, anticipated outcome of the effort, if successful, and impact on the DoW capabilities. Use only characters available on a standard QWERTY keyboard. Spell out all Greek letters, other non-English letters, and symbols. Graphics are not allowed and there is a 4,000-character limit including spaces.

Do not include proprietary or confidential information. The project abstract must be marked by the applicant as "Approved for Public Release". Abstracts of all funded projects will be posted on the public DTIC website: **https://discover.dtic.mil/grant/**

***Any modifications to the Project Narrative or Budget Form require submission of a changed/ corrected Grants.gov application package to Grants.gov prior to the application submission deadline.***

**Submission Dates and Times:** Applications must be received by 5:00 p.m. Eastern Time (ET), on the date specified in the country specific narrative in Attachment 1.

Applicants are responsible for submitting their applications in sufficient time to allow them to reach Grants.gov by the time specified in this announcement. If the application is received by Grants.gov after the exact time and date specified as the deadline for receipt, it will be considered "late" and will not be considered for review. Acceptable evidence to establish the time of receipt by Grants.gov includes documentary evidence of receipt maintained by Grants.gov.

To avoid the possibility of late receipt, which will render the application ineligible for consideration, **it is strongly recommended that applications be uploaded at least 24-48 hours days before the deadline.** This will help avoid problems caused by high system usage or any potential technical and/or input problems involving the applicant's own equipment.

***DHAPP cannot make allowances/exceptions to its policies for submission problems encountered by the applicant organization using system-to-system interfaces with Grants.gov.*** If an emergency or unanticipated event interrupts normal federal government processes so that applications cannot be received by Grants.gov by the exact time specified in this announcement, and the situation precludes amendment of the announcement closing date, the time specified for receipt of applications will be deemed to be extended to the same time of day specified in this announcement on the first work day on which normal federal government processes resume.

**Application Receipt Notices**: After an application is submitted to Grants.gov, the Authorized Representative (listed in Block #19 of the SF-424) will receive a series of three e-mails from Grants.gov. The first e-mail will confirm receipt of the application by the Grants.gov system. The second e-mail will indicate that the application has either been successfully validated by the system prior to transmission to DoW or has been rejected due to errors. This second email will also determine if the proposal is late based on the aforementioned receipt time. The third e-mail should be received once DoW has confirmed receipt of the application usually within 10 days from the application due date. The last e-mail will indicate that the application has been received and provide the assigned tracking number. Applicants can track the status of their applications at https://grants.gov/applicants/grant-applications/track-my-application.

**Funding Restrictions:**

Information regarding funding restrictions can be found in the country specific narrative in Attachment 1.

**Other Submission Information:**

**Applicant Support*:*** Grants.gov provides applicants 24/7 support via the toll-free number 1-800- 518-4726 and email at support@grants.gov. For questions related to the specific grant opportunity, contact the number listed in the application package of the grant you are applying for.

If you are experiencing difficulties with your submission, it is best to call the Grants.gov Support Center and get a ticket number. The Support Center ticket number will assist the DoW with tracking your issue and understanding background information on the issue.

**Timely Receipt Requirements and Proof of Timely Submission:**

The AOR who submitted the application will receive an acknowledgement of receipt and a tracking number (GRANTXXXXXXXX) from Grants.gov with the successful transmission of their application. This AOR will also receive the official date/time stamp and Grants.gov tracking number in an email serving as proof of their timely submission.

When DoW successfully retrieves the application from Grants.gov, and acknowledges the download of submissions, Grants.gov will provide an electronic acknowledgment of receipt of the application to the email address of the AOR who submitted the application. Again, proof of timely submission shall be the official date and time that Grants.gov receives your application.

Applicants using slow internet, such as dial-up connections, should be aware that transmission can take some time before Grants.gov receives your application. Again, Grants.gov will provide either an error or a successfully received transmission in the form of an email sent the AOR attempting to submit the application. The Grants.gov Support Center reports that some applicants end the transmission because they think that nothing is occurring during the transmission process. Please be patient and give the system time to process the application.

**Application Withdrawal:** An applicant may withdraw an application at any time before award by written notice or by email. Notice of withdrawal shall be sent to the Grants Officer identified in this announcement. Withdrawals are effective upon receipt of notice by the Grants Officer.

## E. Application Review Information

**Review Criteria:**

Proposals will be selected through a technical and business decision-making process with technical considerations being most important. The following scored criteria are listed in descending order of importance.

a. Technical Approach
   - Goals and Objectives. The proposal clearly states the overall goal(s) of the program and has specific, measurable objectives. The proposal is relevant to established DHAPP priority activities
   - Work Plan: The proposal contains sound scientific methods, an appropriate work plan described in sufficient detail and appropriate deliverables.
   - Methodology for monitoring and evaluation procedures. The proposed plan includes a description of how the program will have an impact on the country's military and clearly states the indicators of performance that will be used to

monitor effectiveness.

- Schedule and milestones. The proposed plan for HIV prevention efforts is feasible and contains concrete, achievable schedule and milestones.
- Relevance to the host country's military. The proposal clearly describes the involvement of the host country military and the relevance of the proposed program to the needs, priorities, and circumstances of the host country's military.

b. Qualifications
   - Key Personnel are qualified and eligible to perform the work.

In addition, the following **unscored** criteria will also contribute to the overall evaluation of the application:

Whether the applicant qualifies as a local partner. To be considered a local partner, the applicant must submit supporting documentation demonstrating their organization meets at least one of the criteria listed below at the time of application. In the below definition, a region is defined as one of the 2020 State Department / ForeignAssistance.gov Sub Regional groupings

A. Individual: an individual must be a citizen or lawfully admitted permanent resident of, and have his/her principal place of business in the country served by the PEPFAR program with which the individual is or may become involved, and a sole proprietorship must be owned by such an individual; or
B. An entity (e.g., a corporation or partnership): Entity of a sole proprietorship (such as, a corporation or not-for-profit) must meet all three areas of eligibility:
   - Must be incorporated or legally organized under the laws of, and have its principal place of business in, the country served by the PEPFAR program with which the entity is or may become involved; or
     Must exist in the region where the entity's funded PEPFAR programs are implemented.
   - Must be at 75% beneficially owned by individuals who are citizens or lawfully admitted permanent residents of that same country; or
     At least 75% of the entity's staff (senior, mid-level, support) must be citizens or lawfully admitted permanent residents of that same country
   - Where an entity has a Board of Directors, at least 51% of the members of the Board must also be citizens or lawfully admitted permanent residents of such country.

**Review and Selection Process:** Proposals will not be evaluated against each other but will be scored based on the criteria listed above. DHAPP's intent is to review proposals as soon as possible after they arrive; however, proposals may be reviewed periodically for administrative reasons.

The ultimate recommendation for award of proposals is made by DHAPP or other technical experts. Recommended proposals will then be forwarded to the Defense Health Agency Contracting Authority (DHACA). Any notification received from DHACA indicating the Applicant's proposal has been recommended does not ultimately guarantee an award will be made. This notice indicates that the proposal has been selected in accordance with the evaluation criteria stated above and has been sent to the DHACA Grants Division to conduct cost analysis, determine the Applicant's responsibility, to confirm whether funds are available, and to take other relevant steps necessary prior to making the award.

**Anticipated Announcement and Federal Award Dates**: Decisions are expected to be announced by acceptance/declination letters via email. All awards are expected to be in place as specified in the country specific narrative in Attachment 1.

**Recipient Qualification:** The Office of Management and Budget (OMB) has issued final guidance implementing section 872 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 as it applies to grants. As required by section 872, OMB and the General Services Administration have established the Federal Awardee Performance and Integrity Information System (FAPIIS) as a repository for government-wide data related to the integrity and performance of entities awarded federal grants, cooperative agreements, and contracts. This final guidance implements reporting requirements for recipients and awarding agencies; requires awarding agencies to consider information in FAPIIS before awarding a grant or cooperative agreement to a non-federal entity; and addresses how FAPIIS and other information may be used in assessing recipient integrity.

a. Federal awarding agencies must report information to FAPIIS about any termination of an award due to a material failure to comply with the award terms and conditions; any administrative agreement with a non-federal entity to resolve a suspension or debarment proceeding; and any finding that a non-federal entity is not qualified to receive a given award, if the finding is based on criteria related to the entity's integrity or prior performance under federal awards.

b. Federal awarding agencies, prior to making award to a non-federal entity, must review information in FAPIIS to determine that entity's eligibility to receive the award.

c. Recipients of federal contracts, grants, and cooperative agreement awards with a cumulative total value exceeding $10,000,000 are required to provide information to FAPIIS on certain civil, criminal, and administrative proceedings that reached final disposition within the most recent five year period and that were connected with the award or performance of a federal award; and to disclose semiannually the information about the criminal, civil, and administrative proceedings described in section 872(c).

d. Notice of funding opportunities and federal award terms and conditions to inform a non-federal entity that it may submit comments to FAPIIS (https://www.sam.gov/fapiis) about any information the federal awarding agency had reported to the system about the non-federal entity,

for consideration by the awarding agency in making future awards to the non-federal entity.

## F. Federal Award Administration Information

**Federal Award Notices:** Notification of selection of all applications will be e-mailed by the DHACA Grants Officer.

The notification e-mail regarding a successful application must not be regarded as authorization to commit or expend DoW funds. An award signed by the DHACA Grants Officer is the authorizing document. Applicants whose applications are recommended for negotiation of award will be contacted by a DHACA Grant Specialist to discuss any additional information required for award. This may include representations and certifications, revised budgets or budget explanations, or other information as applicable to the proposed award. The award start date will be determined at this time.

**Administrative and National Policy Requirements:** Each cooperative agreement awarded under this announcement will be governed by the general terms and conditions in effect at the time of the award that conform to DoW's implementation of OMB guidance applicable to financial assistance in 2 CFR part 200, "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards."

Awards made under this announcement are subject to the Department of Defense Directive 6485.02E which can be found here: https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodd/648502E.pdf?ver=2018-06-01-130040-790

### A. Certification

Certification of compliance with the national policy requirement regarding lobbying activities is required from all recipients of awards over $100,000. Submission of this certification is required by 31 USC 1352 and is a prerequisite for making or entering into an award over $100,000.

Complete SFLLL (Disclosure of Lobbying Activities), if applicable, and attach to Block 18 of the SF424 (Application for Federal Assistance) Form.

**Certification for Contracts, Grants, Loans, and Cooperative Agreements**

By signing an application, the applicant certifies, to the best of his or her knowledge and belief, that:

(1) No Federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the

awarding of any Federal contract, the making of any Federal grant, and the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid, or will be paid, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit SFLLL (Disclosure of Lobbying Activities), in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 1352 USC 31. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

## B. Representations

All extramural applicants are required to complete the representations below and submit with each application. The form for completion and submission is posted in eBRAP (https://ebrap.org/eBRAP/public/Program.htm). **Upload the form into Grants.gov under Attachments.**

**Representations Regarding Unpaid Federal Tax Liabilities and Conviction of Felony Criminal Violations Under Any Federal Law**

At the time of application submission, the applicant organization represents that it:

(1) Is_____Is not_____a Corporation ("Corporation" means any entity, including any institution of higher education, other non-profit organization, or for-profit entity that has filed articles of incorporation). If the organization is a corporation, complete (2) and (3) below.

(2) Is_____Is not_____a Corporation that has any unpaid Federal tax liability that has been assessed, for which all judicial and administrative remedies have been exhausted or have lapsed, and that is not being paid in a timely manner pursuant to an agreement with the authority responsible for collecting the tax liability.

(3) Is____Is not_____a Corporation that was convicted of a criminal violation under

any
Federal law within the preceding 24 months.

NOTE: If the applicant organization responds in the affirmative to either (2) or (3) of the above representations, the applicant is ineligible to receive an award unless the agency suspension and debarment official has considered suspension or debarment and determined that further action is not required to protect the Government's interests. The applicant organization therefore will be required to provide information about its tax liability and/or conviction, upon request, to the Grants Officer, to facilitate completion of the required consideration before award decisions are made.

In accordance with DoW appropriations, the following representation is required. The applicant, by its signature on the SF424, represents:

**Representation Regarding the Prohibition on Using Funds Under Grants and Cooperative Agreements with Entities That Require Certain Internal Confidentiality Agreements.**

By submission of its application, the applicant represents that it does not require any of its employees, contractors, or subrecipients seeking to report fraud, waste, or abuse to sign or comply with internal confidentiality agreements or statements prohibiting or otherwise restricting those employees, contractors, or subrecipients from lawfully reporting that waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information. Note that (1) the basis for this representation is a prohibition in Section 743 of the Financial Services and General Government Appropriations Act, 2015 (Division E of the Consolidated and Further Continuing Appropriations Act, 2015, Public Law 113-235) and any successor provision of law on making funds available through grants and cooperative agreements to entities with certain internal confidentiality agreements or statements; and (2) Section 743 states that it does not contravene requirements applicable to Standard Form 312, Form 4414, or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

### C. National Policy Requirements

The recipient must comply with the following requirements, as applicable. The full text of National Policy Requirements is available at https://www.dha.mil/Working-with-DHA. Awards will incorporate the most recent set of National Policy Requirements available at the time of award.

**Reporting:**

1) FINANCIAL REPORTING
(a) Interim Federal Financial Report (SF 425) shall be submitted within 30 days following the end of each calendar quarter and must include in the remarks the location of financial records and a point of contact for the Government to obtain access to the financial records associated with this

award. The following reporting period end dates shall be used for interim reports: 3/31, 6/30, 9/30, and 12/31.
(b) Final Federal Financial Report (SF 425) is required within 120 calendar days of the completion date for the term of this award and must include in the remarks the location of financial records and a point of contact for the Government to obtain access to the financial records associated with this award.
(c) Annual report of Implementing Partners Budget and Projected Expenditures will be required for awards funded with PEPFAR funding and will follow PEPFAR guidance for submission.
(d) Annual Expenditure Reporting will be required for awards funded with PEPFAR funding and will follow PEPFAR guidance for submission.

Financial Reporting Format Instruction:

• **Attach the Quarterly Financial Report Spreadsheet with the SF 425.** Submit in excel format along with SF425 in order to monitor expenditures according to the PEPFAR program area(s). The report template will be provided by the Government Program Office/DHA. Submit 30 calendar days after each reporting period (3/31, 6/30, 9/30, and 12/31). The Recipient shall provide the Quarterly Financial Reporting Spreadsheet in accordance with the template provided by DHA.

2) INTERIM PROGRESS: INDICATOR REPORT
This report shall summarize progress in relation to the approved Work Plan as well as monitor grant deliverables. The Grantee shall submit quarterly indicator reports in accordance with the format provided by the Program Office within 45 calendar days following the end of the reporting period: 3/31, 6/30, 9/30 and 12/31. The Recipient shall provide reports in accordance with the guidance and template provided by DHA.

**DHAPP Strategic Information Reporting Requirements:** The grantee is expected to promptly prepare and submit data results that accurately reflect the contributions of those involved, and all significant findings from work conducted under DHAPP awards. Data reporting deadlines and requirements are clearly communicated by DHAPP to all grantees on a routine basis.
DHAPP award recipients are required to:

• If applicable, submit routine program indicator targets and results (e.g. Monitoring, Evaluation and Reporting (MER) Indicators) that reflect expected and achieved results through activities supported by DHAPP awards. Military program indicator data at the Implementing Mechanism level (not at a military site-level) are to be submitted on a quarterly, semi-annual and annual basis into the OGAC hosted system Data for Accountability Transparency and Impact Monitoring (DATIM), within the deadlines established by OGAC. **Instructions will be provided after award.** Military program indicator data at the site-level must also be submitted to DHAPP, using the required DHAPP templates, within the deadlines established by DHAPP. DHAPP will provide all orientation and training related to the reporting of site-level data.

• Implementing Partners are responsible for ensuring the quality of data from the point of data collection through report submission, and should make every attempt to either fix or document and communicate to DHAPP data quality issues.

• Implementing Partners are responsible for following the standards defined in the Site Improvement through Monitoring System (SIMS) and are required to participate in program quality assurance and improvement activities, per guidance provided by OGAC and DHAPP.

3) FINAL TECHNICAL REPORT
Within 120 calendar days of completion or termination of this Agreement, the Recipient shall submit a Final Report addressing the technical achievements of the program. The report should provide a synopsis of the accomplishments made under the Agreement. No proprietary or classified information shall be included in the final report as it is subject to public release.

4) PROPERTY REPORT
Recipients shall submit annually an inventory listing of federally-owned property in their custody. Upon completion of the award, Title to all property and equipment acquired under this grant shall revert to the host nation at the end of the performance period.

You are responsible for adhering to any additional PEPFAR reporting requirements implemented during the life of this award. These requirements can be found at:
**https://datim.zendesk.com/hc/en-us/categories/200342209-PEPFAR-Guidance**

***The Award terms and Conditions will specify if more frequent or other special reporting is required. Should OGAC require additional or different reporting requirements during the award period of performance, awards will be modified to include these requirements.***

Awards resulting from this Program Announcement will incorporate additional reporting requirements related to recipient integrity and performance matters. Recipient organizations that have Federal contract, grant, and cooperative agreement awards with a cumulative total value greater than $10,000,000 are required to provide information to FAPIIS about certain civil, criminal, and administrative proceedings that reached final disposition within the most recent 5-year period and that were connected with performance of a Federal award. Recipients are required to disclose, semiannually, information about criminal, civil, and administrative proceedings as specified in the applicable Representations

## G. Federal Awarding Agency Contacts

Questions regarding program policy, program content, or technical issues should be directed prior to the date indicated in the country specific narrative in Attachment 1 to:

DHAPP Program Manager
Dr. Braden Hale
DHAPP Division Chief
Braden.r.hale.civ@health.mil

Questions regarding administrative issues or grant administration should be directed to:

DHACA Grants Officer
Ebony Simmons

Grants Officer
ebony.s.simmons.civ@health.mil

## H. Other Information

Applications must not include any information that has been identified as classified national security information under authorities established in Executive Order 12958, Classified National Security Information.

Applicants are advised that employees of commercial firms under contract to the government may be used to administratively process applications. By submitting an application, an applicant consents to allowing access to its application(s) by support contractors. These support contracts include nondisclosure agreements prohibiting their contractor employees from disclosing any information submitted by applicants.

**Freedom of Information Act Requests:** The FOIA (5 USC 552) provides a statutory basis for public access to official Government records. The definition of "records" includes documentation received by the Government in connection with the transaction of public business. Records must be made available to any person requesting them unless the records fall under one of nine exceptions to the Act (www.usdoj.gov/oip/index.html).

When a FOIA request asks for information contained in a successful application that has been incorporated into an award document, the submitter will be contacted and given an opportunity to object to the release of all or part of the information that was incorporated. A valid legal basis must accompany each objection to release. Each objection will be evaluated by DoW in making its final determination concerning which information is or is not releasable. If information requested is releasable, the submitter will be given notice of DoW's intent to release and will be provided a reasonable opportunity to assert available action.

**J-1 Visa Waiver:** Each organization, including organizations located outside of the United States, is responsible for ensuring that the personnel associated with any application recommended for funding are able to complete the work without intercession by the DoW for a J-1 Visa Waiver on behalf of a foreign national in the United States under a J-1 Visa.

***Note: The Federal Government will not provide funds to support scientists from countries meeting the criteria for designation as a State Sponsor of Terrorism (https://www.state.gov/j/ct/list/c14151.htm).*** Additional information on J-1 Visa Waivers can be located at the following Department of State website: https://travel.state.gov/content/travel/en/us-visas.html.

Rejection Criteria

- Missing Budget.
- Missing Narrative.
- Missing Data Management Plan.

- Proposals not submitted in English.
- Project Abstract exceeds 4000 characters.

Please note: Noncompliance of “Not to exceed” page limits will result in the excess pages being deleted prior to application review by the Program Office.

## Attachment 1. Country Specific Narratives

Applications may be submitted in accordance with country specific narratives. These narratives can be found as standalone documents in the Country Specific Narratives folder on Grants.gov within this announcement (W81XWH-22-DHAPP). Please note that submission deadlines vary across each narrative.

Angola
Burundi
Ethiopia
Ghana
Mozambique
Multi-Country: Burkina Faso, Central African Republic, Guinea Conakry, Mali and Madagascar
Multi-Country: SABERS
Senegal
Togo
Uganda

**Angola: DHAPP – FAA Partnership for Resilient Military Health Systems for Readiness**

**NOTE: Application submissions for this narrative are due by 12pm EST on 15 May 2026. Submissions received after the deadline will not be considered for funding.**

## Call for Proposals

Proposals are requested to support the Angolan Armed Forces (FAA) to reach sustainable control of the HIV epidemic through the lens of the America First Global Health Strategy, as well as the UNAIDS HIV Treatment 95-95-95; Vertical Transmission 95 targets; and TB prevention 90 and in alignment with the National Security Strategy (NSS) and the National Defense Strategy (NDS) goals to protect the homeland, deter China, and increase burden sharing. Further, proposals must be aligned with any existing Memorandum of Understanding between the U.S. Department of State and Angola. Implementers should be familiar with these strategic guidance documents and include means of addressing them in submitted proposals. **Please see base Program Announcement section D for complete detailed list of application, format and submission requirements. Proposal Technical Narrative may not exceed 45 pages.**

## Introduction

The HIV/AIDS epidemic has devastated 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 other military personnel and their extended communities, and impeding participation in peacekeeping activities. As HIV management improves, many of these impacts are reduced; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries; this is in addition to managing other long-term chronic diseases to maintain high force health readiness in strategically identified recipient militaries. Moreover, given the well-known biobehavioral risk factors among uniformed personnel, reducing HIV acquisition and transmission in this population is an essential component for reaching epidemic control in the recipient country.

The U.S. Government has a long history of providing foreign assistance to combat HIV/AIDS, advancing U.S. national security by promoting stability in key regions. Over the years, the United States DoD HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries to control the HIV epidemic among their respective military services. Working closely with the Department of Defense (DoD, herein referred to using the secondary title Department of War, DoW), U.S. Geographic Combatant Commanders, the Bureau of Global Health Security and Diplomacy (GHSD) and other organizations, DHAPP's mission is to build the capacity of recipient militaries through military-specific HIV/AIDS assistance, creating self-reliant security counterparts. DHAPP is the DoW implementing agency collaborating with the US Department of State, 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 Department of War (Title 10) Defense Health Program (DHP) and funding transfers from the Department of State (Title 22) for PEPFAR.

All proposals must be in full alignment with any existing Memorandum of Understanding (MOU) between the Department of State (DoS) and Angola clearly articulating transition plans for each activity

over the course of the agreement with specific and measurable milestones. Reserving the last year of the agreement for transition planning will not be accepted. Activities to transition responsibilities to the recipient country must begin immediately upon award and continue throughout the life of the agreement to ensure a rapid path to self-sufficiency. The implementer must prepare the recipient country's military to fully own and operate all services, ensuring a complete and final transition of responsibility away from U.S. assistance.

The DoW Combatant Commands (CCMDs) have identified the longstanding DHAPP program with recipient countries as an essential security cooperation tool that serves U.S. interests. Pursuing HIV/AIDS activities with foreign militaries is an important part of maintaining security interests, regional stability through health readiness, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing nations. 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 CCMDs and DHAPP Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under-Secretary of War for Policy and by the Department of State Bureau of Global Health Security and Diplomacy (GHSD). DHAPP provides technical support to defense forces in HIV prevention, care, treatment, and information systems and data use 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. An additional goal supported by GHSD is 95% coverage of services for eliminating vertical transmission. Lastly, the UNAIDS Global AIDS Strategy established a goal that 90% of PLHIV receive preventive treatment for TB.

All proposals must align with the America First Global Health Strategy, which focuses on the following points:

- Address Inefficiency and Dependency: The majority of funding should go directly towards patient care and building resilient health systems. High program management costs will not be funded.
- Pillar 1: Make America Safer: The primary goal is to protect Americans by enhancing global surveillance systems to detect outbreaks within seven days of emergence, notify public health authorities within 1 day and rapidly responding at the source within 7 days with early response actions to prevent pandemics from reaching U.S. shores.
- Pillar 2: Make America Stronger: Foreign health assistance will be used as a strategic tool to strengthen bilateral relationships. The U.S. will enter into multi-year agreements with recipient countries that require co-investment and establish clear benchmarks, ...moving them toward self-sufficiency and away from reliance on U.S. foreign assistance. Proposals must align with any existing country-specific MOU timelines.
- Pillar 3: Make America More Prosperous: The strategy aims to bolster the U.S. economy by preventing costly pandemics and by using foreign assistance programs to promote American companies and health innovations (like diagnostics and pharmaceuticals) in emerging global markets.
- Restructure Aid Delivery: The plan calls for more frontline support, such as medical commodities

and healthcare workers, while significantly reducing all other non-frontline expenditures to ensure accountability to the American taxpayer. It will also streamline efforts by integrating disease-specific programs (HIV, Malaria, TB) and leveraging the private sector and faith-based organizations for more efficient service delivery. The implementer is expected to work with the DHAPP Program Manager (PM) on supporting the integration of disease-specific programs receiving USG funding for the military program.

**Local Implementers**

Local, non-governmental implementers with low overhead costs are encouraged to apply to this announcement. To achieve self-reliance, it is critical that the full range of HIV services are owned and operated by the recipient country's institutions, governments, and community-based and community-led organizations, regardless of current antiretroviral (ARV) coverage levels. The intent of transitioning to local implementers 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 implementers to ensure successful, long-term, community 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.

**Additional Submission Guidance:**

1. Review all documents within the package to ensure consistency in information, budgets, targets, and numbering:
    a. Use numbered lists, including numbered or alphabetized sub-lists, for activities for easier reference and monitoring, especially the SOW Narrative column.
2. Ensure all activities in the Technical Narrative are also listed concisely in the SOW file.
3. Activities must be specific; Do not write “ensure” or “support” or a similar verb as a narrative activity without defining what that means. Each activity must say specifically what the implementer will be doing. It must be measurable and answer the questions Who? What? Where? How? How many? How often?
4. Delineate between a training (i.e.: one time class or series of classes where attendees are gathered in a conference room, away from regular duties) and onsite strategic assistance (on the job guidance while recipient is performing regular duties) and specify as many of the following details as possible for both: how many attendees or sites, how often, how many days, where, specific topics/skills covered, expected outcomes & how they align with program goals, etc. Training should be limited and cost efficient.
5. Please note this project budget cannot include:
    a. Any budget allocations toward World AIDS Day (WAD) events/campaigns.
    b. Prizes, hats, or T-shirts.
    c. Flyers and printed education materials to be given to beneficiaries.
    d. Rental of venues for training or events (must use available military or ministry facilities).
    e. Employment or payments made directly to active-duty foreign military.

**Budget**

The **estimate** budget for this program announcement is as follows. Final authorized budget will be confirmed and communicated at time of official award execution. The link below contains the Financial Classifications Reference Guide and a summary of the classification definitions:
https://help.datim.org
Financial classifications are not regulations governing allowability of federal awards. Nothing in this guidance should be interpreted to mean that costs or activities that are unallowable or excluded under the terms of an award are permitted by virtue of being described herein. All awards are subject to the applicable cost principles and terms set forth and conveyed in the award made.

**Estimated Budget to be used as a Framework**

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.1: Surveillance and Outbreak Response | GHS | 2.1: Outbreak Response Capacities | 50,000 | 50,000 | 50,000 | 50,000 | 200,000 |
| | GHS | 2.1: Outbreak Readiness | 50,000 | 50,000 | 50,000 | 50,000 | 200,000 |
| | | | | | | | - |
| **Subtotal** | | | **100,000** | **100,000** | **100,000** | **100,000** | **400,000** |
| 2.2: Laboratory Systems | HIV | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 42,492 | 38,243 | 34,419 | 30,977 | 146,131 |
| | HIV | 2.2: Lab Consumables Procurement | 2,000 | 1,800 | 1,620 | 1,458 | 6,878 |
| | HIV | 2.2: Frontline Lab Workers | 50,435 | 45,392 | 40,852 | 36,767 | 173,446 |
| | HIV | 2.2: Lab Service and Maintenance Costs | 24,000 | 24,000 | 24,000 | 24,000 | 96,000 |
| **Subtotal** | | | **118,927** | **109,435** | **100,891** | **93,202** | **422,455** |
| 2.3: Commodities | HIV | 2.3: Diagnostic Commodity Procurement | 5,975 | 5,378 | 4,840 | 4,356 | 20,548 |
| | HIV | 2.3: Therapeutic Commodity Procurement | 82,333 | 74,100 | 66,690 | 60,021 | 283,144 |
| | HIV | 2.3: Prevention Commodity Procurement | 8,291 | 7,462 | 6,716 | 6,044 | 28,513 |
| | Malaria | 2.3: Therapeutic Commodity Procurement | 39,600 | 35,640 | 32,076 | 28,868 | 136,184 |
| | Malaria | 2.3: In-Country Warehousing and Distribution | 58,236 | 52,412 | 47,171 | 42,454 | 200,274 |
| | Malaria | 2.3: Diagnostic Commodity Procurement | 13,200 | 11,880 | 10,692 | 9,623 | 45,395 |
| | | | | | | | - |
| **Subtotal** | | | **207,635** | **186,872** | **168,185** | **151,366** | **714,058** |
| 2.4: Frontline Health Workers | HIV | 2.4: Doctors/Clinical Officers | 261,612 | 235,451 | 211,906 | 190,715 | 899,684 |
| | HIV | 2.4: Other Health Workers | 97,910 | 88,119 | 79,307 | 71,376 | 336,712 |
| | Malaria | 2.4: Doctors/Clinical Officers | 130,806 | 117,725 | 105,953 | 95,358 | 449841.834 |
| | Malaria | 2.4: Other Health Workers | 97,910 | 88,119 | 79,307 | 71,376 | 336,712 |
| | GHS | 2.4: Epidemiologists & Surveillance Officers | 179,761 | 179,761 | 179,761 | 179,761 | 719,044 |
| | | | | | | | - |
| **Subtotal** | | | **767,999** | **709,175** | **656,234** | **608,587** | **2,741,994** |
| 2.5: Data Systems | HIV | 2.5: Data Systems Developer Staff | 186,299 | 167,669 | 150,902 | 135,812 | 640,682 |
| | | | | | | | - |
| **Subtotal** | | | **186,299** | **167,669** | **150,902** | **135,812** | **640,682** |
| 2.6: Strategic Assistance | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 250,000 | 225,000 | 202,500 | 182,250 | 859,750 |
| | HIV | 2.6: IP Program Management | 247,500 | 247,500 | 247,500 | 247,500 | 247,500 |
| | Malaria | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 200,000 | 180,000 | 162,000 | 145,800 | 687,800 |
| | Malaria | 2.6: IP Program Management | 198,000 | 198,000 | 198,000 | 198,000 | 792000 |
| | GHS | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 100,000 | 100,000 | 100,000 | 100,000 | 400,000 |
| | GHS | 2.6: IP Program Management | 99,000 | 99,000 | 99,000 | 99,000 | 396,000 |
| **Subtotal** | | | **1,094,500** | **1,049,500** | **1,009,000** | **972,550** | **3,383,050** |
| **Total** | *Budget Estimate to be used as a framework. Final authorized budget will be confirmed and communicated at time of official award. Phase 2-4 option budget Estimates are notional and dependent on availability of US Government available funding. | | **2,475,361** | **2,322,651** | **2,185,212** | **2,061,517** | **8,302,239** |

**Approaches to Reaching Sustainable Epidemic Control & Transitioning Ownership**

Proposals are requested to support the Angolan Armed Forces to reach sustainable control of the HIV epidemic and focus on the America First Global Health Strategy, the latest PEPFAR guidance and UNAIDS HIV Treatment 95-95-95, Vertical Transmission 95 targets, and TB prevention 90 targets, and in alignment with the NSS, NDS, and the MOU between the U.S. DoS and Angola.

In 2025 DHAPP supported the recipient military in conducting a Military Sustainability Index (MilSID). Findings indicate the military health system has made significant progress towards sustainability over the past decade; however, support needs to be strengthened in the areas of planning and coordination, service delivery, quality management, laboratory, resource mobilization, and epidemiological and heath data. The implementer will be responsible for supporting the recipient military in conducting a MilSID each year of the award, ensuring all stakeholders are present (please include as an SOW activity).

In 2025 DHAPP conducted a review of the program against international standards. Findings indicate the military health system must receive greater support in the following areas:

- Offer safe and ethical index testing to all eligible people
- Fully implement "Test and Start" policies
- Offer differentiated service delivery models
- Optimize diagnostic networks for VL, TB, and other co-infections

The implementer will develop and implement a comprehensive transition plan that is in alignment with any existing country MOU, with clearly defined every 6-month milestones demonstrating progressive military assumption of programmatic responsibilities across all technical areas, data collection and reporting areas, and program management. This transition framework prioritizes efficiency, direct patient care investment, and development of resilient health systems capable of independent operation beyond the period of U.S. support. All proposals should detail how the implementer will engage the recipient military leadership as well as personnel at all levels in this work; and, specifically, how the implementer will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Please specify which SOW activities the implementer is supporting the military to take ownership of (showing increasing military ownership) and by when (with detailed milestones). Throughout this progression, the implementer must document evidence of increasing military ownership through specific metrics including percentage of activities led by military staff, number of military personnel trained to competency, and documented military-led decision-making and problem-solving. Failure to attain defined milestones as agreed upon by the implementer, the partner military, and DHAPP may result in award termination.

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

**Technical Narrative & Scope of Work (SOW)**

In alignment with international health guidelines, America First Global Health Strategy, and guidance from PEPFAR/GHSD, coupled with DHAPP's vision to build the capacity of military health systems through military-specific and culturally appropriate services, the recipient will address the approach to each technical area. The implementer, through increasing, demonstrable, military burden-sharing and building self-reliance within the recipient military, will be responsible for providing the following in

close collaboration with other DHAPP-funded implementers.

**Technical Module Building Blocks**

The implementer will work closely with the Ministry of Defense and its medical leadership to make progress towards a resilient and self-reliant military HIV program that is aligned with the national MOU (if applicable), using evidence-based and efficient interventions to reach the three 95s. In alignment with the Transition Plan directive above, the implementer will include specific milestones for program transition for activities within each technical area.

**1. Post Exposure Prophylaxis (PEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PEP services to all HIV-negative individuals (including healthcare workers and non-healthcare workers) who have had a possible exposure to HIV within the last 72 hours.

The implementer will ensure that the following interventions for adults and adolescents include:

- PEP should be started as soon as possible after a potential exposure to HIV, ideally within 24 hours and no later than 72 hours.
- The person seeking PEP should be tested for HIV to confirm they are HIV-negative before starting PEP, although if testing is not available, PEP should be started immediately and can be stopped later once testing is available. Individuals who test positive for HIV should be started on treatment immediately.
- Three ARV drugs for a 28-day prescription are recommended for the HIV PEP regimen. Patients must be properly counseled to understand what PEP is, on adherence, and potential side effects.
- If PEP is not being consistently integrated and offered at military facilities (to the point that the surrounding population knows it is accessible if needed), the recipient will work with the military and PM to update guidelines and SOPs, gain necessary approvals, and start implementation at military facilities. Timely access to PEP is the most crucial factor in PEP effectiveness.
- Individuals who seek PEP services should be counseled on and offered PrEP post PEP if risk is ongoing.
- PEP availability in community settings, as well as task sharing of PEP administration is encouraged to increase timely accessibility post exposure.

**2. HIV Testing Services (HTS)**

HIV Testing Services (HTS) is the forefront for finding the remaining people who are living with HIV (PLHIV) and is a priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know their infection status are men, adolescents, and children. The recipient military HIV/AIDS program is strategically placed to reach men; therefore, the implementer will closely work with the recipient military on HTS for both prevention and diagnosis. Those who test negative should be provided with HIV risk reduction information (including referral to PrEP where relevant) and educated on U=U (Undetectable = Untransmittable). For those who test positive, activities should include information about HIV, offer of Safe and Ethical Index Testing (SEIT), and offer of self-testing for family members (all sexual partners and children under 19 years old) who may not be able to access a testing site. HTS

should be targeted towards military personnel to achieve the target of 95-100% of all recipient military PLHIV knowing their status. HTS should also be provided to beneficiaries and civilians cared for at all military sites. The implementer will ensure they and the recipient military follow GHSD and national guidance on implementing SEIT and use the training materials created by the HTS team with the 10-Step model.

The local epidemiology and situational analysis should guide other testing methods to identify PLHIV. Provider-Initiated Testing and Counseling (PITC) will continue at military facilities for both the military and civilian cohorts. PITC should focus within clinical areas that have shown a high testing yield, such as inpatient wards, tuberculosis (TB) and sexually transmitted infection (STI) clinics. All people newly diagnosed with HIV should be retested to verify their HIV status prior to starting ART. The same testing strategy and algorithm as the original diagnosis should be used, but with a different tester and different test kit lots.

The implementer should support the military to achieve over 95% linkage of HIV-positive individuals identified to treatment initiation, fully implementing "test-and-start" policies across all age, sex, and risk groups. Ensuring that any person with positive results identified is linked to HIV care and treatment is essential to the success of the recipient military program. The implementer will support the military to 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 and other relevant integrated services.

The implementer will be responsible for providing support for the following activities to military bases and facilities:

- Diagnosing HIV, with at least 95% of those diagnosed linked to HIV care, while striving for 100% linkage to treatment services and same day initiation of ART.
- Offering SEIT to all HIV positive clients and testing for all sexual partners and children under 19 years old of HIV positive military personnel and civilians (with at least 1.5 contacts identified on average).
- Documenting HIV status for all children under 19 years of age with mothers living with HIV.
- Facilitating quality improvement and quality assurance for all recipient military HTS sites, including strategic assistance, at least quarterly.
- Conducting proficiency testing for all HTS sites and individuals.
- Tracking PLHIV from HTS to clinical care and treatment services to ensure linkage and retention, including Viral Load Suppression (VLS).

### 3. HIV Treatment

ART optimization is the 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. Moreover, long-term viral load suppression prevents onward transmission and is the cornerstone of HIV prevention. The following factors should be considered in supporting the treatment of PLHIV in military facilities.

- 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. The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission recommends DTG-containing regimen as a Preferred ARV for PBFW and recommends DTG-containing regimen as a Preferred ARV for women who are trying to conceive. Starting in COP20 (FY21), programs were 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 prevent the development of TB in PLHIV as well as diagnose and treat PLHIV with TB disease and ensure they become non-infectious. In addition, all TB infected individuals should be tested for HIV.
    - Routinely screen all PLHIV for TB disease. Standardized symptom screening alone is not sufficient for TB screening among PLHIV and should be complemented with more-sensitive and setting-specific recommended screening tools. Ensure all PLHIV who screen positive for TB receive recommended molecular diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment.
    - For all who do not have active TB, prevention of TB is a priority using nationally approved TB preventive therapy (TPT). The Global AIDS Strategy has set the target of 90% of PLHIV to receive preventive treatment for TB, thus TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Implementers 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 that is consistently documented. In short, all newly diagnosed HIV-positive people should be offered TB treatment or preventive therapy, and all people assessed for TB should be tested for HIV.
    - 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, implementers should also seek opportunities to support effective joint program implementation. Additionally, implementers should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide a 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.
- The implementer should work with the recipient military to offer most clients 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, 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 implementer should work with the recipient 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 HIV-related stigma by integrating a wide array of non-HIV commodities into decentralized sites (e.g. TPT).
- Diagnose and treat people with advanced HIV disease (AHD). People starting treatment, re-engaging in treatment after an interruption of > 1 year, or virally unsuppressed for >1 year should be evaluated for AHD. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease. The PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with advanced disease.

**4. 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 implementer will work closely with the Ministry of Defense in the recipient Angola to scale up VL testing coverage and VL suppression to achieve 95-95-95 goals for military personnel, as well as beneficiaries and civilians. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% VL suppression among PLHIV taking ART. CD4 testing should not be used to determine eligibility for ART and only should be used for assessment of immune status (i.e. identification or ongoing monitoring of patients with advanced HIV disease).

The implementer should ensure that the recipient military has access to timely VL testing (goal turnaround time is within 2 weeks) and that capacity exists to test 95% of people currently on ART annually. To ease logistical challenges associated with the transport of whole blood specimens and to increase access to routine VL monitoring, dried blood spots (DBS) for VL testing can be used as an alternative specimen type to plasma. 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, extending this use for VL testing, as well as improved optimization and effective use of these instruments. Considering this, it is recommended that POC be used for VL testing. Implementers must follow international health guidelines and work with military and MoH network (as necessary) to implement and monitor VL testing schedule of non-PBFW HIV+ adults. POC platforms may also be appropriate for low volume remote military sites.

The implementer will ensure that VL results are available to providers/clients in a reasonable amount of time (goal is within 2 weeks) to both the health care provider and the client. These results should be

available 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. Unsuppressed clients and their sexual partners should be educated on U-U literacy . 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, to minimize inconveniences associated with health system access.

HIV viral suppression is not only critical to improving individual health, but also to prevent sexual transmission, and reduce perinatal transmission. There are three key categories for HIV viral load measurements: unsuppressed (>1000 copies/mL), suppressed (detected but ≤1000 copies/mL) and undetectable (viral load not detected by test used: <40 or <50 copies/ml depending on the machine used). People living with HIV who have an undetectable viral load and continue taking medication as prescribed have zero risk of transmitting HIV to their sexual partner(s) (U=U). PLHIV who have a suppressed but detectable viral load and are taking medication as prescribed have almost zero or negligible risk of transmitting HIV to their sexual partner(s). HIV VL test results can be a motivation for adhering to treatment and achieving the goal of being undetectable. Emphasizing and strengthening adherence counselling during antiretroviral therapy initiation and throughout treatment are essential, including communicating about the benefits of viral load suppression to all PLHIV. HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. The implementer must work with the military to ensure updated and accurate U=U messaging and encourage HIV testing, prevention, and treatment reaches all PLHIV, the general population and health care providers.

**5. Health System Strengthening**

DHAPP is working to enhance the ability of militaries and Ministries of Defense to manage their HIV epidemic, respond to broader health needs impacting their communities, and address new and emerging health concerns. Implementers should describe how they will increase recipient government capacity. A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of the HIV response, including political commitment, building program capacities and capabilities, and financial planning and expenditure.

The procurement of supplies, support and equipment should use recipient government and other donor sources when possible (Global Fund, etc.).

Laboratory:
The implementer will be responsible for the following activities to help recipient militaries build resilient, sustainable, and internationally accredited laboratory systems strongly capable of responding to the HIV epidemic and other future infectious disease outbreaks:

- Laboratory inventory tracking, control, and forecasting; monitoring of commodities procurements to ensure laboratory supplies are procured at cost-effective prices and services are uninterrupted; monitoring facilities storing procured laboratory commodities to ensure they meet International Organization for Standardization (ISO) warehouse principals and standards; obtaining insurance for procured laboratory commodities to protect against natural disasters, fire, theft, etc.
- Supporting and facilitating military participation in national quantification exercises, ensuring that military laboratory commodity needs are incorporated into national

forecasting.

- Routine monitoring of turnaround time (TAT) for VL, TB, and other critical tests, to ensure test results are provided to providers and patients within a reasonable period (2 weeks) to improve and maximize patient care and outcomes.
- Procuring laboratory service maintenance contracts, routine calibration of equipment, and training of laboratory staff on proper use and maintenance of procured equipment.
- Supporting training in proper laboratory biosafety and waste management.
- Ensuring continuous quality improvement of all laboratories (including satellite laboratories and HIV testing sites) and accreditation is in place and transitioned over to the recipient government with key milestones and timeline.
- Monitoring of laboratory quality, adherence to quality systems, and method validation; provision of proficiency testing for rapid HIV testing, VL,TB, STIs, and other tests critical to HIV epidemic control and detecting emerging disease outbreaks.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, address needs and gaps, and provide recommendations for the development of improvement plans to resolve any identified problems.
- Linking recipient military laboratory services to other laboratory resources at the district, provincial, and national levels.

Optimizing diagnostic networks for VL, TB, and other coinfections. In coordination with other Donors and National TB Programs, complete diagnostic network optimization (DNO) and transition to integrated diagnostics and multi-disease testing. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time (goal is 2 weeks). Identify all parts of the laboratory system that are interoperable with the U.S. military system.

## 6. Virtual Communities of Practice/ECHO Platform

The implementer should support the recipient military's use of Virtual Communities of Practice (vCOPs) through the Project ECHO (Extension for Community Healthcare Outcomes) model if an ECHO network already exists within the military program. Project ECHO is evidence-based, virtual model that democratizes medical expertise as a self-reliant tool for continuous clinical knowledge sharing amongst healthcare workers. Since 2020, DHAPP has collaborated with the ECHO Institute (https://hsc.unm.edu/echo/) to lever their vast experience with vCOPs/ECHOs and to assist in establishing ECHO programs with 24 recipient militaries. More information on the establishment of the DHAPP Superhub available at https://pubmed.ncbi.nlm.nih.gov/40984107/. Key requirements are equipment and connectivity as well as personnel who can coordinate, manage, and lead regular vCoP/ECHO sessions. (https://hsc.unm.edu/echo/).

For recipient militaries with existing, launched ECHO programs, the implementer shall provide support focused on transitioning full ownership of the ECHO program to the recipient military. Required support activities include:

- **Program Maintenance:** Assisting the recipient military in the maintenance of existing ECHO hub and spokes – connectivity,
- **Strategic Expansion:** Supporting the addition of new clinical "spokes" to strengthen the military network of integrated care throughout the country.

- **Network Engagement:** Ensuring the recipient military actively engages with the DHAPP ECHO Superhub, and, where applicable, any local ECHO network (i.e., an MOH-led ECHO) for broader collaboration.

The Statement of Work (SOW) narrative must be specific about all proposed ECHO activities (e.g., personnel, number of sites, locations). All equipment purchases listed in the workplan must follow current U.S. laws (Congress) and policies (Executive Branch) and must be reviewed and approved by the DHAPP ECHO Team.

## 7. Commodities

The implementer will assist the military in developing and implementing a supply chain management strategy that aligns with PEPFAR's goals of ensuring sustainable commodity supplies while simultaneously emphasizing and working to improve self-reliance of the commodities recipient, with the full transition of all capabilities to the commodities recipient by award completion or USG/recipient country MOU completion (whichever comes first). This strategy should include, where applicable to a site or sites, as many of the following principles as practical:

- Development of a comprehensive Supply Chain Transition Plan with clearly defined annual milestones for the recipient military to assume responsibility for key functions. A written supply chain risk management plan that is co-developed with and owned by the recipient military. This plan must address risks to commodity availability (e.g., stockouts, expiries) and risks to the transition process itself (e.g., personnel gaps, funding shortfalls). Plans may be specific to a site or group of similar sites, depending on the need identified by the recipient military and recipient.
- Identification and training of supply chain points of contact within each facility on topics to include where applicable, but not limited to:
    - Accurate use of the commodities request system (typically the national system)
    - Completion of necessary paperwork/electronic forms
    - Stockout and overstock mitigation strategies
    - Inter-site commodity movement procedures
    - Establishing relationships with commodities counterparts within the military and national systems, both regionally and nationally
    - Quantification and forecasting, with the goal of the recipient military leading their national quantification exercise for its facilities.
- In alignment with the America First Global Health Strategy, and in compliance with applicable federal acquisition regulations, the recipient will prioritize the evaluation and selection of U.S.-manufactured pharmaceuticals, diagnostics, and supply chain technologies where they are competitive in terms of cost, quality, and availability. The recipient will document efforts to explore U.S.-based sources as part of its procurement strategy.
- Implementation of supply chain best practices, including product and supply chain segmentation, actively identifying and contracting with local and/or U.S.-based private sector logistics partnerships where appropriate to improve efficiency and build a sustainable logistics infrastructure that can be leveraged directly by the recipient military in the future, and establishing end-to-end supply chain visibility using global standards (GS-1) to enable military leadership to make independent, data-driven supply chain decisions.
- Adoption of decentralized drug distribution (DDD) models, such as home deliveries, use of community or private pharmacies, and automated lockers, to improve client convenience and

maximize product availability.

- Collaboration with relevant stakeholders to conduct Diagnostic Network Optimizations (DNOs) to inform laboratory supply chain refinements.
- Development of accurate forecasts that capture total program needs, including considerations for optimized testing and treatment. These forecasts should inform regular (at minimum quarterly) supply plan updates.
- Establishment of systems for increased data visibility and reporting of HIV commodities availability, including granular-level reporting of quantities dispensed and stock availability.
- Active participation in collaborative efforts with recipient governments and other stakeholders to ensure data-informed decision-making and mitigate stock risks.
- Development of a plan for increasing local oversight and utilizing private sector capabilities, where appropriate.
- Implementation of a risk management and monitoring system, which may include third-party monitoring for assessment and oversight of supply chain programs, if required.
- Design and implementation of capacity building initiatives to increase supply chain literacy and fluency across recipients and human resources for health.
- Avoidance of parallel supply chain systems. All efforts must focus on strengthening and utilizing the recipient military's and/or the national health system's existing infrastructure. The recipient should not create separate, temporary, procurement or distribution systems.

The implementer should work towards ensuring a sustainable supply chain and improved regional self-reliance where feasible. This includes ensuring the military is connected to the national procurement system and other already existing procurement systems and resources in-country to avoid creating parallel procurement systems.

## 8. LIVES & Child Safeguarding

The implementer will ensure that all implementer & military health facility staff are trained in and implementing both the DHAPP LIVES and Child Safeguarding interventions (utilizing the curriculum updated in December 2025 that is in alignment with Executive Orders to date); to include re-training all trained staff every 3 years and training all new staff as part of their hiring process. Records for who has been trained and when must be kept by implementer and/or military and accessible upon request.

## 9. Malaria

The implementer is responsible for implementing evidence-based malaria prevention and treatment services. The implementer should work with the recipient military and MoH to ensure that these activities align with national malaria guidelines and target geographic regions with high malaria prevalence.

Malaria remains a significant global health threat, particularly for PLHIV who may be at higher risk of severe infection due to a compromised immune system. Malaria infection may reduce the effectiveness of ART for PLHIV on treatment, making malaria prevention an important tool in the clinical care of PLHIV. Populations which should be prioritized for malaria prevention and treatment services include , PLHIV, and military populations.

The implementer will ensure that activities to address malaria include:

- Promotion of vector control prevention activities to reduce malaria infection, such as the distribution of insecticide-treated mosquito nets and the use of indoor residual spraying (IRS) in areas with high malaria prevalence.
- Distribution of chemoprophylaxis according to MOD and national guidelines as appropriate for active-duty military (ADM) deployed to areas with high malaria prevalence. Dispensing of chemoprophylaxis medications, if indicated, should include clear guidance on timeline and duration of medication usage.
- Training healthcare providers to identify, diagnose, and treat malaria, as well as training on early detection and response to drug-resistant malaria.
- Distribution of appropriate malaria treatment at military health facilities, or referral to other health center where treatment is available. The most common malaria treatments are as follows:
    - Artemisinin-based combination therapy medicines are the most effective treatment for *P. falciparum malaria*.
    - Chloroquine is recommended for treatment of infection with the *P. vivax* parasite only in places where it is still sensitive to this medicine.
    - Primaquine should be added to the main treatment to prevent relapses of infection with the *P. vivax* and *P. ovale* parasites.
- Ongoing surveillance and analysis of malaria cases and health outcome data.

**10. Bio Surveillance (Surveillance and Outbreak Response)**

The implementer will be responsible for implementing bio surveillance activities in coordination with the recipient military and in alignment with international and national health guidelines. Bio surveillance activities include 1) outbreak detection and 2) outbreak response; and will not be duplicative of other U.S. funded bio surveillance activities.

The implementer will work with the military to ensure that outbreak detection activities are military owned and include:

- Assessment and maintenance of existing outbreak detection capacities in military health facilities and assessment of alignment with national protocols.
- Ensure military clinical and laboratory facilities are aware of national reporting requirements for outbreak detection
- Determine gaps in outbreak detection, particularly in laboratory capacity and data management, and implement a plan to correct identified gaps.

The implementer will ensure that outbreak response activities include:

- Assessment of existing outbreak response plans and revision of plans as appropriate.
- Training of personnel in effective outbreak response and establishment of outbreak response SOPs in alignment with national protocol.
- Ensure clinical facility staff are familiar with required barrier protective measures per national guidelines to prevent nosocomial spread of pathogens. Coordinate with national efforts to ensure military facilities are supplied with PPE.

The implementer will work with the PM to tailor and address any other outbreak detection and response activities outlined in the Country MOU Implementation Plan and Operational Plan.

**Monitoring and Evaluation**

To ensure the effective, efficient, and durable use of United States Government funds, the recipient military armed forces shall be responsible for the comprehensive, reliable, and timely reporting of the milestone, outcome and process metrics specified in this announcement. This reporting is critical for two primary objectives: first, to guide the development of health policies and practices that improve the recipient country's force health readiness, and second, to provide rigorous accountability to the United States Congress and the American taxpayer for every dollar appropriated.

The implementer is mandated to coordinate directly with the recipient military to ensure the accurate and transparent delivery of these metrics to all designated stakeholders as specified in the Memorandum of Understanding between the USG and Angola.

The overarching goal is to transition all monitoring, evaluation, and reporting responsibilities to the recipient military, fostering complete self-reliance in the shortest possible timeframe. To verify the integrity of this reporting and safeguard U.S. investment, the implementer will execute regular Data Quality Assessments (DQAs) to evaluate the accuracy and reliability of the data provided by the recipient military, the frequency of which will be determined in consultation with the recipient military.

| **Process Metrics** | **Baseline Targets** |
|---|---|
| # people on ART | 8,367 |
| # new HIV diagnoses among children and adults (age 12 months or older) | 980 |
| % suspected cases receiving diagnostic test for malaria | To be determined |
| % or # confirmed malaria cases that receive first-line antimalarial treatment | To be determined |
| # insecticide-treated nets distributed to populations at risk of malaria | To be determined |
| % accuracy of data fields assessed during the annual data audit | 90% |

To ensure rigorous oversight and accountability, the implementer is required to submit independent performance data. This reporting will serve to verify and corroborate the data provided by the recipient country's Ministry of Defense as compared to actual program implementation. The explicit purpose of this data collection is to guarantee that every American taxpayer dollar is spent effectively, and its impact is demonstrably justified. All implementer performance data shall be reported at the site level or higher through the designated online data collection system (DC2) at the specified quarterly, semi-annual, or annual intervals. The indicators used for this reporting requirement will harmonize with required milestone, process, and outcome metrics.

All proposals must include milestone metrics by activity and which outcome or process metric each

activity supports. Example table headers are provided below.

| Budget, USD | Activity | Milestone | Metric Mapping (Outcome & Process Metric) |
|---|---|---|---|

**Quality Management System**

The Angolan Armed Forces is responsible for maintaining a quality management (QM) system, which will no longer be funded through PEPFAR. Site Improvement through Monitoring System (SIMS) is a QM system that has been supported by DHAPP for many years, and implementers and recipient militaries are encouraged to use this system (or other QM system of their choosing). QM systems provide a standardized approach and set of tools for monitoring program quality. QM 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. QM systems are also used to identify performance issues that may impact patient outcomes or the integrity of program reporting site-level triangulation of program and QM data can be used to contextualize performance and determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

QM systems aim to:

(1) facilitate service improvement,
(2) ensure accountability of U.S. government investments, and
(3) maximize the impact of U.S. government investments on the HIV epidemic.

QM assessment results confirm compliance with minimum quality assurance standards and identify areas where improvements can be made.

The implementer should ensure that all supported sites are familiar with QM standards and make sure that all efforts are taken to follow these standards. DHAPP encourages implementers and militaries to conduct reviews of program performance using the latest QM or SIMS tools which are freely available.

SIMS or other QM system implementation is one strategy available for programs to integrate effective quality assurance (QA) and CQI practices into site and program management. Program management must apply ongoing program and site standards assessment—including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementer agreements and workplans should align with national policy in support of QA/CQI.

**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 recipient military HIV program's ability to monitor progress towards epidemic control. The implementer will work with the recipient military and Ministry of Health (MOH), Ministry of Communications, and 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 recipient military leadership.

The implementer will be responsible for:

- Staffing, support, and mentoring of existing recipient military staff for paper and electronic data collection
- Timely, accurate reporting of all indicators required by the recipient 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 recipient military and DHAPP without prior approval from the recipient 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 recipient military programs and the implementer should include a strategy for conducting baseline, periodic, and ongoing data quality assessments (DQA). In this way, DHAPP, and the recipient military, can be confident in the veracity of the data that it uses for planning and measurement of progress towards programmatic goals. The implementer should plan on conducting periodic 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 recipient 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 from HIV testing to viral load testing, and the complete 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. Frequency of periodic DQAs should be determined in consultation with the recipient military and DHAPP.

**Informatics**
**Health Information Systems**

Informatics (including Digital Health Platforms (DHP) also known as Health Information Systems (HIS) or Medical Information Systems (MIS)) are critical underpinnings of good patient healthcare and good program management. The military's health system requires reliable informatics support to ensure its long-term, sustainable advancement. Key goals for a military HIS include 1) improving quality and safety of care; outbreak detection; data-driven decision-making; efficient deployment of resources; QA/QC; and improved access and improved confidentiality of health data.

The implementer will support the recipient military's HIS to align with the recipient country health information systems (HIS) to the greatest degree possible. The implementer will inventory the current military data systems (paper and electronic) and will provide written recommendations to include identification of gaps in the military HIS and requirements to enable the recipient military HIS to reach all clinical and laboratory locations. The implementer will coordinate with the military and MOH or other

appropriate ministries to 1) ensure the military sites are included in national systems with 2) training, 3) infrastructure improvements such as routers, computers, solar power and satellite internet connectivity, 4) security (physical and cyber), 5) data use policy and governance, 6) data management, 7) data analytics, and 8) data use and dissemination. Where equipment procurements are needed, the recipient will ensure that the equipment will follow US laws and policies (e.g. no equipment from China, USA made, etc.).

The implementer must ensure by 2030 that the military will be capacitated with durable systems, staffing, training, and infrastructure to allow the military to use their systems effectively and independently to monitor client health and conduct national reporting.

**Work Plans**

The implementer 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. A full list of reporting requirements can be found in the base Program Announcement and will be disclosed in the award terms and conditions.

**Burundi: DHAPP - Burundi National Defense Force Partnership for Resilient Military Health Systems for Readiness**

**NOTE: Application submissions for this narrative are due by 12pm EST on 15 May 2026. Submissions received after the deadline will not be considered for funding.**

**Call for Proposals**

Proposals are requested to support the Burundi National Defense Force (BNDF) to reach sustainable control of the HIV epidemic through the lens of the America First Global Health Strategy, as well as the UNAIDS HIV Treatment 95-95-95; Vertical Transmission 95 targets; and TB prevention 90 and in alignment with the National Security Strategy (NSS) and the National Defense Strategy (NDS) goals to protect the homeland, deter China, and increase burden sharing. Further, proposals must be aligned with any existing Memorandum of Understanding between the U.S. Department of State and Burundi. Implementers should be familiar with these strategic guidance documents and include means of addressing them in submitted proposals. **Please see base Program Announcement section D for complete detailed list of application, format and submission requirements. Proposal Technical Narrative may not exceed 45 pages.**

**Introduction**

The HIV/AIDS epidemic has devastated 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 other military personnel and their extended communities, and impeding participation in peacekeeping activities. As HIV management improves, many of these impacts are reduced; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries; this is in addition to managing other long-term chronic diseases to maintain high force health readiness in strategically identified recipient militaries. Moreover, given the well-known biobehavioral risk factors among uniformed personnel, reducing HIV acquisition and transmission in this population is an essential component for reaching epidemic control in the recipient country.

The U.S. Government has a long history of providing foreign assistance to combat HIV/AIDS, advancing U.S. national security by promoting stability in key regions. Over the years, the United States DoD HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries to control the HIV epidemic among their respective military services. Working closely with the Department of Defense (DoD, herein referred to using the secondary title Department of War, DoW), U.S. Geographic Combatant Commanders, the Bureau of Global Health Security and Diplomacy (GHSD) and other organizations, DHAPP's mission is to build the capacity of recipient militaries through military-specific HIV/AIDS assistance, creating self-reliant security counterparts. DHAPP is the DoW implementing agency collaborating with the US Department of State, 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 Department of War (Title 10) Defense Health Program (DHP) and funding transfers from the Department of State (Title 22) for PEPFAR.

All proposals must be in full alignment with any existing Memorandum of Understanding (MOU) between

the Department of State (DoS) and Burundi clearly articulating transition plans for each activity over the course of the agreement with specific and measurable milestones. Reserving the last year of the agreement for transition planning will not be accepted. Activities to transition responsibilities to the recipient country must begin immediately upon award and continue throughout the life of the agreement to ensure a rapid path to self-sufficiency. The implementer must prepare the recipient country's military to fully own and operate all services, ensuring a complete and final transition of responsibility away from U.S. assistance.

The DoW Combatant Commands (CCMDs) have identified the longstanding DHAPP program with recipient countries as an essential security cooperation tool that serves U.S. interests. Pursuing HIV/AIDS activities with foreign militaries is an important part of maintaining security interests, regional stability through health readiness, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing nations. 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 CCMDs and DHAPP Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under-Secretary of War for Policy and by the Department of State Bureau of Global Health Security and Diplomacy (GHSD). DHAPP provides technical support to defense forces in HIV prevention, care, treatment, and information systems and data use 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. An additional goal supported by GHSD is 95% coverage of services for eliminating vertical transmission. Lastly, the UNAIDS Global AIDS Strategy established a goal that 90% of PLHIV receive preventive treatment for TB.

All proposals must align with the America First Global Health Strategy, which focuses on the following points:

- Address Inefficiency and Dependency: The majority of funding should go directly towards patient care and building resilient health systems. High program management costs will not be funded.
- Pillar 1: Make America Safer: The primary goal is to protect Americans by enhancing global surveillance systems to detect outbreaks within seven days of emergence, notify public health authorities within 1 day and rapidly responding at the source within 7 days with early response actions to prevent pandemics from reaching U.S. shores.
- Pillar 2: Make America Stronger: Foreign health assistance will be used as a strategic tool to strengthen bilateral relationships. The U.S. will enter into multi-year agreements with recipient countries that require co-investment and establish clear benchmarks, ...moving them toward self-sufficiency and away from reliance on U.S. foreign assistance. Proposals must align with any existing country-specific MOU timelines.
- Pillar 3: Make America More Prosperous: The strategy aims to bolster the U.S. economy by preventing costly pandemics and by using foreign assistance programs to promote American companies and health innovations (like diagnostics and pharmaceuticals) in emerging global markets.
- Restructure Aid Delivery: The plan calls for more frontline support, such as medical commodities

and healthcare workers, while significantly reducing all other non-frontline expenditures to ensure accountability to the American taxpayer. It will also streamline efforts by integrating disease-specific programs (HIV, Malaria, TB) and leveraging the private sector and faith-based organizations for more efficient service delivery. The implementer is expected to work with the DHAPP Program Manager (PM) on supporting the integration of disease-specific programs receiving USG funding for the military program.

**Local Implementers**

Local, non-governmental implementers with low overhead costs are encouraged to apply to this announcement. To achieve self-reliance, it is critical that the full range of HIV services are owned and operated by the recipient country's institutions, governments, and community-based and community-led organizations, regardless of current antiretroviral (ARV) coverage levels. The intent of transitioning to local implementers 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 implementers to ensure successful, long-term, community 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.

**Additional Submission Guidance:**

1. Review all documents within the package to ensure consistency in information, budgets, targets, and numbering:
    a. Use numbered lists, including numbered or alphabetized sub-lists, for activities for easier reference and monitoring, especially the SOW Narrative column.
2. Ensure all activities in the Technical Narrative are also listed concisely in the SOW file.
3. Activities must be specific; Do not write “ensure” or “support” or a similar verb as a narrative activity without defining what that means. Each activity must say specifically what the implementer will be doing. It must be measurable and answer the questions Who? What? Where? How? How many? How often?
4. Delineate between a training (i.e.: one time class or series of classes where attendees are gathered in a conference room, away from regular duties) and onsite strategic assistance (on the job guidance while recipient is performing regular duties) and specify as many of the following details as possible for both: how many attendees or sites, how often, how many days, where, specific topics/skills covered, expected outcomes & how they align with program goals, etc. Training should be limited and cost efficient.
5. Please note this project budget cannot include:
    a. Any budget allocations toward World AIDS Day (WAD) events/campaigns.
    b. Prizes, hats, or T-shirts.
    c. Flyers and printed education materials to be given to beneficiaries.
    d. Rental of venues for training or events (must use available military or ministry facilities).
    e. Employment or payments made directly to active-duty foreign military.

## Budget

The **estimate** budget for this program announcement is as follows. Final authorized budget will be confirmed and communicated at time of official award execution. The link below contains the Financial Classifications Reference Guide and a summary of the classification definitions.
https://help.datim.org
Financial classifications are not regulations governing allowability of federal awards. Nothing in this guidance should be interpreted to mean that costs or activities that are unallowable or excluded under the terms of an award are permitted by virtue of being described herein. All awards are subject to the applicable cost principles and terms set forth and conveyed in the award made.

## Estimated Budget to be used as a Framework

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.1: Surveillance and Outbreak Response | | | 0 | 0 | 0 | 0 | 0 |
| Subtotal | | | - | - | - | - | - |
| 2.2: Laboratory Systems | HIV | 2.2: Lab Accreditation | 3,624 | 3,262 | 2,935 | 2,642 | 12,463 |
| | HIV | 2.2: Lab Consumables Procurement | 20,694 | 18,625 | 16,762 | 15,086 | 71,167 |
| | HIV | 2.2: Lab Equipment Procurement | 15,926 | 14,333 | 12,900 | 11,610 | 54769.514 |
| | HIV | 2.2: Lab Service and Maintenance Costs | 27,490 | 24,741 | 22,267 | 20,040 | 94,538 |
| | HIV | 2.2: Frontline Lab Workers | 20,712 | 18,641 | 16,777 | 15,099 | 71,229 |
| | HIV | 2.2: Lab Sample Transport | 45,980 | 41,382 | 37,244 | 33,519 | 158,125 |
| **Subtotal** | | | **134,426** | **120,983** | **108,885** | **97,997** | **462,291** |
| 2.3: Commodities | HIV | 2.3: In-Country Warehousing and Distribution | 43,792 | 39,413 | 35,472 | 31,924 | 150,601 |
| | HIV | 2.3: Supply Chain Systems Support | 58,074 | 52,267 | 47,040 | 42,336 | 199,716 |
| **Subtotal** | | | **101,866** | **91,679** | **82,511** | **74,260** | **350,317** |
| 2.4: Frontline Health Workers | HIV | 2.4: Community Health Workers/Community-Based Staff | 79,222 | 71,300 | 64,170 | 57,753 | 272,444 |
| | HIV | 2.4: Other Health Workers | 181,442 | 163,298 | 146,968 | 132,271 | 623,979 |
| **Subtotal** | | | **260,664** | **234,598** | **211,138** | **190,024** | **896,423** |
| 2.5: Data Systems | HIV | 2.5: Data Systems Infrastructure | 31,098 | 27,988 | 25,189 | 22,670 | 106,946 |
| | HIV | 2.5: Licenses & Software | 2,901 | 2,611 | 2,350 | 2,115 | 9,977 |
| | HIV | 2.5: Cybersecurity | 7,000 | 6,300 | 5,670 | 5,103 | 24073 |
| **Subtotal** | | | **40,999** | **36,899** | **33,209** | **29,888** | **140,996** |
| 2.6: Strategic Assistance | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 118,500 | 106,650 | 95,985 | 86,387 | 407,522 |
| | HIV | 2.6: TA to Support Program Transition to Government or Local Partners | 29,380 | 26,442 | 23,798 | 21,418 | 101,038 |
| | HIV | 2.6: Other Health Systems Strengthening | 59,082 | 53,174 | 47,856 | 43,071 | 203182.998 |
| | HIV | 2.6: Other Commodity Procurement | 7,120 | 6,408 | 5,767 | 5,190 | 24,486 |
| | HIV | 2.6: IP Program Management | 226,112 | 203,501 | 183,151 | 164,836 | 777,599 |
| **Subtotal** | | | **440,194** | **396,175** | **356,557** | **320,901** | **1,513,827** |
| **Total** | *Budget Estimate to be used asa framework. Final authorized budget will be confirmed and communicated at time of official award. Phase 2-4 option budget Estimates are notional and dependent on availability of US Government available funding. | | **978,149** | **880,334** | **792,301** | **713,071** | **3,363,854** |

**Approaches to Reaching Sustainable Epidemic Control & Transitioning Ownership**

Proposals are requested to support the Burundi National Defense Force to reach sustainable control of the HIV epidemic and focus on the America First Global Health Strategy, the latest PEPFAR guidance and UNAIDS HIV Treatment 95-95-95, Vertical Transmission 95 targets, and TB prevention 90 targets, and in alignment with the NSS, NDS, and the MOU between the U.S. DoS and Burundi.

In 2025 DHAPP supported the recipient military in conducting a Military Sustainability Index (MilSID). Findings indicate the military health system has made significant strides towards sustainability over the past decade; however, additional support and strengthening is needed in laboratory systems as well as understanding and tracking epidemiology and health data, financial and expenditure data, and performance data.

In 2025, DHAPP conducted a review of the program against international standards. Findings indicate the military health system must receive greater support in the following areas:

- Optimize diagnostic networks for VL/EID, TB, and other coinfections

The implementer will develop and implement a comprehensive transition plan that is in alignment with any existing country MOU, with clearly defined every 6-month milestones demonstrating progressive military assumption of programmatic responsibilities across all technical areas, data collection and reporting areas, and program management. This transition framework prioritizes efficiency, direct patient care investment, and development of resilient health systems capable of independent operation beyond the period of U.S. support. All proposals should detail how the implementer will engage the recipient military leadership as well as personnel at all levels in this work; and, specifically, how the implementer will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Please specify which SOW activities the implementer is supporting the military to take ownership of (showing increasing military ownership) and by when (with detailed milestones). Throughout this progression, the implementer must document evidence of increasing military ownership through specific metrics including percentage of activities led by military staff, proportion of budget executed directly by military, number of military personnel trained to competency, and documented military-led decision-making and problem-solving. Failure to attain defined milestones as agreed upon by the implementer, the partner military, and DHAPP may result in award termination.

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

**Technical Narrative & Scope of Work (SOW)**

In alignment with international health guidelines, America First Global Health Strategy, and guidance from PEPFAR/GHSD, coupled with DHAPP's vision to build the capacity of military health systems

through military-specific and culturally appropriate services, the recipient will address the approach to each technical area. The implementer, through burden-sharing and building self-reliance within the recipient military, will be responsible for providing the following in close collaboration with other DHAPP-funded implementers.

**Technical Module Building Blocks**

The implementer will work closely with the Ministry of Defense and its medical leadership to make progress towards a resilient and self-reliant military HIV program that is aligned with the national MOU (if applicable), using evidence-based and efficient interventions to reach the three 95s. In alignment with the Transition Plan directive above, the implementer will include specific milestones for program transition for activities within each technical area.

1. **Pre-Exposure Prophylaxis (PrEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PrEP services to all HIV-negative individuals at high risk of acquiring HIV.

The implementer will ensure that the following interventions for adults and adolescents include:

- People at a higher risk of acquiring HIV, including PBFW, must be counseled on and offered PrEP in alignment with recipient country government policies. Any person who asks for PrEP should be considered for use.
- Individuals considering PrEP must be confirmed HIV-negative and be willing to attend follow-up appointments to monitor their HIV status on a routine basis. If a PrEP user tests HIV-positive, PrEP must stop immediately and effective HIV treatment must start.
- Differentiated and simplified service delivery for PrEP is encouraged, such as event-driven PrEP (ED PrEP), community delivery, and the use of HIV self-tests (HIVST) for PrEP services.
- PrEP counselors must be equipped to ensure that PrEP users understand adherence to the different DSD options and different PrEP options. Adherence counseling and support must be ongoing, as necessary.
- As Long-acting Lenacapavir (LEN) injectables become available, beneficiaries should be presented with thorough information on all available PrEP options, including each method's relative efficacy and safety, as well as counseling and adherence support, allowing for an informed client choice.
- If PrEP is not being offered at military facilities, the recipient will work with the military and PM to advocate with necessary stakeholders (possibly MoH or military leadership) to update guidelines, gain necessary approvals, and start implementation at military facilities.

**2. Post Exposure Prophylaxis (PEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PEP services to all HIV-negative individuals (including healthcare workers and non-healthcare workers) who have had a possible exposure to HIV within the last 72 hours.

The implementer will ensure that the following interventions for adults and adolescents include:

- PEP should be started as soon as possible after a potential exposure to HIV, ideally within 24 hours and no later than 72 hours.
- The person seeking PEP should be tested for HIV to confirm they are HIV-negative before starting PEP, although if testing is not available, PEP should be started immediately and can be stopped later once testing is available. Individuals who test positive for HIV should be started on treatment immediately.
- Three ARV drugs for a 28-day prescription are recommended for the HIV PEP regimen. Patients must be properly counseled to understand what PEP is, on adherence, and potential side effects.
- If PEP is not being consistently integrated and offered at military facilities (to the point that the surrounding population knows it is accessible if needed), the recipient will work with the military and PM to update guidelines and SOPs, gain necessary approvals, and start implementation at military facilities. Timely access to PEP is the most crucial factor in PEP effectiveness.
- Individuals who seek PEP services should be counseled on and offered PrEP post PEP if risk is ongoing.
- PEP availability in community settings, as well as task sharing of PEP administration is encouraged to increase timely accessibility post exposure.

**3. HIV Testing Services (HTS)**

HIV Testing Services (HTS) is the forefront for finding the remaining people who are living with HIV (PLHIV) and is a priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know their infection status are men, adolescents, and children. The recipient military HIV/AIDS program is strategically placed to reach men; therefore, the implementer will closely work with the recipient military on HTS for both prevention and diagnosis. Those who test negative should be provided with HIV risk reduction information (including referral to PrEP where relevant) and educated on U=U (Undetectable = Untransmittable). For those who test positive, activities should include information about HIV, offer of Safe and Ethical Index Testing (SEIT), and offer of self-testing for family members (all sexual partners and children under 19 years old) who may not be able to access a testing site. HTS should be targeted towards military personnel to achieve the target of 95-100% of all recipient military PLHIV knowing their status. HTS should also be provided to beneficiaries and civilians cared for at all military sites. The implementer will ensure they and the recipient military follow GHSD and national guidance on implementing SEIT and use the training materials created by the HTS team with the 10-Step model.

The local epidemiology and situational analysis should guide other testing methods to identify PLHIV.

Provider-Initiated Testing and Counseling (PITC) will continue at military facilities for both the military and civilian cohorts. PITC should focus within clinical areas that have shown a high testing yield, such as inpatient wards, tuberculosis (TB) and sexually transmitted infection (STI) clinics.

All people newly diagnosed with HIV should be retested to verify their HIV status prior to starting ART. The same testing strategy and algorithm as the original diagnosis should be used, but with a different tester and different test kit lots.

The implementer should support the military to achieve over 95% linkage of HIV-positive individuals identified to treatment initiation, fully implementing “test-and-start” policies across all age, sex, and

risk groups. Ensuring that any person with positive results identified is linked to HIV care and treatment is essential to the success of the recipient military program. The implementer will support the military to 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 and other relevant integrated services.

The implementer will be responsible for providing support for the following activities to military bases and facilities:

- Diagnosing HIV, with at least 95% of those diagnosed linked to HIV care, while striving for 100% linkage to treatment services and same day initiation of ART.
- Offering SEIT to all HIV positive clients and testing for all sexual partners and children under 19 years old of HIV positive military personnel and civilians (with at least 1.5 contacts identified on average).
- Documenting HIV status for all children under 19 years of age with mothers living with HIV.
- Offering self-testing for partners of index clients if they do not volunteer for partner notification.
- Facilitating quality improvement and quality assurance for all recipient military HTS sites, including strategic assistance, at least quarterly.
- Providing HIV self-testing (HIVST) for military personnel, AGYW and their partners, male partners of antenatal care (ANC) clients and other high-risk populations. As part of the HIVST protocol, clients with a positive HIVST should be instructed to follow up with trained staff for further evaluation, including diagnostic testing utilizing the national testing algorithm. It is also vital to engage community groups to advocate for, design, implement, and analyze the success of 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, including Viral Load Suppression (VLS).
- Linking HIV negative, high-risk clients to PrEP services.

**4. HIV Treatment**

ART optimization is the 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. Moreover, long-term viral load suppression prevents onward transmission and is the cornerstone of HIV prevention. The following factors should be considered in supporting the treatment of PLHIV in military facilities.

- 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. The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission recommends DTG-containing regimen as a Preferred ARV for PBFW and recommends DTG-containing regimen as a Preferred ARV for women who are

trying to conceive. Starting in COP20 (FY21), programs were 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 prevent the development of TB in PLHIV as well as diagnose and treat PLHIV with TB disease and ensure they become non-infectious. In addition, all TB infected individuals should be tested for HIV.
    - Routinely screen all PLHIV for TB disease. Standardized symptom screening alone is not sufficient for TB screening among PLHIV and should be complemented with more-sensitive and setting-specific recommended screening tools. Ensure all PLHIV who screen positive for TB receive recommended molecular diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment.
    - For all who do not have active TB, prevention of TB is a priority using nationally approved TB preventive therapy (TPT). The Global AIDS Strategy has set the target of 90% of PLHIV to receive preventive treatment for TB, thus TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Implementers 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 that is consistently documented. In short, all newly diagnosed HIV-positive people should be offered TB treatment or preventive therapy, and all people assessed for TB should be tested for HIV.
    - Pregnant women living with HIV are at high risk of progression from TB infection to disease; thus, it is imperative that Prevention of Mother to Child Transmission (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 PLHIV.
    - 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, implementers should also seek opportunities to support effective joint program implementation. Additionally, implementers should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide a 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 women Living with HIV (WLHIV) should be integrated into routine HIV treatment services in each country program. According to COP 24 Technical Considerations, all PEPFAR supported countries with HIV prevalence above 5.0% among women in the 15-49-year-old age group are expected to provide at least one life-time cervical cancer screen for WLHIV receiving ART.
    - Current international health guidelines recommend screening to start at age 25 or according to national guidelines, whichever is earlier. Programs may also consider earlier

screening among women with long-standing HIV infection, e.g., perinatal infection. WLHIV who are between 50 and 65 years and have not been screened may be offered a single screening test, and screening should be discontinued if they screen negative.
    - Screening for cervical cancer should begin at high-volume military sites and be scaled to all women receiving ART in military ART sites either on-site or through referral to hub sites within the region. Screening should be available in the ART clinic or in affiliated clinics on-site such as women's health or maternal child health clinics for WLHIV to utilize.
    - Programs should ensure that a minimum of 90% of women who screen positive are linked to treatment.
    - 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.
    - Funding may be used for screening with visual inspection with acetic acid (VIA), treatment with cryotherapy, thermal ablation, and loop electrosurgical excision procedure (LEEP), and quality assurance activities.
- The implementer should work with the recipient military to offer most clients 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, 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 implementer should work with the recipient 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 HIV-related stigma by integrating a wide array of non-HIV commodities into decentralized sites (e.g. TPT). DDD models can also be used for decentralized PrEP distribution to improve uptake and continuation.
- Diagnose and treat people with advanced HIV disease (AHD). People starting treatment, re-engaging in treatment after an interruption of > 1 year, or virally unsuppressed for >1 year should be evaluated for AHD and have CD4 T cells measured. Accordingly, the implementer should be working with recipient military and public health leaders to ensure that CD4 testing is available. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease. The PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with advanced disease.

**5. 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 implementer will work closely with the Ministry of Defense in Burundi to scale up VL testing coverage and VL suppression to achieve 95-95-95 goals for military personnel, as well as beneficiaries and civilians. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% VL suppression among PLHIV taking ART. CD4 testing should not be used to determine eligibility for ART and only should be used for assessment of immune status (i.e.

identification or ongoing monitoring of patients with advanced HIV disease).

The implementer should ensure that the recipient military has access to timely VL testing (goal turnaround time is within 2 weeks) and that capacity exists to test 95% of people currently on ART annually. To ease logistical challenges associated with the transport of whole blood specimens and to increase access to routine VL monitoring, dried blood spots (DBS) for VL testing can be used as an alternative specimen type to plasma. 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 POC be used for VL testing among PBFW, infants, and children. Implementers must follow international health guidelines and work with military and MoH network (as necessary) to implement and monitor VL testing schedule for PBFW and HIV-exposed infants (HEI), which differs from the VL testing schedule of non-PBFW HIV+ adults. POC platforms may also be appropriate for low volume remote military sites.

The implementer will ensure that VL results are available to providers/clients in a reasonable amount of time (goal is within 2 weeks) to both the health care provider and the client. These results should be available 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. Unsuppressed clients and their sexual partners should be educated on alternate risk reduction options until they become suppressed, such as PrEP. 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, to minimize inconveniences associated with health system access.

HIV viral suppression is not only critical to improving individual health, but also to prevent sexual transmission, and reduce perinatal transmission. There are three key categories for HIV viral load measurements: unsuppressed (>1000 copies/mL), suppressed (detected but ≤1000 copies/mL) and undetectable (viral load not detected by test used: <40 or <50 copies/ml depending on the machine used). People living with HIV who have an undetectable viral load and continue taking medication as prescribed have zero risk of transmitting HIV to their sexual partner(s) (U=U). PLHIV who have a suppressed but detectable viral load and are taking medication as prescribed have almost zero or negligible risk of transmitting HIV to their sexual partner(s). HIV VL test results can be a motivation for adhering to treatment and achieving the goal of being undetectable. Emphasizing and strengthening adherence counselling during antiretroviral therapy initiation and throughout treatment are essential, including communicating about the benefits of viral load suppression to all PLHIV. HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. The implementer must work with the military to ensure updated and accurate U=U messaging and encourage HIV testing, prevention, and treatment reaches all PLHIV, the general population and health care providers.

## 6. Health System Strengthening

DHAPP is working to enhance the ability of militaries and Ministries of Defense to manage their HIV epidemic, respond to broader health needs impacting their communities, and address new and emerging health concerns. Implementers should describe how they will increase recipient government capacity. A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of the HIV response, including political commitment, building program capacities and capabilities, and financial planning and expenditure.

The procurement of supplies, support and equipment should use recipient government and other donor sources when possible (Global Fund, etc.).

Laboratory:

The implementer will be responsible for the following activities to help recipient militaries build resilient, sustainable, and internationally accredited laboratory systems strongly capable of responding to the HIV epidemic and other future infectious disease outbreaks:

- Laboratory inventory tracking, control, and forecasting; monitoring of commodities procurements to ensure laboratory supplies are procured at cost-effective prices and services are uninterrupted; monitoring facilities storing procured laboratory commodities to ensure they meet International Organization for Standardization (ISO) warehouse principals and standards; obtaining insurance for procured laboratory commodities to protect against natural disasters, fire, theft, etc.
- Supporting and facilitating military participation in national quantification exercises, ensuring that military laboratory commodity needs are incorporated into national forecasting.
- Routine monitoring of turnaround time (TAT) for VL, TB, and other critical tests, to ensure test results are provided to providers and patients within a reasonable period (2 weeks) to improve and maximize patient care and outcomes.
- Procuring laboratory service maintenance contracts, routine calibration of equipment, and training of laboratory staff on proper use and maintenance of procured equipment.
- Supporting training in proper laboratory biosafety and waste management.
- Ensuring continuous quality improvement of all laboratories (including satellite laboratories and HIV testing sites) and accreditation is in place and transitioned over to the recipient government with key milestones and timeline.
- Monitoring of laboratory quality, adherence to quality systems, and method validation; provision of proficiency testing for rapid HIV testing, VL, CD4, TB, STIs, and other tests critical to HIV epidemic control and detecting emerging disease outbreaks.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, address needs and gaps, and provide recommendations for the development of improvement plans to resolve any identified problems.
- Linking recipient military laboratory services to other laboratory resources at the district, provincial, and national levels.

Optimizing diagnostic networks for VL/EID, TB, and other coinfections. In coordination with other Donors and National TB Programs, complete diagnostic network optimization (DNO) and transition to integrated diagnostics and multi-disease testing. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time (goal is 2 weeks). Identify all parts of the laboratory system that are interoperable with the U.S. military system.

## 7. Virtual Communities of Practice/ECHO Platform

The implementer should support the recipient military's use of Virtual Communities of Practice (vCOPs) through the Project ECHO (Extension for Community Healthcare Outcomes) model if an ECHO network already exists within the military program. Project ECHO is evidence-based, virtual model that democratizes medical expertise as a self-reliant tool for continuous clinical knowledge sharing amongst healthcare workers. Since 2020, DHAPP has collaborated with the ECHO Institute (https://hsc.unm.edu/echo/) to lever their vast experience with vCOPs/ECHOs and to assist in establishing ECHO programs with 24 recipient militaries. More information on the establishment of the DHAPP Superhub available at https://pubmed.ncbi.nlm.nih.gov/40984107/. Key requirements are equipment and connectivity as well as personnel who can coordinate, manage, and lead regular vCoP/ECHO sessions. (https://hsc.unm.edu/echo/).

For recipient militaries with existing, launched ECHO programs, the implementer shall provide support focused on transitioning full ownership of the ECHO program to the recipient military. Required support activities include:

- **Program Maintenance:** Assisting the recipient military in the maintenance of existing ECHO hub and spokes – connectivity,
- **Strategic Expansion:** Supporting the addition of new clinical "spokes" to strengthen the military network of integrated care throughout the country.
- **Network Engagement:** Ensuring the recipient military actively engages with the DHAPP ECHO Superhub, and, where applicable, any local ECHO network (i.e., an MOH-led ECHO) for broader collaboration.

The Statement of Work (SOW) narrative must be specific about all proposed ECHO activities (e.g., personnel, number of sites, locations). All equipment purchases listed in the workplan must follow current U.S. laws (Congress) and policies (Executive Branch) and must be reviewed and approved by the DHAPP ECHO Team.

## 8. Commodities

The implementer will assist the military in developing and implementing a supply chain management strategy that aligns with PEPFAR's goals of ensuring sustainable commodity supplies while simultaneously emphasizing and working to improve self-reliance of the commodities recipient, with the full transition of all capabilities to the commodities recipient by award completion or USG/recipient country MOU completion (whichever comes first). This strategy should include, where applicable to a site or sites, as many of the following principles as practical:

- Development of a comprehensive Supply Chain Transition Plan with clearly defined annual milestones for the recipient military to assume responsibility for key functions. A written supply chain risk management plan that is co-developed with and owned by the recipient military. This plan must address risks to commodity availability (e.g., stockouts, expiries) and risks to the transition process itself (e.g., personnel gaps, funding shortfalls). Plans may be specific to a site or group of similar sites, depending on the need identified by the recipient military and recipient.
- Identification and training of supply chain points of contact within each facility on topics to include where applicable, but not limited to:
    - Accurate use of the commodities request system (typically the national system)
    - Completion of necessary paperwork/electronic forms

    - Stockout and overstock mitigation strategies
    - Inter-site commodity movement procedures
    - Establishing relationships with commodities counterparts within the military and national systems, both regionally and nationally
    - Quantification and forecasting, with the goal of the recipient military leading their national quantification exercise for its facilities.
- In alignment with the America First Global Health Strategy, and in compliance with applicable federal acquisition regulations, the recipient will prioritize the evaluation and selection of U.S.-manufactured pharmaceuticals, diagnostics, and supply chain technologies where they are competitive in terms of cost, quality, and availability. The recipient will document efforts to explore U.S.-based sources as part of its procurement strategy.
- Implementation of supply chain best practices, including product and supply chain segmentation, actively identifying and contracting with local and/or U.S.-based private sector logistics partnerships where appropriate to improve efficiency and build a sustainable logistics infrastructure that can be leveraged directly by the recipient military in the future, and establishing end-to-end supply chain visibility using global standards (GS-1) to enable military leadership to make independent, data-driven supply chain decisions.
- Adoption of decentralized drug distribution (DDD) models, such as home deliveries, use of community or private pharmacies, and automated lockers, to improve client convenience and maximize product availability.
- Collaboration with relevant stakeholders to conduct Diagnostic Network Optimizations (DNOs) to inform laboratory supply chain refinements.
- Development of accurate forecasts that capture total program needs, including considerations for optimized testing and treatment. These forecasts should inform regular (at minimum quarterly) supply plan updates.
- Establishment of systems for increased data visibility and reporting of HIV commodities availability, including granular-level reporting of quantities dispensed and stock availability.
- Active participation in collaborative efforts with recipient governments and other stakeholders to ensure data-informed decision-making and mitigate stock risks.
- Development of a plan for increasing local oversight and utilizing private sector capabilities, where appropriate.
- Implementation of a risk management and monitoring system, which may include third-party monitoring for assessment and oversight of supply chain programs, if required.
- Design and implementation of capacity building initiatives to increase supply chain literacy and fluency across recipients and human resources for health.
- Avoidance of parallel supply chain systems. All efforts must focus on strengthening and utilizing the recipient military's and/or the national health system's existing infrastructure. The recipient should not create separate, temporary, procurement or distribution systems.

The implementer should work towards ensuring a sustainable supply chain and improved regional self-reliance where feasible. This includes ensuring the military is connected to the national procurement system and other already existing procurement systems and resources in-country to avoid creating parallel procurement systems.

**9. LIVES & Child Safeguarding**

The implementer will ensure that all implementer & military health facility staff are trained in and implementing both the DHAPP LIVES and Child Safeguarding interventions (utilizing the curriculum updated in December 2025 that is in alignment with Executive Orders to date); to include re-training all trained staff every 3 years and training all new staff as part of their hiring process. Records for who has been trained and when must be kept by implementer and/or military and accessible upon request.

**10. Tuberculosis (TB)**

The implementer will be responsible for working with the recipient military to implement evidence-based TB prevention, care, and treatment services in alignment with the national MOU and implementation plan, specified by the DHAPP Program Manager. The implementer must work with the recipient military to comply with national TB guidelines and move the program towards international TB standards (if there is a discrepancy). The implementer will ensure the military is connected with all relevant TB stakeholders in-country and seamlessly included in national processes, meetings, networks for efficiency, cost effectiveness, and self-reliance. Implementers will specifically work to integrate testing, treatment, care, and patient flow between any siloed HIV and TB departments within military health facilities. Implementers will work with the recipient military to ensure there are military owned TB services to include:

- Tuberculosis Preventive Treatment (TPT) for individuals at the highest risk of progressing from TB infection to active disease, to include PLHIV, household contacts of TB patients, ADM living in barracks, and other at-risk groups.
- Symptom screening at key healthcare facility service delivery points with strict and consistent protocol to reduce in-facility transmission.
- Standardized drug regimen, including fixed-dose combinations (FDCs).
- Directly Observed Therapy (DOT), especially virtual options, to ensure adherence.
- Robust data systems to ensure patients with TB are tracked through a complete course of therapy and minimizing loss to follow-up.

**Monitoring and Evaluation**

To ensure the effective, efficient, and durable use of United States Government funds, the recipient military armed forces shall be responsible for the comprehensive, reliable, and timely reporting of the milestone, outcome and process metrics specified in this announcement. This reporting is critical for two primary objectives: first, to guide the development of health policies and practices that improve the recipient country's force health readiness, and second, to provide rigorous accountability to the United States Congress and the American taxpayer for every dollar appropriated.

The implementer is mandated to coordinate directly with the recipient military to ensure the accurate and transparent delivery of these metrics to all designated stakeholders as specified in the Memorandum of Understanding between the USG and Burundi.

The overarching goal is to transition all monitoring, evaluation, and reporting responsibilities to the recipient military, fostering complete self-reliance in the shortest possible timeframe. To verify the integrity of this reporting and safeguard U.S. investment, the implementer will execute regular Data Quality Assessments (DQAs) to evaluate the accuracy and reliability of the data provided by the recipient

military, the frequency of which will be determined in consultation with the recipient military.

| Process Metrics | Baseline Targets |
|---|---|
| # people on ART | 4,690 |
| # new HIV diagnoses among infants (0-12 months) | 1 |
| # new HIV diagnoses among children and adults (age 12 months or older) | 375 |
| % pregnant and breastfeeding women living with HIV who receive ART | 100% |
| % accuracy of data fields assessed during the annual data audit | 90% |
| # patients with TB notified (i.e., bacteriologically confirmed + clinically diagnosed) | 5 |
| % of patients with TB notified who completed treatment | >95% |
| % accuracy of data fields assessed during the annual data audit | 90% |

To ensure rigorous oversight and accountability, the implementer is required to submit independent performance data. This reporting will serve to verify and corroborate the data provided by the recipient country's Ministry of Defense as compared to actual program implementation. The explicit purpose of this data collection is to guarantee that every American taxpayer dollar is spent effectively, and its impact is demonstrably justified. All implementer performance data shall be reported at the site level or higher through the designated online data collection system (DC2) at the specified quarterly, semi-annual, or annual intervals. The indicators used for this reporting requirement will harmonize with required milestone, process, and outcome metrics.

All proposals must include milestone metrics by activity and which outcome or process metric each activity supports.

| Budget, USD | Activity | Milestone | Metric Mapping (Outcome & Process Metric) |
|---|---|---|---|

**Quality Management System**

The BNDF is responsible for maintaining a quality management (QM) system, which will no longer be funded through PEPFAR. Site Improvement through Monitoring System (SIMS) is a QM system that has been supported by DHAPP for many years, and implementers and recipient militaries are encouraged to use this system (or other QM system of their choosing). QM systems provide a standardized approach and set of tools for monitoring program quality. QM 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. QM systems are also used to identify performance issues that may impact patient outcomes or the integrity of program reporting site-level triangulation of program and QM data can be

used to contextualize performance and determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

QM systems aim to:
(1) facilitate service improvement,
(2) ensure accountability of U.S. government investments, and
(3) maximize the impact of U.S. government investments on the HIV epidemic.

QM assessment results confirm compliance with minimum quality assurance standards and identify areas where improvements can be made.

The implementer should ensure that all supported sites are familiar with QM standards and make sure that all efforts are taken to follow these standards. DHAPP encourages implementers and militaries to conduct reviews of program performance using the latest QM or SIMS tools which are freely available.

SIMS or other QM system implementation is one strategy available for programs to integrate effective quality assurance (QA) and CQI practices into site and program management. Program management must apply ongoing program and site standards assessment—including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementer agreements and workplans should align with national policy in support of QA/CQI.

**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 recipient military HIV program's ability to monitor progress towards epidemic control. The implementer will work with the recipient military and Ministry of Health (MOH), Ministry of Communications, and 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 recipient military leadership.

The implementer will be responsible for:
- Staffing, support, and mentoring of existing recipient military staff for paper and electronic data collection
- Timely, accurate reporting of all indicators required by the recipient 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 recipient military and DHAPP without prior approval from the recipient 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 recipient military programs and the implementer should include a strategy for conducting baseline, periodic, and ongoing data quality assessments (DQA).

In this way, DHAPP, and the recipient military, can be confident in the veracity of the data that it uses for planning and measurement of progress towards programmatic goals. The implementer should plan on conducting periodic 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 recipient 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 from HIV testing to viral load testing, and the complete 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. Frequency of periodic DQAs should be determined in consultation with the recipient military and DHAPP.

**Informatics Health Information Systems**

Informatics (including Digital Health Platforms (DHP) also known as Health Information Systems (HIS) or Medical Information Systems (MIS)) are critical underpinnings of good patient healthcare and good program management. The military's health system requires reliable informatics support to ensure its long-term, sustainable advancement. Key goals for a military HIS include 1) improving quality and safety of care; outbreak detection; data-driven decision-making; efficient deployment of resources; QA/QC; and improved access and improved confidentiality of health data.

The implementer will support the recipient military's HIS to align with the recipient country health information systems (HIS) to the greatest degree possible. The implementer will inventory the current military data systems (paper and electronic) and will provide written recommendations to include identification of gaps in the military HIS and requirements to enable the recipient military HIS to reach all clinical and laboratory locations. The implementer will coordinate with the military and MOH or other appropriate ministries to 1) ensure the military sites are included in national systems with 2) training, 3) infrastructure improvements such as routers, computers, solar power and satellite internet connectivity, 4) security (physical and cyber), 5) data use policy and governance, 6) data management, 7) data analytics, and 8) data use and dissemination. Where equipment procurements are needed, the recipient will ensure that the equipment will follow US laws and policies (e.g. no equipment from China, USA made, etc.).

The implementer must ensure by 2030 that the military will be capacitated with durable systems, staffing, training, and infrastructure to allow the military to use their systems effectively and independently to monitor client health and conduct national reporting.

**Work Plans**

The implementer 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. A full list of reporting requirements can be found in the base Program Announcement and will be disclosed in the award terms and conditions.

**Ethiopia: DHAPP - ENDF Partnership for Resilient Military Health Systems for Readiness**

**NOTE: Application submissions for this narrative are due by 12pm EST on 15 May 2026. Submissions received after the deadline will not be considered for funding.**

## Call for Proposals

Proposals are requested to support the Ethiopian National Defense Force (ENDF) to reach sustainable control of the HIV epidemic through the America First Global Health Strategy, as well as the UNAIDS HIV Treatment 95-95-95; Vertical Transmission 95 targets; and TB prevention 90 and in alignment with the National Security Strategy (NSS) and the National Defense Strategy (NDS) goals to protect the homeland, deter China, and increase burden sharing. Further, proposals must be aligned with the Memorandum of Understanding between the U.S. Department of State and the Government of the Federal Democratic Republic of Ethiopia, signed December 23, 2025. This award is anticipated to begin on or about October 1, 2026, for a base period of one year with up to three option years (four years total). The estimated annual budget is between $5,000,000 and $7,250,000 per year ($25,000,000 total), subject to the availability of funds. An additional performance incentive may be available contingent on achievement of metrics to be determined. Implementers should be familiar with these strategic guidance documents and include means of addressing them in submitted proposals. **Please see base Program Announcement section D for complete detailed list of application, format and submission requirements. Proposal Technical Narrative may not exceed 45 pages.**

## Introduction

The HIV/AIDS epidemic has devastated 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 other military personnel and their extended communities, and impeding participation in peacekeeping activities. As HIV management improves, many of these impacts are reduced; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries; this is in addition to managing other long-term chronic diseases to maintain high force health readiness in strategically identified recipient militaries. Moreover, given the well-known biobehavioral risk factors among uniformed personnel, reducing HIV acquisition and transmission in this population is an essential component for reaching epidemic control in the recipient country.

The U.S. Government has a long history of providing foreign assistance to combat HIV/AIDS, advancing U.S. national security by promoting stability in key regions. Over the years, the United States DoD HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries to control the HIV epidemic among their respective military services. Working closely with the Department of Defense (DoD, herein referred to using the secondary title Department of War, DoW), U.S. Geographic Combatant Commanders, the Bureau of Global Health Security and Diplomacy (GHSD) and other organizations, DHAPP's mission is to build the capacity of recipient militaries through military-specific HIV/AIDS assistance, creating self-reliant security counterparts. DHAPP is the DoW implementing agency collaborating with the US Department of State, 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 Department of War (Title 10) Defense Health Program (DHP) and funding transfers from the Department of State (Title 22) for

PEPFAR.

The new U.S.-Ethiopia health Memorandum of Understanding (MOU) establishes national expectations for HIV, malaria, TB, laboratory systems, commodities, surveillance, and digital health through 2030; DHAPP's Ethiopia effort should mirror and feed into that larger platform through military-specific implementation that preserves command relationships, protects confidentiality, and measurably increases ENDF self-reliance. Proposals must be in full alignment with any existing MOU between the Department of State (DoS) and Ethiopia clearly articulating transition plans for each activity over the course of the agreement with specific and measurable milestones. Reserving the last year of the agreement for transition planning will not be accepted. Activities to transition responsibilities to the recipient country must begin immediately upon award and continue throughout the life of the agreement to ensure a rapid path to self-sufficiency. The implementer must prepare the recipient country's military to fully own and operate all services, ensuring a complete and final transition of responsibility away from U.S. assistance.

The DoW Combatant Commands (CCMDs) have identified the longstanding DHAPP program with recipient countries as an essential security cooperation tool that serves U.S. interests. Pursuing HIV/AIDS activities with foreign militaries is an important part of maintaining security interests, regional stability through health readiness, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing nations. 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 CCMDs and DHAPP Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under-Secretary of War for Policy and by the Department of State Bureau of Global Health Security and Diplomacy (GHSD). DHAPP provides technical support to defense forces in HIV prevention, care, treatment, and information systems and data use 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. An additional goal supported by GHSD is 95% coverage of services for eliminating vertical transmission. Lastly, the UNAIDS Global AIDS Strategy established a goal that 90% of PLHIV receive preventive treatment for TB.

All proposals must align with the America First Global Health Strategy, which focuses on the following points:

- Address Inefficiency and Dependency: The majority of funding should go directly towards patient care and building resilient health systems. High program management costs will not be funded.
- Pillar 1: Make America Safer: The primary goal is to protect Americans by enhancing global surveillance systems to detect outbreaks within seven days of emergence, notify public health authorities within 1 day and rapidly responding at the source within 7 days with early response actions to prevent pandemics from reaching U.S. shores.
- Pillar 2: Make America Stronger: Foreign health assistance will be used as a strategic tool to strengthen bilateral relationships. The U.S. will enter into multi-year agreements with recipient countries that require co-investment and establish clear benchmarks, ...moving them toward self-sufficiency and away from reliance on U.S. foreign assistance. Proposals must align with any existing country-specific MOU timelines.
- Pillar 3: Make America More Prosperous: The strategy aims to bolster the U.S. economy by

preventing costly pandemics and by using foreign assistance programs to promote American companies and health innovations (like diagnostics and pharmaceuticals) in emerging global markets.

- Restructure Aid Delivery: The plan calls for more frontline support, such as medical commodities and healthcare workers, while significantly reducing all other non-frontline expenditures to ensure accountability to the American taxpayer. It will also streamline efforts by integrating disease-specific programs (HIV, Malaria, TB) and leveraging the private sector and faith-based organizations for more efficient service delivery. The implementer is expected to work with the DHAPP Program Manager (PM) on supporting the integration of disease-specific programs receiving USG funding for the military program.

**Local Implementers**

Local, non-governmental implementers with low overhead costs are encouraged to apply to this announcement. To achieve self-reliance, it is critical that the full range of HIV services are owned and operated by the recipient country's institutions, governments, and community-based and community-led organizations, regardless of current antiretroviral (ARV) coverage levels. The intent of transitioning to local implementers 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 implementers to ensure successful, long-term, community 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.

**Additional Submission Guidance:**

1. Review all documents within the package to ensure consistency in information, budgets, targets, and numbering:
    a. Use numbered lists, including numbered or alphabetized sub-lists, for activities for easier reference and monitoring, especially the SOW Narrative column.
2. Ensure all activities in the Technical Narrative are also listed concisely in the SOW file.
3. Activities must be specific; Do not write “ensure” or “support” or a similar verb as a narrative activity without defining what that means. Each activity must say specifically what the implementer will be doing. It must be measurable and answer the questions Who? What? Where? How? How many? How often?
4. Delineate between a training (i.e.: one time class or series of classes where attendees are gathered in a conference room, away from regular duties) and onsite strategic assistance (on the job guidance while recipient is performing regular duties) and specify as many of the following details as possible for both: how many attendees or sites, how often, how many days, where, specific topics/skills covered, expected outcomes & how they align with program goals, etc. Training should be limited and cost efficient.
5. Please note this project budget cannot include:
    a. Any budget allocations toward World AIDS Day (WAD) events/campaigns.
    b. Prizes, hats, or T-shirts.
    c. Flyers and printed education materials to be given to beneficiaries.

d. Rental of venues for training or events (must use available military or ministry facilities).
e. Employment or payments made directly to active-duty foreign military.

**Budget**

The **estimated annual** budget for this program announcement is $5,000,000 to $7,250,000 per year for up to four years ($25,000,000 total), as follows. Final authorized budget will be confirmed and communicated at time of official award execution. The DATIM help site (https://help.datim.org) contains the Financial Classifications Reference Guide and a summary of the classification definitions.

Financial classifications are not regulations governing allowability of federal awards. Nothing in this guidance should be interpreted to mean that costs or activities that are unallowable or excluded under the terms of an award are permitted by virtue of being described herein. All awards are subject to the applicable cost principles and terms set forth and conveyed in the award made.

**Estimated Budget to be used as a Framework**
The completed budget framework is provided below. At this planning stage, activities are aggregated to the MOU Area of Cooperation level. Phases 1-4 correspond to FY27-FY30 base planning assumptions at $5,000,000 per phase. Any future performance incentive funding that may later be authorized under broader U.S.-Ethiopia arrangements is not included in this base framework and should not be presumed in applicant budgets unless specifically directed by DHAPP.

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.1: Surveillance and Outbreak Response | GHS | 2.1: Outbreak Response Capacities | 140,000 | 130,000 | 105,000 | 90,000 | 465,000 |
| | GHS | 2.1: Multisectoral Coordination for Animal and Human Outbreak Surveillance and Response | 70,000 | 65,000 | 50,000 | 35,000 | 220,000 |
| | GHS | 2.1: Outbreak Readiness | 175,000 | 160,000 | 125,000 | 105,000 | 565,000 |
| **Subtotal** | | | **385,000** | **355,000** | **280,000** | **230,000** | **1,250,000** |
| 2.2: Laboratory Systems | HIV | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 250,000 | 210,000 | 170,000 | 105,000 | 735,000 |
| | Malaria | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 45,000 | 35,000 | 25,000 | 15,000 | 120,000 |
| | GHS | 2.2: Lab Equipment Procurement | 325,000 | 220,000 | 170,000 | 110,000 | 825,000 |
| | GHS | 2.2: Lab Service and Maintenance Costs | 170,000 | 130,000 | 135,000 | 125,000 | 560,000 |
| | HIV | 2.2: Lab Sample Transport | 60,000 | 55,000 | 45,000 | 30,000 | 190,000 |
| | GHS | 2.2: Lab System Support | 65,000 | 60,000 | 55,000 | 55,000 | 235,000 |
| | TB | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 105,000 | 95,000 | 85,000 | 75,000 | 360,000 |
| | GHS | 2.2: Frontline Lab Workers | 95,000 | 105,000 | 85,000 | 60,000 | 345,000 |
| | GHS | 2.2: Lab Accreditation | 35,000 | 40,000 | 30,000 | 30,000 | 135,000 |
| **Subtotal** | | | **1,150,000** | **950,000** | **800,000** | **605,000** | **3,505,000** |
| 2.3: Commodities | HIV | 2.3: Prevention Commodity Procurement | 130,000 | 120,000 | 95,000 | 70,000 | 415,000 |
| | HIV | 2.3: Diagnostic Commodity Procurement | 220,000 | 180,000 | 140,000 | 85,000 | 625,000 |
| | HIV | 2.3: Therapeutic Commodity Procurement | 430,000 | 395,000 | 290,000 | 200,000 | 1,315,000 |
| | Malaria | 2.3: Prevention Commodity Procurement | 215,000 | 185,000 | 150,000 | 115,000 | 665,000 |
| | Malaria | 2.3: Diagnostic Commodity Procurement | 90,000 | 75,000 | 60,000 | 45,000 | 270,000 |
| | Malaria | 2.3: Therapeutic Commodity Procurement | 90,000 | 75,000 | 60,000 | 45,000 | 270,000 |
| | TB | 2.3: Diagnostic Commodity Procurement | 65,000 | 60,000 | 50,000 | 35,000 | 210,000 |
| | TB | 2.3: Therapeutic Commodity Procurement | 95,000 | 85,000 | 70,000 | 55,000 | 305,000 |
| | GHS | 2.3: Response Commodity Procurement | 85,000 | 80,000 | 75,000 | 70,000 | 310,000 |
| | GHS | 2.3: In-Country Warehousing and Distribution | 75,000 | 65,000 | 55,000 | 50,000 | 245,000 |
| | GHS | 2.3: Supply Chain Systems Support | 105,000 | 70,000 | 65,000 | 30,000 | 270,000 |
| **Subtotal** | | | **1,600,000** | **1,390,000** | **1,110,000** | **800,000** | **4,900,000** |
| 2.4: Frontline Health Workers | HIV | 2.4: Nurses/Midwives | 150,000 | 160,000 | 140,000 | 110,000 | 560,000 |
| | HIV | 2.4: Doctors/Clinical Officers | 95,000 | 90,000 | 75,000 | 55,000 | 315,000 |
| | GHS | 2.4: Epidemiologists & Surveillance Officers | 120,000 | 115,000 | 105,000 | 90,000 | 430,000 |
| | HIV | 2.4: Community Health Workers/Community-Based Staff | 80,000 | 75,000 | 65,000 | 55,000 | 275,000 |
| | Malaria | 2.4: Campaign Workers | 50,000 | 55,000 | 50,000 | 40,000 | 195,000 |
| | HIV | 2.4: Other Health Workers | 25,000 | 25,000 | 25,000 | 20,000 | 95,000 |
| | TB | 2.4: Other Health Workers | 30,000 | 30,000 | 30,000 | 25,000 | 115,000 |
| | Malaria | 2.4: Other Health Workers | 25,000 | 20,000 | 20,000 | 25,000 | 90,000 |
| **Subtotal** | | | **575,000** | **570,000** | **510,000** | **420,000** | **2,075,000** |
| 2.5: Data Systems | GHS | 2.5: Data Systems Infrastructure | 585,000 | 505,000 | 510,000 | 495,000 | 2,095,000 |
| **Subtotal** | | | **585,000** | **505,000** | **510,000** | **495,000** | **2,095,000** |
| 2.6: Strategic Assistance | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 300,000 | 305,000 | 315,000 | 355,000 | 1,275,000 |
| | GHS | 2.6: TA to Support Program Transition to Government or Local Partners | 340,000 | 440,000 | 605,000 | 860,000 | 2,245,000 |
| | GHS | 2.6: TA to Introduce New Innovative Diagnostics, Vaccines, Drugs, and Other Interventions (Including Integated Services) | 150,000 | 130,000 | 115,000 | 105,000 | 500,000 |
| | GHS | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 195,000 | 175,000 | 170,000 | 195,000 | 735,000 |
| | GHS | 2.6: Other Health Systems Strengthening | 175,000 | 200,000 | 210,000 | 275,000 | 860,000 |
| | GHS | 2.6: IP Program Management | 1,595,000 | 1,300,000 | 1,060,000 | 805,000 | 4,760,000 |
| | Malaria | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 95,000 | 80,000 | 95,000 | 115,000 | 385,000 |
| | TB | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 105,000 | 100,000 | 95,000 | 115,000 | 415,000 |
| **Subtotal** | | | **2,955,000** | **2,730,000** | **2,665,000** | **2,825,000** | **11,175,000** |
| **Total** | ***Budget estimate to be used as a framework. Final authorized budget will be confirmed and communicated at time of official award. Phases 2-4 option budget estimates are notional and depend on availability of U.S. Government funding and satisfactory performance, including transition progress.** | | **7,250,000** | **6,500,000** | **5,875,000** | **5,375,000** | **25,000,000** |

**Approaches to Reaching Sustainable Epidemic Control & Transitioning Ownership**

Proposals are requested to support the Ethiopian National Defense Force (ENDF) to reach sustainable control of the HIV epidemic and focus on the America First Global Health Strategy, the latest PEPFAR guidance and UNAIDS HIV Treatment 95-95-95, Vertical Transmission 95 targets, and TB prevention 90 targets, in alignment with the NSS, NDS, and the MOU between the U.S. DoS and Ethiopia.

Key epidemiological context: The Ethiopian 2024 national adult (15-49) prevalence of 0.67% was estimated by EPHI, which also identified significant regional variation ranging from 3.1% in Gambella to 0.2% in Somali, with an estimated 601,039 PLHIV and 7,962 new infections nationally (EPHI, HIV Related Estimates and Projections in Ethiopia for the Year 2024-2025, June 2025). Recent discussions with ENDF leadership and other stakeholders highlight opportunities for strengthening the military health system in areas such as HIV case-based surveillance, sero-behavioral data collection (possibly through a new SABERS), supply chain management for ARVs and test kits, electronic medical records (EMR) deployment aligned with national standards, malaria prevention and control, TB/HIV integration, outbreak preparedness and the Public Health Emergency Management (PHEM) system including the 7-1-7 framework (detect within 7 days, notify within 1 day, respond within 7 days), and Incident Command System (ICS) capacity.
The implementer will be responsible for supporting the ENDF in conducting a Military Sustainability Index (MilSID) each year of the award, ensuring all stakeholders are present, which should be specifically included as an SOW activity.

DHAPP will support military health systems which require strengthening in one or more areas: (1) same-day ART initiation and test-and-start implementation across all 48 ART sites; (2) index testing and partner notification services; (3) viral load testing coverage and suppression monitoring (current VL testing infrastructure is limited at military sites); (4) TB screening and TPT completion among PLHIV; (5) cervical cancer screening for WLHIV; (6) multi-month dispensing (MMD) implementation; (7) data quality and use at the site level; and (8) quality management system implementation. Additionally, the ENDF requires support in integrating malaria and TB services into existing HIV platforms, and in establishing electronic medical record systems aligned with national HIS standards.

The implementer will develop and implement a comprehensive transition plan that is in alignment with any existing country MOU, with clearly defined every 6-month milestones demonstrating progressive military assumption of programmatic responsibilities across all technical areas, data collection and reporting areas, and program management. This transition framework prioritizes efficiency, direct patient care investment, and development of resilient health systems capable of independent operation beyond the period of U.S. support. All proposals should detail how the implementer will engage the recipient military leadership as well as personnel at all levels in this work; and, specifically, how the implementer will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Please specify which SOW activities the implementer is supporting the military to take ownership of (showing increasing military ownership) and by when (with detailed milestones). Throughout this progression, the implementer must document evidence of increasing military ownership through specific metrics including percentage of activities led by military staff, number of military personnel trained to competency, and documented military-led decision-making and problem-solving. Failure to attain defined milestones as agreed upon by the implementer, the partner military, and DHAPP may result in award termination.

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

**Technical Narrative & Scope of Work (SOW)**

In alignment with international health guidelines, America First Global Health Strategy, and guidance from PEPFAR/GHSD, coupled with DHAPP's vision to build the capacity of military health systems through military-specific and culturally appropriate services, the recipient will address the approach to each technical area. The implementer, through burden-sharing and building self-reliance within the recipient military, will be responsible for providing the following in close collaboration with other DHAPP-funded implementers.

**Technical Module Building Blocks**

The implementer will work closely with ENDF and its medical leadership to build a resilient, self-reliant military health program aligned with the national MOU, using evidence-based and efficient interventions to reach the three 95s. In alignment with the Transition Plan directive above, the implementer will include specific milestones for program transition for activities within each technical area.

1. **Pre-Exposure Prophylaxis (PrEP)**

The implementer will support ENDF in providing client-centered, judgement-free, evidence-based PrEP services to HIV-negative individuals at high risk of acquiring HIV, with military-specific attention to new recruits, personnel separated from families, deployed or mobile forces, serodifferent couples, eligible adolescent girls and young women linked to military communities, and other populations defined by ENDF, MOH policy, and local epidemiology.

The implementer will ensure that the following interventions for adults and adolescents include:

- People at a higher risk of acquiring HIV, including PBFW, must be counseled on and offered PrEP in alignment with recipient country government policies. Any person who asks for PrEP should be considered for use.
- Individuals considering PrEP must be confirmed HIV-negative and be willing to attend follow-up appointments to monitor their HIV status on a routine basis. If a PrEP user tests HIV-positive, PrEP must stop immediately and effective HIV treatment must start.
- Differentiated and simplified service delivery for PrEP is encouraged, such as event-driven PrEP (ED PrEP), community delivery, and the use of HIV self-tests (HIVST) for PrEP services.

- PrEP counselors must be equipped to ensure that PrEP users understand adherence to the different DSD options and different PrEP options. Adherence counseling and support must be ongoing, as necessary.
- As Long-acting Lenacapavir (LEN) injectables become available, beneficiaries should be presented with thorough information on all available PrEP options, including each method's relative efficacy and safety, as well as counseling and adherence support, allowing for an informed client choice.
- If PrEP is not being offered at military facilities, the recipient will work with the military and PM to advocate with necessary stakeholders (possibly MoH or military leadership) to update guidelines, gain necessary approvals, and start implementation at military facilities.

**2. Post Exposure Prophylaxis (PEP)**

The implementer will support ENDF in providing client-centered, judgement-free, evidence-based PEP services to all HIV-negative individuals (including healthcare workers and non-healthcare workers) who have had a possible exposure to HIV within the last 72 hours. The implementer will support ENDF in providing client-centered, judgement-free, evidence-based PEP services to all HIV-negative individuals with possible exposure to HIV within the last 72 hours, including healthcare workers, non-healthcare workers, sexual exposure clients, and military personnel injured or exposed during duty-related events. Proposals should describe how 24/7 access to starter packs and referral pathways will be ensured at referral hospitals and other priority military sites.

The implementer will ensure that the following interventions for adults and adolescents include:

- PEP should be started as soon as possible after a potential exposure to HIV, ideally within 24 hours and no later than 72 hours.
- The person seeking PEP should be tested for HIV to confirm they are HIV-negative before starting PEP, although if testing is not available, PEP should be started immediately and can be stopped later once testing is available. Individuals who test positive for HIV should be started on treatment immediately.
- Three ARV drugs for a 28-day prescription are recommended for the HIV PEP regimen. Patients must be properly counseled to understand what PEP is, on adherence, and potential side effects.
- If PEP is not being consistently integrated and offered at military facilities (to the point that the surrounding population knows it is accessible if needed), the recipient will work with the military and PM to update guidelines and SOPs, gain necessary approvals, and start implementation at military facilities. Timely access to PEP is the most crucial factor in PEP effectiveness.
- Individuals who seek PEP services should be counseled on and offered PrEP post PEP if risk is ongoing.
- PEP availability in community settings, as well as task sharing of PEP administration is encouraged to increase timely accessibility post exposure.

**3. HIV Testing Services (HTS)**

HIV Testing Services (HTS) is the forefront for finding the remaining people who are living with HIV (PLHIV) and is a priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know their infection status are men, adolescents, and children. The recipient military HIV/AIDS program is strategically placed to reach men; therefore, the implementer will closely work with the recipient military on HTS for both prevention and diagnosis. Those who test negative should be provided with HIV risk reduction information (including referral to PrEP where relevant) and educated on U=U (Undetectable = Untransmittable). For those who test positive, activities should include information about HIV, offer of Safe and Ethical Index Testing (SEIT), and offer of self-testing for family members (all sexual partners and children under 19 years old) who may not be able to access a testing site. HTS should be targeted towards military personnel to achieve the target of 95-100% of all recipient military PLHIV knowing their status. HTS should also be provided to beneficiaries and civilians cared for at all military sites. The implementer will ensure they and the recipient military follow GHSD and national guidance on implementing SEIT and use the training materials created by the HTS team with the 10-Step model. The local epidemiology and situational analysis should guide other testing methods to identify PLHIV.

Provider-Initiated Testing and Counseling (PITC) will continue at military facilities for both the military and civilian cohorts. PITC should focus within clinical areas that have shown a high testing yield, such as inpatient wards, tuberculosis (TB) and sexually transmitted infection (STI) clinics.

All people newly diagnosed with HIV should be retested to verify their HIV status prior to starting ART. The same testing strategy and algorithm as the original diagnosis should be used, but with a different tester and different test kit lots.

The implementer should support the military to achieve over 95% linkage of HIV-positive individuals identified to treatment initiation, fully implementing “test-and-start” policies across all age, sex, and risk groups. Ensuring that any person with positive results identified is linked to HIV care and treatment is essential to the success of the recipient military program. The implementer will support the military to 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 and other relevant integrated services.

The implementer will be responsible for providing support for the following activities to military bases and facilities:

- Diagnosing HIV, with at least 95% of those diagnosed linked to HIV care, while striving for 100% linkage to treatment services and same day initiation of ART.
- Offering SEIT to all HIV positive clients and testing for all sexual partners and children under 19 years old of HIV positive military personnel and civilians (with at least 1.5 contacts identified on average).
- Documenting HIV status for all children under 19 years of age with mothers living with HIV.
- Offering self-testing for partners of index clients if they do not volunteer for partner notification.
- Facilitating quality improvement and quality assurance for all recipient military HTS sites,

including strategic assistance, at least quarterly.

- Providing HIV self-testing (HIVST) for military personnel, AGYW and their partners, male partners of antenatal care (ANC) clients and other high-risk populations. As part of the HIVST protocol, clients with a positive HIVST should be instructed to follow up with trained staff for further evaluation, including diagnostic testing utilizing the national testing algorithm. It is also vital to engage community groups to advocate for, design, implement, and analyze the success of 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, including Viral Load Suppression (VLS).
- Linking HIV negative, high-risk clients to PrEP services.

## 4. HIV Treatment

ART optimization is the cornerstone of PEPFAR policy, and uninterrupted HIV treatment is central to ENDF readiness and beneficiary well-being. The implementer should support ENDF treatment sites to provide rapid initiation, strong retention support, differentiated service delivery for mobile military clients, integrated HIV/TB services, and reliable access to the most effective regimens available under national policy. Proposals should describe how treatment continuity will be maintained during transfers, deployments, temporary duty, and leave, and how ENDF clinicians will increasingly manage adherence support, case review, and regimen optimization.

- 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. The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission recommends DTG-containing regimen as a Preferred ARV for PBFW and recommends DTG-containing regimen as a Preferred ARV for women who are trying to conceive. Starting in COP20 (FY21), programs were 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 prevent the development of TB in PLHIV as well as diagnose and treat PLHIV with TB disease and ensure they become non-infectious. In addition, all TB infected individuals should be tested for HIV.
    - Routinely screen all PLHIV for TB disease. Standardized symptom screening alone is not sufficient for TB screening among PLHIV and should be complemented with more-sensitive and setting-specific recommended screening tools. Ensure all PLHIV who screen positive for TB receive recommended molecular diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment.
    - For all who do not have active TB, prevention of TB is a priority using nationally

approved TB preventive therapy (TPT). The Global AIDS Strategy has set the target of 90% of PLHIV to receive preventive treatment for TB, thus TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Implementers 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 that is consistently documented. In short, all newly diagnosed HIV-positive people should be offered TB treatment or preventive therapy, and all people assessed for TB should be tested for HIV.

- Pregnant women living with HIV are at high risk of progression from TB infection to disease; thus, it is imperative that Prevention of Mother to Child Transmission (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 PLHIV.
- 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, implementers should also seek opportunities to support effective joint program implementation. Additionally, implementers should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide a 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 Women Living with HIV (WLHIV) should be integrated into routine HIV treatment services in each country program. All PEPFAR supported countries with HIV prevalence above 5.0% among women in the 15-49-year-old age group are expected to provide at least one life-time cervical cancer screen for WLHIV receiving ART.
  - Current international health guidelines recommend screening to start at age 25 or according to national guidelines, whichever is earlier. Programs may also consider earlier screening among women with long-standing HIV infection, e.g., perinatal infection. WLHIV who are between 50 and 65 years and have not been screened may be offered a single screening test, and screening should be discontinued if they screen negative.
  - Screening for cervical cancer should begin at high-volume military sites and be scaled to all women receiving ART in military ART sites either on-site or through referral to hub sites within the region. Screening should be available in the ART clinic or in affiliated clinics on-site such as women's health or maternal child health clinics for WLHIV to utilize.
  - Programs should ensure that a minimum of 90% of women who screen positive are linked to treatment.
  - 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.
  - Funding may be used for screening with visual inspection with acetic acid (VIA),

treatment with cryotherapy, thermal ablation, and loop electrosurgical excision procedure (LEEP), and quality assurance activities.

- The implementer should work with the recipient military to offer most clients 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, 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 implementer should work with the recipient 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 HIV-related stigma by integrating a wide array of non-HIV commodities into decentralized sites (e.g. TPT). DDD models can also be used for decentralized PrEP distribution to improve uptake and continuation.
- Diagnose and treat people with advanced HIV disease (AHD). People starting treatment, re-engaging in treatment after an interruption of > 1 year, or virally unsuppressed for >1 year should be evaluated for AHD and have CD4 T cells measured. Accordingly, the implementer should be working with recipient military and public health leaders to ensure that CD4 testing is available. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease. The PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with advanced disease.

## 5. 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 implementer will work closely with the Ministry of Defense in Ethiopia to scale up VL testing coverage and VL suppression to achieve 95-95-95 goals for military personnel, as well as beneficiaries and civilians. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% VL suppression among PLHIV taking ART. CD4 testing should not be used to determine eligibility for ART and only should be used for assessment of immune status (i.e. identification or ongoing monitoring of patients with advanced HIV disease).

The implementer should ensure that the recipient military has access to timely VL testing (goal turnaround time is within 2 weeks) and that capacity exists to test 95% of people currently on ART annually. To ease logistical challenges associated with the transport of whole blood specimens and to increase access to routine VL monitoring, dried blood spots (DBS) for VL testing can be used as an alternative specimen type to plasma. 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 POC be used for VL testing among PBFW, infants, and children. Implementers must follow international health guidelines and work with military and MoH network (as necessary) to implement and monitor VL testing schedule for PBFW and HIV-exposed infants (HEI), which differs from the VL testing schedule of non-PBFW HIV+ adults. POC platforms may also be appropriate for low volume remote military sites.

The implementer will ensure that VL results are available to providers/clients in a reasonable amount of time (goal is within 2 weeks) to both the health care provider and the client. These results should be available 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. Unsuppressed clients and their sexual partners should be educated on alternate risk reduction options until they become suppressed, such as PrEP. 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, to minimize inconveniences associated with health system access.

HIV viral suppression is not only critical to improving individual health, but also to prevent sexual transmission, and reduce perinatal transmission. There are three key categories for HIV viral load measurements: unsuppressed (>1000 copies/mL), suppressed (detected but ≤1000 copies/mL) and undetectable (viral load not detected by test used: <40 or <50 copies/ml depending on the machine used). People living with HIV who have an undetectable viral load and continue taking medication as prescribed have zero risk of transmitting HIV to their sexual partner(s) (U=U). PLHIV who have a suppressed but detectable viral load and are taking medication as prescribed have almost zero or negligible risk of transmitting HIV to their sexual partner(s). HIV VL test results can be a motivation for adhering to treatment and achieving the goal of being undetectable. Emphasizing and strengthening adherence counselling during antiretroviral therapy initiation and throughout treatment are essential, including communicating about the benefits of viral load suppression to all PLHIV. HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. The implementer must work with the military to ensure updated and accurate U=U messaging and encourage HIV testing, prevention, and treatment reaches all PLHIV, the general population and health care providers.

### 6. Health System Strengthening

DHAPP is working to enhance the ability of militaries and Ministries of Defense to manage their HIV epidemic, respond to broader health needs impacting their communities, and address new and emerging health threats. A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of the HIV response, including political commitment, building program capacities and capabilities, and financial planning and expenditure. Implementers should describe how support to ENDF will strengthen an integrated military health system capable of delivering HIV, TB, malaria, laboratory, surveillance, and digital health functions with decreasing implementer dependence and increasing ENDF ownership.

The procurement of supplies, support and equipment should use recipient government and other donor

sources when possible (Global Fund, etc.).

Laboratory:

The implementer will be responsible for the following activities to help recipient militaries build resilient, sustainable, and internationally accredited laboratory systems strongly capable of responding to the HIV epidemic and other future infectious disease outbreaks:

- Laboratory inventory tracking, control, and forecasting; monitoring of commodities procurements to ensure laboratory supplies are procured at cost-effective prices and services are uninterrupted; monitoring facilities storing procured laboratory commodities to ensure they meet International Organization for Standardization (ISO) warehouse principals and standards; obtaining insurance for procured laboratory commodities to protect against natural disasters, fire, theft, etc.
- Supporting and facilitating military participation in national quantification exercises, ensuring that military laboratory commodity needs are incorporated into national forecasting.
- Routine monitoring of turnaround time (TAT) for VL, TB, and other critical tests, to ensure test results are provided to providers and patients within a reasonable period (2 weeks) to improve and maximize patient care and outcomes.
- Procuring laboratory service maintenance contracts, routine calibration of equipment, and training of laboratory staff on proper use and maintenance of procured equipment.
- Supporting training in proper laboratory biosafety and waste management.
- Ensuring continuous quality improvement of all laboratories (including satellite laboratories and HIV testing sites) and accreditation is in place and transitioned over to the recipient government with key milestones and timeline.
- Monitoring of laboratory quality, adherence to quality systems, and method validation; provision of proficiency testing for rapid HIV testing, VL, CD4, TB, STIs, and other tests critical to HIV epidemic control and detecting emerging disease outbreaks.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, address needs and gaps, and provide recommendations for the development of improvement plans to resolve any identified problems.
- Linking recipient military laboratory services to other laboratory resources at the district, provincial, and national levels.

Optimizing diagnostic networks for VL/EID, TB, and other coinfections. In coordination with other Donors and National TB Programs, complete diagnostic network optimization (DNO) and transition to integrated diagnostics and multi-disease testing. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time (goal is 2 weeks). Identify all parts of the laboratory system that are interoperable with the U.S. military system.

### 7. Virtual Communities of Practice/ECHO Platform

The implementer should support the recipient military's use of Virtual Communities of Practice (vCOPs) through the Project ECHO (Extension for Community Healthcare Outcomes) model if a nationally-linked ECHO network already exists or can be feasibly linked to supported military sites. Project ECHO is evidence-based, virtual model that democratizes medical expertise as a self-reliant tool for continuous clinical knowledge sharing amongst healthcare workers. Since 2020, DHAPP has collaborated with the

ECHO Institute (https://hsc.unm.edu/echo/) to lever their vast experience with vCOPs/ECHOs and to assist in establishing ECHO programs with 24 recipient militaries. More information on the establishment of the DHAPP Superhub available at https://pubmed.ncbi.nlm.nih.gov/40984107/. Key requirements are equipment and connectivity as well as personnel who can coordinate, manage, and lead regular vCoP/ECHO sessions. (https://hsc.unm.edu/echo/).

If the ENDF has an existing, launched ECHO program, the implementer shall provide support focused on transitioning full ownership of the ECHO program to the recipient military. Required support activities include:

- **Program Maintenance:** Assisting the recipient military in the maintenance of existing ECHO hub and spokes – connectivity,
- **Strategic Expansion:** Supporting the addition of new clinical "spokes" to strengthen the military network of integrated care throughout the country.
- **Network Engagement:** Ensuring the recipient military actively engages with the DHAPP ECHO Superhub, and, where applicable, any local ECHO network (i.e., an MOH-led ECHO) for broader collaboration.

The Statement of Work (SOW) narrative must be specific about all proposed ECHO activities (e.g., personnel, number of sites, locations). All equipment purchases listed in the workplan must follow current U.S. laws (Congress) and policies (Executive Branch) and must be reviewed and approved by the DHAPP ECHO Team.

## 8. Commodities

The implementer will assist ENDF in developing and implementing a supply chain management strategy that aligns with PEPFAR goals, the U.S.-Ethiopia MOU, and national EPSS systems while steadily improving ENDF self-reliance. The proposal should show how military facilities will be connected to existing national quantification, ordering, warehousing, distribution, and reporting processes and how ENDF will increasingly own stock visibility, requisition review, redistribution decisions, and last-mile accountability. No parallel procurement or distribution system for the military should be created. This strategy should include, where applicable to a site or sites, as many of the following principles as practical:

- Development of a comprehensive Supply Chain Transition Plan with clearly defined annual milestones for the recipient military to assume responsibility for key functions. A written supply chain risk management plan that is co-developed with and owned by the recipient military. This plan must address risks to commodity availability (e.g., stockouts, expiries) and risks to the transition process itself (e.g., personnel gaps, funding shortfalls). Plans may be specific to a site or group of similar sites, depending on the need identified by the recipient military and recipient.
- Identification and training of supply chain points of contact within each facility on topics to include where applicable, but not limited to:
    - Accurate use of the commodities request system (typically the national system)
    - Completion of necessary paperwork/electronic forms
    - Stockout and overstock mitigation strategies
    - Inter-site commodity movement procedures

    - Establishing relationships with commodities counterparts within the military and national systems, both regionally and nationally
    - Quantification and forecasting, with the goal of the recipient military leading their national quantification exercise for its facilities.
- In alignment with the America First Global Health Strategy, and in compliance with applicable federal acquisition regulations, the recipient will prioritize the evaluation and selection of U.S.-manufactured pharmaceuticals, diagnostics, and supply chain technologies where they are competitive in terms of cost, quality, and availability. The recipient will document efforts to explore U.S.-based sources as part of its procurement strategy.
- Implementation of supply chain best practices, including product and supply chain segmentation, actively identifying and contracting with local and/or U.S.-based private sector logistics partnerships where appropriate to improve efficiency and build a sustainable logistics infrastructure that can be leveraged directly by the recipient military in the future, and establishing end-to-end supply chain visibility using global standards (GS-1) to enable military leadership to make independent, data-driven supply chain decisions.
- Adoption of decentralized drug distribution (DDD) models, such as home deliveries, use of community or private pharmacies, and automated lockers, to improve client convenience and maximize product availability.
- Collaboration with relevant stakeholders to conduct Diagnostic Network Optimizations (DNOs) to inform laboratory supply chain refinements.
- Development of accurate forecasts that capture total program needs, including considerations for optimized testing and treatment. These forecasts should inform regular (at minimum quarterly) supply plan updates.
- Establishment of systems for increased data visibility and reporting of HIV commodities availability, including granular-level reporting of quantities dispensed and stock availability.
- Active participation in collaborative efforts with recipient governments and other stakeholders to ensure data-informed decision-making and mitigate stock risks.
- Development of a plan for increasing local oversight and utilizing private sector capabilities, where appropriate.
- Implementation of a risk management and monitoring system, which may include third-party monitoring for assessment and oversight of supply chain programs, if required.
- Design and implementation of capacity building initiatives to increase supply chain literacy and fluency across recipients and human resources for health.
- Avoidance of parallel supply chain systems. All efforts must focus on strengthening and utilizing the recipient military's and/or the national health system's existing infrastructure. The recipient should not create separate, temporary, procurement or distribution systems.

The implementer should work towards ensuring a sustainable supply chain and improved regional self-reliance where feasible. This includes ensuring the military is connected to the national procurement system and other already existing procurement systems and resources in-country to avoid creating parallel procurement systems.

## 9. LIVES & Child Safeguarding

The implementer will ensure that all implementer and military health facility staff are trained in and implementing both the DHAPP LIVES and Child Safeguarding interventions, utilizing the current approved curriculum; to include re-training all trained staff every 3 years and training all new staff as part of their hiring process. Records of who has been trained, and when, must be maintained by the implementer and/or ENDF and be accessible upon request.

## 10. Malaria

The implementer is responsible for implementing evidence-based malaria prevention and treatment services. The implementer should work with the recipient military and MoH to ensure that these activities align with national malaria guidelines and target geographic regions with high malaria prevalence.

Malaria remains a significant global health threat, particularly for PLHIV who may be at higher risk of severe infection due to a compromised immune system. Malaria infection may reduce the effectiveness of ART for PLHIV on treatment, making malaria prevention an important tool in the clinical care of PLHIV. Populations which should be prioritized for malaria prevention and treatment services include infants, children under 5 years old, pregnant and breastfeeding women (PBFW), adolescent girls and young women (AGYW), PLHIV, and military populations.

The implementer will ensure that activities to address malaria include:

- Promotion of vector control prevention activities to reduce malaria infection, such as the distribution of insecticide-treated mosquito nets and the use of indoor residual spraying (IRS) in areas with high malaria prevalence.
- Distribution of chemoprophylaxis according to MOD and national guidelines as appropriate for active-duty military (ADM) deployed to areas with high malaria prevalence. Dispensing of chemoprophylaxis medications, if indicated, should include clear guidance on timeline and duration of medication usage.
- Administration of malaria vaccine for children under five years of age living in areas with moderate to high malaria transmission, aligned with international and national vaccine guidelines.
- Intermittent preventive treatment in pregnancy (IPTp) for pregnant women in malaria-endemic areas.
- Training healthcare providers to identify, diagnose, and treat malaria, as well as training on early detection and response to drug-resistant malaria.
- Distribution of appropriate malaria treatment at military health facilities, or referral to other health center where treatment is available. The most common malaria treatments are as follows:
    - Artemisinin-based combination therapy medicines are the most effective treatment for *P. falciparum malaria*.
    - Chloroquine is recommended for treatment of infection with the *P. vivax* parasite only in places where it is still sensitive to this medicine.
    - Primaquine should be added to the main treatment to prevent relapses of infection with the *P. vivax* and *P. ovale* parasites.
- Ongoing surveillance and analysis of malaria cases and health outcome data.

### 11. Tuberculosis (TB)

The implementer will be responsible for working with the recipient military to implement evidence-based TB prevention, care, and treatment services in alignment with the national MOU and implementation plan, specified by the DHAPP Program Manager. The implementer must work with the recipient military to comply with national TB guidelines and move the program towards international TB standards (if there is a discrepancy). The implementer will ensure the military is connected with all relevant TB stakeholders in-country and seamlessly included in national processes, meetings, networks for efficiency, cost effectiveness, and self-reliance. Implementers will specifically work to integrate testing, treatment, care, and patient flow between any siloed HIV and TB departments within military health facilities. Implementers will work with the recipient military to ensure there are military owned TB services to include:

- Tuberculosis Preventive Treatment (TPT) for individuals at the highest risk of progressing from TB infection to active disease, to include PLHIV, household contacts of TB patients, ADM living in barracks, and other at-risk groups.
- Symptom screening at key healthcare facility service delivery points with strict and consistent protocol to reduce in-facility transmission.
- Standardized drug regimen, including fixed-dose combinations (FDCs).
- Directly Observed Therapy (DOT), especially virtual options, to ensure adherence.
- Robust data systems to ensure patients with TB are tracked through a complete course of therapy and minimizing loss to follow-up.

### 12. Bio Surveillance (Surveillance and Outbreak Response)

The implementer will be responsible for implementing bio surveillance activities in coordination with the recipient military and in alignment with international and national health guidelines, including the 7-1-7 framework (detect infectious disease outbreaks within 7 days of emergence, notify relevant authorities within 1 day, and complete initial response actions within 7 days) as specified in the US-Ethiopia Health MOU Section 1.3. Bio surveillance activities include 1) outbreak detection and 2) outbreak response; and will not be duplicative of other U.S. funded bio surveillance activities.

The implementer will work with the military to ensure that outbreak detection activities are military owned and include:

- Assessment and maintenance of existing outbreak detection capacities in military health facilities and assessment of alignment with national protocols.
- Ensure military clinical and laboratory facilities are aware of national reporting requirements for outbreak detection
- Determine gaps in outbreak detection, particularly in laboratory capacity and data management, and implement a plan to correct identified gaps.

The implementer will ensure that outbreak response activities include:

- Assessment of existing outbreak response plans and revision of plans as appropriate.
- Training of personnel in effective outbreak response and establishment of outbreak response SOPs in alignment with national protocol.

- Ensure clinical facility staff are familiar with required barrier protective measures per national guidelines to prevent nosocomial spread of pathogens. Coordinate with national efforts to ensure military facilities are supplied with PPE.

The implementer will work with the PM to tailor and address any other outbreak detection and response activities outlined in the Country MOU Implementation Plan and Operational Plan.

The implementer may be responsible for providing necessary administrative, logistical, and coordination support for completion of a SABERS (Seroprevalence and behavioral Epidemiological Risk Survey) with the ENDF in year 2 of this grant.

**Monitoring and Evaluation**

To ensure the effective, efficient, and durable use of United States Government funds, the recipient military armed forces shall be responsible for the comprehensive, reliable, and timely reporting of the milestone, outcome and process metrics specified in this announcement. This reporting is critical for two primary objectives: first, to guide the development of health policies and practices that improve the recipient country's force health readiness, and second, to provide rigorous accountability to the United States Congress and the American taxpayer for every dollar appropriated.

The implementer is mandated to coordinate directly with the recipient military to ensure the accurate and transparent delivery of these metrics to all designated stakeholders as specified in the Memorandum of Understanding between the USG and Ethiopia.

The overarching goal is to transition all monitoring, evaluation, and reporting responsibilities to the recipient military, fostering complete self-reliance in the shortest possible timeframe. To verify the integrity of this reporting and safeguard U.S. investment, the implementer will execute regular Data Quality Assessments (DQAs) to evaluate the accuracy and reliability of the data provided by the recipient military, the frequency of which will be determined in consultation with the recipient military.

| Process Metrics | Baseline Targets |
|---|---|
| # people on ART | 10,000 |
| # new HIV diagnoses among infants (0-12 months) | TBD |
| # new HIV diagnoses among children and adults (age 12 months or older) | 500 |
| % pregnant and breastfeeding women living with HIV who receive ART | TBD |
| % suspected cases receiving diagnostic test for malaria | TBD |
| % or # confirmed malaria cases that receive first-line antimalarial treatment | TBD |
| # insecticide-treated nets distributed to populations at risk of malaria | TBD |

| | |
|---|---|
| % of pregnant women attending ANC who received at least 2 doses of IPTp | TBD |
| # patients with TB notified (i.e., bacteriologically confirmed + clinically diagnosed) | TBD |
| % of patients with TB notified who completed treatment | TBD |
| TB Detection rate | TBD |
| % accuracy of data fields assessed during the annual data audit | TBD |

To ensure rigorous oversight and accountability, the implementer is required to submit independent performance data. This reporting will serve to verify and corroborate the data provided by the recipient country's Ministry of Defense as compared to actual program implementation. The explicit purpose of this data collection is to guarantee that every American taxpayer dollar is spent effectively, and its impact is demonstrably justified. All implementer performance data shall be reported at the site level or higher through the designated online data collection system (DC2) at the specified quarterly, semi-annual, or annual intervals. The indicators used for this reporting requirement will harmonize with required milestone, process, and outcome metrics.

All proposals must include milestone metrics by activity and which outcome or process metric each activity supports. Example table headers are provided below.

| **Budget, USD** | **Activity** | **Milestone** | **Metric Mapping (Outcome & Process Metric)** |
|---|---|---|---|

**Quality Management System**

The Ethiopian military is responsible for maintaining a quality management (QM) system, which will no longer be funded through PEPFAR. Site Improvement through Monitoring System (SIMS) is a QM system that has been supported by DHAPP for many years, and implementers and recipient militaries are encouraged to use this system (or other QM system of their choosing). QM systems provide a standardized approach and set of tools for monitoring program quality. QM 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. QM systems are also used to identify performance issues that may impact patient outcomes or the integrity of program reporting site-level triangulation of program and QM data can be used to contextualize performance and determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

QM systems aim to:

(1) facilitate service improvement,
(2) ensure accountability of U.S. government investments, and
(3) maximize the impact of U.S. government investments on the HIV epidemic.

QM assessment results confirm compliance with minimum quality assurance standards and identify areas where improvements can be made.

The implementer should ensure that all supported sites are familiar with QM standards and make sure that all efforts are taken to follow these standards. DHAPP encourages implementers and militaries to conduct reviews of program performance using the latest QM or SIMS tools which are freely available.

SIMS or other QM system implementation is one strategy available for programs to integrate effective quality assurance (QA) and CQI practices into site and program management. Program management must apply ongoing program and site standards assessment, including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementer agreements and workplans should align with national policy in support of QA/CQI.

**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 recipient military HIV program's ability to monitor progress towards epidemic control. The implementer will work with the recipient military and Ministry of Health (MOH), Ministry of Communications, and 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 recipient military leadership.

The implementer will be responsible for:

- Staffing, support, and mentoring of existing recipient military staff for paper and electronic data collection
- Timely, accurate reporting of all indicators required by the recipient 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 recipient military and DHAPP without prior approval from the recipient 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 recipient military programs and the implementer should include a strategy for conducting baseline, periodic, and ongoing data quality assessments (DQA). In this way, DHAPP, and the recipient military, can be confident in the veracity of the data that it uses for planning and measurement of progress towards programmatic goals. The implementer should plan on conducting periodic 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 recipient 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 from HIV testing to viral load testing, and the complete 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. Frequency of periodic DQAs should be determined in consultation with the recipient military and DHAPP.

## Informatics
### Health Information Systems

Informatics, including Digital Health Platforms (DHP), Health Information Systems (HIS), and Medical Information Systems (MIS), are critical foundations for good patient care, program management, outbreak detection, data-driven decision-making, and the secure stewardship of military health information. ENDF's health system requires reliable informatics support to ensure its long-term, sustainable advancement. Key goals for a military HIS include 1) improving quality and safety of care; outbreak detection; data-driven decision-making; efficient deployment of resources; QA/QC; and improved access and improved confidentiality of health data.

The implementer will support the recipient military's HIS to align with the recipient country health information systems (HIS) to the greatest degree possible. The implementer will inventory the current military data systems (paper and electronic) and will provide written recommendations to include identification of gaps in the military HIS and requirements to enable the recipient military HIS to reach all clinical and laboratory locations. The implementer will coordinate with the military and MOH or other appropriate ministries to 1) ensure the military sites are included in national systems with 2) training, 3) infrastructure improvements such as routers, computers, solar power and satellite internet connectivity, 4) security (physical and cyber), 5) data use policy and governance, 6) data management, 7) data analytics, and 8) data use and dissemination. Where equipment procurements are needed, the recipient will ensure that the equipment will follow US laws and policies (e.g. no equipment from China, USA made, etc.).

The implementer must ensure by 2030 that the military will be capacitated with durable systems, staffing, training, and infrastructure to allow the military to use their systems effectively and independently to monitor client health and conduct national reporting.

### Work Plans

The implementer 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. A full list of reporting requirements can be found in the base Program Announcement and will be disclosed in the award terms and conditions.

**Ghana: DHAPP – Ghana Armed Forces (GAF) Partnership for Resilient Military Health Systems for Readiness**

**NOTE: Application submissions for this narrative are due by 12pm EST on 15 May 2026. Submissions received after the deadline will not be considered for funding.**

## Call for Proposals

Proposals are requested to support the Ghana Armed Forces to reach sustainable control of the HIV epidemic through the lens of the America First Global Health Strategy, as well as the UNAIDS HIV Treatment 95-95-95; Vertical Transmission 95 targets; and TB prevention 90 and in alignment with the National Security Strategy (NSS) and the National Defense Strategy (NDS) goals to protect the homeland, deter China, and increase burden sharing. Further, proposals must be aligned with any existing Memorandum of Understanding between the U.S. Department of State and Ghana. Implementers should be familiar with these strategic guidance documents and include means of addressing them in submitted proposals. **Please see base Program Announcement section D for complete detailed list of application, format and submission requirements. Proposal Technical Narrative may not exceed 45 pages.**

## Introduction

The HIV/AIDS epidemic has devastated 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 other military personnel and their extended communities, and impeding participation in peacekeeping activities. As HIV management improves, many of these impacts are reduced; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries; this is in addition to managing other long-term chronic diseases to maintain high force health readiness in strategically identified recipient militaries. Moreover, given the well-known biobehavioral risk factors among uniformed personnel, reducing HIV acquisition and transmission in this population is an essential component for reaching epidemic control in the recipient country.

The U.S. Government has a long history of providing foreign assistance to combat HIV/AIDS, advancing U.S. national security by promoting stability in key regions. Over the years, the United States DoD HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries to control the HIV epidemic among their respective military services. Working closely with the Department of Defense (DoD, herein referred to using the secondary title Department of War, DoW), U.S. Geographic Combatant Commanders, the Bureau of Global Health Security and Diplomacy (GHSD) and other organizations, DHAPP's mission is to build the capacity of recipient militaries through military-specific HIV/AIDS assistance, creating self-reliant security counterparts. DHAPP is the DoW implementing agency collaborating with the US Department of State, 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 Department of War (Title 10) Defense Health Program (DHP) and funding transfers from the Department of State (Title 22) for PEPFAR.

All proposals must be in full alignment with any existing Memorandum of Understandings (MOU)

between the Department of State (DoS) and Ghana clearly articulating transition plans for each activity over the course of the agreement with specific and measurable milestones. Reserving the last year of the agreement for transition planning will not be accepted. Activities to transition responsibilities to the recipient country must begin immediately upon award and continue throughout the life of the agreement to ensure a rapid path to self-sufficiency. The implementer must prepare the recipient country's military to fully own and operate all services, ensuring a complete and final transition of responsibility away from U.S. assistance.

The DoW Combatant Commands (CCMDs) have identified the longstanding DHAPP program with recipient countries as an essential security cooperation tool that serves U.S. interests. Pursuing HIV/AIDS activities with foreign militaries is an important part of maintaining security interests, regional stability through health readiness, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing nations. 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 CCMDs and DHAPP Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under-Secretary of War for Policy and by the Department of State Bureau of Global Health Security and Diplomacy (GHSD). DHAPP provides technical support to defense forces in HIV prevention, care, treatment, and information systems and data use 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. An additional goal supported by GHSD is 95% coverage of services for eliminating vertical transmission. Lastly, the UNAIDS Global AIDS Strategy established a goal that 90% of PLHIV receive preventive treatment for TB.

All proposals must align with the America First Global Health Strategy, which focuses on the following points:

- Address Inefficiency and Dependency: The majority of funding should go directly towards patient care and building resilient health systems. High program management costs will not be funded.
- Pillar 1: Make America Safer: The primary goal is to protect Americans by enhancing global surveillance systems to detect outbreaks within seven days of emergence, notify public health authorities within 1 day and rapidly responding at the source within 7 days with early response actions to prevent pandemics from reaching U.S. shores.
- Pillar 2: Make America Stronger: Foreign health assistance will be used as a strategic tool to strengthen bilateral relationships. The U.S. will enter into multi-year agreements with recipient countries that require co-investment and establish clear benchmarks, moving them toward self-sufficiency and away from reliance on U.S. foreign assistance. Proposals must align with any existing country-specific MOU timelines.
- Pillar 3: Make America More Prosperous: The strategy aims to bolster the U.S. economy by preventing costly pandemics and by using foreign assistance programs to promote American companies and health innovations (like diagnostics and pharmaceuticals) in emerging global markets.
- Restructure Aid Delivery: The plan calls for more frontline support, such as medical commodities

and healthcare workers, while significantly reducing all other non-frontline expenditures to ensure accountability to the American taxpayer. It will also streamline efforts by integrating disease-specific programs (HIV, Malaria, TB) and leveraging the private sector and faith-based organizations for more efficient service delivery. The implementer is expected to work with the DHAPP Program Manager (PM) on supporting the integration of disease-specific programs receiving USG funding for the military program.

**Local Implementers**

Local, non-governmental implementers with low overhead costs are encouraged to apply to this announcement. To achieve self-reliance, it is critical that the full range of HIV services are owned and operated by the recipient country's institutions, governments, and community-based and community-led organizations, regardless of current antiretroviral (ARV) coverage levels. The intent of transitioning to local implementers 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 implementers to ensure successful, long-term, community 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.

**Additional Submission Guidance:**

1. Review all documents within the package to ensure consistency in information, budgets, targets, and numbering:
    a. Use numbered lists, including numbered or alphabetized sub-lists, for activities for easier reference and monitoring, especially the SOW Narrative column.
2. Ensure all activities in the Technical Narrative are also listed concisely in the SOW file.
3. Activities must be specific; Do not write “ensure” or “support” or a similar verb as a narrative activity without defining what that means. Each activity must say specifically what the implementer will be doing. It must be measurable and answer the questions Who? What? Where? How? How many? How often?
4. Delineate between a training (i.e.: one time class or series of classes where attendees are gathered in a conference room, away from regular duties) and onsite strategic assistance (on the job guidance while recipient is performing regular duties) and specify as many of the following details as possible for both: how many attendees or sites, how often, how many days, where, specific topics/skills covered, expected outcomes & how they align with program goals, etc. Training should be limited and cost efficient.
5. Please note this project budget cannot include:
    a. Any budget allocations toward World AIDS Day (WAD) events/campaigns.
    b. Prizes, hats, or T-shirts.
    c. Flyers and printed education materials to be given to beneficiaries.
    d. Rental of venues for training or events (must use available military or ministry facilities).
    e. Employment or payments made directly to active-duty foreign military.

**Budget**

The **estimate** budget for this program announcement is as follows. Final authorized budget will be confirmed and communicated at time of official award execution. The link below contains the Financial Classifications Reference Guide and a summary of the classification definitions.
https://help.datim.org
Financial classifications are not regulations governing allowability of federal awards. Nothing in this guidance should be interpreted to mean that costs or activities that are unallowable or excluded under the terms of an award are permitted by virtue of being described herein. All awards are subject to the applicable cost principles and terms set forth and conveyed in the award made.
**Estimated Budget to be used as a Framework**

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.1: Surveillance and Outbreak Response | GHS | 2.1: Outbreak Response Capacities | 110,000 | 110,000 | 110,000 | 110,000 | 440,000 |
| | GHS | 2.1: Outbreak Readiness | 60,000 | 60,000 | 60,000 | 60,000 | 240,000 |
| | GHS | 2.1: Multisectoral Coordination for Animal and Human Outbreak Surveillance and Response | 25,000 | 25,000 | 25,000 | 25,000 | 100,000 |
| **Subtotal** | | | **195,000** | **195,000** | **195,000** | **195,000** | **780,000** |
| 2.2: Laboratory Systems | HIV | 2.2: Lab Service and Maintenance Costs | 55,000 | 55,000 | 50,000 | 45,000 | 205,000 |
| | Malaria | 2.2: Lab Equipment Procurement | 55,000 | 55,000 | 50,000 | 45,000 | 205,000 |
| | HIV | 2.2: Frontline Lab Workers | 25,000 | 25,000 | 20,000 | 16,000 | 86,000 |
| | Malaria | 2.2: Frontline Lab Workers | 25,000 | 25,000 | 20,000 | 16,000 | 86,000 |
| | GHS | 2.2: Frontline Lab Workers | 25,000 | 25,000 | 25,000 | 25,000 | 100,000 |
| | HIV | 2.2: Lab Sample Transport | 25,000 | 25,000 | 20,000 | 16,000 | 86,000 |
| | HIV | 2.2: Lab System Support | 55,000 | 55,000 | 50,000 | 45,000 | 205,000 |
| | Malaria | 2.2: Lab System Support | 25,000 | 25,000 | 20,000 | 18,000 | 88,000 |
| | GHS | 2.2: Lab System Support | 35,000 | 35,000 | 35,000 | 35,000 | 140,000 |
| | HIV | 2.2: Lab Accreditation | 7,500 | 7,500 | 5,500 | 3,500 | 24,000 |
| | Malaria | 2.2: Lab Accreditation | 7,500 | 7,500 | 5,500 | 4,000 | 24,500 |
| | GHS | 2.2: Lab Accreditation | 7,500 | 7,500 | 7,500 | 7,500 | 30,000 |
| | GHS | 2.2: Lab Equipment Procurement | 12,000 | 12,000 | 12,000 | 12,000 | 48,000 |
| | Malaria | 2.2: Lab Service and Maintenance Costs | 12,000 | 12,000 | 10,000 | 8,000 | 42,000 |
| **Subtotal** | | | **371,500** | **371,500** | **330,500** | **296,000** | **1,369,500** |
| 2.4: Frontline Health Workers | GHS | 2.4: Epidemiologists & Surveillance Officers | 60,000 | 60,000 | 60,000 | 60,000 | 240,000 |
| | HIV | 2.4: Doctors/Clinical Officers | 80,000 | 80,000 | 72,000 | 64,000 | 296,000 |
| | HIV | 2.4: Nurses/Midwives | 80,000 | 80,000 | 72,000 | 64,000 | 296,000 |
| | HIV | 2.4: Community Health Workers/Community-Based Staff | 96,000 | 96,000 | 87,000 | 78,000 | 357,000 |
| | HIV | 2.4: Other Health Workers | 12,000 | 12,000 | 11,000 | 10,000 | 45,000 |
| | Malaria | 2.4: Doctors/Clinical Officers | 40,000 | 40,000 | 36,000 | 32,000 | 148,000 |
| | Malaria | 2.4: Nurses/Midwives | 50,000 | 50,000 | 45,000 | 40,000 | 185,000 |
| | Malaria | 2.4: Campaign Workers | 42,000 | 42,000 | 38,000 | 32,000 | 154,000 |
| **Subtotal** | | | **460,000** | **460,000** | **421,000** | **380,000** | **1,721,000** |
| 2.5: Data Systems | HIV | 2.5: Data Systems Infrastructure | 60,000 | 60,000 | 55,000 | 50,000 | 225,000 |
| | Malaria | 2.5: Data Systems Infrastructure | 35,000 | 32,000 | 29,000 | 26,000 | 122,000 |
| | GHS | 2.5: Data Systems Infrastructure | 25,000 | 25,000 | 25,000 | 25,000 | 100,000 |
| | HIV | 2.5: Licenses & Software | 7,500 | 7,500 | 6,000 | 5,000 | 26,000 |
| | Malaria | 2.5: Licenses & Software | 7,500 | 7,500 | 6,000 | 5,000 | 26,000 |
| | GHS | 2.5: Licenses & Software | 7,500 | 7,500 | 7,500 | 7,500 | 30,000 |
| | GHS | 2.5: Data Systems Developer Staff | 30,000 | 30,000 | 30,000 | 30,000 | 120,000 |
| **Subtotal** | | | **172,500** | **169,500** | **158,500** | **148,500** | **649,000** |
| 2.6: Strategic Assistance | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 420,000 | 420,000 | 380,000 | 340,000 | 1,560,000 |
| | Malaria | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 240,000 | 240,000 | 210,000 | 20,000 | 710,000 |
| | HIV | 2.6: IP Program Management | 200,000 | 200,000 | 180,000 | 160,000 | 740,000 |
| | Malaria | 2.6: IP Program Management | 110,000 | 110,000 | 80,000 | 60,000 | 360,000 |
| | GHS | 2.6: IP Program Management | 90,000 | 90,000 | 90,000 | 90,000 | 360,000 |
| | HIV | 2.6: Other Health Systems Strengthening | 100,000 | 100,000 | 90,000 | 80,000 | 370,000 |
| | Malaria | 2.6: Other Health Systems Strengthening | 60,000 | 60,000 | 55,000 | 45,000 | 220,000 |
| | GHS | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 80,000 | 80,000 | 80,000 | 80,000 | 320,000 |
| | GHS | 2.6: Other Health Systems Strengthening | 55,000 | 55,000 | 55,000 | 55,000 | 220,000 |
| **Subtotal** | | | **1,355,000** | **1,355,000** | **1,220,000** | **930,000** | **4,860,000** |
| **Total** | *Budget Estimate to be used as a framework. Final authorized budget will be confirmed and communicated at time of official award. Phase 2-4 option budget Estimates are notional and dependent on availability of US Government available funding. | | **2,554,000** | **2,551,000** | **2,325,000** | **1,949,500** | **9,379,500** |

**Approaches to Reaching Sustainable Epidemic Control & Transitioning Ownership**

Proposals are requested to support the Ghana Armed Forces to reach sustainable control of the HIV epidemic and focus on the America First Global Health Strategy, the latest PEPFAR guidance and UNAIDS HIV Treatment 95-95-95, Vertical Transmission 95 targets, and TB prevention 90 targets. and in alignment with the NSS, NDS, and the MOU between the U.S. DoS and Ghana.

In 2025, DHAPP supported the recipient military in conducting a Military Sustainability Index (MilSID). Findings indicate the Ghana Armed Forces military health system needs support for Resource Mobilization and generation of Financial/Expenditure Data. The implementer will be responsible for supporting the recipient military in conducting a MilSID each year of the award, ensuring all stakeholders are present (please include as an SOW activity).

In 2025, DHAPP conducted a review of international standards. Findings indicate the military health system still faces several gaps:

- Scaling up safe and ethical index testing
- Maintaining 95% linkage to treatment for individuals newly diagnosed with HIV
- Initiating 95% of those newly positive on ART within 7 days of diagnosis
- Scaling up and maintaining HIV viral load coverage

The implementer will develop and implement a comprehensive transition plan that is in alignment with any existing country MOU, with clearly defined every 6-month milestones demonstrating progressive military assumption of programmatic responsibilities across all technical areas, data collection and reporting areas, and program management. This transition framework prioritizes efficiency, direct patient care investment, and development of resilient health systems capable of independent operation beyond the period of U.S. support. All proposals should detail how the implementer will engage the recipient military leadership as well as personnel at all levels in this work; and, specifically, how the implementer will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Please specify which SOW activities the implementer is supporting the military to take ownership of (showing increasing military ownership) and by when (with detailed milestones). Throughout this progression, the implementer must document evidence of increasing military ownership through specific metrics including percentage of activities led by military staff, proportion of budget executed directly by military, number of military personnel trained to competency, and documented military-led decision-making and problem-solving. Failure to attain defined milestones as agreed upon by the implementer, the partner military, and DHAPP may result in award termination.

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

**Technical Narrative & Scope of Work (SOW)**

In alignment with international health guidelines, America First Global Health Strategy, and guidance from PEPFAR/GHSD, coupled with DHAPP's vision to build the capacity of military health systems through military-specific and culturally appropriate services, the recipient will address the approach to each technical area. The implementer, through burden-sharing and building self-reliance within the recipient military, will be responsible for providing the following in close collaboration with other DHAPP-funded implementers.

**Technical Module Building Blocks**

The implementer will work closely with the Ministry of Defense and its medical leadership to make progress towards a resilient and self-reliant military HIV program that is aligned with the national MOU (if applicable), using evidence-based and efficient interventions to reach the three 95s. In alignment with the Transition Plan directive above, the implementer will include specific milestones for program transition for activities within each technical area.

1. **Pre-Exposure Prophylaxis (PrEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PrEP services to all HIV-negative individuals at high risk of acquiring HIV.

The implementer will ensure that the following interventions for adults and adolescents include:

- People at a higher risk of acquiring HIV, including PBFW, must be counseled on and offered PrEP in alignment with recipient country government policies. Any person who asks for PrEP should be considered for use.
- Individuals considering PrEP must be confirmed HIV-negative and be willing to attend follow-up appointments to monitor their HIV status on a routine basis. If a PrEP user tests HIV-positive, PrEP must stop immediately and effective HIV treatment must start.
- Differentiated and simplified service delivery for PrEP is encouraged, such as event-driven PrEP (ED PrEP), community delivery, and the use of HIV self-tests (HIVST) for PrEP services.
- PrEP counselors must be equipped to ensure that PrEP users understand adherence to the different DSD options and different PrEP options. Adherence counseling and support must be ongoing, as necessary.
- As Long-acting Lenacapavir (LEN) injectables become available, beneficiaries should be presented with thorough information on all available PrEP options, including each method's relative efficacy and safety, as well as counseling and adherence support, allowing for an informed client choice.
- If PrEP is not being offered at military facilities, the recipient will work with the military and PM to advocate with necessary stakeholders (possibly MoH or military leadership) to update guidelines, gain necessary approvals, and start implementation at military facilities.

2. **Post Exposure Prophylaxis (PEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PEP services to all HIV-negative individuals (including healthcare workers and non-healthcare workers) who have had a possible exposure to HIV within the last 72 hours.

The implementer will ensure that the following interventions for adults and adolescents include:

- PEP should be started as soon as possible after a potential exposure to HIV, ideally within 24 hours and no later than 72 hours.
- The person seeking PEP should be tested for HIV to confirm they are HIV-negative before starting PEP, although if testing is not available, PEP should be started immediately and can be stopped later once testing is available. Individuals who test positive for HIV should be started on treatment immediately.
- Three ARV drugs for a 28-day prescription are recommended for the HIV PEP regimen. Patients must be properly counseled to understand what PEP is, on adherence, and potential side effects.
- If PEP is not being consistently integrated and offered at military facilities (to the point that the surrounding population knows it is accessible if needed), the recipient will work with the military and PM to update guidelines and SOPs, gain necessary approvals, and start implementation at military facilities. Timely access to PEP is the most crucial factor in PEP effectiveness.
- Individuals who seek PEP services should be counseled on and offered PrEP post PEP if risk is ongoing.
- PEP availability in community settings, as well as task sharing of PEP administration is encouraged to increase timely accessibility post exposure.

### 3. HIV Testing Services (HTS)

HIV Testing Services (HTS) is the forefront for finding the remaining people who are living with HIV (PLHIV) and is a priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know their infection status are men, adolescents, and children. The recipient military HIV/AIDS program is strategically placed to reach men; therefore, the implementer will closely work with the recipient military on HTS for both prevention and diagnosis. Those who test negative should be provided with HIV risk reduction information (including referral to PrEP where relevant) and educated on U=U (Undetectable = Untransmittable). For those who test positive, activities should include information about HIV, offer of Safe and Ethical Index Testing (SEIT), and offer of self-testing for family members (all sexual partners and children under 19 years old) who may not be able to access a testing site. HTS should be targeted towards military personnel to achieve the target of 95-100% of all recipient military PLHIV knowing their status. HTS should also be provided to beneficiaries and civilians cared for at all military sites. The implementer will ensure they and the recipient military follow GHSD and national guidance on implementing SEIT and use the training materials created by the HTS team with the 10-Step model.

The local epidemiology and situational analysis should guide other testing methods to identify PLHIV.

Provider-Initiated Testing and Counseling (PITC) will continue at military facilities for both the military and civilian cohorts. PITC should focus within clinical areas that have shown a high testing yield, such as inpatient wards, tuberculosis (TB) and sexually transmitted infection (STI) clinics.

All people newly diagnosed with HIV should be retested to verify their HIV status prior to starting ART. The same testing strategy and algorithm as the original diagnosis should be used, but with a different tester and different test kit lots.

The implementer should support the military to achieve over 95% linkage of HIV-positive individuals identified to treatment initiation, fully implementing "test-and-start" policies across all age, sex, and risk groups. Ensuring that any person with positive results identified is linked to HIV care and treatment is essential to the success of the recipient military program. The implementer will support the military to 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 and other relevant integrated services.

The implementer will be responsible for providing support for the following activities to military bases and facilities:

- Diagnosing HIV, with at least 95% of those diagnosed linked to HIV care, while striving for 100% linkage to treatment services and same day initiation of ART.
- Offering SEIT to all HIV positive clients and testing for all sexual partners and children under 19 years old of HIV positive military personnel and civilians (with at least 1.5 contacts identified on average).
- Documenting HIV status for all children under 19 years of age with mothers living with HIV.
- Offering self-testing for partners of index clients if they do not volunteer for partner notification.
- Facilitating quality improvement and quality assurance for all recipient military HTS sites, including strategic assistance, at least quarterly.
- Providing HIV self-testing (HIVST) for military personnel, AGYW and their partners, male partners of antenatal care (ANC) clients and other high-risk populations. As part of the HIVST protocol, clients with a positive HIVST should be instructed to follow up with trained staff for further evaluation, including diagnostic testing utilizing the national testing algorithm. It is also vital to engage community groups to advocate for, design, implement, and analyze the success of 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, including Viral Load Suppression (VLS).
- Linking HIV negative, high-risk clients to PrEP services.

### 4. HIV Treatment

ART optimization is the 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. Moreover, long-term viral load suppression prevents onward transmission and is the cornerstone of HIV prevention. The following factors should be

considered in supporting the treatment of PLHIV in military facilities.

- 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. The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission recommends DTG-containing regimen as a Preferred ARV for PBFW and recommends DTG-containing regimen as a Preferred ARV for women who are trying to conceive. Starting in COP20 (FY21), programs were 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 prevent the development of TB in PLHIV as well as diagnose and treat PLHIV with TB disease and ensure they become non-infectious. In addition, all TB infected individuals should be tested for HIV.
    - Routinely screen all PLHIV for TB disease. Standardized symptom screening alone is not sufficient for TB screening among PLHIV and should be complemented with more-sensitive and setting-specific recommended screening tools. Ensure all PLHIV who screen positive for TB receive recommended molecular diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment.
    - For all who do not have active TB, prevention of TB is a priority using nationally approved TB preventive therapy (TPT). The Global AIDS Strategy has set the target of 90% of PLHIV to receive preventive treatment for TB, thus TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Implementers 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 that is consistently documented. In short, all newly diagnosed HIV-positive people should be offered TB treatment or preventive therapy, and all people assessed for TB should be tested for HIV.
    - Pregnant women living with HIV are at high risk of progression from TB infection to disease; thus, it is imperative that Prevention of Mother to Child Transmission (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 PLHIV.
    - 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, implementers should also seek opportunities to support effective joint program implementation. Additionally, implementers should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide a 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 women living with HIV (WLHIV) should be integrated into routine HIV treatment services in each country program. According to COP 24 Technical Considerations, all PEPFAR supported countries with HIV prevalence above 5.0% among women in the 15-49-year-old age group are expected to provide at least one life-time cervical cancer screen for WLHIV receiving ART.
    - Current international health guidelines recommend screening to start at age 25 or according to national guidelines, whichever is earlier. Programs may also consider earlier screening among women with long-standing HIV infection, e.g., perinatal infection. WLHIV who are between 50 and 65 years and have not been screened may be offered a single screening test, and screening should be discontinued if they screen negative.
    - Screening for cervical cancer should begin at high-volume military sites and be scaled to all women receiving ART in military ART sites either on-site or through referral to hub sites within the region. Screening should be available in the ART clinic or in affiliated clinics on-site such as women's health or maternal child health clinics for WLHIV to utilize.
    - Programs should ensure that a minimum of 90% of women who screen positive are linked to treatment.
    - 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.
    - Funding may be used for screening with visual inspection with acetic acid (VIA), treatment with cryotherapy, thermal ablation, and loop electrosurgical excision procedure (LEEP), and quality assurance activities.
- The implementer should work with the recipient military to offer most clients 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, 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 implementer should work with the recipient 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 HIV-related stigma by integrating a wide array of non-HIV commodities into decentralized sites (e.g. TPT). DDD models can also be used for decentralized PrEP distribution to improve uptake and continuation.
- Diagnose and treat people with advanced HIV disease (AHD). People starting treatment, re-engaging in treatment after an interruption of > 1 year, or virally unsuppressed for >1 year should be evaluated for AHD and have CD4 T cells measured. Accordingly, the implementer should be working with recipient military and public health leaders to ensure that CD4 testing is available. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease. The PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with advanced disease.

## 5. 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 implementer will work closely with the Ministry of Defense in Ghana to scale up VL testing coverage and VL suppression to achieve 95-95-95 goals for military personnel, as well as beneficiaries and civilians. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% VL suppression among PLHIV taking ART. CD4 testing should not be used to determine eligibility for ART and only should be used for assessment of immune status (i.e. identification or ongoing monitoring of patients with advanced HIV disease).

The implementer should ensure that the recipient military has access to timely VL testing (goal turnaround time is within 2 weeks) and that capacity exists to test 95% of people currently on ART annually. To ease logistical challenges associated with the transport of whole blood specimens and to increase access to routine VL monitoring, dried blood spots (DBS) for VL testing can be used as an alternative specimen type to plasma. 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 POC be used for VL testing among PBFW, infants, and children. Implementers must follow international health guidelines and work with military and MoH network (as necessary) to implement and monitor VL testing schedule for PBFW and HIV-exposed infants (HEI), which differs from the VL testing schedule of non-PBFW HIV+ adults. POC platforms may also be appropriate for low volume remote military sites.

The implementer will ensure that VL results are available to providers/clients in a reasonable amount of time (goal is within 2 weeks) to both the health care provider and the client. These results should be available 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. Unsuppressed clients and their sexual partners should be educated on alternate risk reduction options until they become suppressed, such as PrEP. 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, to minimize inconveniences associated with health system access.

HIV viral suppression is not only critical to improving individual health, but also to prevent sexual transmission, and reduce perinatal transmission. There are three key categories for HIV viral load measurements: unsuppressed (>1000 copies/mL), suppressed (detected but ≤1000 copies/mL) and

undetectable (viral load not detected by test used: <40 or <50 copies/ml depending on the machine used). People living with HIV who have an undetectable viral load and continue taking medication as prescribed have zero risk of transmitting HIV to their sexual partner(s) (U=U). PLHIV who have a suppressed but detectable viral load and are taking medication as prescribed have almost zero or negligible risk of transmitting HIV to their sexual partner(s). HIV VL test results can be a motivation for adhering to treatment and achieving the goal of being undetectable. Emphasizing and strengthening adherence counselling during antiretroviral therapy initiation and throughout treatment are essential, including communicating about the benefits of viral load suppression to all PLHIV. HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. The implementer must work with the military to ensure updated and accurate U=U messaging and encourage HIV testing, prevention, and treatment reaches all PLHIV, the general population and health care providers.

## 6. Health System Strengthening

DHAPP is working to enhance the ability of militaries and Ministries of Defense to manage their HIV epidemic, respond to broader health needs impacting their communities, and address new and emerging health concerns. Implementers should describe how they will increase recipient government capacity. A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of the HIV response, including political commitment, building program capacities and capabilities, and financial planning and expenditure.

The procurement of supplies, support and equipment should use recipient government and other donor sources when possible (Global Fund, etc.).

Laboratory:

The implementer will be responsible for the following activities to help recipient militaries build resilient, sustainable, and internationally accredited laboratory systems strongly capable of responding to the HIV epidemic and other future infectious disease outbreaks:

- Laboratory inventory tracking, control, and forecasting; monitoring of commodities procurements to ensure laboratory supplies are procured at cost-effective prices and services are uninterrupted; monitoring facilities storing procured laboratory commodities to ensure they meet International Organization for Standardization (ISO) warehouse principals and standards; obtaining insurance for procured laboratory commodities to protect against natural disasters, fire, theft, etc.
- Supporting and facilitating military participation in national quantification exercises, ensuring that military laboratory commodity needs are incorporated into national forecasting.
- Routine monitoring of turnaround time (TAT) for VL, TB, and other critical tests, to ensure test results are provided to providers and patients within a reasonable period (2 weeks) to improve and maximize patient care and outcomes.
- Procuring laboratory service maintenance contracts, routine calibration of equipment, and training of laboratory staff on proper use and maintenance of procured equipment.
- Supporting training in proper laboratory biosafety and waste management.
- Ensuring continuous quality improvement of all laboratories (including satellite laboratories and HIV testing sites) and accreditation is in place and transitioned over to the recipient government with key milestones and timeline.

- Monitoring of laboratory quality, adherence to quality systems, and method validation; provision of proficiency testing for rapid HIV testing, VL, CD4, TB, STIs, and other tests critical to HIV epidemic control and detecting emerging disease outbreaks.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, address needs and gaps, and provide recommendations for the development of improvement plans to resolve any identified problems.
- Linking recipient military laboratory services to other laboratory resources at the district, provincial, and national levels.

Optimizing diagnostic networks for VL/EID, TB, and other coinfections. In coordination with other Donors and National TB Programs, complete diagnostic network optimization (DNO) and transition to integrated diagnostics and multi-disease testing. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time (goal is 2 weeks). Identify all parts of the laboratory system that are interoperable with the U.S. military system.

**7. Commodities**

The implementer will assist the military in developing and implementing a supply chain management strategy that aligns with PEPFAR's goals of ensuring sustainable commodity supplies while simultaneously emphasizing and working to improve self-reliance of the commodities recipient, with the full transition of all capabilities to the commodities recipient by award completion or USG/recipient country MOU completion (whichever comes first). This strategy should include, where applicable to a site or sites, as many of the following principles as practical:

- Development of a comprehensive Supply Chain Transition Plan with clearly defined annual milestones for the recipient military to assume responsibility for key functions. A written supply chain risk management plan that is co-developed with and owned by the recipient military. This plan must address risks to commodity availability (e.g., stockouts, expiries) and risks to the transition process itself (e.g., personnel gaps, funding shortfalls). Plans may be specific to a site or group of similar sites, depending on the need identified by the recipient military and recipient.
- Identification and training of supply chain points of contact within each facility on topics to include where applicable, but not limited to:
    - Accurate use of the commodities request system (typically the national system)
    - Completion of necessary paperwork/electronic forms
    - Stockout and overstock mitigation strategies
    - Inter-site commodity movement procedures
    - Establishing relationships with commodities counterparts within the military and national systems, both regionally and nationally
    - Quantification and forecasting, with the goal of the recipient military leading their national quantification exercise for its facilities.
- In alignment with the America First Global Health Strategy, and in compliance with applicable federal acquisition regulations, the recipient will prioritize the evaluation and selection of U.S.-manufactured pharmaceuticals, diagnostics, and supply chain technologies where they are competitive in terms of cost, quality, and availability. The recipient will document efforts to

explore U.S.-based sources as part of its procurement strategy.

- Implementation of supply chain best practices, including product and supply chain segmentation, actively identifying and contracting with local and/or U.S.-based private sector logistics partnerships where appropriate to improve efficiency and build a sustainable logistics infrastructure that can be leveraged directly by the recipient military in the future, and establishing end-to-end supply chain visibility using global standards (GS-1) to enable military leadership to make independent, data-driven supply chain decisions.
- Adoption of decentralized drug distribution (DDD) models, such as home deliveries, use of community or private pharmacies, and automated lockers, to improve client convenience and maximize product availability.
- Collaboration with relevant stakeholders to conduct Diagnostic Network Optimizations (DNOs) to inform laboratory supply chain refinements.
- Development of accurate forecasts that capture total program needs, including considerations for optimized testing and treatment. These forecasts should inform regular (at minimum quarterly) supply plan updates.
- Establishment of systems for increased data visibility and reporting of HIV commodities availability, including granular-level reporting of quantities dispensed and stock availability.
- Active participation in collaborative efforts with recipient governments and other stakeholders to ensure data-informed decision-making and mitigate stock risks.
- Development of a plan for increasing local oversight and utilizing private sector capabilities, where appropriate.
- Implementation of a risk management and monitoring system, which may include third-party monitoring for assessment and oversight of supply chain programs, if required.
- Design and implementation of capacity building initiatives to increase supply chain literacy and fluency across recipients and human resources for health.
- Avoidance of parallel supply chain systems. All efforts must focus on strengthening and utilizing the recipient military's and/or the national health system's existing infrastructure. The recipient should not create separate, temporary, procurement or distribution systems.

The implementer should work towards ensuring a sustainable supply chain and improved regional self-reliance where feasible. This includes ensuring the military is connected to the national procurement system and other already existing procurement systems and resources in-country to avoid creating parallel procurement systems.

## 8. LIVES & Child Safeguarding

The implementer will ensure that all implementer & military health facility staff are trained in and implementing both the DHAPP LIVES and Child Safeguarding interventions (utilizing the curriculum updated in December 2025 that is in alignment with Executive Orders to date); to include re-training all trained staff every 3 years and training all new staff as part of their hiring process. Records for who has been trained and when must be kept by implementer and/or military and accessible upon request.

## 9. Malaria

The implementer is responsible for implementing evidence-based malaria prevention and treatment services. The implementer should work with the recipient military and MoH to ensure that these activities align with national malaria guidelines and target geographic regions with high malaria prevalence.

Malaria remains a significant global health threat, particularly for PLHIV who may be at higher risk of severe infection due to a compromised immune system. Malaria infection may reduce the effectiveness of ART for PLHIV on treatment, making malaria prevention an important tool in the clinical care of PLHIV. Populations which should be prioritized for malaria prevention and treatment services include infants, children under 5 years old, pregnant and breastfeeding women (PBFW), adolescent girls and young women (AGYW), PLHIV, and military populations.

The implementer will ensure that activities to address malaria include:

- Promotion of vector control prevention activities to reduce malaria infection, such as the distribution of insecticide-treated mosquito nets and the use of indoor residual spraying (IRS) in areas with high malaria prevalence.
- Distribution of chemoprophylaxis according to MOD and national guidelines as appropriate for active-duty military (ADM) deployed to areas with high malaria prevalence. Dispensing of chemoprophylaxis medications, if indicated, should include clear guidance on timeline and duration of medication usage.
- Administration of malaria vaccine for children under five years of age living in areas with moderate to high malaria transmission, aligned with international and national vaccine guidelines.
- Intermittent preventive treatment in pregnancy (IPTp) for pregnant women in malaria-endemic areas.
- Training healthcare providers to identify, diagnose, and treat malaria, as well as training on early detection and response to drug-resistant malaria.
- Distribution of appropriate malaria treatment at military health facilities, or referral to other health center where treatment is available. The most common malaria treatments are as follows:
    - Artemisinin-based combination therapy medicines are the most effective treatment for *P. falciparum malaria*.
    - Chloroquine is recommended for treatment of infection with the *P. vivax* parasite only in places where it is still sensitive to this medicine.
    - Primaquine should be added to the main treatment to prevent relapses of infection with the *P. vivax* and *P. ovale* parasites.
- Ongoing surveillance and analysis of malaria cases and health outcome data.

**10. Tuberculosis (TB)**

The implementer will be responsible for working with the recipient military to implement evidence-based TB prevention, care, and treatment services in alignment with the national MOU and implementation plan, specified by the DHAPP Program Manager. The implementer must work with the recipient military to comply with national TB guidelines and move the program towards international TB standards (if there is a discrepancy). The implementer will ensure the military is connected with all relevant TB stakeholders in-country and seamlessly included in national processes, meetings, networks for efficiency, cost effectiveness, and self-reliance. Implementers will specifically work to integrate testing, treatment, care, and patient flow between any siloed HIV and TB departments within military health facilities.

Implementers will work with the recipient military to ensure there are military owned TB services to include:

- Tuberculosis Preventive Treatment (TPT) for individuals at the highest risk of progressing from TB infection to active disease, to include PLHIV, household contacts of TB patients, ADM living in barracks, and other at-risk groups.
- Symptom screening at key healthcare facility service delivery points with strict and consistent protocol to reduce in-facility transmission.
- Standardized drug regimen, including fixed-dose combinations (FDCs).
- Directly Observed Therapy (DOT), especially virtual options, to ensure adherence.
- Robust data systems to ensure patients with TB are tracked through a complete course of therapy and minimizing loss to follow-up.

**11. Bio Surveillance (Surveillance and Outbreak Response)**

The implementer will be responsible for implementing bio surveillance activities in coordination with the recipient military and in alignment with international and national health guidelines. Bio surveillance activities include 1) outbreak detection and 2) outbreak response; and will not be duplicative of other U.S. funded bio surveillance activities.

The implementer will work with the military to ensure that outbreak detection activities are military owned and include:

- Assessment and maintenance of existing outbreak detection capacities in military health facilities and assessment of alignment with national protocols.
- Ensure military clinical and laboratory facilities are aware of national reporting requirements for outbreak detection
- Determine gaps in outbreak detection, particularly in laboratory capacity and data management, and implement a plan to correct identified gaps.

The implementer will ensure that outbreak response activities include:

- Assessment of existing outbreak response plans and revision of plans as appropriate.
- Training of personnel in effective outbreak response and establishment of outbreak response SOPs in alignment with national protocol.
- Ensure clinical facility staff are familiar with required barrier protective measures per national guidelines to prevent nosocomial spread of pathogens. Coordinate with national efforts to ensure military facilities are supplied with PPE.

The implementer will work with the PM to tailor and address any other outbreak detection and response activities outlined in the Country MOU Implementation Plan and Operational Plan.

**Monitoring and Evaluation**

To ensure the effective, efficient, and durable use of United States Government funds, the recipient military armed forces shall be responsible for the comprehensive, reliable, and timely reporting of the milestone, outcome and process metrics specified in this announcement. This reporting is critical for two primary objectives: first, to guide the development of health policies and practices that improve the

recipient country's force health readiness, and second, to provide rigorous accountability to the United States Congress and the American taxpayer for every dollar appropriated.

The implementer is mandated to coordinate directly with the recipient military to ensure the accurate and transparent delivery of these metrics to all designated stakeholders as specified in the Memorandum of Understanding between the USG and Ghana.

The overarching goal is to transition all monitoring, evaluation, and reporting responsibilities to the recipient military, fostering complete self-reliance in the shortest possible timeframe. To verify the integrity of this reporting and safeguard U.S. investment, the implementer will execute regular Data Quality Assessments (DQAs) to evaluate the accuracy and reliability of the data provided by the recipient military, the frequency of which will be determined in consultation with the recipient military.

| **Process Metrics** | **Baseline Targets** |
|---|---|
| # people on ART | 2651 |
| # new HIV diagnoses among infants (0-12 months) | 8 |
| # new HIV diagnoses among children and adults (age 12 months or older) | 296 |
| % suspected cases receiving diagnostic test for malaria | 67,960 (100%) |
| % or # confirmed malaria cases that receive first-line anti-malaria treatment | 57,766 (85%) |
| # insecticide treated nets distributed to populations at risk of malaria | 678 (0.99%) |
| % accuracy of data fields assessed during the annual data audit | 90% |
| % Mother to Child transmission (MTCT) rate at 6 weeks | TBD |
| % pregnant and breastfeeding women living with HIV who receive ART Prevention of Mother to Child Transmission (PMTCT coverage) | TBD |
| % children aged 3–59 months who received the full number of courses of SMC (3 or 4) per transmission season in the targeted area | TBD |
| % suspected cases receiving diagnostic test for malaria | TBD |
| % pregnant women on Intermittent Preventive Treatment (at least three doses of SP) according to national policy | TBD |
| % population in target areas sprayed with indoor residual spraying in the last 12 months | TBD |

To ensure rigorous oversight and accountability, the implementer is required to submit independent performance data. This reporting will serve to verify and corroborate the data provided by the recipient country's Ministry of Defense as compared to actual program implementation. The explicit purpose of this data collection is to guarantee that every American taxpayer dollar is spent effectively, and its impact

is demonstrably justified. All implementer performance data shall be reported at the site level or higher through the designated online data collection system (DC2) at the specified quarterly, semi-annual, or annual intervals. The indicators used for this reporting requirement will harmonize with required milestone, process, and outcome metrics.

All proposals must include milestone metrics by activity and which outcome or process metric each activity supports. Example table headers are provided below.

| Budget, USD | Activity | Milestone | Metric Mapping (Outcome & Process Metric) |
|---|---|---|---|

**Quality Management System**

The Ghana Armed Forces is responsible for maintaining a quality management (QM) system, which will no longer be funded through PEPFAR. Site Improvement through Monitoring System (SIMS) is a QM system that has been supported by DHAPP for many years, and implementers and recipient militaries are encouraged to use this system (or other QM system of their choosing). QM systems provide a standardized approach and set of tools for monitoring program quality. QM 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. QM systems are also used to identify performance issues that may impact patient outcomes or the integrity of program reporting site-level triangulation of program and QM data can be used to contextualize performance and determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

QM systems aim to:
(1) facilitate service improvement,
(2) ensure accountability of U.S. government investments, and
(3) maximize the impact of U.S. government investments on the HIV epidemic.

QM assessment results confirm compliance with minimum quality assurance standards and identify areas where improvements can be made.

The implementer should ensure that all supported sites are familiar with QM standards and make sure that all efforts are taken to follow these standards. DHAPP encourages implementers and militaries to conduct reviews of program performance using the latest QM or SIMS tools which are freely available.

SIMS or other QM system implementation is one strategy available for programs to integrate effective quality assurance (QA) and CQI practices into site and program management. Program management must apply ongoing program and site standards assessment—including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementer agreements and workplans should align with national policy in support of QA/CQI.

**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 recipient military HIV program's ability to monitor progress towards epidemic control. The implementer will work with the recipient military and Ministry of Health (MOH), Ministry of Communications, and 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 recipient military leadership.

The implementer will be responsible for:

- Staffing, support, and mentoring of existing recipient military staff for paper and electronic data collection
- Timely, accurate reporting of all indicators required by the recipient 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 recipient military and DHAPP without prior approval from the recipient 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 recipient military programs and the implementer should include a strategy for conducting baseline, periodic, and ongoing data quality assessments (DQA). In this way, DHAPP, and the recipient military, can be confident in the veracity of the data that it uses for planning and measurement of progress towards programmatic goals. The implementer should plan on conducting periodic 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 recipient 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 from HIV testing to viral load testing, and the complete 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. Frequency of periodic DQAs should be determined in consultation with the recipient military and DHAPP.

**Informatics**
**Health Information Systems**

Informatics (including Digital Health Platforms (DHP) also known as Health Information Systems (HIS) or Medical Information Systems (MIS)) are critical underpinnings of good patient healthcare and good program management. The military's health system requires reliable informatics support to ensure its long-term, sustainable advancement. Key goals for a military HIS include 1) improving quality and safety of care; outbreak detection; data-driven decision-making; efficient deployment of resources; QA/QC; and

improved access and improved confidentiality of health data.

The implementer will support the recipient military's HIS to align with the recipient country health information systems (HIS) to the greatest degree possible. The implementer will inventory the current military data systems (paper and electronic) and will provide written recommendations to include identification of gaps in the military HIS and requirements to enable the recipient military HIS to reach all clinical and laboratory locations. The implementer will coordinate with the military and MOH or other appropriate ministries to 1) ensure the military sites are included in national systems with 2) training, 3) infrastructure improvements such as routers, computers, solar power and satellite internet connectivity, 4) security (physical and cyber), 5) data use policy and governance, 6) data management, 7) data analytics, and 8) data use and dissemination. Where equipment procurements are needed, the recipient will ensure that the equipment will follow US laws and policies (e.g. no equipment from China, USA made, etc.).

The implementer must ensure by 2030 that the military will be capacitated with durable systems, staffing, training, and infrastructure to allow the military to use their systems effectively and independently to monitor client health and conduct national reporting.

**Work Plans**

The implementer 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. A full list of reporting requirements can be found in the base Program Announcement and will be disclosed in the award terms and conditions.

**Mozambique: DHAPP - FADM Partnership for Resilient Military Health Systems for Readiness**

**NOTE: Application submissions for this narrative are due by 12pm EST on 15 May 2026. Submissions received after the deadline will not be considered for funding.**

## Call for Proposals

Proposals are requested to support the Mozambican Armed Forces to reach sustainable control of the HIV epidemic through the lens of the America First Global Health Strategy, as well as the UNAIDS HIV Treatment 95-95-95; Vertical Transmission 95 targets; and TB prevention 90 and in alignment with the National Security Strategy (NSS) and the National Defense Strategy (NDS) goals to protect the homeland, deter China, and increase burden sharing. Further, proposals must be aligned with any existing Memorandum of Understanding between the U.S. Department of State and Government of the Republic of Mozambique. Implementers should be familiar with these strategic guidance documents and include means of addressing them in submitted proposals. **Please see base Program Announcement section D for complete detailed list of application, format and submission requirements. Proposal Technical Narrative may not exceed 45 pages.**

## Introduction

The HIV/AIDS epidemic has devastated 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 other military personnel and their extended communities, and impeding participation in peacekeeping activities. As HIV management improves, many of these impacts are reduced; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries; this is in addition to managing other long-term chronic diseases to maintain high force health readiness in strategically identified recipient militaries. Moreover, given the well-known biobehavioral risk factors among uniformed personnel, reducing HIV acquisition and transmission in this population is an essential component for reaching epidemic control in the recipient country.

The U.S. Government has a long history of providing foreign assistance to combat HIV/AIDS, advancing U.S. national security by promoting stability in key regions. Over the years, the United States DoD HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries to control the HIV epidemic among their respective military services. Working closely with the Department of Defense (DoD, herein referred to using the secondary title Department of War, DoW), U.S. Geographic Combatant Commanders, the Bureau of Global Health Security and Diplomacy (GHSD) and other organizations, DHAPP's mission is to build the capacity of recipient militaries through military-specific HIV/AIDS assistance, creating self-reliant security counterparts. DHAPP is the DoW implementing agency collaborating with the US Department of State, 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 Department of War (Title 10) Defense Health Program (DHP) and funding transfers from the Department of State (Title 22) for PEPFAR.

All proposals must be in full alignment with any existing Memorandum of Understanding (MOU) between the Department of State (DoS) and Government of the Republic of Mozambique clearly

articulating transition plans for each activity over the course of the agreement with specific and measurable milestones. Reserving the last year of the agreement for transition planning will not be accepted. Activities to transition responsibilities to the recipient country must begin immediately upon award and continue throughout the life of the agreement to ensure a rapid path to self-sufficiency. The implementer must prepare the recipient country's military to fully own and operate all services, ensuring a complete and final transition of responsibility away from U.S. assistance.

The DoW Combatant Commands (CCMDs) have identified the longstanding DHAPP program with recipient countries as an essential security cooperation tool that serves U.S. interests. Pursuing HIV/AIDS activities with foreign militaries is an important part of maintaining security interests, regional stability through health readiness, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing nations. 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 CCMDs and DHAPP Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under-Secretary of War for Policy and by the Department of State Bureau of Global Health Security and Diplomacy (GHSD). DHAPP provides technical support to defense forces in HIV prevention, care, treatment, and information systems and data use 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. An additional goal supported by GHSD is 95% coverage of services for eliminating vertical transmission. Lastly, the UNAIDS Global AIDS Strategy established a goal that 90% of PLHIV receive preventive treatment for TB.

All proposals must align with the America First Global Health Strategy, which focuses on the following points:

- Address Inefficiency and Dependency: The majority of funding should go directly towards patient care and building resilient health systems. High program management costs will not be funded.
- Pillar 1: Make America Safer: The primary goal is to protect Americans by enhancing global surveillance systems to detect outbreaks within seven days of emergence, notify public health authorities within 1 day and rapidly responding at the source within 7 days with early response actions to prevent pandemics from reaching U.S. shores.
- Pillar 2: Make America Stronger: Foreign health assistance will be used as a strategic tool to strengthen bilateral relationships. The U.S. will enter into multi-year agreements with recipient countries that require co-investment and establish clear benchmarks, ...moving them toward self-sufficiency and away from reliance on U.S. foreign assistance. Proposals must align with any existing country-specific MOU timelines.
- Pillar 3: Make America More Prosperous: The strategy aims to bolster the U.S. economy by preventing costly pandemics and by using foreign assistance programs to promote American companies and health innovations (like diagnostics and pharmaceuticals) in emerging global markets.
- Restructure Aid Delivery: The plan calls for more frontline support, such as medical commodities and healthcare workers, while significantly reducing all other non-frontline expenditures to ensure

accountability to the American taxpayer. It will also streamline efforts by integrating disease-specific programs (HIV, Malaria, TB) and leveraging the private sector and faith-based organizations for more efficient service delivery. The implementer is expected to work with the DHAPP Program Manager (PM) on supporting the integration of disease-specific programs receiving USG funding for the military program.

**Local Implementers**

Local, non-governmental implementers with low overhead costs are encouraged to apply to this announcement. We encourage applicants to propose a lean core team, composed of a small number of key personnel responsible for leading the primary programmatic components, to allow the military partner to take greater ownership of day-to-day activities on the ground. To achieve self-reliance, it is critical that the full range of HIV services are owned and operated by the recipient country's institutions, governments, and community-based and community-led organizations, regardless of current antiretroviral (ARV) coverage levels. The intent of transitioning to local implementers 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 implementers to ensure successful, long-term, community engagement and impact.

It is equally highly encouraged that healthcare workers - engaged as needed based on program requirements - be contracted locally to the affiliated health facility. This approach helps minimize challenges related to relocation and supports the retention of cultural expertise and contextual understanding essential for effective service delivery.

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.

**Additional Submission Guidance:**

1. Review all documents within the package to ensure consistency in information, budgets, targets, and numbering:
    a. Use numbered lists, including numbered or alphabetized sub-lists, for activities for easier reference and monitoring, especially the SOW Narrative column.
2. Ensure all activities in the Technical Narrative are also listed concisely in the SOW file.
3. Activities must be specific; Do not write “ensure” or “support” or a similar verb as a narrative activity without defining what that means. Each activity must say specifically what the implementer will be doing. It must be measurable and answer the questions Who? What? Where? How? How many? How often?
4. Delineate between a training (i.e.: one time class or series of classes where attendees are gathered in a conference room, away from regular duties) and onsite strategic assistance (on the job guidance while recipient is performing regular duties) and specify as many of the following details as possible for both: how many attendees or sites, how often, how many days, where, specific

topics/skills covered, expected outcomes & how they align with program goals, etc. Training should be limited and cost efficient.

5. Please note this project budget cannot include:
    a. Any budget allocations toward World AIDS Day (WAD) events/campaigns.
    b. Prizes, hats, or T-shirts.
    c. Flyers and printed education materials to be given to beneficiaries.
    d. Rental of venues for training or events (must use available military or ministry facilities).
    e. Employment or payments made directly to active-duty foreign military.

**Budget**

The **estimate** budget for this program announcement is as follows. Final authorized budget will be confirmed and communicated at time of official award execution. The link below contains the Financial Classifications Reference Guide and a summary of the classification definitions.
https://help.datim.org
Financial classifications are not regulations governing allowability of federal awards. Nothing in this guidance should be interpreted to mean that costs or activities that are unallowable or excluded under the terms of an award are permitted by virtue of being described herein. All awards are subject to the applicable cost principles and terms set forth and conveyed in the award made.

**Estimated Budget to be used as a Framework**

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.1: Surveillance and Outbreak Response | Cross-cutting | 2.1: Multisectoral Coordination for Animal and Human Outb | 30,000 | - | 20,000 | 20,000 | 70,000 |
| | Cross-cutting | 2.1: Surveys and Assessments | 180,000 | 600,000 | - | - | 780,000 |
| | GHS | 2.1: Outbreak Readiness | 6,000 | 16,000 | 6,000 | 10,000 | 38,000 |
| **Subtotal** | | | **216,000** | **616,000** | **26,000** | **30,000** | **888,000** |
| 2.2: Laboratory Systems | Cross-cutting | 2.2: Lab Consumables Procurement | 10,000 | 10,000 | 24,500 | 10,000 | 54,500 |
| | HIV | 2.2: Lab Equipment Procurement | 15,000 | 15,000 | 15,000 | 15,000 | 60,000 |
| | Cross-cutting | 2.2: Lab Sample Transport | 20,000 | 20,000 | 20,000 | 20,000 | 80,000 |
| | HIV | 2.2: Lab Service and Maintenance Costs | 6,500 | 6,500 | 6,500 | 6,500 | 26,000 |
| | Cross-cutting | 2.2: Lab System Support | 72,500 | 78,000 | 76,500 | 74,000 | 301,000 |
| | GHS | 2.2: Lab System Support | 13,500 | 11,500 | 11,000 | 12,000 | 48,000 |
| | HIV | 2.2: Lab System Support | 56,500 | 53,000 | 28,500 | 53,500 | 191,500 |
| | HIV | 2.2: Sample Collection Commodities | 10,000 | 10,000 | 15,000 | 13,000 | 48,000 |
| | GHS | 2.2: Lab Equipment Procurement | 5,000 | 10,000 | 10,000 | 5,000 | 30,000 |
| | GHS | 2.2: Lab Sample Transport | 4,000 | 9,000 | 9,000 | 5,000 | 27,000 |
| **Subtotal** | | | **213,000** | **223,000** | **216,000** | **214,000** | **866,000** |
| 2.3: Commodities | HIV | 2.3: Rapid Diagnostic Commodity Procurement | 30,000 | 30,000 | 47,000 | 35,000 | 142,000 |
| | GHS | 2.3: Response Commodity Procurement | 20,000 | 25,000 | 35,000 | 30,000 | 110,000 |
| | HIV | 2.3: In-Country Warehousing and Distribution | 50,000 | 50,000 | 80,000 | 60,000 | 240,000 |
| | Malaria | 2.3: Prevention Commodity Procurement | 20,000 | 20,000 | 30,000 | 30,000 | 100,000 |
| | HIV | 2.3: Supply Chain Systems Support | 50,000 | 50,000 | 80,000 | 60,000 | 240,000 |
| | HIV | 2.3: Therapeutic Commodity Procurement | 50,000 | 45,000 | 55,000 | 55,000 | 205,000 |
| | | | | | | | - |
| **Subtotal** | | | **220,000** | **220,000** | **327,000** | **270,000** | **1,037,000** |
| 2.4: Frontline Health Workers | HIV | 2.4: Community Health Workers/Community-Based Staff | 313,134 | 313,134 | 313,134 | 313,134 | 1,252,538 |
| | HIV | 2.4: Other Health Workers | 17,617 | 17,617 | 17,617 | 17,617 | 70,469 |
| | HIV | 2.4: Nurses/Midwives | 91,067 | 91,067 | 91,067 | 91,067 | 364,269 |
| **Subtotal** | | | **313,134** | **313,134** | **313,134** | **313,134** | **1,252,538** |
| **2.5: Data Systems** | | | | | | | - |
| **Subtotal** | | | - | - | - | - | - |
| 2.6: Strategic Assistance | HIV | 2.6: Other Commodity Procurement | 295,000 | 316,385 | 297,000 | 215,000 | 1,123,385 |
| | Maternal and Child He | 2.6: Other Commodity Procurement | 101,548 | 101,655 | 101,655 | 35,000 | 339,858 |
| | HIV | 2.6: Other Health Systems Strengthening | 2,727,477 | 3,070,073 | 2,783,000 | 2,376,000 | 10,956,550 |
| | Maternal and Child He | 2.6: Other Health Systems Strengthening | 77,500 | 107,960 | 103,500 | 92,960 | 381,920 |
| | HIV | 2.6: TA to Introduce New Innovative Diagnostics, Vaccines, I | 316,952 | 310,000 | 310,000 | 280,000 | 1,216,952 |
| | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front Li | 1,024,000 | 929,124 | 951,500 | 643,160 | 3,547,784 |
| | Maternal and Child He | 2.6: Training (Pre and In-Service) and Supervision of Front Li | 30,000 | 3,000 | 4,845 | 3,000 | 40,845 |
| | HIV | 2.6: Other Health Worker Costs | 200,000 | 200,000 | 200,000 | 200,000 | 800,000 |
| | TB | 2.6: Other Health Systems Strengthening | 46,000 | 44,500 | 37,500 | 44,500 | 172,500 |
| | TB | 2.6: TA to Introduce New Innovative Diagnostics, Vaccines, I | 18,000 | 20,000 | 13,000 | 15,000 | 66,000 |
| | TB | 2.6: Training (Pre and In-Service) and Supervision of Front Li | 36,000 | 15,500 | 29,500 | 20,500 | 101,500 |
| | Cross-cutting | 2.6: Other Commodity Procurement | 42,000 | 38,000 | 36,000 | 35,000 | 151,000 |
| | Cross-cutting | 2.6: TA to Introduce New Innovative Diagnostics, Vaccines, I | - | - | 9,000 | - | 9,000 |
| | Cross-cutting | 2.6: Training (Pre and In-Service) and Supervision of Front Li | 38,000 | 42,000 | 35,000 | 45,000 | 160,000 |
| | Cross-cutting | 2.6: Other Health Systems Strengthening | 972,990 | 317,270 | 817,551 | 125,964 | 2,233,776 |
| | Cross-cutting | 2.6: IP Program Management | 1,224,350 | 1,224,350 | 1,175,977 | 886,708 | 4,511,385 |
| **Subtotal** | | | **7,149,817** | **6,739,817** | **6,905,028** | **5,017,793** | **25,812,455** |
| **Total** | *Budget Estimate to be used asa framework. Final authorized budget will be confirmed and communicated at time of official award. Phase 2-4 option budget Estimates are notional and dependent on availability of US Government available funding. | | **8,111,951** | **8,111,951** | **7,787,163** | **5,844,927** | **29,855,993** |

**Approaches to Reaching Sustainable Epidemic Control & Transitioning Ownership**

Proposals are requested to support the Mozambican Armed Forces to reach sustainable control of the HIV epidemic and focus on the America First Global Health Strategy, the latest PEPFAR guidance and UNAIDS HIV Treatment 95-95-95, Vertical Transmission 95 targets, and TB prevention 90 targets and in alignment with the NSS, NDS, and the MOU between the U.S. DoS and Government of the Republic of Mozambique.

In 2025, DHAPP supported the recipient military in conducting a Military Sustainability Index (MilSID). Findings indicate the military health system (DO to provide general statements on the areas that require further support to build the capacity of the recipient military). The implementer will be responsible for supporting the recipient military in conducting a MilSID each year of the award, ensuring all stakeholders are present (please include as an SOW activity).

The implementer will develop and implement a comprehensive transition plan that is in alignment with any existing country MOU, with clearly defined every 6-month milestones demonstrating progressive military assumption of programmatic responsibilities across all technical areas, data collection and reporting areas, and program management. This transition framework prioritizes efficiency, direct patient care investment, and development of resilient health systems capable of independent operation beyond the period of U.S. support. All proposals should detail how the implementer will engage the recipient military leadership as well as personnel at all levels in this work; and, specifically, how the implementer will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Please specify which SOW activities the implementer is supporting the military to take ownership of (showing increasing military ownership) and by when (with detailed milestones). Throughout this progression, the implementer must document evidence of increasing military ownership through specific metrics including percentage of activities led by military staff, proportion of budget executed directly by military, number of military personnel trained to competency, and documented military-led decision-making and problem-solving. Failure to attain defined milestones as agreed upon by the implementer, the partner military, and DHAPP may result in award termination.

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

**Technical Narrative & Scope of Work (SOW)**

In alignment with international health guidelines, America First Global Health Strategy, and guidance from PEPFAR/GHSD, coupled with DHAPP's vision to build the capacity of military health systems through military-specific and culturally appropriate services, the recipient will address the approach to each technical area. The implementer, through burden-sharing and building self-reliance within the recipient military, will be responsible for providing the following in close collaboration with other

DHAPP-funded implementers.

**Technical Module Building Blocks**

The implementer will work closely with the Ministry of Defense and its medical leadership to make progress towards a resilient and self-reliant military HIV program that is aligned with the national MOU (if applicable), using evidence-based and efficient interventions to reach the three 95s. In alignment with the Transition Plan directive above, the implementer will include specific milestones for program transition for activities within each technical area.

1. **Pre-Exposure Prophylaxis (PrEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PrEP services to all HIV-negative individuals at high risk of acquiring HIV.

The implementer will ensure that the following interventions for adults and adolescents include:

- People at a higher risk of acquiring HIV, including PBFW, must be counseled on and offered PrEP in alignment with recipient country government policies. Any person who asks for PrEP should be considered for use.
- Individuals considering PrEP must be confirmed HIV-negative and be willing to attend follow-up appointments to monitor their HIV status on a routine basis. If a PrEP user tests HIV-positive, PrEP must stop immediately and effective HIV treatment must start.
- Differentiated and simplified service delivery for PrEP is encouraged, such as event-driven PrEP (ED PrEP), community delivery, and the use of HIV self-tests (HIVST) for PrEP services.
- PrEP counselors must be equipped to ensure that PrEP users understand adherence to the different DSD options and different PrEP options. Adherence counseling and support must be ongoing, as necessary.
- As Long-acting Lenacapavir (LEN) injectables become available, beneficiaries should be presented with thorough information on all available PrEP options, including each method's relative efficacy and safety, as well as counseling and adherence support, allowing for an informed client choice.
- If PrEP is not being offered at military facilities, the recipient will work with the military and PM to advocate with necessary stakeholders (possibly MoH or military leadership) to update guidelines, gain necessary approvals, and start implementation at military facilities.

2. **Post Exposure Prophylaxis (PEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PEP services to all HIV-negative individuals (including healthcare workers and non-healthcare workers) who have had a possible exposure to HIV within the last 72 hours.

The implementer will ensure that the following interventions for adults and adolescents include:

- PEP should be started as soon as possible after a potential exposure to HIV, ideally within 24 hours and no later than 72 hours.
- The person seeking PEP should be tested for HIV to confirm they are HIV-negative before starting PEP, although if testing is not available, PEP should be started immediately and can be stopped later once testing is available. Individuals who test positive for HIV should be started on treatment immediately.
- Three ARV drugs for a 28-day prescription are recommended for the HIV PEP regimen. Patients must be properly counseled to understand what PEP is, on adherence, and potential side effects.
- If PEP is not being consistently integrated and offered at military facilities (to the point that the surrounding population knows it is accessible if needed), the recipient will work with the military and PM to update guidelines and SOPs, gain necessary approvals, and start implementation at military facilities. Timely access to PEP is the most crucial factor in PEP effectiveness.
- Individuals who seek PEP services should be counseled on and offered PrEP post PEP if risk is ongoing.
- PEP availability in community settings, as well as task sharing of PEP administration is encouraged to increase timely accessibility post exposure.

### 3. HIV Testing Services (HTS)

HIV Testing Services (HTS) is the forefront for finding the remaining people who are living with HIV (PLHIV) and is a priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know their infection status are men, adolescents, and children. The recipient military HIV/AIDS program is strategically placed to reach men; therefore, the implementer will closely work with the recipient military on HTS for both prevention and diagnosis. Those who test negative should be provided with HIV risk reduction information (including referral to PrEP where relevant) and educated on U=U (Undetectable = Untransmittable). For those who test positive, activities should include information about HIV, offer of Safe and Ethical Index Testing (SEIT), and offer of self-testing for family members (all sexual partners, needled-sharing partners and biological children under 19 years old) and biological siblings of pediatric index clients who may not be able to access a testing site. HTS should be targeted towards military personnel to achieve the target of 95-100% of all recipient military PLHIV knowing their status. HTS should also be provided to beneficiaries and civilians cared for at all military sites. The implementer will ensure they and the recipient military follow GHSD and national guidance on implementing SEIT and use the training materials created by the HTS team with the 10-Step model.

The local epidemiology and situational analysis should guide other testing methods to identify PLHIV.

Provider-Initiated Testing and Counseling (PITC) will continue at military facilities for both the military and civilian cohorts. PITC should focus within clinical areas that have shown a high testing yield, such as inpatient wards, tuberculosis (TB) and sexually transmitted infection (STI) clinics. All people newly diagnosed with HIV should be retested to verify their HIV status prior to starting ART. The same testing strategy and algorithm as the original diagnosis should be used, but with a different

tester and different test kit lots.

The implementer should support the military to achieve over 95% linkage of HIV-positive individuals identified to treatment initiation, fully implementing "test-and-start" policies across all age, sex, and risk groups. Ensuring that any person with positive results identified is linked to HIV care and treatment is essential to the success of the recipient military program. The implementer will support the military to 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 and other relevant integrated services.

The implementer will be responsible for providing support for the following activities to military bases and facilities:

- Diagnosing HIV, with at least 95% of those diagnosed linked to HIV care, while striving for 100% linkage to treatment services and same day initiation of ART.
- Offering SEIT to all HIV positive clients and testing for all sexual partners and children under 19 years old of HIV positive military personnel and civilians.
- Documenting HIV status for all children under 19 years of age with mothers living with HIV.
- Offering self-testing for partners of index clients if they do not volunteer for partner notification.
- Facilitating quality improvement and quality assurance for all recipient military HTS sites, including strategic assistance, at least quarterly.
- Providing HIV self-testing (HIVST) for military personnel, AGYW and their partners, male partners of antenatal care (ANC) clients and other high-risk populations. As part of the HIVST protocol, clients with a positive HIVST should be instructed to follow up with trained staff for further evaluation, including diagnostic testing utilizing the national testing algorithm. It is also vital to engage community groups to advocate for, design, implement, and analyze the success of 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, including Viral Load Suppression (VLS).
- Linking HIV negative, high-risk clients to PrEP services.

## 4. HIV Treatment

ART optimization is the 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. Moreover, long-term viral load suppression prevents onward transmission and is the cornerstone of HIV prevention. The following factors should be considered in supporting the treatment of PLHIV in military facilities.

- 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. The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission recommends DTG-containing regimen as a Preferred ARV for PBFW and recommends DTG-containing regimen as a Preferred ARV for women who are trying to conceive. Starting in COP20 (FY21), programs were 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 prevent the development of TB in PLHIV as well as diagnose and treat PLHIV with TB disease and ensure they become non-infectious. In addition, all TB infected individuals should be tested for HIV.
    - Routinely screen all PLHIV for TB disease. Standardized symptom screening alone is not sufficient for TB screening among PLHIV and should be complemented with more-sensitive and setting-specific recommended screening tools. Ensure all PLHIV who screen positive for TB receive recommended molecular diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment.
    - For all who do not have active TB, prevention of TB is a priority using nationally approved TB preventive therapy (TPT). The Global AIDS Strategy has set the target of 90% of PLHIV to receive preventive treatment for TB, thus TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Implementers 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 that is consistently documented. In short, all newly diagnosed HIV-positive people should be offered TB treatment or preventive therapy, and all people assessed for TB should be tested for HIV.
    - Pregnant women living with HIV are at high risk of progression from TB infection to disease; thus, it is imperative that Prevention of Mother to Child Transmission (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 PLHIV.
    - 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, implementers should also seek opportunities to support effective joint program implementation. Additionally, implementers should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide a 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 Women Living with HIV (WLHIV) should be integrated into routine HIV treatment services in each country program. According to COP 24 Technical Considerations, all PEPFAR supported countries with HIV prevalence above 5.0% among women in the 15-49-year-old age group are expected to provide at least one life-time cervical cancer screen for WLHIV receiving ART.
    - Current international health guidelines recommend screening to start at age 25 or according to national guidelines, whichever is earlier. Programs may also consider earlier screening among women with long-standing HIV infection, e.g., perinatal infection. WLHIV who are between 50 and 65 years and have not been screened may be offered a single screening test, and screening should be discontinued if they screen negative.
    - Screening for cervical cancer should begin at high-volume military sites and be scaled to all women receiving ART in military ART sites either on-site or through referral to hub sites within the region. Screening should be available in the ART clinic or in affiliated clinics on-site such as women's health or maternal child health clinics for WLHIV to utilize.
    - Programs should ensure that a minimum of 90% of women who screen positive are linked to treatment.
    - 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.
    - Funding may be used for screening with visual inspection with acetic acid (VIA), treatment with cryotherapy, thermal ablation, and loop electrosurgical excision procedure (LEEP), and quality assurance activities.
- The implementer should work with the recipient military to offer most clients 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, 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 implementer should work with the recipient 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 HIV-related stigma by integrating a wide array of non-HIV commodities into decentralized sites (e.g. TPT). DDD models can also be used for decentralized PrEP distribution to improve uptake and continuation.
- Diagnose and treat people with advanced HIV disease (AHD). People starting treatment, re-engaging in treatment after an interruption of > 1 year, or virally unsuppressed for >1 year should be evaluated for AHD and have CD4 T cells measured. Accordingly, the implementer should be working with recipient military and public health leaders to ensure that CD4 testing is available. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease. The PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with advanced disease.

**5. 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 implementer will work closely with the Ministry of Defense in Mozambique to scale up VL testing coverage and VL suppression to achieve 95-95-95 goals for military personnel, as well as beneficiaries and civilians. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% VL suppression among PLHIV taking ART. CD4 testing should not be used to determine eligibility for ART and only should be used for assessment of immune status (i.e. identification or ongoing monitoring of patients with advanced HIV disease).

The implementer should ensure that the recipient military has access to timely VL testing (goal turnaround time is within 2 weeks) and that capacity exists to test 95% of people currently on ART annually. To ease logistical challenges associated with the transport of whole blood specimens and to increase access to routine VL monitoring, dried blood spots (DBS) for VL testing can be used as an alternative specimen type to plasma. 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 POC be used for VL testing among PBFW, infants, and children. Implementers must follow international health guidelines and work with military and MoH network (as necessary) to implement and monitor VL testing schedule for PBFW and HIV-exposed infants (HEI), which differs from the VL testing schedule of non-PBFW HIV+ adults. POC platforms may also be appropriate for low volume remote military sites.

The implementer will ensure that VL results are available to providers/clients in a reasonable amount of time (goal is within 2 weeks) to both the health care provider and the client. These results should be available 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. Unsuppressed clients and their sexual partners should be educated on alternate risk reduction options until they become suppressed, such as PrEP. 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, to minimize inconveniences associated with health system access.

HIV viral suppression is not only critical to improving individual health, but also to prevent sexual transmission, and reduce perinatal transmission. There are three key categories for HIV viral load measurements: unsuppressed (>1000 copies/mL), suppressed (detected but ≤1000 copies/mL) and undetectable (viral load not detected by test used: <40 or <50 copies/ml depending on the machine used). People living with HIV who have an undetectable viral load and continue taking medication as prescribed have zero risk of transmitting HIV to their sexual partner(s) (U=U). PLHIV who have a suppressed but

detectable viral load and are taking medication as prescribed have almost zero or negligible risk of transmitting HIV to their sexual partner(s). HIV VL test results can be a motivation for adhering to treatment and achieving the goal of being undetectable. Emphasizing and strengthening adherence counselling during antiretroviral therapy initiation and throughout treatment are essential, including communicating about the benefits of viral load suppression to all PLHIV. HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. The implementer must work with the military to ensure updated and accurate U=U messaging and encourage HIV testing, prevention, and treatment reaches all PLHIV, the general population and health care providers.

### 6. Health System Strengthening

DHAPP is working to enhance the ability of militaries and Ministries of Defense to manage their HIV epidemic, respond to broader health needs impacting their communities, and address new and emerging health concerns. Implementers should describe how they will increase recipient government capacity. A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of the HIV response, including political commitment, building program capacities and capabilities, and financial planning and expenditure.

The procurement of supplies, support and equipment should use recipient government and other donor sources when possible (Global Fund, etc.).

Laboratory:

The implementer will be responsible for the following activities to help recipient militaries build resilient, sustainable, and internationally accredited laboratory systems strongly capable of responding to the HIV epidemic and other future infectious disease outbreaks:

- Laboratory inventory tracking, control, and forecasting; monitoring of commodities procurements to ensure laboratory supplies are procured at cost-effective prices and services are uninterrupted; monitoring facilities storing procured laboratory commodities to ensure they meet International Organization for Standardization (ISO) warehouse principals and standards; obtaining insurance for procured laboratory commodities to protect against natural disasters, fire, theft, etc.
- Supporting and facilitating military participation in national quantification exercises, ensuring that military laboratory commodity needs are incorporated into national forecasting.
- Routine monitoring of turnaround time (TAT) for VL, TB, and other critical tests, to ensure test results are provided to providers and patients within a reasonable period (2 weeks) to improve and maximize patient care and outcomes.
- Procuring laboratory service maintenance contracts, routine calibration of equipment, and training of laboratory staff on proper use and maintenance of procured equipment.
- Supporting training in proper laboratory biosafety and waste management.
- Ensuring continuous quality improvement of all laboratories (including satellite laboratories and HIV testing sites) and accreditation is in place and transitioned over to the recipient government with key milestones and timeline.
- Monitoring of laboratory quality, adherence to quality systems, and method validation; provision of proficiency testing for rapid HIV testing, VL, CD4, TB, STIs, and other tests critical to HIV epidemic control and detecting emerging disease outbreaks.

- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, address needs and gaps, and provide recommendations for the development of improvement plans to resolve any identified problems.
- Linking recipient military laboratory services to other laboratory resources at the district, provincial, and national levels.

Optimizing diagnostic networks for VL/EID, TB, and other coinfections. In coordination with other Donors and National TB Programs, complete diagnostic network optimization (DNO) and transition to integrated diagnostics and multi-disease testing. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time (goal is 2 weeks). Identify all parts of the laboratory system that are interoperable with the U.S. military system.

## 7. Virtual Communities of Practice/ECHO Platform

The implementer should support the recipient military's use of Virtual Communities of Practice (vCOPs) through the Project ECHO (Extension for Community Healthcare Outcomes) model if an ECHO network already exists within the military program. Project ECHO is evidence-based, virtual model that democratizes medical expertise as a self-reliant tool for continuous clinical knowledge sharing amongst healthcare workers. Since 2020, DHAPP has collaborated with the ECHO Institute (https://hsc.unm.edu/echo/) to lever their vast experience with vCOPs/ECHOs and to assist in establishing ECHO programs with 24 recipient militaries. More information on the establishment of the DHAPP Superhub available at https://pubmed.ncbi.nlm.nih.gov/40984107/. Key requirements are equipment and connectivity as well as personnel who can coordinate, manage, and lead regular vCoP/ECHO sessions. (https://hsc.unm.edu/echo/).

For recipient militaries with existing, launched ECHO programs, the implementer shall provide support focused on transitioning full ownership of the ECHO program to the recipient military. Required support activities include:

- **Program Maintenance:** Assisting the recipient military in the maintenance of existing ECHO hub and spokes – connectivity,
- **Strategic Expansion:** Supporting the addition of new clinical "spokes" to strengthen the military network of integrated care throughout the country.
- **Network Engagement:** Ensuring the recipient military actively engages with the DHAPP ECHO Superhub, and, where applicable, any local ECHO network (i.e., an MOH-led ECHO) for broader collaboration.

The Statement of Work (SOW) narrative must be specific about all proposed ECHO activities (e.g., personnel, number of sites, locations). All equipment purchases listed in the workplan must follow current U.S. laws (Congress) and policies (Executive Branch) and must be reviewed and approved by the DHAPP ECHO Team.

## 8. Commodities

The implementer will assist the military in developing and implementing a supply chain management strategy that aligns with PEPFAR's goals of ensuring sustainable commodity supplies while

simultaneously emphasizing and working to improve self-reliance of the commodities recipient, with the full transition of all capabilities to the commodities recipient by award completion or USG/recipient country MOU completion (whichever comes first). This strategy should include, where applicable to a site or sites, as many of the following principles as practical:

- Development of a comprehensive Supply Chain Transition Plan with clearly defined annual milestones for the recipient military to assume responsibility for key functions. The FADM Supply Chain will be integrated with the national system. A written supply chain risk management plan that is co-developed with and owned by the recipient military. This plan must address risks to commodity availability (e.g., stockouts, expiries) and risks to the transition process itself (e.g., personnel gaps, funding shortfalls). Plans may be specific to a site or group of similar sites, depending on the need identified by the recipient military and recipient, the implementer will work with other key stakeholders to resolve barriers to efficient supply chain management at FADM sites.
- Identification and training of supply chain points of contact within each facility on topics to include where applicable, but not limited to:
    - Accurate use of the commodities request system (typically the national system)
    - Completion of necessary paperwork/electronic forms
    - Stockout and overstock mitigation strategies
    - Inter-site commodity movement procedures
    - Establishing relationships with commodities counterparts within the military and national systems, both regionally and nationally
    - Quantification and forecasting, with the goal of the recipient military leading their national quantification exercise for its facilities.
- In alignment with the America First Global Health Strategy, and in compliance with applicable federal acquisition regulations, the recipient will prioritize the evaluation and selection of U.S.-manufactured pharmaceuticals, diagnostics, and supply chain technologies where they are competitive in terms of cost, quality, and availability. The recipient will document efforts to explore U.S.-based sources as part of its procurement strategy.
- Implementation of supply chain best practices, including product and supply chain segmentation, actively identifying and contracting with local and/or U.S.-based private sector logistics partnerships where appropriate to improve efficiency and build a sustainable logistics infrastructure that can be leveraged directly by the recipient military in the future, and establishing end-to-end supply chain visibility using global standards (GS-1) to enable military leadership to make independent, data-driven supply chain decisions.
- Adoption of decentralized drug distribution (DDD) models, such as home deliveries, use of community or private pharmacies, and automated lockers, to improve client convenience and maximize product availability.
- Collaboration with relevant stakeholders to conduct Diagnostic Network Optimizations (DNOs) to inform laboratory supply chain refinements.
- Development of accurate forecasts that capture total program needs, including considerations for optimized testing and treatment. These forecasts should inform regular (at minimum quarterly) supply plan updates.

- Establishment of systems for increased data visibility and reporting of HIV commodities availability, including granular-level reporting of quantities dispensed and stock availability.
- Active participation in collaborative efforts with recipient governments and other stakeholders to ensure data-informed decision-making and mitigate stock risks.
- Development of a plan for increasing local oversight and utilizing private sector capabilities, where appropriate.
- Implementation of a risk management and monitoring system, which may include third-party monitoring for assessment and oversight of supply chain programs, if required.
- Design and implementation of capacity building initiatives to increase supply chain literacy and fluency across recipients and human resources for health.
- Avoidance of parallel supply chain systems. All efforts must focus on strengthening and utilizing the recipient military's and/or the national health system's existing infrastructure. The recipient should not create separate, temporary, procurement or distribution systems.

The implementer should work towards ensuring a sustainable supply chain and improved regional self-reliance where feasible. This includes ensuring the military is connected to the national procurement system and other already existing procurement systems and resources in-country to avoid creating parallel procurement systems.

## 9. LIVES & Child Safeguarding

The implementer will ensure that all implementer & military health facility staff are trained in and implementing both the DHAPP LIVES and Child Safeguarding interventions (utilizing the curriculum updated in December 2025 that is in alignment with Executive Orders to date); to include re-training all trained staff every 3 years and training all new staff as part of their hiring process. Records for who has been trained and when must be kept by implementer and/or military and accessible upon request.

## 10. Malaria

The implementer is responsible for implementing evidence-based malaria prevention and treatment services. The implementer should work with the recipient military and MoH to ensure that these activities align with national malaria guidelines and target geographic regions with high malaria prevalence.

Malaria remains a significant global health threat, particularly for PLHIV who may be at higher risk of severe infection due to a compromised immune system. Malaria infection may reduce the effectiveness of ART for PLHIV on treatment, making malaria prevention an important tool in the clinical care of PLHIV. Populations which should be prioritized for malaria prevention and treatment services include infants, children under 5 years old, pregnant and breastfeeding women (PBFW), adolescent girls and young women (AGYW), PLHIV, and military populations.

The implementer will ensure that activities to address malaria include:

- Promotion of vector control prevention activities to reduce malaria infection, such as the distribution of insecticide-treated mosquito nets and the use of indoor residual spraying (IRS) in areas with high malaria prevalence.
- Distribution of chemoprophylaxis according to MOD and national guidelines as appropriate for active-duty military (ADM) deployed to areas with high malaria prevalence. Dispensing of

chemoprophylaxis medications, if indicated, should include clear guidance on timeline and duration of medication usage.
- Administration of malaria vaccine for children under five years of age living in areas with moderate to high malaria transmission, aligned with international and national vaccine guidelines.
- Intermittent preventive treatment in pregnancy (IPTp) for pregnant women in malaria-endemic areas.
- Training healthcare providers to identify, diagnose, and treat malaria, as well as training on early detection and response to drug-resistant malaria.
- Distribution of appropriate malaria treatment at military health facilities, or referral to other health center where treatment is available. The most common malaria treatments are as follows:
    - Artemisinin-based combination therapy medicines are the most effective treatment for *P. falciparum malaria*.
    - Chloroquine is recommended for treatment of infection with the *P. vivax* parasite only in places where it is still sensitive to this medicine.
    - Primaquine should be added to the main treatment to prevent relapses of infection with the *P. vivax* and *P. ovale* parasites.
- Ongoing surveillance and analysis of malaria cases and health outcome data.

**11. Tuberculosis (TB)**

The implementer will be responsible for working with the recipient military to implement evidence-based TB prevention, care, and treatment services in alignment with the national MOU and implementation plan, specified by the DHAPP Program Manager. The implementer must work with the recipient military to comply with national TB guidelines and move the program towards international TB standards (if there is a discrepancy). The implementer will ensure the military is connected with all relevant TB stakeholders in-country and seamlessly included in national processes, meetings, networks for efficiency, cost effectiveness, and self-reliance. Implementers will specifically work to integrate testing, treatment, care, and patient flow between any siloed HIV and TB departments within military health facilities. Implementers will work with the recipient military to ensure there are military owned TB services to include:

- Tuberculosis Preventive Treatment (TPT) for individuals at the highest risk of progressing from TB infection to active disease, to include PLHIV, household contacts of TB patients, ADM living in barracks, and other at-risk groups.
- Symptom screening at key healthcare facility service delivery points with strict and consistent protocol to reduce in-facility transmission.
- Standardized drug regimen, including fixed-dose combinations (FDCs).
- Directly Observed Therapy (DOT), especially virtual options, to ensure adherence.
- Robust data systems to ensure patients with TB are tracked through a complete course of therapy and minimizing loss to follow-up.

**12. Bio Surveillance (Surveillance and Outbreak Response)**

The implementer will be responsible for implementing bio surveillance activities in coordination with the recipient military and in alignment with international and national health guidelines. Bio surveillance

activities include 1) outbreak detection and 2) outbreak response; and will not be duplicative of other U.S. funded bio surveillance activities.

The implementer will work with the military to ensure that outbreak detection activities are military owned and include:

- Assessment and maintenance of existing outbreak detection capacities in military health facilities and assessment of alignment with national protocols.
- Ensure military clinical and laboratory facilities are aware of national reporting requirements for outbreak detection
- Determine gaps in outbreak detection, particularly in laboratory capacity and data management, and implement a plan to correct identified gaps.

The implementer will ensure that outbreak response activities include:

- Assessment of existing outbreak response plans and revision of plans as appropriate.
- Training of personnel in effective outbreak response and establishment of outbreak response SOPs in alignment with national protocol.
- Ensure clinical facility staff are familiar with required barrier protective measures per national guidelines to prevent nosocomial spread of pathogens. Coordinate with national efforts to ensure military facilities are supplied with PPE.

The implementer will work with the PM to tailor and address any other outbreak detection and response activities outlined in the Country MOU Implementation Plan and Operational Plan.

**Monitoring and Evaluation**

To ensure the effective, efficient, and durable use of United States Government funds, the recipient military armed forces shall be responsible for the comprehensive, reliable, and timely reporting of the milestone, outcome and process metrics specified in this announcement. This reporting is critical for two primary objectives: first, to guide the development of health policies and practices that improve the recipient country's force health readiness, and second, to provide rigorous accountability to the United States Congress and the American taxpayer for every dollar appropriated.

The implementer is mandated to coordinate directly with the FADM, utilizing the national data collection system, to ensure the accurate and transparent delivery of these metrics to all designated stakeholders as specified in the Memorandum of Understanding between the USG and Government of the Republic of Mozambique.

The overarching goal is to transition all monitoring, evaluation, and reporting responsibilities to the recipient military, fostering complete self-reliance in the shortest possible timeframe. To verify the integrity of this reporting and safeguard U.S. investment, the implementer will execute regular Data Quality Assessments (DQAs) to evaluate the accuracy and reliability of the data provided by the recipient military, the frequency of which will be determined in consultation with the recipient military.

| Process Metrics | Baseline Targets |
|---|---|
| # people on ART | 35,000 |
| # new HIV diagnoses among infants (0-12 months) | 45 |
| # new HIV diagnoses among children and adults (age 12 months or older) | 4,800 |
| % pregnant and breastfeeding women living with HIV who receive ART | 100% |
| % or # confirmed malaria cases that receive first-line antimalarial treatment | |
| # insecticide-treated nets distributed to populations at risk of malaria | |
| # patients with TB notified (i.e., bacteriologically confirmed + clinically diagnosed) | 1,100 |
| % patients with TB notified who completed treatment | 100% |
| % of pregnant women with 4 or more ANC visits during a single pregnancy | 76% baseline; 82% by Year 4 |
| % accuracy of data fields assessed during the annual data audit | 70% baseline; 80% by Year 4 |

To ensure rigorous oversight and accountability, the implementer is required to submit independent performance data. This reporting will serve to verify and corroborate the data provided by the recipient country's Ministry of Defense as compared to actual program implementation. The explicit purpose of this data collection is to guarantee that every American taxpayer dollar is spent effectively, and its impact is demonstrably justified. All implementer performance data shall be reported at the site level or higher through the designated online data collection system (DC2) at the specified quarterly, semi-annual, or annual intervals. The indicators used for this reporting requirement will harmonize with required milestone, process, and outcome metrics.

All proposals must include milestone metrics by activity and which outcome or process metric each activity supports.

| Budget, USD | Activity | Milestone | Metric Mapping (Outcome & Process Metric) |
|---|---|---|---|

**Quality Management System**

The Mozambican Armed Force are responsible for maintaining a quality management (QM) system, which will no longer be funded through PEPFAR. Site Improvement through Monitoring System (SIMS) is a QM system that has been supported by DHAPP for many years, and implementers and recipient militaries are encouraged to use this system (or other QM system of their choosing). QM systems provide a standardized approach and set of tools for monitoring program quality. QM 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. QM systems are also used to identify performance issues that may impact patient outcomes or the integrity of program reporting site-level triangulation of program and QM data can be used to contextualize performance and determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

QM systems aim to:

(1) facilitate service improvement,
(2) ensure accountability of U.S. government investments, and
(3) maximize the impact of U.S. government investments on the HIV epidemic.

QM assessment results confirm compliance with minimum quality assurance standards and identify areas where improvements can be made.

The implementer should ensure that all supported sites are familiar with QM standards and make sure that all efforts are taken to follow these standards. DHAPP encourages implementers and militaries to conduct reviews of program performance using the latest QM or SIMS tools which are freely available.

SIMS or other QM system implementation is one strategy available for programs to integrate effective quality assurance (QA) and CQI practices into site and program management. Program management must apply ongoing program and site standards assessment—including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementer agreements and workplans should align with national policy in support of QA/CQI.

**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 recipient military HIV program's ability to monitor progress towards epidemic control. The implementer will work with the recipient military and Ministry of Health (MOH), Ministry of Communications, and 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 recipient military leadership.

The implementer will be responsible for:

- Staffing, support, and mentoring of existing recipient military staff for paper and electronic data collection
- Timely, accurate reporting of all indicators required by the recipient 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 recipient military and DHAPP without prior approval from the recipient military and from DHAPP
- Support for paper and electronic data entry, cleaning, reporting, and use
- Ensuring data quality

**Data Quality**

Ensuring excellent data quality is a critical component of all recipient military programs and the implementer should include a strategy for conducting baseline, periodic, and ongoing data quality assessments (DQA). In this way, DHAPP, and the recipient military, can be confident in the veracity of the data that it uses for planning and measurement of progress towards programmatic goals. The implementer should plan on conducting periodic 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 recipient 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 from HIV testing to viral load testing, and the complete 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. Frequency of periodic DQAs should be determined in consultation with the recipient military and DHAPP.

**Informatics**
**Health Information Systems**

Informatics (including Digital Health Platforms (DHP) also known as Health Information Systems (HIS) or Medical Information Systems (MIS)) are critical underpinnings of good patient healthcare and good program management. The military's health system requires reliable informatics support to ensure its long-term, sustainable advancement. Key goals for a military HIS include 1) improving quality and safety of care; outbreak detection; data-driven decision-making; efficient deployment of resources; QA/QC; and improved access and improved confidentiality of health data.

The Government of Mozambique envisions the establishment of an integrated national digital health platform designed to support data-driven decision-making across all levels of the health system, irrespective of disease area. The central component of this platform is the Integrated Electronic Medical Record System (SIS-RME), which is owned and operated by the Government of Mozambique. Enhancements to SIS-RME are expected to leverage, adapt, and progressively transition the functionalities and features of the Electronic Patient Tracking System (SESP), developed by the United States Government.

The implementer will support the recipient military's HIS to align with the recipient country health information systems (HIS) to the greatest degree possible. The implementer will inventory the current

military data systems (paper and electronic) and will provide written recommendations to include identification of gaps in the military HIS and requirements to enable the recipient military HIS to reach all clinical and laboratory locations. The implementer will coordinate with the military and MOH or other appropriate ministries to 1) ensure the military sites are included in national systems with 2) training, 3) infrastructure improvements such as routers, computers, solar power and satellite internet connectivity, 4) security (physical and cyber), 5) data use policy and governance, 6) data management, 7) data analytics, and 8) data use and dissemination. Where equipment procurements are needed, the recipient will ensure that the equipment will follow US laws and policies (e.g. no equipment from China, USA made, etc.).

The implementer must ensure by 2030 that the military will be capacitated with durable systems, staffing, training, and infrastructure to allow the military to use their systems effectively and independently to monitor client health and conduct national reporting.

**Work Plans**

The implementer 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. A full list of reporting requirements can be found in the base Program Announcement and will be disclosed in the award terms and conditions.

**Multi-Country (Burkina Faso, Central African Republic, Guinea Conakry, Mali and Madagascar): DHAPP—Burkina Faso Armed Forces, Central African Republic Armed Forces, Republic of Guinea Armed Forces, Malian Armed Forces, and Madagascar Armed Forces Partnership for Resilient Military Health Systems for Readiness**

**NOTE: Application submissions for this narrative are due by 12pm EST on 15 May 2026. Submissions received after the deadline will not be considered for funding.**

**Call for Proposals**

Proposals are requested to support the Burkina Faso, Central African Republic (CAR), Guinea Conakry, Mali, and Madagascar Armed Forces to reach sustainable control of the HIV epidemic through the lens of the America First Global Health Strategy, as well as the UNAIDS HIV Treatment 95-95-95, Vertical Transmission 95 targets, TB prevention 90 targets, and in alignment with the National Security Strategy (NSS) and the National Defense Strategy (NDS) goals to protect the homeland, deter China, and increase burden sharing. Further, proposals must be aligned with any existing Memorandum of Understanding between the U.S. Department of State and Burkina Faso, CAR, Guinea Conakry, Mali, and Madagascar. Implementers should be familiar with these strategic guidance documents and include means of addressing them in submitted proposals. **Please see base Program Announcement section D for complete detailed list of application, format and submission requirements. Proposal Technical Narrative may not exceed 45 pages.**

**Introduction**

The HIV/AIDS epidemic has devastated 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 other military personnel and their extended communities, and impeding participation in peacekeeping activities. As HIV management improves, many of these impacts are reduced; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries; this is in addition to managing other long-term chronic diseases to maintain high force health readiness in strategically identified recipient militaries. Moreover, given the well-known biobehavioral risk factors among uniformed personnel, reducing HIV acquisition and transmission in this population is an essential component for reaching epidemic control in the recipient country.

The U.S. Government has a long history of providing foreign assistance to combat HIV/AIDS, advancing U.S. national security by promoting stability in key regions. Over the years, the United States DoD HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries to control the HIV epidemic among their respective military services. Working closely with the Department of Defense (DoD, herein referred to using the secondary title Department of War, DoW), , U.S. Geographic Combatant Commanders, the Bureau of Global Health Security and Diplomacy (GHSD) and other organizations, DHAPP's mission is to build the capacity of recipient militaries through military-specific HIV/AIDS assistance, creating self-reliant security counterparts. DHAPP is the DoW implementing agency collaborating with the US Department of State, 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 Department of War (Title 10)

Defense Health Program (DHP) and funding transfers from the Department of State (Title 22) for PEPFAR.

All proposals must be in full alignment with any existing Memorandum of Understanding (MOU) between the Department of State (DoS) and Burkina Faso, CAR, Guinea Conakry, Mali, and Madagascar clearly articulating transition plans for each activity over the course of the agreement with specific and measurable milestones. Reserving the last year of the agreement for transition planning will not be accepted. Activities to transition responsibilities to the recipient country must begin immediately upon award and continue throughout the life of the agreement to ensure a rapid path to self-sufficiency. The implementer must prepare the recipient country's military to fully own and operate all services, ensuring a complete and final transition of responsibility away from U.S. assistance.

The DoW Combatant Commands (CCMDs) have identified the longstanding DHAPP program with its recipient countries as an essential security cooperation tool that serves U.S. interests. Pursuing HIV/AIDS activities with foreign militaries is an important part of maintaining security interests, regional stability through health readiness, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing nations. 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 CCMDs and DHAPP Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under-Secretary of War for Policy and by the Department of State Bureau of Global Health Security and Diplomacy (GHSD). DHAPP provides technical support to defense forces in HIV prevention, care, treatment, and information systems and data use for HIV-infected individuals and their families.

PEPFAR adopted the United Nations Program on HIV/AIDS (UNAIDS) global 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. An additional goal supported by GHSD is 95% coverage of services for eliminating vertical transmission. Lastly, the UNAIDS Global AIDS Strategy established a goal that 90% of PLHIV receive preventive treatment for TB.

All proposals must align with the America First Global Health Strategy, which focuses on the following points:

- Address Inefficiency and Dependency: The majority of funding should go directly towards patient care and building resilient health systems. High program management costs will not be funded.
- Pillar 1: Make America Safer: The primary goal is to protect Americans by enhancing global surveillance systems to detect outbreaks within seven days of emergence, notify public health authorities within 1 day and rapidly responding at the source within 7 days with early response actions to prevent pandemics from reaching U.S. shores.
- Pillar 2: Make America Stronger: Foreign health assistance will be used as a strategic tool to strengthen bilateral relationships. The U.S. will enter into multi-year agreements with recipient countries that require co-investment and establish clear benchmarks, ...moving them toward self-sufficiency and away from reliance on U.S. foreign assistance. Proposals must align with any existing country-specific MOU timelines.
- Pillar 3: Make America More Prosperous: The strategy aims to bolster the U.S. economy by

preventing costly pandemics and by using foreign assistance programs to promote American companies and health innovations (like diagnostics and pharmaceuticals) in emerging global markets.

- Restructure Aid Delivery: The plan calls for more frontline support, such as medical commodities and healthcare workers, while significantly reducing all other non-frontline expenditures to ensure accountability to the American taxpayer. It will also streamline efforts by integrating disease-specific programs (HIV, Malaria, TB) and leveraging the private sector and faith-based organizations for more efficient service delivery. The implementer is expected to work with the DHAPP Program Manager (PM) on supporting the integration of disease-specific programs receiving USG funding for the military program.

**Local Implementers**

Local, non-governmental implementers with low overhead costs are encouraged to apply to this announcement. To achieve self-reliance, it is critical that the full range of HIV services are owned and operated by the recipient country's institutions, governments, and community-based and community-led organizations, regardless of current antiretroviral (ARV) coverage levels. The intent of transitioning to local implementers 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 implementers to ensure successful, long-term, community 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.

**Additional Submission Guidance:**

1. Review all documents within the package to ensure consistency in information, budgets, targets, and numbering:
    a. Use numbered lists, including numbered or alphabetized sub-lists, for activities for easier reference and monitoring, especially the SOW Narrative column.
2. Ensure all activities in the Technical Narrative are also listed concisely in the SOW file.
3. Activities must be specific; Do not write “ensure” or “support” or a similar verb as a narrative activity without defining what that means. Each activity must say specifically what the implementer will be doing. It must be measurable and answer the questions Who? What? Where? How? How many? How often?
4. Delineate between a training (i.e.: one time class or series of classes where attendees are gathered in a conference room, away from regular duties) and onsite strategic assistance (on the job guidance while recipient is performing regular duties) and specify as many of the following details as possible for both: how many attendees or sites, how often, how many days, where, specific topics/skills covered, expected outcomes & how they align with program goals, etc. Training should be limited and cost efficient.
5. Please note this project budget cannot include:
    a. Any budget allocations toward World AIDS Day (WAD) events/campaigns.

b. Prizes, hats, or T-shirts.
c. Flyers and printed education materials to be given to beneficiaries.
d. Rental of venues for training or events (must use available military or ministry facilities).
e. Employment or payments made directly to active-duty foreign military.

**Budget**

The **estimate** budget for this program announcement is as follows. Final authorized budget will be confirmed and communicated at time of official award execution. The link below contains the Financial Classifications Reference Guide and a summary of the classification definitions.
https://help.datim.org
Financial classifications are not regulations governing allowability of federal awards. Nothing in this guidance should be interpreted to mean that costs or activities that are unallowable or excluded under the terms of an award are permitted by virtue of being described herein. All awards are subject to the applicable cost principles and terms set forth and conveyed in the award made.

**Estimated Budget to be used as a Framework**

**Burkina Faso**

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.1: Surveillance and Outbreak Response | HIV | 2.1: Outbreak Response Capacities | 12,000 | 12,000 | 12,000 | 12,000 | 48,000 |
| | HIV | 2.1: Multisectoral Coordination for Animal and Human Outbreak Surveillance and Response | 7,000 | 7,000 | 7,000 | 7,000 | 28,000 |
| | HIV | 2.1: Outbreak Readiness | 15,000 | 15,000 | 15,000 | 15,000 | 60,000 |
| **Subtotal** | | | **34,000** | **34,000** | **34,000** | **34,000** | **136,000** |
| 2.2: Laboratory Systems | HIV | 2.2: Lab Equipment Procurement | 30,000 | 30,000 | 30,000 | 30,000 | 120,000 |
| | HIV | 2.2: Lab Sample Transport | 15,000 | 15,000 | 15,000 | 15,000 | 60,000 |
| | HIV | 2.2: Lab System Support | 10,000 | 10,000 | 10,000 | 10,000 | 40,000 |
| | HIV | 2.2: Lab Consumables Procurement | 15,000 | 15,000 | 15,000 | 15,000 | 60,000 |
| | HIV | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 15,000 | 15,000 | 15,000 | 15,000 | 60,000 |
| **Subtotal** | | | **85,000** | **85,000** | **85,000** | **85,000** | **340,000** |
| 2.3: Commodities | HIV | 2.3: Diagnostic Commodity Procurement | 25,000 | 25,000 | 25,000 | 25,000 | 100,000 |
| | HIV | 2.3: Therapeutic Commodity Procurement | 20,000 | 20,000 | 20,000 | 20,000 | 80,000 |
| **Subtotal** | | | **45,000** | **45,000** | **45,000** | **45,000** | **180,000** |
| 2.4: Frontline Health Workers | HIV | 2.4: Community Health Workers/Community-Based Staff | 36,000 | 36,000 | 36,000 | 36,000 | 144,000 |
| | HIV | 2.4: Epidemiologists & Surveillance Officers | 20,000 | 20,000 | 20,000 | 20,000 | 80,000 |
| **Subtotal** | | | **56,000** | **56,000** | **56,000** | **56,000** | **224,000** |
| 2.5: Data Systems | HIV | 2.5: Data Systems Infrastructure | 25,000 | 25,000 | 25,000 | 25,000 | 100,000 |
| | HIV | 2.5: Licenses & Software | 5,000 | 5,000 | 5,000 | 5,000 | 20,000 |
| **Subtotal** | | | **30,000** | **30,000** | **30,000** | **30,000** | **120,000** |
| 2.6: Strategic Assistance | HIV | 2.6: IP Program Management | 60,000 | 60,000 | 60,000 | 60,000 | 240,000 |
| | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 30,000 | 30,000 | 30,000 | 30,000 | 120,000 |
| **Subtotal** | | | **90,000** | **90,000** | **90,000** | **90,000** | **360,000** |
| **Total** | *Budget Estimate to be used as a framework. Final authorized budget will be confirmed and communicated at time of official award. Phase 2-4 option budget Estimates are notional and dependent on availability of US Government available funding. | | **340,000** | **340,000** | **340,000** | **340,000** | **1,360,000** |

# CAR

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.2: Laboratory Systems | HIV | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 15,000 | 15,000 | 15,000 | 15,000 | 60,000 |
| | HIV | 2.2: Lab Consumables Procurement | 10,000 | 10,000 | 10,000 | 10,000 | 40,000 |
| | HIV | 2.2: Lab Equipment Procurement | 10,000 | 10,000 | 10,000 | 10,000 | 40,000 |
| | HIV | 2.2: Lab System Support | 40,000 | 40,000 | 40,000 | 40,000 | 160,000 |
| | HIV | 2.2: Lab Sample Transport | 10,000 | 10,000 | 10,000 | 10,000 | 40,000 |
| **Subtotal** | | | **85,000** | **85,000** | **85,000** | **85,000** | **340,000** |
| 2.3: Commodities | HIV | 2.3: Diagnostic Commodity Procurement | 40,000 | 40,000 | 40,000 | 40,000 | 160,000 |
| | HIV | 2.3: Supply Chain Systems Support | 7,000 | 7,000 | 7,000 | 7,000 | 28,000 |
| **Subtotal** | | | **47,000** | **47,000** | **47,000** | **47,000** | **188,000** |
| 2.5: Data Systems | HIV | 2.5: Data Systems Infrastructure | 8,565 | 8,565 | 8,565 | 8,565 | 34,260 |
| **Subtotal** | | | **8,565** | **8,565** | **8,565** | **8,565** | **34,260** |
| 2.6: Strategic Assistance | HIV | 2.6: IP Program Management | 34,500 | 34,500 | 34,500 | 34,500 | 138,000 |
| | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 15,000 | 15,000 | 15,000 | 15,000 | 60,000 |
| | HIV | 2.6: Other Health Systems Strengthening | 40,000 | 40,000 | 40,000 | 40,000 | 160,000 |
| **Subtotal** | | | **89,500** | **89,500** | **89,500** | **89,500** | **358,000** |
| **Total** | *Budget Estimate to be used as a framework. Final authorized budget will be confirmed and communicated at time of official award. Phase 2-4 option budget Estimates are notional and dependent on availability of US Government available funding. | | **230,065** | **230,065** | **230,065** | **230,065** | **920,260** |

## Guinea Conakry

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.2: Laboratory Systems | HIV | 2.2: Lab Consumables Procurement | 7,000 | 7,000 | 7,000 | 7,000 | 28,000 |
| | HIV | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 18,000 | 18,000 | 18,000 | 18,000 | 72,000 |
| | HIV | 2.2: Lab System Support | 60,900 | 60,900 | 60,900 | 60,900 | 243,600 |
| | HIV | 2.2: Lab Equipment Procurement | 45,000 | 45,000 | 45,000 | 45,000 | 180,000 |
| **Subtotal** | | | **130,900** | **130,900** | **130,900** | **130,900** | **523,600** |
| 2.3: Commodities | HIV | 2.3: Diagnostic Commodity Procurement | 12,000 | 12,000 | 12,000 | 12,000 | 48,000 |
| | HIV | 2.3: Supply Chain Systems Support | 25,000 | 25,000 | 25,000 | 25,000 | 100,000 |
| | HIV | 2.3: Therapeutic Commodity Procurement | 10,000 | 10,000 | 10,000 | 10,000 | 40,000 |
| **Subtotal** | | | **47,000** | **47,000** | **47,000** | **47,000** | **188,000** |
| 2.6: Strategic Assistance | HIV | 2.6: IP Program Management | 84,500 | 84,500 | 84,500 | 84,500 | 338,000 |
| | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 125,000 | 125,000 | 125,000 | 125,000 | 500,000 |
| | HIV | 2.6: Other Health Systems Strengthening | 40,000 | 40,000 | 40,000 | 40,000 | 160,000 |
| **Subtotal** | | | **249,500** | **249,500** | **249,500** | **249,500** | **998,000** |
| **Total** | *Budget Estimate to be used as a framework. Final authorized budget will be confirmed and communicated at time of official award. Phase 2-4 option budget Estimates are notional and dependent on availability of US Government available funding. | | **427,400** | **427,400** | **427,400** | **427,400** | **1,709,600** |

## Mali

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.2: Laboratory Systems | HIV | 2.2: Lab Consumables Procurement | 20,000 | 20,000 | 20,000 | 20,000 | 80,000 |
| | HIV | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 30,000 | 30,000 | 30,000 | 30,000 | 120,000 |
| | HIV | 2.2: Lab Service and Maintenance Costs | 10,000 | 10,000 | 10,000 | 10,000 | 40,000 |
| **Subtotal** | | | **60,000** | **60,000** | **60,000** | **60,000** | **240,000** |
| 2.6: Strategic Assistance | HIV | 2.6: IP Program Management | 64,601 | 64,601 | 64,601 | 64,601 | 258,404 |
| | HIV | 2.6: TA to Introduce New Innovative Diagnostics, Vaccines, Drugs, and Other Interventions (Including Integated Services) | 130,000 | 130,000 | 130,000 | 130,000 | 520,000 |
| | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 70,000 | 70,000 | 70,000 | 70,000 | 280,000 |
| | HIV | 2.6: TA to Support Program Transition to Government or Local Partners | 30,000 | 30,000 | 30,000 | 30,000 | 120,000 |
| | HIV | 2.6: Other Health Systems Strengthening | 30,000 | 30,000 | 30,000 | 30,000 | 120,000 |
| | HIV | 2.6: Other Commodity Procurement | 15,399 | 15,399 | 15,399 | 15,399 | 61,596 |
| **Subtotal** | | | **340,000** | **340,000** | **340,000** | **340,000** | **1,360,000** |
| **Total** | *Budget Estimate to be used as a framework. Final authorized budget will be confirmed and communicated at time of official award. Phase 2-4 option budget Estimates are notional and dependent on availability of US Government available funding. | | **400,000** | **400,000** | **400,000** | **400,000** | **1,600,000** |

## Madagascar

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.2: Laboratory Systems | HIV | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 25,000 | 25,000 | 25,000 | 25,000 | 100,000 |
| | HIV | 2.2: Lab System Support | 30,000 | 30,000 | 30,000 | 30,000 | 120,000 |
| | HIV | 2.2: Lab Consumables Procurement | 5,000 | 5,000 | 5,000 | 5,000 | 20,000 |
| | HIV | 2.2: Lab Service and Maintenance Costs | 5,000 | 5,000 | 5,000 | 5,000 | 20,000 |
| **Subtotal** | | | **65,000** | **65,000** | **65,000** | **65,000** | **260,000** |
| 2.3: Commodities | HIV | 2.3: Supply Chain Systems Support | 35,000 | 35,000 | 35,000 | 35,000 | 140,000 |
| | HIV | 2.3: Diagnostic Commodity Procurement | 10,000 | 10,000 | 10,000 | 10,000 | 40,000 |
| | HIV | 2.3: Therapeutic Commodity Procurement | 10,000 | 10,000 | 10,000 | 10,000 | 40,000 |
| **Subtotal** | | | **55,000** | **55,000** | **55,000** | **55,000** | **220,000** |
| 2.6: Strategic Assistance | HIV | 2.6: IP Program Management | 40,000 | 40,000 | 40,000 | 40,000 | 160,000 |
| | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 50,000 | 50,000 | 50,000 | 50,000 | 200,000 |
| **Subtotal** | | | **90,000** | **90,000** | **90,000** | **90,000** | **360,000** |
| **Total** | *Budget Estimate to be used as a framework. Final authorized budget will be confirmed and communicated at time of official award. Phase 2-4 option budget Estimates are notional and dependent on availability of US Government available funding. | | **210,000** | **210,000** | **210,000** | **210,000** | **840,000** |

## Award Totals

| | | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|
| **Award Total** | *Budget Estimate to be used as a framework. Final authorized budget will be confirmed and communicated at time of official award. Phase 2-4 option budget Estimates are notional and dependent on availability of US Government available funding. | **1,607,465** | **1,607,465** | **1,607,465** | **1,607,465** | **6,429,860** |

## Approaches to Reaching Sustainable Epidemic Control & Transitioning Ownership

Proposals are requested to support the Burkina Faso, CAR, Guinea Conakry, Mali, and Madagascar Armed Forces to reach sustainable control of the HIV epidemic and focus on the America First Global Health Strategy, the latest PEPFAR guidance and UNAIDS HIV Treatment 95-95-95, Vertical Transmission 95 targets, TB prevention 90 targets, and in alignment with the NSS, NDS, and the MOU between the U.S. DoS and each of the above listed countries, if existent.

In 2025 DHAPP supported the Partner Military in Burkina Faso in conducting a Military Sustainability Index (MilSID). Findings indicate the military health system has made progress in resource allocation and supply chain management, but needs additional support in coordination planning, epidemiology, and health data in order to further build the military's capacity.

In 2025 DHAPP supported the Partner Military in Guinea Conakry in conducting a MilSID. Findings indicate the military health system has made progress in service delivery, policies and governance and access to information, but needs additional support in domestic resource mobilization, quality management and technical/allocative efficiencies in order to further build the military's capacity.

In 2024 DHAPP supported the Partner Military in CAR in conducting a MilSID. Findings indicate the military health system has made progress in access to information, planning and coordination, and commodity security and supply chain but needs additional support in policies and governance, service delivery, military health care staffing, laboratory, mobilization of resources, technical and allocative efficiencies, financial/expenditure data, and performance data, in order to further build the military's capacity.

In 2025 DHAPP supported the Partner Military in Madagascar in conducting a MilSID. Findings indicate the military health system has made progress in policies and governance, service delivery, and military healthcare staffing, but needs additional support in mobilization of resources, supply chain, technical and allocative efficiencies, and financial/expenditure data, in order to further build the military's capacity.

In 2024 DHAPP supported the Partner Military in Mali in conducting a MilSID. Findings indicate the military health system has made progress in access to health information, policies and governance, planning and coordination, and service delivery, but needs additional support in quality management, Laboratory service, resource mobilization, epidemiological and health performance data to further build the military's capacity.

The implementer will be responsible for supporting the recipient military in conducting a MilSID each year of the award, ensuring all stakeholders are present (please include as an SOW activity).

In 2024, DHAPP conducted a review of the program against international standards. Findings indicate the military health system in Burkina Faso and Mali must provide greater support in the following areas:

- Offer safe and ethical index testing to all eligible people and expand access to self-testing.
- Optimize diagnostic networks for VL/EID, TB, and other coinfections

The implementer will develop and implement a comprehensive transition plan that is in alignment with any existing country MOU, with clearly defined every 6-month milestones demonstrating progressive military assumption of programmatic responsibilities across all technical areas, data collection and

reporting areas, and program management. This transition framework prioritizes efficiency, direct patient care investment, and development of resilient health systems capable of independent operation beyond the period of U.S. support. All proposals should detail how the implementer will engage the recipient military leadership as well as personnel at all levels in this work; and, specifically, how the implementer will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Please specify which SOW activities the implementer is supporting the military to take ownership of (showing increasing military ownership) and by when (with detailed milestones). Throughout this progression, the implementer must document evidence of increasing military ownership through specific metrics including percentage of activities led by military staff, proportion of budget executed directly by military, number of military personnel trained to competency, and documented military-led decision-making and problem-solving. Failure to attain defined milestones as agreed upon by the implementer, the partner military, and DHAPP may result in award termination.

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

**Technical Narrative & Scope of Work (SOW)**

In alignment with international health guidelines, America First Global Health Strategy, and guidance from PEPFAR/GHSD, coupled with DHAPP's vision to build the capacity of military health systems through military-specific and culturally appropriate services, the recipient will address the approach to each technical area in the proposal. The implementer, with a focus on military burden-sharing and building self-reliance, will be responsible for providing the following in close collaboration with other DHAPP-funded implementers.

**Technical Module Building Blocks**

The implementer will work closely with the Ministry of Defense and its medical leadership to make progress towards a resilient and self-reliant military HIV program that is aligned with the national MOU (if applicable), using evidence-based and efficient interventions to reach the three 95s. In alignment with the Transition Plan directive above, the implementer will include specific milestones for program transition for activities within each technical area.

1. **Pre-Exposure Prophylaxis (PrEP) [Burkina Faso, Guinea Conakry]**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PrEP services to all HIV-negative individuals at high risk of acquiring HIV.

The implementer will ensure that the following interventions for adults and adolescents include:

- People at a higher risk of acquiring HIV, including PBFW, must be counseled on and offered PrEP in alignment with recipient country government policies. Any person who asks for PrEP should be considered for use.
- Individuals considering PrEP must be confirmed HIV-negative and be willing to attend follow-up appointments to monitor their HIV status on a routine basis. If a PrEP user tests HIV-positive, PrEP must stop immediately and effective HIV treatment must start.
- Differentiated and simplified service delivery for PrEP is encouraged, such as event-driven PrEP (ED PrEP), community delivery, and the use of HIV self-tests (HIVST) for PrEP services.
- PrEP counselors must be equipped to ensure that PrEP users understand adherence to the different DSD options and different PrEP options. Adherence counseling and support must be ongoing, as necessary.
- As Long-acting Lenacapavir (LEN) injectables become available, beneficiaries should be presented with thorough information on all available PrEP options, including each method's relative efficacy and safety, as well as counseling and adherence support, allowing for an informed client choice.
- If PrEP is not being offered at military facilities, the recipient will work with the military and PM to advocate with necessary stakeholders (possibly MoH or military leadership) to update guidelines, gain necessary approvals, and start implementation at military facilities.

**2. Post Exposure Prophylaxis (PEP) [Burkina Faso, Mali, Guinea Conakry]**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PEP services to all HIV-negative individuals (including healthcare workers and non-healthcare workers) who have had a possible exposure to HIV within the last 72 hours.

The implementer will ensure that the following interventions for adults and adolescents include:

- PEP should be started as soon as possible after a potential exposure to HIV, ideally within 24 hours and no later than 72 hours.
- The person seeking PEP should be tested for HIV to confirm they are HIV-negative before starting PEP, although if testing is not available, PEP should be started immediately and can be stopped later once testing is available. Individuals who test positive for HIV should be started on treatment immediately.
- Three ARV drugs for a 28-day prescription are recommended for the HIV PEP regimen. Patients must be properly counseled to understand what PEP is, on adherence, and potential side effects.
- If PEP is not being consistently integrated and offered at military facilities (to the point that the surrounding population knows it is accessible if needed), the recipient will work with the military and PM to update guidelines and SOPs, gain necessary approvals, and start implementation at military facilities. Timely access to PEP is the most crucial factor in PEP effectiveness.
- Individuals who seek PEP services should be counseled on and offered PrEP post PEP if risk is ongoing.

- PEP availability in community settings, as well as task sharing of PEP administration is encouraged to increase timely accessibility post exposure.

### 3. HIV Testing Services (HTS) [Burkina Faso, CAR, Guinea Conakry, Mali, Madagascar]

HIV Testing Services (HTS) is the forefront for finding the remaining people who are living with HIV (PLHIV) and is a priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know their infection status are men, adolescents, and children. The recipient military HIV/AIDS program is strategically placed to reach men; therefore, the implementer will closely work with the recipient military on HTS for both prevention and diagnosis. Those who test negative should be provided with HIV risk reduction information (including referral to PrEP where relevant) and educated on U=U (Undetectable = Untransmittable). For those who test positive, activities should include information about HIV, offer of Safe and Ethical Index Testing (SEIT), and offer of self-testing for sexual contacts and family members (all sexual partners and children under 19 years old) who may not be able to access a testing site. HTS should be targeted towards military personnel to achieve the target of 95-100% of all recipient military PLHIV knowing their status. HTS should also be provided to beneficiaries and civilians cared for at all military sites. The implementer will ensure they and the recipient military follow GHSD and national guidance on implementing SEIT and use the training materials created by the HTS team with the 10-Step model.

The local epidemiology and situational analysis should guide other testing methods to identify PLHIV.

Provider-Initiated Testing and Counseling (PITC) will continue at military facilities for both the military and civilian cohorts. PITC should focus within clinical areas that have shown a high testing yield, such as inpatient wards, tuberculosis (TB) and sexually transmitted infection (STI) clinics.

All people newly diagnosed with HIV should be retested to verify their HIV status prior to starting ART. The same testing strategy and algorithm as the original diagnosis should be used, but with a different tester and different test kit lots.

The implementer should support the military to achieve over 95% linkage of HIV-positive individuals identified to treatment initiation, fully implementing “test-and-start” policies across all age, sex, and risk groups. Ensuring that any person with positive results identified is linked to HIV care and treatment is essential to the success of the recipient military program. The implementer will support the military to 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 and other relevant integrated services.

The implementer will be responsible for providing support for the following activities to military bases and facilities:

- Diagnosing HIV, with at least 95% of those diagnosed linked to HIV care, while striving for 100% linkage to treatment services and same day initiation of ART.
- Offering SEIT to all HIV positive clients and testing for all sexual partners and children under 19 years old of HIV positive military personnel and civilians.
- Documenting HIV status for all children under 19 years of age with mothers living with HIV.

- Offering self-testing for partners of index clients if they do not volunteer for partner notification (excluding CAR, Madagascar, and Mali).
- Facilitating quality improvement and quality assurance for all recipient military HTS sites, including strategic assistance, at least quarterly.
- Providing HIV self-testing (HIVST) for military personnel (excluding CAR, Madagascar, and Mali), AGYW and their partners, male partners of antenatal care (ANC) clients and other high-risk populations. As part of the HIVST protocol, clients with a positive HIVST should be instructed to follow up with trained staff for further evaluation, including diagnostic testing utilizing the national testing algorithm. It is also vital to engage community groups to advocate for, design, implement, and analyze the success of 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, including Viral Load Suppression (VLS).
- Linking HIV negative, high-risk clients to PrEP services, where available.

**4. HIV Treatment [Burkina Faso, CAR, Guinea Conakry, Mali, Madagascar]**

ART optimization is the 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. Moreover, long-term viral load suppression prevents onward transmission and is the cornerstone of HIV prevention. The following factors should be considered in supporting the treatment of PLHIV in military facilities.

- 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. The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission recommends DTG-containing regimen as a Preferred ARV for PBFW and recommends DTG-containing regimen as a Preferred ARV for women who are trying to conceive. Starting in COP20 (FY21), programs were 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 prevent the development of TB in PLHIV as well as diagnose and treat PLHIV with TB disease and ensure they become non-infectious. In addition, all TB infected individuals should be tested for HIV.
    - Routinely screen all PLHIV for TB disease. Standardized symptom screening alone is not sufficient for TB screening among PLHIV and should be complemented with more-sensitive and setting-specific recommended screening tools. Ensure all PLHIV who screen positive for TB receive recommended molecular diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment.
    - For all who do not have active TB, prevention of TB is a priority using nationally

approved TB preventive therapy (TPT). The Global AIDS Strategy has set the target of 90% of PLHIV to receive preventive treatment for TB, thus TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Implementers 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 that is consistently documented. In short, all newly diagnosed HIV-positive people should be offered TB treatment or preventive therapy, and all people assessed for TB should be tested for HIV.

  - Pregnant women living with HIV are at high risk of progression from TB infection to disease; thus, it is imperative that Prevention of Mother to Child Transmission (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 PLHIV.
  - 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, implementers should also seek opportunities to support effective joint program implementation. Additionally, implementers should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide a 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 women living with HIV (WLHIV) should be integrated into routine HIV treatment services in each country program (excluding CAR, Madagascar, and Mali). According to COP 24 Technical Considerations, all PEPFAR supported countries with HIV prevalence above 5.0% among women in the 15-49-year-old age group are expected to provide at least one life-time cervical cancer screen for WLHIV receiving ART.
  - Current international health guidelines recommend screening to start at age 25 or according to national guidelines, whichever is earlier. Programs may also consider earlier screening among women with long-standing HIV infection, e.g., perinatal infection. WLHIV who are between 50 and 65 years and have not been screened may be offered a single screening test, and screening should be discontinued if they screen negative.
  - Screening for cervical cancer should begin at high-volume military sites and be scaled to all women receiving ART in military ART sites either on-site or through referral to hub sites within the region. Screening should be available in the ART clinic or in affiliated clinics on-site such as women's health or maternal child health clinics for WLHIV to utilize.
  - Programs should ensure that a minimum of 90% of women who screen positive are linked to treatment.
  - 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.

    - Funding may be used for screening with visual inspection with acetic acid (VIA), treatment with cryotherapy, thermal ablation, and loop electrosurgical excision procedure (LEEP), and quality assurance activities.
- The implementer should work with the recipient military to offer most clients 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, 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 implementer should work with the recipient 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 HIV-related stigma by integrating a wide array of non-HIV commodities into decentralized sites (e.g. TPT). DDD models can also be used for decentralized PrEP distribution to improve uptake and continuation.
- Diagnose and treat people with advanced HIV disease (AHD). People starting treatment, re-engaging in treatment after an interruption of > 1 year, or virally unsuppressed for >1 year should be evaluated for AHD and have CD4 T cells measured. Accordingly, the implementer should be working with recipient military and public health leaders to ensure that CD4 testing is available. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease. The PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with advanced disease.

### 5. Viral Load (VL) Suppression [Burkina Faso, CAR, Guinea Conakry, Mali, Madagascar]

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 implementer will work closely with the Ministries of Defense in in Burkina Faso, CAR, Guinea Conakry, Mali, and Madagascar to scale up VL testing coverage and VL suppression to achieve 95-95-95 goals for military personnel, as well as beneficiaries and civilians in each country. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% VL suppression among PLHIV taking ART. CD4 testing should not be used to determine eligibility for ART and only should be used for assessment of immune status (i.e. identification or ongoing monitoring of patients with advanced HIV disease).

The implementer should ensure that the recipient military has access to timely VL testing (goal turnaround time is within 2 weeks) and that capacity exists to test 95% of people currently on ART annually. To ease logistical challenges associated with the transport of whole blood specimens and to increase access to routine VL monitoring, dried blood spots (DBS) for VL testing can be used as an alternative specimen type to plasma. 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 POC be used for VL testing among PBFW, infants, and children. Implementers must follow international health guidelines and work with military and MoH network (as necessary) to implement and monitor VL testing schedule for PBFW and HIV-exposed infants (HEI), which differs from the VL testing schedule of non-PBFW HIV+ adults. POC platforms may also be appropriate for low volume remote military sites.

The implementer will ensure that VL results are available to providers/clients in a reasonable amount of time (goal is within 2 weeks) to both the health care provider and the client. These results should be available 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. Unsuppressed clients and their sexual partners should be educated on alternate risk reduction options until they become suppressed, such as PrEP. 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, to minimize inconveniences associated with health system access.

HIV viral suppression is not only critical to improving individual health, but also to prevent sexual transmission, and reduce perinatal transmission. There are three key categories for HIV viral load measurements: unsuppressed (>1000 copies/mL), suppressed (detected but ≤1000 copies/mL) and undetectable (viral load not detected by test used: <40 or <50 copies/ml depending on the machine used). People living with HIV who have an undetectable viral load and continue taking medication as prescribed have zero risk of transmitting HIV to their sexual partner(s) (U=U). PLHIV who have a suppressed but detectable viral load and are taking medication as prescribed have almost zero or negligible risk of transmitting HIV to their sexual partner(s). HIV VL test results can be a motivation for adhering to treatment and achieving the goal of being undetectable. Emphasizing and strengthening adherence counselling during antiretroviral therapy initiation and throughout treatment are essential, including communicating about the benefits of viral load suppression to all PLHIV. HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. The implementer must work with the military to ensure updated and accurate U=U messaging and encourage HIV testing, prevention, and treatment reaches all PLHIV, the general population and health care providers.

### 6. Health System Strengthening [Burkina Faso, CAR, Guinea Conakry, Mali, Madagascar]

DHAPP is working to enhance the ability of militaries and Ministries of Defense to manage their HIV epidemic, respond to broader health needs impacting their communities, and address new and emerging health concerns. Implementers should describe how they will increase recipient government capacity. A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of the HIV response, including political commitment, building program capacities and capabilities, and financial planning and expenditure.

The procurement of supplies, support and equipment should use recipient government and other donor sources when possible (Global Fund, etc.).

Laboratory:

The implementer will be responsible for the following activities to help recipient militaries build resilient, sustainable, and internationally accredited laboratory systems strongly capable of responding to the HIV epidemic and other future infectious disease outbreaks:

- Laboratory inventory tracking, control, and forecasting; monitoring of commodities procurements to ensure laboratory supplies are procured at cost-effective prices and services are uninterrupted; monitoring facilities storing procured laboratory commodities to ensure they meet International Organization for Standardization (ISO) warehouse principals and standards; obtaining insurance for procured laboratory commodities to protect against natural disasters, fire, theft, etc.
- Supporting and facilitating military participation in national quantification exercises, ensuring that military laboratory commodity needs are incorporated into national forecasting.
- Routine monitoring of turnaround time (TAT) for VL, TB, and other critical tests, to ensure test results are provided to providers and patients within a reasonable period (2 weeks) to improve and maximize patient care and outcomes.
- Procuring laboratory service maintenance contracts, routine calibration of equipment, and training of laboratory staff on proper use and maintenance of procured equipment.
- Supporting training in proper laboratory biosafety and waste management.
- Ensuring continuous quality improvement of all laboratories (including satellite laboratories and HIV testing sites) and accreditation is in place and transitioned over to the recipient government with key milestones and timeline.
- Monitoring of laboratory quality, adherence to quality systems, and method validation; provision of proficiency testing for rapid HIV testing, VL, CD4, TB, STIs, and other tests critical to HIV epidemic control and detecting emerging disease outbreaks.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, address needs and gaps, and provide recommendations for the development of improvement plans to resolve any identified problems.
- Linking recipient military laboratory services to other laboratory resources at the district, provincial, and national levels.

Optimizing diagnostic networks for VL/EID, TB, and other coinfections. In coordination with other Donors and National TB Programs, complete diagnostic network optimization (DNO) and transition to integrated diagnostics and multi-disease testing. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time (goal is 2 weeks). Identify all parts of the laboratory system that are interoperable with the U.S. military system.

7. **Virtual Communities of Practice/ECHO Platform [Burkina Faso, CAR, Guinea Conakry, Madagascar]**

The implementer should support the recipient military's use of Virtual Communities of Practice (vCOPs) through the Project ECHO (Extension for Community Healthcare Outcomes) model if an ECHO network already exists within the military program. Project ECHO is evidence-based, virtual model that democratizes medical expertise as a self-reliant tool for continuous clinical knowledge sharing amongst healthcare workers. Since 2020, DHAPP has collaborated with the ECHO Institute (https://hsc.unm.edu/echo/) to lever their vast experience with vCOPs/ECHOs and to assist in establishing ECHO programs with 24 recipient militaries. More information on the establishment of the DHAPP

Superhub available at https://pubmed.ncbi.nlm.nih.gov/40984107/. Key requirements are equipment and connectivity as well as personnel who can coordinate, manage, and lead regular vCOP/ECHO sessions. (https://hsc.unm.edu/echo/).

For recipient militaries with existing, launched ECHO programs, the implementer shall provide support focused on transitioning full ownership of the ECHO program to the recipient military. Required support activities include:

- **Program Maintenance:** Assisting the recipient military in the maintenance of existing ECHO hub and spokes – connectivity,
- **Strategic Expansion:** Supporting the addition of new clinical "spokes" to strengthen the military network of integrated care throughout the country.
- **Network Engagement:** Ensuring the recipient military actively engages with the DHAPP ECHO Superhub, and, where applicable, any local ECHO network (i.e., an MOH-led ECHO) for broader collaboration.

The Statement of Work (SOW) narrative must be specific about all proposed ECHO activities (e.g., personnel, number of sites, locations). All equipment purchases listed in the workplan must follow current U.S. laws (Congress) and policies (Executive Branch) and must be reviewed and approved by the DHAPP ECHO Team.

**8. Commodities [Burkina Faso, CAR, Guinea Conakry, Mali, Madagascar]**

The implementer will assist the military in developing and implementing a supply chain management strategy that aligns with PEPFAR's goals of ensuring sustainable commodity supplies while simultaneously emphasizing and working to improve self-reliance of the commodities recipient, with the full transition of all capabilities to the commodities recipient by award completion or USG/recipient country MOU completion (whichever comes first). This strategy should include, where applicable to a site or sites, as many of the following principles as practical:

- Development of a comprehensive Supply Chain Transition Plan with clearly defined annual milestones for the recipient military to assume responsibility for key functions. A written supply chain risk management plan that is co-developed with and owned by the recipient military. This plan must address risks to commodity availability (e.g., stockouts, expiries) and risks to the transition process itself (e.g., personnel gaps, funding shortfalls). Plans may be specific to a site or group of similar sites, depending on the need identified by the recipient military and recipient.
- Identification and training of supply chain points of contact within each facility on topics to include where applicable, but not limited to:
    - Accurate use of the commodities request system (typically the national system)
    - Completion of necessary paperwork/electronic forms
    - Stockout and overstock mitigation strategies
    - Inter-site commodity movement procedures
    - Establishing relationships with commodities counterparts within the military and national systems, both regionally and nationally
    - Quantification and forecasting, with the goal of the recipient military leading their national quantification exercise for its facilities.

- In alignment with the America First Global Health Strategy, and in compliance with applicable federal acquisition regulations, the recipient will prioritize the evaluation and selection of U.S.-manufactured pharmaceuticals, diagnostics, and supply chain technologies where they are competitive in terms of cost, quality, and availability. The recipient will document efforts to explore U.S.-based sources as part of its procurement strategy.
- Implementation of supply chain best practices, including product and supply chain segmentation, actively identifying and contracting with local and/or U.S.-based private sector logistics partnerships where appropriate to improve efficiency and build a sustainable logistics infrastructure that can be leveraged directly by the recipient military in the future, and establishing end-to-end supply chain visibility using global standards (GS-1) to enable military leadership to make independent, data-driven supply chain decisions.
- Adoption of decentralized drug distribution (DDD) models, such as home deliveries, use of community or private pharmacies, and automated lockers, to improve client convenience and maximize product availability.
- Collaboration with relevant stakeholders to conduct Diagnostic Network Optimizations (DNOs) to inform laboratory supply chain refinements.
- Development of accurate forecasts that capture total program needs, including considerations for optimized testing and treatment. These forecasts should inform regular (at minimum quarterly) supply plan updates.
- Establishment of systems for increased data visibility and reporting of HIV commodities availability, including granular-level reporting of quantities dispensed and stock availability.
- Active participation in collaborative efforts with recipient governments and other stakeholders to ensure data-informed decision-making and mitigate stock risks.
- Development of a plan for increasing local oversight and utilizing private sector capabilities, where appropriate.
- Implementation of a risk management and monitoring system, which may include third-party monitoring for assessment and oversight of supply chain programs, if required.
- Design and implementation of capacity building initiatives to increase supply chain literacy and fluency across recipients and human resources for health.
- Avoidance of parallel supply chain systems. All efforts must focus on strengthening and utilizing the recipient military's and/or the national health system's existing infrastructure. The recipient should not create separate, temporary, procurement or distribution systems.

The implementer should work towards ensuring a sustainable supply chain and improved regional self-reliance where feasible. This includes ensuring the military is connected to the national procurement system and other already existing procurement systems and resources in-country to avoid creating parallel procurement systems.

**9. LIVES & Child Safeguarding [Burkina Faso, CAR, Guinea Conakry, Mali, Madagascar]**

The implementer will ensure that all implementer & military health facility staff are trained in and implementing both the DHAPP LIVES and Child Safeguarding interventions (utilizing the curriculum updated in December 2025 that is in alignment with Executive Orders to date); to include re-training all trained staff every 3 years and training all new staff as part of their hiring process. Records for who has

been trained and when must be kept by implementer and/or military and accessible upon request.

**Monitoring and Evaluation**

To ensure the effective, efficient, and durable use of United States Government funds, the recipient military armed forces shall be responsible for the comprehensive, reliable, and timely reporting of the milestone, outcome and process metrics specified in this announcement. This reporting is critical for two primary objectives: first, to guide the development of health policies and practices that improve the recipient country's force health readiness, and second, to provide rigorous accountability to the United States Congress and the American taxpayer for every dollar appropriated.

The implementer is mandated to coordinate directly with the recipient military to ensure the accurate and transparent delivery of these metrics to all designated stakeholders as specified in any existent Memorandum of Understanding between the USG and Burkina Faso or Mali.

The overarching goal is to transition all monitoring, evaluation, and reporting responsibilities to the recipient military, fostering complete self-reliance in the shortest possible timeframe. To verify the integrity of this reporting and safeguard U.S. investment, the implementer will execute regular Data Quality Assessments (DQAs) to evaluate the accuracy and reliability of the data provided by the recipient military, the frequency of which will be determined in consultation with the recipient military.

| **Burkina Faso Process Metrics** | |
|---|---|
| **Metric** | **Baseline Target** |
| # people on ART | 708 |
| # new HIV diagnoses among infants (0-12 months) | 0 |
| # new HIV diagnoses among children and adults (age 12 months or older) | 90 |
| % pregnant and breastfeeding women living with HIV who receive ART | 100% |
| % accuracy of data fields assessed during the annual data audit | 90% |

| **Mali Process Metrics** | |
|---|---|
| **Metric** | **Baseline Target** |
| # people on ART | 510 |
| # new HIV diagnoses among infants (0-12 months) | 0 |
| # new HIV diagnoses among children and adults (age 12 months or older) | 140 |
| % pregnant and breastfeeding women living with HIV who receive ART | 100% |
| % accuracy of data fields assessed during the annual data audit | 90% |

To ensure rigorous oversight and accountability, the implementer is required to submit independent performance data. This reporting will serve to verify and corroborate the data provided by the recipient country's Ministry of Defense as compared to actual program implementation. The explicit purpose of this data collection is to guarantee that every American taxpayer dollar is spent effectively, and its impact is demonstrably justified. All implementer performance data shall be reported at the site level or higher through the designated online data collection system (DC2) at the specified quarterly, semi-annual, or annual intervals. The indicators used for this reporting requirement will harmonize with required

milestone, process, and outcome metrics.

All proposals must include milestone metrics by activity and which outcome or process metric each activity supports. Example table headers are provided below.

| Budget, USD | Activity | Milestone | Metric Mapping (Outcome & Process Metric) |
|---|---|---|---|

**Quality Management System**

The recipient militaries are responsible for maintaining a quality management (QM) system. Site Improvement through Monitoring System (SIMS) is a QM system that has been supported by DHAPP for many years, and implementers and recipient militaries are encouraged to use this system (or another QM system of their choice). QM systems provide a standardized approach and set of tools for monitoring program quality. QM 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. QM systems are also used to identify performance issues that may impact patient outcomes or the integrity of program reporting. Site-level triangulation of program and QM data can be used to contextualize performance and determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

QM systems aim to:
(1) facilitate service improvement,
(2) ensure accountability of U.S. government investments, and
(3) maximize the impact of U.S. government investments on the HIV epidemic.

QM assessment results confirm compliance with minimum quality assurance standards and identify areas where improvements can be made.

The implementer should ensure that all supported sites are familiar with QM standards and make sure that all efforts are taken to follow these standards. DHAPP encourages implementers and militaries to conduct reviews of program performance using the latest QM or SIMS tools which are freely available.

SIMS or other QM system implementation is one strategy available for programs to integrate effective quality assurance (QA) and CQI practices into site and program management. Program management must apply ongoing program and site standards assessment—including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementer agreements and workplans should align with national policy in support of QA/CQI.

**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 recipient military HIV program's ability to monitor progress towards epidemic control. The implementer will work with the recipient military and Ministry of Health (MOH), Ministry of

Communications, and 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 recipient military leadership.

The implementer will be responsible for:

- Staffing, support, and mentoring of existing recipient military staff for paper and electronic data collection
- Timely, accurate reporting of all indicators required by the recipient 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 recipient military and DHAPP without prior approval from the recipient 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 recipient military programs and the implementer should include a strategy for conducting baseline, periodic, and ongoing data quality assessments (DQA). In this way, DHAPP, and the recipient military, can be confident in the veracity of the data that it uses for planning and measurement of progress towards programmatic goals. The implementer should plan on conducting periodic DQAs at the highest volume sites comprising 80% of the total number of people living with HIV and conducting DQAs of non-treatment technical programs, too.

Protocols for DQAs will be reviewed by recipient 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 from HIV testing to viral load testing, and the complete 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. Frequency of periodic DQAs should be determined in consultation with the recipient military and DHAPP.

**Informatics**
**Health Information Systems**

Informatics (including Digital Health Platforms (DHP) also known as Health Information Systems (HIS) or Medical Information Systems (MIS)) are critical underpinnings of good patient healthcare and good program management. The military's health system requires reliable informatics support to ensure its long-term, sustainable advancement. Key goals for a military HIS include 1) improving quality and safety of care; outbreak detection; data-driven decision-making; efficient deployment of resources; QA/QC; and improved access and improved confidentiality of health data.

The implementer will support the recipient military’s HIS to align with the recipient country health

information systems (HIS) to the greatest degree possible. The implementer will inventory the current military data systems (paper and electronic) and will provide written recommendations to include identification of gaps in the military HIS and requirements to enable the recipient military HIS to reach all clinical and laboratory locations. The implementer will coordinate with the military and MOH or other appropriate ministries to 1) ensure the military sites are included in national systems with 2) training, 3) infrastructure improvements such as routers, computers, solar power and satellite internet connectivity, 4) security (physical and cyber), 5) data use policy and governance, 6) data management, 7) data analytics, and 8) data use and dissemination. Where equipment procurements are needed, the recipient will ensure that the equipment will follow US laws and policies (e.g. no equipment from China, USA made, etc.).

The implementer must ensure by 2030 that the military will be capacitated with durable systems, staffing, training, and infrastructure to allow the military to use their systems effectively and independently to monitor client health and conduct national reporting.

**Work Plans**

The implementer 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. A full list of reporting requirements can be found in the base Program Announcement and will be disclosed in the award terms and conditions.

**Multi-country SABERS Support in 4 to-be-determined [TBD] Recipient Countries: DHAPP Partnership for Resilient Military Health Systems for Readiness**

**NOTE: Application submissions for this narrative are due by 12pm EST on 15 May 2026. Submissions received after the deadline will not be considered for funding.**

## Call for Proposals

Proposals are requested to support 4 multi-country SABERS to reach sustainable control of the HIV epidemic through the lens of the America First Global Health Strategy, as well as the UNAIDS HIV Treatment 95-95-95; Vertical Transmission 95 targets; and tuberculosis (TB) prevention 90 and in alignment with the National Security Strategy (NSS) and the National Defense Strategy (NDS) goals to protect the homeland, deter China, and increase burden sharing. Further, for countries supported through the President's Emergency Plan for AIDS Relief (PEPFAR), proposals must be aligned with any existing Memorandum of Understanding (MOU) between the U.S. Department of State (DoS) and the TBD countries. Implementers should be familiar with these strategic guidance documents and include means of addressing them in submitted proposals. **Please see base Program Announcement section D for complete detailed list of application, format and submission requirements. Proposal Technical Narrative may not exceed 45 pages.**

## Introduction

The HIV/AIDS epidemic has devastated 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 other military personnel and their extended communities, and impeding participation in peacekeeping activities. As HIV management improves, many of these impacts are reduced; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries; this is in addition to managing other long-term chronic diseases to maintain high force health readiness in strategically identified recipient militaries. Moreover, given the well-known biobehavioral risk factors among uniformed personnel, reducing HIV acquisition and transmission in this population is an essential component for reaching epidemic control in the recipient country.

The U.S. Government has a long history of providing foreign assistance to combat HIV/AIDS, advancing U.S. national security by promoting stability in key regions. Over the years, the United States DoD HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries to control the HIV epidemic among their respective military services. Working closely with the Department of Defense (DoD, herein referred to using the secondary title Department of War, DoW), DoW Combatant Commanders, the Bureau of Global Health Security and Diplomacy (GHSD) and other organizations, DHAPP's mission is to build the capacity of recipient militaries through military-specific HIV/AIDS assistance, creating self-reliant security counterparts. DHAPP is the DoW implementing agency for PEPFAR, collaborating with the DoS and the Centers for Disease Control and Prevention (CDC). DHAPP receives funding for its programs from two sources: a congressional plus up to the DoW (Title 10) Defense Health Program (DHP) and funding transfers from the DoS (Title 22) for PEPFAR.

All proposals for the 4 TBD recipient countries must clearly articulate plans for each activity over the course of the agreement with specific and measurable milestones. Financial and non-financial

contributions from each recipient military to support the SABERS are encouraged and required. Building capacity activities in the recipient militaries must begin immediately upon award of the agreement and throughout the life of the agreement. In addition, for TBD recipient countries supported through PEPFAR, proposals must be in full alignment with any existing Memorandum of Understanding (MOU) between the Department of State (DoS) and TBD recipient country.

The DoW Combatant Commands (CCMDs) have identified the longstanding DHAPP program with recipient countries as an essential security cooperation tool that serves U.S. interests. Pursuing HIV/AIDS activities with foreign militaries is an important part of maintaining security interests, regional stability through health readiness, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing nations. 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 CCMDs and DHAPP Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under-Secretary of War for Policy and by the DoS GHSD. DHAPP provides technical support to defense forces in HIV prevention, care, treatment, and information systems and data use 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 living with HIV (PLHIV) are diagnosed, 95% of PLHIV are on antiretroviral therapy (ART), and 95% of PLHIV are virally suppressed. An additional goal supported by GHSD is 95% coverage of services for eliminating vertical transmission. Lastly, the UNAIDS Global AIDS Strategy established a goal that 90% of PLHIV receive preventive treatment for TB.

All proposals must align with the America First Public Health Strategy, which focuses on the following points:

- Address Inefficiency and Dependency: The majority of funding for the SABERS should go directly towards strengthening and building resilient health systems. High project management costs will not be funded.
- Pillar 1: Make America Safer: The primary goal is to protect Americans by enhancing global surveillance systems, which can assist in disease outbreak detection, reporting, and response (with early actions to prevent pandemics from reaching U.S. shores).
- Pillar 2: Make America Stronger: Foreign health assistance will be used as a strategic tool to strengthen bilateral relationships. The U.S. will enter into agreements with recipient countries that require co-investment and establish clear benchmarks, moving them toward self-sufficiency and away from reliance on U.S. foreign assistance. For PEFPAR supported countries, proposals must align with any existing country-specific MOU timelines.
- Pillar 3: Make America More Prosperous: The strategy aims to bolster the U.S. economy by preventing costly pandemics and by using foreign assistance programs to promote American companies and health innovations (like diagnostics and pharmaceuticals) in emerging global markets.
- Restructure Aid Delivery: The plan calls for more frontline support, such as medical commodities and healthcare workers, while significantly reducing all other non-frontline expenditures to ensure accountability to the American taxpayer.

**Local Implementers**

Local, non-governmental implementers with low overhead costs are encouraged to apply to this announcement. It is critical the implementer ensure core SABERS activities are owned and operated by the recipient country's military. The intent of recipient military ownership is to establish sufficient capacity, capability, and durability within their forces to ensure successful long-term engagement and impact.

All respondents must demonstrate previous experience in the design, management, and implementation of epidemiological research and surveillance.

**Additional Submission Guidance:**

1. Review all documents within the package to ensure consistency in information, budgets, targets, and numbering:
    a. Use numbered lists, including numbered or alphabetized sub-lists, for activities for easier reference and monitoring, especially the scope of work (SOW) Narrative column.
2. Ensure all activities in the Technical Narrative are also listed concisely in the SOW file.
3. Activities must be specific; Do not write "ensure" or "support" or a similar verb as a narrative activity without defining what that means. Each activity must say specifically what the implementer will be doing. It must be measurable and answer the questions Who? What? Where? How? How many? How often?
4. Delineate between a training (i.e.: one time class or series of classes where attendees are gathered in a conference room, away from regular duties) and onsite strategic assistance (on the job guidance while recipient is performing regular duties) and specify as many of the following details as possible for both: how many attendees or sites, how often, how many days, where, specific topics/skills covered, expected outcomes & how they align with program goals, etc. Training should be limited and cost efficient.
5. Please note this project budget cannot include:
    a. Any budget allocations toward World AIDS Day (WAD) events/campaigns.
    b. Prizes, hats, or T-shirts.
    c. Flyers and printed education materials to be given to beneficiaries.
    d. Rental of venues for training or events (must use available military or ministry facilities).
    e. Employment or payments made directly to active-duty foreign military.

**Budget**

The **estimated** budget for this program announcement is provided below. Final authorized budget will be confirmed and communicated at time of official award execution. The link below contains the Financial Classifications Reference Guide and a summary of the classification definitions.
https://help.datim.org

Financial classifications are not regulations governing allowability of federal awards. Nothing in this guidance should be interpreted to mean that costs or activities that are unallowable or excluded under the terms of an award are permitted by virtue of being described herein. All awards are subject to the applicable cost principles and terms set forth and conveyed in the award made.

**Estimated Budget to be used as a Framework to Cover 4 TBD Recipient Countries**

| MOU Area of Cooperation | Health Program Area | Sub category | Recipient Country | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Totals |
|---|---|---|---|---|---|---|---|---|
| 2.1: Surveillance and Outbreak Response | HIV | 2.1 Surveys & Assesments | TBD 1 | $ 550,000 | | | | $ 550,000 |
| | HIV | 2.1 Surveys & Assesments | TBD 2 | $ 550,000 | | | | $ 550,000 |
| | HIV | 2.1 Surveys & Assesments | TBD 3 | | $ 550,000 | | | $ 550,000 |
| | HIV | 2.1 Surveys & Assesments | TBD 4 | | | $ 550,000 | | $ 550,000 |
| | | | | | | | | $ - |
| | | | | | | | | $ - |
| | | | | | | | | $ - |
| | | | | | | | | $ - |
| | | | | | | | | $ - |
| **Totals** | | | - | **$ 1,100,000** | **$ 550,000** | **$ 550,000** | **$ -** | **$ 2,200,000** |

Note that there may be overlap in SABERS activities with recipient countries year over year. Timing may vary and depend on the context of each recipient country. Up to 4 studies may be supported through this award.

**Approaches to Reaching Sustainable Epidemic Control & Facilitating Military Ownership**

Proposals are requested to support the 4 multi-country SABERS to reach sustainable control of the HIV epidemic and focus on the America First Global Health Strategy, the latest PEPFAR guidance and UNAIDS HIV Treatment 95-95-95, Vertical Transmission 95 targets, and TB prevention 90 targets, in alignment with the NSS, NDS, and the MOU between the U.S. DoS and TBD recipient country (for countries supported through PEPFAR).

The implementer should emphasize a collaborative partnership with the recipient military, and capacity building across all activities and technical areas. All proposals should detail how the implementer will engage recipient military leadership and personnel; and, specifically, how the implementer will utilize the organizational structure of the military to strengthen their internal capacity to conduct these activities. Please specify which SOW activities the implementer is supporting the recipient military to take financial and non-financial responsibility and ownership. Throughout the SABERS process, the implementer must clearly define evidence of military responsibility and ownership through specific metrics including activities led by military staff, financial and non-financial obligations executed directly by the military, number of military personnel trained to competency, and documented military-led decision-making and problem-solving. Failure to attain defined milestones as agreed upon by the implementer, the recipient military, and DHAPP may result in award termination.

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

Team.

**Technical Narrative & SOW**

In alignment with international health guidelines, America First Global Health Strategy, and guidance from PEPFAR/GHSD, coupled with DHAPP's vision to build the capacity of military health systems through military-specific and culturally appropriate services, the recipient will address the approach to the technical area of Health System Strengthening. The implementer, through burden sharing and building self-reliance within the recipient military, will include specific milestones for that technical area.

**Health System Strengthening**

DHAPP is working to enhance the ability of militaries and Ministries of Defense in recipient countries to manage their HIV epidemic, respond to broader health needs impacting their communities, and address new and emerging health concerns. Implementers should describe how they will increase recipient military capacity to monitor the HIV epidemic and conduct routine surveillance. A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of the HIV response, including political commitment, building program capacities and capabilities, and financial planning and expenditure. The procurement of supplies, support and equipment should use recipient government and other donor sources when possible (Global Fund, etc.).

SABERS study sizes range from 1,500 – 3,000 participants across multiple military sites within the same country. All data will be collected electronically through surveys that are interviewer-administered or self-completed, depending on the military context. Studies may incorporate the collection and testing of biological samples comprising but not limited to HIV (including viral load and CD4 count for participants who test HIV-positive), syphilis, gonorrhea, chlamydia, Hepatitis B, Hepatitis C, TB, and malaria. The implementer will work in collaboration with DHAPP, recipient military leadership, and in-country program partners, with DHAPP leading these efforts. The SABERS implementer will be required to support the following core tasks:

- Direct a portion of the SABERS funds to the military's HIV program implementer (hereon referred to as the DHAPP country implementer) or another local partner to support the study effort from the ground, as needed. As part of this activity, coordinate a meeting with DHAPP to differentiate the SABERS roles and responsibilities of the SABERS implementer and the DHAPP country implementer or local partner, and determine the amount of funds that will be directed to the DHAPP country implementer or local partner.

- Provide administrative, logistical, and technical support for the entire SABERS process including but not limited to:

    - Protocol submission and payment of fees to ethical review boards.

    - Modification and translation (if needed) of surveys and documents.

- Coordination and support of regular communication between all stakeholders (including language interpretation as needed), and documentation and distribution of meeting minutes.

- Direction of a portion of SABERS funds to facilitate and support laboratory training and proficiency testing on all biological tests included in the SABERS, as needed.

- Procurement and evaluation of supplies needed for the SABERS. Confirm approved purchases are cost-efficient, high quality, and prioritized from American companies.

- Development of an itemized budget and tracking of all transactions. Routine reporting of expenses and obligations to DHAPP.

- Support of SABERS trainings and dissemination activities (e.g., including report translation).

**Data Monitoring and Quality**

Successful collection, evaluation, and use of SABERS data is critical to the success of the recipient military HIV program's ability to monitor progress towards HIV epidemic control. The implementer will work with the recipient military and other organizations, as appropriate, to support the collection of SABERS data. The implementer will be responsible for including a strategy for proficiency testing of laboratory personnel to understand gaps and improve data quality and accuracy. The strategy should also include the development of a remediation plan to address identified gaps.

**Work Plans**

The implementer 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. A full list of reporting requirements can be found in the base Program Announcement and will be disclosed in the award terms and conditions.

**Senegal: DHAPP - Senegalese Armed Forces (SAF) Partnership for Resilient Military Health Systems for Readiness**

**NOTE: Application submissions for this narrative are due by 12pm EST on 15 May 2026. Submissions received after the deadline will not be considered for funding.**

## Call for Proposals

Proposals are requested to support the Senegalese Armed Forces to reach sustainable control of the HIV epidemic through the lens of the America First Global Health Strategy, as well as the UNAIDS HIV Treatment 95-95-95; Vertical Transmission 95 targets; and TB prevention 90 and in alignment with the National Security Strategy (NSS) and the National Defense Strategy (NDS) goals to protect the homeland, deter China, and increase burden sharing. Further, proposals must be aligned with any existing Memorandum of Understanding between the U.S. Department of State and [Senegal]. Implementers should be familiar with these strategic guidance documents and include means of addressing them in submitted proposals. **Please see base Program Announcement section D for complete detailed list of application, format and submission requirements. Proposal Technical Narrative may not exceed 45 pages.**

## Introduction

The HIV/AIDS epidemic has devastated 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 other military personnel and their extended communities, and impeding participation in peacekeeping activities. As HIV management improves, many of these impacts are reduced; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries; this is in addition to managing other long-term chronic diseases to maintain high force health readiness in strategically identified recipient militaries. Moreover, given the well-known biobehavioral risk factors among uniformed personnel, reducing HIV acquisition and transmission in this population is an essential component for reaching epidemic control in the recipient country.

The U.S. Government has a long history of providing foreign assistance to combat HIV/AIDS, advancing U.S. national security by promoting stability in key regions. Over the years, the United States DoD HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries to control the HIV epidemic among their respective military services. Working closely with the Department of Defense (DoD, herein referred to using the secondary title Department of War, DoW), U.S. Geographic Combatant Commanders, the Bureau of Global Health Security and Diplomacy (GHSD) and other organizations, DHAPP's mission is to build the capacity of recipient militaries through military-specific HIV/AIDS assistance, creating self-reliant security counterparts. DHAPP is the DoW implementing agency collaborating with the US Department of State, 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 Department of War (Title 10) Defense Health Program (DHP) and funding transfers from the Department of State (Title 22) for PEPFAR.

All proposals must be in full alignment with any existing Memorandum of Understanding (MOU)

between the Department of State (DoS) and Senegal clearly articulating transition plans for each activity over the course of the agreement with specific and measurable milestones. Reserving the last year of the agreement for transition planning will not be accepted. Activities to transition responsibilities to the recipient country must begin immediately upon award and continue throughout the life of the agreement to ensure a rapid path to self-sufficiency. The implementer must prepare the recipient country's military to fully own and operate all services, ensuring a complete and final transition of responsibility away from U.S. assistance.

The DoW Combatant Commands (CCMDs) have identified the longstanding DHAPP program with recipient countries as an essential security cooperation tool that serves U.S. interests. Pursuing HIV/AIDS activities with foreign militaries is an important part of maintaining security interests, regional stability through health readiness, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing nations. 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 CCMDs and DHAPP Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under-Secretary of War for Policy and by the Department of State Bureau of Global Health Security and Diplomacy (GHSD). DHAPP provides technical support to defense forces in HIV prevention, care, treatment, and information systems and data use 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. An additional goal supported by GHSD is 95% coverage of services for eliminating vertical transmission. Lastly, the UNAIDS Global AIDS Strategy established a goal that 90% of PLHIV receive preventive treatment for TB.

All proposals must align with the America First Global Health Strategy, which focuses on the following points:

- Address Inefficiency and Dependency: The majority of funding should go directly towards patient care and building resilient health systems. High program management costs will not be funded.
- Pillar 1: Make America Safer: The primary goal is to protect Americans by enhancing global surveillance systems to detect outbreaks within seven days of emergence, notify public health authorities within 1 day and rapidly responding at the source within 7 days with early response actions to prevent pandemics from reaching U.S. shores.
- Pillar 2: Make America Stronger: Foreign health assistance will be used as a strategic tool to strengthen bilateral relationships. The U.S. will enter into multi-year agreements with recipient countries that require co-investment and establish clear benchmarks, ...moving them toward self-sufficiency and away from reliance on U.S. foreign assistance. Proposals must align with any existing country-specific MOU timelines.
- Pillar 3: Make America More Prosperous: The strategy aims to bolster the U.S. economy by preventing costly pandemics and by using foreign assistance programs to promote American companies and health innovations (like diagnostics and pharmaceuticals) in emerging global markets.
- Restructure Aid Delivery: The plan calls for more frontline support, such as medical commodities

and healthcare workers, while significantly reducing all other non-frontline expenditures to ensure accountability to the American taxpayer. It will also streamline efforts by integrating disease-specific programs (HIV, Malaria, TB) and leveraging the private sector and faith-based organizations for more efficient service delivery. The implementer is expected to work with the DHAPP Program Manager (PM) on supporting the integration of disease-specific programs receiving USG funding for the military program.

**Local Implementers**

Local, non-governmental implementers with low overhead costs are encouraged to apply to this announcement. To achieve self-reliance, it is critical that the full range of HIV services are owned and operated by the recipient country's institutions, governments, and community-based and community-led organizations, regardless of current antiretroviral (ARV) coverage levels. The intent of transitioning to local implementers 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 implementers to ensure successful, long-term, community 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.

**Additional Submission Guidance:**

1. Review all documents within the package to ensure consistency in information, budgets, targets, and numbering:
    a. Use numbered lists, including numbered or alphabetized sub-lists, for activities for easier reference and monitoring, especially the SOW Narrative column.
2. Ensure all activities in the Technical Narrative are also listed concisely in the SOW file.
3. Activities must be specific; Do not write “ensure” or “support” or a similar verb as a narrative activity without defining what that means. Each activity must say specifically what the implementer will be doing. It must be measurable and answer the questions Who? What? Where? How? How many? How often?
4. Delineate between a training (i.e.: one time class or series of classes where attendees are gathered in a conference room, away from regular duties) and onsite strategic assistance (on the job guidance while recipient is performing regular duties) and specify as many of the following details as possible for both: how many attendees or sites, how often, how many days, where, specific topics/skills covered, expected outcomes & how they align with program goals, etc. Training should be limited and cost efficient.
5. Please note this project budget cannot include:
    a. Any budget allocations toward World AIDS Day (WAD) events/campaigns.
    b. Prizes, hats, or T-shirts.
    c. Flyers and printed education materials to be given to beneficiaries.
    d. Rental of venues for training or events (must use available military or ministry facilities).
    e. Employment or payments made directly to active-duty foreign military.

## Budget

The **estimate** budget for this program announcement is as follows. Final authorized budget will be confirmed and communicated at time of official award execution. The link below contains the Financial Classifications Reference Guide and a summary of the classification definitions.
https://help.datim.org

Financial classifications are not regulations governing allowability of federal awards. Nothing in this guidance should be interpreted to mean that costs or activities that are unallowable or excluded under the terms of an award are permitted by virtue of being described herein. All awards are subject to the applicable cost principles and terms set forth and conveyed in the award made.

## Estimated Budget to be used as a Framework

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.1: Surveillance and Outbreak Response | HIV | 2.1: Outbreak Response Capacities | 40,000 | 40,000 | - | - | 80,000 |
| | HIV | 2.1: Outbreak Readiness | 35,000 | 35,000 | - | - | 70,000 |
| | TB | 2.1: Outbreak Response Capacities | 40,000 | 40,000 | 25,000 | 25,000 | 130,000 |
| | TB | 2.1: Outbreak Readiness | 35,000 | 35,000 | 15,000 | 15,000 | 100,000 |
| | Malaria | 2.1: Outbreak Response Capacities | 40,000 | 40,000 | 25,000 | 25,000 | 130,000 |
| | Malaria | 2.1: Outbreak Readiness | 35,000 | 35,000 | 15,000 | 15,000 | 100,000 |
| **Subtotal** | | | **225,000** | **225,000** | **80,000** | **80,000** | **610,000** |
| 2.2: Laboratory Systems | HIV | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 20,000 | 20,000 | - | - | 40,000 |
| | HIV | 2.2: Lab Consumables Procurement | 20,000 | 20,000 | - | - | 40,000 |
| | TB | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 20,000 | 20,000 | 10,000 | 10,000 | 60000 |
| | TB | 2.2: Lab Consumables Procurement | 20,000 | 20,000 | 10,000 | 10,000 | 60,000 |
| | Malaria | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 20,000 | 20,000 | 10,000 | 10,000 | 60,000 |
| | Malaria | 2.2: Lab Consumables Procurement | 20,000 | 20,000 | 10,000 | 10,000 | 60,000 |
| **Subtotal** | | | **120,000** | **120,000** | **40,000** | **40,000** | **320,000** |
| 2.3: Commodities | HIV | 2.3: Prevention Commodity Procurement | 20,000 | 20,000 | - | - | 40,000 |
| | HIV | 2.3: Diagnostic Commodity Procurement | 20,000 | 20,000 | - | - | 40,000 |
| | HIV | 2.3: Therapeutic Commodity Procurement | 20,000 | 20,000 | - | - | 40,000 |
| | HIV | 2.3: Response Commodity Procurement | 10,000 | 10,000 | - | - | 20,000 |
| | TB | 2.3: Prevention Commodity Procurement | 20,000 | 20,000 | 15,000 | 15,000 | 70,000 |
| | TB | 2.3: Diagnostic Commodity Procurement | 20,000 | 20,000 | 15,000 | 15,000 | 70,000 |
| | TB | 2.3: Therapeutic Commodity Procurement | 20,000 | 20,000 | 15,000 | 15,000 | 70,000 |
| | TB | 2.3: Response Commodity Procurement | 10,000 | 10,000 | 5,000 | 5,000 | 30,000 |
| | Malaria | 2.3: Prevention Commodity Procurement | 20,000 | 20,000 | 15,000 | 15,000 | 70,000 |
| | Malaria | 2.3: Diagnostic Commodity Procurement | 20,000 | 20,000 | 15,000 | 15,000 | 70,000 |
| | Malaria | 2.3: Therapeutic Commodity Procurement | 20,000 | 20,000 | 15,000 | 15,000 | 70,000 |
| | Malaria | 2.3: Response Commodity Procurement | 10,000 | 10,000 | 5,000 | 5,000 | 30,000 |
| **Subtotal** | | | **210,000** | **210,000** | **100,000** | **100,000** | **620,000** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **2.4: Frontline Health Workers** | HIV | 2.4: Doctors/Clinical Officers | 30,000 | 30,000 | - | - | 60,000 |
| | HIV | 2.4: Community Health Workers/Community-Based Staff | 15,000 | 15,000 | - | - | 30,000 |
| | TB | 2.4: Doctors/Clinical Officers | 30,000 | 30,000 | 20,000 | 20,000 | 100000 |
| | TB | 2.4: Community Health Workers/Community-Based Staff | 15,000 | 15,000 | 10,000 | 10,000 | 50,000 |
| | Malaria | 2.4: Doctors/Clinical Officers | 30,000 | 30,000 | 20,000 | 20,000 | 100,000 |
| | Malaria | 2.4: Community Health Workers/Community-Based Staff | 15,000 | 15,000 | 10,000 | 10,000 | 50,000 |
| **Subtotal** | | | **135,000** | **135,000** | **60,000** | **60,000** | **390,000** |
| **2.5: Data Systems** | HIV | 2.5: Data Systems Infrastructure | 20,000 | 20,000 | - | - | 40,000 |
| | HIV | 2.5: Licenses & Software | 10,000 | 10,000 | - | - | 20,000 |
| | TB | 2.5: Data Systems Infrastructure | 20,000 | 20,000 | 10,000 | 10,000 | 60000 |
| | TB | 2.5: Licenses & Software | 10,000 | 10,000 | 5,000 | 5,000 | 30,000 |
| | Malaria | 2.5: Data Systems Infrastructure | 20,000 | 20,000 | 10,000 | 10,000 | 60,000 |
| | Malaria | 2.5: Licenses & Software | 10,000 | 10,000 | 5,000 | 5,000 | 30,000 |
| **Subtotal** | | | **90,000** | **90,000** | **30,000** | **30,000** | **240,000** |
| **2.6: Strategic Assistance** | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 15,000 | 15,000 | - | - | 30,000 |
| | HIV | 2.6: TA to Support Program Transition to Government or Local Partners | 25,000 | 25,000 | - | - | 50,000 |
| | HIV | 2.6: TA to Support Public Financial Management | 20,000 | 20,000 | - | - | 40000 |
| | HIV | 2.6: TA Support to Achieve Co-Financing | 20,000 | 20,000 | - | - | 40,000 |
| | HIV | 2.6: Other Health Systems Strengthening | 15,000 | 15,000 | - | - | 30,000 |
| | HIV | 2.6: IP Program Management | 80,000 | 80,000 | - | - | 160,000 |
| | TB | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 15,000 | 15,000 | 10,000 | 10,000 | 50,000 |
| | TB | 2.6: TA to Support Program Transition to Government or Local Partners | 25,000 | 25,000 | 15,000 | 15,000 | 80,000 |
| | TB | 2.6: TA to Support Public Financial Management | 20,000 | 20,000 | 10,000 | 10,000 | 60,000 |
| | TB | 2.6: TA Support to Achieve Co-Financing | 20,000 | 20,000 | 10,000 | 10,000 | 60,000 |
| | TB | 2.6: Other Health Systems Strengthening | 15,000 | 15,000 | 10,000 | 10,000 | 50,000 |
| | TB | 2.6: IP Program Management | 80,000 | 80,000 | 60,000 | 60,000 | 280,000 |
| | Malaria | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 15,000 | 15,000 | 10,000 | 10,000 | 50,000 |
| | Malaria | 2.6: TA to Support Program Transition to Government or Local Partners | 25,000 | 25,000 | 15,000 | 15,000 | 80,000 |
| | Malaria | 2.6: TA to Support Public Financial Management | 20,000 | 20,000 | 10,000 | 10,000 | 60,000 |
| | Malaria | 2.6: TA Support to Achieve Co-Financing | 20,000 | 20,000 | 10,000 | 10,000 | 60,000 |
| | Malaria | 2.6: Other Health Systems Strengthening | 15,000 | 15,000 | 10,000 | 10,000 | 50,000 |
| | Malaria | 2.6: IP Program Management | 80,000 | 80,000 | 60,000 | 60,000 | 280,000 |
| **Subtotal** | | | **525,000** | **525,000** | **230,000** | **230,000** | **1,510,000** |
| **Total** | *Budget Estimate to be used asa framework. Final authorized budget will be confirmed and communicated at time of official award. Phase 2-4 option budget Estimates are notional and dependent on availability of US Government available funding. | | **1,305,000** | **1,305,000** | **540,000** | **540,000** | **3,690,000** |

## Approaches to Reaching Sustainable Epidemic Control & Transitioning Ownership

Proposals are requested to support the Senegalese Armed Forces to reach sustainable control of the HIV epidemic and focus on the America First Global Health Strategy, the latest PEPFAR guidance and UNAIDS HIV Treatment 95-95-95, Vertical Transmission 95 targets, and TB prevention 90 targets, and in alignment with the NSS, NDS, and the MOU between the U.S. DoS and [Senegal ].

In 2025, DHAPP supported the recipient military in conducting a Military Sustainability Index (MilSID). Findings indicate the military health system requires additional investments in planning and coordination, security and the supply chain for essential commodities, as well as resource mobilization to ensure program sustainability. The implementer will be responsible for supporting the recipient military in conducting a MilSID each year of the award, ensuring all stakeholders are present (please

include as an SOW activity).

In 2026 DHAPP conducted a review of the program against international standards. Findings indicate the military health system must improve the delivery with fidelity index testing HIV services, assessment and follow-up for intimate partner violence as well as offer testing to any child under the age of 19 Senegalese military HIV program, the program aims to improve and scale index testing to fidelity, improving HIV case-finding by reaching the partners of positive individuals. This will be coupled with the assurance of routine assessment and confidential follow-up for intimate partner violence to provide holistic patient support.

Furthermore, to close critical care gaps within families, the program will guarantee that HIV tests are offered to all biological children up to 19 years of age of a known HIV-positive parent. Another key priority for the Senegalese military HIV program is to significantly improve the coverage of 6-month Multi-Month Dispensing (MMD) for all stable clients on antiretroviral therapy. We are directing our implementor to focus their efforts on expanding this initiative, as it is critical for enhancing long-term patient adherence and decongesting clinical services. Their strategy should include identifying all eligible patients and ensuring they are successfully transitioned to this less burdensome, more sustainable model of care.

It is imperative that the implementor understands that while this cooperative agreement may cover various other disease areas, the central focus must be on ensuring all HIV-related activities are fully integrated into routine clinical services. This includes embedding robust quality improvement and quality assurance plans so that HIV services become self-sustaining and no longer require external funding. The HIV portion of our engagement will formally conclude with this grant, and therefore, it is mandatory that all transition activities are successfully completed by the end of this agreement, leaving a fully independent program.

The implementer will develop and implement a comprehensive transition plan that is in alignment with any existing country MOU, with clearly defined every 6-month milestones demonstrating progressive military assumption of programmatic responsibilities across all technical areas, data collection and reporting areas, and program management. This transition framework prioritizes efficiency, direct patient care investment, and development of resilient health systems capable of independent operation beyond the period of U.S. support. All proposals should detail how the implementer will engage the recipient military leadership as well as personnel at all levels in this work; and, specifically, how the implementer will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Please specify which SOW activities the implementer is supporting the military to take ownership of (showing increasing military ownership) and by when (with detailed milestones). Throughout this progression, the implementer must document evidence of increasing military ownership through specific metrics including percentage of activities led by military staff, proportion of budget executed directly by military, number of military personnel trained to competency, and documented military-led decision-making and problem-solving. Failure to attain

defined milestones as agreed upon by the implementer, the military, and DHAPP may result in award termination.

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

**Technical Narrative & Scope of Work (SOW)**

In alignment with international health guidelines, America First Global Health Strategy, and guidance from PEPFAR/GHSD, coupled with DHAPP's vision to build the capacity of military health systems through military-specific and culturally appropriate services, the recipient will address the approach to each technical area. The implementer, through burden-sharing and building self-reliance within the recipient military, will be responsible for providing the following in close collaboration with other DHAPP-funded implementers.

**Technical Module Building Blocks**

The implementer will work closely with the Ministry of Defense and its medical leadership to make progress towards a resilient and self-reliant military HIV program that is aligned with the national MOU (if applicable), using evidence-based and efficient interventions to reach the three 95s. In alignment with the Transition Plan directive above, the implementer will include specific milestones for program transition for activities within each technical area.

1. **Pre-Exposure Prophylaxis (PrEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PrEP services to all HIV-negative individuals at high risk of acquiring HIV.

The implementer will ensure that the following interventions for adults and adolescents include:

- People at a higher risk of acquiring HIV, including PBFW, must be counseled on and offered PrEP in alignment with recipient country government policies. Any person who asks for PrEP should be considered for use.
- Individuals considering PrEP must be confirmed HIV-negative and be willing to attend follow-up appointments to monitor their HIV status on a routine basis. If a PrEP user tests HIV-positive, PrEP must stop immediately and effective HIV treatment must start.
- Differentiated and simplified service delivery for PrEP is encouraged, such as event-driven PrEP (ED PrEP), community delivery, and the use of HIV self-tests (HIVST) for PrEP services.
- PrEP counselors must be equipped to ensure that PrEP users understand adherence to the different DSD options and different PrEP options. Adherence counseling and support must be ongoing, as necessary.

- As Long-acting Lenacapavir (LEN) injectables become available, beneficiaries should be presented with thorough information on all available PrEP options, including each method's relative efficacy and safety, as well as counseling and adherence support, allowing for an informed client choice.
- If PrEP is not being offered at military facilities, the recipient will work with the military and PM to advocate with necessary stakeholders (possibly MoH or military leadership) to update guidelines, gain necessary approvals, and start implementation at military facilities.

**2. Post Exposure Prophylaxis (PEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PEP services to all HIV-negative individuals (including healthcare workers and non-healthcare workers) who have had a possible exposure to HIV within the last 72 hours.

The implementer will ensure that the following interventions for adults and adolescents include:

- PEP should be started as soon as possible after a potential exposure to HIV, ideally within 24 hours and no later than 72 hours.
- The person seeking PEP should be tested for HIV to confirm they are HIV-negative before starting PEP, although if testing is not available, PEP should be started immediately and can be stopped later once testing is available. Individuals who test positive for HIV should be started on treatment immediately.
- Three ARV drugs for a 28-day prescription are recommended for the HIV PEP regimen. Patients must be properly counseled to understand what PEP is, on adherence, and potential side effects.
- If PEP is not being consistently integrated and offered at military facilities (to the point that the surrounding population knows it is accessible if needed), the recipient will work with the military and PM to update guidelines and SOPs, gain necessary approvals, and start implementation at military facilities. Timely access to PEP is the most crucial factor in PEP effectiveness.
- Individuals who seek PEP services should be counseled on and offered PrEP post PEP if risk is ongoing.
- PEP availability in community settings, as well as task sharing of PEP administration is encouraged to increase timely accessibility post exposure.

**3. HIV Testing Services (HTS)**

HIV Testing Services (HTS) is the forefront for finding the remaining people who are living with HIV (PLHIV) and is a priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know their infection status are men, adolescents, and children. The recipient military HIV/AIDS program is strategically placed to reach men; therefore, the implementer will closely work with the recipient military on HTS for both prevention and diagnosis. Those who test negative should be provided with HIV risk reduction information (including referral to PrEP where relevant) and educated on

U=U (Undetectable = Untransmittable). For those who test positive, activities should include information about HIV, offer of Safe and Ethical Index Testing (SEIT), and offer of self-testing for family members (all sexual partners and children under 19 years old) who may not be able to access a testing site. HTS should be targeted towards military personnel to achieve the target of 95-100% of all recipient military PLHIV knowing their status. HTS should also be provided to beneficiaries and civilians cared for at all military sites. The implementer will ensure they and the recipient military follow GHSD and national guidance on implementing SEIT and use the training materials created by the HTS team with the 10-Step model.

The local epidemiology and situational analysis should guide other testing methods to identify PLHIV.

Provider-Initiated Testing and Counseling (PITC) will continue at military facilities for both the military and civilian cohorts. PITC should focus within clinical areas that have shown a high testing yield, such as inpatient wards, tuberculosis (TB) and sexually transmitted infection (STI) clinics.

All people newly diagnosed with HIV should be retested to verify their HIV status prior to starting ART. The same testing strategy and algorithm as the original diagnosis should be used, but with a different tester and different test kit lots.

The implementer should support the military to achieve over 95% linkage of HIV-positive individuals identified to treatment initiation, fully implementing “test-and-start” policies across all age, sex, and risk groups. Ensuring that any person with positive results identified is linked to HIV care and treatment is essential to the success of the recipient military program. The implementer will support the military to 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 and other relevant integrated services.

The implementer will be responsible for providing support for the following activities to military bases and facilities:

- Diagnosing HIV, with at least 95% of those diagnosed linked to HIV care, while striving for 100% linkage to treatment services and same day initiation of ART.
- Offering SEIT to all HIV positive clients and testing for all sexual partners and children under 19 years old of HIV positive military personnel and civilians (with at least 1.5 contacts identified on average).
- Documenting HIV status for all children under 19 years of age with mothers living with HIV.
- Offering self-testing for partners of index clients if they do not volunteer for partner notification.
- Facilitating quality improvement and quality assurance for all recipient military HTS sites, including strategic assistance, at least quarterly.
- Providing HIV self-testing (HIVST) for military personnel, AGYW and their partners, male partners of antenatal care (ANC) clients and other high-risk populations. As part of the HIVST protocol, clients with a positive HIVST should be instructed to follow up with trained staff for further evaluation, including diagnostic testing utilizing the national testing algorithm. It is also vital to engage community groups to advocate for,

design, implement, and analyze the success of 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, including Viral Load Suppression (VLS).
- Linking HIV negative, high-risk clients to PrEP services.

## 4. HIV Treatment

ART optimization is the 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. Moreover, long-term viral load suppression prevents onward transmission and is the cornerstone of HIV prevention. The following factors should be considered in supporting the treatment of PLHIV in military facilities.

- 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. The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission recommends DTG-containing regimen as a Preferred ARV for PBFW and recommends DTG-containing regimen as a Preferred ARV for women who are trying to conceive. Starting in COP20 (FY21), programs were 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 prevent the development of TB in PLHIV as well as diagnose and treat PLHIV with TB disease and ensure they become non-infectious. In addition, all TB infected individuals should be tested for HIV.
    - Routinely screen all PLHIV for TB disease. Standardized symptom screening alone is not sufficient for TB screening among PLHIV and should be complemented with more-sensitive and setting-specific recommended screening tools. Ensure all PLHIV who screen positive for TB receive recommended molecular diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment.
    - For all who do not have active TB, prevention of TB is a priority using nationally approved TB preventive therapy (TPT). The Global AIDS Strategy has set the target of 90% of PLHIV to receive preventive treatment for TB, thus TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Implementers 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 that is consistently documented. In short, all newly diagnosed HIV-positive people should be offered TB treatment or preventive therapy, and all people assessed for TB should be tested for HIV.

    - Pregnant women living with HIV are at high risk of progression from TB infection to disease; thus, it is imperative that Prevention of Mother to Child Transmission (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 PLHIV.
    - 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, implementers should also seek opportunities to support effective joint program implementation. Additionally, implementers should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide a 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 Women Living with HIV (WLHIV) should be integrated into routine HIV treatment services in each country program. According to COP 24 Technical Considerations, all PEPFAR supported countries with HIV prevalence above 5.0% among women in the 15-49-year-old age group are expected to provide at least one life-time cervical cancer screen for WLHIV receiving ART.
    - Current international health guidelines recommend screening to start at age 25 or according to national guidelines, whichever is earlier. Programs may also consider earlier screening among women with long-standing HIV infection, e.g., perinatal infection. WLHIV who are between 50 and 65 years and have not been screened may be offered a single screening test, and screening should be discontinued if they screen negative.
    - Screening for cervical cancer should begin at high-volume military sites and be scaled to all women receiving ART in military ART sites either on-site or through referral to hub sites within the region. Screening should be available in the ART clinic or in affiliated clinics on-site such as women's health or maternal child health clinics for WLHIV to utilize.
    - Programs should ensure that a minimum of 90% of women who screen positive are linked to treatment.
    - 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.
    - Funding may be used for screening with visual inspection with acetic acid (VIA), treatment with cryotherapy, thermal ablation, and loop electrosurgical excision procedure (LEEP), and quality assurance activities.
- The implementer should work with the recipient military to offer most clients 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, 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 implementer should work with the recipient 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 HIV-related stigma by integrating a wide array of non-HIV commodities into decentralized sites (e.g. TPT). DDD models can also be used for decentralized PrEP distribution to improve uptake and continuation.
- Diagnose and treat people with advanced HIV disease (AHD). People starting treatment, re-engaging in treatment after an interruption of > 1 year, or virally unsuppressed for >1 year should be evaluated for AHD and have CD4 T cells measured. Accordingly, the implementer should be working with recipient military and public health leaders to ensure that CD4 testing is available. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease. The PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with advanced disease.

## 5. 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 implementer will work closely with the Ministry of Defense in the recipient Senegal to scale up VL testing coverage and VL suppression to achieve 95-95-95 goals for military personnel, as well as beneficiaries and civilians. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% VL suppression among PLHIV taking ART. CD4 testing should not be used to determine eligibility for ART and only should be used for assessment of immune status (i.e. identification or ongoing monitoring of patients with advanced HIV disease).

The implementer should ensure that the recipient military has access to timely VL testing (goal turnaround time is within 2 weeks) and that capacity exists to test 95% of people currently on ART annually. To ease logistical challenges associated with the transport of whole blood specimens and to increase access to routine VL monitoring, dried blood spots (DBS) for VL testing can be used as an alternative specimen type to plasma. 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 POC be used for VL testing among PBFW, infants, and children. Implementers must follow international health guidelines and work with military and MoH network (as necessary) to implement and monitor VL testing schedule for PBFW and HIV-exposed infants (HEI),

which differs from the VL testing schedule of non-PBFW HIV+ adults. POC platforms may also be appropriate for low volume remote military sites.

The implementer will ensure that VL results are available to providers/clients in a reasonable amount of time (goal is within 2 weeks) to both the health care provider and the client. These results should be available 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. Unsuppressed clients and their sexual partners should be educated on alternate risk reduction options until they become suppressed, such as PrEP. 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, to minimize inconveniences associated with health system access.

HIV viral suppression is not only critical to improving individual health, but also to prevent sexual transmission, and reduce perinatal transmission. There are three key categories for HIV viral load measurements: unsuppressed (>1000 copies/mL), suppressed (detected but ≤1000 copies/mL) and undetectable (viral load not detected by test used: <40 or <50 copies/ml depending on the machine used). People living with HIV who have an undetectable viral load and continue taking medication as prescribed have zero risk of transmitting HIV to their sexual partner(s) (U=U). PLHIV who have a suppressed but detectable viral load and are taking medication as prescribed have almost zero or negligible risk of transmitting HIV to their sexual partner(s). HIV VL test results can be a motivation for adhering to treatment and achieving the goal of being undetectable. Emphasizing and strengthening adherence counselling during antiretroviral therapy initiation and throughout treatment are essential, including communicating about the benefits of viral load suppression to all PLHIV. HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. The implementer must work with the military to ensure updated and accurate U=U messaging and encourage HIV testing, prevention, and treatment reaches all PLHIV, the general population and health care providers.

### 6. Health System Strengthening

DHAPP is working to enhance the ability of militaries and Ministries of Defense to manage their HIV epidemic, respond to broader health needs impacting their communities, and address new and emerging health concerns. Implementers should describe how they will increase recipient government capacity. A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of the HIV response, including political commitment, building program capacities and capabilities, and financial planning and expenditure.

The procurement of supplies, support and equipment should use recipient government and other donor sources when possible (Global Fund, etc.).

Laboratory:

The implementer will be responsible for the following activities to help recipient militaries build resilient, sustainable, and internationally accredited laboratory systems strongly capable of responding to the HIV epidemic and other future infectious disease outbreaks:

- Laboratory inventory tracking, control, and forecasting; monitoring of commodities procurements to ensure laboratory supplies are procured at cost-effective prices and services are uninterrupted; monitoring facilities storing procured laboratory commodities to ensure they meet International Organization for Standardization

(ISO) warehouse principals and standards; obtaining insurance for procured laboratory commodities to protect against natural disasters, fire, theft, etc.
- Supporting and facilitating military participation in national quantification exercises, ensuring that military laboratory commodity needs are incorporated into national forecasting.
- Routine monitoring of turnaround time (TAT) for VL, TB, and other critical tests, to ensure test results are provided to providers and patients within a reasonable period (2 weeks) to improve and maximize patient care and outcomes.
- Procuring laboratory service maintenance contracts, routine calibration of equipment, and training of laboratory staff on proper use and maintenance of procured equipment.
- Supporting training in proper laboratory biosafety and waste management.
- Ensuring continuous quality improvement of all laboratories (including satellite laboratories and HIV testing sites) and accreditation is in place and transitioned over to the recipient government with key milestones and timeline.
- Monitoring of laboratory quality, adherence to quality systems, and method validation; provision of proficiency testing for rapid HIV testing, VL, CD4, TB, STIs, and other tests critical to HIV epidemic control and detecting emerging disease outbreaks.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, address needs and gaps, and provide recommendations for the development of improvement plans to resolve any identified problems.
- Linking recipient military laboratory services to other laboratory resources at the district, provincial, and national levels.

Optimizing diagnostic networks for VL/EID, TB, and other coinfections. In coordination with other Donors and National TB Programs, complete diagnostic network optimization (DNO) and transition to integrated diagnostics and multi-disease testing. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time (goal is 2 weeks). Identify all parts of the laboratory system that are interoperable with the U.S. military system.

### 7. Virtual Communities of Practice/ECHO Platform

The implementer should support the recipient military's use of Virtual Communities of Practice (vCOPs) through the Project ECHO (Extension for Community Healthcare Outcomes) model if an ECHO network already exists within the military program. Project ECHO is evidence-based, virtual model that democratizes medical expertise as a self-reliant tool for continuous clinical knowledge sharing amongst healthcare workers. Since 2020, DHAPP has collaborated with the ECHO Institute (https://hsc.unm.edu/echo/) to lever their vast experience with vCOPs/ECHOs and to assist in establishing ECHO programs with 24 recipient militaries. More information on the establishment of the DHAPP Superhub available at https://pubmed.ncbi.nlm.nih.gov/40984107/. Key requirements are equipment and connectivity as well as personnel who can coordinate, manage, and lead regular vCoP/ECHO sessions. (https://hsc.unm.edu/echo/).

For recipient militaries with existing, launched ECHO programs, the implementer shall provide support focused on transitioning full ownership of the ECHO program to the recipient military. Required support activities include:

- **Program Maintenance:** Assisting the recipient military in the maintenance of existing ECHO hub and spokes – connectivity,
- **Strategic Expansion:** Supporting the addition of new clinical "spokes" to strengthen the military network of integrated care throughout the country.
- **Network Engagement:** Ensuring the recipient military actively engages with the DHAPP ECHO Superhub, and, where applicable, any local ECHO network (i.e., an MOH-led ECHO) for broader collaboration.

The Statement of Work (SOW) narrative must be specific about all proposed ECHO activities (e.g., personnel, number of sites, locations). All equipment purchases listed in the workplan must follow current U.S. laws (Congress) and policies (Executive Branch) and must be reviewed and approved by the DHAPP ECHO Team.

## 8. Commodities

The implementer will assist the military in developing and implementing a supply chain management strategy that aligns with PEPFAR's goals of ensuring sustainable commodity supplies while simultaneously emphasizing and working to improve self-reliance of the commodities recipient, with the full transition of all capabilities to the commodities recipient by award completion or USG/recipient country MOU completion (whichever comes first). This strategy should include, where applicable to a site or sites, as many of the following principles as practical:

- Development of a comprehensive Supply Chain Transition Plan with clearly defined annual milestones for the recipient military to assume responsibility for key functions. The SAF Supply Chain will be integrated with the national system. A written supply chain risk management plan that is co-developed with and owned by the recipient military. This plan must address risks to commodity availability (e.g., stockouts, expiries) and risks to the transition process itself (e.g., personnel gaps, funding shortfalls). Plans may be specific to a site or group of similar sites, depending on the need identified by the recipient military and recipient, the implementer will work with other key stakeholders to resolve barriers to efficient supply chain management at SAF sites.

- Identification and training of supply chain points of contact within each facility on topics to include where applicable, but not limited to:
    - Accurate use of the commodities request system (typically the national system)
    - Completion of necessary paperwork/electronic forms
    - Stockout and overstock mitigation strategies
    - Inter-site commodity movement procedures
    - Establishing relationships with commodities counterparts within the military and national systems, both regionally and nationally
    - Quantification and forecasting, with the goal of the recipient military leading their national quantification exercise for its facilities.
- In alignment with the America First Global Health Strategy, and in compliance with applicable

federal acquisition regulations, the recipient will prioritize the evaluation and selection of U.S.-manufactured pharmaceuticals, diagnostics, and supply chain technologies where they are competitive in terms of cost, quality, and availability. The recipient will document efforts to explore U.S.-based sources as part of its procurement strategy.

- Implementation of supply chain best practices, including product and supply chain segmentation, actively identifying and contracting with local and/or U.S.-based private sector logistics partnerships where appropriate to improve efficiency and build a sustainable logistics infrastructure that can be leveraged directly by the recipient military in the future, and establishing end-to-end supply chain visibility using global standards (GS-1) to enable military leadership to make independent, data-driven supply chain decisions.
- Adoption of decentralized drug distribution (DDD) models, such as home deliveries, use of community or private pharmacies, and automated lockers, to improve client convenience and maximize product availability.
- Collaboration with relevant stakeholders to conduct Diagnostic Network Optimizations (DNOs) to inform laboratory supply chain refinements.
- Development of accurate forecasts that capture total program needs, including considerations for optimized testing and treatment. These forecasts should inform regular (at minimum quarterly) supply plan updates.
- Establishment of systems for increased data visibility and reporting of HIV commodities availability, including granular-level reporting of quantities dispensed and stock availability.
- Active participation in collaborative efforts with recipient governments and other stakeholders to ensure data-informed decision-making and mitigate stock risks.
- Development of a plan for increasing local oversight and utilizing private sector capabilities, where appropriate.
- Implementation of a risk management and monitoring system, which may include third-party monitoring for assessment and oversight of supply chain programs, if required.
- Design and implementation of capacity building initiatives to increase supply chain literacy and fluency across recipients and human resources for health.
- Avoidance of parallel supply chain systems. All efforts must focus on strengthening and utilizing the recipient military's and/or the national health system's existing infrastructure. The recipient should not create separate, temporary, procurement or distribution systems.

The implementer should work towards ensuring a sustainable supply chain and improved regional self-reliance where feasible. This includes ensuring the military is connected to the national procurement system and other already existing procurement systems and resources in-country to avoid creating parallel procurement systems.

## 9. LIVES & Child Safeguarding

The implementer will ensure that all implementer & military health facility staff are trained in and implementing both the DHAPP LIVES and Child Safeguarding interventions (utilizing the curriculum updated in December 2025 that is in alignment with Executive Orders to date); to include re-training all trained staff every 3 years and training all new staff as part of their hiring process. Records for who has been trained and when must be kept by implementer and/or military and accessible upon request.

## 10. Malaria

The implementer is responsible for implementing evidence-based malaria prevention and treatment services. The implementer should work with the recipient military and MoH to ensure that these activities align with national malaria guidelines and target geographic regions with high malaria prevalence.

Malaria remains a significant global health threat, particularly for PLHIV who may be at higher risk of severe infection due to a compromised immune system. Malaria infection may reduce the effectiveness of ART for PLHIV on treatment, making malaria prevention an important tool in the clinical care of PLHIV. Populations which should be prioritized for malaria prevention and treatment services include infants, children under 5 years old, pregnant and breastfeeding women (PBFW), adolescent girls and young women (AGYW), PLHIV, and military populations.

The implementer will ensure that activities to address malaria include:

- Promotion of vector control prevention activities to reduce malaria infection, such as the distribution of insecticide-treated mosquito nets and the use of indoor residual spraying (IRS) in areas with high malaria prevalence.
- Distribution of chemoprophylaxis according to MOD and national guidelines as appropriate for active-duty military (ADM) deployed to areas with high malaria prevalence. Dispensing of chemoprophylaxis medications, if indicated, should include clear guidance on timeline and duration of medication usage.
- Administration of malaria vaccine for children under five years of age living in areas with moderate to high malaria transmission, aligned with international and national vaccine guidelines.
- Intermittent preventive treatment in pregnancy (IPTp) for pregnant women in malaria-endemic areas.
- Training healthcare providers to identify, diagnose, and treat malaria, as well as training on early detection and response to drug-resistant malaria.
- Distribution of appropriate malaria treatment at military health facilities, or referral to other health center where treatment is available. The most common malaria treatments are as follows:
    - Artemisinin-based combination therapy medicines are the most effective treatment for *P. falciparum malaria*.
    - Chloroquine is recommended for treatment of infection with the *P. vivax* parasite only in places where it is still sensitive to this medicine.
    - Primaquine should be added to the main treatment to prevent relapses of infection with the *P. vivax* and *P. ovale* parasites.
- Ongoing surveillance and analysis of malaria cases and health outcome data.

## 11. Tuberculosis (TB)

The implementer will be responsible for working with the recipient military to implement evidence-based TB prevention, care, and treatment services in alignment with the national MOU and implementation plan, specified by the DHAPP Program Manager. The implementer must work with the recipient military to comply with national TB guidelines and move the program towards international TB standards (if there is a discrepancy). The implementer will ensure the military is connected with all relevant TB stakeholders

in-country and seamlessly included in national processes, meetings, networks for efficiency, cost effectiveness, and self-reliance. Implementers will specifically work to integrate testing, treatment, care, and patient flow between any siloed HIV and TB departments within military health facilities. Implementers will work with the recipient military to ensure there are military owned TB services to include:

- Tuberculosis Preventive Treatment (TPT) for individuals at the highest risk of progressing from TB infection to active disease, to include PLHIV, household contacts of TB patients, ADM living in barracks, and other at-risk groups.
- Symptom screening at key healthcare facility service delivery points with strict and consistent protocol to reduce in-facility transmission.
- Standardized drug regimen, including fixed-dose combinations (FDCs).
- Directly Observed Therapy (DOT), especially virtual options, to ensure adherence.
- Robust data systems to ensure patients with TB are tracked through a complete course of therapy and minimizing loss to follow-up.

**12. Bio Surveillance (Surveillance and Outbreak Response)**

The implementer will be responsible for implementing bio surveillance activities in coordination with the recipient military and in alignment with international and national health guidelines. Bio surveillance activities include 1) outbreak detection and 2) outbreak response; and will not be duplicative of other U.S. funded bio surveillance activities.

The implementer will work with the military to ensure that outbreak detection activities are military owned and include:

- Assessment and maintenance of existing outbreak detection capacities in military health facilities and assessment of alignment with national protocols.
- Ensure military clinical and laboratory facilities are aware of national reporting requirements for outbreak detection
- Determine gaps in outbreak detection, particularly in laboratory capacity and data management, and implement a plan to correct identified gaps.

The implementer will ensure that outbreak response activities include:

- Assessment of existing outbreak response plans and revision of plans as appropriate.
- Training of personnel in effective outbreak response and establishment of outbreak response SOPs in alignment with national protocol.
- Ensure clinical facility staff are familiar with required barrier protective measures per national guidelines to prevent nosocomial spread of pathogens. Coordinate with national efforts to ensure military facilities are supplied with PPE.

The implementer will work with the PM to tailor and address any other outbreak detection and response activities outlined in the Country MOU Implementation Plan and Operational Plan.

**Monitoring and Evaluation**

To ensure the effective, efficient, and durable use of United States Government funds, the recipient

military armed forces shall be responsible for the comprehensive, reliable, and timely reporting of the milestone, outcome and process metrics specified in this announcement. This reporting is critical for two primary objectives: first, to guide the development of health policies and practices that improve the recipient country's force health readiness, and second, to provide rigorous accountability to the United States Congress and the American taxpayer for every dollar appropriated.

The implementer is mandated to coordinate directly with the recipient military to ensure the accurate and transparent delivery of these metrics to all designated stakeholders as specified in the Memorandum of Understanding between the USG and Senegal.

The overarching goal is to transition all monitoring, evaluation, and reporting responsibilities to the recipient military, fostering complete self-reliance in the shortest possible timeframe. To verify the integrity of this reporting and safeguard U.S. investment, the implementer will execute regular Data Quality Assessments (DQAs) to evaluate the accuracy and reliability of the data provided by the recipient military, the frequency of which will be determined in consultation with the recipient military.

| **Outcome Metrics** | |
|---|---|
| % People With HIV Who Know Their Status | |
| % People Who Know Their HIV Status on Treatment | |
| % People On Antiretroviral Treatment (ART) Who Are Virally Suppressed | |
| # Malaria Deaths in Children Under 5 | |
| Malaria incidence per 1000 population at risk | |
| % Children <5 who slept under an ITN the previous night | |
| # TB Deaths | |
| TB Treatment Success Rate | |

| **Process Metrics** | **Baseline Targets** |
|---|---|
| # people on ART | 1106 |
| # new HIV diagnoses among infants (0-12 months) | 0 |
| # new HIV diagnoses among children and adults (age 12 months or older) | 106 |
| % pregnant and breastfeeding women living with HIV who receive ART | 100% |
| % suspected cases receiving diagnostic test for malaria | TBD |
| % or # confirmed malaria cases that receive first-line antimalarial | TBD |

| | |
|---|---|
| treatment | |
| # insecticide-treated nets distributed to populations at risk of malaria | TBD |
| % of pregnant women attending ANC who received at least 2 doses of IPTp | TBD |
| # patients with TB notified (i.e., bacteriologically confirmed + clinically diagnosed) | TBD |
| % of patients with TB notified who completed treatment | TBD |
| TB Detection rate | TBD |
| % accuracy of data fields assessed during the annual data audit | 90% |

To ensure rigorous oversight and accountability, the implementer is required to submit independent performance data. This reporting will serve to verify and corroborate the data provided by the recipient country's Ministry of Defense as compared to actual program implementation. The explicit purpose of this data collection is to guarantee that every American taxpayer dollar is spent effectively, and its impact is demonstrably justified. All implementer performance data shall be reported at the site level or higher through the designated online data collection system (DC2) at the specified quarterly, semi-annual, or annual intervals. The indicators used for this reporting requirement will harmonize with required milestone, process, and outcome metrics.

All proposals must include milestone metrics by activity and which outcome or process metric each activity supports.

| Budget, USD | Activity | Milestone | Metric Mapping (Outcome & Process Metric) |
|---|---|---|---|

**Quality Management System**

The Senegalese Armed Forces is responsible for maintaining a quality management (QM) system, which will no longer be funded through PEPFAR. Site Improvement through Monitoring System (SIMS) is a QM system that has been supported by DHAPP for many years, and implementers and recipient militaries are encouraged to use this system (or other QM system of their choosing). QM systems provide a standardized approach and set of tools for monitoring program quality. QM 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. QM systems are also used to identify performance issues that may impact patient outcomes or the integrity of program reporting site-level triangulation of program and QM data can be used to contextualize performance and determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

QM systems aim to:

(1) facilitate service improvement,

(2) ensure accountability of U.S. government investments, and
(3) maximize the impact of U.S. government investments on the HIV epidemic.

QM assessment results confirm compliance with minimum quality assurance standards and identify areas where improvements can be made.

The implementer should ensure that all supported sites are familiar with QM standards and make sure that all efforts are taken to follow these standards. DHAPP encourages implementers and militaries to conduct reviews of program performance using the latest QM or SIMS tools which are freely available.

SIMS or other QM system implementation is one strategy available for programs to integrate effective quality assurance (QA) and CQI practices into site and program management. Program management must apply ongoing program and site standards assessment—including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementer agreements and workplans should align with national policy in support of QA/CQI.

**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 recipient military HIV program's ability to monitor progress towards epidemic control. The implementer will work with the recipient military and Ministry of Health (MOH), Ministry of Communications, and 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 recipient military leadership.

The implementer will be responsible for:

- Staffing, support, and mentoring of existing recipient military staff for paper and electronic data collection
- Timely, accurate reporting of all indicators required by the recipient 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 recipient military and DHAPP without prior approval from the recipient 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 recipient military programs and the implementer should include a strategy for conducting baseline, periodic, and ongoing data quality assessments (DQA). In this way, DHAPP, and the recipient military, can be confident in the veracity of the data that it uses for planning and measurement of progress towards programmatic goals. The implementer should plan on conducting periodic 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 recipient 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 from HIV testing to viral load testing, and the complete 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. Frequency of periodic DQAs should be determined in consultation with the recipient military and DHAPP.

**Informatics**
**Health Information Systems**

Informatics (including Digital Health Platforms (DHP) also known as Health Information Systems (HIS) or Medical Information Systems (MIS)) are critical underpinnings of good patient healthcare and good program management. The military's health system requires reliable informatics support to ensure its long-term, sustainable advancement. Key goals for a military HIS include 1) improving quality and safety of care; outbreak detection; data-driven decision-making; efficient deployment of resources; QA/QC; and improved access and improved confidentiality of health data.

The implementer will support the recipient military's HIS to align with the recipient country health information systems (HIS) to the greatest degree possible. The implementer will inventory the current military data systems (paper and electronic) and will provide written recommendations to include identification of gaps in the military HIS and requirements to enable the recipient military HIS to reach all clinical and laboratory locations. The implementer will coordinate with the military and MOH or other appropriate ministries to 1) ensure the military sites are included in national systems with 2) training, 3) infrastructure improvements such as routers, computers, solar power and satellite internet connectivity, 4) security (physical and cyber), 5) data use policy and governance, 6) data management, 7) data analytics, and 8) data use and dissemination. Where equipment procurements are needed, the recipient will ensure that the equipment will follow US laws and policies (e.g. no equipment from China, USA made, etc.).

The implementer must ensure by 2030 that the military will be capacitated with durable systems, staffing, training, and infrastructure to allow the military to use their systems effectively and independently to monitor client health and conduct national reporting.

**Work Plans**

The implementer 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. A full list of reporting requirements can be found in the base Program Announcement and will be disclosed in the award terms and conditions.

**Togo: DHAPP - Togolese Armed Forces Partnership for Resilient Military Health Systems for Readiness**

**NOTE: Application submissions for this narrative are due by 12pm EST on 15 May 2026. Submissions received after the deadline will not be considered for funding.**

## Call for Proposals

Proposals are requested to support the Togolese Armed Forces (FAT) to reach sustainable control of the HIV epidemic through the lens of the America First Global Health Strategy, as well as the UNAIDS HIV Treatment 95-95-95, Vertical Transmission 95 targets, TB prevention 90 targets, and in alignment with the National Security Strategy (NSS) and the National Defense Strategy (NDS) goals to protect the homeland, deter China, and increase burden sharing. Further, proposals must be aligned with any existing Memorandum of Understanding between the U.S. Department of State and Togo. Implementers should be familiar with these strategic guidance documents and include means of addressing them in submitted proposals. **Please see base Program Announcement section D for complete detailed list of application, format and submission requirements. Proposal Technical Narrative may not exceed 45 pages.**

## Introduction

The HIV/AIDS epidemic has devastated 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 other military personnel and their extended communities, and impeding participation in peacekeeping activities. As HIV management improves, many of these impacts are reduced; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries; this is in addition to managing other long-term chronic diseases to maintain high force health readiness in strategically identified recipient militaries. Moreover, given the well-known biobehavioral risk factors among uniformed personnel, reducing HIV acquisition and transmission in this population is an essential component for reaching epidemic control in the recipient country.

The U.S. Government has a long history of providing foreign assistance to combat HIV/AIDS, advancing U.S. national security by promoting stability in key regions. Over the years, the United States DoD HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries to control the HIV epidemic among their respective military services. Working closely with the Department of Defense (DoD, herein referred to using the secondary title Department of War, DoW), U.S. Geographic Combatant Commanders, the Bureau of Global Health Security and Diplomacy (GHSD) and other organizations, DHAPP's mission is to build the capacity of recipient militaries through military-specific HIV/AIDS assistance, creating self-reliant security counterparts. DHAPP is the DoW implementing agency collaborating with the US Department of State, 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 Department of War (Title 10) Defense Health Program (DHP) and funding transfers from the Department of State (Title 22) for PEPFAR.

All proposals must be in full alignment with any existing Memorandum of Understanding (MOU)

between the Department of State (DoS) and Togo clearly articulating transition plans for each activity over the course of the agreement with specific and measurable milestones. Reserving the last year of the agreement for transition planning will not be accepted. Activities to transition responsibilities to the recipient country must begin immediately upon award and continue throughout the life of the agreement to ensure a rapid path to self-sufficiency. The implementer must prepare the recipient country's military to fully own and operate all services, ensuring a complete and final transition of responsibility away from U.S. assistance.

The DoW Combatant Commands (CCMDs) have identified the longstanding DHAPP program with recipient countries as an essential security cooperation tool that serves U.S. interests. Pursuing HIV/AIDS activities with foreign militaries is an important part of maintaining security interests, regional stability through health readiness, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS as a destabilizing factor in developing nations. 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 CCMDs and DHAPP Country Support Teams to offer military-to-military HIV/AIDS program assistance using country priorities set by the US Under-Secretary of War for Policy and by the Department of State Bureau of Global Health Security and Diplomacy (GHSD). DHAPP provides technical support to defense forces in HIV prevention, care, treatment, and information systems and data use for HIV-infected individuals and their families.

PEPFAR adopted the United Nations Program 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. An additional goal supported by GHSD is 95% coverage of services for eliminating vertical transmission. Lastly, the UNAIDS Global AIDS Strategy established a goal that 90% of PLHIV receive preventive treatment for TB.

All proposals must align with the America First Global Health Strategy, which focuses on the following points:

- Address Inefficiency and Dependency: The majority of funding should go directly towards patient care and building resilient health systems. High program management costs will not be funded.
- Pillar 1: Make America Safer: The primary goal is to protect Americans by enhancing global surveillance systems to detect outbreaks within seven days of emergence, notify public health authorities within 1 day and rapidly responding at the source within 7 days with early response actions to prevent pandemics from reaching U.S. shores.
- Pillar 2: Make America Stronger: Foreign health assistance will be used as a strategic tool to strengthen bilateral relationships. The U.S. will enter into multi-year agreements with recipient countries that require co-investment and establish clear benchmarks, ...moving them toward self-sufficiency and away from reliance on U.S. foreign assistance. Proposals must align with any existing country-specific MOU timelines.
- Pillar 3: Make America More Prosperous: The strategy aims to bolster the U.S. economy by preventing costly pandemics and by using foreign assistance programs to promote American companies and health innovations (like diagnostics and pharmaceuticals) in emerging global markets.
- Restructure Aid Delivery: The plan calls for more frontline support, such as medical commodities

and healthcare workers, while significantly reducing all other non-frontline expenditures to ensure accountability to the American taxpayer. It will also streamline efforts by integrating disease-specific programs (HIV, Malaria, TB) and leveraging the private sector and faith-based organizations for more efficient service delivery. The implementer is expected to work with the DHAPP Program Manager (PM) on supporting the integration of disease-specific programs receiving USG funding for the military program.

**Local Implementers**

Local, non-governmental implementers with low overhead costs are encouraged to apply to this announcement. To achieve self-reliance, it is critical that the full range of HIV services are owned and operated by the recipient country's institutions, governments, and community-based and community-led organizations, regardless of current antiretroviral (ARV) coverage levels. The intent of transitioning to local implementers 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 implementers to ensure successful, long-term, community 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.

**Additional Submission Guidance:**

1. Review all documents within the package to ensure consistency in information, budgets, targets, and numbering:
    a. Use numbered lists, including numbered or alphabetized sub-lists, for activities for easier reference and monitoring, especially the SOW Narrative column.
2. Ensure all activities in the Technical Narrative are also listed concisely in the SOW file.
3. Activities must be specific; Do not write “ensure” or “support” or a similar verb as a narrative activity without defining what that means. Each activity must say specifically what the implementer will be doing. It must be measurable and answer the questions Who? What? Where? How? How many? How often?
4. Delineate between a training (i.e.: one time class or series of classes where attendees are gathered in a conference room, away from regular duties) and onsite strategic assistance (on the job guidance while recipient is performing regular duties) and specify as many of the following details as possible for both: how many attendees or sites, how often, how many days, where, specific topics/skills covered, expected outcomes & how they align with program goals, etc. Training should be limited and cost efficient.
5. Please note this project budget cannot include:
    a. Any budget allocations toward World AIDS Day (WAD) events/campaigns.
    b. Prizes, hats, or T-shirts.
    c. Flyers and printed education materials to be given to beneficiaries.
    d. Rental of venues for training or events (must use available military or ministry facilities).
    e. Employment or payments made directly to active-duty foreign military.

## Budget

The **estimate** budget for this program announcement is as follows. Final authorized budget will be confirmed and communicated at time of official award execution. The link below contains the Financial Classifications Reference Guide and a summary of the classification definitions.

https://help.datim.org

Financial classifications are not regulations governing allowability of federal awards. Nothing in this guidance should be interpreted to mean that costs or activities that are unallowable or excluded under the terms of an award are permitted by virtue of being described herein. All awards are subject to the applicable cost principles and terms set forth and conveyed in the award made.

## Estimated Budget to be used as a Framework

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.2: Laboratory Systems | HIV | 2.2: Lab Equipment Procurement | 30,000 | 30,000 | 30,000 | 30,000 | 120,000 |
| | HIV | 2.2: Lab Consumables Procurement | 30,000 | 30,000 | 30,000 | 30,000 | 120,000 |
| | HIV | 2.2: Lab Reagents and Diagnostic Test Kit Procurement | 35,000 | 35,000 | 35,000 | 35,000 | 140000 |
| Subtotal | | | 95,000 | 95,000 | 95,000 | 95,000 | 380,000 |
| 2.6: Strategic Assistance | HIV | 2.6: TA to Introduce New Innovative Diagnostics, Vaccines, Drugs, and Other Interventions (Including | 125,000 | 125,000 | 125,000 | 125,000 | 500,000 |
| | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front Line Health Care Workers | 50,000 | 50,000 | 50,000 | 50,000 | 200,000 |
| | HIV | 2.6: Other Health Systems Strengthening | 75,000 | 75,000 | 75,000 | 75,000 | 300000 |
| | HIV | 2.6: IP Program Management | 62,000 | 62,000 | 62,000 | 62,000 | 248,000 |
| | HIV | 2.6: Other Commodity Procurement | 30,000 | 30,000 | 30,000 | 30,000 | 120,000 |
| Subtotal | | | 342,000 | 342,000 | 342,000 | 342,000 | 1,368,000 |
| Total | *Budget Estimate to be used asa framework. Final authorized budget will be confirmed and communicated at time of official award. Phase 2-4 | | 437,000 | 437,000 | 437,000 | 437,000 | 1,748,000 |

## Approaches to Reaching Sustainable Epidemic Control & Transitioning Ownership

Proposals are requested to support the Togolese Armed Forces to reach sustainable control of the HIV epidemic and focus on the America First Global Health Strategy, the latest PEPFAR guidance and UNAIDS HIV Treatment 95-95-95, Vertical Transmission 95 targets, and TB prevention 90 targets, and in alignment with the NSS, NDS, and the MOU between the U.S. DoS and Togo.

In 2025, DHAPP supported the recipient military in conducting a Military Sustainability Index (MilSID). Findings indicate the military health system requires targeted improvements to advance program sustainability and strengthen health outcomes. Priority areas include enhancing planning and coordination to improve strategic collaboration with other local government health agencies, strengthening service delivery to ensure quality and accessibility, and addressing stockout risks, to

ensure consistent availability of commodities within the supply chain. Additionally, improving epidemiological, financial, and performance data systems is critical for better collection, analysis, and utilization to inform health decision-making. The implementer will be responsible for supporting the recipient military in conducting a MilSID each year of the award, ensuring all stakeholders are present (please include as an SOW activity).

In 2025, DHAPP conducted a review of the program against international standards and findings indicate the military health system in Togo must provide greater support in the following core standards:

- Offer safe and ethical index testing to all eligible people and expand access to self-testing across all military health facilities.
- Optimize diagnostic networks for VL/EID across all military health facilities

The implementer will develop and implement a comprehensive transition plan that is in alignment with any existing country MOU, with clearly defined every 6-month milestones demonstrating progressive military assumption of programmatic responsibilities across all technical areas, data collection and reporting areas, and program management. This transition framework prioritizes efficiency, direct patient care investment, and development of resilient health systems capable of independent operation beyond the period of U.S. support. All proposals should detail how the implementer will engage the recipient military leadership as well as personnel at all levels in this work; and, specifically, how the implementer will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. Please specify which SOW activities the implementer is supporting the military to take ownership of (showing increasing military ownership) and by when (with detailed milestones). Throughout this progression, the implementer must document evidence of increasing military ownership through specific metrics including percentage of activities led by military staff, proportion of budget executed directly by military, number of military personnel trained to competency, and documented military-led decision-making and problem-solving. Failure to attain defined milestones as agreed upon by the implementer, the military, and DHAPP may result in award termination.

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

**Technical Narrative & Scope of Work (SOW)**

In alignment with international health guidelines, America First Global Health Strategy, and guidance from PEPFAR/GHSD, coupled with DHAPP's vision to build the capacity of military health systems through military-specific and culturally appropriate services, the implementor will address the approach to each technical area. The implementer, through burden-sharing and building self-reliance within the recipient military, will be responsible for providing the following in close collaboration with other DHAPP-funded implementers.

**Technical Module Building Blocks**

The implementer will work closely with the Ministry of Defense and its medical leadership to make progress towards a resilient and self-reliant military HIV program that is aligned with the national MOU (if applicable), using evidence-based and efficient interventions to reach the three 95s. In alignment with the Transition Plan directive above, the implementer will include specific milestones for program transition for activities within each technical area.

1. **Pre-Exposure Prophylaxis (PrEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PrEP services to all HIV-negative individuals at high risk of acquiring HIV.

The implementer will ensure that the following interventions for adults and adolescents include:

- People at a higher risk of acquiring HIV, including PBFW, must be counseled on and offered PrEP in alignment with recipient country government policies. Any person who asks for PrEP should be considered for use.
- Individuals considering PrEP must be confirmed HIV-negative and be willing to attend follow-up appointments to monitor their HIV status on a routine basis. If a PrEP user tests HIV-positive, PrEP must stop immediately and effective HIV treatment must start.
- Differentiated and simplified service delivery for PrEP is encouraged, such as event-driven PrEP (ED PrEP), community delivery, and the use of HIV self-tests (HIVST) for PrEP services.
- PrEP counselors must be equipped to ensure that PrEP users understand adherence to the different DSD options and different PrEP options. Adherence counseling and support must be ongoing, as necessary.
- As Long-acting Lenacapavir (LEN) injectables become available, beneficiaries should be presented with thorough information on all available PrEP options, including each method's relative efficacy and safety, as well as counseling and adherence support, allowing for an informed client choice.
- If PrEP is not being offered at military facilities, the implementor will work with the military and PM to advocate with necessary stakeholders (possibly MoH or military leadership) to update guidelines, gain necessary approvals, and start implementation at military facilities.

2. **Post Exposure Prophylaxis (PEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PEP services to all HIV-negative individuals (including healthcare workers and non-healthcare workers) who have had a possible exposure to HIV within the last 72 hours.

The implementer will ensure that the following interventions for adults and adolescents include:

a. PEP should be started as soon as possible after a potential exposure to HIV, ideally within 24 hours and no later than 72 hours.
b. The person seeking PEP should be tested for HIV to confirm they are HIV-negative before starting PEP, although if testing is not available, PEP should be started immediately and

can be stopped later once testing is available. Individuals who test positive for HIV should be started on treatment immediately.

c. Three ARV drugs for a 28-day prescription are recommended for the HIV PEP regimen. Patients must be properly counseled to understand what PEP is, on adherence, and potential side effects.
d. If PEP is not being consistently integrated and offered at military facilities (to the point that the surrounding population knows it is accessible if needed), the implementor will work with the military and PM to update guidelines and SOPs, gain necessary approvals, and start implementation at military facilities. Timely access to PEP is the most crucial factor in PEP effectiveness.
e. Individuals who seek PEP services should be counseled on and offered PrEP post PEP if risk is ongoing.
f. PEP availability in community settings, as well as task sharing of PEP administration is encouraged to increase timely accessibility post exposure.

### 3. HIV Testing Services (HTS)

HIV Testing Services (HTS) is the forefront for finding the remaining people who are living with HIV (PLHIV) and is a priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know their infection status are men, adolescents, and children. The recipient military HIV/AIDS program is strategically placed to reach men; therefore, the implementer will closely work with the recipient military on HTS for both prevention and diagnosis. Those who test negative should be provided with HIV risk reduction information (including referral to PrEP where relevant) and educated on U=U (Undetectable = Untransmittable). For those who test positive, activities should include information about HIV, offer of Safe and Ethical Index Testing (SEIT), and offer of self-testing for family members (all sexual partners and children under 19 years old) who may not be able to access a testing site. HTS should be targeted towards military personnel to achieve the target of 95-100% of all recipient military PLHIV knowing their status. HTS should also be provided to beneficiaries and civilians cared for at all military sites. The implementer will ensure they and the recipient military follow GHSD and national guidance on implementing SEIT and use the training materials created by the HTS team with the 10-Step model.

The local epidemiology and situational analysis should guide other testing methods to identify PLHIV.

Provider-Initiated Testing and Counseling (PITC) will continue at military facilities for both the military and civilian cohorts. PITC should focus within clinical areas that have shown a high testing yield, such as inpatient wards, tuberculosis (TB) and sexually transmitted infection (STI) clinics.

All people newly diagnosed with HIV should be retested to verify their HIV status prior to starting ART. The same testing strategy and algorithm as the original diagnosis should be used, but with a different tester and different test kit lots.

The implementer should support the military to achieve over 95% linkage of HIV-positive individuals identified to treatment initiation, fully implementing “test-and-start” policies across all age, sex, and risk groups. Ensuring that any person with positive results identified is linked to HIV care and

treatment is essential to the success of the recipient military program. The implementer will support the military to 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 and other relevant integrated services.

The implementer will be responsible for providing support for the following activities to military bases and facilities:

- Diagnosing HIV, with at least 95% of those diagnosed linked to HIV care, while striving for 100% linkage to treatment services and same day initiation of ART.
- Offering SEIT to all HIV positive clients and testing for all sexual partners and children under 19 years old of HIV positive military personnel and civilians (with at least 1.5 contacts identified on average).
- Documenting HIV status for all children under 19 years of age with mothers living with HIV.
- Offering self-testing for partners of index clients if they do not volunteer for partner notification.
- Facilitating quality improvement and quality assurance for all recipient military HTS sites, including strategic assistance, at least quarterly.
- Providing HIV self-testing (HIVST) for military personnel, AGYW and their partners, male partners of antenatal care (ANC) clients and other high-risk populations. As part of the HIVST protocol, clients with a positive HIVST should be instructed to follow up with trained staff for further evaluation, including diagnostic testing utilizing the national testing algorithm. It is also vital to engage community groups to advocate for, design, implement, and analyze the success of 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, including Viral Load Suppression (VLS).
- Linking HIV negative, high-risk clients to PrEP services.

## 4. HIV Treatment

ART optimization is the 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. Moreover, long-term viral load suppression prevents onward transmission and is the cornerstone of HIV prevention. The following factors should be considered in supporting the treatment of PLHIV in military facilities.

- 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. The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission recommends DTG-containing regimen as a Preferred ARV for PBFW and recommends DTG-containing regimen as a Preferred ARV for women who are trying to conceive. Starting in COP20 (FY21), programs were 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 prevent the development of TB in PLHIV as well as diagnose and treat PLHIV with TB disease and ensure they become non-infectious. In addition, all TB infected individuals should be tested for HIV.
    - Routinely screen all PLHIV for TB disease. Standardized symptom screening alone is not sufficient for TB screening among PLHIV and should be complemented with more-sensitive and setting-specific recommended screening tools. Ensure all PLHIV who screen positive for TB receive recommended molecular diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment.
    - For all who do not have active TB, prevention of TB is a priority using nationally approved TB preventive therapy (TPT). The Global AIDS Strategy has set the target of 90% of PLHIV to receive preventive treatment for TB, thus TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Implementers 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 that is consistently documented. In short, all newly diagnosed HIV-positive people should be offered TB treatment or preventive therapy, and all people assessed for TB should be tested for HIV.
    - Pregnant women living with HIV are at high risk of progression from TB infection to disease; thus, it is imperative that Prevention of Mother to Child Transmission (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 PLHIV.
    - 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, implementers should also seek opportunities to support effective joint program implementation. Additionally, implementers should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide a 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 women living with HIV (WLHIV) should be integrated into routine HIV treatment services in each country program. According to COP 24 Technical Considerations, all PEPFAR supported countries with HIV prevalence above 5.0% among women in the 15-49-year-old age group are expected to provide at least one life-time cervical

cancer screen for WLHIV receiving ART.
    - Current international health guidelines recommend screening to start at age 25 or according to national guidelines, whichever is earlier. Programs may also consider earlier screening among women with long-standing HIV infection, e.g., perinatal infection. WLHIV who are between 50 and 65 years and have not been screened may be offered a single screening test, and screening should be discontinued if they screen negative.
    - Screening for cervical cancer should begin at high-volume military sites and be scaled to all women receiving ART in military ART sites either on-site or through referral to hub sites within the region. Screening should be available in the ART clinic or in affiliated clinics on-site such as women's health or maternal child health clinics for WLHIV to utilize.
    - Programs should ensure that a minimum of 90% of women who screen positive are linked to treatment.
    - 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.
    - Funding may be used for screening with visual inspection with acetic acid (VIA), treatment with cryotherapy, thermal ablation, and loop electrosurgical excision procedure (LEEP), and quality assurance activities.
- The implementer should work with the recipient military to offer most clients 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, 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 implementer should work with the recipient 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 HIV-related stigma by integrating a wide array of non-HIV commodities into decentralized sites (e.g. TPT). DDD models can also be used for decentralized PrEP distribution to improve uptake and continuation.
- Diagnose and treat people with advanced HIV disease (AHD). People starting treatment, re-engaging in treatment after an interruption of > 1 year, or virally unsuppressed for >1 year should be evaluated for AHD and have CD4 T cells measured. Accordingly, the implementer should be working with recipient military and public health leaders to ensure that CD4 testing is available. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease. The PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with advanced disease.

## 5. 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 implementer will work closely with the Ministry of Defense in Togo to scale up VL testing coverage and VL suppression to achieve 95-95-95 goals for military personnel, as well as beneficiaries and civilians. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% VL suppression among PLHIV taking ART. CD4 testing should not be used to determine eligibility for ART and only should be used for assessment of immune status (i.e. identification or ongoing monitoring of patients with advanced HIV disease).

The implementer should ensure that the recipient military has access to timely VL testing (goal turnaround time is within 2 weeks) and that capacity exists to test 95% of people currently on ART annually. To ease logistical challenges associated with the transport of whole blood specimens and to increase access to routine VL monitoring, dried blood spots (DBS) for VL testing can be used as an alternative specimen type to plasma. 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 POC be used for VL testing among PBFW, infants, and children. Implementers must follow international health guidelines and work with military and MoH network (as necessary) to implement and monitor VL testing schedule for PBFW and HIV-exposed infants (HEI), which differs from the VL testing schedule of non-PBFW HIV+ adults. POC platforms may also be appropriate for low volume remote military sites.

The implementer will ensure that VL results are available to providers/clients in a reasonable amount of time (goal is within 2 weeks) to both the health care provider and the client. These results should be available 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. Unsuppressed clients and their sexual partners should be educated on alternate risk reduction options until they become suppressed, such as PrEP. 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, to minimize inconveniences associated with health system access.

HIV viral suppression is not only critical to improving individual health, but also to prevent sexual transmission, and reduce perinatal transmission. There are three key categories for HIV viral load measurements: unsuppressed (>1000 copies/mL), suppressed (detected but ≤1000 copies/mL) and undetectable (viral load not detected by test used: <40 or <50 copies/ml depending on the machine used). People living with HIV who have an undetectable viral load and continue taking medication as prescribed have zero risk of transmitting HIV to their sexual partner(s) (U=U). PLHIV who have a suppressed but detectable viral load and are taking medication as prescribed have almost zero or negligible risk of transmitting HIV to their sexual partner(s). HIV VL test results can be a motivation for adhering to treatment and achieving the goal of being undetectable. Emphasizing and strengthening adherence

counselling during antiretroviral therapy initiation and throughout treatment are essential, including communicating about the benefits of viral load suppression to all PLHIV. HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. The implementer must work with the military to ensure updated and accurate U=U messaging and encourage HIV testing, prevention, and treatment reaches all PLHIV, the general population and health care providers.

## 6. Health System Strengthening

DHAPP is working to enhance the ability of militaries and Ministries of Defense to manage their HIV epidemic, respond to broader health needs impacting their communities, and address new and emerging health concerns. Implementers should describe how they will increase recipient government capacity. A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of the HIV response, including political commitment, building program capacities and capabilities, and financial planning and expenditure.

The procurement of supplies, support and equipment should use recipient government and other donor sources when possible (Global Fund, etc.).

Laboratory:

The implementer will be responsible for the following activities to help recipient militaries build resilient, sustainable, and internationally accredited laboratory systems strongly capable of responding to the HIV epidemic and other future infectious disease outbreaks:

- Laboratory inventory tracking, control, and forecasting; monitoring of commodities procurements to ensure laboratory supplies are procured at cost-effective prices and services are uninterrupted; monitoring facilities storing procured laboratory commodities to ensure they meet International Organization for Standardization (ISO) warehouse principals and standards; obtaining insurance for procured laboratory commodities to protect against natural disasters, fire, theft, etc.
- Supporting and facilitating military participation in national quantification exercises, ensuring that military laboratory commodity needs are incorporated into national forecasting.
- Routine monitoring of turnaround time (TAT) for VL, TB, and other critical tests, to ensure test results are provided to providers and patients within a reasonable period (2 weeks) to improve and maximize patient care and outcomes.
- Procuring laboratory service maintenance contracts, routine calibration of equipment, and training of laboratory staff on proper use and maintenance of procured equipment.
- Supporting training in proper laboratory biosafety and waste management.
- Ensuring continuous quality improvement of all laboratories (including satellite laboratories and HIV testing sites) and accreditation is in place and transitioned over to the recipient government with key milestones and timeline.
- Monitoring of laboratory quality, adherence to quality systems, and method validation; provision of proficiency testing for rapid HIV testing, VL, CD4, TB, STIs, and other tests critical to HIV epidemic control and detecting emerging disease outbreaks.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, address needs and gaps, and provide recommendations for the development of improvement plans to resolve any identified problems.

- Linking recipient military laboratory services to other laboratory resources at the district, provincial, and national levels.

Optimizing diagnostic networks for VL/EID, TB, and other coinfections. In coordination with other Donors and National TB Programs, complete diagnostic network optimization (DNO) and transition to integrated diagnostics and multi-disease testing. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time (goal is 2 weeks). Identify all parts of the laboratory system that are interoperable with the U.S. military system.

## 7. Virtual Communities of Practice/ECHO Platform

The implementer should support the recipient military's use of Virtual Communities of Practice (vCOPs) through the Project ECHO (Extension for Community Healthcare Outcomes) model if an ECHO network already exists within the military program. Project ECHO is evidence-based, virtual model that democratizes medical expertise as a self-reliant tool for continuous clinical knowledge sharing amongst healthcare workers. Since 2020, DHAPP has collaborated with the ECHO Institute (https://hsc.unm.edu/echo/) to lever their vast experience with vCOPs/ECHOs and to assist in establishing ECHO programs with 24 recipient militaries. More information on the establishment of the DHAPP Superhub available at https://pubmed.ncbi.nlm.nih.gov/40984107/. Key requirements are equipment and connectivity as well as personnel who can coordinate, manage, and lead regular vCoP/ECHO sessions. (https://hsc.unm.edu/echo/).

For recipient militaries with existing, launched ECHO programs, the implementer shall provide support focused on transitioning full ownership of the ECHO program to the recipient military. Required support activities include:

- **Program Maintenance:** Assisting the recipient military in the maintenance of existing ECHO hub and spokes – connectivity,
- **Strategic Expansion:** Supporting the addition of new clinical "spokes" to strengthen the military network of integrated care throughout the country.
- **Network Engagement:** Ensuring the recipient military actively engages with the DHAPP ECHO Superhub, and, where applicable, any local ECHO network (i.e., an MOH-led ECHO) for broader collaboration.

The Statement of Work (SOW) narrative must be specific about all proposed ECHO activities (e.g., personnel, number of sites, locations). All equipment purchases listed in the workplan must follow current U.S. laws (Congress) and policies (Executive Branch) and must be reviewed and approved by the DHAPP ECHO Team.

## 8. Commodities

The implementer will assist the military in developing and implementing a supply chain management strategy that aligns with PEPFAR's goals of ensuring sustainable commodity supplies while simultaneously emphasizing and working to improve self-reliance of the commodities recipient, with the full transition of all capabilities to the commodities recipient by award completion or USG/recipient

country MOU completion (whichever comes first). This strategy should include, where applicable to a site or sites, as many of the following principles as practical:

- Development of a comprehensive Supply Chain Transition Plan with clearly defined annual milestones for the recipient military to assume responsibility for key functions. A written supply chain risk management plan that is co-developed with and owned by the recipient military. This plan must address risks to commodity availability (e.g., stockouts, expiries) and risks to the transition process itself (e.g., personnel gaps, funding shortfalls). Plans may be specific to a site or group of similar sites, depending on the need identified by the recipient military and recipient.
- Identification and training of supply chain points of contact within each facility on topics to include where applicable, but not limited to:
    - Accurate use of the commodities request system (typically the national system)
    - Completion of necessary paperwork/electronic forms
    - Stockout and overstock mitigation strategies
    - Inter-site commodity movement procedures
    - Establishing relationships with commodities counterparts within the military and national systems, both regionally and nationally
    - Quantification and forecasting, with the goal of the recipient military leading their national quantification exercise for its facilities.
- In alignment with the America First Global Health Strategy, and in compliance with applicable federal acquisition regulations, the recipient will prioritize the evaluation and selection of U.S.-manufactured pharmaceuticals, diagnostics, and supply chain technologies where they are competitive in terms of cost, quality, and availability. The recipient will document efforts to explore U.S.-based sources as part of its procurement strategy.
- Implementation of supply chain best practices, including product and supply chain segmentation, actively identifying and contracting with local and/or U.S.-based private sector logistics partnerships where appropriate to improve efficiency and build a sustainable logistics infrastructure that can be leveraged directly by the recipient military in the future, and establishing end-to-end supply chain visibility using global standards (GS-1) to enable military leadership to make independent, data-driven supply chain decisions.
- Adoption of decentralized drug distribution (DDD) models, such as home deliveries, use of community or private pharmacies, and automated lockers, to improve client convenience and maximize product availability.
- Collaboration with relevant stakeholders to conduct Diagnostic Network Optimizations (DNOs) to inform laboratory supply chain refinements.
- Development of accurate forecasts that capture total program needs, including considerations for optimized testing and treatment. These forecasts should inform regular (at minimum quarterly) supply plan updates.
- Establishment of systems for increased data visibility and reporting of HIV commodities availability, including granular-level reporting of quantities dispensed and stock availability.
- Active participation in collaborative efforts with recipient governments and other stakeholders to ensure data-informed decision-making and mitigate stock risks.

- Development of a plan for increasing local oversight and utilizing private sector capabilities, where appropriate.
- Implementation of a risk management and monitoring system, which may include third-party monitoring for assessment and oversight of supply chain programs, if required.
- Design and implementation of capacity building initiatives to increase supply chain literacy and fluency across recipients and human resources for health.
- Avoidance of parallel supply chain systems. All efforts must focus on strengthening and utilizing the recipient military's and/or the national health system's existing infrastructure. The recipient should not create separate, temporary, procurement or distribution systems.

The implementer should work towards ensuring a sustainable supply chain and improved regional self-reliance where feasible. This includes ensuring the military is connected to the national procurement system and other already existing procurement systems and resources in-country to avoid creating parallel procurement systems.

**9. LIVES & Child Safeguarding**

The implementer will ensure that all implementer & military health facility staff are trained in and implementing both the DHAPP LIVES and Child Safeguarding interventions (utilizing the curriculum updated in December 2025 that is in alignment with Executive Orders to date); to include re-training all trained staff every 3 years and training all new staff as part of their hiring process. Records for who has been trained and when must be kept by implementer and/or military and accessible upon request.

**Monitoring and Evaluation**

To ensure the effective, efficient, and durable use of United States Government funds, the recipient military armed forces shall be responsible for the comprehensive, reliable, and timely reporting of the milestone, outcome and process metrics specified in this announcement. This reporting is critical for two primary objectives: first, to guide the development of health policies and practices that improve the recipient country's force health readiness, and second, to provide rigorous accountability to the United States Congress and the American taxpayer for every dollar appropriated.

The implementer is mandated to coordinate directly with the recipient military to ensure the accurate and transparent delivery of these metrics to all designated stakeholders as specified in the Memorandum of Understanding between the USG and Togo.

The overarching goal is to transition all monitoring, evaluation, and reporting responsibilities to the recipient military, fostering complete self-reliance in the shortest possible timeframe. To verify the integrity of this reporting and safeguard U.S. investment, the implementer will execute regular Data Quality Assessments (DQAs) to evaluate the accuracy and reliability of the data provided by the recipient military, the frequency of which will be determined in consultation with the recipient military.

| **Outcome Metrics** |
| --- |
| % People With HIV Who Know Their Status |

| |
|---|
| % People Who Know Their HIV Status on Treatment |
| % People On Antiretroviral Treatment (ART) Who Are Virally Suppressed |

| **Process Metrics** | **Baseline Targets** |
|---|---|
| # people on ART | 2,100 |
| # new HIV diagnoses among children and adults (age 12 months or older) | 188 |
| % pregnant and breastfeeding women living with HIV who receive ART | 100% |
| % accuracy of data fields assessed during the annual data audit | 90% |

To ensure rigorous oversight and accountability, the implementer is required to submit independent performance data. This reporting will serve to verify and corroborate the data provided by the recipient country's Ministry of Defense as compared to actual program implementation. The explicit purpose of this data collection is to guarantee that every American taxpayer dollar is spent effectively, and its impact is demonstrably justified. All implementer performance data shall be reported at the site level or higher through the designated online data collection system (DC2) at the specified quarterly, semi-annual, or annual intervals. The indicators used for this reporting requirement will harmonize with required milestone, process, and outcome metrics.

All proposals must include milestone metrics by activity and which outcome or process metric each activity supports.

| **Budget, USD** | **Activity** | **Milestone** | **Metric Mapping (Outcome & Process Metric)** |
|---|---|---|---|

**Quality Management System**

The Togolese Armed Forces is responsible for maintaining a quality management (QM) system, which will no longer be funded through PEPFAR. Site Improvement through Monitoring System (SIMS) is a QM system that has been supported by DHAPP for many years, and implementers and recipient militaries are encouraged to use this system (or other QM system of their choosing). QM systems provide a standardized approach and set of tools for monitoring program quality. QM 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. QM systems are also used to identify performance issues that may impact patient outcomes or the integrity of program reporting site-level triangulation of program and QM data can be used to contextualize performance and determine if performance challenges

at a site are due to issues related to the underlying quality of service provision.

QM systems aim to:
(1) facilitate service improvement,
(2) ensure accountability of U.S. government investments, and
(3) maximize the impact of U.S. government investments on the HIV epidemic.

QM assessment results confirm compliance with minimum quality assurance standards and identify areas where improvements can be made.

The implementer should ensure that all supported sites are familiar with QM standards and make sure that all efforts are taken to follow these standards. DHAPP encourages implementers and militaries to conduct reviews of program performance using the latest QM or SIMS tools which are freely available.

SIMS or other QM system implementation is one strategy available for programs to integrate effective quality assurance (QA) and CQI practices into site and program management. Program management must apply ongoing program and site standards assessment—including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementer agreements and workplans should align with national policy in support of QA/CQI.

**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 recipient military HIV program's ability to monitor progress towards epidemic control. The implementer will work with the recipient military and Ministry of Health (MOH), Ministry of Communications, and 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 recipient military leadership.

The implementer will be responsible for:
- Staffing, support, and mentoring of existing recipient military staff for paper and electronic data collection
- Timely, accurate reporting of all indicators required by the recipient 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 recipient military and DHAPP without prior approval from the recipient 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 recipient military programs and the implementer

should include a strategy for conducting baseline, periodic, and ongoing data quality assessments (DQA). In this way, DHAPP, and the recipient military, can be confident in the veracity of the data that it uses for planning and measurement of progress towards programmatic goals. The implementer should plan on conducting periodic DQAs at the highest volume sites comprising 80% of the total number of people living with HIV and conducting DQAs of non-treatment technical programs, too.

Protocols for DQAs will be reviewed by recipient 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 from HIV testing to viral load testing, and the complete 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. Frequency of periodic DQAs should be determined in consultation with the recipient military and DHAPP.

**Informatics**
**Health Information Systems**

Informatics (including Digital Health Platforms (DHP) also known as Health Information Systems (HIS) or Medical Information Systems (MIS)) are critical underpinnings of good patient healthcare and good program management. The military's health system requires reliable informatics support to ensure its long-term, sustainable advancement. Key goals for a military HIS include 1) improving quality and safety of care; outbreak detection; data-driven decision-making; efficient deployment of resources; QA/QC; and improved access and improved confidentiality of health data.

The implementer will support the recipient military's HIS to align with the recipient country health information systems (HIS) to the greatest degree possible. The implementer will inventory the current military data systems (paper and electronic) and will provide written recommendations to include identification of gaps in the military HIS and requirements to enable the recipient military HIS to reach all clinical and laboratory locations. The implementer will coordinate with the military and MOH or other appropriate ministries to 1) ensure the military sites are included in national systems with 2) training, 3) infrastructure improvements such as routers, computers, solar power and satellite internet connectivity, 4) security (physical and cyber), 5) data use policy and governance, 6) data management, 7) data analytics, and 8) data use and dissemination. Where equipment procurements are needed, the recipient will ensure that the equipment will follow US laws and policies (e.g. no equipment from China, USA made, etc.).

The implementer must ensure by 2030 that the military will be capacitated with durable systems, staffing, training, and infrastructure to allow the military to use their systems effectively and independently to monitor client health and conduct national reporting.

**Work Plans**

The implementer 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. A full list of reporting requirements can be found in the base Program Announcement and will be disclosed in the award terms and conditions.

**Uganda: DHAPP- UPDF Partnership for Resilient Military Health Systems for Readiness**

**NOTE: Application submissions for this narrative are due by 12pm EST on 15 May 2026. Submissions received after the deadline will not be considered for funding.**

## Call for Proposals

Proposals are requested to support the Uganda Peoples Defence Force (UPDF) to reach sustainable control of the HIV epidemic through the lens of the America First Global Health Strategy, as well as the UNAIDS HIV Treatment 95-95-95; Vertical Transmission 95 targets; and TB prevention 90 and in alignment with the National Security Strategy (NSS) and the National Defense Strategy (NDS) goals to protect the homeland, deter China, and increase burden sharing. Further, proposals must be aligned with any existing Memorandum of Understanding [MOU] between the U.S. Department of State and Uganda Implementers should be familiar with these strategic guidance documents and include means of addressing them in submitted proposals. **Please see base Program Announcement section D for complete detailed list of application, format and submission requirements. Proposal Technical Narrative may not exceed 45 pages.**

## Introduction

The HIV/AIDS epidemic has devastated 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 other military personnel and their extended communities, and impeding participation in peacekeeping activities. As HIV management improves, many of these impacts are reduced; however, militaries now need to sustain life-long HIV treatment for their HIV-infected beneficiaries; this is in addition to managing other long-term chronic diseases to maintain high force health readiness in strategically identified recipient militaries. Moreover, given the well-known biobehavioral risk factors among uniformed personnel, reducing HIV acquisition and transmission in this population is an essential component for reaching epidemic control in the recipient country.

The U.S. Government has a long history of providing foreign assistance to combat HIV/AIDS, advancing U.S. national security by promoting stability in key regions. Over the years, the United States DoD HIV/AIDS Prevention Program (DHAPP) has successfully engaged over 80 countries to control the HIV epidemic among their respective military services. Working closely with the Department of Defense (DoD, herein referred to using the secondary title Department of War, DoW), U.S. Geographic Combatant Commanders, the Bureau of Global Health Security and Diplomacy (GHSD) and other organizations, DHAPP's mission is to build the capacity of recipient militaries through military-specific HIV/AIDS assistance, creating self-reliant security counterparts. DHAPP is the DoW implementing agency collaborating with the US Department of State, 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 Department of War (Title 10) Defense Health Program (DHP) and funding transfers from the Department of State (Title 22) for PEPFAR.

All proposals must be in full alignment with any existing Memorandum of Understanding (MOU) between the Department of State (DoS) and Uganda clearly articulating transition plans for each activity

over the course of the agreement with specific and measurable milestones. Reserving the last year of the agreement for transition planning will not be accepted. Activities to transition responsibilities to the recipient country must begin immediately upon award and continue throughout the life of the agreement to ensure a rapid path to self-sufficiency. The implementer must prepare the recipient country's military to fully own and operate all services, ensuring a complete and final transition of responsibility away from U.S. assistance.

The DoW Combatant Commands (CCMDs) have identified the longstanding DHAPP program with recipient countries as an essential security cooperation tool that serves U.S. interests. Pursuing HIV/AIDS activities and integrated service delivery for priority diseases with foreign militaries is an important part of maintaining security interests, regional stability through health readiness, counterterrorism, and peacekeeping efforts due to the impact of HIV/AIDS, infectious diseases, limited laboratory capacity, and limited surveillance/outbreak detection as destabilizing factors in developing nations. DHAPP employs an integrated bilateral and regional strategy for HIV/AIDS and integrated service delivery, cooperation, and security assistance. DHAPP implements bilateral and regional strategies in coordination with respective CCMDs and DHAPP Country Support Teams to offer military-to-military HIV/AIDS and integrated service delivery program assistance using country priorities set by the US Under-Secretary of War for Policy and by the Department of State Bureau of Global Health Security and Diplomacy (GHSD). DHAPP provides technical support to defense forces in HIV prevention, care, treatment, and information systems and data use 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. An additional goal supported by GHSD is 95% coverage of services for eliminating vertical transmission. Lastly, the UNAIDS Global AIDS Strategy established a goal that 90% of PLHIV receive preventive treatment for TB. In Uganda, the MOU stipulates additional goals of reduced malaria deaths in children under 5 (from 9,567 at baseline (2025) to 3,608 (2030), reduced malaria death total (from 15,945 (2025) to 4,950 (2030), an increase from 95% to 99% of confirmed malaria cases receiving first line anti-malarial treatment, an increase in distribution of LLINs, and an increase in patients with TB notified who successfully complete treatment from 91% (2025) to 95% (2030).

All proposals must align with the America First Global Health Strategy, which focuses on the following points:

- Address Inefficiency and Dependency: The majority of funding should go directly towards patient care and building resilient health systems. High program management costs will not be funded.
- Pillar 1: Make America Safer: The primary goal is to protect Americans by enhancing global surveillance systems to detect outbreaks within seven days of emergence, notify public health authorities within 1 day and rapidly responding at the source within 7 days with early response actions to prevent pandemics from reaching U.S. shores.
- Pillar 2: Make America Stronger: Foreign health assistance will be used as a strategic tool to strengthen bilateral relationships. The U.S. will enter into multi-year agreements with recipient countries that require co-investment and establish clear benchmarks, ...moving them toward self-sufficiency and away from reliance on U.S. foreign assistance. Proposals must align with any

existing country-specific MOU timelines.

- Pillar 3: Make America More Prosperous: The strategy aims to bolster the U.S. economy by preventing costly pandemics and by using foreign assistance programs to promote American companies and health innovations (like diagnostics and pharmaceuticals) in emerging global markets.
- Restructure Aid Delivery: The plan calls for more frontline support, such as medical commodities and healthcare workers, while significantly reducing all other non-frontline expenditures to ensure accountability to the American taxpayer. It will also streamline efforts by integrating disease-specific programs (HIV, Malaria, TB) and leveraging the private sector and faith-based organizations for more efficient service delivery. The implementer is expected to work with the DHAPP Program Manager (PM) on supporting the integration of disease-specific programs receiving USG funding for the military program.

**Local Implementers**

Local, non-governmental implementers with low overhead costs are encouraged to apply to this announcement. To achieve self-reliance, it is critical that the full range of HIV services are owned and operated by the recipient country's institutions, governments, and community-based and community-led organizations, regardless of current antiretroviral (ARV) coverage levels. The intent of transitioning to local implementers 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 implementers to ensure successful, long-term, community 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.

**Additional Submission Guidance:**

1. Review all documents within the package to ensure consistency in information, budgets, targets, and numbering:
    a. Use numbered lists, including numbered or alphabetized sub-lists, for activities for easier reference and monitoring, especially the SOW Narrative column.
2. Ensure all activities in the Technical Narrative are also listed concisely in the SOW file.
3. Activities must be specific; Do not write “ensure” or “support” or a similar verb as a narrative activity without defining what that means. Each activity must say specifically what the implementer will be doing. It must be measurable and answer the questions Who? What? Where? How? How many? How often?
4. Delineate between a training (i.e.: one time class or series of classes where attendees are gathered in a conference room, away from regular duties) and onsite strategic assistance (on the job guidance while recipient is performing regular duties) and specify as many of the following details as possible for both: how many attendees or sites, how often, how many days, where, specific topics/skills covered, expected outcomes & how they align with program goals, etc. Training should be limited and cost efficient.

5. Please note this project budget cannot include:
    a. Any budget allocations toward World AIDS Day (WAD) events/campaigns.
    b. Prizes, hats, or T-shirts.
    c. Flyers and printed education materials to be given to beneficiaries.
    d. Rental of venues for training or events (must use available military or ministry facilities).
    e. Employment or payments made directly to active-duty foreign military.

## Budget

The **estimate** budget for this program announcement is as follows. Final authorized budget will be confirmed and communicated at time of official award execution. The link below contains the Financial Classifications Reference Guide and a summary of the classification definitions.
https://help.datim.org
Financial classifications are not regulations governing allowability of federal awards. Nothing in this guidance should be interpreted to mean that costs or activities that are unallowable or excluded under the terms of an award are permitted by virtue of being described herein. All awards are subject to the applicable cost principles and terms set forth and conveyed in the award made.

## Estimated Budget to be used as a Framework

**Note, activities described in the narrative below can be allocated to the strategic assistance section of the budget.**

| MOU Area of Cooperation | Health Program Area | Sub category | Phase 1 | Phase 2 | Phase 3 | Phase 4 | Total |
|---|---|---|---|---|---|---|---|
| 2.1: Surveillance and Outbreak Response | GHS | 2.1: Multisectoral Coordination for Animal and Human Outb | $282,441 | $283,622 | $286,437 | $267,193 | $1,119,693 |
| | GHS | 2.1: Outbreak Readiness | $0 | $108,047 | $0 | $114,511 | $222,558 |
| | HIV | 2.1: Outbreak Readiness | $430,386 | $432,186 | $436,475 | $458,045 | $1,757,092 |
| | HIV | 2.1: Outbreak Response Capacities | $717,310 | $720,310 | $727,459 | $763,408 | $2,928,487 |
| Subtotal | | | $1,430,137 | $1,544,165 | $1,450,371 | $1,603,157 | $6,027,830 |
| 2.2: Laboratory Systems | HIV | 2.2: Lab Accreditation | $435,766 | $540,233 | $545,594 | $572,556 | $2,094,149 |
| | HIV | 2.2: Lab System Support | $1,691,059 | $1,878,208 | $1,805,916 | $2,051,659 | $7,426,842 |
| | HIV | 2.2: Lab Equipment Procurement | $1,625,030 | $1,424,738 | $1,075,148 | $1,128,280 | $5,253,196 |
| Subtotal | | | $3,751,855 | $3,843,179 | $3,426,658 | $3,752,495 | $14,774,187 |
| 2.3: Commodities | | | | | | | $0 |
| Subtotal | | | $0.00 | $0 | $0 | $0 | $0 |
| 2.4: Frontline Health Workers | HIV | 2.4: Doctors/Clinical Officers | $700,000 | $350,000 | $300,000 | $0 | $1,350,000 |
| | HIV | 2.4: Epidemiologists & Surveillance Officers | $215,000 | $165,000 | $130,000 | $0 | $510,000 |
| | HIV | 2.4: Community Health Workers/Community-Based Staff | $435,000 | $271,800 | $150,000 | $0 | $856,800 |
| Subtotal | | | $1,350,000 | $786,800 | $580,000 | $0 | $2,716,800 |
| 2.5: Data Systems | HIV | 2.5: Data Systems Infrastructure | $811,951 | $815,346 | $823,438 | $959,556 | $3,410,291 |
| | HIV | 2.5: Cybersecurity | $224,160 | $225,097 | $227,331 | $238,565 | $915,153 |
| Subtotal | | | $1,036,111 | $1,040,443 | $1,050,769 | $1,198,121 | $4,325,444 |
| 2.6: Strategic Assistance | HIV | 2.6: TA to Introduce New Innovative Diagnostics, Vaccines | $4,104,030 | $4,121,191 | $4,236,659 | $4,541,452 | $17,003,332 |
| | HIV | 2.6: Training (Pre and In-Service) and Supervision of Front | $941,469 | $972,419 | $1,009,348 | $1,097,399 | $4,020,635 |
| | HIV | 2.6: Other Health Systems Strengthening | $3,299,628 | $3,182,871 | $2,987,129 | $3,319,205 | $12,788,833 |
| | GHS | 2.6: Other Health Systems Strengthening | $488,668 | $490,711 | $495,581 | $520,072 | $1,995,032 |
| | Malaria | 2.6: Other Health Systems Strengthening | $1,479,453 | $1,665,718 | $2,091,444 | $2,297,000 | $7,533,615 |
| | HIV | 2.6: Other Commodity Procurement | $2,093,649 | $2,327,503 | $2,647,041 | $1,646,099 | $8,714,292 |
| | HIV | 2.6: IP Program Management | $3,525,000 | $3,525,000 | $3,525,000 | $3,525,000 | $14,100,000 |
| Subtotal | | | $15,931,897 | $16,285,413 | $16,992,202 | $16,946,227 | $66,155,739 |
| Total | | | $23,500,000 | $23,500,000 | $23,500,000 | $23,500,000 | $94,000,000 |

## Approaches to Reaching Sustainable Epidemic Control & Transitioning Ownership

Proposals are requested to support the Uganda Peoples Defense Force (UPDF) to reach sustainable control of the HIV epidemic and focus on the America First Global Health Strategy, the latest PEPFAR guidance and UNAIDS HIV Treatment 95-95-95, Vertical Transmission 95 targets, and TB prevention 90 targets and in alignment with the NSS, NDS, and the MOU between the U.S. DoS and Uganda.

In 2026, DHAPP supported the recipient military in conducting a Military Sustainability Index (MilSID). Findings indicate the military health system needs support in HRH (staffing and capacity), resource mobilization, generation and management of epidemiological data, and internal financial management. The implementer will be responsible for supporting the recipient military in conducting a MilSID each year of the award, ensuring all stakeholders are present (please include as an SOW activity).

In 2026 DHAPP conducted a review of the program against international gold standards. Findings indicate the military health system would benefit from a focus on adoption and institutionalization of best practices for public health case surveillance, increasing partner government leadership, enhancing local capacity for sustainable HIV response, continuing to optimize diagnostic networks for VL/EID, TB, and other coinfections, and further integration of TB services into HIV programming.

The implementer will develop and implement a comprehensive transition plan that is in alignment with any existing country MOU, with clearly defined every 6-month milestones demonstrating progressive military assumption of programmatic responsibilities across all technical areas, data collection and reporting areas, health systems, and program management. This transition framework prioritizes efficiency, direct patient care investment, and development of resilient health systems capable of independent operation beyond the period of U.S. support. All proposals should detail how the implementer will engage the recipient military leadership as well as personnel at all levels in this work; and, specifically, how the implementer will utilize the organizational structure of the military to strengthen the internal capacity of the military to conduct these activities. The implementer should plan to create and participate in a Transition Management Unit driven by UPDF. Please specify which SOW activities the implementer is supporting the military to take ownership of (showing increasing military ownership) and by when (with detailed milestones). Throughout this progression, the implementer must document evidence of increasing military ownership through specific metrics including percentage of activities led by military staff, proportion of budget executed directly by military, number of military personnel trained to competency, and documented military-led decision-making and problem-solving. Failure to attain defined milestones as agreed upon by the implementer, UPDF, and DHAPP may result in award termination.

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

**Technical Narrative & Scope of Work (SOW)**

In alignment with international health guidelines, America First Global Health Strategy, and guidance

from PEPFAR/GHSD, coupled with DHAPP's vision to build the capacity of military health systems through military-specific and culturally appropriate services, the recipient will address the approach to each technical area. The implementer should ensure each technical area is addressed with integrated service delivery in mind. The implementer, through burden-sharing and building self-reliance within the recipient military, will be responsible for providing the following in close collaboration with other DHAPP-funded implementers.

**Technical Module Building Blocks**

The implementer will work closely with the Ministry of Defense and its medical leadership to make progress towards a resilient and self-reliant military HIV program that is aligned with the national MOU (if applicable), using evidence-based and efficient interventions to reach the three 95s. In alignment with the Transition Plan directive above, the implementer will include specific milestones for program transition for activities within each technical area.

1. **Pre-Exposure Prophylaxis (PrEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PrEP services, Oral and Injectable, to all HIV-negative individuals at high risk of acquiring HIV.

The implementer will ensure that the following interventions for adults and adolescents include:

- People at a higher risk of acquiring HIV, including PBFW, must be counseled on and offered PrEP in alignment with recipient country government policies. Any person who asks for PrEP should be considered for use.
- Individuals considering PrEP must be confirmed HIV-negative and be willing to attend follow-up appointments to monitor their HIV status on a routine basis. If a PrEP user tests HIV-positive, PrEP must stop immediately and effective HIV treatment must start.
- Differentiated and simplified service delivery for PrEP is encouraged, such as event-driven PrEP (ED PrEP), community delivery, and the use of HIV self-tests (HIVST) for PrEP services.
- PrEP counselors must be equipped to ensure that PrEP users understand adherence to the different DSD options and different PrEP options. Adherence counseling and support must be ongoing, as necessary.
- As Long-acting Lenacapavir (LEN) injectables become available, beneficiaries should be presented with thorough information on all available PrEP options, including each method's relative efficacy and safety, as well as counseling and adherence support, allowing for an informed client choice.
- If PrEP is not being offered at military facilities, the recipient will work with the military and PM to advocate with necessary stakeholders (possibly MoH or military leadership) to update guidelines, gain necessary approvals, and start implementation at military facilities.

2. **Post Exposure Prophylaxis (PEP)**

The implementer will support the military in providing client-centered, judgement-free, evidence-based PEP services to all HIV-negative individuals (including healthcare workers and non-healthcare workers)

who have had a possible exposure to HIV within the last 72 hours.

The implementer will ensure that the following interventions for adults and adolescents include:

- PEP should be started as soon as possible after a potential exposure to HIV, ideally within 24 hours and no later than 72 hours.
- The person seeking PEP should be tested for HIV to confirm they are HIV-negative before starting PEP, although if testing is not available, PEP should be started immediately and can be stopped later once testing is available. Individuals who test positive for HIV should be started on treatment immediately.
- Three ARV drugs for a 28-day prescription are recommended for the HIV PEP regimen. Patients must be properly counseled to understand what PEP is, on adherence, and potential side effects.
- If PEP is not being consistently integrated and offered at military facilities (to the point that the surrounding population knows it is accessible if needed), the recipient will work with the military and PM to update guidelines and SOPs, gain necessary approvals, and start implementation at military facilities. Timely access to PEP is the most crucial factor in PEP effectiveness.
- Individuals who seek PEP services should be counseled on and offered PrEP post PEP if risk is ongoing.
- PEP availability in community settings, as well as task sharing of PEP administration is encouraged to increase timely accessibility post exposure.

### 3. HIV Testing Services (HTS)

HIV Testing Services (HTS) is the forefront for finding the remaining people who are living with HIV (PLHIV) and is a priority for reaching HIV epidemic control. Current epidemiology shows that most of those who do not yet know their infection status are men, adolescents, and children. The recipient military HIV/AIDS program is strategically placed to reach men; therefore, the implementer will closely work with the recipient military on HTS for both prevention and diagnosis. Those who test negative should be provided with HIV risk reduction information (including referral to PrEP where relevant) and educated on U=U (Undetectable = Untransmittable). For those who test positive, activities should include information about HIV, offer of Safe and Ethical Index Testing (SEIT), and offer of self-testing for family members (all sexual partners and children under 19 years old) who may not be able to access a testing site. HTS should be targeted towards military personnel to achieve the target of 95-100% of all recipient military PLHIV knowing their status. HTS should also be provided to beneficiaries and civilians cared for at all military sites. The implementer will ensure they and the recipient military follow GHSD and national guidance on implementing SEIT and use the training materials created by the HTS team with the 10-Step model.

The local epidemiology and situational analysis should guide other testing methods to identify PLHIV.

Provider-Initiated Testing and Counseling (PITC) will continue at military facilities for both military and civilian cohorts. PITC should focus within clinical areas that have shown a high testing yield, such

as inpatient wards, tuberculosis (TB) and sexually transmitted infection (STI) clinics.

All people newly diagnosed with HIV should be retested to verify their HIV status prior to starting ART. The same testing strategy and algorithm as the original diagnosis should be used, but with a different tester and different test kit lots.

The implementer should support the military to achieve over 95% linkage of HIV-positive individuals identified to treatment initiation, fully implementing "test-and-start" policies across all age, sex, and risk groups. Ensuring that any person with positive results identified is linked to HIV care and treatment is essential to the success of the recipient military program. The implementer will support the military to 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 and other relevant integrated services.

The implementer will be responsible for providing support for the following activities to military bases and facilities:

- Diagnosing HIV, with at least 95% of those diagnosed linked to HIV care, while striving for 100% linkage to treatment services and same day initiation of ART.
- Offering SEIT to all HIV positive clients and testing for all sexual partners and children under 19 years old of HIV positive military personnel and civilians (with at least 1.5 contacts identified on average).
- Documenting HIV status for all children under 19 years of age with mothers living with HIV.
- Offering self-testing for partners of index clients if they do not volunteer for partner notification.
- Facilitating quality improvement and quality assurance for all recipient military HTS sites, including strategic assistance, at least quarterly.
- Providing HIV self-testing (HIVST) for military personnel, AGYW and their partners, male partners of antenatal care (ANC) clients and other high-risk populations. As part of the HIVST protocol, clients with a positive HIVST should be instructed to follow up with trained staff for further evaluation, including diagnostic testing utilizing the national testing algorithm. It is also vital to engage community groups to advocate for, design, implement, and analyze the success of 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, including Viral Load Suppression (VLS).
- Linking HIV negative, high-risk clients to PrEP services.

## 4. HIV Treatment

ART optimization is the 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. Moreover, long-term viral load suppression prevents onward transmission and is the cornerstone of HIV prevention. The following factors should be considered in supporting the treatment of PLHIV in military facilities.

- 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. The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission recommends DTG-containing regimen as a Preferred ARV for PBFW and recommends DTG-containing regimen as a Preferred ARV for women who are trying to conceive. Starting in COP20 (FY21), programs were 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 prevent the development of TB in PLHIV as well as diagnose and treat PLHIV with TB disease and ensure they become non-infectious. In addition, all TB infected individuals should be tested for HIV.
    - Routinely screen all PLHIV for TB disease. Standardized symptom screening alone is not sufficient for TB screening among PLHIV and should be complemented with more-sensitive and setting-specific recommended screening tools. Ensure all PLHIV who screen positive for TB receive recommended molecular diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment.
    - For all who do not have active TB, prevention of TB is a priority using nationally approved TB preventive therapy (TPT). The Global AIDS Strategy has set the target of 90% of PLHIV to receive preventive treatment for TB, thus TPT must be scaled up for all PLHIVs as an integral part of the clinical care package. Implementers 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 that is consistently documented. In short, all newly diagnosed HIV-positive people should be offered TB treatment or preventive therapy, and all people assessed for TB should be tested for HIV.
    - Pregnant women living with HIV are at high risk of progression from TB infection to disease; thus, it is imperative that Prevention of Mother to Child Transmission (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 PLHIV.
        - To strengthen PMTCT and MNCH services, the implementer will procure and install modern delivery beds and complete delivery sets in at least 18 UPDF health facilities. The implementer will also fund the acquisition of other essential maternal/newborn equipment and support the remodeling of maternity facilities to optimize patient flow. To extend the continuum of care, the project will support integrated maternal-child health and HIV outreaches for UPDF personnel, their dependents, and surrounding civilian populations.

    - 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, implementers should also seek opportunities to support effective joint program implementation. Additionally, implementers should implement TB infection prevention and control activities to minimize the risk of TB transmission and provide a 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 Women Living with HIV (WLHIV) should be integrated into routine HIV treatment services in each country program. Initial treatment (thermocoagulation) should be provided for women who screen positive, in line with Uganda MOH standards. According to COP 24 Technical Considerations, all PEPFAR supported countries with HIV prevalence above 5.0% among women in the 15-49-year-old age group are expected to provide at least one life-time cervical cancer screen for WLHIV receiving ART.
    - Current international health guidelines recommend screening to start at age 25 or according to national guidelines, whichever is earlier. Programs may also consider earlier screening among women with long-standing HIV infection, e.g., perinatal infection. WLHIV who are between 50 and 65 years and have not been screened may be offered a single screening test, and screening should be discontinued if they screen negative.
    - Screening for cervical cancer should begin at high-volume military sites and be scaled to all women receiving ART in military ART sites either on-site or through referral to hub sites within the region. Screening should be available in the ART clinic or in affiliated clinics on-site such as women's health or maternal child health clinics for WLHIV to utilize.
    - Programs should ensure that a minimum of 90% of women who screen positive are linked to treatment.
    - 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.
    - Funding may be used for screening with visual inspection with acetic acid (VIA), treatment with cryotherapy, thermal ablation, and loop electrosurgical excision procedure (LEEP), and quality assurance activities.
- The implementer should work with the recipient military to offer most clients 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, 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 implementer should work with the recipient military to improve facilities at ART clinics and enable them to deliver integrated service delivery.
- The implementer should work with the recipient 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 HIV-related stigma by integrating a wide array of non-HIV commodities into decentralized sites (e.g. TPT). DDD models can also be used for decentralized PrEP distribution to improve uptake and continuation.

- Diagnose and treat people with advanced HIV disease (AHD). People starting treatment, re-engaging in treatment after an interruption of > 1 year, or virally unsuppressed for >1 year should be evaluated for AHD and have CD4 T cells measured. Accordingly, the implementer should be working with recipient military and public health leaders to ensure that CD4 testing is available. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease. The PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with advanced disease.

## 5. 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 implementer will work closely with the Ministry of Defense in the recipient Uganda to scale up VL testing coverage and VL suppression to achieve 95-95-95 goals for military personnel, as well as beneficiaries and civilians. Targets for HIV/AIDS care and treatment will focus on generating significant progress towards the third 95: 95% VL suppression among PLHIV taking ART. CD4 testing should not be used to determine eligibility for ART and only should be used for assessment of immune status (i.e. identification or ongoing monitoring of patients with advanced HIV disease).

The implementer should ensure that the recipient military has access to timely VL testing (goal turnaround time is within 2 weeks) and that capacity exists to test 95% of people currently on ART annually. To ease logistical challenges associated with the transport of whole blood specimens and to increase access to routine VL monitoring, dried blood spots (DBS) for VL testing can be used as an alternative specimen type to plasma. 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 POC be used for VL testing among PBFW, infants, and children. Implementers must follow international health guidelines and work with military and MoH network (as necessary) to implement and monitor VL testing schedule for PBFW and HIV-exposed infants (HEI), which differs from the VL testing schedule of non-PBFW HIV+ adults. POC platforms may also be appropriate for low volume remote military sites.

The implementer will ensure that VL results are available to providers/clients in a reasonable amount of time (goal is within 2 weeks) to both the health care provider and the client. These results should be available 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. Unsuppressed clients and their sexual partners should be educated on alternate risk reduction options until they become suppressed, such as PrEP. 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, to minimize inconveniences associated with health system access.

HIV viral suppression is not only critical to improving individual health, but also to prevent sexual transmission, and reduce perinatal transmission. There are three key categories for HIV viral load measurements: unsuppressed (>1000 copies/mL), suppressed (detected but ≤1000 copies/mL) and undetectable (viral load not detected by test used: <40 or <50 copies/ml depending on the machine used). People living with HIV who have an undetectable viral load and continue taking medication as prescribed have zero risk of transmitting HIV to their sexual partner(s) (U=U). PLHIV who have a suppressed but detectable viral load and are taking medication as prescribed have almost zero or negligible risk of transmitting HIV to their sexual partner(s). HIV VL test results can be a motivation for adhering to treatment and achieving the goal of being undetectable. Emphasizing and strengthening adherence counselling during antiretroviral therapy initiation and throughout treatment are essential, including communicating about the benefits of viral load suppression to all PLHIV. HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. The implementer must work with the military to ensure updated and accurate U=U messaging and encourage HIV testing, prevention, and treatment reaches all PLHIV, the general population and health care providers.

### 6. Health System Strengthening

DHAPP is working to enhance the ability of militaries and Ministries of Defense to manage their HIV epidemic, respond to broader health needs impacting their communities, and address new and emerging health concerns. Implementers should describe how they will increase recipient government capacity. A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of integrated disease management and the HIV response, including political commitment, building program capacities and capabilities, and financial planning and expenditure.

The procurement of supplies, support and equipment should use recipient government and other donor sources when possible (Global Fund, etc.).

Laboratory:

The implementer will be responsible for the following activities to help recipient militaries build resilient, sustainable, and internationally accredited laboratory systems strongly capable of responding to the HIV epidemic and other future infectious disease outbreaks:

- Laboratory inventory tracking, control, and forecasting; monitoring of commodities procurements to ensure laboratory supplies are procured at cost-effective prices and services are uninterrupted; monitoring facilities storing procured laboratory commodities to ensure they meet International Organization for Standardization (ISO) warehouse principals and standards; obtaining insurance for procured laboratory commodities to protect against natural disasters, fire, theft, etc.

- Strategic Assistance: Procurement of: Specialized laboratory reagents & consumables for Rapid Pathogen Identification, diagnostic equipment for forward-deployed surveillance sites, biomedical engineering equipment for UPDF Health Centre IIIs and IVs, solar power systems, UPS & voltage stabilizers for laboratories, and equipment (inclusive of sample storage equipment) for the rear public health laboratory (as defined collaboratively by UPDF and DHAPP).
- Strategic Assistance: The implementer will expand and standardize Antimicrobial Resistance (AMR) surveillance in five key UPDF laboratories by upgrading infrastructure, supply chains, biosafety, and workforce capacity. A key activity is the development of data integration tools to ensure AMR data flows from the laboratory into the Electronic Medical Record (EMR) for real-time clinician access and reporting to national surveillance systems. This will provide clinicians with critical data to improve treatment outcomes, inform antimicrobial stewardship, and enhance overall force health protection.
- Supporting and facilitating military participation in national quantification exercises, ensuring that military laboratory commodity needs are incorporated into national forecasting.
- Routine monitoring of turnaround time (TAT) for VL, TB, and other critical tests, to ensure test results are provided to providers and patients within a reasonable period (2 weeks) to improve and maximize patient care and outcomes.
- Procuring laboratory service maintenance contracts, routine calibration of equipment, and training of laboratory staff on proper use and maintenance of procured equipment.
- Supporting training in proper laboratory biosafety and waste management.
- Ensuring continuous quality improvement of all laboratories (including satellite laboratories and HIV testing sites) and accreditation is in place and transitioned over to the recipient government with key milestones and timeline.
- Monitoring of laboratory quality, adherence to and/or establishment of quality systems, and method validation; provision of proficiency testing for rapid HIV testing, VL, CD4, TB, STIs, and other tests critical to HIV epidemic control and detecting emerging disease outbreaks.
- Institutionalization of diagnostic network optimization framework
- Support for accreditation of laboratories with relevant certifying bodies
- Support for UPDF in strengthening their sample transportation network.
- Conducting routine visits to laboratories to assess achievements, review/evaluate activities, address needs and gaps, and provide recommendations for the development of improvement plans to resolve any identified problems.
- Linking recipient military laboratory services to other laboratory resources at the district, provincial, and national levels.
- Optimizing diagnostic networks for VL/EID, TB, and other coinfections. In coordination with other Donors and National TB Programs, complete and institutionalize diagnostic network optimization (DNO) and transition to integrated diagnostics and multi-disease testing. Ensure UPDF is positioned to sustain DNO following completion of implementation. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time (goal is 2 weeks). Identify all parts of the laboratory system that are interoperable with the U.S. military system.

**Infection Prevention and Control:**

To reduce the transmission of healthcare-associated infections and enhance outbreak response readiness, the implementer will strengthen Infection Prevention and Control (IPC) across all UPDF health facilities and forward mission bases. The implementer is responsible for the following integrated activities:

Establish a National IPC Program: The implementer will support the development of a national UPDF IPC program, which includes designating and training a focal person at each facility to implement standardized IPC plans and guidance. The project will ensure the consistent availability of essential IPC supplies and equipment for both routine use and emergency outbreak response.

Implement Safe Waste Management: The implementer will establish a comprehensive and safe biomedical waste management system by implementing standardized collection and disposal protocols. This includes establishing secure holding areas and procuring and installing 10 modern incinerators at designated high-volume facilities to mitigate environmental and public health risks and ensure compliance with national standards.

Establish Isolation and Treatment Capacity: In conjunction with the Ministry of Health, the implementer will procure and install prefabricated isolation units at select sites. These units will ensure the safe case management of patients with MDR-TB and other high-consequence pathogens, reducing facility-based transmission and improving outbreak containment capabilities. This will be supported by routine surveillance for healthcare-associated pathogens and robust communication between laboratory and clinical teams to ensure appropriate transmission-based precautions are implemented, directly contributing to the reduction of TB deaths and other preventable mortality.

**Human Resources for Health:**

The implementer will support the military's human resources for health, through direct contracting with clinical staff and explicit capacity building activities. The recipient will support existing UPDF clinical staff to participate in designated training exercises and coursework in support of their clinical and continuous professional development. To most efficiently deliver capacity building and training programs, the implementer will conduct a capacity needs assessment to identify priority workforce skill gaps in UPDF health services and align these priorities with areas of investment derived from MOU. The implementer will conduct capacity building of UPDF health teams in emergency preparedness, outbreak response and field medical operations. The recipient will support certification training of 250 Community Health Workers (CHWs) to become Community Health Extension Workers (CHEWs). Given UPDFs existing gaps, the recipient will support salary for frontline staff (CHW/CHEWs) (160), Physicians (15), and Epidemiologists & Surveillance Officers (25). Implementer support for clinical FTEs will reduce year over year as defined in the MOU Implementation Plan. By 2031, UPDF will absorb these FTEs into their budget.

**7. Virtual Communities of Practice/ECHO Platform**

The implementer should support the recipient military's use of Virtual Communities of Practice (vCOPs) through the Project ECHO (Extension for Community Healthcare Outcomes) model if an ECHO network

already exists within the military program. Project ECHO is evidence-based, virtual model that democratizes medical expertise as a self-reliant tool for continuous clinical knowledge sharing amongst healthcare workers. Since 2020, DHAPP has collaborated with the ECHO Institute (https://hsc.unm.edu/echo/) to lever their vast experience with vCOPs/ECHOs and to assist in establishing ECHO programs with 24 recipient militaries. More information on the establishment of the DHAPP Superhub available at https://pubmed.ncbi.nlm.nih.gov/40984107/. Key requirements are equipment and connectivity as well as personnel who can coordinate, manage, and lead regular vCoP/ECHO sessions. (https://hsc.unm.edu/echo/).

For recipient militaries with existing, launched ECHO programs, the implementer shall provide support focused on transitioning full ownership of the ECHO program to the recipient military. Required support activities include:

- **Program Maintenance:** Assisting the recipient military in the maintenance of existing ECHO hub and spokes – connectivity,
- **Strategic Expansion:** Supporting the addition of new clinical "spokes" to strengthen the military network of integrated care throughout the country.
- **Network Engagement**: Ensuring the recipient military actively engages with the DHAPP ECHO Superhub, and, where applicable, any local ECHO network (i.e., an MOH-led ECHO) for broader collaboration.
- Strategic Assistance: Establish Tele-monitoring and Telemedicine at UPDF healthcare facilities, inclusive of necessary equipment procurement (power and telemonitoring systems).

The Statement of Work (SOW) narrative must be specific about all proposed ECHO activities (e.g., personnel, number of sites, locations). All equipment purchases listed in the workplan must follow current U.S. laws (Congress) and policies (Executive Branch) and must be reviewed and approved by the DHAPP ECHO Team.

## 8. Commodities

The implementer will assist the military in developing and implementing a supply chain management strategy that aligns with PEPFAR's goals of ensuring sustainable commodity supplies while simultaneously emphasizing and working to improve self-reliance of the commodities recipient, with the full transition of all capabilities to the commodities recipient by award completion or USG/recipient country MOU completion (whichever comes first). This strategy should include, where applicable to a site or sites, as many of the following principles as practical:

- Development of a comprehensive Supply Chain Transition Plan with clearly defined annual milestones for the recipient military to assume responsibility for key functions. A written supply chain risk management plan that is co-developed with and owned by the recipient military. This plan must address risks to commodity availability (e.g., stockouts, expiries) and risks to the transition process itself (e.g., personnel gaps, funding shortfalls). Plans may be specific to a site or group of similar sites, depending on the need identified by the recipient military and recipient.
- Identification and training of supply chain points of contact within each facility on topics to include where applicable, but not limited to:
    - Accurate use of the commodities request system (typically the national system)
    - Completion of necessary paperwork/electronic forms

    - Stockout and overstock mitigation strategies
    - Inter-site commodity movement procedures
    - Establishing relationships with commodities counterparts within the military and national systems, both regionally and nationally
    - Quantification and forecasting, with the goal of the recipient military leading their national quantification exercise for its facilities.
- In alignment with the America First Global Health Strategy, and in compliance with applicable federal acquisition regulations, the recipient will prioritize the evaluation and selection of U.S.-manufactured pharmaceuticals, diagnostics, and supply chain technologies where they are competitive in terms of cost, quality, and availability. The recipient will document efforts to explore U.S.-based sources as part of its procurement strategy.
- Implementation of supply chain best practices, including product and supply chain segmentation, actively identifying and contracting with local and/or U.S.-based private sector logistics partnerships where appropriate to improve efficiency and build a sustainable logistics infrastructure that can be leveraged directly by the recipient military in the future, and establishing end-to-end supply chain visibility using global standards (GS-1) to enable military leadership to make independent, data-driven supply chain decisions.
- Adoption of decentralized drug distribution (DDD) models, such as home deliveries, use of community or private pharmacies, and automated lockers, to improve client convenience and maximize product availability.
- Collaboration with relevant stakeholders to conduct Diagnostic Network Optimizations (DNOs) to inform laboratory supply chain refinements.
- Development of accurate forecasts that capture total program needs, including considerations for optimized testing and treatment. These forecasts should inform regular (at minimum quarterly) supply plan updates.
- Establishment of systems for increased data visibility and reporting of HIV commodities availability, including granular-level reporting of quantities dispensed and stock availability.
- Active participation in collaborative efforts with recipient governments and other stakeholders to ensure data-informed decision-making and mitigate stock risks.
- Development of a plan for increasing local oversight and utilizing private sector capabilities, where appropriate.
- Implementation of a risk management and monitoring system, which may include third-party monitoring for assessment and oversight of supply chain programs, if required.
- Design and implementation of capacity building initiatives to increase supply chain literacy and fluency across recipients and human resources for health.
- Avoidance of parallel supply chain systems. All efforts must focus on strengthening and utilizing the recipient military's and/or the national health system's existing infrastructure. The recipient should not create separate, temporary, procurement or distribution systems.

The implementer should work towards ensuring a sustainable supply chain and improved regional self-reliance where feasible. This includes ensuring the military is connected to the national procurement system and other already existing procurement systems and resources in-country to avoid creating parallel

procurement systems.

## 9. LIVES & Child Safeguarding

The implementer will ensure that all implementer & military health facility staff are trained in and implementing both the DHAPP LIVES and Child Safeguarding interventions (utilizing the curriculum updated in December 2025 that is in alignment with Executive Orders to date); to include re-training all trained staff every 3 years and training all new staff as part of their hiring process. Records for who has been trained and when must be kept by implementer and/or military and accessible upon request.

## 10. Malaria

The implementer is responsible for implementing evidence-based malaria prevention and treatment services. The implementer should work with the recipient military and MoH to ensure that these activities align with national malaria guidelines and target geographic regions with high malaria prevalence.

Malaria remains a significant global health threat, particularly for PLHIV who may be at higher risk of severe infection due to a compromised immune system. Malaria infection may reduce the effectiveness of ART for PLHIV on treatment, making malaria prevention an important tool in the clinical care of PLHIV. Populations which should be prioritized for malaria prevention and treatment services include infants, children under 5 years old, pregnant and breastfeeding women (PBFW), adolescent girls and young women (AGYW), PLHIV, and military populations.

The implementer will ensure that activities to address malaria include:

- Promotion of vector control prevention activities to reduce malaria infection, such as the distribution of insecticide-treated mosquito nets, procurement and use of environmentally friendly insecticide, procurement of insecticide treated uniforms, and the use of indoor residual spraying (IRS) in areas with high malaria prevalence.
- Training healthcare providers to identify, diagnose, and treat malaria, as well as training on early detection and response to drug-resistant malaria.
- Distribution of appropriate malaria treatment at military health facilities, or referral to other health center where treatment is available. The most common malaria treatments are as follows:
    - Artemisinin-based combination therapy medicines are the most effective treatment for *P. falciparum malaria*.
    - Chloroquine is recommended for treatment of infection with the *P. vivax* parasite only in places where it is still sensitive to this medicine.
    - Primaquine should be added to the main treatment to prevent relapses of infection with the *P. vivax* and *P. ovale* parasites.
- Ongoing surveillance and analysis of malaria cases and health outcome data, inclusive of resistance monitoring.
- Establishment of an entomological unit within UPDF to support surveillance and analysis of vector control activity and malaria epidemiology.

## 11. Tuberculosis (TB)

The implementer will be responsible for working with the recipient military to implement evidence-based TB prevention, care, and treatment services in alignment with the national MOU and implementation plan, specified by the DHAPP Program Manager. The implementer must work with the recipient military to comply with national TB guidelines and move the program towards international TB standards (if there is a discrepancy). The implementer will ensure the military is connected with all relevant TB stakeholders in-country and seamlessly included in national processes, meetings, networks for efficiency, cost effectiveness, and self-reliance. Implementers will specifically work to integrate testing, treatment, care, and patient flow between any siloed HIV and TB departments within military health facilities. Implementer will procure necessary equipment and infrastructure (mobile x-ray, mobile TB screening platforms) in line with MOU implementation plan. Implementers will work with the recipient military to ensure there are military owned TB services to include:

- Tuberculosis Preventive Treatment (TPT) for individuals at the highest risk of progressing from TB infection to active disease, to include PLHIV, household contacts of TB patients, ADM living in barracks, and other at-risk groups.
- Symptom screening at key healthcare facility service delivery points with strict and consistent protocol to reduce in-facility transmission.
- Standardized drug regimen, including fixed-dose combinations (FDCs).
- Directly Observed Therapy (DOT), especially virtual options, to ensure adherence.
- Robust data systems to ensure patients with TB are tracked through a complete course of therapy and minimizing loss to follow-up.

**12. Bio Surveillance (Surveillance and Outbreak Response)**

The implementer will be responsible for implementing bio surveillance activities in coordination with the recipient military and in alignment with international and national health guidelines (7-1-7). Bio surveillance activities include 1) outbreak detection and 2) outbreak response; and will not be duplicative of other U.S. funded bio surveillance activities. In Uganda, the implementer will work with UPDF to improve infrastructure related to surveillance and outbreak response capabilities.

The implementer will work with the military to ensure that outbreak detection activities are military owned and include:

- Assessment and maintenance of existing outbreak detection capacities in military health facilities and assessment of alignment with national protocols. Development of gap closure plan.
- Ensure military clinical and laboratory facilities are aware of national reporting requirements for outbreak detection
- Determine gaps in outbreak detection, particularly in laboratory capacity and data management, and implement a plan to correct identified gaps.
- Development and equipping of sentinel surveillance network in 21 sites and missions
- Development and equipping border health and returnee holding centers to enable surveillance and reporting.
- Development of infrastructure and capabilities in to enable monitoring of zoonotic pathogen spill overs from wildlife across Uganda's 10 national parks in support of One Health.
- To prepare the UPDF for unconventional health threats, the implementer will establish a national

Chemical, Biological, Radiological, and Nuclear (CBRN) response capability by conducting a nationwide HAZMAT assessment to inform a joint national security plan. Subsequently, the implementer will build the capacity of UPDF first responders by providing specialized Detection, Identification, and Monitoring (DIM) equipment, appropriate Personal Protective Equipment (PPE), and the skills to operate safely in a contaminated environment, directly enhancing national and global health security.

The implementer will ensure that outbreak response activities include:

- Assessment of existing outbreak response plans and revision of plans as appropriate.
- Training of personnel in effective outbreak response and establishment of outbreak response SOPs in alignment with national protocol.
- Ensure clinical facility staff are familiar with required barrier protective measures per national guidelines to prevent nosocomial spread of pathogens. Coordinate with national efforts to ensure military facilities are supplied with PPE.

The implementer will work with the PM to tailor and address any other outbreak detection and response activities outlined in the Country MOU Implementation Plan and Operational Plan.

**Monitoring and Evaluation**

To ensure the effective, efficient, and durable use of United States Government funds, the recipient military armed forces shall be responsible for the comprehensive, reliable, and timely reporting of the milestone, outcome and process metrics specified in this announcement. This reporting is critical for two primary objectives: first, to guide the development of health policies and practices that improve the recipient country's force health readiness, and second, to provide rigorous accountability to the United States Congress and the American taxpayer for every dollar appropriated.

The implementer is mandated to coordinate directly with the recipient military to ensure the accurate and transparent delivery of these metrics to all designated stakeholders as specified in the Memorandum of Understanding between the USG and Uganda.

The overarching goal is to transition all monitoring, evaluation, and reporting responsibilities to the recipient military, fostering complete self-reliance in the shortest possible timeframe. To verify the integrity of this reporting and safeguard U.S. investment, the implementer will execute regular Data Quality Assessments (DQAs) to evaluate the accuracy and reliability of the data provided by the recipient military, the frequency of which will be determined in consultation with the recipient military.

| **Outcome Metrics** | |
|---|---|
| % People With HIV Who Know Their Status | |
| % People Who Know Their HIV Status on Treatment | |
| % People On Antiretroviral Treatment (ART) Who Are Virally Suppressed | |

| | |
|---|---|
| # Malaria Deaths in Children Under 5 | |
| Malaria incidence per 1000 population at risk | |
| % Children <5 who slept under an ITN the previous night | |
| # TB Deaths | |
| TB Treatment Success Rate | |

| **Process Metrics** | **Baseline Targets** |
|---|---|
| # people on ART | 22,180 |
| # new HIV diagnoses among infants (0-12 months) | 2 |
| # new HIV diagnoses among children and adults (age 12 months or older) | 1,506 |
| % pregnant and breastfeeding women living with HIV who receive ART | 100% |
| % suspected cases receiving diagnostic test for malaria | >95% |
| % or # confirmed malaria cases that receive first-line antimalarial treatment | >95% |
| # insecticide-treated nets distributed to populations at risk of malaria | >90% |
| % of pregnant women attending ANC who received at least 2 doses of IPTp | >80% |
| # patients with TB notified (i.e., bacteriologically confirmed + clinically diagnosed) | >95% |
| % of patients with TB notified who completed treatment | >95% |
| TB Detection rate | |
| % accuracy of data fields assessed during the annual data audit | 90% |

To ensure rigorous oversight and accountability, the implementer is required to submit independent performance data. This reporting will serve to verify and corroborate the data provided by the recipient country's Ministry of Defense as compared to actual program implementation. The explicit purpose of this data collection is to guarantee that every American taxpayer dollar is spent effectively, and its impact

is demonstrably justified. All implementer performance data shall be reported at the site level or higher through the designated online data collection system (DC2) at the specified quarterly, semi-annual, or annual intervals. The indicators used for this reporting requirement will harmonize with required milestone, process, and outcome metrics.

All proposals must include milestone metrics by activity and which outcome or process metric each activity supports. An example table format is below:

| Budget, USD | Activity | Milestone | Metric Mapping (Outcome & Process Metric) |
|---|---|---|---|

**Quality Management System**

The UPDF is responsible for maintaining a quality management (QM) system, which will no longer be funded through PEPFAR. Site Improvement through Monitoring System (SIMS) is a QM system that has been supported by DHAPP for many years, and implementers and recipient militaries are encouraged to use this system (or other QM system of their choosing). QM systems provide a standardized approach and set of tools for monitoring program quality. QM 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. QM systems are also used to identify performance issues that may impact patient outcomes or the integrity of program reporting site-level triangulation of program and QM data can be used to contextualize performance and determine if performance challenges at a site are due to issues related to the underlying quality of service provision.

QM systems aim to:
(1) facilitate service improvement,
(2) ensure accountability of U.S. government investments, and
(3) maximize the impact of U.S. government investments on the HIV epidemic.

QM assessment results confirm compliance with minimum quality assurance standards and identify areas where improvements can be made.

The implementer should ensure that all supported sites are familiar with QM standards and make sure that all efforts are taken to follow these standards. DHAPP encourages implementers and militaries to conduct reviews of program performance using the latest QM or SIMS tools which are freely available.

SIMS or other QM system implementation is one strategy available for programs to integrate effective quality assurance (QA) and CQI practices into site and program management. Program management must apply ongoing program and site standards assessment—including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementer agreements and workplans should align with national policy in support of QA/CQI.

**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 recipient military HIV program's ability to monitor progress towards epidemic control. The implementer will work with the recipient military and Ministry of Health (MOH), Ministry of Communications, and 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 recipient military leadership.

The implementer will be responsible for:

- Staffing, support, and mentoring of existing recipient military staff for paper and electronic data collection
- Timely, accurate reporting of all indicators required by the recipient 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 recipient military and DHAPP without prior approval from the recipient military and from DHAPP
- Support for paper and electronic data entry, cleaning, reporting, and use, including procurement, installation, and support to UPDF to manage EMR and/or Health Information Systems hardware.
- Supporting UPDF to initiate an Epidemiological forecast center in support of data management, outbreak detection and forecasting, and integration with national outbreak management systems.
- Development and implementation of a secure data warehouse inclusive of disaster recovery systems.
- Ensuring data quality

**Data Quality**

Ensuring high data quality is a critical component of all recipient military programs and the implementer should include a strategy for conducting baseline, periodic, and ongoing data quality assessments (DQA). In this way, DHAPP, and the recipient military, can be confident in the veracity of the data that it uses for planning and measurement of progress towards programmatic goals. The implementer should plan on conducting periodic 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 recipient 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 from HIV testing to viral load testing, and the complete 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. Frequency of periodic DQAs should be determined in consultation with the recipient military and DHAPP.

**Informatics**
**Health Information Systems**

Informatics (including Digital Health Platforms (DHP) also known as Health Information Systems (HIS) or Medical Information Systems (MIS)) are critical underpinnings of good patient healthcare and good program management. The military's health system requires reliable informatics support to ensure its long-term, sustainable advancement. Key goals for a military HIS include 1) improving quality and safety of care; outbreak detection; data-driven decision-making; efficient deployment of resources; QA/QC; and improved access and improved confidentiality of health data.

The implementer will support the recipient military's HIS to align with the recipient country health information systems (HIS) to the greatest degree possible. The implementer will inventory the current military data systems (paper and electronic) and will provide written recommendations to include identification of gaps in the military HIS and requirements to enable the recipient military HIS to reach all clinical and laboratory locations. The implementer will coordinate with the military and MOH or other appropriate ministries to 1) ensure the military sites are included in national systems with 2) training, 3) infrastructure improvements such as routers, computers, solar power and satellite internet connectivity, 4) security (physical and cyber), 5) data use policy and governance, 6) data management, 7) data analytics, and 8) data use and dissemination. Where equipment procurements are needed, the recipient will ensure that the equipment will follow US laws and policies (e.g. no equipment from China, USA made, etc.).

The implementer must ensure by 2030 that the military will be capacitated with durable systems, staffing, training, and infrastructure to allow the military to use their systems effectively and independently to monitor client health and conduct national reporting.

**Work Plans**

The implementer 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. A full list of reporting requirements can be found in the base Program Announcement and will be disclosed in the award terms and conditions.