Subject: **DRAFT REQUEST FOR APPLICATION (RFA) #386-06-005, entitled "HIV/AIDS PROGRAM IN INDIA" for Comment.**

Dear Interested Party,

The United States Government, represented by the United States Agency for International Development Mission in India (USAID/India), is publishing the subject RFA (solicitation) as a **DRAFT**, in order to obtain comments/input from all public and private interested parties. Your comment/input for the RFA, and may be taken into consideration for the preparation of the final RFA.

1) written comments may be sent directly at e-mail IndiaRCO@usaid.gov or to Marcus A. Johnson, Jr., Regional Agreement Officer at email address marcusjohnson@usaid.gov by Thursday, February 2, 2006; or

2) alternatively may ask questions in person at the upcoming Pre-Solicitation Conference.

USAID will conduct a Pre-Solicitation Conference on Friday, January 27, 2006. Technical representatives from the USAID/India mission will be made available for a question & answer (Q&A) session. The pre-solicitation conference on this draft RFA will be at the date and location stated below.

Location: Hyatt Regency Delhi
Bhikaiji Cama Place, Ring Road
New Delhi 110066 INDIA
Tel: +91 11 2679 1234 Fax: +91 11 2679 1122
Website: http://delhi.hyatt.com/

Date: Friday, January 27, 2006

Time: 8:30am until

USAID will provide lunch for all pre-registered attendees. Attendees are strongly advised to pre-register on or before Thursday, January 19, 2006 via an email to IndiaRCO@usaid.gov with the following information -- name of attendee, company represented and it street address, email address, telephone number, and facsimile number.

Those who have pre-registered prior to Amendment #1 of the Pre-Solicitation Notice do **not** need to pre-register again. You remain pre-registered unless you inform us to cancel.

The complete draft version of RFA #386-06-005 is posted at http://www.usaid.gov/in/ under the "Working with us" link for review by all interested parties and conference attendees.

In summary, once the final RFA is released USAID will seek proposals from US and non-US based organizations, including Indian indigenous organizations that have experience in: a) HIV/AIDS programming implementation including prevention, care and support and treatment through public and private sector interventions, and b) providing technical assistance/capacity building in HIV/AIDS prevention, care and support and treatment.

Applicants must have an excellent understanding of the epidemic in the country, the epidemiology and the factors, which fuel the epidemic and opportunities for prevention and care. Applicant should demonstrate a strong track record in working closely with local stakeholders including government, private sector and civil society. Indigenous organizations are strongly encouraged to apply either as prime (lead) applicant or sub-grantee or subcontractor, if they think have the experience and expertise to undertake programs attached.

The USG strongly encourages partnerships among several organizations to best use comparative strengths and ensure maximum impact. Eligible organizations include foundations, non-governmental organizations, faith based organizations, community-based organizations, private organizations, public international organizations, private companies, professional associations and various consortiums (combinations) of the above. [Note successful applicants will be required to comply with AAPD 05-04 found at http://www.usaid.gov/business/business_opportunities/cib/pdf/aapd05_04.pdf]

Applicants should demonstrate strong linkages with NACO and State governments to operate and deliver services in the geographical areas proposed. Services must be delivered in a manner consistent with policies, standards and practices of the national program and the Emergency Plan. The applicant should demonstrate sufficient familiarity with the policies and reporting requirement of the Emergency Plan. The Applicant must discuss sustainability aspects of the program to assure that activities undertaken can be rolled into Government and other donor programs. Building ownership of programs is important to ensure that programs can be taken up by host governments after USG exits. There should be an appropriate level of community and host country involvement in planning for and contributing to financial and other sustainability and cost recovery.

USAID expects that the total available funding for the overall program will be in the range of $35 million to $ 45 million over a period of five years.

Applicants may propose to undertake only one, two or all three components if they chose based on their comparative advantages and what provides the best value to US Government. USAID anticipates up to three awards through the solicitation. The notional distribution amongst the components of the funding is as follows.

Component 1: 40-50% of available funding
Component 2: 30-35% of available funding
Component 3: 20-30% of available funding

All comments will be taken into consideration for the preparation of the final RFA.

USAID/India is not requesting proposals at this time only written comments to e-mail: IndiaRCO@usaid.gov or marcusjohnson@usaid.gov by closing date/time. Any proposal that is received in response to this **DRAFT** RFA will be discarded prior to issuance of the RFA.

USAID will not pay for any expenses associated with devising comment to USAID or in preparing proposals. USAID reserves the right not to incorporate any and all comments into the final RFA or even issue a final RFA.

Sincerely,

Marcus A. Johnson, Jr.
Regional Agreement Officer

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HIV/AIDS
United States Agency for International Development

SECTION I - GRANT APPLICATION FORMAT

PREPARATION GUIDELINES

All applications received by the deadline will be reviewed for responsiveness to the specifications outlined in these guidelines and the application format. Section II addresses the technical evaluation procedures for the applications. Applications which are submitted late or are incomplete run the risk of not being considered in the review process. Late applications will be considered for award if the Agreement Officer determines it is in the Government's interest.

Applications shall be submitted in two separate parts: (a) technical and (b) cost or business application and should be prepared according to the structural format set forth below. Applications must be submitted no later than the date and time indicated on the cover page of this RFA, to the location indicated on the cover page of the cover letter accompanying this RFA.

Technical applications should be specific, complete and presented concisely and should demonstrate the applicant's capabilities and expertise with respect to achieving the goals of this program. The applications should take into account the technical evaluation criteria found in Section II. The maximum page limit for the technical proposal is 30 pages, for each of the three components. Thus no more than 90 pages total. Use font size 12 point, font type - Times New Roman or Courier.

Applicants should retain for their records one copy of the application and all enclosures which accompany their application. Erasures or other changes must be initialed by the person signing the application. To facilitate the competitive review of the applications, USAID will consider only applications conforming to the format prescribed below.

COST APPLICATION FORMAT

The Cost or Business Application is to be submitted under a separate cover (file) from the technical application. The technical proposals must not make any reference to the price data in order to ensure that the technical evaluation may be made strictly on the basis of the technical merit. Certain documents are required to be submitted by an applicant in order for the Grant Officer to make a determination of responsibility. However, it is USAID policy not to burden applicants with undue reporting requirements if that information is readily available through other sources.

The following sections describe the documentation that applicants for Assistance award must submit to USAID at the time of application. While there is no page limit for this portion, applicants are encouraged to be as concise as possible, but still provide the necessary detail to address the following:

A. A copy of the program description that was detailed in the applicants' program description, formatted in MS Word 2000 or later and provided electronically to USAID.

B. Include a budget with an accompanying budget narrative which provides in detail the total costs for implementation of the program your organization is proposing. The budget must be submitted using Standard Form 424 and 424A which can be downloaded from the USAID web site:
http://www.usaid.gov/procurement_bus_opp/procurement/forms/sf424/

- the breakdown of all costs associated with the program according to costs of, if applicable, headquarters, regional and/or country offices;

- the breakdown of all costs according to each partner organization involved in the program;

- the costs associated with external, expatriate technical assistance and those associated with local in-country technical assistance;

- the breakdown of the financial and in-kind contributions of all organizations involved in implementing this Cooperative Agreement;

- potential contributions of non-USAID or private commercial donors to this Cooperative Agreement;

- procurement plan for commodities (excluding contraceptives and condoms).

C. A current Negotiated Indirect Cost Rate Agreement;

D. Required certifications and representations (as attached):

E. Cost share target. The exact percentage target is not stated but some amount of cost-sharing, matching arrangement, and/or in-kind contribution is required to be eligible for consideration of award.

F. Applicants who do not currently have a Negotiated Indirect Cost Rate Agreement (NICRA) from their cognizant agency shall also submit the following information:

1. copies of the applicant's financial reports for the previous 3-year period, which have been audited by a certified public accountant or other auditor satisfactory to USAID;

2. projected budget, cash flow and organizational chart;

3. A copy of the organization's accounting manual.

G. Applicants should submit any additional evidence of responsibility deemed necessary for the agreement officer to make a determination of responsibility. The information submitted should substantiate that the Applicant:

1. Has adequate financial resources or the ability to obtain such resources as required during the performance of the award.

2. Has the ability to comply with the award conditions, taking into account all existing and currently prospective commitments of the applicant, nongovernmental and governmental.

3. Has a satisfactory record of performance. Past relevant unsatisfactory performance is ordinarily sufficient to justify a finding of non-responsibility, unless there is clear evidence of subsequent satisfactory performance.

4. Has a satisfactory record of integrity and business ethics; and

5. Is otherwise qualified and eligible to receive a grant under applicable laws and regulations (e.g., EEO and the recently issued AAPD 05-04).

H. Applicants that have never received a grant, cooperative agreement or contract from the U.S. Government are required to submit a copy of their accounting manual. If a copy has already been submitted to the U.S. Government, the applicant should advise which Federal Office has a copy.

In addition to the aforementioned guidelines, the applicant is requested to take note of the following:

I. Unnecessarily Elaborate Applications - Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective application in response to this RFA are not desired and may be construed as an indication of the applicant's lack of cost consciousness. Elaborate art work, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor desired.

J. Acknowledgement of Amendments to the RFA - Applicants shall acknowledge receipt of any amendment to this RFA by signing and returning the amendment. The Government must receive the acknowledgement by the time specified for receipt of applications.

K. Receipt of Applications - Applications must be received at the place designated and by the date and time specified in the cover letter of this RFA.

L. Submission of Applications:

1. Applications and modifications thereof shall be submitted electronically by one of the following methods.

a) Email with attachments. No more than 6 attachments (4MB limit) per email in any software application compatible with MS Word 2003 and MS Excel and/or Adobe Portable Document Format (PDF);

b) Grants.gov. Proposers may use this method to submit proposals in lieu of all other methods stated in the RFA;

c) Disk. CD or 3 ½ floppy disks may be hand-carried or mailed to USAID. U.S. based mailing address is 9000 New Delhi Place, Washington, DC 20521-9000. Note however that your letter or package must arrive prior to the closing date and time to the USAID/India office. Alternatively, letters or packages with CDs or floppy diskettes may be hand (or commercial courier)-delivered to U.S. Embassy, West Building (Gate 7), Shanti Path, Chanakya Puri, New Delhi-110 021 INDIA.

Finally, regardless of which method described above is used, hard copy of applications and modifications are not required or desired unless the cognizant Regional Agreement Officer states otherwise.

2. Faxed applications will not be considered. However, the completed, signed Standard Form 424 "Application for Federal Assistance" and 424A "Budget Information" and other required signed pages of bidders electronic application packages may be faxed, if received by the time specified for receipt of applications on the cover page.

M. Preparation of Applications:

1. Applicants are expected to review, understand, and comply with all aspects of this RFA. Failure to do so will be at the applicant's risk.

2. Each applicant shall furnish the information required by this RFA. The applicant shall sign the application and print or type its name on the Cover Page of the technical and cost applications. Erasures or other changes must be initialed by the person signing the application. Applications signed by an agent shall be accompanied by evidence of that agent's authority, unless that evidence has been previously furnished to the issuing office.

3. Each Applicant should clearly provide the name of the person(s) who contributed to writing the proposal and provide details of their affiliation to the Applicant.

4. Applicants who include data that they do not want disclosed to the public for any purpose or used by the U.S. Government except for evaluation purposes, should:

(a) Mark the title page with the following legend:

"This application includes data that shall not be disclosed outside the U.S. Government and shall not be duplicated, used, or disclosed - in whole or in part - for any purpose other than to evaluate this application. If, however, a grant is awarded to this applicant as a result of - or in connection with - the submission of this data, the U.S. Government shall have the right to duplicate, use, or disclose the data to the extent provided in the resulting grant. This restriction does not limit the U.S. Government's right to use information contained in this data if it is obtained from another source without restriction. The data subject to this restriction are contained in sheets; and

(b) Mark each sheet of data it wishes to restrict with the following legend:

"Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this application."

N. Explanation to Prospective Applicants - Any prospective applicant desiring an explanation or interpretation of this RFA must request it in writing within three weeks of receipt of the application to allow a reply to reach all prospective applicants before the submission of their applications. Oral explanations or instructions given before the award of a grant will not be binding. Any information given to a prospective applicant concerning this RFA will be furnished promptly to all other prospective applicants as an amendment of this RFA, if that information is necessary in submitting applications or if the lack of it would be prejudicial to any other prospective applicants.

O. Grant Award:

1. The Government may award one, two or three awards resulting from this RFA to the responsible applicant(s) whose application(s) conforming to this RFA offers the greatest value (see also Section III of this RFA). The Government may (a) reject any or all applications, (b) accept other than the lowest cost application, (c) accept more than one application (see Section II, Selection Criteria), (d) accept alternate applications, and (e) waive informalities and minor irregularities in applications received.

2. The Government may award one, two or three awards on the basis of initial applications received, without discussions. Therefore, each initial application should contain the applicant's best terms from a cost and technical standpoint.

3. Neither financial data submitted with an application nor representations concerning facilities or financing, will form a part of the resulting Grant(s).

P. Authority to Obligate the Government - The agreement officer is the only individual who may legally commit the Government to the expenditure of public funds. No costs chargeable to the proposed Grant may be incurred before receipt of either a fully executed award or a specific, written authorization from the agreement officer.

Q. Non-Financial Commitments - USAID may consider more than financial commitment as a mean of its support. Example, to obtain the maximum public-private

alliance partnership possible an offeror requests that the Cognizant Technical Officer (CTO) and/or the Mission Director to meet annually with the Board of Directors of a corporation or foundation at its HQ somewhere in the world to present the view of the U.S. Government as to how the alliance is performing. The expense would be outside the financing of the award but is a specific request of the offeror e.g., the alliance partner(s).

SECTION II - SELECTION CRITERIA

The criteria presented below have been tailored to the requirements of this particular RFA. Applicants should note that these criteria serve to: (a) identify the significant matters which applicants should address in their applications and (b) set the standard against which all applications will be evaluated. To facilitate the review of applications, applicants should organize the narrative sections of their applications in the same order as the selection criteria. The Technical Evaluation Criteria will look favorably at evidence-based programming and the level of effort made into coordinating activities with other USG partners.

The technical applications will be evaluated in accordance with the Technical Evaluation Criteria set forth below. Thereafter, the cost application of all applicants submitting a technically acceptable application will be opened and costs will be evaluated for general reasonableness, allowability, and allocability. To the extent that they are necessary (if award is made based on initial applications), negotiations will then be conducted with all applicants, whose application, after discussion and negotiation, has a reasonable chance of being selected for award. Awards will be made to responsible applicants whose applications offer the greatest value, cost and other factors considered.

Awards will be made based on the ranking of proposals according to the technical selection criteria identified below. The Regional Agreement Officer in consultation with the Office of Population, Health, and Nutrition will review applications in accordance with selection criteria specified in this Request for Application.

The application must include a description of the organization's technical resources and expertise in HIV/AIDS. This should include a description of the organization history, mission, current and past programming in India, any US Government support received in the past five years, financial management and reporting systems, and experience in developing and managing similar programs of the type required for the awards.

MANDATORY CRITERIA

Applications must satisfy this minimum criterion to be eligible (e.g. responsible) for further consideration.

1. Cost Sharing, Matching Arrangement and/or In-Kind Contribution from the recipient is required. USAID policy does not state a specific minimum or maximum percentage of recipient contribution. However some amount of contribution from non-U.S. Federal sources is required.

"Cost- sharing" means the application presents cash from non-US Federal sources which the offeror will use in the performance of the award. "Matching-Arrangement" means the application presents cash from non-US Federal sources which will be provided at a set ratio (e.g. for every 2 dollars USAID obligates the recipient will provide 1 dollar.) "In-Kind Contribution" means the donation of tangible property (such as computers, medical and lab equipment, intellectual property rights, technology transfer, but excluding real) or services (such as rent, utilities, etc.) provided by the recipient to the Government.

EVALUATION CRITERIA: BEST VALUE

A review panel established under the direction of the Regional Agreement Officer will evaluate proposals. The review panel and the Regional Agreement Officer will use "Best Value" criteria to determine the proposal most advantageous to the U.S. Government. **All evaluation factors other than cost or price, when combined, are significantly more important than cost or price. Technical evaluation factors, and the sub-factors thereof, are listed below. The "Qualification of Key Personnel" significant factor is of the same weight as the "Technical Approach" and "Past Performance" factors when they are combined. All subfactors under each significant technical factor are of equal weight to each other**. **Cost evaluation factors, and the sub-factors thereof, are listed below are of equal weight to each other.** The award shall be made to the responsive and responsible offeror whose combined technical and cost factor offer the best value to the U.S. Government.

If the applicant is responding to more than one component they need to ensure that the technical and cost proposal for each component is separate. The Applicant can highlight though the cost effectiveness or efficiency (i.e. economies of scale) as a result of implementing more than one component if that is the case. If a consortium like arrangement is being proposed the Applicant should clearly state who will be leading which component and the management arrangements. The Applicant is also strongly advised to seek guidance directly from the Regional Agreement Officer prior to submission.

A. Technical Evaluation

1) Qualifications of key personnel

a. Appropriate technical experience for the position proposed;
b. Appropriate educational background for the position proposed;
c. Previous work in the South Asia region, or other background, that demonstrates the ability to work effectively in the position proposed;
d. Demonstrated networks with key stakeholders in India;
e. Ability to work effectively in English and other local languages.

2) Technical Approach:

a. The likelihood that the programs for which funding is sought will make a recognizable, significant and measurable contribution towards achieving the results identified in this RFA. Together with the outcomes identified for the various technical domains, these provide a guide on the nature of programs envisaged. For example, proposed sustainability targets on an annual basis (plan). This would include building the capacity of the indigenous partners. Applicants are encouraged to propose additional indicators as appropriate.

[Comment: Applicants are advised to consult the indicators given by the President's Emergency Plan for AIDS Relief (described in resources available) to make sure that to the maximum extent possible appropriate indicators are used for proposed activities in each of the intervention areas to demonstrate project impact. Note the importance of the indicators linked to activities for which proposals are being requested in judging this criteria. In addition, a proper strategic fit should also take into consideration.]

b. Mobilization Plan. Along with the Technical Proposal the offeror must submit a Mobilization Plan. The mobilization plan will provide details of work to be carried out in the initial 90-day period of the contract. At a minimum, it will cover the anticipated logistics of award start-up and the process and timing of establishing administrative and financial control systems. It will also cover the timing for hiring appropriately qualified local staff, and the plan for the initial activities to be executed by these staff members.

c. Demonstrated existing relationships or the ability to establish such with key Government of India, State Governments and other indigenous stakeholders.

d. Emphasis will be placed on soundness of the proposed technical strategies and responsiveness to the approaches mentioned in the RFA, evidence based, clearly defined and an achievable plan for a rapid program start up, demonstration of leveraging resources, coverage of target populations with planned programming and a coordination plan with other (indigenous) partners in the field.

e. Monitoring and Evaluation plan.

3) Past Performance

a. Offeror demonstrates the relationship between the methods and techniques, which it proposes to undertake in this award and its past performance and experience with similar or related activities;
b. Previous performance for USAID, other donors, or other entities in the health field in India.
c. Demonstrated capacity to manage personnel needs and requirements for a large multi-faceted program operating in India.
d. Demonstrated an effective system for managing sub-grants, joint-venture relationships or any other method proposed for involving the work of other

organizations to carry out the Agreement. Experience of the applicant in transferring technical expertise and management to local partners should be discussed.

(Note: The U.S. Government will evaluate the quality of the offeror's past performance. This evaluation is separate and distinct from the Contracting Officer's responsibility determination. The assessment of the offeror's past performance will be used to evaluate the relative capability of the offeror and other competitors to successfully carryout the program. Past performance of significant and critical subcontractors and other types of partnerships in bidders applications will be considered to the extent warranted by their involvement in the proposed effort.)

The U.S. Government reserves the right to obtain information for use in the evaluation of past performance from any and all sources inside and or outside of the U.S. Government. Offerors lacking relevant past performance history will receive a neutral rating for past performance. However, the proposal of an offeror with no relevant past performance, may not represent the most advantageous proposal to the U.S. Government and thus, may be an unsuccessful proposal when compared to the proposals of the other offerors. The offeror must provide the information requested above for past performance evaluation or affirmatively state that it possesses no relevant directly related or similar past performance experience. The Government reserves the right not to evaluate or consider for award the entire proposal from an offeror which fails to provide the past performance information or which fails to assert that it has no relevant directly related or similar past performance experience.

4) Coordination among Program Components and other USG programs

Applicants must demonstrate that there is effective coordination between the three program components described in this RFA. Although the three components are described as stand alone programs it is expected that there will be a great deal of interaction between and among all of them. It is important to USAID that all programs feed into each other so as to maximize benefits for the overall USG vision.

B. COST EVALUATION

The recipient should have a structure that will allow it to provide the greatest value (highest results) at the lowest cost; minimizing or eliminating overall administrative costs, overhead, subcontract and sub-grant pass-through costs, international staff benefits, home office communications and other administrative support costs. The commitment of the applicant will be measured by the amount of resources and partners planned on being leveraged for proposed activities.

Each offeror's cost proposal of the base program (and options program if applicable) shall be evaluated based on the following criteria in comparison with the cost proposal of other offerors:

1) Effectiveness of proposed cost control structure
a. Budget transparency to effectively track expenditures; and
b. Subcontracting/grant-making methods are clearly defined.

2) Reasonableness of proposed labor cost and structure
a. Expatriate salary structure and expense; and
b. Local salary structure and expense

3) Cost efficiency of proposed Other Direct Costs (ODCs)
a. Offers market competitive pricing estimates of tangible items to be used for performance; and
b. Competitiveness of pricing and sound purchase methods of international and in-country air travel and surface transportation.

4) Amount of cost-sharing, matching arrangements, and/or market value of in-kind contributions proposed.
a. Amount and/or market value from non-U.S. Federal sources; and
b. Amount and/or market value from all sources, if different than "a."

5) Reasonableness of overall proposed Total Estimated Cost.

SECTION III - PROGRAM DESCRIPTION

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(Contracts fill in)

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7. **USAID Funding for the Program**

ACRONYMS AND ABBREVIATIONS

ABC	Abstinence, Be Faithful, Correct and Consistent Condom use
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
BCC	Behavior Change Communication
CA	Cooperating Agency
CBD	Community-based distributor/distribution
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CHP	Care and Health Program
CIDA	Canadian International Development Agency
COP	Chief of Party
CRS	Catholic Relief Service
CS	Child Survival
CSW	Commercial Sex Workers
CT	Counseling and Testing
DFID	Department for International Department
DHS	Demographic and Health Survey
EGPAF	Elisabeth Glaser Pediatric AIDS Foundation
FFP	Food for Peace
FHA	Family Health and AIDS
FS	Field Support
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GOI	Government of India
GIPA	Greater involvement of people with AIDS
HIV	Human Immunodeficiency Virus
HR	Human Resource
HRG	high Risk Groups
ID	Infections diseases
IEC	Information, Education and Communication
JHU	Johns Hopkins University
LTTA	Long Term Technical Assistance
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSM	Men who have sex with Men
MTCT	Mother-to-Child Transmission

NFHS	National Family Health Survey
NGO	Non Governmental Organization
OE	Operating Expense
OR	Operations Research
PHN	Office of Population, Health, and Nutrition
PLWHA	People Living with HIV/AIDS
PEPFAR	President's emergency Plan for AIDS Relief
PMTCT	Prevention of MTCT
PNP	Policy Norms and Procedures
PSC	Personal Service Contract
PSI	Population Services International
PVO	Private voluntary organization
RBM	Roll Back Malaria
RFA	Request for Application
STTA	Short Term Technical Assistance
SACS	State AIDS Control Societies
SO	Strategic Objective
STI	Sexually Transmitted Infections
TA	Technical Assistance
TAACS	Technical Advisors in AIDS and Child Survival
TB	Tuberculosis
UNAIDS	The Joint United Nations Program on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USDH	United States Direct Hire
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

1. BACKGROUND

1.2. HIV/AIDS Scenario in India

India has been battling HIV/AIDS since it was first detected in Chennai, Tamil Nadu in 1986. The number of HIV-infected persons has increased to an estimated 5.1 million, second only to South Africa, which has about 5.3 million HIV infected people. The overall adult prevalence rate in India is estimated to be 0.9 percent, designating a low prevalence situation. However, close to 300 million of the population live in six states designated as high prevalence. The World Bank has estimated that, if the present rate of increase in numbers infected continues, India will have the highest number of HIV-infected persons in the world by 2010.

India's population base of about 1 billion makes the challenge of containing the present concentrated epidemic even harder. India's vast population and the decentralization of government services to the states is a major challenge to HIV/AIDS prevention and control. The second decade of the epidemic (1996-2006) has been marked by

heterogeneity, simultaneous sub-epidemics and wide regional variations in prevalence, for instance, the predominately heterosexual epidemics in the southern states of Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu, and an IDU epidemic in at least two Northeastern States, Manipur and Nagaland. The number of high-prevalence districts increased from 45 in the 2003 national sentinel surveillance report to 111 in 2004 as defined by antenatal prevalence, indicating expanding vulnerability to the spread of the epidemic. The epidemic continues to shift towards women and young people with an accompanying increase in vertical transmission and pediatric AIDS. It is estimated that now, 60 percent of infected people are in rural areas. Based on results from the sentinel surveillance system, the National AIDS Control Organization (NACO) has concluded that in some states HIV is "percolating from various at-risk groups to low-risk groups", and in most States the epidemic is moving into the rural areas.

According to the NACO, 111,608 AIDS cases were reported as of July 31, 2005. As this is a passive surveillance system, AIDS cases are substantially underreported nationally. Among reported cases, more than 45 percent are from the state of Tamil Nadu.

1.3. The Government Response

A National AIDS Committee was constituted in 1986, shortly after the first case of AIDS was identified, and the National AIDS Control Program was launched in 1987. The Government of India established the National AIDS Control Organization (NACO) in 1992. The emphasis of the first phase (1992-1999) of the national program was on generating awareness, improving blood safety and capacity building. By 1999, the GOI initiated the second National AIDS Control Plan (1999-2004) with a $191 million loan from the World Bank. This phase focused on encouraging and strengthening responses at the State level through a decentralized program that focused on those at greatest risk of infection, preventive interventions for the general population, provision of low cost care, institutional strengthening and capacity building.

A National AIDS Council, based in the Prime Minister's Office, was constituted in December 2004 which has multi-sectoral representation from government ministries, NGOs, and other stakeholders, including the national network of HIV-positive people. The GOI, supported by multilateral agencies and donors, has launched planning for the third National AIDS Control Plan, 2006-2010. USG participation in NACP3 has informed the development of the USG strategy.

Sentinel surveillance efforts were started in the late 1980s by NACO and the system was formalized in 1994, with 55 sentinel sites, primarily in urban antenatal sites. The program was expanded in 1998 to 180 sites and to 670 sites by 2004. Data are collected from STI clinics, antenatal clinics, and at-risk groups such as IDUs and MSM. The GOI has also established an ongoing system for behavioral surveillance.

1.4. USAID HIV/AIDS Programs

In May 2005, India was included as one of the five priority non focus countries under PEPFAR. It implies that there will be a common USG HIV/AIDS strategy for the country and all USG agencies including USAID will support the strategy. There will also be a common annual country operational plan for the USG agencies. All funds received by USAID and provided to different agencies will be included under the PEPFAR umbrella and will be subject to PEPFAR guidelines for planning, resource allocation and reporting as they may be applicable in different situations. The USG's program in India is similar to a regional program in the size of populations addressed, the socio-economic and cultural difference between states, the different HIV/AIDS epidemics, and the need to work with separate government bodies in each state. USAID's interventions have been primarily focused in the States of Tamil Nadu and Maharashtra, which account for over 60 percent of all of India's HIV-infected cases. Combined, the population of Tamil Nadu and Maharashtra exceeds 159 million (or about 16 percent of India's total population) which is larger than all but 6 countries world-wide. The USG has been one of the largest donors to HIV/AIDS prevention and control activities in India, providing approximately $30 million in resources in FY05.

The bilateral programs are USAID assistance for HIV/AIDS to the Government of India which include the AIDS Prevention and Control (APAC) Project in Tamil Nadu and Pondicherry and the Avert Project in Maharashtra. These projects were created as bilateral models for USAID HIV assistance. The APAC Project, the first major state-wide intervention in India, started in 1995 in Tamil Nadu, targeting high-risk behavior groups with HIV prevention interventions based on extensive behavioral research. The project, which works with over 70 NGOs, has developed innovative methodologies for NGO capacity-building. The Avert Project in Maharashtra, started in 2001, similarly focused initially on HIV prevention. Both projects are now strengthening and scaling up care and support activities while continuing prevention interventions.

USAID currently also supports through Population Services International (PSI) an innovative program of HIV prevention in 12 port cities, which combines communication initiatives with VCT and STI services and an HIV/AIDS hotline. USAID's program through FHI for Orphans and Vulnerable Children (OVC) - known in India as Children Affected by AIDS (CAA) – is the largest intervention with OVC in India, and provides psychosocial care, support for education and livelihood support to over 34,000 children infected or affected by AIDS. USAID, through CARE India, works in four highly vulnerable states and Delhi to carry out interventions with high-risk groups and urban youth, and to integrate HIV into reproductive health programs in rural villages. USAID also supports Johns Hopkins University for communication interventions and the Policy project for policy related work. USAID supports the Program for the Advancement of Commercial Technology/Child and Reproductive Health (PACT/CRH), which provides financial support and technical assistance to the Indian commercial sector to expand condom marketing and development/marketing of such new products as HIV and STI diagnostics.

1.5. Other USG agencies

CDC/GAP is conducting a program to strengthen diagnostics, health information systems and capacity; and provides training to health workers in HIV/AIDS care and treatment. HHS/CDC-GAP key program areas include building capacity for HIV/AIDS prevention, treatment and care; strengthening infrastructure for training in HIV/AIDS treatment and care; and strengthening the local and national response to HIV/AIDS in India. CDC/GAP funds home and community care projects that are being implemented in the predominantly rural Salem District, Tamil Nadu, in urban slum areas of Pune in Maharashtra State, and more recently in Andhra Pradesh, Manipur and Nagaland. CDC/GAP also provides direct technical support to the GOI.

The National Institutes of Health (NIH) has been supporting HIV/AIDS research in India for many years. Areas of research covered include HIV clinical trials, basic and vaccine research, and HIV prevention and behavioral research related to MSM, HIV related infections, MTCT, sero-epidemiology, stigma, and truckers. The Department of Health and Human Services (HHS) plays a leading role in supporting the Indo-US Vaccine Action Program. In addition HHS is working with the US Federal Drug Administration (FDA) to guide Indian manufacturers through the FDA expedited review process for ARVs.

The US Department of defense through the Office of Defense Cooperation (ODC) give technical assistance to the GOI Ministry of Defense, including assistance in upgrading laboratory and clinic facilities, and technical training. The Department of State's INL Office provides assistance to the GOI to control licit and illicit narcotic and psychotropic drugs, both used by India's IDU population.

The USG has also provided funding from Washington-based projects to support HIV/AIDS interventions in India. The Elisabeth Glaser Pediatric AIDS Foundation (EGPAF) was funded to assist in scaling up Prevention of Parent to Child Transmission (PPTCT)[1] under the GOI and Global Fund Initiative. The Department of Labor is funding a major project with the International Labor Organization to reach labor unions in four states in India; the project collaborates with USAID's program in Maharashtra.

1.6 Other Donor Responses

A number of bilateral agencies and multilateral organizations such as the World Bank, the Global Fund for AIDS, TB and Malaria (The Global Fund), UNAIDS and UNICEF are supporting the national HIV/AIDS program. The World Bank, Dfid, Bill and Melinda Gates Foundation and USG are currently the largest donors. A large number of bilateral and foundation donors provide smaller amounts of funding.

The Global Fund provided several grants to GOI of about $390 million to strengthen and expand the GOI's existing HIV/AIDS, TB and Malaria control programs. The Global Fund grants will focus in establishing a comprehensive care package for HIV prevention and care for mothers, their families and PLWHA through scaling up PMTCT services and

[1] Prevention of Mother to Child Transmission in India is termed Prevention of Parent to Child Transmission (PPTCT) to stress both parents' role.

public private sector antiretroviral treatment; accessing the Antiretroviral treatment to HIV/AIDS infected persons in six high prevalence States and NCT Delhi; and expanding effective public and private sector intervention in HIV and TB prevention and treatment in India.

UN agencies supporting the national program include WHO, UNICEF, UNDP, ILO and UNAIDS. UNAIDS provides assistance to the National AIDS program through advocacy, capacity building, and social mobilization. UNDP is working in the area of mainstreaming HIV/AIDS. The ILO, funded by USG, works with unions and the corporate sector to promote workplace interventions. UNICEF heads the sub-group on Communication and Advocacy and is providing technical leadership in PPTCT.

DfID's program supports targeted intervention activities with high-risk groups and capacity building of State AIDS Control Societies in the states of West Bengal, Kerala, Andhra Pradesh, Gujarat and Orissa. DfID has extended the program to fund activities in Uttar Pradesh and Bihar. DfID is also contributing to the HIV component of NFHS 3 and supports IEC/BCC activities through the BBC World Service Trust.

The Bill and Melinda Gates Foundation (BMGF)'s Avahan Project is a five-year $200 million program that focuses on implementing targeted interventions among high risk groups (sex workers and their clients, truckers, IDUs, and bridge populations) in over 70 high prevalence districts in six high prevalence states.

The William J. Clinton Foundation provides technical assistance in the development and implementation of comprehensive plans for scaling up treatment and care, including training, monitoring and evaluation, laboratory capacities, and assistance with community mobilization efforts.

1.8. Program Strategy and Objectives

The President's Emergency Plan's approach to global HIV/AIDS is focused, coordinated and accountable for results. It capitalizes on expertise and the strengths of partnerships with host governments, multilateral institutions, nongovernmental organizations and the private sector.

Some of the main strategic principles of the Emergency Plan are:

- New and more effective ways to fight the HIV/AIDS pandemic including leveraging funds
- Evidence-based policy decisions
- Accountability for results
- Implement programs suited to local needs and host government policies and strategies
- Develop and strengthen integrated HIV/AIDS prevention, treatment and care services
- Employ preventions lessons learned from the "ABC" model

- Combat stigma and denial
- Involvement of PLHAs
- Encourage and strengthen faith based and community based organizations

1.9. Useful Resources

USAID recommends that applicants become familiar with the following resources:

1. USG HIV/AIDS strategy (2006-2010)

Annual reports of current USAID projects in the area of HIV/AIDS
- APAC www.apacvhs.org
- Avert www.avertsociety.org
- PSI www.psiopl.org
- FHI www.fhi.org

NACP 3 strategic priorities www.nacp.nic.in

PRESIDENT'S EMERGENCY PLAN strategy
www.state.gov/s/gac/rl/or/c11652.htm

2. DETAILED TECHNICAL REQUIREMENTS

2.1. Activity Description

2.1. 1. Overview

The new activity will support the Strategic Objective 14 of USAID, "Improved Health and Reduced Fertility in Targeted Areas of India" and the IR 14.2 "Increased use of prevention, and care and support interventions to prevent/mitigate HIV/AIDS." Activities implemented through the new agreement/s will support and complement the priorities highlighted by the National AIDS Control Program in the NACP 3, and the President's Emergency Plan guidance (see useful resources above). The program will also support the "Three Ones" principle (i.e. one national authority on HIV/AIDS, one strategic framework and one Monitoring and Evaluaiton plan) of UNAIDS and the US Government aimed at co-ordination and harmonization of the country's response to HIV/AIDS.

The President's Emergency Plan provides a holistic vision for combating the HIV epidemic and using the principles of leveraging, local capacity building, coordination and evidence based programming will be the defined priorities for this program. The specific activities will build on the lessons learned from current USAID-funded activities to replicate good practices. The proposed new activity will replicate and consolidate current activities strategically to ensure maximum impact. The comparative strength of USAID remains in the development of models of excellence such as the APAC project. Through

such model programs, USAID expects to demonstrate best practices, which could then be taken forward by other partners and the governments. It is very important that all programs are based on evidence and mid course corrections are made based on new information and priorities. Leveraging with other partners including other USG activities must be demonstrated. Even though USAID wants to emphasize the importance of ensuring a continuum of prevention, care and support and treatment for the client, it is not expected that the applicant will implement each of the activities. Instead it is expected that the Applicant will coordinate and leverage resources with other partners and ongoing activities through a network model to ensure that the clients are receiving the complete package.

Long-term sustainability will depend on strong indigenous organizations and government structures. Capacity building and institutional strengthening at all levels will be an overarching theme for program activities. Skill development of civil society members, policy makers, private sector players and other stakeholders will be crucial in enhancing program outcome in the long run.

Changing priorities requires that USAID build new alliances and partnerships to leverage a variety of resources. The very nature of the HIV/AIDS epidemic requires active participation of the private sector and USAID believes that the time is right to build stronger alliances with the private sector and other important players such as the Global Fund. Active engagement and support of the National and State governments is considered critical to sustain the program benefits over time. Capacity building of indigenous organizations, technical assistance to various government bodies and training of officials is also an integral part of the USG strategy.

This Request for Assistance (RFA) is being used to structure new awards in the three areas specified above including implementing a comprehensive program in a new State (Andhra Pradesh or Karnataka), developing new leveraging private sector programs and providing technical assistance.

Applicants are encouraged to be creative in developing proposals to address the three components described in the following pages. An example is using comparative strengths of several organizations to develop a consortium, which supports all the components. Organizations can also submit proposals to address only one component based on their expertise and experience. It is also possible that Applicants may submit an independent proposal for one component and as part of a consortium for other components. This RFA may lead up to three separate awards, one for each component. USAID is open to separate awards for each component or a combination. It is possible that an applicant may want to work in more than one component and could send a consolidated proposal addressing different components. All strategies listed with each component are only expected to be illustrative and the Applicant is not expected to use only those strategies specified in this scope of work.

The three components for this RFA include:

Component 1: Designing and managing a comprehensive program addressing prevention, care and support and treatment in a new high prevalence State.
Component 2: Leveraging and building public and private alliances.
Component 3: Providing technical assistance, capacity building, training and institutional strengthening support.

2.1.2. Overall Program Approaches

USAID has identified some program approaches, which are expected to be common to each component. They will form the guiding principles for Applicants around which the program is designed and implemented. The Applicant/s for each of the awards is/are strongly encouraged to consider the following principles in developing their proposals.

a. Evidence Based Programming

All program activities will be guided by field based evidence and should be monitored to ensure that new evidence is used to do mid course corrections. Evidence based programming refers to determining program interventions not only on data on HIV prevalence alone, but also consider existing programs and partners and the response. This strategy will assist in developing critical interventions, which address gaps and do not duplicate efforts. As stated in the Emergency plan the USG programs will make policy decisions, which are evidence based.

b. Gender Considerations

Gender will play an important role in the design and implementation. The recipient will promote an analytical and proactive approach to ensure that program activities address gender issues and constraints determining sexual and other behaviors.

In accordance with USAID's recognition that gender issues are important considerations in development, applicants should look for gender implications or opportunities in the program, seeking to address embedded gender issues and promote gender equity as appropriate in all its activities and internal management. Proposals should make best efforts to define gender-based barriers especially stigma to achieving the tasks outlined in this program description. The program will provide equal access to male and female, youth and older people for participation in the program activities. This position will be reflected in all components and program activities.

c. Leveraging and coordinating Resources

Opportunities to coordinate with or capitalize on the comparative advantages of the other partner organizations (DFID, UNICEF), private foundations (Gates and Clinton), the Global Fund or other networks to implement comprehensive prevention, care and support and treatment program will be considered an important part of any proposed strategy. The Emergency plan clearly articulates the need for leveraging resources from other partners including the Global Fund in India. Applicants will demonstrate in their

proposals how they intend to build synergies and leverage resources with existing activities to ensure a continuum of prevention, care and treatment activities for the target population. Decisions on which activities will be implemented will be based on knowledge of what other partners are doing (to avoid duplication) as well as creating programmatic links with activities undertaken. In particular, U.S. Government policies do not permit certain program interventions such as needle exchange. Compliance with USG policies and Congressional mandates is non negotiable. In these areas, reliance on implementation by other organizations will be paramount. Furthermore, strategically targeted activities will be encouraged by the USG rather than general approaches.

d. Linkages with the National AIDS program

It is expected that the new activity will support program priorities envisioned by NACO, complement the programmatic focus of APAC and Avert and provide technical assistance when needed. Working with the government is considered crucial to the success and ultimate sustainability of the program. USAID expects that the recipient(s) will use creative approaches to work with the government bodies at the national, state and district level. Interventions should be complementary to the national and state HIV control programs, and complement (as well as develop appropriate linkages to) other prevention, care and support and treatment interventions. Applicant(s) should demonstrate past and present strategies used in working with the National and State governments.

e. Mainstreaming

The Emergency Plan emphasizes the need to mainstream HIV/AIDS activities. Applicants are encouraged to i) explore mechanisms to mainstream HIV/AIDS with other technical areas, within and outside USAID such as reproductive health, urban health, education, child survival, anti-trafficking in persons and nutrition, ii) create institutional links with a variety of institutions such as Railways, Transport, Aviation, Tourism and other institutions to reach out to high risk groups or bridge populations, and iii) develop cross linkages with ongoing USAID programs in the area of HIV/AIDS. Many opportunities exist for linkages outside the health sector to improve the livelihoods of those infected and affected of HIV/AIDS. Applicants are encouraged to illustrate how they will network with other activities with these initiatives.

f. GIPA

Programs will actively promote the principle of Greater Involvement of People Living with HIV/AIDS (GIPA) to ensure that PLWHAs are actively involved in program design and implementation. All interventions including communication interventions will also address stigma and discrimination, positive living, and community involvement in care and support. It is important to strengthen and promote “Prevention for Positives” programs to improve the health of PLWHA and interrupt HIV transmission especially among discordant couples. The Emergency plan also emphasizes the need to seek the involvement of people infected with and affected by HIV/AIDS as they can make unique

contributions in identifying their needs, testifying to program effectiveness, advocating for an improved response, and combating stigma and discrimination.

The Applicants' proposal should describe how they will plan to empower national, state and district level PLWHA organizations, nascent local PLWHA organizations and organizations for women living with AIDS. Planned activities should focus directly on building and strengthening such networks. It could include technical support for advocacy efforts, including legal protection for PLWHA organizations and providing PLWHA with opportunities as educators and spokespersons for prevention messages.

G .Local Capacity Building

USAID/India recognizes that many indigenous national, regional and faith-based NGOs have the networks and infrastructure to create a robust platform to expand prevention, care and support programs but still gaps remain. The recipient will make every effort to build and strengthen the technical and organizational capacity of Indian government entities and the non-government partners, CBOs, FBOs and other institutions to design, implement, measure and replicate prevention and care and support interventions. USAID will emphasize the sharing of information and technical assistance among NGOs working in the same thematic area to promote uniform adoption of best practices and lessons learned.

Areas of capacity building will be identified by the recipient and technical assistance (TA) and/or training will be developed and tailored to the specific needs and audiences. An illustrative list of TA includes:

- Counseling skills;
- Social support and care of PLWHA;
- Peer Education;
- Organizational development such as grant writing, financial management, information management and analysis and strategic planning;
- Design, monitoring and evaluation of HIV/AIDS prevention programs for special risk groups;
- Basic principles of behavior change communications programs for HIV/AIDS prevention based on the ABC approach and outreach techniques.

h. Documentation and Dissemination

Active learning is an important strategy to combat the epidemic of HIV/AIDS. The recipient will document approaches, strategies and learning through different methods. The Applicant should clearly discuss the strategies for documentation and dissemination in its application and elaborate their plans to leverage lessons learned with the government and the donor community stakeholders.

All of the above approaches are expected to be common to each of the three components described below and the Applicant is encouraged to use them in the design of their proposal.

2.2. COMPONENT ONE: COMPREHENSIVE HIV/AIDS PROGRAM IN NEW STATE

USAID encourages promoting the network model proposed by The Emergency Plan with the aim of providing a complete package of appropriate prevention, care and treatment services through implementation linkages and leveraging. Previous experience shows that dispersed activities do not contribute to the overall goal of reducing HIV/AIDS and USAID expects the new activity will concentrate efforts to make greater gains through innovative and client centered approaches.

Combating HIV/AIDS will require creative thinking to ensure that prevention, care, and treatment activities are not compartmentalized. The Applicant needs to demonstrate that their plan has identified current activities and gaps by location so that programs address those gaps. It is not expected that all activities will be undertaken in all districts but be based on what other partners may be already doing and other need-based evidence. The strategies suggested below are only meant to be illustrative and Applicants are encouraged to suggest and use other strategies based on their experience and knowledge of the field.

2.2.1. Prevention

2.2.1.1. Targeted Interventions for High Risk Groups (HRG)

The program will develop targeted interventions based on evidence to address HRGs, including but not limited to, sex workers, male and female, MSM, IDUs, and Migrants. In working with sex workers, it's expected that activities will continue to seek synergies with anti-trafficking programs such as providing opportunities for education and training for their children to help prevent second generation sex trafficking and also seek alternative livelihood operations. The Emergency Plan has highlighted that experience elsewhere has shown that a balanced and appropriate 'ABC' approach to HIV/AIDS prevention is effective. This approach promotes abstinence (A), being faithful to one partner (B), or the correct and consistent use of condoms (C). Programs will emphasize that there is an appropriate mix of messages for respective target populations.

The target population includes, but is not limited to:

Women in Prostitution: There is a large and diverse sex industry in India. Access to the sex industry presents a challenge to effective intervention, since it varies from city to city.[2] Sex-workers are frequently isolated, stigmatized, fearful of authority, and therefore hard to reach. They tend to stay away from health clinics and services – both government

[2] Sex workers in Mumbai are found primarily through a network of brothels, Sex workers in Chennai are found through private homes and are integrated into the community.

and NGO – that are not familiar with their needs. Many different approaches are therefore required to meet their needs for prevention, care and support and treatment services.

Men Who Have Sex with Men (MSM): Reports indicate that there is a varied high-risk MSM behaviors existing in the communities. Many MSM also have sex with women, and few identify themselves as gay or bi-sexual. However, due to high stigma, MSM often do not go to government health clinics for services or patronize NGO clinics and services, unless the NGOs specifically targets MSM. Additionally, reaching *hijras* (eunuchs) who sell sex, either full-time or in addition to other employment, requires different strategies.

Injecting Drug Users: There are a number of behavior change approaches to reducing transmission of HIV through injecting drug use. If an IDU cannot or will not stop injecting, interventions should be focused on changing risk behaviors such as not sharing equipment and using condoms with all sexual partners. In addition, anti-drug campaigns can be supported to increase public awareness on drug abuse and to generate more support for the provision of information and services to those that need them. Present USAID policy restricts use of USG funds for purchase of needles and syringes.

Examples of program interventions to address this include:

Behavior-Change Communication (BCC) will include programs to enable high-risk individuals to know about HIV/AIDS and how to protect themselves and their partners, negotiation skills, learn their sero-status, and cope with HIV infection. Activities will include peer education, outreach to clients, life skills demonstrations and training tailored to particular needs and circumstances of specific high-risk groups to increase knowledge of risk and risk reduction skills. All BCC activities will use the ABC model focusing its messages on appropriate groups.

The applicant shall describe their approach to increase coverage of the most vulnerable, high-risk populations with effective, high-quality interventions addressing risk reduction and healthy behaviors, which would lead to increased knowledge, reduced risk behaviors, and decreased HIV transmission. The objectives of BCC would include awareness, demand generation for services, community mobilization and advocacy. Generic mass media campaigns have not proven to be cost effective in HIV/AIDS and will not be considered high priority.

Condom Promotion: Interventions will encourage and increase condom use for the prevention of HIV among all high risk groups. Under this award, USAID also seeks to support an increased access and demand for and use of condoms among HRGs. This may include piloting ways to increase access to and acceptability of condoms among HRGs such as social marketing, working with condom manufacturers and other innovative ways to increase access to condoms.

Sexually transmitted infections (STIs) impose an enormous burden of morbidity and mortality. USAID will provide support to improve STI services and referral mechanisms between STI care providers and HIV services. Coordination with existing STI programs supported by other partners will be critical to increase outreach and leverage resources in the identification, care and treatment of HIV+ individuals. STI services will act as an entry point for referral to Counseling and testing (CT) for HIV/AIDS. However, the Emergency plan promotes use of resources for STIs if they can be clearly demonstrated to have clear links with HIV/AIDS programs. Generic strengthening of STI control, programs are not promoted using HIV/AIDS resources, although STI control is an important disease control program otherwise.

Counseling and testing (CT): CT is an essential component of an HIV/AIDS prevention and control program. People who are counseled and tested change their behavior in ways that lower rates of HIV transmission. Those who test negative tend to adopt protective behaviors to maintain their negative status. Accessible CT services reduces HIV stigma and encourages community support for those affected. CT also provides an essential early entry point to social support services and associated care for those infected with HIV. Outreach, prevention, and care and support services can be delivered effectively only within a supportive environment. USAID would support program activities in the new grant to increase the number and quality of counseling and testing centers and strengthen referrals of CT with care and support services. Many of the existing BCC programs have weak or non-existent links with CT and STI services. It is important to improve the quality and accessibility of these services, their links to follow-up care, and monitoring the efficacy of referrals. Programs will be as closely linked as possible to the State AIDS Control Societies (SACS) and district level health services to increase opportunities for institutional capacity-building and skills training

Illustrative Outcomes:

1. Increase in the condom used by targeted groups as seen through increased number of condom service outlets, individuals reached, condoms sold and persons trained,
2. Improved counseling and testing services for targeted groups through increase in the number of men and women tested and counseled and results received, number of outlets providing counseling and testing, number of individuals provided counseling and testing and the number of individuals trained to provide counseling and testing according to national standards.
3. Increased number of persons provided care and support.

Note: Specific target amounts are to be proposed by applicants.

2.2.1.2. Interventions for the General Population especially targeting Youth

Campaigns targeted at the general population will be developed to ensure that awareness of counseling and testing services is increased. The focus here will not be on general awareness messages. Youth groups will be specifically targeted with A and B messages.

Youth who are considered to be at high risk (OVCs, clients of sex workers) will be targeted for delayed sexual debut and abstinence/return to abstinence; the sexually active general population will be targeted for faithfulness to one partner interventions. Counseling and age appropriate education about HIV/AIDS, as well as other services to prevent drug abuse and movement into sex work, are key prevention strategies for this group.

Interventions with youth should address the gender and power issues that place both young women and young men at risk of infection. The activities will review activities to ensure that there is increased public awareness of the ABC message mix. The program will need to support the development and testing of school-based prevention programs. In addition, programs to train teachers and parents to effectively deliver prevention messages need to be explored. USAID/India will continue to support and scale-up interventions to reach youth and youth-focused efforts within its broader HIV/AIDS prevention activities. There will be particular emphasis on incorporating AB messages into the interventions the Mission is supporting. The ABC approach will also be integrated in all communication campaigns and programs.

Some of the strategies will be similar to those described for high-risk groups but the focus and approach will differ. BCC activities will focus on expansion of advocacy activities for prevention interventions and education, psycho-social skills in critical thinking, communication, decision making, self awareness, negotiation and life skills for adolescents/youth in and out of schools. Help-lines is another strategy USAID would support activities to promote for increasing access to care and support for PWLHA. The Help Lines will target the general population and also the high-risk groups identified earlier.

Illustrative Outcomes:

1. Increase in the number of youth delaying sexual debut.
2. Reduction in the number of sex partners.
3. Increase in the number of youth who are sexually active getting counseling and testing services.
4. Increased awareness among the general population of counseling and testing services.
5. Parents and teachers trained on delivering prevention messages.
6. School based prevention programs implemented.
7. Increase in the number of persons referred for care and support services.

Note: Specific target amounts are to be proposed by applicants.

2.2.2. Care and Treatment

Scaling up facilities for care and treatment of PLWHA and their families is an essential and urgent task. The programs so far have primarily focused on prevention. There are few initiatives, hospitals, NGOs and institutions providing care, only a limited number of

trained providers willing to treat patients with HIV and insufficient community-level programs to follow-up and refer PLWHA regularly. Private sector institutions to date have not been fully engaged in the response, and need to be more engaged. The GOI and some SACS have committed to increasing service coverage at primary and secondary health service levels, but scaling up good quality care and treatment will be a major challenge over the next few years. The scale up of ARV treatment is slow with only a limited number of institutions providing good quality treatment. There is a need to strengthen all aspects of service delivery, from policy issues to community-based support, as briefly described below.

There are opportunities to expand linkages between prevention and care, to strengthen follow-up and linkages to care from CT, and to provide better means to track linkages between patient treatment and community-support programs. Faith based organizations (FBOs) and their contributions to care and support are under-recognized; their activities need to be strengthened and their potential role expanded and replicated more effectively. The involvement of PLWHA in care and treatment programs is weak and underutilized, as are PLWHA organizations. Coordination with other USG efforts especially CDC in this area will also be emphasized.

Stigma and discrimination remain strong barriers to prevention and care, particularly for women. Positive women find it harder to access care and may be thrown out of the household or deprived of property. Reduction of stigma will continue to be a priority in prevention and care and support activities.

Understanding the long-term treatment and care needs of the patient from the time of HIV diagnosis onward is needed. There is a need to ensure that there are adequate linkages between prevention, care and support and treatment delivery followed by care and support including adherence to treatment. One without the other will not provide effective benefits. Treatment and care and support efforts initiated by CDC will be an important resource for replication as needed. A multidisciplinary approach that includes medical, psychological and social services with strategies to guarantee high levels of patient adherence to prescribed medical regimens is seen to be important. In addition to building technical capacities in AIDS treatment, provision of care and support for those who infected with HIV and who have developed AIDS is essential. All these will require training and involvement of non-judgmental, skilled providers with knowledge of counseling services and ARV treatment protocols. Emphasis will be put on training and capacity building of health providers and community organizations to provide care and support. CDC has been particularly effective in this area and their expertise will be sought.

2.2.2.1. Interventions for care and support of adults

Examples of strategies to address this sub-component include the following. However, the applicants are expected to suggest their own evidence based strategies.

Community based care: The program will strengthen and facilitate quality home based care and psycho-social support in communities, improve access to health services and increase the involvement of community members in the care and support of PLWHA, as well as support indigenous associations of PLWHA and other organizations working with infected and affected individuals in provision of home-based and other care and support programs. The applicant will demonstrate strong linkages with other USG programs including CDC to ensure appropriate clinical services.
Support to PLWHA networks: The program should include support for PLWHA associations to provide home-based care (HBC) training and procure the provisions necessary to implement basic HBC to PLWHA and their family members.
Referrals to network models: There is a need for effective referral systems and linkages between different sections of the health system. There are opportunities to expand linkages between prevention and care, to strengthen follow-up and linkages to care from CT, and to provide better means to track linkages between patient care and community support programs.
Counseling and Testing: There needs to be a continuum of counseling including pre-post test and follow up for those who test positive or negative. Counseling targeting family members will be important for care and support. Creative marketing approaches will be applied to accelerate coverage of CT services.
Job creation and skill training: People Living with HIV/AIDS need access to employment. This is a concern, given an environment of acute stigma and discrimination. Programs encouraging creation of livelihood opportunities through strategic interventions will be developed.

Illustrative Outcomes:

1. Increase in number of programs providing community services and number of people provided HIV-related community services.
2. Increased number of outlets providing non-ART, non TB/ HIV clinical care to HIV+ people.
3. Increased number of people provided non-ART, non TB/ HIV clinical care.
4. Increased number of people/ providers/ caretakers trained to provide, HIV related community services, clinical prophylaxis and/or treatment for TB to HIV+ people, caring for OVC and non-ART, non TB/ HIV clinical care.
5. Enhanced capacity of community, local and state organizations in providing prevention and care and support services for HIV/AIDS.
6. Links established to programs that do provide ART and TB services

Note: Specific target amounts are to be proposed by applicants.

2.2.2.2.. Interventions for care and support of children

Presently, the government, donors, and NGOs are providing support to OVCs to a limited extent. The urgency of scale-up of the response to address the needs of children orphaned by AIDS and other vulnerable children at high risk of contracting HIV are well recognized. Child centered approaches will form the basis of all activities. OVC services

should emphasize retention/reintegration of children in family and community life, with institutions only "a solution of last resort." The applicant will illustrate how the network will provide care and support to meet both the psychosocial and material needs of OVC, while ensuring the OVC participate in defining their needs. USAID's experience in working with OVC suggests that it is important to focus and integrate its efforts for best results. For this reason, USAID will ask that applicants ensure that OVC activities are integrated with others' efforts.

Strategies to address this component include:

Community Care: Support should be centered on family and community mechanisms as opposed to institutional care. Activities should emphasize strengthening communities to meet the needs of orphans and other vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents to meet their own needs, and creating a supportive social and policy environment. This program will develop activities to increase the capacity of communities to identify vulnerable children and to design, implement and monitor their own OVC community and faith-based support activities.

Life skills education: Programs working with children will offer targeted life skills education programs. Such programs enable children to develop healthy lifestyles and enhance their coping skills.

Counseling: Given the strong stigma against HIV, effective counseling programs are critical for behavior and attitude change among those affected by HIV.

Linkages with the network system: Programs should encourage strong linkages to strengthened clinical care and support services and contribute to overall monitoring for quality of care. USAID expects that the activities will assist in integrating OVC support with home-based care, CT and PMTCT prevention programs.

Mainstreaming: Regardless of projected reductions in HIV transmission, the number of orphans will continue to rise over the next decade. Without access to food, shelter, and essential services such as education and health care, this population of children is acutely vulnerable to a host of dangers, including HIV/AIDS. The recipient will support NGOs and FBOs to develop linkages or referrals to financial assistance, healthcare, legal aid and housing.

Illustrative Outcomes:

1. Increased number of vulnerable children with access to community support.
2. Increased number of community initiatives and community organizations providing support to care for OVC.

Note: Specific target amounts are to be proposed by applicants.

2.2.2.3. HIV and TB and Other Opportunistic Infections

Since the most common opportunistic infection of HIV/AIDS is tuberculosis, stronger linkages with the National TB program are essential as integrated services are generally

unavailable. Patients who are co-infected with HIV and TB must be provided TB services. Ultimately, all TB patients should be screened for HIV/AIDS and vice versa. While complicated by issues of heightened stigma, those co-infected with HIV and TB face the same challenges as other TB patients. While limited data on co-infection are available, the systems themselves present an urgent need for reform. Linkages between counseling and testing centers and microscopy centers will need to be made more effective. It is important that there those tested positive for TB are also encouraged to be tested for HIV and those patients testing positive for HIV are able to access TB services.

The applicant shall describe its proposed approach to support HIV case finding among people with TB and of TB among people living with HIV/AIDS (PLWHA) and those at high risk of HIV infection.

Illustrative Outcomes:

1. Increased number of outlets providing clinical prophylaxis and/or treatment for TB to HIV+ people.
2. Increased number of HIV + people attending HIV/care/treatment also being treated for TB.

Note: Specific target amounts are to be proposed by applicants.

2.2.3. Treatment

Treatment is the third and equally important link to combating HIV/AIDS. USAID/India would support interventions to better incorporate this area into its programs. The recipient is expected to identify and facilitate linkages prerequisite to appropriate referral of HIV infected persons to care and treatment and from clinical settings into home based care. It will target the large and unengaged private health care sector to facilitate the transition of HIV infected persons into a successful outpatient model of HIV care.

2.2.3.1. Strengthening Program Linkages with Prevention and Care

The strategy will work at several levels to strengthen linkages, including coordination with State and District AIDS Control Societies, linkages with TB, STI, MCH, and RH services; strengthening hospital outreach and home care services; and ensuring that prevention NGOs have complete information and training for timely referrals. As CT services are expanded, referral systems will be evaluated and strengthened as necessary. Some highly vulnerable populations, including prostitutes, IDUs, and MSM are under-represented in the patient population at the Government Hospitals. The recipient will devise strategies to strengthen the linkages between NGOs working with these groups and ART services in order to increase the number of referrals. Health department staff will be trained in establishing and maintaining effective linkages between community outreach programs and other referral services. Activities will include negotiating with other service providers (such as pharmacies, CT, care and treatment facilities) and establish links to enhance benefits for clients. It is important that the client is the most

important stakeholder for all services so that prevention messages also link the client to the testing, which has linkages with care and support along with follow up and finally treatment.

Illustrative Outcomes:

1. Increase in the number of linkages created between HIV+ persons and treatment centers.
2. Increased adherence to the treatment.
3. Increase in follow up care and support for PLWHA under treatment.
4. Increased number of health workers newly trained in providing health care.
5. Increased number of positive persons on ART.

Note: Specific target amounts are to be proposed by applicants.

2.2.3.2. Laboratory and Equipment Support

USAID has not been engaged in this area in its current programs and plans to build some engagement where it sees comparative advantage and can links to goals of other programs. USAID foresees providing capacity building programs for laboratory staff especially in the private sector. Other USG agencies like CDC have expertise in this area and the applicants will work in collaboration with those agencies.

Illustrative Outcomes:

1. Improved capacity in selected laboratories for improving services, diagnosis, monitoring and information gathering.

Note: Specific target amounts are to be proposed by applicants.

2.2.4. Cross Cutting Interventions

2.2.4.1. Policy and Advocacy

State and local policies are a critical factor influencing the success of any program. The program will support advocacy efforts to improve the policy framework for reducing HIV/AIDS.

Advocacy campaigns to support the rights of PLWHA will be important both for stigma reduction and care and support. Faith based organizations need to be mobilized and adequate workplace policies supported. Advocacy efforts will be supported to get greater buy-in from different religious groups.

Illustrative outcomes

1. Improved government policies supporting reduction of the HIV/AIDS epidemic.

2. Advocacy efforts to improve human resource policies in the work place.
3. Protection against stigma and discrimination, particularly within key settings such as workplaces and schools.
4. Religious forum established for delivering HIV/AIDS messages.

Note: Specific target amounts are to be proposed by applicants.

2.2.4.2. Strategic Information and Monitoring and Evaluation

Measuring prevention, care and treatment activities will help to provide useful feedback to programs for accountability and quality improvement. Targeted program evaluations will provide evidence-based information to improve program and information management systems will facilitate data storage and data flow.

USAID will continue to fund Behavioral Surveillance Survey (BSS) and other surveys to gain a better understanding of risk taking behavior and service utilization among high risk groups so as to improve HIV/AIDS prevention interventions in Tamil Nadu and Maharashtra (and Pondicherry).

The project will conduct surveillance to monitor the prevalence rate of STD/HIV and to identify emerging groups with high risk behavior and service utilization among high risk groups so as to improve HIV/AIDS prevention and care, develop innovative approaches for advocacy and communication with policy makers, and monitor behavior change among high risk groups.

The Applicant will be responsible for collecting strategic information on all its project activities and develop strong Monitoring and Evaluation systems. The recipient will be tasked to collect surveillance information to track HIV related behaviors and if required, prevalence through its programs. Strategic information to support care must measure both home and clinical surveillance activities. National Family Health Survey results will also provide useful information related to HIV/AIDS.

Illustrative Outcomes:

1. Surveillance studies, monitoring and evaluation surveys, needs assessments and other needed surveys/studies completed.
2. Improved tools for collection of strategic information and monitoring and evaluation.
3. Technical assistance provided to government bodies on standardized M&E tools.

Note: Specific target amounts are to be proposed by applicants.

OPTIONS: USAID reserves the right to increase the geographic scope of this program in the future although for the purpose of this RFA the Applicants will only define a program for one new high prevalence state identified in the program description. This would

include a highly focused prevention and care program in the "hot spots" of a highly vulnerable state. This will be based on solid evidence and opportunities for programming.

2.3. COMPONENT TWO: LEVERAGING PUBLIC-PRIVATE ALLIANCES

HIV/AIDS is more than just a health crisis. In some countries it has already caused major damage to the economy, which will take years to reverse with widespread implications. In high-prevalence countries, HIV/AIDS erodes economic growth through its negative impact on labor supply, productivity, savings, and the delivery of essential services. It not only affects individual companies but the overall business climate as well. The success of business is based on the health, not only of employees, but customers, investors, suppliers and the communities in which the businesses operates. AIDS increases the cost of doing business, especially for small businesses and the informal economy. The magnitude of the problem will require the active involvement of a large number of new partners and significant leveraging of private sector resources. A strong commitment from the private and public sectors can prove critical in containing and reversing the HIV/AIDS trend.

Public-private partnerships offer a unique and sustainable opportunity for the provision of quality HIV/AIDS services with wide-reach, as they combine the strengths of government, business and civil society. Private sector innovations, resource and expertise are essential to the battle against HIV/AIDS, which has strained government and civil society responses. India is leading the world in innovative business practices, information technology, the development of low-cost drugs, and many other areas. Some of the largest industries in India have demonstrated their commitment. The Confederation of Indian Industry (CII) and other associations are working to expand that commitment and have reached nearly 700 companies with HIV/AIDS prevention and care programs. The U.S. private sector is also involved. Private entities such as the Bill and Melinda Gates Foundation, the Clinton Foundation, the Richard Gere Foundation and the Elizabeth Glaser foundation have contributed large resources for HIV/AIDS in India. The Emergency Plan suggests that the comparative advantages of these partnerships will be maximized to complement services provided by the public and non-governmental/faith-based organization sectors.

USAID/India's interest in forming public-private partnerships stems from the recognition that foundations, private companies, non-governmental organizations (NGOs) and other entities, are increasingly active in financing development efforts. By forging a variety of alliances, resources can be combined to broaden impact and better coordinate country-level efforts. In recognition of the many changes in today's development assistance environment and in the context of USAID's new Global Development Alliance (GDA) pillar[3], USAID/India encourages the formation of public-private alliances in the implementation of its programs. The Global Development Alliance serves as a catalyst to mobilize ideas, efforts, and resources of the public sector, the private sector and non-governmental organizations in support of shared objectives. USAID considers this

[3] http://www.usaid.gov/gda/

approach to take center stage in the design of program activities, as sustainability will depend on successful leveraging and mobilizations of industries and the private sector in the fight against HIV/AIDS. This would include development of a corporate fund where Indian and US companies could provide resources for HIV related activities.

USAID/ India encourages a vibrant program to enlist a larger number of private sector partnerships. The applicant will develop an intensified and coordinated strategy for reaching out to private sector organizations and industry associations. The objective will be to go beyond awareness-raising to substantially increase the number of industries and businesses implementing programs for their workforce, developing HIV/AIDS policies, reaching out to the surrounding community, and engaging in discussions on issues such as health insurances, employment practices, and the long-term impact of HIV/AIDS.

It will provide technical assistance to help the corporate sector identify ways to support and expand treatment programs through improved workplace policies, delivery of services, leveraging of commercial resources, and the application of new technologies. Business champions who provide effective HIV/AIDS treatment and care support services will be identified. Alliances will be encouraged to coordinate with private corporations to include treatment services for community members in their corporate health facilities. One focus of the program will be small and medium-sized enterprises (SME), which have so far remained in the background. The supply chain of every industry will also be emphasized as evidence has shown that those lower on the supply chain often are neglected. It is important to look at all the stakeholders in the chain.

The new program will encourage and strengthen public-private partnerships. It will help to mobilize private sector resources for HIV/AIDS programs, including pooling of resources to gain economies of scale. Program activities will create an enabling environment for the private sector to contribute their core competencies to achieving some of the national goals defined by NACO in NACP-3 and the objectives defined in the Emergency Plan.

Efforts need to be expanded to include workers in the unorganized sector who are highly vulnerable to the disease but who have the least access to health care. The corporate sector, besides planning HIV workplace programs for their own workers, could also support workplace programs for the unorganized sector.

The Applicant should discuss the kinds of alliances it expects to build. Special considerations will be given to applicants who have a history of forging public-private partnerships.

2.3.1. Development of Workplace policies

The first step in commitment from the private sector is developing appropriate workplace policies. The applicant will provide technical expertise and advocate for developing such policies in both small and large organizations. For example, the port industry is considered a high-risk group and USAID would support work with various port industries to develop work place policies. Faith based organizations will be specifically targeted.

Illustrative Outcomes:

1. Increased number of industries/ organizations, which have developed workplace policies.
2. Increase in the number of faith based organizations with workplace policies.

Note: Specific target amounts are to be proposed by applicants.

2.3.2. Prevention and care interventions in Industries

This includes activities ranging from developing HIV/AIDS workplace policies to conducting sensitization workshops for industries, educational/ training programs for industrial workers, interventions for management of industries and improving access to HIV prevention, care and support and treatment services for the workers and in some case these services are also extended to the communities surrounding the industries. USAID is focusing increasingly on private partnerships and the Applicant will demonstrate how it will enlist the engagement of private industry. The continuum of prevention, care and support and treatment will be particularly important here.

Illustrative Outcomes:

1. Improved counseling and testing services for industrial workers through increase in the number of outlets providing counseling and testing,
2. Increased awareness of HIV/AIDS among industrial communities and the management as measured by knowledge of HIV prevention methods, number of persons expressing accepting attitudes towards people with HIV and reduced number of sexual partners.
3. Increased resource commitment by the private industry for HIV/AIDS programs.

Note: Specific target amounts are to be proposed by applicants.

2.3.3. Prevention and care Interventions in Port Communities

The USAID supported program, Operation Lighthouse (OPL) has developed successful interventions for port communities in several States. Port communities are considered to be high-risk groups with special needs and priorities necessitating the need to develop unique ways to address them. The USAID supported OPL project was designed to address this issue through a comprehensive, integrated approach to dissemination of information and services. To help strategically consolidate its overall program, interventions in non-priority states will be phased out through leveraging other support to and ensure that activities will be continued by other partners.

In the four high prevalence states (Maharashtra, Tamil Nadu, Karnataka and Andhra Pradesh), the new activity will continue to support HIV prevention programs in port communities based on lessons learned from the Operation Lighthouse project. The new

activity will put greater emphasis on strengthening linkages from counseling and testing to providing care and support services. The applicant will also explore activities to address migrant bridge populations in communities around the ports.

Illustrative Outcomes

1. Increase knowledge of and demand for HIV/AIDS prevention products and services.
2. Improved access to high quality HIV/AIDS prevention products and care, support and treatment services.
3. Improved environment for sustainable HIV/AIDS programs.

Note: Specific target amounts are to be proposed by applicants.

2.3.4. Stigma Reduction in the Workplace and Community

Stigma remains a primary barrier to combating HIV/AIDS. Workplace stigma is even more significant given the impact it has on the livelihood options for HIV/AIDS victims. Lack of awareness among both employers and employees leads to a negative work environment for people living with HIV/AIDS, often making it impossible to continue working. The program will work with the private sector to address this important area through awareness programs, advocacy and establishment of support systems. A key focus must be to mainstream PLWHA into the greater community. Opportunities as educators and spokespersons for prevention, care and support and treatment messages not only empowers PLWHA but also serves to de-stigmatize the disease by reducing the social distance between those who are infected and those who are not. USAID is seeking creative and innovative approaches to raising awareness and motivating supportive attitudes and practices through strategic and targeted communication.

Illustrative Outcomes:

1. Increase in support for PLWHA in the workplace by employers and other workers.
2. Increase in community support for PLWHA as demonstrated by greater understanding and awareness.

Note: Specific target amounts are to be proposed by applicants.

2.3.5. Antiretroviral (AR) drug treatment and care for employees

Availability of AR drugs is an essential component of care and support and treatment of PLWHA. Although USAID does not expect to provide drugs, it will advocate for the private sector to include this element in its support for employees living with HIV/AIDS. Through this award, USAID will also provide technical assistance in developing appropriate systems in delivering the drugs. Other interventions could include

advocating with pharmaceutical companies and creating linkages with other industries such as the health insurance programs.

Illustrative Outcomes:

1. Increase in the number of employees provided ART by the employers.
2. Increase in the number of referrals made to ART centers.
3. Increase engagement of the private health industry in HIV/AIDS prevention, care and support and treatment.

Note: Specific target amounts are to be proposed by applicants.

The applicant will, depending upon the need, be required to provide Technical Assistance on private sector issues to USAID supported projects, the national Government and the state Governments. This may include supporting consultants in these organizations, undertaking specific surveys related to the private sector, assistance in planning private sector strategies, plans and specific training activities on private sector, organizing meetings, lessons learned workshops, dissemination workshops to share best practices on private sector in HIV/AIDS and so on.

OPTIONS: (The possibility and scope to be determined)

2.4. COMPONENT THREE: TECHNICAL ASSISTANCE AND CAPACITY BUILDING

USAID/India recognizes the need to support national and state level capacity building efforts both for the short and long term. This cannot be met without significant technical assistance at the institutional level through organizational development and program management. The different government supported bodies (NACO, SACS and DACS) will be key stakeholders of this intervention. The USG provides significant resources to the Global Fund and the new activity will be expected to provide technical assistance and capacity building support when and where needed for the Global Fund planning or implementing. The recipient will also provide high-level technical assistance and capacity building to USAID partners on specific technical areas in all its focus states. Ability to procure and provide TA and Capacity Building support rapidly will be critical. Applicants should describe how they will be able to fulfill this need.

2.4.1. Technical Assistance

It is important that the applicant has the experience and expertise to be able to provide technical assistance as appropriate to National AIDS Control organization, Ministry of Health, other government agencies, and State AIDS control societies. Assistance could be in the form of technical staff being placed in a particular government office, which has expressed a specific need. We request that the applicant propose to us what assistance would be useful to the HIV program in India.

The USG provides over 30% of the funding for the Global Fund and is a critical stakeholder for the USG. USAID would endeavor to strengthen the Global Fund and assist through technical assistance in needs identified by them.

The project partners of USAID as well as the NGOs would also need TA on specific issues on prevention, care and treatment. All the TA to be provided will be to support the Emergency Plan, NACP-3 and the three ones principles.

The elements for the TA to Government, USG partners and the Global Fund could be varied and range from prevention, care and treatment. The technical areas could include, but are not limited to, Behavior Change, prevention for positives, Treatment protocols, pediatric AIDS, orphans and vulnerable children, ART roll out and logistics, second line ARVs, lab strengthening, surveillance, PPTCT, OVC, quality assurance, prevention among MSMs and so on. The program management areas could include, but are not limited to, SI/M and E (described in detail below), documentation and dissemination, strategy planning, and program management.

Illustrative Outcomes:

1. Technical assistance and trainings strengthen ongoing USAID/India's bilateral programs.
2. Improved Monitoring and Evaluation tools developed for NACO, SACS and the USAID partners.
3. Improved data based planning and decision making.
4. Improved logistics management in GFATM programs.
5. Other to be proposed by applicant

Note: Specific target amounts are to be proposed by applicants.

2.4.2. Strategic Information

USAID would support activities to strengthen and build national, state and district level strategic information capacity for use in program management and policy formulation. The Applicant is encouraged to plan and design activities for advocating for the utilization of information for policy and program planning and design at the national, state and district level. Areas of support could include support for behavior and biological surveillance, quality assurance, targeted evaluations and evidence based programming.

Illustrative Outcomes:

1. Increased number of staff trained in strategic information (includes monitoring and evaluation, surveillance and MIS).
2. Improved data based planning and decision making.
3. Increase use of evidence based national and district programs.

4. Staff support provided to National, State and District governments.

2.4.3. Capacity Building and Training

The capacity building and training activities will fulfill the need expressed by GOI, state governments as well as the USAID partners and NGOs.

The areas for capacity building will be along the similar lines as mentioned in the above section on TA. It may include developing a capacity building plan, training designs and implementation. It is expected that the target audience for capacity building will be highly varied and include among others, health practitioners, lab technicians, M and E officers, research officers, technical staff of GOI and the state governments, media personnel, USAID project staff and NGOs.

Methods of capacity building and training can vary, and may include supporting consultants in Government agencies such as NACO/SACS, specific consultancies, study tours, support for sending participants to national and International Conferences, trainings and study tours, specific workshops, meetings and seminars, lessons learned and data dissemination meetings, . It is expected that the recipient will demonstrate flexibility in supporting the activities. The list of activities will be evolving continuously as new needs emerge and specific requests are made, it is important that the applicant supports requests made by USAID.

Illustrative Outcomes:

1. Enhanced capacity of government staff at national, state and district levels.
2. In-country training events hosted and/or supported for key government and civil society members.
3. Support participation of key stakeholders in high level international conferences, meetings and trainings.

2.4.4. Engendering Bold Leadership

A lack of management and administrative systems training among the nation's healthcare leadership may hinder the quick dispersal and utilization of funds. USAID would encourage a national leadership profile for HIV/AIDS activities that includes coordinated inter-ministerial, multi-sectoral policy and planning approaches and inclusive technical implementation committees. Both national and local leadership should be engaged in a coordinated and integrated fashion with new and emerging partners, including NGOs and FBOs.
Current programs depend on the support of various government, non-government organizations and other donors to ensure continuity of HIV prevention program targeting vulnerable populations. Future support and engagement of all facets of the government and others given the responsibility to respond to the HIV/AIDS epidemic is critical to long-term effectiveness and sustainability of all interventions. USAID expects to support

and enhance such multi-sectoral collaboration through activities such as workshops, lessons learned meetings and developing adequate communication tools.

Illustrative Outcomes:

1. Increased awareness of USG programs among key stakeholders.
2. Increased collaboration by key stakeholders in USG programs.
3. Increased awareness of HIV/AIDS among government and business leaders.

Note: Specific target amounts are to be proposed by applicants.

2.4.5. Communication

Technology has made the need for communication results and impacts in a timely manner a critical need. This is important for ensuring collaboration, coordination and ownership by different stakeholders. USAID would support effective communication of its HIV/AIDS activities and achievements to a variety of audiences. The Applicant will be expected to develop and implement a communication plan to support these needs. USAID would be realistic in the area of communications and support only essential activities, given the limited resources.

Illustrative Outcomes:

1. Increased number of success stories in national and international media.
2. Case studies developed and disseminated to key stakeholders in the US and India.
3. Enhanced visibility of programs.
4. Production of IEC materials targeting different audiences in coordination with other USAID programs.
5. Assistance with site visits of CODELS or other key decision makers that wish to understand the nature of the epidemic and our program.

Note: Specific target amounts are to be proposed by applicants.

OPTIONS: To be determined

3. GEOGRAPHICAL SCOPE

The USAID mission wants to maximize its impact by consolidating the activities by geographical location rather than being spread thinly over a large region. The Mission will continue its commitment to work in the high-prevalence states of Tamil Nadu, Pondicherry and Maharashtra.

It is expected that activities for a comprehensive program as elaborated under component 1 will be implemented in a new high-prevalence state (Andhra Pradesh or Karnataka). Recognizing the complexity of the epidemic in such a large and heterogeneous population, the recipient of component I award will also be asked to collect evidence on

HIV/AIDS, develop a response plan and follow it with a highly targeted program in a highly vulnerable State such as Uttar Pradesh, Uttaranchal or Jharkand.

Activities designed to address Component 2, public-private alliances and Component 3, capacity building/technical assistance will have a wider coverage and include all focus States (Tamil Nadu, Maharashtra, a new high-prevalence states and other) in which USAID has HIV/AIDS activities. Activities will also have a national thrust even though some specific assistance will be targeted to the three focus States. APAC and Avert will continue to implement activities in Tamil Nadu and Maharashtra respectively, but will receive support from the new component activities as and when needed.

4. Reporting Requirements

The recipients will adhere to all planning and reporting requirements listed below.

a) Annual Work Plan: The first year work plans are due 90 days after award and, thereafter, 30 calendar days before the beginning of the next reporting period. The work plan will include: 1) a comparison of actual accomplishments with the goals and objectives established for the period; 2) identification of quantifiable outputs of the program; 3) reasons why goals were not met; and 4) analysis and explanation of cost overruns of high unit costs, when appropriate.
b) Semi-annual Performance Monitoring Report: The recipient shall submit an updated report on progress towards agreed targets six months after each of the Annual Work Plans.
c) Final Report: This is required 90 days after the completion of a Cooperative Agreement.
d) All reporting must comply with PEPFAR, NACP-3 and three ones requirements.

Management Review and External Evaluation: The annual work plan will form the basis of a joint management review by USAID and program staff to review program directions, achievement of the prior year work plan objectives and major management and implementation issues, and to make recommendations for any changes as appropriate.

During the third year of the program, USAID may conduct an external mid-term evaluation or assessment to review overall progress, assess the continuing appropriateness of the program design, and identify any factors impeding effective implementation. USAID will utilize the results of the mid-term evaluation to make mid-course changes in strategy if needed and to help determine appropriate future directions.