U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HRSA
Health Resources & Services Administration

HIV/AIDS Bureau
Office of HIV Training and Capacity Development, Global Division

Health Workforce for HIV and Chronic Disease Service Delivery Global Initiative

Funding Opportunity Number: HRSA-17-033

Announcement Type: New

Catalog of Federal Domestic Assistance (CFDA) No. 93.266

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2017

Application Due Date: June 12, 2017

Ensure SAM.gov and Grants.gov registrations and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration in all systems, including SAM.gov and Grants.gov,
may take up to one month to complete.

Issuance Date: April 12, 2017

Myat-Htoo Razak
Director, Division of Global Programs
Office of Training and Capacity Development, HAB
Telephone: (301) 443-2166
E-mail: mrazak@hrsa.gov

Authority: Public Law 108-25 (the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003) [22 U.S.C. 7601, et seq.]; and Public Law 110-293 (the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008), as reauthorized and amended by Public Law 113-56 (the PEPFAR Stewardship and Oversight Act of 2013). See, e.g., 22 U.S.C. § 7603 and 22 U.S.C. §§ 2151b-2(b)(1)(B), 2151b-2(c)(1), and 2151b-2(d)(6)(G)(ii).

EXECUTIVE SUMMARY

Supported through the President's Emergency Plan for AIDS Relief (PEPFAR), the Health Resources and Services Administration's (HRSA's) HIV/AIDS Bureau (HAB) is accepting applications for fiscal year (FY) 2017 in support of the Health Workforce for HIV and Chronic Disease Service Delivery Global Initiative. The purpose of this initiative is to provide innovative approaches to increasing the adequacy, capacity, coordination, employment, complementarity, deployment and retention of physicians, nurses, midwives, pharmacists, community health workers (CHWs), social service workers, lay health workers, laboratory technicians and other related cadres that provide primary care and community health services to people living with HIV, tuberculosis (TB), and chronic diseases in sub-Saharan Africa, Central Asia, Eastern Europe, the Caribbean, and/or Latin America.

The awarded organization(s) will work with the in-country U.S. Government officials and Ministries of Health to access additional programmatic funds through the PEPFAR Country Operational Plans or other sources of HRSA funding. The awards will not be country specific.

Funding Opportunity Title:	Health Workforce for HIV and Chronic Disease Service Delivery Global Initiative
Funding Opportunity Number:	HRSA-17-033
Due Date for Applications:	June 12, 2017
Anticipated Total Annual Available FY 2017 Funding:	Up to $30,000,000
Estimated Number and Type of Award(s):	Up to two (2) cooperative agreements
Estimated Award Amount:	Up to $30,000,000 per year
Cost Sharing/Match Required:	No
Project Period/Period of Performance:	September 30, 2017 – September 29, 2022 (5 years)
Eligible Applicants:	Eligible applicants include domestic and foreign public and private nonprofit entities, including institutions of higher education, faith-based and community-based organizations, Tribes and tribal organizations, and for profit entities. See Section III-1 of this notice of funding opportunity (NOFO), formerly known as the funding opportunity announcement (FOA) for complete eligibility information.

Application Guide

You (the applicant organization/agency) are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide,* available online at

http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf, except where instructed in this NOFO to do otherwise. A short video explaining the *Application Guide* is available at http://www.hrsa.gov/grants/apply/applicationguide/.

Technical Assistance

A technical assistance webinar has been scheduled to assist potential applicants in preparing applications that address the requirements of this NOFO. Participation is optional. The webinar information is as follows:

Day and Date: Tuesday, May 9, 2017
Time: 1 – 2:30 p.m. ET.
Conference Number: 1-877-929-1552 for all callers (U.S. and international)
Participant passcode: 24325735 for all callers (U.S. and international)
Weblink: https://hrsa.connectsolutions.com/dtcd2.

The pre-application technical assistance webinar will be recorded and should be available for viewing by May 25, 2017 at https://careacttarget.org/calendar/hrsa-17-033.

Table of Contents

I. Program Funding Opportunity Description

1. Purpose

This announcement solicits applications for the Health Workforce for HIV and Chronic Disease Service Delivery Global Initiative (Health Workforce Global Initiative). The purpose of this initiative is to develop and implement innovative approaches to increasing the adequacy, capacity, employment, coordination, complementarity, deployment and retention of physicians, nurses, midwives, pharmacists, community health workers (CHWs), social service workers, lay health workers, laboratory technicians and other related health cadres that provide primary care and community health services to people living with HIV (PLHIV), tuberculosis (TB), other infectious and chronic diseases in sub-Saharan Africa, Central Asia, Eastern Europe, the Caribbean, and/or Latin America.

Pending the availability of funds, up to $30,000,000 annually will be available to fund up to two awards. The awarded organization(s) will work with the in-country U.S. Government (USG) officials and Ministries of Health to access additional programmatic funds through the President's Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plans (COPs). COP is the present vehicle for documenting USG annual investments and anticipated results in HIV/AIDS and the basis for approval of annual USG bilateral HIV/AIDS funding in most countries.

In support of PEPFAR 3.0 and its focus on reaching the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 global treatment targets, the Health Workforce Global Initiative aims to: (1) strengthen and expand the health workforce to improve access to comprehensive health services, adherence to treatment, retention in care, and the quality of life among PLHIV, TB, other infectious and chronic diseases which co-exist and complicate care and treatment for PLHIV; and (2) promote governments' and stakeholders' commitment to employ, deploy, and retain qualified health workers in areas with the highest burden of HIV.

The objectives of the Health Workforce Global Initiative are to:

- Support host country and local governments, professional associations and councils, and institutions in the planning, development, expansion, regulation, employment, distribution, retention, and management of the health workforce to effectively, efficiently, and sustainably meet the increasing demands for human resources for health in high HIV prevalence areas, particularly as differentiated models of HIV care and chronic disease management are established and implemented;
- Support educational and health care institutions in the area of pre-service and in-service training to improve the quality and relevance of training programs by increasing competencies related to HIV, TB, infectious and chronic diseases, the patient care continuum including preventive care and retention in care, stigma and discrimination mitigation, key populations, new service delivery models, management/administration, leadership, and supervision/mentorship; and
- Strengthen primary care and community health systems by piloting, studying, adopting, and scaling-up task shifting approaches, cadre formalization, and

ensuring health worker inter-professional coordination and linkages around provision of the continuum of care related to HIV, TB, and other infectious diseases, and chronic disease care services in these settings.

The overarching goal of the PEPFAR Human Resources for Health (HRH) Strategy is to "ensure adequate supply and quality of human resources for health to expand HIV/AIDS services in PEPFAR-supported moderate- and high-volume sites and/or high HIV-burden areas." According to the HRH Strategy, HRH data at the facility and/or community level in most PEPFAR countries are inadequate, there is a shortage of health workers with appropriate skills at high HIV volume sites, HIV care provider vacancy rates are 50-79 percent in many PEPFAR countries, the countries' financing for sustaining HRH capacity is insufficient, and performance of health workers providing HIV services needs to improve.[1] The Health Workforce Global Initiative seeks to contribute to the achievement of PEPFAR's HRH goals and objectives.

The Health Workforce Global Initiative will address the following priorities and will continuously measure output, outcomes and impact around these priorities throughout the life of the project.

Priority 1: Adequate supply and appropriate skill mix of qualified health workers to deliver comprehensive and quality care services within existing and new innovative models of care.

Problem Statement: To achieve universal access to HIV/AIDS treatment, care, prevention, and support, health organizations must determine the levels of services required and what cadres of health workers (e.g., physicians, nurses, midwives, pharmacists, CHWs, social service workers, lay health workers, laboratory technicians) will provide these services, the knowledge and skills these health workers will require, and how many of these workers will be needed.[2] Many PEPFAR countries currently face a shortage of well-trained health care workers who can efficiently and effectively provide HIV treatment and care.

Opportunities and Potential Approaches: Task shifting is an effective strategy for addressing such shortages. Task shifting provides high-quality, cost-effective care to more patients than a physician-centered only model.[3] Clinicians, including nurses, midwives, CHWs, pharmacists, pharmacy technicians or technologists, and laboratory technicians, can safely and effectively undertake a majority of clinical tasks in the context of HIV service delivery.[4]

Severe physician shortages, increasing HIV disease burden, and the need for improved access to antiretroviral treatment (ART) has resulted in the shift of ART management from physicians to nurses in many African countries. Studies show that task shifting

[1] U.S. President's Emergency Plan for AIDS Relief (2015). PEPFAR Human Resources for Health Strategy: PEPFAR 3.0. Retrieved from: http://www.pepfar.gov/documents/organization/237389.pdf

[2] Pat Daoust et al (2008). Addressing the Health Workforce Crisis: A Toolkit for Health Professional Advocates. Retrieved from: http://www.who.int/workforcealliance/knowledge/resources/hwai_advocacytoolkit/en/

[3] Mike Callaghan, Nathan Ford, and Helen Schneider (2010). Systematic review of task- shifting for HIV treatment and care in Africa. Human Resources for Health 2010, 8:8. Retrieved from: http://www.human-resources-health.com/content/8/1/8

[4] WHO (2008). Task shifting: global recommendations and guidelines. Retrieved from: www.who.int/healthsystems/TTR-TaskShifting.pdf

from physicians to nurses in HIV settings has resulted in better patient retention and lower client loss to follow-up. Despite the successes of task shifting, challenges remain, including forecasted nurse shortages most notably in Africa.[5] Additionally the expansion in nurses' roles and practice in HIV care has resulted in an increased nursing workload. The introduction of nurse-initiated and -managed antiretroviral therapy (NIMART) has also resulted in challenges regarding nurse legislation, and ensuring adequate acquisition, storage and medication supply.

Although task shifting for chronic disease management, including HIV services, has been rolled out in many countries, new differentiated models of care are resulting in additional shifts, specifically toward increased utilization of community and lay health workers, resulting in changes across the health system related to health workforce utilization.

Changes in HIV treatment guidelines are resulting in increased PLHIV in HIV care, as well as, the need for long-term care options within the community to ensure retention and adherence on treatment. New systems and models of care are being adapted and developed to meet this need, resulting in expanded and shifting roles for health care workers. These shifts, compounded with continued physician and nurse shortages, result in the need for continued task shifting and expansion of cadres such as community and lay health workers, pharmacists, pharmacy support staff, and mid-level/auxiliary care providers.

Challenges: The main challenges to implementation of task shifting approaches include adequate and sustainable training, support and pay for staff in new roles, the integration of new members into healthcare teams, and the compliance of regulatory bodies.[6] According to the World Health Organization (WHO), task shifting should be implemented in conjunction with other efforts to increase the numbers of skilled health workers. Expansion of health worker roles and development of new cadres results in the need for countries to define the roles and the associated competency levels. These standards should be the basis for establishing recruitment, training and evaluation criteria. They should adopt a systematic approach to harmonized, standardized and competency-based training that is needs-driven and accredited so that all health workers are equipped with the appropriate competencies to undertake the tasks they are to perform. Training programs and continuing educational support for health workers should be tied to certification, registration and career progression mechanisms that are standardized and nationally endorsed.[7]

Goals: In collaboration with country governments and stakeholders, the Health Workforce Global Initiative will identify and implement innovative models for expansion of the health workforce, while ensuring inclusive and integrated team based inter-professional and patient centered care. It will address challenges related to task shifting through clinical training, technical assistance, capacity building, policy development or

---

5 World Health Organization (2016). The Global Strategic Directions for Strengthening Nursing and Midwifery. Retrieved from: http://www.who.int/hrh/nursing_midwifery/global-strategic-midwifery2016-2020.pdf?ua=1

6 Mike Callaghan, Nathan Ford, and Helen Schneider (2010). Systematic review of task- shifting for HIV treatment and care in Africa. Human Resources for Health 2010, 8:8. Retrieved from: http://www.human-resources-health.com/content/8/1/8

7 WHO (2008). Task shifting: global recommendations and guidelines. Retrieved from: www.who.int/healthsystems/TTR-TaskShifting.pdf

revision, regulatory reforms, professional development, enhancing the competencies of faculty training health workers, and health worker remuneration. The Initiative will help the countries refine and explicitly define the roles of existing cadres, as well, as the new cadres that are being created to support the adoption and implementation of new models of care. It will strengthen the quality of physicians, nurses, midwives and other health care workers through pre-service and in-service training, increasing their competencies in HIV, TB, infectious and chronic diseases, stigma and discrimination mitigation, key populations, new service delivery models, management/administration, leadership, and supervision/mentorship.

Priority 2: Employment and retention of health workers.

Problem Statement: Many nurses, pharmacists and other health professionals in some African countries and other parts of the world are unemployed and underemployed. Their unemployment and underemployment are due to lack of appropriate skills and experience, lack of resources and funds to support their salaries and compensations, weak local government planning, labor markets' inability to expand rapidly enough to incorporate newly trained skilled labor into the workforce, leading to oversupply, bureaucratic delays in hiring, competition between groups of health professionals, and other reasons.[8,9,10] Unemployment and underemployment of essential care providers impact the delivery of health services and compromises access to and quality of care. Countries faced with high or increasing demands for HIV, TB and chronic disease care services should ensure that their health workforce is participating in health care delivery to the greatest extent possible, to ensure that the health needs of their population are met.

For employed health workers, retention can be a challenge. Health care workers, especially CHWs, often work long hours with limited remuneration and get burned out or are forced to find secondary employment. Many leave for wealthy nations like the United States, South Africa and United Kingdom, while others move to more urban areas within their own country. Some leave the public sector for a more lucrative for-profit private sector, whose services are often unaffordable for much of the population. Others leave the health sector altogether.[11]

Opportunities and Approaches: To address the issues of deployment and retention, countries should consider measures such as financial and/or non-financial incentives, performance-based incentives or other methods as means by which to retain health workers, commensurate with available resources in a sustainable manner. In cases where health workers serve as volunteers, institutions need to recognize that essential health services cannot be provided by people working on a voluntary basis if they are to

---

8 Joanne Spetz for the International Centre for Human Resources in Nursing (2011). Retrieved from: http://www.icn.ch/images/stories/documents/pillars/sew/ICHRN/Policy_and_Research_Papers/Unemployed_and_Underemployed_Nurses.pdf

9 Mamadou Mika Lom (2011). SENEGAL: Plight of thousands of jobless graduates. Retrieved from: http://www.universityworldnews.com/article.php?story=20110917100621179

10 John A. Arthur (2016). The African Diaspora in the United States and Europe: The Ghanaian Experience. Retrieved from: https://searchworks.stanford.edu/view/7548357

11 Pat Daoust et al (2008). Addressing the Health Workforce Crisis: A Toolkit for Health Professional Advocates. Retrieved from: http://www.who.int/workforcealliance/knowledge/resources/hwai_advocacytoolkit/en/

be sustainable.[12] While volunteers can make a valuable contribution on a short term or part time basis, trained health workers who are providing essential health services, including lay persons and CHWs, should receive adequate wages and/or other appropriate and commensurate incentives.[13] For the contribution of CHWs to be sustained, they need to be recognized, remunerated and integrated in wider health systems.[14]

Challenges: Enhancing deployment of health care workers requires strong human resource management systems that are often limited in PEPFAR countries. As countries continue to build their human resources information system, they should utilize complementary tools, such as workload indicators of staffing need (WISN) and the HRH Rapid Assessment Tool, to identify needs and place health care workers where they are most needed.

Many PEPFAR countries are supporting salaries and remuneration of health care workers to support immediate delivery of HIV services. This can limit the ability of host governments to sustainability employ and retain HIV service providers. These PEPFAR investments need to be tracked across sites and transition plans for these health care workers must be developed.

Goal: The Health Workforce Global Initiative will identify and utilize innovative approaches to health workforce distribution and retention. It will work to minimize the migration of those health care workers who provide the majority of HIV services and will focus on ensuring these key cadres work in geographic areas where they can have the largest impact on the health of populations. It will prioritize deployment of health workers to high HIV prevalence areas and will focus on ensuring these health workers are retained through quality management and other model interventions. The Health Workforce Global Initiative will focus on an interdisciplinary model for training, utilizing, and retaining health workers to provide an integrated approach to HIV service delivery and primary health care for other acute and chronic diseases.

Priority 3: Linkage and retention of patients in health care.

Problem Statement: In Sub-Saharan Africa and other regions, health care institutions increasingly face challenges in providing care and treatment for infectious and chronic diseases, as well as difficulties in linking and retaining patients to care services. There are a number of known barriers to linkage and retention which include poor motivation, hopelessness and burn out, limited health literacy, lack of knowledge and/or understanding around the need to engage in care, preferences in alternative medicine, use of alcohol/drugs, cultural beliefs and social norms, stigma, discrimination, lack of finances and service fees, distance/access to the health facility, slow service, inadequate perception of severity of disease and symptoms experienced, lack of partner support/discordance, and inadequate social support. Some of the facilitators that promote linkage and retention include strong personal initiative, belief in treatment,

---

12 WHO (2008). Task shifting: global recommendations and guidelines. Retrieved from: www.who.int/healthsystems/TTR-TaskShifting.pdf

13 ibid

14 Grace W Mwai et al (2013). Role and outcomes of community health workers in HIV care in sub-Saharan Africa: a systematic review. Retrieved from: http://www.jiasociety.org/index.php/jias/article/view/18586

family responsibilities and fear of losing a child, good provider-patient relationships, accessibility of the health facility, provision of integrated services, available services, peer support/testimonies, and family and social support.[15]

Opportunities and Approaches: The integration of care and treatment services across an array of diseases may be a vital strategy to encourage engagement in appropriate care. The HIV epidemic has strained the health care system with many more patients presenting at all levels of care and with the implementation of test and start there will likely be an increase in patients. PEPFAR will need to meet the increased demand for coverage with the most efficient use of human resources. Innovative service delivery models providing wellness care for stable patients will help ensure they are retained and will help to decongest facilities. Some 80 percent of patients can follow less expensive, differentiated service delivery follow-up and yearly viral load tests.[16] These differentiated models of care aim to improve patient linkages, adherence and retention; these models include targeted services for stable patients and also for key/priority populations, adolescents, as well as, young men and women.

Challenges: Implementation of differentiated care models often require shifts in and the addition of health worker roles, such as the utilization of patient extenders, peer navigators, or CHWs. Strategic consideration to development and formalization of these cadres, as well as ensuring appropriate education, will be key to carrying out such integrated and innovative approaches.

Goal: In collaboration with country governments and stakeholders, the Health Workforce Global Initiative will develop, implement and evaluate innovative models of care to ensure linkage to care and retention of HIV patients. It will work to establish well-functioning provider care teams and networks for integration of care, treatment and support services across an array of diseases, including HIV, TB and chronic diseases to support the comprehensive provision of service. The Initiative will also ensure there is adequate training and support for health care workers to improve linkage, adherence and retention of patients in care.

Priority 4: Coordination and linkages among different health care cadres in delivery of primary care and community health services.

Problem Statement: Successful roll out of test and start and meeting the 90-90-90 targets will likely increase the number of patients in care. Many high volume sites are already over-crowded and need to be decongested. The treatment cascade is optimized by bringing HIV testing and counselling services closer to the community. HIV prevention, testing and treatment must be accelerated through innovative community service delivery models to increase access to essential health interventions and social support networks. The community health workforce, including volunteers, has the capacity to provide almost 40 percent of HIV service-related tasks. Mobilizing and engaging affected communities in the HIV response facilitates access to HIV

[15] Beth Rachlis et al (2016). Identifying common barriers and facilitators to linkage and retention in chronic disease care in western Kenya. Retrieved from: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-3462-6

[16] PEPFAR Country/Regional Operational Plan (COP/ROP) Guidance (2017). Retrieved from: https://2009-2017.pepfar.gov/documents/organization/267162.pdf

prevention, testing and counselling; improves treatment; combats stigma and discrimination; and supports health-seeking behavior.

Opportunities and Approaches: When early antiretroviral therapy is initiated at primary level facilities, antiretroviral therapy-related tasks, such as drug dispensing, treatment adherence and helping PLHIV to navigate through the health system, can be shifted to CHWs and volunteers. Shifting tasks to community health care providers empowers communities to provide support for retention and re-engagement into care and integrates HIV testing and counselling and antiretroviral therapy services with other health and social services, enhancing positive health, dignity and prevention throughout the treatment cascade.[17]

Task shifting clearly exists in community health settings. According to the WHO, countries that adopt the task shifting approach should define a nationally endorsed framework that can ensure harmonization and provide stability for the HIV services that are provided throughout the public and non-state sectors. Countries should ensure that efficient referral systems are in place to support the decentralization of service delivery in the context of a task shifting approach. Health workers should be knowledgeable about available referral systems and trained to use them. Additionally, supportive supervision and clinical mentoring should be regularly provided to all health workers within the structure and functions of health teams. Individuals who are tasked with providing supportive supervision or clinical mentoring to health workers to whom tasks are being shifted should themselves be competent and have appropriate supervisory skills.[18]

Challenges: Implementing a mix of community-based approaches and services requires optimum coordination and linkages among a network of community and primary care health workers of different types and levels of training and experience. Nurses, CHWs and other lay workers are central to the delivery of essential health services and the strengthening of health systems. They can play a critical role in the coordination and linkages of various health workers and services in communities. At the same time many of these essential health care workers are already overburdened, many are not adequately trained, and there is limited information in many countries regarding the current composition of the community-based workforce and how these health care workers are being utilized to support HIV. There is a need to better understand the available workforce at the community level and how to enhance linkages with facilities.

Goal: The Health Workforce Global Initiative will look to maximize the capacities of nurses, CHWs and other lay cadres to link, coordinate and collaborate with intra- and inter-professional teams within primary and community health systems. It will seek to strengthen competencies of health care workers, particularly nurses and CHWs, in leadership, management, planning, and supportive supervision.

---

[17] International Federation of Red Cross and Red Crescent Societies (2014). A community-based service delivery model to expand HIV prevention and treatment: Guidance. Retrieved from: http://www.gnpplus.net/assets/wbb_file_updown/4981/1281301-Brochure%20CBSD%20-%20EN_Web-signed.pdf

[18] WHO (2008). Task shifting: global recommendations and guidelines. Retrieved from: www.who.int/healthsystems/TTR-TaskShifting.pdf

2. Background

This PEPFAR initiative was first authorized in 2003 under the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 (Pub. Law 108-25; 22 U.S.C. 7601 et seq.). The PEPFAR program was re-authorized in 2008 through the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (Pub. Law 110-293), and reauthorized and amended by the PEPFAR Stewardship and Oversight Act of 2013 (Pub. Law 113-56.)

Under PEPFAR, the President is authorized to furnish assistance, on such terms and conditions as the President may determine, for HIV/AIDS, including to prevent, treat, and monitor HIV/AIDS, and carry out related activities, in countries in sub-Saharan Africa, the Caribbean, Central Asia, Eastern Europe, Latin America, and other countries and areas. In addition, under PEPFAR, it is a policy objective of the United States to strengthen the capacity to deliver primary health care and community health services for people living with HIV, TB, other infectious diseases, and chronic diseases in developing countries, especially in sub-Saharan Africa.

Specifically, the USG's role is to:

- Invest appropriated resources under PEPFAR;
- Carry out activities to strengthen HIV/AIDS, tuberculosis, and malaria health policies and health systems;
- Provide workforce training and capacity-building consistent with the goals and objectives of PEPFAR; and
- Support the development of a sound policy environment in partner countries to increase the ability of such countries to maximize utilization of health care resources from donor countries; to increase host country investments in health and education and maximize the effectiveness of such investments; to improve national HIV/AIDS, tuberculosis, and malaria strategies; to deliver evidence-based services in an effective and efficient manner; and to reduce barriers that prevent recipients of services from achieving maximum benefit from such services.

As PEPFAR began in 2003, the world grappled with the severity of the AIDS crisis. The first phase of PEPFAR focused on building an emergency response. The second phase emphasized sustainability through working closely with partner governments, promoting mutual accountability and sustainability. During that phase, an emphasis was placed on increasing the impact of PEPFAR's investments by scaling up access to ART, preventing mother-to-child transmission (PMTCT) and voluntary medical male circumcision (VMMC). The current phase, otherwise known as PEPFAR 3.0, is focused on a sustainable control of the epidemic and achievement of the UNAIDS 90-90-90 targets to ultimately reach an AIDS-free generation.

HRSA, an agency of the U.S. Department of Health and Human Services (HHS), provides health care to people who are geographically isolated and economically or medically vulnerable. This includes PLHIV, pregnant women, mothers, their families, and those in need of high quality primary health care. HRSA also supports the training

of health professionals, the distribution of providers to areas where they are needed most, and improvements in health care delivery.

The Health Workforce Global Initiative will build on the successes of HRSA's Global Nursing Capacity Building Program (GNCBP). As part of the GNCBP focus, of which the Nursing Education Partnership Initiative (NEPI) and General Nursing are sub-projects, HRSA has been working in the last five years to strengthen the quality, quantity and relevance of nurses and midwives in over 10 resource-poor countries in Africa. Among its many accomplishments, the program has provided HIV care and treatment in-service training and mentorship to nurses and midwives; supported nursing and midwifery schools; supported the training of new nursing faculty and completion of advanced degrees for existing faculty; hosted south-to-south exchange programs for faculty, ministry of health, ministry of education, nursing council and association members; and developed National guidelines and standards related to education and practice in Malawi, Ethiopia, Democratic Republic of Congo (DRC), and Cote d'Ivoire.

In early 2015, HRSA directed a program evaluation of the GNCBP which found that despite increased number of faculty, schools are likely to continue struggling with ensuring quality education in the short term due to frequently government-mandated enrollment increases. In addition, faculty-student and clinical preceptor ratios remain high in most schools, making it difficult to produce nurses who can immediately deliver high-quality, highly safe, and efficient health care.

The Health Workforce Global Initiative will build on the successes of the Medical Education Partnership Initiative (MEPI), which was a five-year, $130 million initiative designed to develop, expand, and/or enhance models of medical education in sub-Saharan Africa. MEPI was funded by PEPFAR through the Office of the U.S. Global AIDS Coordinator (OGAC) and managed by the National Institutes for Health (NIH) and HRSA. MEPI was a flagship program helping to assure there are adequate numbers of well-trained health care workers in sub-Saharan Africa who can provide the HIV/AIDS services needed to address the epidemic. All MEPI activities were aimed at improving the quality of education as well as increasing retention of graduates and academic faculty in host countries through partnerships and research opportunities. Students and faculty who participated in MEPI programs are on the frontlines of HIV/AIDS care and are modeling evidence-based practices. MEPI optimized host-country leadership, collaboration and impact. As a result, this five-year program supported medical education as well as education of other health cadres by ensuring quantity and quality of healthcare workers, while filling health system gaps. Upstream, the related outcomes addressed threats to quality care in sub-Saharan Africa.

The GNCBP will end in September 2017, and HRSA's investments in MEPI will end in April 2017. This new five-year program, the Health Workforce Global Initiative, will encompass nurses, midwives, CHWs, and other cadres such as physicians, pharmacists, laboratory technicians, social service workers, and lay workers. The Health Workforce Global Initiative will focus on: task shifting; development of provider care team networks to ensure different health care cadres involved in the HIV care continuum are adequately and effectively trained and coordinated in the implementation of new service delivery models; linkages of health cadres and social service providers; supervision of cadres at different levels; absorption and retention of health workers;

retention of patients in health care; wellness (ensuring health workers are able to provide services and meet the increasing demands for services and patients are provided differentiated care); and sustainability. The Health Workforce Global Initiative will address management of HIV, TB, other infectious and chronic diseases. It aims to produce reliable and relevant HRH, HIV and other data that can be used for planning, policy development, and decision-making.

The applicant will detail the approach and activities necessary and sufficient to achieve the overarching objectives and priorities of this initiative. Illustrative examples of activities are provided below. While applicants will be asked to address the needs of PEPFAR-funded countries in their application, the countries in which activities will take place will be determined through the formal PEPFAR country operating plan review process. HRSA's HIV/AIDS Bureau will then facilitate the coordination/collaboration with country teams and the cooperative agreement recipient(s).

Progress towards achieving the anticipated results must be tracked by outcomes, impact and outputs. There must be measurable results linked to health outcomes and attainment of 90-90-90. Progress towards targets should be disaggregated by year, country, and other factors as outlined in the applicant's Monitoring and Evaluation (M&E) Plan, detailed in Section IV. Illustrative indicators are also provided below.

Priority 1: Adequate supply and appropriate skill mix of qualified health workers to deliver comprehensive and quality care services within existing and new innovative models of care.

Illustrative Activities

- Strengthen the capacity of learning institutions to produce priority health care worker cadres and/or develop new cadres
- Facilitate the development and implementation of educational and legal frameworks which support the inclusion of CHWs, lay workers, and other related cadres as formal cadres
- Support ministries of health in refinement and definition of health care worker roles and qualifications within differentiated models of care
- Support government and provider stakeholders to develop, implement and evaluate models for task shifting to lay cadres to strengthen the community-facility linkages
- Work with host country governments to ensure new task shifting policies are: strategically implemented, not fragmented; systematically tracked to monitor progress of implementation; and have adequate planning and resources to ensure cadres are provided consistent preparation for new tasks
- Support local governments and certification bodies in formalization of lay cadres
- Support local governments and educational institutions in ensuring leadership capacity of health worker cadres tasked with increasing management activities
- Increase health workers' competencies through development and/or revision of models of learning, including curriculum development and optimization of clinical practicums
- Support development or updating of policies to expand scopes of practice

- Rapidly upgrade skills of the existing health workforce to deliver quality health services that meet the needs of the country's population
- Deploy innovative instructional and mentoring platforms to diversify and efficiently deliver training and supportive supervision
- Train facility managers and community health care organizations on national regulations related to service delivery
- Promote continuous quality improvement, critical thinking, personal accountability, and self-reliance through mentorship
- Provide technical assistance or capacity building for health care workers (including nurses and CHWs) related to activities pivotal to their new roles within the context of task shifting/differentiated models of care (e.g., improved data use for quality management, budgeting, pharmaceutical monitoring, and leading HIV care teams)

Illustrative Outputs or Outcomes

Health Care Workforce:

- Increased number of health workers at every level that are employed
- Roles of health workers are clearly defined and executable
- Increased number of CHWs and other cadres formalized

Educational Framework:

- Increased educational standards
- Increased number of accredited programs and trainings
- Increased number of revised or newly developed curriculums
- Increased number of revised or updated national policies related to scopes of practice
- Decreased ratio of students to patients during clinical practicums
- Decreased ratio of students to clinical preceptorship mentors
- Increased exposure of students to community and home settings during community health training

Service Delivery:

- Increased competencies in providing care for patients with HIV, TB and/or chronic diseases based on pre- and post-tests and observation of performance
- Improved health worker confidence in delivery of services
- Increased quality of care services
- Increased patient satisfaction
- Improved health outcomes for patients

Retention:

- Increased job satisfaction and/or retention of health workers
- Increased competence of nurses related to activities pivotal to their new roles within the context of task shifting/differentiated models of care \
- Decreased nursing workload and burn out

Priority 2: Employment and retention of health workers.

Illustrative Activities

- Conduct surveys, assessments or evaluations to understand causes of unemployment and underemployment of health workers
- Conduct surveys, assessments or evaluations to identify health worker retention strategies
- Support host country and local governments to develop, improve, and implement HRH strategies to increase employment/absorption, deployment, and retention of health workers in high HIV burden areas
- Support PEPFAR country teams and host governments to develop and implement transition plans for PEPFAR-supported workers to ensure they are retained
- Support governments and provider stakeholders to develop plans for remuneration of CHWs and other related cades and their integration in wider health systems
- Help governments and provider stakeholders to address the issue of CHW burn out, development of career paths, and strengthening linkages to facilities for adequate support

Illustrative Outputs or Outcomes

Retention Challenges:

- Barriers to employment, deployment, and retention of health workers are identified
- Strategies for elimination or reduction of barriers to employment, deployment, and retention of health workers are identified and implemented

Placement & Compensation:

- Number of qualified health workers placed in high volume HIV sites and other priority sites is increased
- CHWs and other volunteer health workers receive salaries and/or other compensations
- Health workers are retained in priority sites providing HIV, infectious, and chronic disease care

Priority 3: Linkage and retention of patients in health care.

Illustrative Activities

- Support host countries and PEPFAR country teams to establish well-functioning provider care teams and networks
- Ensure there in on-going support and mentoring of staff in care teams and networks so they are adequately supported to take on their new tasks and responsibilities
- Develop and implement interdisciplinary clinical training and mentorship programs for health workers that address barriers to patient care linkages and retention
- Provide support to governments in identification and application of health worker roles within differentiated models of care

- Train health workers on methods to improve linkage, adherence and retention of patients in care
- Develop methods for integration of care, treatment, and support services across an array of diseases, including HIV, TB and chronic diseases to support the comprehensive provision of services and integration with primary care using interdisciplinary teams
- Facilitate creation or scale up and formalization of lower health worker cadres, such as patient extenders, peer navigators, or CHWs to optimize patient linkages, adherence, and retention

Illustrative Outputs or Outcomes

Patient Linkage:

- Increased number of training programs or modules on methods for improving linkages to and retention in care
- Increased number of health workers trained on approaches to improving linkages and retention among patients
- Increased competencies and confidence among health workers in delivery of new methods to promote linkages and retention
- Patient linkages, adherence, and retention are improved

Service Delivery:

- Quality of care is improved
- Patient satisfaction is improved
- Increased number of PLHIV with suppressed viral load
- Decreased mortality rates among PLHIV

Priority 4: Coordination and linkages among different health care cadres in delivery of primary care and community health services.

Illustrative Activities

- Support coordination of services delivered by different health workers within primary care and community health settings
- Support development of plans for linking health cadres to social services and civil society organizations
- Train health workers and social service workers on referral systems and proper ways to engage with one another
- Evaluate the effectiveness of methods or models for coordinating the different health workers and linkage of health cadres to social and community services
- Develop, implement, and evaluate models for providing wellness care for stable patients and integrate this into the delivery of primary health care for stable patients
- Train health workers at all levels on supportive supervision and clinical mentoring
- Facilitate intra- and inter-professional collaborations among health workers within primary and community health systems
- Train nurses, midwives, and other cadres on leadership, management, and planning

Illustrative Outputs or Outcomes

Coordination/Linkage:

- Plans and methods for coordinating health workers are effective and efficient
- Plans and methods for linking health cadres to social service workers and civil society organizations are effective
- Referral processes within and between primary and community health care settings are systematic and efficient
- Health workers have clear understanding of their roles and maintain collaborative partnerships with one another

Skills Proficiency:

- Nurses, midwives, and other cadres demonstrate increased competencies in leadership, management, and planning
- Each health worker receives regular supervision
- Health workers have the competence and confidence to supervise staff, including other cadres

Service Delivery:

- Improved health outcomes for patients along the continuum of care

II. Award Information

1. Type of Application and Award

Type of applications sought: New

HRSA will provide funding in the form of a cooperative agreement. A cooperative agreement is a financial assistance mechanism where substantial programmatic involvement is anticipated between HRSA and the recipient during performance of the contemplated project.

HRSA programmatic involvement will include:

- Providing consultation and technical assistance in planning, implementing, and evaluating program activities, including the identification and selection of in-country partners.
- Facilitating the coordination and collaboration among program partners, such as the U.S. Department of State's Office of the U.S. Global AIDS Coordinator (S/GAC), other HHS agencies, the U.S. Agency for International Development (USAID), other USG, foreign governments, international donors and other key stakeholders.
- Participating, as appropriate, in the planning and production of any meetings or workgroups to be conducted during the project period.
- Maintaining an ongoing dialogue with the recipient(s) concerning program plans, policies and other issues that have major implications for any activities under the cooperative agreement.

- Organizing an orientation call or meeting with the recipient(s) to brief them on applicable USG, HHS, and PEPFAR expectations, regulations, and key management requirements as well as report formats and contents. The orientation may include meetings with staff from HHS agencies and S/GAC.
- Reviewing and approving recipient's M&E plan, including for compliance with the strategic information guidance established by S/GAC.
- Providing technical assistance, as mutually agreed upon, and revising annually during validation of the first and subsequent annual work plans. This could include expert technical assistance and targeted training activities in specialized areas, such as strategic information, project management, confidential counseling and testing, palliative care, treatment literacy, and adult learning techniques.
- Facilitating access to the expertise of HRSA personnel and other relevant resources to the project.
- Collecting and analyzing data relative to unmet need, special populations, other key health indicators, and emerging priorities or policy shifts to guide current/future strategic planning, developmental efforts, and work plan activities.
- Reviewing on an on-going basis activities, procedures, measures, and tools to be established and implemented for accomplishing the goals of the cooperative agreement.
- Participating in the dissemination of project findings, best practices, and lessons learned across the initiative.

The Health Workforce Global Initiative cooperative agreement recipient's major responsibilities will include:

- Collaborate closely with HRSA, country governments, in-country USG teams, and other key stakeholders to gain a greater understanding of each country's situation and needs around health workforce development, management, and planning relative to HIV, TB, infectious and chronic diseases.
- Identify short and long-term needs and priorities in order to better mobilize, build consensus, and efficiently plan and coordinate successful interventions for the highest impact.
- Consult with HRSA and USG field teams as applicable, to inform HRSA on program progress and barriers encountered, identify activities to be planned jointly, and discuss matters that require HRSA input and approval.
- Implement strategies for facilitating scale-up and sustainability of activities supported under this agreement that include building on and strengthening previous and/or existing efforts by governments, local networks, and institutions that benefit the populations served. They should endeavor to strengthen indigenous capacity in all aspects of the agreement.
- Develop and execute a final M&E plan within six months of the receipt of the award, in consultation with HRSA and key stakeholders.
- Support the relevant governmental, academic, and regulatory bodies by partnering with local organizations and through the provision of technical support to the government. It is expected that the partnerships will expand through the project period.

- Support health systems strengthening interventions that are grounded in primary health care and universal health coverage principles and capable of responding to diverse and unexpected challenges that might arise in the future.

2. Summary of Funding

Up to $30,000,000 is expected to be available annually to fund up to two recipients. You may apply for a ceiling amount of up to $30,000,000 total cost (includes both direct and indirect/facilities and administrative costs) per year. Award amounts will be determined based on the scope of work in participating countries while ensuring no duplication of effort. This information is only an estimate and does not obligate HRSA in any way. The final award amount will depend on the amount of funding available. Estimated funding amounts may increase or decrease at any time based on current and future appropriations.

The actual amount available will not be determined until enactment of the final FY 2017 federal budget. This program announcement is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, applications can be processed, and funds can be awarded in a timely manner.

The project period is September 30, 2017 through September 29, 2022 (five (5) years). Funding beyond the first year is dependent on the availability of appropriated funds for the Health Workforce Global Initiative in subsequent fiscal years, satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

All HRSA awards are subject to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements at 45 CFR part 75.

Indirect Costs: Indirect costs on awards to foreign organizations and performed outside of the territorial limits of the United States may be paid to support the costs of compliance with federal requirements at a fixed rate of 8 percent of modified total direct costs (MTDC) exclusive of tuition and related fees, direct expenditures for equipment, and subawards and contracts under the grant in excess of $25,000.

III. Eligibility Information

1. Eligible Applicants

Eligible applicants include domestic and foreign public or private, nonprofit entities, including institutions of higher education, and for-profit entities. Faith-based and community-based organizations, Indian Tribes, and tribal organizations are eligible to apply.

Applications from U.S. domestic organizations are strongly encouraged to form a consortium of partners to include foreign institutions with the relevant expertise, with the long-term goal of increasing the adequacy, capacity, coordination, employment, deployment and retention of health care workers. Foreign applicants may include

collaboration with U.S. and other foreign institutions with particular expertise in the proposed priority areas as subrecipient consortium partners.

The applicant institution must meet the eligibility requirements and assumes all legal, programmatic, and financial responsibilities under the award. Consortium participants would be considered subrecipients under the award. Subrecipients are subject to all programmatic terms and conditions of the award. Depending on the type of engagement and scope of work, consortium agreements may be in the form of memorandums of understanding (MOUs), subawards, or contracts.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

Applications that exceed the ceiling amount will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to satisfy the deadline requirements referenced in *Section IV.4* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Multiple applications from an organization are not allowable.

If for any reason (including submitting to the wrong funding opportunity number or making corrections/updates), an application is submitted more than once prior to the application due date, HRSA will only accept your **last** validated electronic submission, under the correct funding opportunity number, prior to the Grants.gov application due date as the final and only acceptable application.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** you to apply electronically through Grants.gov. You must download the SF-424 application package associated with this NOFO following the directions provided at http://www.grants.gov/applicants/apply-for-grants.html.

HRSA recommends that you supply an email address to Grants.gov on the grant opportunity synopsis page, and when downloading the NOFO (also known as "Instructions" on Grants.gov) or application package. This allows Grants.gov to email organizations that supply an email address in the event the NOFO is changed and/or republished on Grants.gov before its closing date. Responding to an earlier version of a modified announcement may result in a less competitive or ineligible application. *Please note you are ultimately responsible for reviewing the Find Grant Opportunities page for all information relevant to desired opportunities.*

2. Content and Form of Application Submission

Section 4 of HRSA's *SF-424 Application Guide* provides instructions for the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program specific information below. You are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide* except where instructed in the NOFO to do otherwise. Applications must be submitted in the English language and must be in the terms of U.S. dollars (45 CFR § 75.111(a)).

See Section 8.5 of the *Application Guide* for the Application Completeness Checklist.

Application Page Limit
The total size of all uploaded files may not exceed the equivalent of **80 pages** when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this NOFO. Standard OMB-approved forms that are included in the application package do not count in the page limitation. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) will not be counted in the page limit. **We strongly urge you to take appropriate measures to ensure your application does not exceed the specified page limit.**

Applications must be complete, within the specified page limit, and validated by Grants.gov under the correct funding opportunity number prior to the deadline to be considered under the announcement.

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

1) The prospective recipient certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
2) Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. 3321).
3) Where the prospective recipient is unable to attest to the statements in this certification, an explanation shall be included. Attachment 11: Other Relevant Documents.

See Section 4.1 viii of HRSA's *SF-424 Application Guide* for additional information on all certifications.

Program-Specific Instructions
In addition to application requirements and instructions in Section 4 of HRSA's *SF-424 Application Guide* (including the budget, budget narrative, staffing plan and personnel requirements, assurances, certifications, and abstract), please include the following:

i. Project Abstract
See Section 4.1.ix of HRSA's *SF-424 Application Guide*.

In addition to the information required in the Guide, the abstract must include the following information:

- Specific, measurable goals to be addressed.

ii. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Use the following section headers for the Narrative:

- *INTRODUCTION -- Corresponds to Section V's Review Criterion #1*

Provide a brief description of the proposed strategy and approaches to be undertaken to strengthen the health system and to improve the production, capacity, employment, deployment and retention of the health workforce in PEPFAR-supported countries. Summarize the existing gaps, design and rationale of supporting the development of health care workers in PEPFAR countries with high HIV, TB other infectious disease, and chronic disease burdens. Discuss how the program will engage and collaborate with stakeholders to collectively develop practical, unique, and innovative solutions. Discuss how the proposed program aligns with needs identified in existing national health strategic plans and how the program will, in partnership with Ministry of Health and other stakeholders, contribute to longer term, sustainable health outcomes.

- *NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion #1*

Provide a concise summary of the literature that demonstrates a comprehensive, up-to-date understanding of the issues related to pre-service and in-service training and capacity building of health care workers to address HIV and TB, chronic and non-communicable diseases, stigma and discrimination, key populations, and new service delivery models, and to increase competencies in management/administration, leadership, and supervision/mentorship. Describe known needs, challenges and risks associated with task shifting and expansion, capacity building, coordination, linkage, employment, distribution, and retention of health workers. Detail current health leadership and governance issues, as well as the state-of-the-art related to the need to implement innovative service delivery models. Describe the need for workforce development that supports primary and community health care services in the delivery of new service models for PEPFAR-supported countries.

- *METHODOLOGY -- Corresponds to Section V's Review Criterion #2*

Describe in detail the proposed project's vision, objectives, goals, and intended outcomes. Objectives should be specific, measurable, realistic, and achievable within the project period. Describe the technical approach/methods for implementing the proposed project, project priorities, objectives and goals to the program expectations outlined in this NOFO. Highlight those activities linked to the goals outlined in PEPFAR 3.0 and the PEPFAR HRH Strategy for achievement of 90-90-90 goals and targets. Describe the proposed approach for improving access to and

the quality of services to HIV/AIDS, TB, non-HIV chronic diseases, and other priority health areas while at the same time strengthening HRH systems. This section must include a plan for promoting sustainability through capacity-building for and hand-over of decision-making to relevant partner country decision-makers.

The methodology must address how you will achieve the following:

- Build and maintain effective strategic partnerships with relevant government agencies, education institutions, regulatory bodies, health management teams, civil society organizations, other USG-funded programs, and other stakeholders to ensure relevancy and timeliness of education, training and technical assistance;
- Ensure that plans are in alignment with host country strategic plans and current health priorities;
- Ensure that technical assistance, training and capacity development activities address the gaps and needs of health care providers to ensure a sustainable health workforce;
- Strengthen the link between pre-service and in-service training to ensure relevancy and responsiveness of the curriculum and faculty to new developments in HIV, TB, other infectious and chronic diseases in response to local priorities;
- Ensure up to-date knowledge and skills in HIV, TB, and other infectious and chronic diseases in response to local health priorities in PEPFAR-supported countries address the health care needs of key and priority populations (key and priority populations include women and girls, men who have sex with men, sex workers, people who inject drugs and use alcohol);
- Enhance the collection, analysis, and use of surveillance and health workforce data to support policy and program decision-making;
- Plan for accountability, including transparency with which transactions occur, resources are allocated, and money is spent, as well as for the way resources are used (monetary and non-monetary);
- Include strategies for facilitating scale-up and sustainability of activities that include building on and strengthening previous and/or existing efforts by host and the USG and/or other donors;
- Include strategies for enhancing primary and community health care as an important extension of the health system;
- Ensure sustainability of these approaches and reduce any negative effects on the health workforce;
- Balance efforts to have immediate impact with efforts to establish longer-term and more sustainable interventions;
- Supply the current health workforce with appropriate technical assistance, training, and capacity development;
- Coordinate with similar activities that are supported by other funding sources; and
- Collaborative with other partners including USG, other implementing partners, donors, and Ministries. You should demonstrate a strong capacity to understand, manage, and leverage different types of relationships to implement the Health Workforce Global Initiative.

- *WORK PLAN -- Corresponds to Section V's Review Criteria #2 and #4*
  Provide a work plan that demonstrates how the outcomes, strategies, activities, timelines, and staffing will take place over the course of the award. Include a detailed work plan for the first year of the project and a high level plan for the four subsequent years. The work plan should include goals, objectives, and outcomes that are SMART (specific, measureable, achievable, realistic, and time-measured). Include all aspects of planning, implementation, and evaluation, along with the role of key staff involved in each activity. The work plan must relate to the needs identified in the needs assessment section and to the activities described in the project narrative. If funds will be sub-awarded or expended on contracts, describe how your organization will ensure the funds are properly documented.

  Provide a timeline that delineates the goals, objectives, action steps, responsible staff, timeline for action steps, and measurable outcomes for each activity. The work plan and timeline must demonstrate the ability to reach stated program objectives within the required time of performance, including a plan for rapid launch of project activities. Expected milestones for first six months of Year 1 include:

  Development/Planning Phase: First six months of Year 1
  - Hold initial in-country work planning meetings and consultations
  - Establish program and operational structure and procedures
  - Develop meeting and coordination schedule
  - Finalize sub-agreements
  - Revise, confirm, and finalize work plans and budgets
  - Complete needs assessments and proposals for addressing identified needs and gaps
  - Develop and finalize monitoring and evaluation plan, including a process for continuous quality improvement using these data
  - Develop training materials

  Implementation Phase: Second six months of Year 1
  - Begin implementation of interventions
  - Measure program progress and outcomes; collect and report data
  - Establish technical partnerships and networks with relevant stakeholders

  The work plan should include as much detail as possible with the understanding that the final plan will be developed after the cooperative agreement is awarded and after initial consultations with HRSA and in-country stakeholders. Include the project's work plan as **Attachment 1**. This section is often best presented and/or summarized in a chart format.

  Describe the proposed quality management plan, which should include activities to assure both the quality of products and outputs and improvement as needed. Include the performance measures used to assess implementation, efficiency, and impact. Describe how the plan will:
  - Identify staff responsible for the quality management activities

- Monitor program staff and measure and track program goals, objectives and activities, especially those outlined in the approved work plan; and deliver technical assistance to USG and international partners as needed; and
- Ensure the activities reflect the needs of the population, are delivered in an effective manner, are reflective of the current knowledge base, and are aligned with PEPFAR 3.0 priorities.

You must submit a logic model for designing and managing the project as a part of Attachment 1. A logic model is a one-page diagram that presents the conceptual framework for a proposed project and explains the links among program elements and the benefits of changes that result. It is the core of program planning, evaluation, program management, and communications. The logic model must describe the inputs, influential factors, outputs, and short-term and long-term outcomes as a means towards reaching the program goals and the goals of PEPFAR 3.0 and the PEPFAR HRH Strategy. Logic models should be consistent with the work plan submitted. While there are many versions of logic models, for the purposes of this announcement, the logic model should summarize the connections between the:

- Goals of the project (the mission or purpose of the program)
- Outcomes (short-term, intermediate, and long-term results of the program)
- Outputs (the direct products or deliverables of program activities and the targeted participants/populations to be reached). Include the number of trainees anticipated to be trained, by level of training, training site, and discipline
- Activities (approach, key interventions, action steps, etc.)
- Inputs (investments and other resources such as time, staff and money)

You can find additional information on developing logic models at the following website:
https://www.cdc.gov/eval/logicmodels/index.htm.

Although there are similarities, a logic model is not a work plan. A work plan is an action guide with a timeline used during program implementation; the work plan provides the "how to" steps. You can find information on how to distinguish between a logic model and work plan at the following website:
http://www.cdc.gov/healthyyouth/evaluation/pdf/brief5.pdf

- *RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion #2*

Discuss challenges that you are likely to encounter in designing and implementing the activities described in the work plan. Include challenges in working with country governments, training institutions, professional associations and councils, and other stakeholders in carrying out the proposed activities. Provide realistic and appropriate approaches, linked to your clinical quality improvement process, that will be used to resolve such challenges. Identify and describe potential barriers to program implementation and provide reasonable and actionable solutions to address these barriers.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criteria #3, #4, and #5*

  Describe your capacity to monitor program goals and objectives. Describe plans to track and quantify the utilization of tools, systems, and strategies developed. Describe methods and measures that will be used to evaluate the system-level impacts of the overall project and demonstrate the effectiveness of project activities.

  Describe how the performance management plan will link with expenditure reporting for the proposed project. The performance management plan should also include a well-defined set of quarterly indicators with yearly benchmarks for the proposed activities delineated in the work plan. Such indicators and benchmarks should conform to the proposed timeline described in the work plan, as continued support during years two (2) through five (5) will be provided only while timely achievement of indicators and benchmarks can be demonstrated. These will be reconsidered on a quarterly basis in accordance with the PEPFAR quarterly country review process. The successful recipient(s), in consultation with HRSA, will work with relevant stakeholders to co-develop the five-year M&E plan.

  Identify methods to be used for effective tracking of performance outcomes, including a description of how the organization will collect and manage data (e.g., assigned skilled staff, data management software) in a way that allows for accurate and timely reporting of program outcomes. Describe the role of key program partners in the evaluation and performance measurement planning processes.

  Describe how you will develop and implement a comprehensive evaluation plan to measure (annually and for the entire project period) the impact of education, training, and capacity development activities on trainees' knowledge, skills, and behaviors; increases in the health workforce; improved access to care in the community; clinical practice transformation; and patients' clinical outcomes. Describe how you will establish and report on baseline data and measure process and outcome data in alignment with host country and PEPFAR goals.

  Describe processes for developing appropriate evaluation tools, systems and strategies to electronically receive, store, manage, and maintain data. Indicate how these will include data specific to the PEPFAR program (e.g., monitoring, evaluation, and reporting indicators and annual progress reports).

  Describe current experience, skills, and knowledge, including individuals on staff, materials published, and previous work of a similar nature. As appropriate, describe the strategy to collect, analyze, and track data to measure process and impact/outcomes, and explain how the data will be used to inform program development and service delivery. You must describe any potential obstacles for implementing the program performance evaluation and how those obstacles will be addressed.

Describe the experience of proposed key project personnel (including any consultants and subcontractors) in writing and publishing study findings in peer reviewed journals and in disseminating findings to local communities, national conferences, and to policy makers.

- *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion #5*

  In this section, provide four major elements: an organizational description and chart, an outline of the management and staffing plan, an outline of the administrative and fiscal oversight plan, and an outline of technical partners and other key collaborators. Each element is described in more detail below.

  Organizational Description and Chart
  Provide information on your current mission and structure, scope of current activities, and history of developing and strengthening HRH activities. If applicable, provide this information for each organization in the consortium. Discuss how your organization will follow the approved plan, as outlined in the application, properly account for the federal funds, and document all costs so as to avoid audit findings.

  Describe your organizational knowledge, capability, and experience in managing programs that provide training, technical assistance, and HRH development activities in resource-poor settings. Include any experience in the provision of training, technical assistance, and capacity development within the scope of PEPFAR. Discuss any examples of previous projects that reflect the expertise of proposed personnel in working collaboratively with Ministerial, education institutions, USG/PEPFAR team, regulatory bodies, health management teams, civil society organizations, other USG-funded programs, and other stakeholders.

  Provide a table that lists previous global health grants, cooperative agreements, and/or contracts managed over the past ten years as **Attachment 9**.

  Provide a project organizational chart as **Attachment 5**. The organizational chart should be a one-page figure that depicts the organizational structure of the project and should include consortium members (if applicable) and all other collaborators and contractors.

  Management and Staffing Plan
  Provide a management plan for project implementation showing how responsibility and lines of authority will be managed within your institution. The management plan must describe how the project will relate to and respond to HRSA and to in-country USG. You must describe capacity for rapid start-up of the project, including plans for rapidly accessing and deploying key personnel and essential technical staff to support program implementation. Also, please include a description of your organization's timekeeping process to ensure that you will comply with the federal standards related to documenting personnel costs.

As the prime partner, indicate your method of identifying collaborating partners, and the tasks/functions they will be performing. Outline which partners will carry out the various tasks specified in the technical approach; a matrix or table may be helpful to organize this section. You, the applicant institution, will be responsible for all technical activities regardless of the activities implemented by the consortium partners or other member of the team. Specify the composition and organizational structure of the entire team (including subrecipients and/or country offices) and specify the nature of organizational linkages (includes their relationships between each other, lines of authority and accountability, and patterns for utilizing and sharing resources).

Provide descriptive information on your resources and capabilities to support the provision of culturally and linguistically competent training and capacity development services. Cultural competence means having a set of congruent behaviors, attitudes, and policies that come together in a system or organization or among professionals that enables effective work in cross-cultural situations. It includes an understanding of integrated patterns of human behavior, including language, beliefs, norms, and values, as well as socioeconomic and political factors that may have significant impact on psychological well-being. See U.S. Government National Standards for Culturally and Linguistically Appropriate Services at.https://https://www.thinkculturalhealth.hhs.gov/clas/standards.

Include a Staffing Plan and Job Descriptions for Key Personnel as **Attachment 2**.

The staffing plan must include key personnel and core technical staff, and an organizational chart demonstrating lines of authority and staff responsibility. The staffing plan must also indicate personnel who are already employed by the organization and their level of involvement (FTE) on this project.

Administrative and Fiscal Oversight

- Describe your capacity to administratively manage a federally-funded training and technical assistance program, and past experience managing awards and contracts;
- Describe the proposed processes to be used for oversight of and technical assistance for subrecipients' services; and
- Describe your capacity to fiscally manage a federally-funded training and technical assistance program, including the capacity to develop a standardized method to manage, execute in a timely manner, and monitor contracts and subcontracts.

Key Collaborators and Partners

Describe how you will work collaboratively and partner with key stakeholders. Propose how you will liaise and coordinate with the partner government(s) as well as with other district and local government partners, USG partners, and other stakeholders working across PEPFAR program areas. If you plan to team up with other organizations or government agencies for the implementation of the proposed activities, then you should outline the services to be provided by each such agency or organization. You should state whether or not you have any

existing relationships with the proposed partner(s) and, if so, should include the MOUs in **Attachment 4**.

NARRATIVE GUIDANCE In order to ensure that you fully address the review criteria, this table provides a crosswalk between the narrative language and where each section falls within the review criteria.	
Narrative Section	**Review Criteria**
Introduction	(1) Need
Needs Assessment	(1) Need
Methodology	(2) Response
Work Plan	(2) Response and (4) Impact
Resolution of Challenges	(2) Response
Evaluation and Technical Support Capacity	(3) Evaluative Measures (4) Impact (5) Resources/Capabilities
Organizational Information	(5) Resources/Capabilities
Budget and Budget Narrative (below)	(5) Resources/Capabilities (6) Support Requested

iii. Budget

See Section 4.1.iv of HRSA's *SF-424 Application Guide*. Please note: the directions offered in the SF-424 Application Guide may differ from those offered by Grants.gov. Please follow the instructions included in the Application Guide and, *if applicable*, the additional budget instructions provided below. A budget that follows the Application Guide will ensure that, if the application is selected for funding, you will have a well-organized plan and by carefully following the approved plan can avoid audit issues during the implementation phase.

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) incurred by the recipient to carry out a HRSA-supported project or activity. Total project or program costs include costs charged to the award and costs borne by the recipient to satisfy a matching or cost-sharing requirement, as applicable.

In addition, the Health Workforce Global Initiative requires the following:

The budget should highlight activities directly linked to HIV. Such activities should be in alignment with PEPFAR 3.0 and the PEPFAR HRH Strategy.

Indirect Costs: Indirect costs on grants awarded to foreign organizations and performed outside of the territorial limits of U.S. may be paid to support the costs of compliance with federal requirements at a fixed rate of eight (8) percent of modified total direct costs (MTDC) exclusive of tuition and related fees, direct expenditures for

equipment, and subawards and contracts under the grant in excess of $25,000.

Multiple allocation indirect cost rates: For institutions of higher education and nonprofits that have indirect costs benefitting major programs disproportionately, indirect rates will vary. HRSA will honor the federally-negotiated indirect cost rate.

iv. Budget Narrative

See Section 4.1.v. of HRSA's *SF-424 Application Guide*. Note that the line item budget is submitted as a separate, stand-alone document as described in **Attachment 6** below.

v. Attachments

Please provide the following items in the order specified below to complete the content of the application. **Unless otherwise noted, attachments count toward the application page limit.** Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. **Each attachment must be clearly labeled**.

Attachment 1: Work Plan, required

Attach the work plan for the project that includes all information detailed in Section IV. ii. The required logic model, is included in this attachment.

Attachment 2: Staffing Plan and Job Descriptions for Key Personnel (see Section 4.1. of HRSA's *SF-424 Application Guide), required*

Keep each job description to one page in length. Include the role, responsibilities, and qualifications of proposed project staff.

Attachment 3: Biographical Sketches of Key Personnel, required

Include biographical sketches for persons occupying the key positions described in Attachment 2, not to exceed two pages in length per person. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the biographical sketch.

Attachment 4: Letters of Support, Letters of Agreement, Memoranda of Understanding, and/or Description(s) of Proposed/Existing Contracts, required

Each application must include letters of support from the Ministry of Health and Ministry of Education from each proposed country to implement the Health Workforce Global Initiative. Applications should also include letters from all participating institutions' leadership, substantiating the institution's commitment to the proposed program and to sustaining the results of the proposed activities. Provide any documents that describe working relationships between your institution, consortium participants, and other entities and programs cited in the proposal. Documents that confirm actual or pending contractual agreements should clearly describe the roles of the contractors and any deliverable. Letters of support/agreement and MOUs must be signed and dated.

Attachment 5: Project Organizational Chart, required

Provide a one-page figure that depicts the organizational structure of the project.

Attachment 6: Line-Item Budget, required

Submit separate line item budgets for each year of the proposed project period as a single spreadsheet table, using the Section B Budget Categories of the SF-424A and breaking down sub-categorical costs as appropriate. Excel spreadsheets are strongly preferred.

Attachment 7: Fifth Year Budget (NOT counted in page limit), *required*

After using columns (1) through (4) of the SF-424A Section B for a five-year project period, you will need to submit the budget for year 5 as an attachment. Use the SF-424A Section B. See Section 4.1.iv of HRSA's SF-424 Application Guide.

Attachment 8: Indirect Cost Rate Agreement, if applicable

If indirect costs are requested, attach current federally-negotiated Indirect Cost Rate Agreement.

Attachment 9: Global Health Federal Grants and/or Cooperative Agreements, if applicable

Provide a table that lists previous global health grants, cooperative agreements, and/or contracts that you have managed over the past ten years. In the table include: source of funding; name of project director/principal investigator; institution holding the award; grant, cooperative agreement, or contract number; total amount of award; and end date. The table may include all collaborating institutions listed in this application to meet the requirement.

Attachment 10: Past Performance References, required

You and any consortium participants must provide up to three past performance references from the last three years for contracts, grants and/or cooperative agreements of similar size, scope and complexity. These references should include information about quality of activities, successful implementation and impact.

Attachments 11– 15: Other Relevant Documents (as applicable)

Include here any other documents that are relevant to the application.

3. Dun and Bradstreet Data Universal Numbering System (DUNS) Number and System for Award Management

You must obtain a valid DUNS number, also known as the Unique Entity Identifier, for your organization/agency and provide that number in the application. You must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which you have an active federal award or an application or plan under consideration by an agency (unless the applicant is an individual or federal agency that is exempted from those requirements under 2 CFR § 25.110(b) or (c), or has an exception approved by the agency under 2 CFR § 25.110(d))**.**

HRSA may not make an award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time HRSA is ready to make an award, HRSA may determine that the applicant is not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If you have already completed Grants.gov registration for HRSA or another federal agency, confirm that the registration is still active and that the Authorized Organization Representative (AOR) has been approved.

The Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (http://www.dnb.com/duns-number.html)
- System for Award Management (SAM) (https://www.sam.gov)
- Grants.gov (http://www.grants.gov/)

For further details, see Section 3.1 of HRSA's *SF-424 Application Guide*.

If you fail to allow ample time to complete registration with SAM or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

4. Submission Dates and Times

Application Due Date
The due date for applications under this NOFO is *June 12, 2017 at 11:59 p.m. Eastern Time*.

See Section 8.2.5 – Summary of e-mails from Grants.gov of HRSA's *SF-424 Application Guide* for additional information.

5. Intergovernmental Review

The Health Workforce Global Initiative is not a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR part 100.

6. Funding Restrictions

You may request funding for a project period of up to five (5) years, at no more than $30,000,000 per year. Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

You may not use funds under this announcement for the following purposes:

- Research
- Construction
- To promote or advocate the legalization or practice of prostitution or sex trafficking

- Travel, per diem, hotel expenses, meals, conference fees or other conference costs for any member of a foreign government's delegation to an international conference sponsored by a multilateral organization, as defined below, unless approved by HRSA in writing

  Definitions:
  - A foreign government delegation is appointed by the host country government (including ministries and agencies but excluding local, state and provincial entities) to act on behalf of the appointing authority at the international conference. A conference participant is a delegate for the purposes of this provision, only when there is an appointment or designation that the individual is authorized to officially represent the government or agency. A delegate may be a private citizen.
  - An international conference is a meeting where there is an agenda, an organizational structure, and delegations from countries other than the conference location, in which country delegations participate through discussion, votes, etc.
  - A multilateral organization is an organization established by international agreement and whose governing body is composed principally of foreign governments or other multilateral organizations.

In addition, please note the following:

- Consistent with numerous United Nations Security Council resolutions, including UNSCR 1267 (1999), UNSCR 1368 (2001), UNSCR 1373 (2001), UNSCR 1989 (2011), and UNSCR 2253 (2015) [https://www.un.org/sc/suborg/en/sanctions/un-sc-consolidated-list], both HRSA and the recipient are firmly committed to the international fight against terrorism, and in particular, against the financing of terrorism. Award funds may not be used, directly or indirectly, to provide support to individuals or entities associated with terrorism. In accordance with this policy, the recipient agrees to use reasonable efforts to ensure that none of the funds provided under this award are used to provide support to individuals or entities associated with terrorism, including those identified on the U.S. Department of Treasury Office of Foreign Assets Control Specially Designated Nationals List (https://www.treasury.gov/resource-center/sanctions/SDN-List/Pages/default.aspx). This provision must be included in all subagreements, including contracts and subawards, issued under this award.
- No funds or other support provided under the award may be used for support to any military or paramilitary force or activity, or for support to any police, prison authority, or other security or law enforcement forces without the prior written consent of HRSA.
- Award funds may not be used, directly or indirectly, to provide support to individuals or entities designated for United Nations Security Council sanctions. In accordance with the policy, the recipient agrees to use reasonable efforts to ensure that none of the funds provided under this award are used to provide support of individuals or entities designated for UN Security Council Sanctions (compendium of Security Council Targeted Sanctions Lists at: https://www.un.org/sc/suborg/en/sanctions/un-sc-consolidated-list). This provision must be included in all sub-agreements, including contracts and subawards, issued under this award.

- No funds or other support provided hereunder may be used for any activity that contributes to the violation of internationally recognized worker rights in the recipient country. In the event the recipient is requested or wishes to provide assistance in areas that involve workers' rights or the recipient requires clarification from HRSA as to whether the activity would be consistent with the limitation set forth above, the recipient must notify the HRSA and provide a detailed description of the proposed activity. The recipient must not proceed with the activity until advised by HRSA that it may do so. The recipient must ensure that all employees and subcontractors and subrecipients providing employment-related services hereunder are made aware of the restrictions set forth in this clause and must include this clause in all subcontracts and other sub-agreements entered into hereunder. The term "internationally recognized worker rights" includes-- the right of association; the right to organize and bargain collectively; a prohibition on the use of any form of forced or compulsory labor; a minimum age for the employment of children, and a prohibition on the worst forms of child labor; and acceptable conditions of work with respect to minimum wages, hours of work, and occupational safety and health. The term "worst forms of child labor" means-- all forms of slavery or practices similar to slavery, such as the sale or trafficking of children, debt bondage and serfdom, or forced or compulsory labor, including forced or compulsory recruitment of children for use in armed conflict; the use, procuring, or offering of a child for prostitution, for the production of pornography or for pornographic purposes; the use, procuring, or offering of a child for illicit activities in particular for the production and trafficking of drugs; and work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety, or morals of children, as determined by the laws, regulations, or competent authority of [COUNTRY]."
- HRSA reserves the right to terminate this award or take other appropriate measures if the recipient or a key individual of the recipient is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140. HRSA reserves the right to terminate assistance to, or take other appropriate measures with respect to, any participant approved by HRSA who is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140.
- An organization, including a faith-based organization, that is otherwise eligible to receive funds under this award for HIV/AIDS prevention, treatment, or care—
  1) Shall not be required, as a condition of receiving such assistance—
     (a) To endorse or utilize a multi-sectoral or comprehensive approach to combating HIV/AIDS; or
     (b) To endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the organization has a religious or moral objection; and
  2) Shall not be discriminated against in the solicitation or issuance of grants, contracts, or cooperative agreements for refusing to meet any requirement described in paragraph (a) above.
- Information provided about the use of condoms as part of projects or activities funded under the award must be medically accurate and must include the public health benefits and failure rates of such use.

- Funds made available under this award must not be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any individual to practice sterilization.
- No funds made available under this award will be used to finance, support, or be attributed to the following activities: 1) procurement or distribution of equipment intended to be used for the purpose of inducing abortions as a method of family planning; 2) special fees or incentives to any person to coerce or motivate them to have abortions; 3) payments to persons to perform abortions or to solicit persons to undergo abortions; 4) information, education, training, or communication programs that seek to promote abortion as a method of family planning; and 5) lobbying for or against abortion. The term "motivate," as it relates to family planning assistance, must not be construed to prohibit the provision, consistent with local law, of information or counseling about all pregnancy options. No funds made available under this award will be used to pay for any biomedical research that relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilizations as a means of family planning. Epidemiologic or descriptive research to assess the incidence, extent or consequences of abortions is not precluded.
- No funds or other support provided hereunder may be used to provide a financial incentive to a business enterprise currently located in the United States for the purpose of inducing such an enterprise to relocate outside the United States if such incentive or inducement is likely to reduce the number of employees of such business enterprise in the United States because United States production is being replaced by such enterprise outside the United States.
    - In the event the Recipient requires clarification from HRSA as to whether the activity would be consistent with the limitation set forth above, the Recipient must notify HRSA and provide a detailed description of the proposed activity. The Recipient must not proceed with the activity until advised by HRSA that it may do so.
    - The Recipient must ensure that its employees and subcontractors and subrecipients providing investment promotion services hereunder are made aware of the restrictions set forth in this clause and must include this clause in all subcontracts and other sub-agreements entered into hereunder.

Note that the above-described or other funding restrictions will apply in FY 2017, as required by law.

The General Provisions in Division H of the Consolidated Appropriations Act, 2016 (P.L. 114-113) do not apply to this program. Please see Section 4.1 of HRSA's *SF-424 Application Guide* for additional information.

You are required to have the necessary policies, procedures and financial controls in place to ensure that your organization complies with all legal requirements and restrictions applicable to the receipt of federal funding including statutory restrictions on use of funds for lobbying, abortion, etc. Like those for all other applicable requirements, the effectiveness of these policies, procedures and controls is subject to audit.

All program income generated as a result of awarded funds is considered additive and must be added to the funded amount and used for otherwise allowable costs to further the objectives of the Health Workforce Global Initiative program.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist you in understanding the standards against which your application will be judged. Critical indicators have been developed for each review criterion to assist you in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

These criteria are the basis upon which the reviewers will evaluate and score the merit of the application. The entire proposal will be considered during objective review.

Review criteria are used to review and rank applications. The Health Workforce Global Initiative has *six* review criteria:

Criterion 1: NEED (15 points) – Corresponds to Section IV's Introduction and Needs Assessment sections of the Narrative.
The extent to which the application demonstrates the problem and associated contributing factors to the problem.

Reviewers will consider the quality with which and extent to which the applicant:

- Provides an overview of the national host country health strategic plan and HRH priorities of the PEPFAR-supported countries.
- Demonstrates a comprehensive, up-to date understanding of the following issues/challenges/needs in PEPFAR-supported countries:
    - The issues related to strategic planning for health system-level change
    - Challenges and risks associated with task shifting and expansion, capacity building, coordination, linkage, employment, distribution, and retention of health workers
    - HRH management and capacity challenges
    - Current health leadership and governance issues
    - Need for primary and community health care services in the delivery of new service models for PEPFAR-supported countries
    - Health worker training and capacity building to address HIV and TB, chronic and non-communicable diseases, stigma and discrimination, key populations, new service delivery models, and to increase competencies in management/administration, leadership, and supervision/mentorship
- Identifies the proposal's areas of foci, by priority objective, with an evidence-based justification responsive to each country's needs and gaps

Criterion 2: RESPONSE (30 points) –Corresponds to Section IV's Methodology, Work Plan, and Resolution of Challenges

Reviewers will consider:
Methodology (15 points)

- The extent to which the proposed overall strategy clearly relates to the program objectives, goals, and expectations as outlined in this NOFO
- The extent to which the overall strategy addresses the current and evolving HRH priorities, and highlights the goals outlined in PEPFAR 3.0 and the PEPFAR HRH Strategy
- The extent to which the proposed broader HRH strengthening efforts will impact HIV/AIDS, TB, chronic diseases, and other service delivery as demonstrated in the work plan and anticipated outcomes
- The strength of the proposed partnerships and strategies for facilitating scale-up and sustainability of activities that build upon and strengthen previous and/or existing efforts by the host country, USG, or other donors
- The extent to which the applicant adequately outlines the proposed process and timeline for subaward management and subrecipient monitoring, including the subaward process from initiation to approval
- The strength of the proposed plan to track performance outcomes, including how the data will be collected and managed (e.g., assigned skilled staff, data management software) in a way that allows for accurate and timely reporting to HRSA

Work Plan (10 points)

- The strength and feasibility of the proposed work plan to reach stated program objectives within the required time of performance
- The extent to which the work plan is aligned with the needs identified in the needs assessment and to the strategy outlined in the methodology
- The extent to which the work plan focused on training the workforce to treat HIV/AIDS, TB, and chronic diseases and an integrated approach to providing comprehensive primary care
- The strength and feasibility of the timeline that delineates the goals, objectives, action steps, responsible staff, and timeline for action steps; and measures outcomes for each activity
- The extent to which the proposed goals, objectives, and outcomes outlined in the proposed plans are SMART (specific, measureable, achievable, realistic, and time-measured)
- The strength and feasibility of the quality management plan to assess implementation, efficiency, and impact
- The extent to which the applicant's logic model clearly describes the inputs, influential factors, outputs, and short-term and long-term outcomes as a means towards reaching the program objectives and the goals of PEPFAR 3.0 and PEPFAR HRH Strategy

Resolution of Challenges (5 points)
Reviewers will consider the quality with which and extent to which the applicant:

- Demonstrates knowledge of the challenges that may be encountered in designing and implementing the activities described in the work plan, and

- Provides realistic and appropriate approaches, including partnerships with local entities, to resolving the challenges

Criterion 3: EVALUATIVE MEASURES (15 points) – Corresponds to Section IV's Evaluation and Technical Support Capacity

Evaluation Plan (5 points)

- The strength and feasibility of the proposed evaluation plan to develop appropriate evaluation tools, systems, and strategies to electronically receive, store, manage, and maintain data; including data specific to the PEPFAR program
- For HIV-related activities, the extent to which the applicant incorporates baseline and performance measures that demonstrate progress towards PEPFAR goals
- The strength of the proposed strategy to collect, analyze and track data to measure process and impact/outcomes, and the clarity of the description of how the data will be used to inform program development and implementation
- The strength of the applicant's proposed baseline data and measures, and the extent to which the proposed evaluative measures will be able to assess: 1) that the program objectives have been met and 2) the extent these can be attributed to the project
- The strength of the applicant's proposed methods and measures that will be used to evaluate the system-level impacts of the overall project and demonstrate the effectiveness of project activities

Capacity (10 points)

- The strength of local experience and/or partnerships with local entities necessary to implement performance monitoring and evaluation of the project
- The extent to which the applicant demonstrates a thorough understanding of any potential obstacles for implementing the program performance evaluation, and the strength of the proposed plans to address those obstacles
- The extent to which the performance management plan will link with expenditure reporting for the proposed project
- The extent to which the applicant clearly articulates the role of key program partners in the evaluation and performance measurement planning processes

Criterion 4: IMPACT (10 points) – Corresponds to Section IV's Work Plan and Section IV, Evaluation and Technical Support Capacity

The feasibility and effectiveness of plans for dissemination of project results, the extent to which project results may be multi-national in scope, and the degree to which the project activities are replicable and sustainable after federal funding.

- The strength and feasibility of the proposed plan to achieve and disseminate project objectives, activities, and results
- The strength and feasibility of the proposed plan for promoting sustainability after the period of federal funding ends through capacity building, and the appropriateness of the plan to transition decision-making to relevant partner country stakeholders

- The extent to which the applicant demonstrates a thorough understanding of the likely challenges to be encountered in sustaining the program, and the strength of the proposed approaches to resolving such challenges

Criterion 5: RESOURCES/CAPABILITIES (20 points) – Corresponds to Section IV's Evaluation and Technical Support Capacity, Organizational Information, Budget and Budget Justification Narrative, and Attachments 2, 3, 4, 5, 9 and 10

Reviewers will consider:

Organizational Description and Chart (5 points)

- The strength and clarity of the proposed project organizational chart (**Attachment 5**) in relation to the project description and proposed activities
- The strength and clarity of the current organizational structure, proposed staff, and scope of current activities that contribute to the applicant's ability to conduct the proposed program and meet the expectations of the program requirements
- The extent to which the quality and availability of facilities and personnel will support the needs and requirements of the proposed project
- The extent to which the applicant institution has experience in implementing and managing programs aimed at strengthening the delivery of services for HIV/AIDS, TB, chronic diseases, or other relevant health areas
- The extent to which the applicant institution has experience in implementing and managing health workforce, technical assistance, and capacity building programs in resource-constrained countries (**Attachment 9**)
- The extent to which references addressing past performance (**Attachment 10**) demonstrate an institution's capacity to successfully carry out the proposed program

Management and Staffing Plan (5 points)

- The strength and clarity of the proposed staffing plan (**Attachment 2**) and project organizational chart (**Attachment 5**) in relation to the project description and proposed activities; including evidence that the staffing plan includes sufficient personnel with adequate time to successfully implement all of the project activities throughout the project as described in the work plan
- The extent to which the qualifications of the identified Project Director (by training and experience) support the ability to lead a project of similar size and scope; the extent to which competence is appropriately demonstrated (e.g., publications, funded research) in HRH with appropriate academic preparation and clinical expertise
- The extent to which key project personnel are qualified by training and/or experience to implement the project

Administrative and Fiscal Oversight (5 points)

- The strength and feasibility of the proposed processes for oversight of and technical assistance for subrecipients' services
- The extent to which the applicant institution demonstrates the capacity to fiscally manage a federally-funded program, including the capacity to develop a

standardized method to manage, execute in a timely manner, and monitor subawards and contracts

Key Collaborations (5 points)

- The extent to which the applicant demonstrates successful established or planned partnership(s) in the specified country with relevant ministerial, educational institutions, regulatory bodies, health management teams, civil society organizations, and other entities in order to successfully carry out the proposed program
- The extent to which the applicant demonstrates a strong capacity to successfully build, manage, leverage, and engage in various types of partnerships
- Extent to which the applicant demonstrates their ability to relate to and respond to HRSA and to in-country USG; and
- Extent to which Letters of Agreement and MOUs (**Attachment 4**) demonstrate sufficient and necessary support for the proposed project

Criterion 6: SUPPORT REQUESTED (10 points) – Corresponds to Section IV's Budget and Budget Narrative

Reviewers will consider:

- How well the costs in the proposed budget and budget narrative align with the proposed project work plan
- The reasonableness of the proposed budget for each year of the project period, in relation to the scope of work, objectives and the anticipated results.
- The budget and budget narrative demonstrate that key personnel have adequate time devoted to the project to achieve project objectives

2. Review and Selection Process

The independent review process provides an objective evaluation to the individuals responsible for making award decisions. The highest ranked applications receive consideration for award within available funding ranges. In addition to the ranking based on merit criteria, HRSA approving officials may also apply other factors in award selection (e.g., geographical distribution), if specified below in this NOFO. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3 below.

Please see Section 5.3 of HRSA's *SF-424 Application Guide* for more details.

This program does not have any funding priorities, preferences or special considerations.

3. Assessment of Risk and Other Pre-Award Activities

HRSA may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory or other requirements (45 CFR § 75.205).

Applications receiving a favorable objective review are reviewed for other considerations that include past performance, as applicable, cost analysis of the project/program budget, assessment of your management systems, ensuring continued applicant eligibility, and compliance with any public policy requirements, including those requiring just-in-time submissions. You may be asked to submit additional programmatic or administrative information (such as an updated budget or "other support" information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that an award will be made. Following review of all applicable information, HRSA's approving and business management officials will determine whether an award can be made, if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and are not subject to appeal to any HRSA or HHS official or board.

Effective January 1, 2016, HRSA is required to review and consider any information about your organization that is in the Federal Awardee Performance and Integrity Information System (FAPIIS). You may review and comment on any information about your organization that a federal awarding agency previously entered. HRSA will consider any of your comments, in addition to other information in FAPIIS in making a judgment about your organization's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed as described in 45 CFR § 75.205 HHS Awarding Agency Review of Risk Posed by Applicants.

A determination that an applicant is not qualified will be reported by HRSA to FAPIIS (45 CFR § 75.212).

HRSA will consider past performance in managing contracts, grants and/or cooperative agreements of similar size, scope and complexity. Past performance includes timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous awards, and if applicable, the extent to which any previously awarded federal funds will be expended prior to future awards.

4. Anticipated Announcement and Award Dates

HRSA anticipates issuing/announcing awards prior to the start date of September 30, 2017.

VI. Award Administration Information

1. Award Notices

HRSA will issue the Notice of Award prior to the start date of September 30, 2017. See Section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2.2 of HRSA's *SF-424 Application Guide*.

Human Subjects Protection:
Federal regulations (45 CFR part 46) require that applications and proposals involving human subjects must be evaluated with reference to the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained. If research involving human subjects is anticipated, you must meet the requirements of the HHS regulations to protect human subjects from research risks as specified in the Code of Federal Regulations, Title 45 – Public Welfare, Part 46 – Protection of Human Subjects (45 CFR part 46), available online at http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html.

Prostitution and Sex Trafficking
A standard term and condition of award will be included in the final notice of award; all applicants will be subject to a term and condition that none of the funds made available under this award may be used to promote or advocate the legalization or practice of prostitution or sex trafficking. In addition, non-U.S. nongovernmental organizations will also be subject to an additional term and condition requiring the organization's opposition to the practices of prostitution and sex trafficking.

PEPFAR Branding
All PEPFAR-funded programs or activities must adhere to PEPFAR branding guidance, which includes guidance on the use of the PEPFAR logo and/or written attribution to PEPFAR. PEPFAR branding guidance can be found at http://www.pepfar.gov/reports/guidance/branding/index.htm.

3. Reporting

Award recipients must comply with Section 6 of HRSA's *SF-424 Application Guide* **and** the following reporting and review activities:

1) **NON-COMPETING CONTINUATION PROGRESS REPORT**
   a. Annual Work Plan
   b. Budget Documents

2) **SEMI-ANNUAL PROGRESS REPORTS**
   The report shall describe progress made during the reporting period and assess overall progress to that date versus agreed upon indicators including the agreement-level outputs achieved, using the agreement-level performance indicators established in the annual work plan. The reports shall also describe the accomplishments of the recipient and the progress made during the past reporting period and shall include information on all activities, both ongoing and completed during that reporting period. The progress reports shall highlight any issues or problems that are affecting the delivery or timing of services provided by the recipient. The reports will include financial information on the expense

incurred, available funding for the remainder of the activity and any variances from planned expenditures.

3) **PEPFAR PERFORMANCE REPORTS**
The recipient will be required to prepare and submit quarterly performance reports that reflect detailed data on achievements and targets as part of the PEPFAR Oversight and Accountability Result Team (POART) process**.**

4) **MONITORING AND EVALUATION PLAN**
The M&E plan should include the data collection plan which discusses the data flow, collection tools, baseline data collection and data quality assessments; discussion of the monitoring plan which includes how progress to targets will be measured, a trends analysis, work plan review, periodic stakeholder meetings, and evaluation plan; and data dissemination which includes a discussion about the donor reports, stakeholder meetings, international meetings, networking, and research publications.

5) **FINAL PROGRESS REPORT**
The recipient shall submit a final/completion report to HRSA which summarizes the accomplishments of this agreement, methods of work used, budget and disbursement activity, and recommendations regarding unfinished work and/or program continuation. The final/completion report shall also contain an index of all reports and information products produced under this agreement. The report shall be submitted no later than 90 days following the estimated completion date of the agreement.

6) **QUARTERLY PEPFAR OBLIGATION AND OUTLAYS REPORTS**
The recipient will submit to HRSA a quarterly financial report within 20 days after the end of the USG's first fiscal year quarter, and quarterly thereafter. Quarterly financial reports should be provided in summary and by cost category and contain at a minimum:
- Total funds awarded to date by HRSA
- Total funds previously reported as expended by recipient main line items
- Total funds expended in the current quarter by the recipient by the main line items
- Total un-liquidated obligations by main line items
- Unobligated balance of HRSA funds

VII. Agency Contacts

You may request additional information regarding business, administrative, or fiscal issues related to this NOFO by contacting:

Olusola Dada
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10SWH03

Rockville, MD 20857
Telephone: (301) 443-0195
Fax: (301) 443-9810
E-mail: ODada@hrsa.gov

You may request additional information regarding the overall program issues and/or technical assistance related to this NOFO by contacting:

Myat-Htoo Razak
Director, Division of Global Programs
Office of Training and Capacity Development, HAB
Attn: Health Workforce Global Initiative
Health Resources and Services Administration
5600 Fishers Lane, Room 9N116
Rockville, MD 20857
Telephone: (301) 443-2166
E-mail: mrazak@hrsa.gov

You may need assistance when working online to submit your application forms electronically. Always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
E-mail: support@grants.gov
Self-Service Knowledge Base: https://grants-portal.psc.gov/Welcome.aspx?pt=Grants

Successful applicants/recipients may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Contact Center, Monday-Friday, 8 a.m. to 8 p.m. ET, excluding federal holidays at:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
Web: http://www.hrsa.gov/about/contact/ehbhelp.aspx

VIII. Other Information

Logic Models:

Additional information on developing logic models can be found at the following website: http://www.acf.hhs.gov/sites/default/files/fysb/prep-logic-model-ts.pdf.

Although there are similarities, a logic model is not a work plan. A work plan is an "action" guide with a time line used during program implementation; the work plan

provides the “how to” steps. Information on how to distinguish between a logic model and work plan can be found at the following website: http://www.cdc.gov/healthyyouth/evaluation/pdf/brief5.pdf.

Technical Assistance

A technical assistance webinar has been scheduled to assist potential applicants in preparing applications that address the requirements of this NOFO. Participation is optional. The webinar information is as follows:

Day and Date: Tuesday, May 9, 2017
Time: 1 – 2:30 p.m. ET.
Conference Number: 1-877-929-1552 for all callers (U.S. and international)
Participant passcode: 24325735 for all callers (U.S. and international)
Weblink: https://hrsa.connectsolutions.com/dtcd2.

The pre-application technical assistance webinar will be recorded and should be available for viewing by May 30, 2017 at https://careacttarget.org/calendar/hrsa-17-033.

IX. Tips for Writing a Strong Application

See Section 4.7 of HRSA’s *SF-424 Application Guide*.