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Place of Performance:	Uganda

Subject: Request for Application RFA-617-12-000006:

The United States Agency for International Development (USAID) Uganda is seeking applications to fund one or more organizations through a Cooperative Agreement for a three (3) year DELIVERY OF INTEGRATED HIV COUNSELING AND TESTING (HCT) SERVICES IN TARGETED POPULATION GROUPS WITHIN KAMPALA REGION program in Uganda as described in Section I of this RFA. The authority for the RFA is found in the Foreign Assistance Act of 1961, as amended. Subject to the availability of funds, USAID intends to provide approximately \$9 million in total USAID funding to be allocated over the three (3) year period. USAID reserves the right to fund any or none of the applications submitted and expects one award as a result of this solicitation; however, more than one award may result. Credible, innovative and capable Ugandan indigenous organizations are encouraged to apply individually or as consortia, offering well-defined roles and value added.

This is a limited regional competition, under which any type of organization, large or small, commercial (for profit) firms, faith-based, and non-profit organizations in partnerships or consortia from East African region, are eligible to compete. In accordance with the Federal Grants and Cooperative Agreement Act, USAID encourages competition in order to identify and fund the best possible applications to achieve program objectives.

For the purposes of this RFA, the term "Grant" is synonymous with "Cooperative Agreement"; "Grantee" is synonymous with "Recipient"; and "Grant Officer" is synonymous with "Agreement Officer".

Pursuant to 22 CFR 226.81, it is USAID policy not to award profit under assistance instruments. However, all reasonable, allocable, and allowable expenses, both direct and indirect, which are related to the grant program and are in accordance with applicable cost standards (22 CFR 226, OMB Circular A-122 for non-profit organizations, OMB Circular A-21 for universities, and the Federal Acquisition Regulation (FAR) Part 31 for-profit organizations), may be paid under the grant.

This RFA and any future amendments can be downloaded from <http://www.grants.gov>. Select "Find Grant Opportunities," then click on "Browse by Agency," and select the "U.S. Agency for International Development" and search for the RFA. In the event of an inconsistency between the documents comprising this RFA, it shall be resolved at the discretion of the Agreement Officer. If you have difficulty registering or accessing the RFA, please contact the Grants.gov Helpdesk at 1-800-518-4726 or via e-mail at support@grants.gov for technical assistance.

Any questions concerning this RFA should be submitted in writing to KampalaUSAIDSolicita@usaid.gov, by the date stated above. Questions sent to any other e-mail address will not be answered. The e-mail transmitting the questions must reference the

RFA number and title on the subject line of the e-mail. The deadline for receiving questions is **12 March 2012**. Applicants are requested to submit both Technical and Cost Proposals of their applications in separate volumes. Award will be made to that responsible applicant whose application offers the best value to the Government. Please note, however, that technical application will be significantly more important than cost.

If you decide to submit an application, please note that electronic submission is required. Applications should be sent as email attachments to KampalaUSAIDSolicita@USAID.gov, to the attention of Florence Alimo, A&A Specialist, and Tracy J. Miller, Agreement Officer. Late applications will not be considered for award. Applications must be directly responsive to the terms and conditions of this RFA. Telegraphic or fax applications (entire proposal) are not authorized for this RFA and will not be accepted.

An applicant under consideration for an award that has never received funding from USAID may be subject to a pre-award survey to determine fiscal responsibility, capacity, and ensure adequacy of financial controls.

Award will be made to that responsible applicant whose application best meets the requirements of this RFA and the selection criteria contained herein.

Issuance of this RFA does not constitute an award commitment on the part of the Government, nor does it commit the Government to pay for costs incurred in the preparation and submission of an application. Further, the Government reserves the right to reject any or all applications received. In addition, final award of any resultant grant cannot be made until funds have been fully appropriated, allocated, and committed through internal USAID procedures. While it is anticipated that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for award. Applications are submitted at the risk of the applicant. Should circumstances prevent USAID from making an award, all preparation and submission costs are at the applicant's expense.

Sincerely,

Tracy J. Miller
Agreement Officer.

TABLE OF CONTENTS

SECTION I – FUNDING OPPORTUNITY DESCRIPTION.....2
 PROGRAM DESCRIPTION.....2
 AUTHORIZING LEGISLATION.....16
SECTION II – BASIC AWARD INFORMATION.....18
SECTION III – ELIGIBILITY INFORMATION.....19
SECTION IV – APPLICATION AND SUBMISSION INFORMATION.....20
SECTION V – APPLICATION REVIEW INFORMATION.....25
SECTION VI – AWARD ADMINISTRATION INFORMATION.....27
SECTION VII – AGENCY CONTACTS.....29
SECTION VIII – OTHER INFORMATION.....30
SECTION IX – REFERENCES AND ATTACHMENTS.....31

SECTION I – FUNDING OPPORTUNITY DESCRIPTION

PROGRAM DESCRIPTION: DELIVERY OF INTEGRATED HIV COUNSELING AND TESTING (HCT) SERVICES IN TARGETED POPULATION GROUPS WITHIN KAMPALA REGION

I.1 EXECUTIVE SUMMARY

USAID/Uganda under Development Objective 3; Improved Health and Nutritional Status in Focus Areas and Populations (DO3) anticipates to award a three-year, \$9 million program to a qualified indigenous local or regional organization to provide integrated counseling and testing services within the five regions of Kampala, namely Nakawa, Central, Kawempe, Rubaga and Makindye reaching approximately 1.8 million individuals including day time dwellers. Addressing HIV counseling and testing as part of a broader set of interventions for this heterogeneous urban population will provide a model for addressing some of the biggest causes of morbidity and mortality in Uganda and presents an opportunity to leverage PEPFAR resources to achieve broader health outcomes. The program's overall goal is to prevent further HIV transmission and improve the quality of life of individuals infected through early diagnosis and linkage to prevention, care and treatment services. The program will exclusively focus at community level and aim to reach special population groups with an elevated risk of HIV infection including couples, commercial sex workers, incarcerated populations, individuals in wide sexual networks, pregnant women not attending antenatal care, as well as out of school youth engaged in the informal sector particularly, taxi drivers and conductors, skilled artisans (mechanics, carpenters, builders, welders), hotel and bar maids. The activity will complement efforts of other facility-based HIV/AIDS prevention, care and treatment providers who will be expected to receive and enroll individuals graduating from HCT into their programs.

Activities implemented through this program will be linked to other USG supported HIV/AIDS prevention, care, treatment and other health services to ensure prompt entry into care by those testing HIV-positive and sustained positive behaviors by those testing negative. Over the past decade, Uganda has been able to scale up HCT services through the Ministry of Health (MOH), with the support of the US Government and other development partners. Through these interventions, many important lessons have been learned, including that:

1. Overall, HCT acceptance is high in the general population and in many instances demand outstrips the supply. Demand for HCT has notably grown in tandem with improved access to quality care and treatment services which have given people, especially those testing HIV-positive hope of living after an HIV diagnosis.
2. Unlike other HIV/AIDS services, HCT access has been more equitable among men and women, with 52% women and 48% men accessing HCT services in general. However, this trend is sharply reversed in HIV care where 67% are women and 33% men signaling the need for interventions to reach more men.
3. HCT has no significant impact on long term sexual behavior of individuals especially if there is no follow up support to facilitate disclosure to couples or other significant members of an individual's social network. Evidence from HIV/AIDS care and treatment sites indicates that engaging in unprotected sex is similarly high among

individuals whose status is kept discrete. Therefore, all HIV/AIDS prevention, care and treatment services should prioritize the socially valued action of disclosure as a key factor in achieving sustainable behavior change.

4. The inability of individuals to maintain positive post-test behavior has resulted in high rates of repeat testing currently estimated at 40% of all the individuals tested annually. This undermines the cost-effectiveness of HCT programs and their ability to identify HIV infected individuals. Therefore, HCT strategies should prioritize pre-test risk perception and assessment as critical components of effective service delivery.
5. HIV prevalence in rural areas remains low, averaging only 1-3.5% in many communities. Therefore, mass counseling and testing, especially in rural areas only serves to enable individuals to know their HIV status but does not yield enough HIV-positive individuals for linkage to care and treatment services and ultimately impact population level HIV transmission. Therefore, HCT services should be directed to reach urban and peri-urban populations and high risk groups in rural areas.
6. Innovations and best practices in HCT such as provider-initiated counseling and testing (PICT) and home based HCT have proven to be effective in increasing access to services for populations with high risk of HIV infection. These approaches will become increasingly relevant as the body of evidence to support treatment for prevention grows and translates into implementation. It is acknowledged that these innovations are largely clinical and other practices and approaches that address the social and community aspects of HCT are equally necessary to address barriers to HCT utilization.
7. Reaching couples with effective messaging and consequent uptake of couple HCT is still generally low, especially in urban areas. Anecdotal evidence shows that uptake also varies by religion with more Muslims testing as couples than non-muslims.
8. Increasingly, couples are impressively coping with HIV discordancy as evidenced by cohesiveness among discordant couples especially if the female is negative and the male is positive, further emphasizing the need for disclosure.
9. Most at risk populations such as commercial sex workers, incarcerated populations and uniformed personnel can be better reached through their peer leaders than themselves as individuals. Similarly adoption of appropriate post-test behavior is more effective if peer leaders are involved in the client support system.
10. Access to HCT for most urban residents can be optimized at hours when they are free from work, such as early evenings or week-ends when their minds are in one place. Therefore, HCT strategies need to be cognizant of the context in which target populations operate.

This activity will build on these lessons learned and good practices. The activity will also build on the outstanding leadership by Ugandan Civil Society Organizations in the nation's HIV/AIDS response.

This activity will directly support the implementation of the Government of Uganda's, USAID's and the Emergency Plan's (EP) joint commitment to strengthen the national response and increase HIV/TB prevention, care and treatment services to vulnerable and at risk populations in Uganda. USAID/Uganda seeks an indigenous, well-networked organization that can demonstrate the capacity to reach high risk population groups and substantially increase access to quality HIV counseling and testing (HCT) services for high risk populations in the Kampala region.

It is expected that in year one, full-scale implementation will begin. Emphasis will be placed on creating demand for services and establishment of a functional referral system for HIV/AIDS and other health services including, but not limited to prevention of safe male circumcision (SMC), mother-to-child transmission (PMTCT), management of tuberculosis, diagnosis and treatment of sexually transmitted infections (STI), HIV/AIDS care and support as well as ART. This activity should also increase referrals for access to family planning, nutritional programs for people living with HIV and their families by leveraging funds through effective partnerships with other USG and non-USG programs.

I.2 CONTEXT

Uganda has a population of approximately 30 million people, with 85 percent of them living in rural areas. The population grows at an annual rate of 3.2% and total fertility, still among the world's highest, has stagnated between 6.7%- 6.9% over the past fifteen years. This rate of population growth in the context of a high HIV prevalence translates into a very high rate of new infections. The country continues to experience a high burden of HIV infection with an estimated 6.4% of sexually active individuals aged 15-49 years infected (Uganda Sero-Behavioural Survey (UHSBS) 2004/2005). There is considerable heterogeneity across regions, sex, age and marital status with low prevalence rates of 3.5% and 2.3% in North East and North Western regions respectively while the Central and North Central regions had the highest HIV prevalence with rates of 8.5% and 8.2%, respectively. Urban areas are much worse hit with prevalence estimated to be ten times higher than that in rural areas. Kampala had the highest prevalence in the country with 8.5% of its sexually active residents aged 15-49 years infected. Despite this still astonishingly high rate of HIV prevalence, only 44% of the city residents have tested for HIV and know their status. HIV prevalence was also higher among women (7.5%) compared to men (5%).

In spite of more than a decade of intensive, internationally-supported counter efforts, various cohort studies and trend analyses highlight Uganda's stagnating and/or rising HIV prevalence. For instance, HIV prevalence from the ante-natal surveillance was 7% in 2009. Using mathematical modeling techniques, Uganda AIDS Commission and UNAIDS provide annual estimates of new infections. In 2007, there were an estimated 132,000 new infections in Uganda, 124,000 infections in 2009, and probably more infections have occurred since 2009. The rise in new infections has a direct bearing on overall HIV prevalence and consequently the national programs' ability to achieve targets in this area. For instance, the HSSPII and the NSP 2007/8-2011/12 had the goals of reducing HIV prevalence by 50% and by 45% respectively.

However, the rising life expectancy of people living with HIV (PLHIV) due to ART and the rising HIV incidence combine to make these targets unachievable. With support from development partners, MOH is currently undertaking an AIDS Indicator Survey (AIS), as follow on to the UHSBS. Results from the survey, expected early next year, are expected to provide new, insights into the HIV/AIDS epidemic in Uganda.

There have also been shifts in epidemiological patterns, with new infections now occurring more in married and co-habiting couples than in youth, as was the case a few years ago. Available data and analyses highlight that sexual transmission accounts for 76% of all new infections, followed by mother to child transmission at 22%. Women, urban dwellers and those living in regions formerly riddled by conflict are the most

severely affected. Various studies conducted on the emerging patterns of the epidemic reveal that the key HIV risk factors include: multiple concurrent sexual partnerships, discordance and non-disclosure among couples, low condom use, transactional sex, cross-generational sex, and behavioral dis-inhibition due to antiretroviral treatment (ART).

The President's Emergency Plan for AIDS Relief (PEPFAR) has provided an historic opportunity for Uganda to continue rolling back the HIV/AIDS epidemic. Because of PEPFAR support, Uganda has been able to scale up its pre-PEPFAR HIV/AIDS activities and has initiated a number of interventions, which have significantly changed the HIV/AIDS prevention, care and treatment landscape in the country. For instance access to ART has risen from 9,000 individuals in 2004 to 290,000 in 2010. The number of individuals receiving HIV/AIDS chronic care has also substantially risen from less than 20% to over 50% of all HIV-infected individuals. The quality and capacity of care have also risen substantially and innovations in prevention and treatment of opportunistic infections such as chemoprophylaxis, point-of-use safe water systems and use of mosquito nets have resulted into improved quality of life for HIV-infected individuals. PEPFAR support has also facilitated building of a strong family and community response and improving service delivery systems and institutions

Despite significant achievement in Uganda's national response to HIV/AIDS, significant challenges and gaps remain including the high HIV incidence among sexually active couples; low coverage of services (47% of eligible PHA access treatment and slightly over 50% of PHA accesses chronic care), as well as overcoming Uganda's recent political lassitude for Ugandan leaders and social celebrities to address the issue. Early identification and retention of PHA into care and treatment remains a primary challenge, resulting in high mortality due to late initiation of treatment. Approximately 85-90% of Ugandans know that a healthy-looking person can have HIV infection, yet still only an estimated 23% of Ugandans aged 15-49 years know their HIV status. Poor access to HCT is also still extremely prevalent in urban areas despite being relatively more endowed with HIV/AIDS services than rural areas. Even in Kampala, only 44% of the sexually active individuals know their status. The high population of Kampala and the high HIV prevalence strongly suggests that in spite of years of HCT-oriented communication campaigns, there is a large number of HIV infected individuals who have not even been tested much less identified or linked to care and treatment services. This presents a high risk for onward HIV transmission and makes a case for a new wave of HCT programming efforts to systematically identify and assist such individuals with HIV prevention care and treatment interventions.

More attention should also be directed to couple testing and disclosure given that HIV incidence is known to be highest among married and cohabiting couples as a result of discordancy. The Uganda Sero-Behavioural Survey 2004/2005 revealed that approximately 43% of HIV-infected individuals in Uganda are living with an HIV-negative spouse. Other studies and anecdotal reports from existing HIV/AIDS programs indicate that awareness of HIV status among sero discordant couples can motivate individuals to protect themselves against infection. Despite this evidence, couple counseling, testing and disclosure remains severely limited.

Uganda is reported to have still the highest fertility rate in the world, with population projected to hit 72 million in 2050 up from 12.6 million in 1980. The age group 15-34

years constitutes approximately 33% of the entire population. HIV prevalence in Uganda increases with age but peaks at different ages for men and women. For women, it peaks at 30-34 years and at 35-44 years for men, implying that men are more affected at older ages than women. A higher prevalence rate among women in young ages has considerable implications for HIV prevention given that these are the prime reproductive ages and hence the higher propensity for vertical HIV transmission. These findings highlight the need to address sexual and reproductive health needs as an integral component of comprehensive HIV/AIDS services. In particular, emphasis needs to be put on improving access to Family Planning (FP) services for HIV-positive individuals, particularly broadening contraceptive choice, which remain largely unaddressed, resulting in high incidences of unwanted pregnancies, high adolescent fertility and inappropriate reproductive health choices which in many ways compromise the outcomes in HIV prevention, care and treatment. Therefore, unless Ugandan citizens take more aggressive measures to exercise more informed, reproductive choices, social conditions could become calamitous.

The Government of Uganda (GOU) is conducting a mid-term evaluation of the (2007-2012) National HIV and AIDS Strategic Plan (NSP) which is a blue print of the national HIV/AIDS response. The five-year targets under this plan are that by 2012, Uganda should have: reduced the incidence of HIV by 40%, increased the number of people living with AIDS accessing ART from 105,000 to 240,000, extensively scaled up access to counseling and testing to facilitate universal access to ART, and increased access to quality care for people living with HIV/AIDS as well as orphans and other vulnerable children. Uganda has made considerable progress on many of the NSP targets such as increasing access to care and treatment, rolling out prevention of mother to child transmission as well as enacting and ratifying national policies and guidelines to support the national response. The results from the evaluation will serve to provide a basis for renewed commitment and strategic thinking.

This activity aims to contribute to Uganda's national efforts towards not only increasing access to quality HIV counseling and testing but also stemming, given Ugandan demographic trends, what could be dire health and socio-economic outcomes. The activity is designed, therefore, for Ugandan actors to take more aggressive measures to enhance early identification and enrollment of individuals living with HIV/AIDS into care and treatment and positively influence HIV prevention efforts.

I.3 THE U.S. PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)

PEPFAR is one of the most significant global initiatives assisting high prevalence countries in responding to the HIV/AIDS epidemic. The second phase of PEPFAR was enacted on July 30, 2008 and aims to:

- 1) Transition from an emergency response to the promotion of sustainable country programs;
- 2) Support host governments to take active leadership in the response and entrench HIV/AIDS services into their national health and development systems;
- 3) Expand HIV/AIDS prevention, care and treatment in concentrated epidemics;
- 4) Integrate and coordinate HIV/AIDS activities with broader global health and development programs to maximize impact on health systems; and

5) Invest in innovation and operations research to evaluate impact, improve service delivery and maximize outcomes.

The PEPFAR II global targets include: providing antiretroviral treatment to 4 million people with HIV/AIDS; preventing 12 million new HIV infections; and providing care for 12 million people, including 5 million orphans and vulnerable children. PEPFAR Uganda activities are expected to significantly contribute to these global targets. Currently PEPFAR supports more than 80% of Uganda's national HIV/AIDS response and as of March 2011, 218,000 out of the 274,000 individuals accessing ART nationally were directly supported by PEPFAR. This is in addition to supporting the national PMTCT acceleration plan and strengthening of the health systems.

Aligning itself with Uganda's National Development Plan, National Strategic Plan (NSP), Health Sector Strategic Investment Plan (HSSIP), SSP and other key GOU strategies, PEPFAR Uganda will continue to expand and strengthen the coverage and scope of HIV/AIDS services in Uganda as well as building institutional capacity and systems for long-term sustainability. The vision of the USG in Uganda under the U.S. President's Emergency Plan remains: "Within the framework of Uganda's multi-sectoral response, the Emergency Plan will contribute to strengthening national capacity to address the HIV/AIDS epidemic, achieving improved quality of life, equitable access to services, and sustainable systems". This will be done through a number of pillars that were identified by the Emergency Plan team:

- Strong family and community response to HIV/AIDS;
- Effective decentralization through broad national reach and work with a host of partners;
- Broad portfolio of quality activities, some of which have already proven to be effective, some of which are innovative new programs and pilots; and
- Focus on outcomes to reach Emergency Plan Uganda's five year targets

I.4: USAID/UGANDA PROGRAM

The USAID Program in Uganda contributes to GOU's National Development Plan (NDP) whose goal is to transform Uganda from a peasant to a modern and prosperous country within the next 30 years. USAID has just begun implementing its new, 2011-2015 Country Development Cooperation Strategy (CDCS) with the goal of accelerating Uganda's transition to a prosperous and modern country.

The CDCS has four Development Objectives (DO) namely: economic growth from agriculture and the natural resource base increased in selected areas and population groups; democracy and governance systems strengthened and made more accountable; improved health and nutrition status in focus areas and key population groups; as well as peace and security improved in Karamoja. These development objectives directly contribute to Uganda's NDP objectives of increasing household incomes, increasing access to quality social services as well as strengthening good governance, defence and security.

The Improved Health and Nutrition Status in Focus Areas and Population Groups Development Objective (DO3), aims to contribute to the National Development Plan by helping the Ugandan Government and private sector to tackle the heavy disease burden,

malnutrition, and still extensively unmet need for family planning by improving health service delivery systems. This program will focus on the attainment of intermediate result 3.1 under DO3; More Effective Use of Sustainable Health Services, as well as all the lower level intermediate results namely: IR 3.1.1 “Health Seeking Behaviors Increased”, 3.1.2 “Improved Quality of Health Services”, 3.1.3 “Increased Availability of Health Services, and 3.1.4 “Increased Accessibility of Health Services.

I.5: RESULTS, RELATIVE EFFORT, INDICATORS AND TARGETS

I.5.1: Overview

This activity will directly support the implementation of GOU's, USAID's and PEPFAR's joint commitment to scaling up HCT services to all persons at a high risk of HIV infection. The activity will specifically target populations of critical epidemiological importance including couples, commercial sex workers, incarcerated populations, individuals in wide sexual networks, pregnant women not attending antenatal care, as well as out of school youth in the informal sector. The proven low HIV prevalence among youth in schools and universities discounts this cohort as a priority for this activity. Services shall be delivered in an integrated manner to address other health challenges that impact HIV/AIDS prevention and care outcomes. These include high prevalence of other non-HIV sexually transmitted infections, high fertility and high burden and yet low case detection of tuberculosis especially among people with HIV, high loss to follow up of patients on treatment as well as low access to HIV/AIDS care and treatment for children due to poor coverage of Early Infant Diagnosis (EID) services. To ensure that the most important, vulnerable populations are reached and resources used more effectively, comprehensive risk assessment shall be emphasized for all clients receiving services. (Sub-results USAID proposes for key results are illustrative).

I.5.2: Result 1: Increased demand for HCT services

This activity will direct specific attention to regions with a population that is relatively affluent, more literate and exposed to HIV/AIDS information compared to rural areas of Uganda. However, perhaps due to the population's heterogeneity, still poorly developed effective public health messaging, lack of cohesive community structures and economic pressures, the propensity to engage in risky behavior is higher in Kampala than in rural areas. This partly accounts for the higher HIV prevalence in the Kampala area compared to other areas. Furthermore, whereas 44% of the residents in Kampala have accessed an HIV test at least once during the past five years against a national average of 22% (UDHS 2006), the 56% who have not accessed a test either lack knowledge of existing services and importance of testing, or they know and do not perceive themselves at risk of HIV infection. This has serious implications for HIV prevention given the high population density, the high HIV prevalence and most importantly the wide and complex sexual networks that are active among many city dwellers. Such a high resistance to testing among most of the Ugandan population also suggests that, while Ugandans have made important public health gains, years of internationally-supported health and HIV/AIDS efforts in Uganda continue to face significant challenges. Increasing knowledge and actual uptake of integrated HIV counseling and testing services are therefore of critical importance to other HIV interventions in this region.

The recipient shall implement realistic and verifiable approaches to:

- Seeking innovative methods to market and demystify HIV counseling and testing to make it a user-friendly service.
- Mobilizing distinctly at risk populations to access and utilize HCT services
- Raising knowledge of the general population on the importance of HIV testing and counseling, including the phenomenon and implications of sero-discordancy, etiological linkages between STDs and HIV, and benefits and risks of high fertility.
- Improving community knowledge and utilization of other proven, effective, high impact interventions such as long lasting treated bednets, cotrim prophylaxis, safe water and safe male circumcision.

Illustrative Results:

- Number of couples accessing HIV counseling and testing services.
- Increased knowledge of HIV counseling and testing within the target population

I.5.3: Result 2: Increase the number of people accessing and utilizing HCT services.

- Identify and reach the target populations, particularly sero-discordant couples within the highly mobile and fluid urban and peri-urban environment.
- Reach other, distinctly different and highly vulnerable populations
- Increase understanding of HIV sero-discordancy and support discordant couples
- Ensure uninterrupted delivery of counseling and testing services, including logistics management of HCT commodities.
- Integrate other key health services such as family planning, management of sexually transmitted infections and concurrent TB symptom screening.
- Strengthen community based monitoring and adherence to TB and HIV/AIDS treatment.
- Align services with national guidelines, policies and priorities, including routine quality and compliance measurements.
- Link with and complement the work of other non-PEPFAR HCT providers within the region.

Illustrative Results:

- Increased disclosure of HIV status among stable and long-term couples
 - Number and types of vulnerable population this activity is expected to reach?
- Reports on operational research for improved uptake, service delivery, and behavior change (including rates of sero-conversion) in relation to messaging, counseling and testing.

I.5.4: Result 3: Strengthen networks, referral systems and linkages to other HIV/AIDS, TB, reproductive health, maternal and child health services

The primary purpose of this activity is to assist key high risk population cohorts to know their status and subsequently facilitate their early entry into HIV/AIDS prevention, care and treatment services. Early entry and retention into care and treatment for HIV-positive

individuals are therefore emphasized as critical elements in improving quality of life for those infected and preventing further transmission of HIV. Building strong, functional and measurable referral linkages between HCT, care, treatment, PMTC, MMC and other HIV prevention services will be an essential piece of this program.

Networking with other key HCT stakeholders is an equally important element of this program to optimize use of resources and align activities to national policies and newly emerging evidence. Therefore, working within the framework on the National Strategic Plan (NSP) and the Health Sector Strategic Plan (HSSP) II, the recipient will be expected to participate as a key HCT stakeholder and engage in district and national level forums and activities that influence the strategic and policy direction of HCT in Uganda. In line with the on-going partner rationalization movement, the recipient is required to coordinate with existing USG supported HCT partners to avoid duplication and to ensure maximum coverage of quality services

The program shall:

- Build effective referral networks to link individuals graduating from HCT services into other HIV services such as safe male circumcision, PMTCT, behavior change communication initiatives, as well as HIV/AIDS care and treatment.
- Establish effective, operational relationships with other HCT providers
- Work with and establish a mutually supportive relationship with Ministry of Health
- Identify and link infants born to HIV positive mothers to EID services
- Identify and link eligible children to other relevant health services such as immunization and nutrition

Illustrative Results:

- Number of HIV-negative men referred and ultimately circumcised
- Number of newly diagnosed discordant couples who receive prevention with positives (PwP) services through HIV/AIDS care and support programs
- Number of infants born to HIV positive mothers referred for EID services

I.5.5: Result 4: Capacity Building for Sustainability

USAID has a long history of working with and supporting the evolution of indigenous organizations as key means of developing sustainable local capacity. Strengthening local capacity, as well as fostering host country ownership have also been re-emphasized under the new USAID Forward initiative. The first two objectives of this initiative affirmatively seek to create more opportunities for governmental entities and private organizations to assume increasing leadership in implementation of USAID supported programs. Local capacity development as well as intensified geographic focusing for demonstrative and measurable impact are therefore prioritized as key characteristics for programming USAID assistance. In pursuance of these objectives, the recipient is required to present an objective status and diagnosis of its key organizational capacity(s) based on self or externally conducted capacity assessment. Organizations' partnering and development experiences, including budgeting, staffing, programming performance, fund raising and accounting systems, as well as evaluations, audits,

strategic plans and other key organizational events, should be carefully considered and described in any assessment provided to USAID.

Illustrative Results:

- A realistic, coherent sustainability/exit plan that describes how the organization or other local actors will be able to continue key aspects of the program activities, after USAID funding ceases
- A comprehensive organizational capacity development plan, with the organization's anticipated income and expense streams projected from 2012 to 2015.
- The implementing organization is able to deliver high quality, state of the art and sustainable HCT services

I.6: ESSENTIAL DESIGN ELEMENTS

Increasing access to, coverage of and utilization of HIV Counseling and Testing services in target populations will be guided by a set of principles, particularly germane to the USG vision of the Emergency Plan in Uganda as well as USAID Uganda's Results Framework for its Development Objective 3 (DO3); Improve Health and Nutritional Status in Focus Areas and Populations. Therefore the program should meaningfully integrate the key design elements below across all the technical approaches.

I.6.1: Coordination, Collaboration and Partnership - Today, more than ever, the principles of coordination, collaboration and partnership are needed to ensure a comprehensive, quality response to the HIV/AIDS epidemic in Uganda. Over the past decade, Uganda has seen substantial increases in financial and technical resources flowing into the country to address HIV/AIDS. As partners in the response, it is our collective responsibility to ensure that we are working in partnership with the GOU, civil society, private sector, development partners and other stakeholders to maximize use of our resources, harmonize our approaches and coordinate our activities.

It is expected that this activity will work in close partnership with the NGO self-coordinating entity under the Uganda AIDS Commission and serve as a member of the National CT-17 under the Ministry of Health. Collaboration and communication with the central Ministry of Health is essential as is strong partnership with local government (administrative and technical) counterparts. Understanding of, coordination and complementarity with other USG and non-USG supported activities will also be critical. This activity should not in any way duplicate but rather complement the support of other partners. The awardee is expected to coordinate, collaborate, and share best approaches, practices and lessons learned with other USG and non-USG supported activities operating in the same geographical zones.

I.6.2: The Network Model – In Uganda, HIV/AIDS affects predominantly individuals and consequently creates physical, social, psychological and economic needs of varying intensity and dimensions. These needs should be addressed in order to optimize the quality of life for those affected. However, no single service provider can entirely meet all of these needs, hence the need for networking among the various providers to ensure that HIV positive individuals and their families access quality HIV counseling and testing services that they require.

A critical mandate in the President's Emergency Plan (EP) legislation is for countries to develop and implement a network model approach for care and treatment. The USG defines the network model as a continuum of care focusing on identifying and supporting HIV positive individuals so that they can receive a range of prevention, care and treatment services. The network model recognizes that any institution providing these services operates within a milieu of other institutions providing complementary services. By networking these service organizations, the range of services available to patients is greatly expanded. Through strong referral mechanisms between networked HCT service facilities (both public and private), an individual who is identified in one part of the system, for example, a VCT site, should be effectively referred to be able to receive services at a clinic providing HIV care and treatment as well as psychosocial support at an AIDS support organization or home-based care. PHA, families and communities are at the heart of the network model because of their instrumental role in identifying individuals needing care and supporting HIV positive individuals to enter and stay in the 'network'.

People living with HIV/AIDS (PHA) liaise with individuals, families and communities to create supportive social environments that encourage people to get tested; to stay negative through effective prevention strategies; to prevent further HIV transmission and to stay healthy when HIV+. They can play a vital role in influencing and supporting individuals and their families to access care and treatment and other support services; and to adhere to opportunistic infection and ARV treatment regimens. In this way, PHA groups are vital to an effective network, creating demand for services and supporting adherence to these services.

Households with people living with HIV/AIDS are very often the same households supporting orphans and other vulnerable children. Understanding this dynamic and identifying effective ways to increase access to HIV counseling and testing services will benefit all members of the household, particularly HIV positive individuals and OVC.

I.6.3: Family and Community- Focus on families and a community is also one of the pillars of USG Uganda team's strategy to achieve the Emergency Plan goals. Families and communities are the hub of all HIV/AIDS interventions, playing roles of testing advocates, service providers as well as consumers. They play key roles in mobilization and referral of individuals for services and provide supportive care to those who are HIV positive. At the same time, families and communities are also the primary clients for HIV/AIDS interventions, such as counseling and testing, care and treatment.

I.6.4: Gender -Despite efforts made by the GOU and its development partners address gender inequities, wide variations remain between men, women, girls, and boys with regard to access to health services, employment, nutrition, education and economic security. HIV prevalence for women is nearly twice that of men nationwide, speaking to biological factors that increase the likelihood of transmission, but also social factors related to sexual behavior such as gender violence and alcohol use/abuse. HIV/AIDS has also increased the burden for family care on women and girls, as they are the first and often primary responders/care providers to people suffering from the HIV/AIDS disease. Within the Kampala region, 45% of women have ever tested compared to 42% of men (UDHS 2006).

Gender variations are wider with regard to accessing care. For instance, 63% of individuals enrolling in HIV/AIDS care programs at TASO are women.

I.6.5: Sustainability- One of the dimensions of rapid-scale up of HIV/AIDS prevention, care and treatment services is ensuring sustainability of positive behavior and uptake of HCT services among the most at risk populations cited in this program. The sustainability of HIV/AIDS prevention, care and treatment services and support to their families is dependent on the development of more political and popular leadership as well as Ugandan capacity to not only design, manage and maintain these services but more seriously tackle Uganda's pressing demographic crisis.

I.6.6: The Greater Involvement of People with HIV/AIDS (GIPA) - Uganda's Ministry of Health (MOH) and the Ugandan AIDS Commission have acknowledged PHAs' important contribution in the fight against HIV/AIDS. In 1994, the GOU signed the Paris Declaration publicly affirming that the greater involvement of people living with or affected by HIV/AIDS is critical to ethical and effective national responses to the epidemic. USAID/Uganda also strongly supports the involvement of PHA networks in promoting importance of testing, demystification and facilitating access to HIV/AIDS prevention, care and treatment services to their members. .

I.6.7: People with Disabilities (PWD) – USAID/Uganda encourages its partners to work with people with disabilities whenever possible to minimize discrimination and promote equal opportunity and their inclusion within USAID funded programs in Uganda.

I.6.8: Collaboration, learning and adapting (CLA) - As part of a wider interest for USAID programming, documentation of best practices and innovations will be crucial to supporting replication of interventions and approaches by other programs. USAID/Uganda's currently looking at different opportunities to address continuous learning and will update the recipient accordingly.

I.6.9: GHI principles- The recipient will ensure that the proposed program and interventions reflect the core principles of Global Health Initiative including: taking a women and girl centered approach; encouraging country led plans; increasing impact of interventions through strategic partnerships; leveraging key multilateral institutions and global health partnerships; improving metrics, monitoring and evaluation; and integration.

I.6.10: Corruption and fraud- To support USAID/Uganda's zero tolerance policy against corruption and fraud, and to support the new Mission-wide initiative, the recipient will be required to develop and enforce compliance to judicious internal control measures to ensure that adequate safeguards and measures exist to prevent the misuse of funds and other public resources.

The recipient is also expected to develop and implement professional governance systems that engender transparency, participation and accountability.

1.6.11: Monitoring and Evaluation- The progress of the program will be monitored in accordance with the Performance Monitoring Plan. In executing the monitoring and evaluation functions under this program, the recipient shall collaborate and coordinate with the Uganda Monitoring and Evaluation Management Services (UMEMS) (and any

follow-on program) and the Monitoring and Evaluation of the Emergency Plan Progress (MEEPP) contractors.

The five-year PEPFAR strategy places emphasis on building the evidence base through program evaluation. PEPFAR-supported programs must contribute to the advancement of global HIV research, and programs must expand the tracking of quality, outcomes, cost-effectiveness, innovation and impact.

This project will thus contribute to the CLA agenda through its use of comprehensive evaluation of HCT campaigns and interventions thereby contributing to the growing evidence base on the outcomes of HCT programs and their role in increasing adoption of positive HIV-related behaviors.

I.6.12: Environmental Compliance- The Foreign Assistance Act of 1961, as amended, Section 117 requires that the impact of USAID's activities on the environment be considered and that USAID include environmental sustainability as a central consideration in designing and carrying out its development programs. This mandate is codified in Federal Regulations (22 CFR 216) and in USAID's Automated Directives System (ADS) Parts 201.3.11.2.b and 204 (<http://www.usaid.gov/policy/ads/200/>), which, in part, require that the potential environmental impacts of USAID-financed activities are identified prior to a final decision to proceed and that appropriate environmental safeguards are adopted for all activities. Recipient environmental compliance obligations under these regulations and procedures are specified in the following paragraphs of this RFA.

- 1a) In addition, the recipient must comply with host country environmental regulations unless otherwise directed in writing by USAID. In case of conflict between host country and USAID regulations, the latter shall govern.
- 1b) No activity funded under this Cooperative Agreement will be implemented unless an environmental threshold determination, as defined by 22 CFR 216, has been reached for that activity, as documented in an Initial Environmental Examination (IEE), or Environmental Assessment (EA) duly signed by the Bureau Environmental Officer (BEO). Hereinafter, such documents are described as "approved Regulation 216 environmental documentation."
- 2) An Initial Environmental Examination (IEE) file name: Uganda FY08 S08 IIP IEE 091608.doc has been approved for the Program that will fund this cooperative agreement (CA). The IEE covers activities expected to be implemented under this CA. USAID has determined that a **Negative Determination with Conditions** applies to the proposed activities. This indicates that if these activities are implemented subject to the specified conditions, they are expected to have no significant adverse effect on the environment. The recipient shall be responsible for implementing all IEE conditions pertaining to activities to be funded under this award.
- 3) As part of its initial Implementation Plan, and all Annual Implementation Plans thereafter, the recipient in collaboration with the USAID Agreement Officer's Representative and Mission Environmental Officer or Bureau Environmental Officer, as appropriate, shall review all ongoing and planned activities under this

CA to determine if they are within the scope of the approved Regulation 216 environmental documentation.

- 3a) If the recipient plans any new activities outside the scope of the approved Regulation 216 environmental documentation, it shall prepare an amendment to the documentation for USAID review and approval. No such new activities shall be undertaken prior to receiving written USAID approval of environmental documentation amendments.
- 3b) Any ongoing activities found to be outside the scope of the approved Regulation 216 environmental documentation shall be halted until an amendment to the documentation is submitted and written approval is received from USAID.
- 4) When the approved Regulation 216 documentation is (1) an IEE that contains a Negative Determination with Conditions the recipient shall:

Prepare an environmental mitigation and monitoring plan (EMMP) or project mitigation and monitoring (M&M) plan describing how the recipient will, in specific terms, implement all IEE and/or EA conditions that apply to proposed project activities within the scope of the award. The EMMP or M&M Plan shall include monitoring the implementation of the conditions and their effectiveness. If the approved Regulation 216 documentation contains a complete EMMP or project mitigation and monitoring (M&M) plan, the recipient does not need to complete a new plan. Guidance is available to assist with the EMMP and M&M process at <http://www.encapafrika.org/meoEntry.htm>.

- 4a) Integrate a completed EMMP or M&M Plan into the initial implementation plan.
- 4b) Integrate an EMMP or M&M Plan into subsequent Annual Implementation Plan, making any necessary adjustments to activity implementation in order to minimize adverse impacts to the environment.
- 5) If a provision for sub-grants is included under this solicitation requiring the recipient to use the Environmental Review Form (ERF) or Environmental Review (ER) checklist to screen grant proposals to ensure the funded proposals will result in no adverse environmental impact, to develop mitigation measures, as necessary, and to specify monitoring and reporting. Use of the ERF or ER checklist is called for when the nature of the grant proposals to be funded is not well enough known to make an informed decision about their potential environmental impacts, yet due to the type and extent of activities to be funded, any adverse impacts are expected to be easily mitigated. Implementation of sub-grant activities cannot go forward until the ERF or ER checklist is completed by the recipient and approved by USAID. Recipient] is responsible for ensuring that mitigation measures specified by the ERF or ER checklist process are implemented and addressed in annual reports. Guidance is available to assist with the ERF and ER checklist process at <http://www.encapafrika.org/meoEntry.htm>

- 5a) The recipient will be responsible for periodic reporting to the USAID Agreement Officer's Representative, as specified in the Program Description.
- 6) USAID anticipates that environmental compliance and achieving optimal development outcomes for the proposed activities will require environmental management expertise.

(See Section IV of the RFA for detailed instructions regarding environmental considerations to be included in the technical and cost applications).

I.7: KEY PERSONNEL

A Chief of Party and up to four additional key positions are considered essential for the implementation of the program.

I.8 AUTHORIZING LEGISLATION

The authority for this RFA is found in the Foreign Assistance Act of 1961 and the resulting award(s) will be administered in accordance with OMB Circulars, 22 CFR 226, and USAID's Automated Directives Systems (ADS) Chapter 303, "Grants and Cooperative Agreements with Non-Governmental Organizations" as applicable. These policies and regulations can be viewed or downloaded from USAID's Web Site <http://www.usaid.gov/business/regulations/>.

Pursuant to 22 CFR 226.81, it is USAID policy not to award profit under assistance instruments. However, all reasonable, allocable, and allowable expenses, both direct and indirect, which are related to this program and are in accordance with applicable cost standards (22 CFR 226, OMB Circular A-122 for non-profit organization, OMB Circular A-21 for universities, and the Federal Acquisition Regulation (FAR) Part 31 for-profit organizations), may be paid under the cooperative agreement. **USAID reserves the right to fund any or none of the applications submitted.**

[END OF SECTION I]

SECTION II – BASIC AWARD INFORMATION

II.1 ESTIMATED FUNDING: The total estimated budget for this RFA is US \$9 million.

USAID may make one or more award(s) without discussions to responsible applicants whose applications offer the greatest value to the extent they are necessary, negotiations will be conducted with the apparently successful applicant(s). Award(s) will be made to the responsible applicant(s) whose application(s) offers the greatest value, cost and other factors considered. USAID reserves the right to fund any or none of the applications submitted.

II.2 PERFORMANCE PERIOD: The anticipated program start date is **from May 2012 to May 2015**.

II.3 AWARD TYPE: USAID anticipates the award will be a **Cooperative Agreement. Substantial Involvement** under the award is expected to be as follows:

- Approval of the recipient's annual Implementation Plans and Performance Monitoring Plan;
- Approval of any changes to specified Key Personnel;
- *Monitoring (Site Visits and Periodic Program Reviews) and Direction and Redirection of Activities:* USAID may conduct site visits and organize and/or participate in periodic program reviews, and may direct or redirect activities because of interrelationships with other USG programs, program elements/activities. However, such directed or redirected activities must fall within the scope of activities outlined in the Program Description, negotiated in the budget, and made part of the Cooperative Agreement;
- Approval of sub-recipients;
- USAID participation as a member of any program advisory committee. The advisory committee will only deal with programmatic or technical issues, not routine administrative matters;
- Agency authority to immediately halt a construction activity, as applicable.

II.4 AUTHORIZED GEOGRAPHIC CODE: The Authorized Geographic Code is **935** for the procurement of goods and services. Reference ADS 310 for current information.

[END OF SECTION II]

SECTION III – ELIGIBILITY INFORMATION

III.1. This is a limited regional competition, under which any type of organization, large or small, commercial (for profit) firms, faith-based, and non-profit organizations in partnerships or consortia from East African region, are eligible to compete. In accordance with the Federal Grants and Cooperative Agreement Act, USAID encourages competition in order to identify and fund the best possible applications to achieve program objectives.

III.2. USAID encourages applications from potential new partners.

III.3. A cost share of **up to 3% is encouraged** in all applications. Cost-sharing, once accepted, becomes a condition of payment of the federal share.

[END OF SECTION III]

SECTION IV - APPLICATION AND SUBMISSION INFORMATION

IV.1 ELECTRONIC SUBMISSION OF APPLICATIONS via EMAILS IS REQUIRED

Applications are to be submitted via email. Please submit your applications to the email address below by Friday, March 29th, 4pm (EST) Washington RECEIPT TIME IS WHEN THE APPLICATION IS RECEIVED BY THE AID/Washington INTERNET SERVER. **Only electronic submission of applications is accepted.** The address for the receipt of proposals is: KampalaUSAIDSolicita@USAID.gov , to the Attention of Florence Alimo, A&A Specialist and Tracy J. Miller, Agreement Officer. Applications which are submitted late or do not follow the instructions contained herein run the risk of not being considered in the review process.

All applications received by the deadline will be reviewed for responsiveness to the specifications outlined in these guidelines and the application format. Note this RFA includes a recommended cost share percentage of up to 3 percent of the total proposed USAID contribution to the program.

Applications should take into account the evaluation criteria provided in **Section V** and must include as an annex to the application, the Representations and Certifications provided in **Attachment B**. In the event Representations and Certifications are not submitted with the Application, they must be completed before final award is made.

Please note that Technical and Cost Applications should be kept separate. USAID wants to leverage its assistance and applicants are encouraged to provide a commitment to providing cost sharing and a statement of how much (in percentage terms) of the budget they are going to raise from other sources. If cost share is proposed, the Cost Application must contain a clearly identified section on cost sharing including sources for those funds.

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

IV.2 TECHNICAL APPLICATION FORMAT

Applications must be submitted electronically in MS Word and .pdf (Adobe Acrobat) versions. In case of any conflicts between the MS Word and .pdf versions of the application, the .pdf version will govern as it will be the version presented to the Technical Evaluation Panel.

Applicants are advised that any pages exceeding any of the prescribed limits below will not be considered for evaluation.

Applications must be legible and must *not* require **magnification** (!). Please be kind to the evaluators and keep the technical application clear, concise, easy to follow, while

also in complete compliance with the instructions herein.

The technical application (**maximum 30 pages – not including annexes**) should clearly and concisely outline how the Applicant proposes to meet the critical needs identified in the objective(s) and how the Applicant will achieve its expected results.

Technical Approach:

Data and evidence-based interventions related to HCT, prevention, care and treatment of HIV are becoming increasingly available, in Uganda as well as other countries.

Applicants shall:

- Develop and propose strategies and technical approaches that are reflective of available data, innovative social research and evidence.
- Highlight how new data and information will effectively be integrated into program strategies and activities as it becomes available.
- As needed for the design, rollout and improvement of program activities, the applicant should propose what types of assessments and operational research will be undertaken beyond those highlighted in Section I.
- Set forth the conceptual framework and applicants' development hypotheses for behavioral change among key at-risk populations, as well as proposed approaches and techniques for the accomplishment of the stated objectives.
- Reflect a thorough understanding of the current context and Uganda's HCT and reproductive health policy environment.
- Present an approach that will provides geographic focus, intensifies CT coverage, is innovative, cost-effective and sustainable.
- Provide a succinct description of their overall approach to HCT
- Present realistic and result-based approaches to effectively achieve the objectives of this activity
- Based on this assessment, the applicant should indicate areas of key organizational strengths and comparative advantages, relative weaknesses and the plan for further sustainably strengthening its organizational capacity.
- Present strategies that reflect family and community focus in the program's implementation, and how social support for respective hard to reach groups, can be harnessed to sustain uptake of testing and positive behaviors.
- Describe how this program will address gender issues, and provide viable strategies for increasing access to HCT services by men.
- Considering partner institutions, private and third sector actors, as well as other funding opportunities, the applicant should indicate, through a realistic exit strategy, how this program's key activities and results realized could still be advanced and sustained within other Ugandan institutions.
- Required to demonstrate how PLHAs will be involved in the program's implementation.
- Include strategies for increasing opportunities for PWD to access HIV/AIDS services and to play active roles in the delivery of these services.
- Any planned operations research to be conducted during project implementation should also be indicated as a key aspect of the applicant's and USAID'd learning agenda. The applicant will work collaboratively with other USAID programs to

- foster transfer of knowledge on innovations within their field and implementation of tested interventions to increase impact.
- Provide an illustrative (draft) Performance Monitoring Plan (Annex III) for this activity that includes meaningful indicators beyond those which are required through the Presidential Emergency Plan for AIDS Relief. The PMP should include ambitious but achievable
 - Performance targets and benchmarks for integrated HCT services that will be achieved by the end of the three years. Identify the data collection method, type, and source of information to be collected. Describe how USAID reporting requirements will be met.
 - Describe how data generated through this activity will feed into national and sectoral/line ministry reporting systems and requirements. Up to 10% of the budget may be allocated to monitoring and evaluation including operations research.
 - Include a plan for achieving sustainability over the life of the program. (see Section IV.3 Annexes)
 - Include your approach to achieving **environmental compliance and management** (reference Section I.6.12), including:
 - Approach to developing and implementing an IEE or EA or environmental review process for a grant fund and/or an EMMP or M&M Plan, as applicable.
 - Approach to providing necessary environmental management expertise, including examples of past experience of environmental management of similar activities.
 - An illustrative budget for implementing the environmental compliance activities. For the purposes of this solicitation, applicants should reflect illustrative costs for environmental compliance implementation and monitoring in their cost proposal.

Management Plan and Personnel

Full mobilization of staff is expected within 30 days and implementation of activities within 60 days after initiation of the award. Applicants shall provide a management plan consistent with the project's technical expectations and stakeholders. The composition and organizational structure of the entire implementation team shall be provided. The staffing pattern will reflect the minimum number of highly experienced technical staff sufficient to manage and implement activities under this award.

The application must include a detailed description of the management approach for implementing the proposed program, which includes specifying the composition and organizational structure of the entire implementation team (including home office support); describing each team member's role and level of effort.

Key personnel will be proposed by name and position. Each key personnel position requires USAID approval, as noted in substantial involvement provisions.

Applicants may consider developing operational partnerships with other complementary organizations in the interest of meeting the program objectives. If the applicant presents as a partnership of organizations or groups, the proposal shall clearly demonstrate the

justification for participating partners, and the unique set of experience and expertise they bring to strengthen the activities undertaken within this RFA. At the same time, the management plan proposed needs to be efficient and cost-effective in response to budgetary constraints.

The applicant should demonstrate impeccable understanding the drivers of the epidemic as well as state of the art models for delivering effective messaging, outreach and HCT services across facilities and communities.

The applicant should take into consideration USAID's and the Government of Uganda's desire to have qualified Ugandans and regional nationals holding substantive program management positions.

The section on personnel capability in the application's main body will include brief statements of staff member's role, technical expertise, and estimated amount of time each will devote to the project for each of the key personnel and other senior program staff. Resumes for key personnel, other senior program staff and any long-term professional staff/advisors will be limited to three (3) pages in length and should be included as Annex I . The annexes will also include letters of intent to participate for those not already employed by the proposing organization and letters of commitment from proposed key personnel.

The applicant shall include:

- Organizational chart with roles and responsibilities
- Management structure of all proposed partners and their roles and contributions
- Lines of authority
- Personnel Management
- Plans for rapid start up, including draft first year implementation plan (see section IV.3 Annexes, below) that identifies the major activities to be undertaken for each objective; a detailed timeline for implementation of activities is not necessary.
- Financial management, reporting and cost containment strategies.

Institutional Capacity and Past Performance

Implementation of activities should be undertaken by a partner(s) with the relevant strategic, technical and experience to facilitate increased access and utilization of HCT services in urban settings services, particularly reaching high risk groups. Strong partnerships with health service providers and civil society organizations is needed to facilitate referral for HIV prevention, care and treatment services.

Past Performance: This is a unique activity that requires delivery of high quality services and outputs within the shortest possible time. It is expected that within two months after award, the applicant shall begin reporting outputs. Therefore, care should be taken to establish the relevance of the organization's past performance to the management of this program and the basis for reliance upon that experience as an indicator of anticipated program success. Information in this section should include (but is not limited to) the following:

- Brief description of organizational history/expertise;
- Pertinent work experience and representative accomplishments in developing and implementing programs of the type required under the proposed RFA;
- Relevant experience with proposed approaches;
- Institutional strength as represented by the breadth and depth of experienced personnel in projects in relevant disciplines/areas;

As Annex IV, please provide relevant past performance references which describe any contracts, grants, cooperative agreements which the applicant organization has implemented involving similar or related programs over the past **three years**. Please provide these references in the annex and include the following information: current telephone number and email address of responsible representative from the organization for which the work was performed; contract/grant name and number (if any), annual amount received for each of the last three years and beginning and end dates; brief description of the project/assistance activity and key project accomplishments/results achieved to date.

USAID will contact the named references and use the past performance data along with other information, to evaluate the applicants' quality of performance and responsibility.

IV.3 Annexes

The following six annexes should be submitted within the page limits indicated; any pages exceeding the limits for each annex will not be considered.

Annex I. CVs for Key Personnel – Three (3) pages maximum per CV.

A more detailed description of proposed key personnel including the Chief of Party and up to four additional key personnel, as well as any other personnel position for who the applicant wishes to provide CVs. For all Key Personnel, a CV and Contractor Biographical Data Sheet (USAID FORM 1420-17) including the candidate's employment history and past performance references for each long-term position held within the last ten years must be included for each proposed candidate. The use of local expertise is highly encouraged. Equal consideration should be given to equally-qualified women and men when recruiting for the project.

Annex II. Draft Implementation Plan (Max. 5 pages)

A draft implementation plan for all activities through the end of the current fiscal year, including milestones.

Annex III. Draft Performance Monitoring Plan (Max. 5 pages)

A draft PMP shall be submitted with the application, and shall include performance indicators, planned data sources, data collection and calculation methods, baseline data and annual targets directly linked to proposed activities.

Annex IV. Past Performance References and Information – ONE (1) page maximum per reference.

An applicant must provide a list of all its contracts, grants, or cooperative agreements involving similar or related programs during the past three years. The reference information for these awards must include the performance location, award number (if available), a brief description of the work performed, and a point of contact listed with current telephone number and email address. The Agreement Officer may also consult other resources and references not provided by the applicant related to the applicant's past performance.

Annex V. Representations and Certifications, Assurances: (See Attachment B for the required representations and certifications that are to be included as Annex V to the technical proposal).

NOTE: When these Certifications, Assurances, and Other Statements of Recipient are used for cooperative agreements, the term "Grant" means "Cooperative Agreement."

Annex VI: Draft Sustainability Plan (Max. 3 pages)

The applicant will submit to USAID a draft sustainability plan as part of this application that includes milestones demonstrating full program sustainability by the time the award ends. This must include, but is not limited to, how HCT will build sustainable services. The Offeror should describe the anticipated sustainable elements of the program, whether implemented by the public or private sector, and any specific approaches proposed to achieve more sustainable outcomes (e.g. recruitment, retention, and motivation of health workers; strengthening local training institutions and universities; increased logistics management; improved community level capacity and advocacy, etc.).

IV.4 Cost Application Format

The Cost Application is to be submitted via a separate email from the Technical Application. Certain documents are required to be submitted by an applicant in order for the Agreement Officer to make a determination of responsibility. However, it is USAID policy not to burden applicants with undue reporting requirements if that information is readily available through other sources. A Cost Application consists of:

- **SF-424***, Application for Federal Assistance;
- **SF-424A***, Budget Information – Non-Construction Program;
- **SF-424B***, Assurances – Non-Construction Programs;
- a summary budget;
- a detailed/itemized budget; including illustrative costs for environmental compliance implementation and monitoring
- a budget narrative explaining costs to be incurred; and
- other administrative documentation as required.

*These forms may be downloaded from the following website:
http://www.grants.gov/agencies/aforms_repository_information.jsp

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

The required budget format is found in Attachment C of this RFA.

Please be sure that the budget includes at least the following elements:

- the breakdown of all costs associated with the program according to costs of, if applicable, headquarters, regional and/or country offices;
- the breakdown of all costs according to each partner organization involved in the program, in the same detail and format as the budget template;
- potential contributions of non-USAID or private commercial donors to this Cooperative Agreement, including, the breakdown of the financial and in-kind contributions (cost sharing) of all organizations involved in implementing this Cooperative Agreement.

NOTE: The award will not provide for the reimbursement of pre-award costs.

Also include:

- a) Information that confirms and ensures that the proposed cost sharing will materialize.
- b) Details of sub-award arrangements to the extent they are known at the time of application development: In case there are multiple organizations and partners, please explain as clearly as possible the management structure and how the parties are going to interact. If there are formal legal arrangements such as sub awards or sub contracts please clearly explain how these are to be structured and list past experience between the organizations.

NOTE: If sub-awards are anticipated and not explained in the original application, the agreement officer's approval (after award) is required before the sub-agreement may be executed.

- c) A copy of the self-certification for compliance with USAID policies and procedures for personnel, procurement, and travel.
- d) A copy of the organization's U.S. Government Negotiated Indirect Cost Rate Agreement (NICRA), if applicable.
- e) Applicants should submit additional evidence of responsibility they deem necessary for the Agreement Officer to make a determination of responsibility. The information submitted should substantiate that the Applicant:
 1. Has adequate financial resources or the ability to obtain such resources as required during the performance of the award.
 2. Has the ability to comply with the award conditions, taking into account all

existing and currently prospective commitments of the applicant, non-governmental and governmental.

3. Has a satisfactory record of performance. Past relevant unsatisfactory performance is ordinarily sufficient to justify a finding of non-responsibility, unless there is clear evidence of subsequent satisfactory performance.
4. Has a satisfactory record of integrity and business ethics; and
5. Is otherwise qualified and eligible to receive a cooperative agreement under applicable laws and regulations (e.g., EEO).

IV.5 Marking and Branding

MARKING AND BRANDING: Pursuant to ADS 303.3.6.3.f and ADS 320.3.1.2, the apparently Recipient will be requested to submit a Branding Strategy and Marking Plan that will have to be successfully negotiated before a cooperative agreement will be awarded. These plans shall be prepared in accordance with the guidance in ADS 320.3.3, 22 CFR 226.91 and the references therein. **Please note that the Branding Strategy and Marking Plan shall not be included with the original application but shall be provided only after a written request of the Agreement Officer.**

[END OF SECTION IV]

SECTION V – APPLICATION REVIEW INFORMATION

Overview

The Technical Evaluation Criteria are tailored to the requirements of this particular RFA and are set forth below. Applicants should note that these criteria serve to: (a) identify the significant matters which applicants should address in their applications and (b) set the standard against which all applications will be evaluated. To facilitate the review of applications, applicants must organize the narrative sections of their applications with the same headings and in the same order as the selection criteria.

USAID Uganda intends to evaluate the applications and award an agreement without discussions with the applicants. However, USAID reserves the right to conduct discussions if the latter is determined by the Agreement Officer to be necessary. Therefore, the initial offer should contain the applicant's best terms from a Technical and Cost/Price stand point.

The criteria by which the Application will be assessed are as follows: Technical Approach and Institutional Capacity & Past Performance are of equal importance. 3. Management Plan & Personnel is of less importance.

1. Technical Approach (sub-criteria of equal importance):

Applicants will be evaluated on the extent to which they have:

A. Strategic and Technical Fit: The extent that the proposed approach is responsive to the stated objectives and requirements, aligned with accepted, effective practices, appropriate for the country and beneficiary context, and likely to contribute to overall USAID's strategy goals in Uganda.

B. Sustainability of the Approach: The likelihood that the set program outcomes will continue beyond and without USG funding – because critical activities initiated by the project are assumed (and financed) by local institutions, necessary capacity is fostered among local stakeholders, and/or partners and beneficiaries sustainably adopt key behaviors.

C. Application of key design elements/principles: Key design elements/principles cited in this RFA, including geographic focus and anticipated, measurable impact, must be meaningfully integrated and reflected throughout the applicant's proposed strategic and technical approaches and the performance monitoring plan.

2. Institutional Capacity & Past Performance* (sub-criteria of equal importance):

Applicants will also be evaluated based on the extent to which they can:

- A. Demonstrate organizational knowledge and institutional capability to develop, manage and implement similar programs.
- B. Ability to facilitate rapid roll-out and guarantee outputs within the shortest possible time.
- C. Describe relevant work experience and representative accomplishments in managing and implementing similar programs.
- D. Past performance, including a review of applicants relevant performance by prime and subs; instances of good and/or poor performance, significant achievements, significant problems; and any indications of excellent or exceptional performance in the most critical areas.

USAID reserves the right to obtain past performance information from other sources including those not named in the applicant's application.

*See Section IV.3, Annex IV for instructions for submission of past performance information

Management Plan and Personnel (sub-criteria of equal importance):

Application demonstrates that:

- A. Key personnel have requisite breadth and depth of technical expertise and experience in the management, planning and provision of specialized technical assistance necessary for achievement of program results.
- B. Demonstrates an effective and cost-efficient management structure to achieve project goals, objectives and targets.
- C. Proposes personnel who have relevant professional qualifications and experience appropriate to manage and achieve results.
- D. Demonstrates commitment to using Ugandan and regional professionals and managers who hold significant positions in the program's management and implementation.

COST EVALUATION

Cost has not been assigned a score but will be evaluated for cost reasonableness, allocability, allowability, cost effectiveness - including cost share - and realism, adequacy of budget detail and and cost sharing. While cost may be a determining factor in the final award(s) decision, especially between closely ranked applicants, the technical merit of applications is substantially more important under this RFA. Applications providing the best value to the Government, including cost share, will be more favorably considered for award. Applications will be ranked in accordance with the

selection criteria identified above. USAID reserves the right to determine the resulting level of funding selected for award.

[END OF SECTION V]

SECTION VI – AWARD ADMINISTRATION INFORMATION

- 1) Following selection for award, a Recipient will receive an electronic copy of the notice of award signed by the Agreement Officer which serves as the authorizing document. USAID will issue the award to the contacts specified by the applicant in its application documents and/or the Authorized Individuals submitted by the applicant.
- 2) The applicable Standard Provisions that will apply in any resulting award document can be viewed or downloaded from USAID's Web Site:
<http://www.usaid.gov/policy/ads/300/303.pdf>.
- 3) The following programmatic reporting requirements shall be made part of any award issued under this RFA:

VI.1 Program Reporting

The Recipient shall submit one original, two (2) hard copies and an electronic copy of the following reports in English to the USAID/Uganda Agreement Officer Representative (AOR) for approval:

1. Annual Implementation Plans and Budgets

First Implementation Plan

- Due no later than **60 days after the effective date of this award**.
- Shall describe planned activities arranged by the overall objectives of the Program Description and further broken down by sub-activities and tasks and by geographic location. Also include budgetary forecasts and notes tied to proposed activities. The plans will include proposed activities for the given year, for implementation of annual activities, detailed budget, as well as review of previous year's accomplishments, problems and lessons learned, and progress towards achieving award outputs and proposed annual accomplishments.

Annual Implementation Plans

- **60 days prior to the end of the activity year**. Shall contain the same information as described above.

2. Performance Monitoring Plan (PMP)

- Due no later than **90 days after the effective date of this award**.
- Shall cover the entire period of performance of this Award and may be adjusted based on any changes in planned activities.

- The Performance Monitoring Plan will outline key program activities, targets and indicators for measuring achievement, which should support the achievement of the President's Emergency Plan targets and USAID/Uganda's intermediate results. This plan will be reviewed and approved by the AOR and the USAID/Uganda Monitoring and Evaluation Specialist.
- Shall include relevant indicators to measure performance annually and at the end of the program, with baselines and targets for each indicator. Indicators shall be quantitative and qualitative and used to track program impact, including related to stability, with less importance on tracking outputs. Where applicable, indicators should be disaggregated by gender, age cohorts, and geographical location. Program management and cross-cutting indicators are encouraged. The data collection process and tools to be used, and proposed plans for periodic evaluations, assessments, studies, documentation on data source and quality etc. shall also be included.

3. Reports

Quarterly Performance Reports

- Due to the AOR every three months, no later than **30 days after the end of each calendar quarter**. The narrative reports, which give insight into the progress of planned activities. The reports shall include qualitative and quantitative information, which describes activities conducted and specific results achieved during the quarter. In addition, the reports shall indicate key implementation challenges encountered and how they were or are planned to be resolved. Accrued program costs for the quarter and planned expenditures for the next one shall also be indicated. The programs reports shall as much as possible include success stories and pictures to reflect the real impact of activities on the lives of beneficiaries. Following receipt of the report a "quarterly review" meeting will be held to discuss results, challenges and way forward.
- Recipient may be required to present results un verbal and/or visual format
- *Accruals*: Shall be due **one week before the end of each quarter per year**; i.e. December 31, March 30, June 30, and September 30.

Quarterly Financial Reports: 30 days after the end of each calendar quarter along with the progress report. Shall include a report on expenditures accrued during the report period and projected accrued expenditures for the next quarter, against Award line items.

Annual Financial Reports: The July-September Quarterly Financial Report will constitute the Annual Financial Progress Report.

Final Performance Report

- Shall be submitted 90 days after the award end date. A draft shall be submitted 45 days after the award end date. The final report shall be in English. It shall cover the entire five-year period of the award and include the cumulative results achieved, an assessment of the impact of the program, lessons learned and recommendations, any particularly notable impact stories, and detailed financial information. It should be grounded in evidence and data. A copy of the final

results shall be filed with the Development Experience Clearinghouse at:
<http://dec.usaid.gov> or <http://www.DocSubmit@usaid.gov>.

President’s Emergency Plan Reporting

Bi-annual reports will be required and the timing may vary according to funding schedules.

USAID/Uganda may also request ad hoc information and reports for use in the routine progress monitoring and in response to requests from Washington.

Final Performance Report

Within the last month of the program, the recipient shall submit to USAID/Uganda an end-of activity report, summarizing the major achievements, impact and issues including lessons learned generated by the activity. The report should also indicate the contextual opportunities remaining that could easily be harnessed to sustain the results of the program.

SYNOPSIS of PLANS & REPORTS

Name/Title of Report/Plan	Frequency of Report/Plan	Content
Implementation Plan	Initial plan due 60 days after award. Annual plan – 60 days prior to the end of the activity year.	Planned activities arranged by overall objectives – sub-activities and tasks by geographic location. Budgetary forecasts
Performance Monitoring Plan	Initial plan due no later than 90 days after award.	Outline key activities, targets, results, etc.
Quarterly Performance Reports	No later than 30 days after the end of each quarter.	As determined by the AOR
Accruals report	One week before the end of each quarter	Report format as designated by USAID/FMO
Quarterly Financial Reports	30 days after the end of each calendar	As required.
Annual Financial Report	Annually – (July-Sept. quarterly will constitute the annual report)	As required.
Final Performance Report	Draft – 45 days after the end of award. Final due 90 days after the award end date.	As required.

[END SECTION VI]

SECTION VII – AGENCY CONTACTS

Agreement Officer
USAID/Uganda
US Embassy Compound
Plot 1577 Ggaba Road
Kampala, Uganda

[END SECTION VII]

SECTION VIII – OTHER INFORMATION

Resulting awards to U.S. Non-government Organizations will be administered in accordance with Chapter 303 of USAID's Automated Directives System (ADS 303), 22 CFR 226, applicable OMB Circulars (i.e., A-21 for Universities or A-122 for Non-Profit Organizations, and A-133), and Standard Provisions for Non-Governmental Organizations.

- ADS 303 is available at: <http://www.usaid.gov/policy/ads/300/303maa.pdf>.
- 22 CFR 226 is available at: http://www.access.gpo.gov/nara/cfr/waisidx_06/22cfr226_06.html. Applicable
- OMB Circulars are available at: <http://www.whitehouse.gov/OMB/circulars/index.html>.
- Standard Provisions for U.S. Non-Governmental Organizations are available at: <http://www.usaid.gov/policy/ads/300/303maa.pdf>.

Resulting award to Public International Organizations (PIOs, or IOs) will be administered in accordance with Chapter 308 of USAID's ADS including the Standard Provisions set forth in ADS 308.5.15.

Potential for-profit applicants should note that USAID policy prohibits the payment of fee/profit to the prime recipient under grants and cooperative agreements. However, if a prime recipient has a subcontract with a for-profit organization for the acquisition of goods or services (i.e., if a buyer-seller relationship is created), fee/profit for the subcontractor is authorized.

Standard Provisions for Non-U.S. Non-Governmental Organizations are available at: <http://www.usaid.gov/policy/ads/300/303mab.pdf>. ADS 308 is available at: <http://www.usaid.gov/policy/ads/300/308mab.pdf>.

The USAID Inspector-General's "Guidelines for Financial Audits Contracted by Foreign Recipients" is available at: <http://www.usaid.gov/oig/legal/audauth/rcapguid.pdf>.

[END SECTION VIII]

SECTION IX – REFERENCES AND ATTACHMENTS (Attachment A is included, below; Attachment B and C are separate documents).

Attachment A	Acronyms
Attachment B	Representations, Certifications, & Assurances
Attachment C	Budget Template

ATTACHMENT A – LIST OF ACRONYMS

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AIM	AIDS Integrated Model District Program
ART	Anti Retroviral Therapy
ARV	Anti-Retroviral Drugs

CBO	Community Based Organization
CSO	Civil Society Organizations
CT	Counseling and Testing
CTO	Cognizant Technical Officer
FBO	Faith Based Organizations
EP	Emergency Plan
GIPA	Greater Involvement of People with HIV/AIDS
GOU	Government of Uganda
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HSSPII	Health Sector Strategic Plan II
LRA	The Lord Resistance Army
MACA	Multi-sectoral Approach to Control of HIV/AIDS
MEEP	Monitoring and Evaluation of the Emergency Plan Progress
MOH	Ministry of Health
NSP	National Strategic Plan
NGO	Non-Government Organization
NOP	National Operational Plan
NSF	National Strategic Framework
OVC	Orphan and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PEAP	Poverty Eradication Action Plan
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
PHAs	Persons living with HIV/AIDS
RFA	Request for Application
SO	Strategic Objective
STI	Sexually Transmitted Infections
TASO	The AIDS Support Organization
TB	Tuberculosis
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UHSP	Uganda HIV/AIDS Services Project
USG	United States Government
UPHOLD	Uganda Program for Human and Holistic Development
USAID	United States Agency for International Development
WHO	World Health Organization
VCT	Voluntary Counseling and Testing

