Amendment No. 1 and 2 for #05-A-2

Amendment 1: Extension of Deadline

Community REACH is amending the following Request for Applications (RFAs) #05-A-2 released on August 10, 2005 by extending the initial due date for concept papers from September 7, 2005 to close of business (5:00pm Washington DC eastern standard time) **Tuesday, October 11, 2005**. Separate correspondence will be sent to all organizations who have applied during the initial concept paper solicitation time period.

Submission requirements will follow the same guidelines that were included in the RFA (refer to Section D).

Questions may be sent via e-mail to Reachgrants@pacthq.org until October 4, 2005. All e-mails should include as the subject of the e-mail "RFA #05-A-2."

Amendment 2: Eligible Participating Countries

Community REACH is amending RFA #05-A-2 to exclude Liberia as an eligible country. The list of participating countries consists of the following ten countries: Malawi, Zimbabwe, Cambodia, India, Indonesia, Nepal, Dominican Republic, Honduras, Russia, and Ukraine.

Request for Applications (RFA) # 05-A-2

Pact's Community REACH Program for NGO HIV/AIDS Activities

Engaging and Supporting Community Caregivers in Home-Based Care and Support for People Living with HIV/AIDS (PLWHAs)

Date of Issuance: 10 August 2005
Due Date for Concept Paper Applications: 7 September 2005
Applications Shall Be Submitted by Mail to:
Polly Mott, Program Director
1200 18th Street, NW; Suite 350
Washington, DC 20036
USA

Questions by email ONLY: reachgrants@pacthq.org
Deadline for Questions: 25 August 2005

Issued by the
Community REACH Program

Table of Contents

I. PURPOSE **1**

II. PROGRAM OVERVIEW **1**

A. PROGRAM OBJECTIVES AND FOCUS 1
B. GUIDING PRINCIPLES 2

III. ENGAGING AND SUPPORTING CAREGIVERS IN COMMUNITY HOME-BASED CARE AND SUPPORT FOR PLWHAS **3**

A. BACKGROUND 3
B. THE BURDEN OF CARE 4

IV. PROGRAM INDICATORS **8**

V. APPLICATION **9**

A. ELIGIBILITY 9
B. TWO TIERED REVIEW PROCESS 9
C. ADMINISTRATION OF THE SUB-GRANTS 10
D. GENERAL INFORMATION/APPLICATION FORMAT 10

V. EVALUATION PROCESS AND CRITERIA **12**

A. TIMING 12
B. EVALUATION PROCESS 12
C. EVALUATION CRITERIA 12

RFA 05-A-2
ENGAGING AND SUPPORTING COMMUNITY CAREGIVERS IN HOME-BASED CARE AND SUPPORT FOR PLWHAS

I. Purpose

The purpose of this Request for Application (RFA) is to disseminate information about Pact's USAID-funded Community REACH Program and to solicit applications for funding from prospective indigenous, local NGO grant recipients. This RFA describes the program objectives, explains the technical area of focus, qualifications of organizations applying, criteria for evaluating applications and provides information on funding, application format and other relevant information.

These grants will focus on engaging and supporting community caregivers in home-based care and support for PLWHAs. Pending the availability of funding, the Community REACH Project anticipates awarding grants or cooperative agreements (hereafter called agreements) to fund applications submitted in response to this RFA.

Concept papers must be submitted by 7 September 2005. It is anticipated that grants will be funded for a period up to two (2) years and will not exceed $150,000 for the life of project. Organizations submitting successful concept papers will be requested to submit a full proposal and detailed budget from which final selections will be made.

Issuance of this RFA does not constitute an award commitment on the part of Community REACH or USAID nor does it commit to pay for costs incurred in the submission of an application. Furthermore, Community REACH reserves the right to reject any and all applications, or to award a grant without further discussion or negotiations if it is considered to be in the best interests of Community REACH and USAID.

II. Program Overview

A. Program Objectives and Focus

The goal of the "Engaging and supporting community caregivers in home-based care and support for PLWHAs" RFA is to support initiatives that work to provide psychosocial and economic support to formal and informal caregivers that are providing support to PLWHAs in home-based care settings in one or more of the following participating countries:

Liberia, Malawi, Zimbabwe, Cambodia, India, Indonesia, Nepal, Dominican Republic, Honduras, Russia and Ukraine

Specifically, it calls for proposals that:

- Strengthen and support the capacity of PLWHA groups, NGOs, FBOs and CBOs to provide supportive services to formal and informal caregivers.
- Identify and support formal and informal caregivers through the provision of psychosocial support, meeting economic and social needs, creating supportive organizational environments and providing respite care.

The focus of this RFA will be on promoting support to caregiver initiatives that advance increased quality of care to PLWHAs by protecting and promoting the physical and psychosocial well-being of community caregivers.

This RFA will focus on caregivers including family members within the household, informal volunteers (friends and neighbors) and formal volunteers who have been trained, recruited and are supervised by a NGO/CBO/FBO.

B. Guiding Principles

Community REACH provides a rapid response to the HIV/AIDS pandemic by achieving community-level impact in the hardest-hit regions and countries. The program's guiding principles include community participation, active stakeholder and target audience involvement, strengthening community-based networks and adding to the body of knowledge on effective responses to HIV/AIDS by documenting lessons learned by Community REACH grantees. Successful applicants will explicitly incorporate one or more of the following crosscutting strategic areas.

Community Participation and Stakeholder Involvement
Applicants should explain in detail how they will involve the targeted communities in each aspect of the program. This participation can be at all levels, from the individual to the organizational, in all sectors from the social and cultural to the economic and political. In an operational sense, this involvement should include a variety of roles at various levels. Specifically, attention must be given to ensure that caregivers and the PLWHAs that they care for receive the training and support they need to be involved at different levels.

Strengthening Networks and Linkages
Community REACH anticipates that its grants to local NGOs, CBOs and FBOs will be components of larger scale initiatives and/or national programs. Applicants should detail the ways in which their program will encourage and foster linkages to networks, to other donor-funded programs, and to local USAID-sponsored programs as a way of encouraging grantees to establish close coordination and collaboration with other groups providing complementary services. These may include hospitals, clinics, government programs, community groups, PLWHA support groups and advocacy bodies, STI treatment facilities and others.

III. Engaging and supporting caregivers in community home-based care and support for PLWHAs

A. Background

An estimated 42 million people worldwide are now living with HIV, 95% of them in developing countries, and 14,000 new infections occur daily. HIV/AIDS is destroying families and communities and undermining the economic vitality of countries. The AIDS pandemic in many developing countries is eroding the limited resources already available and drastically affecting the most productive age cohorts of people so urgently needed for social and economic development.

The scale of the human capacity crisis caused by the AIDS pandemic varies across regions. However, it is clear that there is an urgent need to increase the human capacity to deliver critical HIV/AIDS prevention, care, treatment and support services. Doctors, nurses, allied health professionals, traditional healers, pharmacists, social workers, community volunteers, and family members all play an important role in providing services to HIV infected and affected persons, and they are needed in greater numbers to respond to the pandemic.

Skilled health and social service professionals are essential for the delivery of vital services. In many countries, these professionals are being lost due to HIV/AIDS and the loss of this human capital is directly impacting the long-term institutional capacity to respond effectively and efficiently to HIV/AIDS. AIDS causes between 20-50% of all government health employee deaths in African countries. While one response to this workforce shortage has been to increase and expand training of health care providers at all levels, at the same time, there has been an increasing/growing reliance on lay people as the primary caregivers of PLWHAs in community settings.

As the AIDS pandemic spreads and adversely affects human and institutional capacity to provide health care, the focus of some health care service provision has shifted to a home setting. Home based care for PLWHAs is now accepted as part of the overall continuum of care and support with an estimated 90% of care for PLWHAs in many countries occurring in a home setting. The responsibility for day-to-day PLWHA care has become the responsibility of lay caregivers – family members and trained community volunteers who bear the burden of caring for PLWHAs. Given the enormous impact of the pandemic, AIDS is not only a serious disease for most households, but also a challenge to their survival. The economic effects are devastating and include increased expenses, significantly decreased income and a decline in savings and investments. Increased expenditures parallel a decrease in income as family members have to leave paying jobs to care for the sick and households have to pay for medicines. Almost universally, the care economy as it relates to HIV/AIDS has a female face with women and girls disproportionately having caregiving responsibilities – families often resort to taking children, mostly girls, out of school and women with seriously ill husbands may have to give up paid work to take on a caregiver role at home.

Psychological affects on the family and volunteer caregivers can be equally devastating. Family members may experience a sense of isolation, changes in their personal relationships and family

dynamics, insecurity and fear for the future, difficulty in communicating with children and a painful struggle in facing bereavement.

According to UNAIDS, the least-acknowledged caregivers within the home are children. When one parent dies in a nuclear family there is often no one else except the children to look after the other parent who falls sick. This will be the case most especially in places where the intense stigma and shame of AIDS make people fearful of disclosing their infection. Many children are left to cope with terrifying conditions and witness the suffering of the person they most love and depend on, without skills or knowledge and often without anyone ever having talked to them directly about what is happening.

Furthermore, it is a condition that stigmatizes not only infected individuals but very often uninfected people providing care. This is known as “secondary stigma” and it can have a powerful effect on the caregiver’s status with family, friends and the public at large.

B. The burden of care

Of the many care delivery models being implemented, community- and home-based care is the most important in terms of reaching the most affected, infected and vulnerable populations. The approach to home-based care for people living with HIV/AIDS in resource-poor settings is not just clinical—it is holistic. Home care is effective in reducing stigma. It builds the patient’s self-confidence, promotes involvement of the family, and enhances prevention. Successful home-care teams include not only professionals but also helpers and volunteers from the community and community-based organizations.

Other reasons that make home care a good choice in resource-poor settings:

- Patients are often unable to travel to a clinic for treatment.
- The health care worker is available to the patient and the family.
- Staying at home helps patients maintain family ties.
- Governments find the practice cost-effective.
- Home care reduces the pressure on already overwhelmed medical facilities.

While community and home-based care is a necessary and critical response to the impact of AIDS pandemic, very little attention has been paid to “caring for the carers” who comprise the core support for individual PLWHAs in the home and community. These caregivers are often thought of only as formal or informal “service providers” and not as people/individuals that are as deeply impacted by HIV/AIDS as those individuals to whom they are providing care and support. In reality, the quality of care and the ability to provide care on a sustainable basis is only possible if caregivers’ physical and psychosocial well-being are provided for and protected. According to UNAIDS, “caring for carers of people with AIDS is not only a humanitarian imperative, it is a social and economic necessity”.

Who are the caregivers in HBC?

UNAIDS' definition of caregivers includes health care professionals, family members within the household, informal volunteers (friends or neighbors) and formal volunteers who are recruited, trained and supervised by a non-governmental organization/community-based organization/faith-based organization (NGO/CBO/FBO) providing care services at the community level. A further elaboration of these definitions can be found in a Horizons Report *"Expanding the Care Continuum for HIV/AIDS: Bringing Carers into Focus"* that discusses the differences between "unlinked care" that is provided in the home by unpaid and untrained family members, friends and neighbors and efforts of formal community initiatives (NGOs, CBOs, FBOs etc.) to fill the care gap left by an overstretched formal health sector. As discussed in this document, trained health care professionals in the formal sector are mostly attached to clinical settings whether it is at a tertiary, secondary or primary health care level. Most NGOs/CBOs/FBOs tend to have a limited number of trained care professional on staff. These employees, typically nurses and/or counselors, usually do not work directly with clients and families but instead they are responsible for the recruitment, training and supervision of volunteer caregivers in the community.

This RFA will focus on caregivers including family members within the household, informal volunteers (friends and neighbors) and formal volunteers who have been trained, recruited and are supervised by a NGO/CBO/FBO.

Caregiver challenges and causes of stress

A review of needs assessments for home-based care in different settings provides important insights to the needs of people living with HIV/AIDS and their family caregivers. The needs are divided into the following categories:

- Basic day-to-day needs, such as food, soap, linen, clothes, and drugs
- Medical and nursing needs, such as primary health care, tuberculosis-related care, and care for diarrhea and other symptoms
- Economic strengthening needs
- Emotional needs, such as treatment for depression, suicidal thoughts, and worries, empathy, and security of survivors
- Spiritual needs.

In addition, family caregivers report respite-related needs: exhaustion and feeling overwhelmed, emotional burnout, lost opportunities, lack of information and training, poverty and lack of access to care, neglect of their own needs, and property grabbing. By extension, volunteer caregivers, whether formal or informal, find themselves in similar positions as family caregivers. As individuals they face some of the same psychosocial stresses as family members including feeling overwhelmed, emotional burnout, neglect of their own needs and at times unprepared in terms of information and training. As friends, neighbors and community members, they live and work in an environment where HIV/AIDS is destroying community support structures and coping mechanisms.

As the AIDS pandemic spreads, responsibility for PLWHAs has fallen increasingly upon these lay caregivers in families and communities. These caregiver roles are highly stressful and take a

substantial mental and physical toll on those fulfilling them as they bear witness to the physical, emotional, and economic needs of their patients.

Some of the commonly reported causes of stress among formal, family and volunteer caregivers include:

- Lack of referral mechanism
- Personal identification and/or over-involvement with PLWHAs and their families
- Inadequate support, supervision and recognition of their work
- Lack of clarity about what the caregiver is expected to do
- Oppressive workloads
- Financial hardships
- Isolation, insecurity and fear for the future
- Inability to meet the unique needs of children

As documented by UNAIDS these stress factors may manifest in a variety of areas. For example, the stress of over-involvement comes from the caregiver developing expectations of the client, and feeling a sense of personal failure or disappointment when advice is not heeded. Several caregivers may struggle with the news that an HIV-positive woman whom they had been counseling has become pregnant, putting her health and that of her partner and her unborn baby at risk.

Manifestations of stress take different forms and they include a range of psychological, behavioral and physical signs and symptoms:

- Loss of interest in and commitment to work (loss of concentration);
- Loss of confidence and self-esteem;
- Feelings of inadequacy, helplessness and guilt;
- Irritability
- Loss of sensitivity in dealing with clients (compassion fatigue)
- Depression;
- Sleeplessness and excessive fatigue;
- A tendency to withdraw – both from clients and colleagues;

In many settings, caregivers are themselves HIV positive. In these situations, the risks of stress and burnout are very high. Feelings of inadequacy and guilt related to not being able to help clients can lead to lasting anxiety for a caregiver who is HIV positive her/himself – anxiety about family members who will be left behind to anxiety related to personal identification with a client's illness and impending death.

Management of stress and burnout

While understanding that stress and burnout are complex phenomena with many causes and manifestations, there are some lessons learned regarding management of stress and burnout among caregivers:

- The capacity of individual caregivers to cope with the duties and responsibilities involved in HBC need to be strengthened;
- NGOs/CBOs/FBOs need to ensure that working conditions, practices and policies of care programs offer a supportive environment to caregivers and are not causes of stress in themselves; and
- There is need to advocate for national policies and laws that are sensitive to the needs of caregivers.

Some key measures that can be taken to operationalize support to caregivers include:

- Recognizing and valuing the work of caregivers at all levels: Many families and volunteer caregivers feel unable to meet the myriad of needs of their loved ones/clients, or they may not receive positive reinforcement when providing good care (this may be in the form of biannual outings or placing a greater emphasis on a sensitive, caring staff member who oversee volunteers);
- Relieving caregivers of the burden of responsibility for things that they cannot help; (This is particularly important to child carers, since they are most vulnerable to feelings of guilt about suffering they cannot relieve.) Engaging spiritual leaders and groups (e.g. prayer groups) to provide counseling and support;
- Empowering caregivers with confidence and care choices through regular training (e.g. training on nutritional support, recognizing mental health issues, bereavement, etc.);
- Developing strong support networks for caregivers and providing a forum for discussion of experiences with other caregivers (including provision of counseling and mental health support);
- Relieving poverty as a top priority through income-generation/micro-credit/savings schemes, nutritional support and transportation related services;
- Establishing an organizational environment whereby realistic work targets, regular time off, enhanced job training, recognition and biannual outings, and clear job descriptions are the norm;
- Ensuring that adequate referral mechanisms are established and can be monitored successfully: Poor communication between the health care sector and communities makes it difficult to facilitate an expanded response to HIV/AIDS at the local level. This linkage is especially critical at a time when the roll-out of ARVs is a top priority of many national AIDS programs. Linkages between the community and the clinical health sector are critical not only to ensure ARV adherence but also access to palliative care. Comprehensive palliative care that “encompasses not just the patient but also the whole family” provides for a continuum of care and support from the formal health sector right down to the household level and in the absence of ARVs, it allows PLWHAs to live and die in peace and dignity. Comprehensive referral mechanisms that allow for follow-up with a client provide the caregiver and the client with consistency, continuity and an increased sense of empowerment over their care;
- Relieving caregivers of feeling overwhelmed by providing respite care on a regular basis.

By focusing on the needs of caregivers, countries severely impacted by the AIDS pandemic will be able to draw upon the skills and commitment of these caring, compassionate community members as a long-term, viable way to provide critical HIV care and support.

IV. Program Indicators

All applications must include specific, detailed plans to monitor and document program performance. Applicants for funding under this RFA should state clearly how activities they are proposing relate to program objectives and how data will be tracked, collected, verified and reported to document progress toward these objectives. Community REACH will evaluate progress by monitoring selected indicators and assessing these in relation to targeted program objectives, as listed in this RFA. A limited set of program monitoring indicators will be used to track the progress of key Community REACH-funded activities, and are based on administrative records, project reports, and routine logistical and facility-based information systems. Applicants are encouraged to include in their application the measurement and reporting of indicators of program progress and effectiveness, as appropriate to proposed activities. Monitoring and Evaluation (M & E) efforts should be based on effective monitoring to measure the scope and reach of grantee activities.

Applicants should be prepared for revisions in program indicators and reporting requirements during the lifetime of the award and as part of the project closeout processes.

The five-year global targets that have been set by the Emergency Plan of treating more than two million HIV-infected persons with effective combination antiretroviral therapy, preventing seven million new HIV infections, and caring for ten million HIV-infected persons and those orphaned by HIV/AIDS, are the key goals that applicants will be required to support as a result of their programs. Applicants are strongly encouraged to submit Monitoring & Evaluation (M & E) plans that will directly contribute to the Emergency Plan's 2-7-10 goals.

Expected outcomes include, but are not limited to:

- Total number of caregivers that received referrals to support groups or mental health services for caregivers
- Total number of caregivers that received socio economic support such as micro-credit, nutritional support, transportation related services, disaggregated by sex
- Total number of volunteers trained to provide care-giving responsibilities
- Total number of caregivers trained who demonstrate (a) they are applying competencies/skills (b) retain volunteer positions after one year
- Percent of caregivers with accepting attitudes toward PLWHA
- Total number of caregivers that received respite care, disaggregated by sex
- Impact Indicator: Improved quality of life of PLWHA
- Number of effective referral/counter-referrals

Quality Assurance

Applicants are encouraged to conduct quality assurance activities, including program level assessments, or reviews, in order to monitor and manage their projects to: 1) ensure optimal efficiency; and 2) to improve programming by identifying whether the current activities are the best use of resources - financial and human resources.

V. Application

A. Eligibility

Community REACH is committed to moving resources to the grassroots level. Prime applicants must be locally registered indigenous national and local organizations (NGOs/CBOs/FBOs) implementing local, national and regional HIV/AIDS activities in one or more of the participating countries listed in Section IIa:

Partnerships between NGOs and local, national, regional and international PLWHA networks/associations are strongly encouraged.

The following organizations/programs are **not** eligible to apply for grants under this RFA:

- International organizations and local affiliates of international organizations (Note: these may be sub-recipients with local organizations)
- Pact and the Futures Group Inc. offices/programs
- Public International Organizations such as United Nations entities

Preference will be given to applicants with experience managing multi-year grants of $100,000 or more.

Pact's grants program will identify and support organizations that are poised to rapidly and accountably implement activities. Successful grant winners must commit to implement programming within forty-five (45) days of grant award.

B. Two tiered review process

Applicants will participate in a two-tiered review process as detailed below. Favorable evaluation of the concept paper, as described in Tier I of the review process, is not an indication that funding will eventually be awarded. Only full applications that have been invited following a Tier I review will be considered for further review and funding. Moreover, Community REACH reserves the right to make any number of awards or none at all.

Tier I: Concept Paper and Summary Budget
All interested applicants must submit a concept paper in English of **not more than five pages**. This will be reviewed as part of the first tier. The concept paper should include all of the information listed below in Section D:

Tier II: Full Application and Detailed Budget
Based on review of the Tier I concept paper including the summary budget, those submitting applications deemed to be most responsive to this RFA will be invited to prepare and submit a full application. A format for submission of full applications and detailed budgets will be provided with the invitation.

C. Administration of the Sub-Grants

1. Authority

The authority for these awards is found in the Foreign Assistance Act of 1961, as amended, and re-delegated to Pact, Inc. under its cooperative agreements No. GPH-A-00-01-00007-00 with the U.S. Agency for International Development.

2. Policies and provisions

Awards will be administered in accordance with the USAID policies and procedures. Awards to U.S. organizations will be administered in accordance with 22 CFR part 226, the applicable OMB Circulars and USAID Standard Provisions. To find these regulations and policies see the web-sites below. If applicants are not able to access these documents via the web, they can request hard copies from Community REACH:

22 CFR 226 - http://www.access.gpo.gov/nara/cfr/waisidx_03/22cfr226_03.html
OMB Circulars A-122 and A-133 – http://www.whitehouse.gov/omb/circulars
USAID Standard Provisions - http://www.usaid.gov/policy/ads/300/303maa.pdf

Awards to Non-U.S. organizations will be administered in accordance with the cost principles contained in OMB Circular A-122 and USAID Standard Provisions for Non-U.S. Non-governmental Organizations. These documents are available at the following websites. If applicants cannot access these documents via the web, hard copies will be made available through Community REACH:

OMB Circular A-122 – http://www.whitehouse.gov/omb/circulars/a122/a122.html
Standard Provisions - http://www.usaid.gov/policy/ads/300/303mab.pdf

3. Substantial Involvement

Pact, Inc. anticipates exercising the following substantial involvement in working with the applicant to achieve its program objectives:

1. Designation of key positions and approval of key personnel
2. Approval of annual workplans and all modifications, which describe the specific activities to be carried out under the Agreement and progress reports
3. Approval of monitoring and evaluation plans and involvement in monitoring progress.

D. General Information/Tier 1: Concept Paper and Summary Budget Formats

Pact will acknowledge receipt to applicants within 15 days of receipt of a concept paper and summary budget. All concept papers and summary budgets received by the deadline will be reviewed for responsiveness to the program requirements and compliance with preparation

guidelines provided below. Concept papers and summary budgets that are non-responsive will not be considered for further review.

1. Concept Paper and Summary Budget must be as follows:

- in English
- typed in a Microsoft Word compatible program, single-spaced with a 12 point font and one inch margins
- received in hard copy and electronic copy on diskette or CD
- a single-sided original of the application which should be "photo-ready," i.e., printed on one side only and **unbound; and three (3) copies for distribution**
- labelled with page numbers, the RFA number (RFA 05-A-2) and name of applicant organization on each and every page.
- simple in its presentation and reflective of the organization's cost consciousness

2. Concept paper and summary budget content must include:

- Cover Page with program title; organization name and contact information including address, telephone, fax, and email address
- Executive summary**; not to exceed one (1) page**
- Technical application including
  - Technical approach/intended results (project goals, objectives, types of activities/interventions and processes; sequence and time-frame for implementing each activity; anticipated outcome of each activity; proposed geographic coverage and rationale for selection; numbers and types of anticipated beneficiaries, with rationale for selection; target group participation strategic fit and linkages to community); **three (3) pages**
  - Project Management (past performance and experience implementing HIV/AIDS programs; proposed implementing/organizational development partners & division of responsibility; linkages to other HIV/AIDS interventions; sustainability plan); **one (1) page**
- Summary budget organized in the following categories: Direct Labor; Fringe benefits; supplies & equipment; travel & per diem; administrative support costs; other direct costs; proposed sub-grants/sub-contracts. *(The summary budget is not included in the five-page limit for concept papers and should be prepared separately from the concept paper.)*
- An organizational capacity statement that provides an understanding of the applicant's capacity to implement the proposed program. The statement should present a brief overview of the applicant's mission and goals and how they relate to the present program; relevant experience in relation to the proposed program and geographic area; key personnel, including name and short description of experience and capacity relevant to the program objectives; comparative advantage in carrying out this work, such as prior successes in similar endeavors. All applicants must submit contact information for at least three (3) partners with whom they have worked in the past three (3) years, in the implementation of a similar program. The reference information shall include the procuring/financing organization, location, current telephone or e-mail information,

points of contact, award number if available, dollar value of activity, and brief description of work and dates performed; **Attachment, maximum two (2) pages**

- Completed Organizational Background Questionnaire (Appendix A)

V. Evaluation Process and Criteria

Community REACH will evaluate applications in keeping with the standards established in Sections VI.B and VI.C below.

A. Timing

Applications (see Section V. D above) must be received by Community REACH no later than close of business (5:00pm EDT) on **Wednesday, 7 September 2005** for consideration for funding. It is not anticipated that late applications will be reviewed. However, Community REACH reserves the right to consider any application for review at its discretion. Applications shall be addressed to:

Polly Mott, Program Director
Pact, Inc.
1200 18th Street, NW
Suite 350
Washington, DC 20036
USA

B. Evaluation Process

Community REACH team members will conduct a technical review of each application for basic responsiveness to the instructions in this RFA and technical merits, including relevance to program objectives against the evaluation criteria set forth below.

Upon completion of the assessment, the Community REACH team will invite select applicants submitting technically superior concepts to submit full applications. A full application should **only** be submitted by invited applicants upon request by Community REACH.

C. Evaluation Criteria

The criteria presented below have been tailored to the requirements of this RFA. A total of 100 points are possible for the complete application. The relative importance of each criterion is indicated by approximate weight by points. Applicants are advised that the questions under each bulleted scoring criterion are intended to broadly inform the scoring process and will not be individually scored or equally weighted.

The technical applications will be evaluated in accordance with the technical evaluation criteria set forth below. Applicants should note that these criteria: (1) serve as the standard against

which all proposals will be evaluated, and (2) serve to identify the significant matters, which applicants should address in their proposals.

The following evaluation criteria will be used for the concept paper review and weighted in favor of results-oriented programs:

• Technical approach	50 points
• Project Management	25 points
• Organizational capacity and performance	15 points
• Cost	10 points

Technical approach	50 points

- ***Excellence of design and feasibility to achieve results and impact*** A strong technical design will include discussion and analysis of current best practices in HBC service provision and recruitment, training and supervision of caregivers within the context of the applicant's unique environment. Do the proposed activities respond to the needs of caregivers and PLWHAs? Is there a clear linkage between strategies to retain caregivers and strategies to provide quality HBC to individual PLWHAs? Does the applicant have an adequate plan to assure the confidentiality needs of PLWHAs? ***15 points***

- ***Demonstrated linkages to ongoing programs and commitment to target community.*** The review committee wants to see that the applicant has kept the context of its proposed program in mind and is not operating in a vacuum or without considering the community's post-funding issues. The committee will review the application's connectedness, plans for referrals, synergies, assessing whether the application explicitly identifies the gaps it will fill. Applicants should describe potential synergies with other ongoing programs, especially existing USG-funded activities. The committee will evaluate proposed partnerships in terms of planned sub-grants and capacity building activities. ***10 points***

- ***GIPA*** Reviewers will evaluate whether the proposed technical approach conforms to recognized principles of Greater Involvement of People Living with AIDS (GIPA) and can be reasonably expected to produce the intended outcomes. How and to what extent are the principles of GIPA integrated into the proposed project? What is the role of PLWHAs in the design, execution and evaluation of the project? ***15 points*** More information on GIPA principles can be found in the document "From Principles to Practice: Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA) UNAIDS. September 1999. HTML version: http://www.unaids.org/html/pub/publications/irc-pub01/jc252-gipa-i_en_pdf.htm

- ***Implementation, Monitoring and Evaluation Plan.*** Are the proposed implementation plan, inputs, and outputs realistic and achievable within the proposed budget and timeframe? The evaluators will assess if the application has proposed indicators that are feasible and relevant. Has the applicant proposed feasible methods to collect the data necessary to report on the chosen indicators? Does the implementation, monitoring and evaluation plan include

milestones and expected accomplishments? Are indicators disaggregated by age, gender and target population? Additionally, does the application include a plan to use the data to identify and address programmatic weaknesses, so that the organization can use data to improve service delivery? ***10 points***

Project management	25 points

- ***Management plan.*** Does the applicant have an existing presence in the geographic region where they are proposing to implement activities? Does the applicant have an existing and established network of local partners? If relevant, what is the rationale provided for partnering with another organization? ***15 points***

- ***Sustainability plan***. How is the grant application structured to increase the sustainability of the organization and what steps are put in place, so that funded activities will continue beyond the life of this project? ***10 points***

Organizational capacity and performance	15 points

- ***Key personnel.*** It is important to determine if the key personnel are up to the task. This can be determined through a review of experience and education. Does the proposed staff have HIV/AIDS-related experience? Is there sufficient level of effort designated to the program to carry out the scope of work? Also, if volunteers will be used, what are their functional roles, and how will the organization address the issue of turnover? ***10 points***
- ***Past performance on similar programs:*** The review committee will consider the following - quality of service (including consistency in meeting goals and targets, effectiveness in fixing problems); Cost control (including forecasting costs as well as accuracy in financial reporting); Timeliness of performance (including adherence to schedules and effectiveness of home and field office management to make prompt decisions and ensure efficient operation); Customer satisfaction; Effectiveness of key personnel. ***5 points***

Cost	10 points

- ***Cost Realism (including Program vs. Administrative Costs) and Sub-grants***: Budget should reflect cost realism in keeping with the applicable Cost Principles and USAID regulations and policy. The total budget will be evaluated for reasonableness and realism as it relates to the proposed program description. The overall budgetary competitiveness of the application may be determined based on composing an average ratio of program vs. administrative costs as well as activity costs. ***10 points***

Appendix A: Organizational Background Questionnaire

Directions: Complete form electronically, then print out and submit with hard copy application.

RFA Number:

Organization Name:

Contact Name:
Title:
Address:

City:
State/Province:
Country:
Zip Code:
Telephone:
Fax Number:
E-mail Address:
Website:

Please indicate type of Organization (please select one only):
Local NGO ☐ Local Faith-Based Organization (FBO) ☐ Local Foundation ☐
Local Educational Institution ☐ Local Private Company ☐
Other ☐ Please Explain___________

Amount of Funding Requested (in US $):

Duration of project:

Country where project will be implemented:

Geographic district where project will be implemented:

Estimated numbers of people targeted through this project:

Year when organization was established:

Years of experience in HIV/AIDS programming

What is your organization's approximate annual operating budget (in US $)?

What is the number of staff members of your organization?

Does your organization have a board? Yes ☐ No ☐

How many volunteers does your organization have?

Is your organization currently receiving direct USAID (e.g. mission) funds?
Yes ☐ No ☐
If yes, please indicate:

Is your organization currently receiving USAID funds through another NGO (eg. INGOs such as FHI, CARE, CRS, Pathfinder etc)
Yes ☐ No ☐
If yes, please indicate:

If you have other sources of funding, please indicate (list up to three):

Is your organization currently receiving UN/Other funds?
Yes ☐ No ☐
If yes, please indicate:

Does your application propose a partner/subgrantee?
Yes ☐ No ☐
If yes, list organization name and proposed subgrant amount (use a separate sheet if more than one partner is anticipated)

Local Partner Contact Name(s) (potential subgrantees only):
Organization:
Title:
Address:

City:
State/Province:
Country:
Zip Code:

Telephone:
Fax Number:
E-mail Address:
Website:

Please indicate type of Organization (please select one only):
Local NGO ☐ Local Educational Institution ☐ Local Foundation ☐
Local Faith-Based Organization (FBO) ☐ Local Private Company ☐
Other ☐ Please Explain___________

What is your partner's approximate annual operating budget (in US $)?

What is the number of staff members of your partner?

Does your partner currently receive direct USAID funds?
Yes ☐ No ☐
If yes, please indicate:

Is partner currently receiving USAID funds through another NGO (eg. INGOs such as FHI, CARE, CRS, Pathfinder etc)?
Yes ☐ No ☐
If yes, please indicate:

Is your partner currently receiving UN/Other funds?
Yes ☐ No ☐
If yes, please indicate:

Appendix III: Technical References

USAID HIV/AIDS website:
http://www.usaid.gov/pop_health/aids/

USAID CFR and Standard Provisions
http://www.usaid.gov/pubs/ads/cfr22/22cfr226.pdf
http://www.usaid.gov/pubs/ads/300/303.doc

Other USAID publications:
http://www.usaid.gov/pop_health/aids/Publications/index.html

WHO 3 by 5 Initiative:
http://www.who.int/3by5

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www.icrw.org/docs/2004_info_carecontinuum.pdf

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