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Issuance Date:	**October 26, 2020**
Closing Date:	**October 25, 2021, 17:00 GMT**
Deadline for Submission of Questions for Phase One:	**November 5, 2020, 17:00 GMT**
Deadline for Submission of Phase Concept Papers:	**November 23, 2020, 17:00 GMT**
Deadline for submission of Full Applications:	**To be provided after Co-creation**

Subject: **Annual Program Statement (APS) Number: 72068521APS00001**

Program Title: **Improving Health Status and Human Capital in Senegal**

Catalog of Federal Domestic Assistance (CFDA) Number: **98.001**

Ladies/Gentlemen:

The United States Agency for International Development (USAID)/**Senegal** is seeking applications for **one or multiple cooperative agreement(s)** from qualified entities to implement the ***Improving Health Status and Human Capital in Senegal*** program. Eligibility for this award is **not restricted**.

USAID/**Senegal** intends to make an award(s) to the Applicant(s) **whose concept paper passes the concept paper review stage and whose application** best meets the objectives of this funding opportunity based on the merit review criteria described in this **APS** subject to a risk assessment. Eligible parties interested in submitting **concept papers** are encouraged to read this **APS** thoroughly to understand the type of **activities** being sought, submission requirements and selection process.

Pursuant to 2 CFR 200.400(g) and 2 CFR 700.13, 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 activity and are in accordance with applicable cost principles, may be paid under the award.

To be eligible for award, the Applicant must provide all information as required in this **APS** and meet eligibility standards in Section C of this **APS**. This funding opportunity is posted on www.grants.gov, and may be amended. It is the responsibility of the Applicant to regularly check the website to ensure they have the latest information pertaining to this notice of funding opportunity and to ensure that the **APS** has been received from the internet in its entirety. USAID bears no responsibility for data errors resulting from transmission or conversion process. If you have difficulty registering on www.grants.gov or accessing the **APS**, please contact the Grants.gov Helpdesk at 1-800-518-4726 or via email at support@grants.gov for technical assistance.

USAID may not award to an Applicant unless the Applicant has complied with all applicable unique entity identifier and System for Award Management (SAM) requirements detailed in **this APS** (Section D.6.f). The registration process may take many weeks to complete. Therefore, Applicants are encouraged to begin registration early in the process.

Please send any questions to the point(s) of contact identified in Section D of this **APS**. The deadline for questions is shown above. Responses to questions received prior to the deadline will be furnished to all potential Applicants through an amendment to this notice posted to www.grants.gov.

Issuance of this notice of funding opportunity does not constitute an award commitment on the part of the Government nor does it commit the Government to pay for any costs incurred in preparation or submission of **concept papers or a full application**. Applications are submitted at the risk of the applicant. All preparation and submission costs are at the Applicant's expense.

Thank you for your interest in USAID programs.

Sincerely,

Chadwick Cannon Mills

Digitally signed by Chadwick Cannon Mills
Date: 2020.10.24 17:42:38 Z

Chadwick Mills
Regional Agreement Officer

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SECTION A: PROGRAM DESCRIPTION

This funding opportunity is authorized under the Foreign Assistance Act (FAA) of 1961, as amended. The resulting award will be subject to 2 CFR 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, and USAID's supplement, 2 CFR 700, as well as the additional requirements found in Section F.

Note: The term "program" as used in 2 CFR 200 and this NOFO is typically considered by USAID to be an Activity supporting one or more Project(s) pursuant to specific Development Objectives. Please see 2 CFR 700 for the USAID specific definitions of the terms "Activity" and "Project" as used in the USAID context for purposes of planning, design, and implementation of USAID development assistance.

UMBRELLA PROGRAM DESCRIPTION

Improving Health Status and Human Capital in Senegal

USAID/SENEGAL's Office of Health, Population and Nutrition (USAID/Senegal HPNO) is pleased to issue this Annual Program Statement (APS), *Improving Health Status and Human Capital in Senegal*, to fund one or multiple awards to implement activities necessary for achieving the strategic results of its HPN portfolio for fiscal years (FY) 2021-2026.

The APS comprises : the "umbrella" APS (this document), which presents the project context and background information, as well as general guiding principles, including the evaluation criteria and submission requirements; three Component documents which represent the three program components under this APS; and annexes. Each program component details specific objectives, expected results, funding ceilings, and other requirements. These include:

● Component 1, Central-level Health Systems Strengthening, focused on strengthening key health systems at the central Ministry of Health level.

● Component 2, Integrated District Health, which will provide comprehensive support to health districts in five priority regions (Diourbel, Kolda, Sedhiou, Tambacounda, and Kedougou).

● Component 3, Urban Health, focused on improving reproductive, maternal, newborn, child and adolescent health (RMNCAH), family planning (FP), malaria (M), nutrition (N), and water, sanitation and hygiene (WASH) outcomes through approaches tailored to an urban context in marginalized, underserved districts of the Dakar Region.

1. Background

Senegal is at an important crossroads in its Journey to Self-Reliance: the country has set forth ambitious goals for continued economic and social development, as outlined in the *Plan Senegal Emergent (PSE)*, and must follow through with building capacity and demonstrate its commitment to development, if it is to achieve these goals. The U.S. Government, through USAID, one of the

largest bilateral donors in Senegal, has built a strong and close partnership with the Government of Senegal (GOS). With over 50 years of collaboration, USAID is poised to assist the Senegalese people to achieve their journey to self-reliance and realize the vision of the *PSE* . Since 1979, the USAID health program has supported the Ministry of Health and local communities to reduce maternal and child deaths, prevent infectious disease and other illnesses to help people live healthier lives.

Senegal has achieved significant results in reducing child mortality: between 1997 and 2018, under five child mortality decreased from 139 to 51 per 1,000 live births (cDHS 2018). Despite these impressive results, disaggregation of the data reveals a more challenging situation: success is uneven, with substantial disparities in terms of geographic area, age and gender. In addition, urban areas, which may have relatively better overall statistics, are home to a large number of poor and vulnerable populations with high rates of morbidity and mortality.

Overall, the Senegalese health system faces many challenges that constrain its ability to fulfill the vision of the PSE, which includes the development of the health sector as part of its objective of improving population wealth by 2035. Three fundamental constraints, which are the focus of the National Health and Social Development plan 2019-2029 under the Human Capital pillar, include: (1) limited access to quality care; (2) social norms and behaviors that limit demand for health services; and (3) an underperforming health system. These major issues affecting health outcomes in Senegal also include the following:

- **Maternal, Newborn, and Child Health (MNCH)**: The lack of access to quality services is a critical factor that limits sustained and continued improvements in MNCH interventions. The lack of affordable transportation and weak emergency referral services prevent people from accessing health care services, especially in situations of greatest need. Adequately staffed and performing delivery points of essential health care services are unevenly distributed across and within rural and urban areas, and staff absenteeism and negative attitudes towards clients are further factors inhibiting access to needed health care services. Even when qualified staff is available, the lack of equipment, supplies and medicines are additional barriers to the provision of quality health care. Social norms and health seeking behaviors are another obstacle, with many pregnant women waiting until their second trimester or the beginning of their third before visiting a health facility.

- **Family Planning (FP)**: Fertility has consistently decreased, with a total fertility rate (TFR) of 4.6 children per woman; however, this varies from 3.0 in Dakar to 6.4 children in the region of Kedougou (cDHS 2017). While Senegal has developed and costed a robust FP implementation plan, actual execution of the plan has been uneven, and annual district work plans (PTAs) have not adequately addressed family planning. High fertility rates are attributable to several underlying factors, including women and girls' limited decision-making power, early sexual debut, early marriage, low contraceptive use, poor birth spacing, and social norms that value larger family size.

- **Nutrition (NUT)**: Food insecurity and undernutrition remain critical challenges, exacerbated by a lack of dietary diversity and yearly "hunger seasons." Overall, 17 percent of children under five are classified as stunted; however, this masks regional variations

across the country (cDHS 2017). While nearly all infants under six months are breastfed, only about 42 percent are exclusively breastfed (cDHS 2017). Implementation of the 1,000 days approach and Essential Nutrition Actions (ENA) is uneven. There is a great need for improved management, monitoring and follow-up of severe acute malnutrition at the community level.

● **Water, Sanitation and Hygiene (WASH)**: In Senegal, the lack of access to safe drinking water and poor sanitation is still a major obstacle to improving maternal, newborn and child health outcomes, particularly in underserved rural areas, where the prevalence of diarrheal diseases is high. Substantial gaps exist in the availability of materials for handwashing, with just 29 percent of rural households and 20 percent of households in the poorest wealth quintile observed to have soap and water at handwashing stations.

● **Malaria**: The percentage of children under five years old with malaria parasites in their blood decreased from 6 percent in 2008 to 0.4 percent in 2017, demonstrating significant progress in the malaria prevention program. More than 77 percent of households have at least one mosquito net, but only 56 percent of pregnant women and children under-five slept under an insecticide-treated net (cDHS 2018). Senegal has set a goal of reaching malaria elimination by 2030, which will require capacity building at the regional, district and community levels.

● **Global Health Security Agenda (GHSA):** The key GHSA objectives in Senegal include strengthening surveillance systems, including monitoring of antimicrobial resistance (AMR); addressing workforce development; and strengthening laboratory capacity. Due to the multisectoral nature of the GHSA, coordination across ministries is critical, yet remains a challenge as ministries lack the authority to convene one another.

● **Emerging Pandemic Threats**: Health systems must be resilient to respond to new and emerging health challenges. Most recently, the COVID-19 pandemic has added significant additional stressors to Senegal's already stretched health system. USAID contributes to the response through both GHSA and non-GHSA programming in the domains of Coordination, Planning and Monitoring; Infection Prevention and Control; Surveillance and Rapid Response; Points of Entry; Lab Strengthening; and Risk Communications and Community Engagement.

● **HIV**: Senegal faces a concentrated HIV epidemic with low prevalence (0.4 percent) in the general population (UNAIDS 2018), but with substantially higher rates among key populations: 27.6 percent among men who have sex with men (MSM) (UNAIDS 2017), and 6.5 percent among female sex workers (IBBSS FSW Senegal: Spectrum 2017). Important strides are being made in providing HIV treatment to these key populations, but national policies criminalize MSM. Stigma and discrimination pose a significant barrier to HIV testing and treatment and adversely affect provider attitudes and behavior.

● **Neglected Tropical Diseases**: Neglected Tropical Diseases (NTDs), endemic throughout Senegal, cause significant morbidity and mortality. Even though Senegal is on track to eliminate trachoma, eliminating and controlling other NTDs faces several challenges,

including the lack of adequate staff and system capacity to diagnose and treat NTDs, lack of active surveillance, insufficient preventive chemotherapy and limited funding.

● **Health Services in the Private Sector**: The private sector is involved at different levels of the health system, yet the quality of these services varies widely and is largely unregulated. The expansion of *mutuelles* (community-based health insurance schemes), designed to provide affordable health insurance coverage to everyone, could further fuel the growth of private sector providers. This presents both an opportunity and a challenge: the GOS needs to leverage the resources and expertise of private sector health care providers in order to increase customer access to essential health care services, and it will need to improve oversight to ensure the sector's compliance with health policies, norms, protocols, and quality assurance.

● **Urbanization**: The Dakar Region is home to more than one fifth of the nation's total population, living on only 0.25 percent of its land area. The urban public health system is struggling to keep pace with the rapidly expanding population's healthcare needs. These challenges are compounded by widening socioeconomic gaps. With Senegal's urban population projected to reach 60 percent by 2030, there is a particularly urgent need to address inequitable access to quality care services and other health promoting resources for the urban poor.

● **Youth and Adolescent Health**: The large and growing youth population lacks access to youth-friendly services, and the quality of services provided to youth varies widely. Youth centers are reported to be low functioning and neglected, and many face challenges to self-sustain, hire and pay for trained health care professionals.

● **Social Norms**: While various social norms may affect health-seeking behaviors within the household and the utilization of health services, managing the household resources often determines who controls the access to health care. Men are often the principal decision-makers and gatekeepers for health services within the household, while women are usually responsible for caregiving. Men's perception of the importance of health care may differ from women's, and their control, or lack thereof, over resources may be an obstacle. Other social norms also affect women's agency around health decision-making: 71 percent of women reported that their husband/partner is solely responsible for health decision-making (cDHS 2017). Social norms support early marriage and encourage large family size. The average age of marriage for women is 20 years, and one-third of women are married before the age of 18, with the first pregnancy quickly following.

● **Underperforming Health System**: Achieving universal health coverage is inhibited by systemic weaknesses in accountability, affordability, accessibility, and reliability of health services. Obstacles include poor mobilization and use of public and private resources, including financial, human resources, and commodities. Issues with the health workforce capacity, recruitment, retention and distribution lead to problems in service access, quality and equity. Capacity-building for both private and public providers does not consistently focus on the latest policies and technologies nor include the full range of skills required for managing health services, including administration and management, use and interpretation

of health data, and working with communities and local authorities. Inadequate accountability and civil society engagement also remain a challenge. In general, community oversight, management and monitoring of health facilities and the health system need strengthening, and there is an inability to hold health systems and local governments fully accountable for providing quality services. Timely care-seeking is discouraged by unaffordable user fees and medicines, or limited insurance coverage, long waiting times before seeing a provider, the lack of private areas for confidential counseling, and the recurrent stock-outs of essential medicines.

2. Statement of APS Goal, Purpose and Expected Results

This USAID Senegal Health Population and Nutrition (HPN) Annual Program Statement (APS) is a strategic and comprehensive response to the key challenges confronting the health sector.

The overall **goal** of the APS is defined as:

Improving health status and human capital in Senegal

The APS goal directly contributes to the Senegal 2020-2025 Country Development Cooperative Strategy (CDCS) as Development Objective 2 (DO 2). The overall goal of the CDCS is for Senegal to be better able to plan and finance inclusive development by: implementing key reforms; actively engaging with a strengthened private sector and a vibrant civil society; and harnessing the potential of women and youth. DO 2 is focused on *Improved Human Capital* through better, more sustainable outcomes in health and education. The APS goal specifically addresses Intermediate Result 2 (IR 2), *Health Status Improved*, and is aligned with *PSE* Pillar 2 on human capital and sustainable development. USAID will strengthen systems, increase access to services, improve the quality of those services, and increase the participation of communities and other stakeholders, so that the health and overall human capital status of the Senegalese population is improved. DO 2 activities address the challenges seen in scores on Country Roadmap metrics, such as Child Health, along with the regional and gender inequalities that prevent large portions of Senegalese society from maximizing their potential. DO 2 directly supports USG priorities such as: Pillar IV of the National Security Strategy (Advance American Influence/Encourage Aspiring Partners); Objective 2.2 of the Department of State-USAID Joint Strategic Plan (Promote Healthy, Educated and Productive Populations); and other priorities and initiatives such as the President's Emergency Plan for AIDS Relief (PEPFAR), and the President's Malaria Initiative (PMI).

In line with the new CDCS, this APS is an opportunity for USAID to do things differently. USAID will leverage its assistance as a tool to increase GOS commitment, both financially and with respect to policy reforms that constrain inclusive development. As the largest bilateral donor in Senegal, USAID will use its leadership of numerous donor working groups to help redefine the GOS-donor relationship and more effectively advocate for the policies (or effective implementation of existing policies) required to spur inclusive development. These efforts will support Senegal in advancing its Journey to Self-Reliance.

Self-reliance in health is a function of the country's capacity and commitment to deliver and finance health care in partnership with the public and private sectors, as well as civil society, community,

and faith-based organizations. The APS addresses the four key pillars of self-reliance within the health sector:

1. Drive accountability by increasing the engagement of civil society organizations to ensure transparency and that health needs are met;
2. Mobilize domestic resources;
3. Engage the private sector to leverage technology and resources to address gaps and extend the reach of the public system; and
4. Build Senegal's health system capacity.

In addition, the APS is a central component of the Mission's approach to both youth engagement and women's empowerment. The APS seeks to address gender-based violence (GBV) and supports gender sensitive policies in the health sector. The APS also targets and engages youth, seeking to improve services that are better oriented towards their needs as well as directly engaging them in health promotion through targeted social and behavior change programming.

The **purpose** of the APS, which defines a level of achievement between the Goal and Intermediate Results, is:

> ***The Senegalese health system is sustainably improved and effectively utilized to reduce child and maternal deaths, protect communities from infectious diseases, and contribute to controlling the AIDS epidemic.***

This APS builds on the successes and lessons learned from the current USAID health portfolio 2016-2021, and the legacy of USAID's investments in the health sector both globally and in Senegal. USAID has supported Senegal to make significant strides in improving the health of its population and has developed several important and innovative approaches. Examples include: the Tutorat model of mentorship, which the Ministry of Health is seeking to institutionalize; the extension of Government-to-Government (G2G) programming at the Regional level; the Home Care Provider (*Dispensateur de Soins à Domicile (DSDOM)*), led by the PMI, that provides an essential package of support at the community level; the establishment of Health Development Committees at local level; and, the Governance for Local Development (GOLD) model that has successfully leveraged local resources and enhanced community engagement and ownership in the management of health at the local level.

Success will require close engagement and collaboration between Implementing Partners, USAID, Ministry of Health (MOH) counterpart staff, GOS officials, and other technical and donor partners (PTF). In addition, it will require increased engagement with the private sector and civil society, including faith-based and other local partners, in order to expand the participation of local partners in their own development, which will contribute to building self-reliance and effective partnering, and procurement reform (EPPR). Implementing partners (IPs) resulting from the APS will help strengthen the role of civil society organizations (CSOs) to provide oversight of health and other social services, and will ensure local partners' capacities are being enhanced to serve as direct recipients of U.S. Government assistance.

USAID Senegal's past achievements, along with well-established high-impact practices, have laid the foundation for understanding what works in regard to health interventions that are needed to further reduce child and maternal morbidity and mortality. The APS seeks to institutionalize these interventions within the Senegalese health system and identify new and innovative approaches to both strengthen and leverage the GOS systems, while simultaneously engaging the private sector and civil society, including religious leaders and institutions. Together, these efforts will help strengthen the capacity and reinforce the commitment of the GOS to plan, implement and finance the development of the health sector.

Expected Results:
In order to achieve the overarching goal of improving health status and human capital in Senegal, the APS is built around the following **theory of change**
:

***IF** the system is strengthened; and*
***IF** access to services is improved; and*
***IF** the quality of services is improved; and*
***IF** participation by communities and other stakeholders is increased;*
***THEN** the health status of Senegal will be improved.*

Intermediate Result 1: Strengthened Systems
The goal of strong health systems is to ensure that all people and communities have equitable access to quality essential services without incurring financial hardship. High performing health systems optimize resources to ensure health care is available and that it is of sufficient quality to be effective. This requires a cross-cutting and integrated approach that focuses on Senegal's areas of greatest need across the objectives of accountability, affordability, accessibility and reliability.

In the next five years, USAID/Senegal will improve access to, and reliability of, essential health services by strengthening the host country's health systems, including financing, policy and governance, supply chain, human resources for health (HRH), information systems, and health care service delivery. USAID/Senegal will better leverage the government to government fixed amount reimbursement agreements (G2G FARA) to increase domestic resource mobilization and build the capacity of the MOH to enhance the efficiency and accountability of health care services. G2G will be complemented by district subgrants under an IP that will incentivize quality and accountability. Additionally, USAID/Senegal will identify opportunities to better leverage private sector resources in order to address gaps in health sector staffing and services. Finally, USAID/Senegal will strengthen the affordability of services by improving the efficient and sustainable use of domestic resources, supporting sound strategic purchasing mechanisms, and strengthening coverage and access.

Program Component 1 will lead USAID's approaches to resolving systems level issues in the health sector at the national level. Component 1 will also support central level entities to provide technical assistance to and oversight of component 2 (IDH) and G2G regions. Component 2 will address systems issues, primarily at the district level and below, with additional support provided at the regional level to promote effective supervision and oversight of lower-level interventions. Component 3 will provide support at the same levels as Component 2, with a geographic focus on

the region of Dakar, given the unique needs of the urban context. Component 3 will also play a key role in strengthening the private health sector.

Health systems at the central, regional and district levels will be strengthened through the following:

- **Sub-IR 1.1: Improved management of the health system**
- **Sub-IR 1.2: Optimized use of resources to achieve better health outcomes**
- **Sub-IR 1.3: Health sector policies and guidelines effectively implemented**

Intermediate Results 2 & 3: (IR 2) Increased Access to Services; (IR 3) Improved Quality of Services

Senegalese face many obstacles to accessing care. A lack of staff, weak emergency referral services, delayed care seeking behavior, delayed service provision, a lack of equipment, supplies and medicines, and insufficient access to services for youth are examples of the many barriers that must be overcome. Ensuring the availability and continuing to scale high-impact practices in both public and private sectors is essential to increasing access. This APS will support the implementation of comprehensive annual health work plans (*Plans de travail annuels (PTAs)*) at the district level that address the key drivers of maternal, neonatal, and child morbidity and mortality.

All Components will need to work collaboratively and in close collaboration with the MOH, technical and financial partners, the private sector, civil society and faith-based organizations and community-based organizations to increase access to care. Component 2 will be USAID/Senegal's flagship effort in this area, providing support to service delivery, social and behavior change and health systems at district level and below. A hallmark of Component 2 are demand-driven subgrants awarded to districts to support implementation of the *PTA*. These subgrants will include two components: base grants for reproductive, maternal, neonatal, child and adolescent health (RMNCAH), malaria and nutrition that all districts receive and innovation grants that are awarded competitively for innovative approaches in RMNCAH and nutrition. Component 3 will focus on increasing access to services among underserved populations in Dakar. Component 3 will play a leadership role in developing innovative approaches to scaling access to both the public and private sector services in an urban context. Component 1 will play a key role in strengthening the systems that reinforces access to care and will also strengthen the capacity of the medical regions to in turn support access at the district level.

Closely related to challenges with accessing care are issues affecting the quality of care. Quality of care standards for maternal and newborn health, pediatric care, and small and sick newborn care are well established, but there are many obstacles to implementing these standards. Issues of respectful care and provider behavior are important elements in quality care. Facilities lacking important infrastructure, for example access to safe water in health facilities, are yet another barrier to quality care. This APS seeks to improve the quality of care provided in both the public and private sectors.

Access to health services will be increased and improved through the following:

- **Sub-IRs 2.1 and 3.1: Increased access to evidence-based, high impact health care interventions**
- **Sub-IRs 2.2 and 3.2: Quality of care improved**

- **Sub-IRs 2.3 and 3.3: Private sector providers engaged**

Intermediate Result 4: Increased Participation by Communities and Other Stakeholders
Communities, civil society, community-based organizations (CBOs) and local governmental structures, such as the Health Development Committee *(Comité de Développement Sanitaire (CDS))*, the Regional Audit Committee *(Comité Régional de Vérification (CRV))*, as well as informal structures, play a variety of important roles in health provision. Leaders may be influencers of others in their communities, and local structures have a critical role in the management and provision of health care in their communities. They influence and reinforce the practice of healthy behaviors and the utilization of health products and services. All these actors should actively participate in the development of the *PTA*.

Component 1 will focus on developing and reinforcing systems that increase engagement of civil society in the health sector, especially around advocacy and accountability. Component 2 will support communities, civil society and local government to engage in the management of health at the local level, including active participation in the development of the *PTA.* Component 2 will also support local organizations to implement key social and behavior change activities. Component 3 will play a lead role in identifying effective strategies for strengthening community participation and SBC in an urban context and identifying new and innovative modalities for reaching underserved urban populations with key services.

Increased participation by communities, civil society and CSOs will be achieved through the following:

- **Sub-IR 4.1: Increased engagement of communities, CSOs and local governments in health sector activities and governance**
- **Sub-IR 4.2: Priority/gateway behaviors adopted by individuals, families and communities**

Cross-Cutting Priorities and Principles
The APS and its components will be guided by the following fundamental, cross-cutting priorities and principles underlying the expected results and outcomes:

Sustainability
The APS incorporates sustainability into the design in several ways. First, the approach relies on reinforcing GOS systems. USAID provides base grants to districts as part of its assistance to the annual GOS work planning exercise. In turn, using their base grant resources, health districts award sub-grants to CBOs to support community-based activities, thereby reinforcing an approach that can continue beyond the life of the project. District innovation grants will require matching funds, thus incentivizing increased commitment to health at the local level. Second, the APS will engage the private sector in all three components both to increase local philanthropy and to capitalize on local private health providers' potential to expand access. Third, the APS will strengthen the capacity of civil society to engage in oversight of the health system and hold the GOS entities accountable, which will further reinforce sustainability. Finally, systems strengthening activities through Component 1 and other wrap-around support provided under a complementary activity, will assist medical regions to transition from subgrants under an implementing partner to direct

G2G assistance. The expansion of G2G will be conditional upon increased resource commitment from the GOS.

Gender:
Gender is a critical consideration when designing effective health sector interventions, and USAID recognizes the importance of addressing root causes of gender inequity. USAID Senegal strives to streamline gender considerations into all of its activities, and requests that its partners also integrate GOS strategies and directives into activity design. In Senegal, women tend to encounter more barriers to acquiring education, economic resources, political power, and other positions of social influence. As such, USAID's efforts to promote gender equity tend to focus more heavily on women. However, the health office recognizes that effective gender mainstreaming approaches are inclusive, and thus carries out interventions that reach men as well as women.

Health challenges in Senegal are compounded by social, cultural and economic factors that exert strong influence in many areas of Senegalese society. Gender disparities contribute significantly to inefficiencies in the health system and to reduced health-seeking behavior as a result of unequal access to financial resources and education and the limited ability of women to make decisions concerning their health and the well-being of their children. Forced and early marriage, early first pregnancy, limited education, harmful taboos and stigma, and female genital mutilation and cutting (FGM/C) also contribute to poor health outcomes. Consequently, women's health status and that of their families is adversely affected, limiting their full access, participation and choice in healthcare and placing them at higher risk of diseases, gender-based violence, and unintended pregnancies. The ability of caregivers, primarily women, to make prompt decisions about care-seeking for their children is often hampered by a woman's educational level and need for consent either from their spouse, in-laws and/or village chief. Gender norms often mean that men act as gatekeepers around the use of health services, although they too may lack knowledge about or access to health resources, be it family planning and reproductive health, maternal and child health, or infectious diseases including malaria. Thus, empowering women, particularly their capacity to make decisions concerning the health and nutritional status of themselves and their children, is essential. Encouraging dialogue between men and women in order to promote the well-being of their families and communities is also important.

Youth and Adolescents
Adolescent Reproductive Health: Senegal's large and growing youth population lacks sufficient access to youth friendly health services, and the quality of services provided to youth varies widely. Youth centers are reported to be low functioning and neglected, and many face challenges to self-sustain or to hire and pay trained health professionals. Recent findings have shown that separate youth-focused services (specifically in the reproductive health area) are under-utilized and distrusted due to privacy concerns. As such," Youth Friendly Services" as a stand-alone entity does not receive the support from youth advocates as it once did.

"Safe spaces," often held in schools or clinics, may be set aside for co-ed, all-female, or all-male groups to meet regularly and provide a designated time with a health provider who can conduct educational programs and answer questions which youth may not feel comfortable asking in other spaces. Armed with a better understanding of their bodies and health needs, adolescents are more likely to seek care and to be forthcoming in why they sought care. Positive Youth Development

approaches should be employed when establishing these types of programs to ensure youth needs are truly being met. This can be achieved by engaging youth during ideation, planning, and execution phases.

Urban Migration:
Mass urbanization is partially the result of migration of youth between 15-24 years old who move to cities in search of education or employment opportunities unavailable to them in rural areas. These young people often shoulder the responsibility of supporting themselves, rural family members, and sometimes even their own young children. This type of migration increases urban sub-populations in need of specific support programs, including: youth who have age-specific development needs (biological, social, and emotional); youth who are increasingly vulnerable due to loss of social safety networks, putting them at higher risk of engaging in behaviors that could negatively affect physical and mental health outcomes; and people whose primary need for financial security must be met before other interventions can have an impact. In light of rapid urbanization, a burgeoning youth population in Dakar, and growing health disparities, there is a need to improve urban health service delivery models that better serve young people.

Climate Risk Management:
The 2017 Climate Change Risk Profile[1] for Senegal identifies the most significant climate risks as reduced availability or degraded quality of freshwater due to flooding, storm water runoff, shifts in participation patterns or salt water intrusion; sea level rise; flooding or other extreme weather events; and rising temperatures. This will have impacts on all sectors, including impacting health outcomes. For example, increased, erratic rainfall and extreme weather events could damage infrastructure reducing the ability to access health facilities. Waterborne diseases may also shift with local changes in temperature and rainfall leading to increased cases of diarrhea. Senegal is prone to environmental shocks that will increase in magnitude due to increased climate variability. The Government of Senegal and development partners have begun to determine climate change adaptation priorities, but gaps in implementation plans still exist due to financial constraints and limited data on climate impacts at the local level. These climate change impacts will be compounded by increasing population growth and urbanization that will increase stress on the health systems.

Collaboration, Learning and Adaptation (CLA):
HPN will facilitate collaboration, learning and adaptation across the portfolio through several approaches. First, HPN will continue to hold a semi-annual Comité de Pilotage (CDP), chaired jointly by the HPN Office Director and the Secretary General of the MOH. Second, HPN will hold quarterly meetings with Chiefs of Party. Third, HPN will conduct semi-annual joint site visits to the field to discuss successes, challenges and lessons learned, with IP staff, MOH counterparts, health providers and community leaders. Fourth, the team will utilize the mission-wide Monitoring Evaluation and Learning (MEL) activity to assist with the compilation, analysis and sharing of data collected by the GOS (DHIS2) and IPs to closely monitor health system performance. Fifth, to complement USAID's efforts under the Global Health Security Agenda (GHSA), each of the APS Component Activities will support interventions to adapt/respond to the COVID-19 crisis, as necessary.

[1] https://www.climatelinks.org/resources/climate-change-risk-profile-senegal

The mission-wide MEL activity implements a comprehensive methodology to track results and progress toward achieving the Mission's strategic goal. The MEL activity will assist each component activity with monitoring, compilation, analysis and sharing of data collection by the GOS (DHIS2) and IPs. The MEL activity methodology targets the specific, measurable, realistic, and applicable goals and objectives of each component activity. A variety of tools will be used by the MEL activity to gather quantitative and qualitative data for purposes of accountability, to verify if intended results were achieved, and to inform future decision-making, programming, resource allocation, and implementation adaptation.

Do No Harm:
All proposed activities will be screened and assessed to avoid undermining existing functional systems. Examples include: commercial systems organized through the current activities, ongoing government efforts, and other donor programs working under similar principles. To be avoided are subsidies, donor-dependent practices, or other approaches that undermine the development of local solutions and engender a culture of dependence or disempowerment. Working with partners should involve a true sense of engagement, rather than an undue imposition of activities.

(END OF UMBRELLA PROGRAM DESCRIPTION)

COMPONENT 1 PROGRAM DESCRIPTION

Central-Level Health Systems Strengthening

The U.S. Agency for International Development Senegal's Office of Health Population and Nutrition (USAID/Senegal HPNO) is pleased to issue Component 1, **Central-Level Health Systems Strengthening**, of its Annual Program Statement (APS), *Improving Health Status and Human Capital in Senegal*. Component 1 aims to strengthen the central-level health systems of the central Ministry of Health (MOH) of the Government of Senegal (GOS), including human resources for health, financing, governance, supply chain and health commodity management, and data for decision-making. This focus is an integral element of USAID's agenda to support host country partners on their journey to self-reliance.

Self-reliance in health is a function of the country's capacity and commitment to deliver and finance health care in partnership with public and private sectors, civil society, community and faith-based organizations.

A. Component 1 Background

Since 1979, the USAID health program has supported the Ministry of Health (MOH) and local communities to reduce maternal and child deaths, prevent infectious diseases, ensure access to family planning, and help people live healthier. Efforts to strengthen national and local health systems are a key element of ensuring sustainable progress in these areas.

Senegal has achieved significant results in reducing child mortality: between 1997 and 2018, under five child mortality decreased from 139 to 51 per 1,000 live births (cDHS 2018). Although significant national progress has been made, positive health outcomes cannot be maintained if health systems are weak. Investments to strengthen the health system will help the GOS plan, finance, and manage its own health system; protect citizens from financial hardship; achieve equitable coverage of quality care for people who are vulnerable, marginalized or underserved; improve coverage through availability and utilization of high quality health services; and build a responsive health system that ensures dignity, builds trust and timely services.

USAID programs in Senegal are closely aligned with the overall objectives of the GOS, as outlined in the National Health and Social Development Plan (*Plan National de Développement Sanitaire et Social (PNDSS*). The objectives include: (1) Strengthening health sector governance and funding; (2) Expanding the availability of health and social services; and (3) Promoting social protection for all Senegalese people.

Senegal is at an important crossroads in its journey to self-reliance: the country has set ambitious goals for continued economic and social development, as outlined in the GOS Development Plan (*Plan Senegal Emergent (PSE)*), and must follow through with building capacity and demonstrate its commitment to development if it is to achieve these goals. USAID, one of the largest bilateral donors in Senegal, has built a strong and close partnership with the GOS over 50 years of collaboration, and is well-positioned to assist the Senegalese to advance their journey to self-reliance and realize the vision of the *PSE* .

B. Component 1 Program Description

This activity seeks to strengthen key systems within the MOH and GOS, including policy and governance, information systems, human resources for health, supply chain, health financing, and MOH engagement with the private sector. The primary target is the central MOH and the GOS universal health coverage (*Couverture Maladie Universelle (CMU)*) program. The mechanism will also support the central level to fulfill their role as providers of technical assistance and oversight at the regional level. Interventions under this component will complement district-level activities, while helping to institutionalize and further operationalize policies deemed important to advancing Senegal's J2SR. This mechanism will also support effective coordination of the USAID Health portfolio by providing technical assistance (TA) to the MOH *Comité de Pilotage* that oversees USAID Health activities.

This Component 1 of the APS supports the Country Development Cooperation Strategy (CDCS)' second Development Objective (DO2), *Improved Human Capital*, and Intermediate Result (IR 2.1), *Health Status Improved*. The Senegalese health system aims to deliver quality care, but faces many challenges that limit its ability to fulfill the vision of the *PSE*, which includes strategic development of the health sector to improve the delivery of quality health care at affordable costs for all the population by 2035. Optimal performance of the health system is critical to increasing access to quality services.

Health systems strengthening is the foundation for all of USAID's health interventions in Senegal. This activity will support the GOS in achieving its goal of universal health coverage (UHC). UHC encompasses broad access to essential health care, including safe, effective, quality and affordable essential medicines and vaccines, along with protection from catastrophic financial risk. Achieving UHC must incorporate all available resources from the government and non-governmental actors, including the private sector and civil society. It requires contribution from both public and private health institutions to create high quality care that is accountable, affordable, accessible and reliable. Sustainably addressing health systems constraints will enable the health system to reduce child and maternal deaths and protect communities from infectious diseases, advancing Senegal along its journey to self-reliance through improved human capital. Understanding there are many challenges affecting the health system, USAID seeks to prioritize catalyst interventions at the central level that will produce the greatest impact on health system performance at all levels.

C. Expected Results

In order to achieve the intermediate results of the APS, key challenges need to be addressed using an integrated approach to improve accountability, affordability, accessibility and reliability of the health sector. Component 1 of this APS will seek to improve health systems management and performance at the central level to increase quality access of health services. The Central Health Systems activity will strengthen competencies at the central level to carry out its functions. This in turn will reinforce implementation of policies and guidelines at the regional and district levels. Component 1 will have a particular focus on key systems within the Ministry of Health and the

Government of Senegal and ensure effective coordination of the USAID health portfolio. The Central Health System mechanism will leverage opportunities for synergy between the Integrated District Health, Urban Health and other USAID Senegal activities in order to ensure proper management and allocation of resources across all regions of Senegal. Close collaboration during the co-creation phase will ensure a harmonized approach between programs. During co-creation, the apparently successful applicants will have an opportunity to detail, in collaboration with USAID, the MOH and other stakeholders, precisely how these Components will interface at the regional level. This activity will also collaborate with other USAID non-health activities that are working in areas such as governance and finance that are relevant to the health system.

Component 1 will focus on achieving Intermediate Result (IR) 1 of the APS.

Intermediate Result 1: Strengthened Systems

While the Government of Senegal strives towards achieving its goal of universal health coverage and protection from global health threats, these goals are inhibited by systemic weaknesses in the health system. Acute weaknesses include poor mobilization and inefficient use of public and private resources, including financial resources, human resources, equipment and commodities. USAID will work at the central level to strengthen the health system's capacity and commitment to perform its core functions effectively.

USAID Senegal seeks to improve coordination at the central level between donors across sectors. In Senegal, multi and bilateral donors — including USAID, Global Fund, the World Bank, the Belgian Development Agency (CTB), Luxembourg Development Agency (LuxDev), the Japanese International Cooperation Agency (JICA), the World Health Organization (WHO), UNICEF, the Gates Foundation, and other non-profit organizations — account for an estimated 18.62 percent of all financing to the health sector. USAID Senegal is the largest donor in health and plays a leadership role in several donor coordination groups. USAID and the Ministry of Health co-chair a *Comité de Pilotage* (steering committee) that oversees all activities funded by USAID. Component 1 will provide technical and logistical support to USAID and the MOH to ensure effective use of this committee.

A key challenge to accountability is lack of effective implementation of national policies and guidelines. Component 1 will support the MOH to review regional *Plan de Travail Annuel (PTA)* to ensure inclusion of MOH priority interventions. The *PTA* brings together all the inputs into the health sector, governmental and donor, in one document. This approach reinforces the GOS system, promotes transparency and facilitates mutual accountability across all parties involved. This is to ensure that the *PTA* includes implementation of existing MOH policies as applicable.

Though implementation of existing policies is the critical gap in Senegal, there are cases where the GOS seeks to update policies and guidelines. In these cases, Component 1 should provide technical assistance for such updates and strengthen the planning and organizational capacity of the GOS. It will be essential to coordinate with Component 2, Integrated District Health and with Component 3 Urban Health, to ensure central level policies are implemented at the regional and district level.

Additionally, the health system is challenged by weak financing and governance structures such as insufficient resources allocated to the health sector; the lack of transparency of resources allocation,

budget planning and execution; inefficiency and ineffectiveness in the use of funds; lack of development and implementation of the strategic purchasing policy under the UHC multi-year plan, and insufficient use of evidence in decision-making. A transparent budget promotes a constructive dialogue between policy makers and citizens regarding execution of public policies and government priorities. USAID seeks to build capacity for effective oversight to ensure appropriate implementation of regulations that will improve commitment to policies and programs aimed at UHC.

Evidence-based decision making requires an increase in the availability of timely quality data through integrated information systems. However, numerous challenges remain to the collection, analysis, dissemination and use of information throughout the health system. One such challenge is the integration of private sector data into health information systems. In order to fully understand the health system landscape and make informed decisions in the allocation of public sector resources, the MOH needs information about the services and capacities of private sector providers in each geographic area. In addition, the MOH requires data on health services delivered by the private sector in order to better understand the utilization of health services by the population. Component 1 seeks to improve health information systems and the analysis and use of quality information at the central level. Of particular interest are the District Health Information Systems 2 (DHIS2) for service delivery, the logistics management information system (LMIS) for supply chain, and integrated Human Resource Information Systems (iHRIS).

A key challenge to affordability is the allocation of financial and human resources for health to meet priority needs, and lack of coordination with the private sector and civil society to increase domestic funding and ensure the adequate distribution of such resources. As Senegal's economy develops, the share of donor assistance for health will decline. During this transition, public spending tends to slowly increase while out-of-pocket expenditure increases rapidly. USAID seeks to improve efficient use of existing resources, mobilize domestic resources including increasing resources from the private sector and coordinating between the public and private sector to improve provision of resources for health services. USAID also seeks to strengthen community-based health insurance, Mutuelles, to expand coverage of the population improving access and affordability of quality health services.

One key challenge to access to quality services is the availability of equipment and essential medicines and supplies throughout Senegal. Senegal must ensure that people have sustained access to, and make appropriate use of, essential medical products that are safe, effective, and of assured quality. Coordination between MOH, donors and other stakeholders is necessary for improved supply chain management and improved regulation of the pharmaceutical system. The National Supply Pharmacy (*Pharmacie Nationale d'Approvisionnement (PNA))* is an autonomous entity that manages public sector drugs including all generics. Within the Ministry of Health, the Directorate for Pharmacies and Laboratories *(DPL)* is responsible for monitoring and regulating the drug market. The *DPL* suffers from a serious lack of human resources and material and financial means to be able to effectively conduct its inspections. USAID will build the capacity of Senegal's supply chain system to ensure efficient procurement, distribution, and use of high quality-assured essential health commodities for maternal and child health, family planning, and malaria and other infectious diseases. Incomplete and inadequately shared Logistics data is a significant barrier to efficiency, transparency, accountability and data driven decision-making to prevent stockouts of medicines

and medical products. Component 1 will work closely with the *PNA*, other GOS entities and other donors to identify appropriate approaches to strengthen the logistic information system (LMIS) and improve efficiency, transparency and accountability. The Directorate of Pharmacy and Medicine, which is responsible for issuing marketing authorizations also needs to be strengthened in order to play its role in regulating the pharmaceutical system. In order to ensure appropriate distribution of equipment, including donations, the Directorate for Infrastructure, Equipment and Maintenance (*Direction des Infrastructures, des Équipements et de la Maintenance (DIEM)*) requires strengthened approaches to inventory management and tracking.

A key challenge to reliability are issues with health workforce capacity, recruitment, retention and distribution, which lead to problems in service access, quality and equity. Senegal needs to have technically competent, well-deployed human resources who provide essential services in accordance with standards in a timely, patient-centered manner. Capacity building for both private and public providers often ignores the latest policies and technologies and does not capture the full range of skills required for managing health services, including administration and management, use and interpretation of health data, and working with communities and local authorities. Health workers are concentrated in urban areas, leading to a significant shortage in rural and hard to reach areas. USAID has supported the development and revision of human resources for health policies and guidelines to improve human resource management. Implementation of these policies is essential to meet the Senegalese health needs.

USAID is committed to partnering with the private sector. Applicants are encouraged to explore partnering opportunities with the private sector through strategic and ongoing collaboration in order to increase impact, reach, efficiency and effectiveness of the activities. Aligning with USAID's Private Sector Engagement Strategy, USAID Senegal seeks to support MOH efforts under the private public partnership division to leverage untapped resources to improve access to quality healthcare. Private enterprises have a key role to play in ensuring a high performing healthcare system. Strategic and proactive engagement of the private sector improves the identification and definition of critical economic and social development problems; strengthens the design and implementation of promising solutions to those problems; and increases the sustainable impact of investments. Component 1 will increase private sector resources in alignment with MOH priorities through corporate social responsibility, philanthropy and/or public private partnerships to strengthen the health system.

Component 1 of the APS will contribute to strengthening health systems through the following:

- ***Sub-IR 1.1: Improved Management of the Health Systems***
- ***Sub-IR 1.2: Optimized use of resources to achieve better health outcomes***
- ***Sub-IR1.3: Health sector policies and guidelines effectively implemented***

Expected outcomes:

Expected outcomes under Component 1 of the APS could include but are not limited to:

- Improved supply chain management

- Strengthened information systems and improved quality and use of data for decision making, including DHIS2, LMIS, and iHRIS, and inventory management systems to ensure proper planning, management and financing.
- Improved leadership, management, and governance of the health sector, including both public and private sectors
- Improved implementation of existing national policies, guidelines, standard operating procedures and tools, as well as revision and update as needed
- Improved training, recruitment and retention systems for human resources for health and improved allocation of human resources
- Increased domestic resource mobilization for health, including through public-private partnerships, and increased efficiency in health sector spending
- Improved financial management and budget capacities, including improved budget execution and transparency in line with new reforms;
- Improved insurance systems.
- Improved coordination across USAID activities and between donors and government entities.

D. Cross-cutting Priorities and Principles

For cross-cutting priorities and principles, See Umbrella APS, pp. 12-15.

E. Geographic Scope

The focus of Component 1 is at the central level of the health system. Component 1 will not have staff at the regional level. However, Component 1 will support central level entities to fulfill their role of providing technical assistance to, and oversight of, the medical regions, with a focus on IDH and G2G-assisted regions. Additionally, the PMI supports activities in all fourteen regions of Senegal. In coordination with PMI, Component 1 may identify select health systems activities to support in other regions.

(END OF COMPONENT 1 PROGRAM DESCRIPTION)

COMPONENT 2 PROGRAM DESCRIPTION

Integrated District Health (IDH)

The U. S. Agency for International Development Senegal Health, Population and Nutrition (HPN) is pleased to issue Component 2, entitled **Integrated District Health (IDH)**, under the Improving Health Status and Human Capital in Senegal Annual Program Statement (APS). The APS is a strategic and comprehensive response to the key challenges confronting the health sector designed to strengthen Senegal's capacity and commitment to deliver and finance health care in partnership with public and private sectors, civil society, community and faith-based organizations, advancing the country along its journey to self-reliance. Component 2 is focused on providing comprehensive support to strengthen the capacity and commitment of the health system at the district and regional levels to improve the health of the Senegalese people. Component 2 aligns with the national health plan *(Le Plan National de Développement Sanitaire et Social 2019-2028 (PNDSS))*. Component 2 will adapt its approaches to maintain this alignment as *PNDSS* reforms, the District Reform and the reform to establish Regional Health Directorates (*Directions Régionales de la Santé*) are implemented.

A. Component 2 Background

Senegal has achieved significant results in reducing child mortality: between 1997 and 2018, under five child mortality decreased from 139 to 51 per 1,000 live births (cDHS 2018). Although significant national progress has been made, the disaggregation of this data highlights a much more challenging situation. For example, the under-five child mortality is higher in rural areas (57 per 1,000 live births) than in urban areas (41 per 1,000 live births). Region-level child mortality ranges from 39 per 1,000 live births in the west to a maximum of 89 per 1,000 live births in the south (cDHS 2018). This variation is also reflected across wealth quintiles, with the lowest under five mortality (30 per 1,000 live births) in the wealthiest quintile and more than double this rate (76 per 1,000 live births) in the poorest quintile (cDHS 2017). Similar variation exists by level of education, urban-rural location, and family size. These variations are affected by unequal access to quality health care, and a range of additional systemic, environmental and behavioral factors.

B. Component 2 Program Description

Component 2 – IDH – will support the implementation of comprehensive health plans at the district level that address the key drivers of maternal, neonatal, and child morbidity and mortality in five priority regions of Senegal to improve the health status of the target populations. The activity combines technical assistance for service delivery and universal health coverage, social and behavior change, subgrant funding and health systems strengthening into one mechanism. The focus of the mechanism is at district, health facility, and community levels, with support at the regional level to effectively supervise and monitor lower-level interventions.

Key to the approach will be demand-driven subgrants awarded to districts to support implementation of the *PTAs*. Through application criteria and conditionality, the activity will incentivize districts and associated governance structures to commit financial and other resources to the health sector and to comply with MOH policies and guidelines. Subgrants may support *PTA*

activities by the public and private sectors and by community-based organizations, which could be the primary implementers of SBC activities.

The mechanism will provide an integrated package of malaria, maternal and child health, family planning, nutrition and HSS activities in five priority regions (Diourbel, Kolda, Sedhiou, Tambacounda and Kedougou). Over time, it is envisioned that subgrants will transition from the Implementing Partner to direct government-to-government (G2G) assistance, commensurate with increased GOS financial commitment to G2G. By the end of the award, USAID anticipates that up to three of the five regions will transition to direct G2G assistance.

Component 2 will work in close partnership with Component 1, focused on strengthening the central level health system. Component 2 will also coordinate with Component 3, which addresses issues of urban health in Dakar, integrating new approaches in urban health into activities in urban areas under Component 2. Component 2 will also work in close collaboration with the Ministry of Health (MOH), especially at the regional and district levels; regional and district level administrative and governance structures; HPN's G2G Operational Support mechanism, to help ensure the preparation and transition of IDH beneficiaries to G2G; other donors and their implementing partners; the private sector; civil society; and faith-based and community-based organizations (FBOs and CBOs).

C. Expected Results

Component 2 will contribute to the following Intermediate Results (IR):

IR 1: Strengthened Systems
IR 2: Increased Access to Services
IR 3: Improved Quality of Services
IR 4: Increased Participation by Communities and Other Stakeholders

Intermediate Result 1: Strengthened Systems
The goal of strong health systems is to ensure that all people and communities have equitable access to quality essential services without incurring financial hardship. High performing health systems optimize resources to ensure health care is available and that it is of sufficient quality to be effective. This requires a cross-cutting and integrated approach that focuses on Senegal's areas of greatest need across the objectives of accountability, affordability, accessibility and reliability. Through Component 1, USAID/Senegal will seek to build the capacity of the central level of the health system, and to support the central level to carry out its function to strengthen the capacity of the system at the regional level.

Under Component 2, USAID/Senegal will invest in system strengthening interventions appropriate at the district level and below. Challenges for the health system include: governance; management; human resources; financing; pharmaceutical and supply chain management; and, information systems. USAID seeks to support innovative and catalytic solutions to these interconnected challenges. Component 2 will target its assistance at the regional level to those functions of the medical region that reinforce the district level.

Components 1 and 2 will collaborate closely at the regional level to ensure a harmonized and consistent approach to capacity building initiatives and avoid duplication of support. During the co-creation phase, the apparently successful applicants will have an opportunity to detail, in collaboration with USAID, the MOH and other stakeholders, precisely how these Components will interface at the regional level.

Sub-IR 1.1: Improved Management of the Health System

Regional and District level structures play a critical role in the management and oversight of the delivery of health care. However, their ability to fulfill these obligations varies. Likewise, key structures, including the Health Development Committee *(Comite de Developpement Sanitaire (CDS))*, the Regional Audit Committee *(Comite Regionale de Verification (CRV))*, and civil society, need to be more effectively engaged in the management of the health system. The full range of stakeholders in the district, including the *CDS* and other donors and implementers, must play an active role in the development of the *PTA*. Hampering these efforts, health information is often incomplete or of poor quality, and where there is data, it is underutilized for planning and decision-making and does not capture data pertaining to health promotion and SBC. Regions also play an important role in quality assurance through the supervision of the districts and ensuring the successful adoption and scale up of policies and guidelines, but their effectiveness is uneven. Essential medicines and commodities are often available at a regional level, yet many health facilities experience stock outs. Regions and districts similarly play a vital role in human resources management. Although policies must emanate from the central level, there are many opportunities for districts to develop creative solutions to issues of retention, distribution and motivation, and also address the challenge of public sector employees operating as private sector providers during hours of operation.

Sub-IR 1.2: Optimized Use of Resources (to achieve better health outcomes)

Medical regions often struggle to coordinate the use of donor resources and fail to fully leverage private sector and civil society resources. Enhancing this coordination role will improve the rational distribution of health resources and optimize the use of those resources to the areas of greatest need. Linked to this are issues of accountability and lack of transparency over the use of resources. Financial resources are often difficult to track, and budgeting can be an opaque process. There are opportunities to mobilize domestic resources at the local level, as well as expand the percent of the local budget allocated to health. Improving access to and use of *mutuelles* will also increase access to health care and strengthen financial protection. In addition, there are opportunities to better leverage the private sector for staffing needs and expanding access to care. Access to certain services is often challenged by critical equipment not being available or functional at specified levels of the health system.

Sub-IR 1.3: Health Sector Policies and Guidelines Effectively Implemented

Senegal has a well-developed policy environment. However, operationalizing these policies and guidelines from central to the district levels remains a challenge. Strengthening implementation will improve the quality and availability of care. Policies and guidelines must be applied, as appropriate, to the private sector to ensure quality of care. However, it is not simply about oversight; improving the enabling environment for private sector providers can help expand access to care. In all of these efforts, it will be essential to strengthen the engagement of the *CDS* as well as civil society.

Intermediate Results 2 and 3: (2) Increased Access to Services; (3) Improved Quality of Services

The population of Senegal faces many obstacles to accessing care. A lack of staff, weak emergency referral services, delayed care seeking behavior, delayed service provision, a lack of equipment, supplies and medicines, and insufficient access to services for youth are examples of the many barriers that must be overcome. Timely care-seeking is discouraged by user fees and long wait times, while geographic access creates barriers for many Senegalese, especially rural populations. USAID will support increased access to high-impact interventions, improving the availability of services that address the needs of youth and adolescents, and better incorporating private sector service providers as part of the overall solution to the health needs of Senegal.

Complementing improvements in the availability of services are efforts to improve the quality of services to reduce maternal, newborn and child mortality. Even where services are accessible, use may be low due to poor quality or unresponsiveness, especially for stigmatized groups. Quality of care standards for maternal and newborn health, pediatric care, and small and sick newborn care, based on WHO and UNICEF guidelines and recommendations, emphasize increasing the delivery of evidence-based clinical services, promoting respectful care and family engagement in care, equipping and motivating health workers, and ensuring that health facilities foster patient safety and comfort. Multisectoral coordination and collaboration are needed to ensure that health facilities have the necessary infrastructure, for example access to safe water in healthcare facilities, and that they are supported to operate and maintain equipment, e.g. for providing high-quality clinical services for sick newborns. Poor data also impacts service quality and even when available, effective use of the data for decision-making remains a challenge.

Sub-IRs 2.1 and 3.1: Increased Access to Evidence-based, High Impact Health Care Interventions

The Public Sector Role. While there have been substantial improvements in health indicators, Senegal still faces significant challenges to accessing care, including distance, financial cost, opportunity costs, lack of agency to access care, and, when they do arrive, a lack of availability of services at the facility. Patients need to be able to reach the appropriate level of care in time to receive critical, often life-saving services, and a functioning referral system is an important aspect of care. The *CDS* and other community structures play a critical role in ensuring a functional referral system and reinforcing appropriate care seeking behaviors. At the facility level, there are challenges with ensuring an adequate number of trained staff are at post and that they have the tools – medicines, supplies and equipment – they need to effectively deliver high impact interventions. And despite a network of primary care and community health services, facilities show uneven uptake of high-impact interventions to reduce maternal and newborn mortality.

The *PTA* should ensure that required services are available at facilities and in the community. For example, there are opportunities to reinforce the availability and functioning of emergency obstetric care; and to expand access to FP high impact interventions. Malaria interventions, such as the promotion of long-lasting insecticide treated nets (LLINs) use, intermittent preventive treatment in pregnancy (IPTp), seasonal malaria chemoprevention (SMC), social behavior change and case management at the clinical and community levels (iCCM), all continue to be important components to health care. In addition, in pre-elimination areas, case investigation will continue to be implemented.

Availability of essential newborn care services are also critically important, including newborn resuscitation, weighing at birth, and identification and referral of small babies to kangaroo care. In addition, protective behaviors such as early initiation of breastfeeding, skin-to-skin care, and exclusive breastfeeding are important to reducing newborn mortality. Identifying populations who are not receiving postnatal care for mothers and/or newborns is also important to ensure that these mothers receive continued support for breastfeeding and are aware of danger signs for early care seeking. Even as overall under-five mortality decreases in Senegal, considerable numbers of children continue to die in the neonatal period. Improving caregiver, family, and community adherence to preventive and promotive behaviors for the leading infectious causes of childhood illness, namely pneumonia, diarrhea, and malaria, is essential to continuing to drive further reductions in child mortality. Ensuring implementation of the 1,000 days approach and ENA is essential to increasing access to nutrition interventions. The management of severe acute malnutrition remains a gap, and improved monitoring and follow up at the community level is needed. In addition, continued attention needs to be given to maternal nutrition and infant and young child feeding practices.

Engaging the Private Sector: The private sector is an increasingly important provider of care, and many people first seek care from pharmacies and private providers, many of whom are unlicensed. As such, the private sector is also a tremendous opportunity to expand access to services, especially in areas where the public sector is unable to meet demand. It is important for districts, under the supervision of the Directorate for Human Resources, to take advantage of their authority to hire health professionals as contractors, capitalizing on the high volume of trained midwives seeking employment, without overburdening public sector payroll. In addition, the ability to contract out services to private facilities is essential to continued expansion of health services. However, to do so, the MOH will need to address gaps in the *mutuelle* system to better incorporate private providers.

Sub-IRs 2.2 and 3.2: Quality of Care Improved

Public Sector Role: Similar to issues with access to care, quality health care cannot be delivered when essential medicines, supplies and equipment are unavailable at the point of service. Medicines, when not properly stored and managed, can lose effectiveness. Providers need the right skills to be able to effectively deliver high impact practices. And, in order to do so, providers need support to deliver services; supervision is one part of this, but mentoring and other modalities to facilitate continued learning and skill building is also important. Quality improvement processes, such as the maternal death surveillance and response (MDSR) and perinatal audits, are important to continuing to reduce mortality.

A lack of quality, respectful health services can erode trust in the healthcare system, discourage clients from seeking care, or drive them to seek care from other sources. Provider norms, attitudes, and behaviors have direct bearing upon clients' experience of care and the potential to influence both perceptions of service quality and demand for services at the community level. In turn, providers' motivation to deliver high-quality care can be influenced by the supportive or constraining context in which they work.

Private Sector Engagement: Compliance with national policies and guidelines in service provision is important for ensuring quality and can be an issue with private sector providers. The medical region must ensure that private providers in the region are accredited, licensed, and receive proper oversight. Regions and districts also need to strengthen their ability to attract and coordinate engagement and donations from private commercial sector partners that are investing in health either through philanthropy or corporate social responsibility.

Sub-IRs 2.3 and 3.3: Private Sector Providers Engaged
USAID will continue to build on successful efforts to expand the role of the private sector in providing essential services. This includes, but will not be limited to:

- Assisting private providers to deliver quality health services and fully comply with MOH requirements, including data reporting;
- Assisting local governments to leverage the private sector to increase access to quality services.

Intermediate Result 4: Increased Participation by Communities and Other Stakeholders
Communities, civil society, community-based organizations (CBOs) and local governmental structures, such as the *CDS*, the *CRV*, as well as informal structures, play a variety of important roles in health provision. Leaders may be influencers, and there are numerous ways in which to leverage their talents and influence to improve healthcare.

Sub-IR 4.1: Increased Engagement of Communities, Civil Society, Private Sector Organizations and Local Governments in Health Sector Activities and Governance
Key structures at the local level, including *CDS*, *CRV* and CBOs, have a critical role in the management and oversight of health care in their communities. These organizations need to be more effectively engaged and actively participate in the development and monitoring of the PTA. Engagement by *CDS* is low in many areas where consistent efforts have not been made to increase their involvement. Local actors, such as community health workers and youth leaders, are often not involved in decision-making processes. There is a need to ensure mechanisms are in place to promote transparency and accountability in the management of the health sector. Local governments can help raise resources, financial and otherwise, to support health care delivery, establish "watchdog" committees to support pregnant women, monitor for stock outs of essential medicines or other gaps in services, and mobilize communities for key events, such as vaccination campaigns. CSOs should help advocate for accountability in the health sector, including effective use of resources and quality care.

Sub-IR 4.2: Priority/Gateway Behaviors Adopted by Individuals, Families and Communities
Social and behavior change (SBC) interventions can increase both utilization of health services and the practice of healthy behaviors within the household and community. For example, protective behaviors such as early initiation of breastfeeding, skin-to-skin care, and exclusive breastfeeding are important to reducing newborn mortality, while recognizing danger signs in the post newborn period can be critical to seeking prompt and urgent care. However, many health interventions do not effectively address existing socio-cultural barriers to health seeking behavior. Continued awareness raising around family planning for all segments of the population, including men,

women, youth, administrative and local authorities and religious leaders, will be essential to increasing demand. When individuals, families and communities participate in high-quality, targeted SBC interventions, they are better able to practice healthy behaviors within the home and utilize available health products and services, resulting in improved health, family planning, and nutritional outcomes. Detailed audience segmentation and profiling allows SBC and service delivery experts to develop a shared foundation upon which they may define realistic and common behavioral objectives and harmonize messages and interventions to achieve better outcomes. Improving the quality of SBC activities provided by CBOs, and ensuring alignment between SBC activities and service delivery in both the public and private sectors is critical to effective adoption of priority behaviors.

District and Regional Level Grants in Support of Annual Work Plans *(PTAs)*
District grants will be a central approach to achieving the outcomes above. USAID will support the development of a district grants program to support and incentivize achievement of the 4 IRs. This approach will also help advance Senegal along its journey to self-reliance. District level grants will support district annual work plans, or *PTAs*.

The *PTA* brings together all the inputs into the health sector, governmental and donor, in one document. This approach reinforces the GOS system, promotes transparency and facilitates mutual accountability across all parties involved. The *PTA* is developed by the Health facilities with the participation of the *CDSs*, which is chaired by the mayor, and requires participation from all the relevant stakeholders. The *PTA* is required to outline all the GOS and donor support to the district in terms of both activities and resource levels and articulate the roles that each of the actors, including the *CDS*, *CRV*, and other community structures and civil society organizations, will play in the oversight and management of health services. The *PTA*, including the operation plan of the local government *(Plan d'Opération de la Collectivité Territoriale (POCT))*, is consolidated at the district level and afterwards at the regional level and can include contracts with community organizations and *mutuelles*.

USAID will support a process that is both demand-driven and results-based. The grants must not displace GOS resources that would otherwise be provided to the districts. The application process should be simple and straightforward and not present a barrier to districts. In order to both ensure basic needs of all districts are met, and to incentivize innovation and motivate staff, USAID envisions a dual approach:

1. **Base Grants**: All districts in a region will receive grants tailored to district priorities articulated in the *PTA*. This will ensure that districts do not lag behind and fail to meet the basic health needs of their communities. Base grants will support RMNCAH, FP, malaria, and nutrition interventions. Regions will also receive base grants to facilitate oversight of district efforts.
2. **Innovation Grants**: In addition to the base grant, districts will apply, on a competitive basis, for additional funds that leverage local resources and reward innovative and ambitious efforts to expand access to quality care and advance self-reliance in the areas of RMNCAH, FP, malaria and nutrition. Local financial contributions will be required as part of the application process, commensurate with local ability to generate revenue and attract private sector donations.

Expected Outcomes:

Expected outcomes under Component 2 of the APS could include but are not limited to:

Outcome 1: Management and Coordination of the Health System Improved
USAID will support efforts that improve planning, budgeting, coordination, management, administration and oversight of the health system at the regional and district levels and below. These efforts should complement and must not duplicate or replace the roles of the central MOH in supporting the medical regions. There should be strong coordination and oversight of all donors' resources and interventions, and key actors, including the *CDS*, *CRV* and civil society, should be actively engaged in the management of the health system.

Outcome 2: Human Resources Developed and Engaged
USAID is seeking to support appropriate solutions to the myriad of challenges that plague human resources for health at the regional and district level and below. Specifically, through the *PTA*, USAID will support locally developed approaches to resolving issues related to lack of trained staff, retention and motivation, with emphasis on those issues that drive access to, and quality of, health care. These approaches may target the public and/or private sectors and emphasize underserved areas. USAID expects that proposed approaches will address not only provider knowledge and competencies, but also normative, attitudinal, and structural factors to the extent possible.

Outcome 3: Improved Availability and Management of Essential Commodities and Equipment
At the district and facility level, USAID seeks to support approaches to encourage the rational use of medicines and commodities, address localized stock outs, and ensure proper storage and handling with controls that minimize the risk of leakage or falsification. USAID is also interested in approaches that address the proper maintenance and upkeep of equipment. Under certain circumstances, USAID may also support procurement of critically needed equipment where these investments will have a significant impact on reducing child and maternal morbidity and mortality.

Outcome 4: Health System Financing and Affordability of Healthcare Services Improved
USAID will strengthen health financing at the district level to improve efficiency, leverage domestic resource mobilization, and ensure transparency and accountability for both budgeting and expenditures. USAID will also address issues of affordability within the health system through support to mutuelles and to implementation of new approaches under the country's health financing strategy.

Outcome 5: Health Information Systems Strengthened
USAID/Senegal will support appropriate, cost-effective approaches that strengthen data quality and use at the regional and district levels and below to inform services, policy, budgeting and decision-making. Efforts to strengthen health information should take into consideration issues of interoperability and sustainability by the GOS at the appropriate level.

Outcome 6: Access to Health Care Increased
High-impact practices are well-established and, for the most part, incorporated into existing policies and guidelines. However, consistent and widespread implementation of high-impact practices with fidelity remains a challenge. USAID will support districts with both technical assistance and financial assistance through the *PTA* to scale up, with fidelity, high-impact interventions at facilities and the community level. USAID seeks novel, cost-effective approaches that can be reliably sustained by the GOS. Support from USAID should complement assistance from other donors and leverage maximum GOS contributions to further advance the journey to self reliance. Efforts under this outcome will link closely with, and be complemented by, activities developed to address Outcomes 1 through 5.

USAID also seeks to expand access to health care through the private sector. This may require increasing access to financial resources for private providers, addressing challenges in the regulatory environment, and/or improving and expanding reimbursement for care delivery through the *mutuelle* system.

Outcome 7: Quality of Health Care Improved
USAID will support cost-effective efforts to improve the performance of health providers, avoiding off-site workshops and training that take health workers out of the facility and away from providing services. USAID will also support appropriate quality improvement processes that help drive reductions in maternal, newborn and child mortality. USAID also seeks to improve the knowledge and skills of service providers to deliver high-impact interventions and provide care in a respectful and client-friendly environment, reflecting emerging best practices in improving provider motivation and performance. Interventions under outcomes 1 through 5 will be critical to ensuring quality service provision. Engagement of local actors, such as *CDS, CRV* and civil society, will help ensure oversight and accountability for quality of care. USAID will also support efforts to strengthen collaboration between the public and private sectors and ensure quality service provision by private sector providers.

Outcome 8: Enhanced participation by Communities, CSOs and Local Government
At the district level, USAID will support communities, civil society and local government to participate in the development of the *PTA*. USAID will also support engagement by these entities in the management of the health system; ideally this engagement will be built into the *PTA*.

Outcome 9: Increased Adoption of Priority Behaviors
USAID seeks to build upon previous successes in building the capacity of the National Service for Health Education and Information *(Service National de l'Education et de l'Information pour la Santé (SNEIPS))* at the national level, and the Regional Office for Health Education and Information *(Bureau Régional de l'Education et de l'Information pour la Santé (BREIPS))* at the regional level and SBC organizations to support local CBOs to implement SBC activities. Recognizing that these organizations are most closely in touch with their communities and understand the specific factors that influence and drive priority and gateway behaviors, through the *PTA*, USAID will support these CBOs including association of community health actors to deliver SBC activities.

Level of Effort:
USAID anticipates the following Level of Effort (LOE) by Outcome:

- Outcomes 1 through 5 (health systems) should be approximately 20 to 30 percent.
- Outcomes 6 and 7 (access and quality) should range from 40 percent to 50 percent.
- Outcomes 8 and 9 (community and stakeholder engagement) should range from 20 percent to 30 percent.

D. Cross-Cutting Priorities

For cross-cutting priorities and principles, See Umbrella APS, pp 13-16.

E. Geographic Scope

Component 2 Integrated District Health will provide integrated support in MCH, FP, Malaria, and Nutrition in five focus regions: Diourbel, Kedougou, Kolda, Sedhiou, and Tambacounda. Support will be tailored to individual district needs as expressed in the *PTA*. These regions were identified by USAID based on a range of criteria, including poor health indicators, limited donor presence , and opportunities to leverage other USAID investments. Component 2 support will focus on the district level and below but will also support the medical region to fulfill their role of supervising and monitoring the districts.

Component 1 will focus on central health systems strengthening activities and will not have staff at the regional level. Component 1 will support central level entities to fulfill their technical assistance and oversight role of the five IDH medical regions and the G2G regions. Component 1 interventions will be limited to the regional level and will not support district level implementation. To avoid duplication of effort, further refinement of the distinction between interventions carried out by Component 1 versus Component 2 will occur during the co-creation process. As Component 3 will focus on the larger urban center of Dakar, there will be no geographic overlap between Components 2 and 3.

USAID is currently providing Government-to-Government (G2G) support to two medical regions: Kaffrine and Ziguinchor. Additional G2G programs are anticipated in Kaolack and Thies. IDH may be periodically called upon to provide short-term technical assistance to G2G regions but will not base staff in these regions. During the course of this award, USAID anticipates transitioning up to three of the five IDH regions from subgrants under IDH to direct G2G assistance. A separate implementing partner (G2G Operational Support, G2GOps) will provide technical assistance related to G2G. A joint transition plan by IDH, G2GOps, and USAID will be developed immediately upon award to ensure the smooth transition of regions to G2G. Continued technical assistance by IDH is envisioned during the first year following a region's transition to G2G. In subsequent years, USAID and the MOH will determine to what extent continued technical assistance to G2G regions is required, based on regional capacity and the ability of the MOH to meet pre-financing requirements through the G2G line item.

(END OF COMPONENT 2 PROGRAM DESCRIPTION)

COMPONENT 3 PROGRAM DESCRIPTION

Urban Health

The U.S. Agency for International Development/Senegal's Health, Population and Nutrition Office is pleased to issue Component 3, **Urban Health**, as part of the *Improving Health Status and Human Capital in Senegal* Annual Program Statement (APS). Component 3 seeks to improve Reproductive, Maternal, Newborn, Child and Adolescent Health, Family Planning, Nutrition, the prevention and treatment of Malaria (RMNCAH/FP/NUT, M), and water, sanitation and hygiene (WASH) activities in the most vulnerable districts of the Dakar Region. This approach includes leveraging private sector resources and services, improving the Ministry of Health (MOH)'s capacity to utilize and oversee private providers, and developing cross-sectoral interventions that tackle the root causes of health disparities in urban zones. This focus is an integral element of USAID's agenda to support host country partners on their Journey to Self-Reliance. Self-reliance in health is a function of the country's capacity and commitment to deliver and finance health care in partnership with public and private sectors, civil society, community and faith-based organizations.

A. Component 3 Background

In 2019, Senegal had an estimated total population of 16.7 million. Over 50% of the country's population lives in urban areas. With a total estimated population of 3.7 million, the region of Dakar makes up over one fifth of the nation's entire population, living on 0.25% of the country's land area. The region of Dakar has 43 communes, 4 departments and 4 cities: Dakar, Pikine, Guediawaye and Rufisque. In Senegal, it is estimated that 60% of the population is under the age of 25.

While significant progress has been made to improve the overall health status of the Senegalese population, this progress has not necessarily been evenly distributed and may not reflect the full range of health outcomes in the country's urban areas. Cities often include pockets of intense poverty, as well as sub-populations experiencing poorer health outcomes, sometimes even lagging behind their rural counterparts. In the Dakar Region in particular, perceived urban prosperity and overall good health indicators can mask smaller-scale variations in poverty levels and social indicators.

For certain health indicators, performance in urban districts varies greatly within the region of Dakar and can even lag behind Senegal's rural regions. For instance, while 99 percent of children 0-11 months in West Dakar have complete vaccination coverage, this figure is only 50 percent in Yeumbeul, more on par with a coverage rate of 47 percent (11-24 months) in the Tambacounda Region. Although Senegal's national average rate of assisted delivery by qualified personnel is 68%, significantly lower rates have been reported within the Dakar Region: 57% in Diamniadio, 36% in Yeumbeul and 31% in Pikine.

Health service delivery indicators also reveal variations in regional performance. For example, the percentage of health workers who reported having received continuing education around neonatal care in 2017 was 57 percent in Dakar, lower than 66 percent in Diourbel and 60 percent in Fatick.

The percentage of maternal and neonatal health providers who received continuing education in Dakar was 65 percent as opposed to 76 percent in Fatick. In order to improve the health status of Dakar's most vulnerable populations and boost health outcomes in underperforming urban health districts, these disparities must be addressed.

B. Program Description

Component 3 is designed to improve the health status of vulnerable populations in underserved districts of the Dakar Region. To this end, the awardee(s) will assist with improving health outcomes through impactful, integrated interventions in the areas of RMNCAH/FP/NUT, M, and WASH, including but not limited to strengthening the urban healthcare system. These innovative approaches should be tailored to an urban context, leverage resources and expertise from public, private sector, non-governmental and donor organizations, and improve the capacity and commitment of central and participating local authorities to utilize and oversee private providers. WASH activities are supported by co-financing from the Economic Growth Office. WASH funds under Component 3 will not support the management of medical or household waste.

The awardee will assist local government authorities *(Collectivités Territoriales Locales)*, the MOH, and representatives from other applicable sectors to develop and implement comprehensive plans to improve health outcomes amongst vulnerable populations within the region of Dakar, with a focus on districts reporting poor maternal and child health outcomes. Department-level coordination should also figure into the activity design. A cross-sectoral approach to urban health promotion will enable the activity to differentiate models of care and address social and behavioral factors that differ from rural areas. Proposals may include household level behavior change or the promotion of healthy home environments and approaches that would further strengthen health mutuelles and their capacity to generate the demand for and access to health services. Part of the activity will actively engage private sector providers and identify opportunities to leverage their services and resources. It will also improve the capacity of the MOH to oversee and collaborate with private sector providers. The award will also include subgrants to support innovative, impactful interventions in select urban districts.

Under Component 3, USAID/Senegal will support the Ministry of Health and Social Action's National Plan for Health and Social Development *(Plan National de Développement Sanitaire et Social, PNDSS)* for 2019–2028. Proposed activities will also support Senegal's Act III of Decentralization, which grants significant responsibility for urban development to municipalities. This includes management of infrastructure and social services.

Dakar's public healthcare facilities include 14 hospitals (including the Cheikh Anta Diop *University Hospital Center,* or *CHU*), 13 of which offer maternal and child care services; 24 health centers, which also provide RMNCAH/FP/NUT/M care; and 126 health posts, with only 75 offering maternal care. In Dakar, the Private Health Sector Alliance (*l'Alliance du Secteur Privé de la Santé,* or *ASPS*) plays an important role in coordinating private sector activities. In the formal private sector, there are 1,384 facilities including 284 medical offices, 69 clinics, 17 health centers, 1 hospital and 79 company medical care services. It is important to note that the supply of maternity and childcare services is mainly concentrated at the secondary (health center) and tertiary (hospital) level. The Component 3 awardee will support the MOH, decentralized levels of the *Collectivité*

Territoriale/Municipality (Departments, Communes), health care facilities, health districts, and the private sector to develop and implement comprehensive plans to address urban health disparities within the Dakar Region, particularly in regards to maternal and child health. Key to this component will be competitively awarded, demand-driven subgrants to support targeted health districts' annual work plans (*plans de travail annuels,* or *PTAs*). Subgrants may support *PTA* interventions carried out by the public and/or private sector, or by community-based organizations, which will be the primary implementers of social and behavior change (SBC) programs. The grant-funded *PTAs* will incorporate local, central government and donor-funded activities and reinforce transparency and accountability. In addition to the grants, the activity will provide technical assistance in the areas of domestic resource mobilization, strategic planning, data analysis and use, supply chain management, and health workforce planning and oversight.

Implementing Partner(s) under Component 3 will work closely with health care facilities and other entities that comprise the urban health landscape to improve RMNCAH/FP/NUT/M and WASH outcomes in underserved, marginalized health districts in the Dakar Region.

USAID/Senegal currently supports several health and development activities in the Dakar Region, including ongoing HIV/AIDS and malaria control activities. In terms of maternal and newborn health, USAID has provided assistance to Dakar's *Grande Coalition* of Maternal and Child Health. In addition, the Global Health Security Agenda (GHSA) supports the Government of Senegal in improving disease surveillance and detection across all regions, including Dakar. Other relevant sectoral and development work supported by USAID/Senegal includes a fecal sludge management activity managed by the Economic Growth Office. While USAID's Democracy and Governance (DRG) Office has no ongoing activities in Dakar related to the health sector, it is planning to extend the Governance and Local Development (GoLD) contract, to further support advocacy activities at the central GOS level in order to remove bottlenecks in the health, education and WASH sectors at the community level. Activities implemented under Component 3 should be designed to complement other USAID initiatives to the greatest extent possible.

C. Expected Results

The Component 3 awardee(s) will work closely with all stakeholders and, as needed, with Component 1 and 2 implementing partners to contribute to the achievement of all four (4) intermediate results (IRs) and sub-intermediate results (sub-IRs) identified below:

Intermediate Result 1 (IR): Strengthened Systems
Component 3 of the APS seeks to sustainably strengthen the capacity and commitment of the healthcare system in the target districts of the Dakar Region to address pressing healthcare needs. Component 3 of the APS Component will target up to three (3) districts in the Dakar Region with poor health indicators. Objectives include: improving the health status of vulnerable populations by reducing maternal, newborn, and child mortality and morbidity; increasing access to family planning and reproductive health resources; boosting child nutrition; and preventing and treating malaria. This will be achieved by applying innovative approaches tailored to an urban context, and by leveraging private sector resources and services.

A sustainably performing healthcare system requires investment in all domains, including leadership and governance, policies and guidelines, workforce, infrastructure, commodities and supplies, service delivery, information systems and financing. Working with the MOH and municipal councils, the Urban Health activity will strengthen the capacity and commitment of health systems at the regional and district levels to sustainably improve health outcomes in targeted areas. Component 3 will support the Ministry of Health, decentralized local governments *(Collectivités Territoriales)*, and municipal councils to strengthen health coordination, management and governance in order to expand and improve the access to, and availability of, RMNCAH/FP/NUT, malaria, and WASH services. Component 3 will leverage opportunities for synergy with other health activities, such as USAID's centrally funded health activities, including the New Partnerships Initiative for Global Health (NPI GH). Close collaboration during the co-creation phase will ensure a harmonized approach across activities and programs. Activity proposals should also outline plans for collaboration with other USAID non-health activities intervening in development areas such as education, governance, and economic growth that are relevant to the health system.

Health systems will be strengthened under Component 3 through the following:

- ***Sub IR 1.1: Improved management of health systems***
- ***Sub IR 1.2: Optimized use of resources to achieve better health outcomes***
- ***Sub IR 1.3: Effectively implemented health sector policies and guidelines***

Intermediate Result (2): Increased Access to Services
Component 3 of the APS will contribute to IR2 by increasing coverage of high-impact, evidence-based, and culturally acceptable interventions and services that address the health needs of targeted populations in select urban districts within the region of Dakar. This includes RMNCAH/FP/NUT, malaria, and WASH services. The implementing partner will apply an integrated approach to expand access to preventative and curative healthcare and WASH services.

The Government of Senegal's vision to achieve universal health coverage by 2035 cannot be achieved without strengthening its private health sector. The private health sector in Senegal consists of for-profit, non-profit, faith-based, and civil society organizations. Over 80 percent of Senegal's private health facilities are located in Dakar. The private sector is increasingly expanding its products and services; however, service quality varies widely, due to a large extent to a lack of compliance with nationally validated norms and protocols, and insufficient or ineffective oversight. While the MOH is responsible for oversight of all health services, its engagement with the private sector healthcare providers has been limited.

Comprehensive efforts to increase access to healthcare services in Dakar should involve the private sector. Private sector providers and local organizations can play an important role in disseminating important health information and delivering essential services. As such, it will be essential to foster partnerships between private healthcare structures and local government authorities, public healthcare structures, local or locally based non-governmental and private sector organizations, and other key stakeholders at the community level. These relationships can serve as a platform for identifying and addressing barriers for underserved populations to access priority healthcare services, and for improving linkages between local communities and these key actors to help

increase access to care for difficult to reach urban dwellers. Such partnerships around healthcare services are critical for building local ownership and sustainability of target interventions beyond the bound timeframe of USAID assistance.

Access to health care services under Component 3 will be increased through the following:

- ***Sub IR 2.1: Access to evidenced high impact interventions increased***
- ***Sub IR 2.2: Quality of Care Improved***
- ***Sub IR 2.3: Private Sector providers engaged***

Intermediate Result 3: Improved Quality of Services

Under Component 3, the implementing partner will support efforts aimed at improving the quality of healthcare services with a particular focus on decreasing maternal, newborn and child morbidity and mortality, boosting reproductive health indicators, improving nutrition, and effectively preventing and treating malaria. The implementing partner will work closely with public and private healthcare providers to improve accessibility, affordability, and quality of services. High quality services will stimulate frequent demand and regular use by satisfied clients, and ultimately contribute to improving the health status of target populations in Dakar.

One key challenge affecting access to quality services is the availability of equipment and essential medicines and supplies throughout Senegal. The implementing partner will support efforts to leverage the services and resources of private sector providers that can contribute to the offer of high-impact health care services, information, equipment and supplies in the target urban districts. In this regard, a particular focus will also be placed on strengthening the capacity and commitment of the MOH to both utilize and oversee private sector providers.

Increasing access to high quality health services and products, fostering the commitment of individuals and communities in the management of their own health and health care services, and strengthening the performance of the health system include: increasing the delivery of evidence-based clinical services, promoting respectful care and family engagement in care, equipping and motivating health workers, and ensuring that healthcare facilities foster patient safety and comfort. Multisectoral coordination and collaboration between stakeholders are needed to ensure that healthcare facilities have critical infrastructure (for example, access to safe water), and that they are able to operate and maintain equipment needed to deliver essential services where and when patients need them. Finally, easy-to-use systems that facilitate the collection, analysis, and application of health data will be important for improving healthcare services and adaptive decision-making.

Improving the quality of healthcare services under Component 3 will be achieved through the following:

- ***Sub IR 3.1 Access to evidence based high impact interventions increased***
- ***Sub IR 3.2 Quality of Care improved***
- ***Sub IR 3.3 Private providers engaged***

Intermediate Result 4: Increased Participation by Communities and Other Stakeholders

In order to improve health outcomes in target districts, Component 3 aims to harness community partner networks, foster linkages between stakeholders and local health facilities, and develop platforms that extend and complement the reach of public health services. The Awardee under Component 3 will work closely with local communities and government entities, such as Municipalities, Health Development Committees *(CDSs)*, the Regional Audit Committee *(Comité Régional de Vérification (CRV)*, with civil society (CSOs), community-based (CBOs), and faith-based organizations (FBOs), private sector providers, other donors and stakeholders, who play an important role in promoting health outcomes in the region of Dakar. The implementing partner will explore and utilize numerous ways to leverage the expertise, talents and/or resources of these local partners to improve health outcomes in the region of Dakar, particularly in underserved target districts.

Increased participation by communities and other stakeholders in health care services under Component 3 will be achieved through the following:

- ***Sub IR 4.1: Increased, effective participation of community-based, civil society organizations and local governments in health sector activities and governance***
- ***Sub IR 4.2: Priority/gateway behaviors effectively adopted by individuals, families and communities.***

Expected Outcomes

Expected outcomes under Component 3 of the APS could include but are not limited to:

- Innovative, sustainable, multisectoral approaches developed and implemented that are specifically tailored to improve health outcomes in an urban environment, particularly as they relate to RMNCAH/FP/NUT, M and WASH;
- Strengthened engagement between target communities, public health facilities, private health facilities, CSOs, CBOs, FBOs, and other stakeholders such as WASH service providers, to improve urban health outcomes through integrated and impactful RMNCAH/FP/NUT, M and WASH interventions;
- Improved RMNCAH/FP/NUT, M and WASH practices at the district, community, and household levels;
- Enhanced capacity of health districts, municipalities, Health Development Committees *(CDSs)*, the Regional Audit Committee (CRV), CSO, CBO, and FBO partners to plan and manage RMNCAH/FP/NUT, M prevention and promotion activities and WASH promotion activities;
- Increased demand for quality healthcare services and WASH products and services in targeted districts;
- Increased commitments and accountability for relevant authorities and community leaders to make improvements in urban health outcomes.

D. Cross-Cutting Priorities and Principles

For cross-cutting priorities and principles, See Umbrella APS, pp.12-15.

E. Geographic Focus

Geographic Area: Component 3 addresses urban health disparities by focusing on RMNCAH, FP M, N, and WASH interventions in the most vulnerable districts of the Dakar Region.

Applicants will propose relevant activities, approaches, strategies and methodologies to achieve the results and outcomes identified above for Component 3 in up to three focus districts within the Dakar Region. Applicants may identify specific districts in their proposals; however, it is anticipated that the final identification of particularly vulnerable districts will occur during the co-creation phase following consultation with project stakeholders.

F. Inception Phase:

For the first time, USAID/Senegal has decided to strategically invest health resources in an urban health design. For this reason, the Mission has decided to set aside time for a comprehensive landscape analysis to better understand the operating environment for the proposed activity, including but not limited to key actors and beneficiary groups. The award will have an initial inception phase of three to six months, which will be used to analyze and understand system dynamics, the nature of the problem to be addressed, and where the activity might best intervene to achieve the activity purposes. Further interventions will be informed by findings from the inception phase, including any studies. The applicant/offeror will utilize collaborative planning (with USAID and key stakeholders) in order to allocate appropriate resources for the proposed design, scale, and sequence of the activity. This will allow the activity to achieve maximum impact, while employing an adaptive approach.

G. Active Social Inclusion:

The activity should work alongside local actors and poor and vulnerable populations to reduce any barriers to health they may face, including stigma. In the face of increasing economic disparities and various forms of exclusion and discrimination in urban areas, public health approaches and interventions under Component 3 will need to specifically engage and empower marginalized and vulnerable populations throughout all stages of activity design and implementation. To this end, proposals may include approaches such as participatory action research (PAR) and planning.

(END OF COMPONENT 3 PROGRAM DESCRIPTION)

[END OF SECTION A]

SECTION B: FEDERAL AWARD INFORMATION

1. Estimate of Funds Available and Number of Awards Contemplated

USAID intends to award three cooperative agreements pursuant to this notice of funding opportunity. Subject to funding availability and at the discretion of the Agency, USAID intends to provide up to **$88,000,000.00** in total USAID funding over a five-year period. If the same organization happens to win more than one component of this APS, USAID may, at its discretion, issue a single award covering more than one component. The anticipated breakdown of funds across the three components is as follows:

Component 1: ($18,000,000 – 20,000,000);
Component 2: ($45,000,000 – 55,500,000);
Component 3: ($10,000,000 – 12,500,000).

Note that the $55,500,000 maximum for Component 2 assumes no transition of regions from subawardees under Component 2 to Government-to-Government assistance, whereas the minimum assumes three regions transitioned to G2G.

2. Start Date and Period of Performance for Federal Awards

The anticipated period of performance is five years. The estimated start date will be upon the signature of the award, on or about June 1, 2021.

3. Substantial Involvement

Substantial Involvement during implementation of the program will include the following:

a. Approval of the Recipients' Annual Implementation Plans include:
   i. Approval Work Plans;
   ii. Approval of the Recipients' Monitoring & Evaluation Plans;
   iii. Approval of the Environment Mitigation Plans.

b. The Agency's review and approval of substantive provisions of proposed subawards :
   i. Agreement Officer's prior approval required for the subaward, transfer, or contracting out of any work under an award;
   ii. USAID will have substantial involvement in the criteria and selection of sub-award recipients through means of collaboration and joint participation;
   iii. Unless otherwise directed by the Agreement Officer, USAID will approve the selection of all sub-award recipients and substantive provisions of the sub-awards.

c. The Agency's involvement in the selection of key recipient personnel. In accordance with the Substantial Involvement, prior approval from the Agreement Officer is required for the specified "Key Personnel".

d. The Agency and recipient collaboration or joint participation, such as when the recipient's successful accomplishment of program objectives would benefit from USAID's technical knowledge. There should be sufficient reason for the Agency's involvement and the involvement should be specifically tailored to support identified elements in the program description.

e. Agency monitoring to permit specific kinds of direction or redirection of the work because of the interrelationships with other projects or activities. All such direction or redirection must be within the program description budget, and other terms and conditions of the award.

f. Direct agency operational involvement or participation to ensure compliance with statutory requirements such as civil rights, environmental protection, and provisions for the handicapped that exceeds the Agency's role that is normally part of the general statutory requirements understood in advance of the award.

g. Highly prescriptive Agency requirements established prior to award that limit the recipient's discretion with respect to the scope of services offered, organizational structure, staffing, mode of operation, and other management processes, coupled with close monitoring or operational involvement during performance over and above the normal exercise of Federal stewardship responsibilities to ensure compliance with these requirements.

4. Authorized Geographic Code

The geographic code for the procurement of commodities and services under this program is **935 –** Any area or country including the cooperating country but excluding the foreign policy restricted countries**.**

5. Nature of the Relationship between USAID and the Recipient

The principal purpose of the relationship with the Recipient(s) and under the subject program is to transfer funds to accomplish a public purpose of support or stimulation of the ***Improving Health Status and Human Capital in Senegal*** which is authorized by Federal statute. The successful Recipient(s) will be responsible for ensuring the achievement of the program objectives and the efficient and effective administration of the award through the application of sound management practices. The Recipient(s) will assume responsibility for administering Federal funds in a manner consistent with underlying agreements, program objectives, and the terms and conditions of the Federal award.

[END OF SECTION B]

SECTION C: ELIGIBILITY INFORMATION

1. Eligible Applicants

Eligibility for this APS **is not** restricted.

USAID welcomes applications from organizations that have not previously received financial assistance from USAID.

Type of Partnership	Eligibility Requirements
1. Direct Awards to New and Underutilized Local Entities	For the purposes of this APS, local entity means an individual, a corporation, a nonprofit organization, or another body of persons that— (1) is legally organized under the laws of Senegal; (2) has as its principal place of business or operations in Senegal; (3) is majority owned by individuals who are citizens or lawful permanent residents of; and (4) managed by a governing body the majority of who are citizens or lawful permanent residents of Senegal;
2. Direct Awards to New and Underutilized Locally-Established Partners (LEP)	LEP must: ● Have maintained continuous operations in-country for at least five years and materially demonstrate a long-term presence in a country through adherence or alignment to the following: o Local staff should comprise at least 50% of office personnel, o Maintenance of a dedicated local office, o Registration with the appropriate local authorities, o A local bank account, and o A portfolio of locally implemented programs. ● Have demonstrated links to the local community, including: o If the organization has a governing body or board of directors, then it must include a majority of local citizens; o A letter of support from a local organization to attest to its work; and o Other criteria that an organization proposes to demonstrate its local roots.
3. Mentoring Awards to organizations that provide sub-grants	Promote local leadership through training and mentoring. Mentoring Approach: * Facilitate Partnership; * Transition Awards
4. Leverage Awards to organizations that co-fund	Any partner that mobilizes non-US Government resources at a minimum of **2.1** funding ratio.

2. Cost Sharing or Matching

USAID has established a suggested minimum recipient cost share of 5% of projected award amount for the award. Such funds may be provided directly by the recipient; other multilateral, bilateral, and foundation donors; host governments; and local organizations, communities and

private businesses that contribute financially and in-kind to implementation of activities at the country level. This may include contribution of staff level of effort, office space or other facilities or equipment which may be used for the program, provided by the recipient. For guidance on cost sharing in grants and cooperative agreements see 2 CFR 200.306 .

3. Other

If the applicant proposes to partner with other organizations through sub-awards, it should present a clear structure in terms of roles and responsibilities of each recipient, lines of authority and managerial decision-making process. Resources should be shared among the sub-recipients based on their contributions to the program. In preparing their applications, applicants must not enter exclusive arrangements for labor or local organizations.

Risk Assessment: In accordance with ADS 303.3.9, the Agreement Officer is required to evaluate the risks posed by applicants before making the award in accordance with the principles established by USAID and the Office of Management and Budget (OMB) (see 2 CFR 200.205). Applicants and sub-awardees, if any, must submit additional evidence they deem necessary for the Agreement Officer to make a Risk Assessment Decision. The information submitted should substantiate that the applicant:

a. Has adequate financial resource or the ability to obtain such resources, as required during the performance of the Cooperative Agreement;
b. Has the ability to comply with the cooperative agreement terms and conditions, taking into account all existing and currently prospective commitment of the applicant, nongovernmental and governmental;
c. Has a satisfactory record of performance. Generally, unsatisfactory past performance is enough to justify a finding of non-responsibility, unless there is a clear evidence of subsequent satisfactory performance or the applicant has taken corrective measures to assure that it will be able to perform its functions satisfactorily;
d. Has satisfactory record of business integrity;
e. Is otherwise qualified to receive a Cooperative Agreement under applicable laws and regulations.

The Recipient must be a responsible entity. The AO may determine a pre-award survey is required and may conduct an examination that will determine whether the prospective recipients has the necessary organization, experience, accounting and operational controls, and technical skills – or ability to obtain them – in order to obtain the objectives of the program and comply with the terms and conditions of the awards.

Upon request by USAID, all apparently successful applicants will be required to submit a copy of their accounting manual and audited financial statements for the previous three (03) year period by a certified public accountant or other auditor satisfactory to USAID

[END OF SECTION C]

SECTION D: APPLICATION AND SUBMISSION INFORMATION

I. SUBMISSION INFORMATION FOR CONCEPT PAPERS

1. Agency Point of Contact

Name: Maria-Teresa Roberto Marillat
Title: Senior Acquisition & Assistance Specialist
Email: **mroberto@usaid.gov**

Name: Ndeye Aminata Wilane
Title: Acquisition & Assistance Specialist
Email: **nawilane@usaid.gov**

2. Questions and Answers

Questions regarding this APS must be submitted in writing by email to **mroberto@usaid.gov** and **nawilane@usaid.gov** and copy to **SenegalHealthAPS@usaid.gov** no later than the date and time indicated on the cover letter, or as amended. **All questions submitted by email must have the APS number included in the email subject line**. **No telephone contacts will be accommodated**. Any information given to a prospective Applicant concerning this APS will be furnished promptly to all other prospective Applicants as an amendment to this APS, if that information is necessary in submitting applications or if the lack of it would be prejudicial to any other prospective Applicant.

3. General Content and Form of Concept Paper

Each Component will include a three-phase process where applicants first submit a concept paper for an initial competitive review:

a) **Concept Papers – First Phase**: Applicants must first submit a concept paper before being invited into a virtual co-creation workshop if eligible.

PHASE 1: CONCEPT PAPER SUBMISSION PROCESS AND PRESENTATIONS

A Concept Paper is a short, five (5) page document where the applicant provides an overview of its idea. Concept papers must be submitted in English and in French and the **English version is considered the official version**.

Applicants must submit a Concept Paper in response to an active Component by the deadline. USAID will acknowledge receipt of the Concept Paper submission. Each Component will review Concept Papers against its merit review criteria. If there is no one standout among the concept papers, USAID will invite the top applicants to present their concept papers through a 45-minute

virtual presentation, followed by questions and answers. The presentation will allow the applicants to provide further detail regarding the approach outlined in the concept paper.

USAID will notify potential applicants of significant changes in the review process timeline through a written amendment to the Component. USAID, at its sole discretion, reserves the right to review Concept Papers out of cycle. USAID reserves the right to pose clarifying questions and conduct discussions with any applicant but may not opt to do so if it believes it has sufficient information in the concept paper itself. Posing clarifying questions and conducting discussions with one applicant does not obligate USAID to do so with all applicants.

USAID anticipates two (2) possible results from the Concept Paper and Presentations merit review process:

- **Conditional Acceptance** - Most Highly Rated Applicants for each component are invited for Co-Creation: Concept Paper and Presentation generally meets Component objectives and receives a PASS when evaluated against the Component merit review criteria. USAID invites most highly rated applicants to engage in co-creation.

- **Concept Paper does not receive Conditional Acceptance**: Concept Paper does not meet the category of Most Highly Rated Applicants and/or does not meet Component objectives and/or receives a FAIL when evaluated against the Component merit review criteria. USAID does not invite applicants to participate in co-creation. Due to the number of concept papers received, USAID will not provide additional details on why concept papers were not selected or categorized as Most Highly Rated Applicants.

USAID also reserves the right to make an award without discussions if determined to be in the Government's best interest.

Proposed concept papers must not exceed maximum funding amounts for the Component as described in this APS. Further, if an organization does not submit a successful concept paper and is not invited to attend the co-creation workshop/submit a full application in a specific Component then that organization may still submit another concept paper in a future round, in the event that USAID develops additional components that will be solicited under the umbrella APS. Merit review/evaluation criteria will be revised to the specifics of the round.

Concept papers that are submitted late or are incomplete may not be considered for the co-creation workshop. Additional information in the concept paper not requested by each Component of the APS may be removed and may adversely affect an applicant's evaluation/review.

i. Concept Paper Content:

No additions or modifications to concept papers will be accepted after the submission date. Applicants must submit only the information and materials requested and in the format specified below.

- Concept Papers MUST be submitted in English and French electronically via e-mail in searchable and editable Microsoft Word or Adobe PDF format. The

English copy will be considered the official version and the French copy will facilitate review by French speakers on the Merit Review Committee. English is the official language of all award documents

- ❖ Concept Papers MUST not exceed five (5) pages, using 1" page margins with 12 point Times New Roman font and single spacing. 10 point font can be used for graphs and charts. Tables must comply with the 12 point Times New Roman requirement. Applications must be single-sided and use left justification and footers on each page including consecutive page numbers, date of submission, and applicant's name.
- ❖ USAID will not review any pages in excess of five pages. Please ensure that applications comply with the page limitations.
- ❖ Clarity and specificity are important as is ensuring that the Concept Paper narrative addresses the Merit Review Criteria that will be used to review the Concept Paper. During the merit review process, USAID may reject those Concept Papers that are vague or merely restate language found in the APS.

a. Concept Paper Cover Page – (*please complete the following questions below)*

- Name of the organization(s) submitting the application;
- Identification and signature of the primary contact person (by name, title, organization, mailing address, telephone number and email address) and the identification of the alternate contact person (by name, title, organization, mailing address, telephone number and email address);
- Program Component name;
- Annual Program Statement (APS) number;
- Name of any proposed sub-recipients or partnerships (identify if any of the organizations are local organizations, per USAID's definition of 'local entity' under ADS 303.

b. Concept Introduction and context: (approximately one [1] page).

Identify the problem your organization will address, linking it to the Component's expected results and briefly describe your organization's approach to tackling this problem. What are the biggest challenges and opportunities? Describe why there is a strategic need for your organization's concept, how it differs from alternatives, and any relevant partner-specific considerations for the problem or solution.

c. Program approach: (approximately two [2] pages).

Building on the introduction, expand on your approach and its innovations for achieving the desired impact. Briefly describe critical barrier(s) or problem(s) that your organization's concept addresses. Be sure to include sufficient rationale that addresses the technical soundness, feasibility, scalability, and contribution towards sustainability of the proposed idea/approach. Explain how the proposed project supports or relates to the Plan National de Developpement Sanitaire et Social(PNDSS) 2019-2028 and how the program advances the country's Journey to Self-Reliance. Describe the types of benefits the

approach will produce and the types and range of people who will benefit. Has it been, or can it be, adapted to reach women and men, youth, and disadvantaged populations?

d. Program results: (approximately one [1] page).
As specifically as possible, describe the anticipated outputs the Applicant will support to achieve the expected outcomes detailed in the APS. What will be the approach to Collaborating, Learning, and Adapting (CLA)?

e. (If applicable) Partner roles: (approximately 1⁄2 page).
Describe and define the role of other entities in the partnership. This must include a description of sub-awardees and their scope. Identification of potential partnerships should reflect recognition of the value of diverse perspectives and capabilities, including significant thought to engaging and collaborating with local partners.

f. Applicant capacity: (approximately 1⁄2 page).
Describe organizational capacity – technical, managerial, financial, etc. – to carry out the proposed intervention. Briefly describe Programs of similar size and scope that the organization and its subawardees have supported.

ii. Merit Review for Concept Papers

1. A separate USAID Merit Review Committee (MRC) will be established for each Component to review concept papers received and to evaluate them for responsiveness to the merit review criteria outlined in each Component.

2. On the basis of the concept notes and presentations, the Merit Review Committees will independently identify the apparently successful applicant (ASA) from each Component to participate in a co-creation workshop together with Government of Senegal staff from Central, Regional and District levels, USAID staff, the ASAs from the other components, representatives of Civil Society and other donors, and representatives from other USAID programs. Through the co-creation process, participants will further identify and develop the activities and approaches that will help achieve the results desired under this APS and specific Component(s). The participants will determine respective roles and responsibilities related to the implementation of those activities, including refining how the three Components will collaborate amongst themselves and with other stakeholders during implementation.

<u>Evaluation Criteria #1</u>

The extent to which the concept paper proposes sound approaches to achieve the expected outcomes described in the APS. Applicants should refer to expected outcomes on pp. 21 for Component 1, pp.29 for Component 2, and pp. 37 for Component 3.

Evaluation Criteria #2

The extent to which the proposed approach will facilitate sustainable progress on the Journey to Self-Reliance such that the interventions and/or achievements will continue beyond the life of the Program without funding from USAID.

Evaluation Criteria #3

The extent to which the Applicant and its sub-awardees demonstrate the institutional capacity to achieve expected outcomes detailed in the Technical Approach.

b) Co-Creation Workshop (Virtual) – Second Phase: If a proposed activity (submitted as a concept paper) meets the requirements of this APS, an Applicant will be invited to the Virtual Co-Creation Workshop.

PHASE 2: CO-CREATION

Applicants that have successful Concept Papers will be invited for co-creation, and will engage with the USAID Mission, the Government of Senegal (Central, Regional and District Level), ASAs for other components, other USAID implementers and other stakeholders. Through co-creation, participants will work through areas of weakness, respond to USAID and other stakeholder questions, and clarify aspects of the concept that are not clear. Co-creation will also include discussion of best practices, lessons learned in the relevant technical sectors, and pertinent research and evaluations and various other matters. Co-creation will also clarify how the three Components will work together and with other stakeholders during implementation. After concept papers have been submitted, USAID personnel can have highly specific, detailed activity design discussions with the applicants throughout the remainder of the process, e.g., up to and through any award that might be issued under a Component of this APS.

Concept papers should be free of any intellectual property that the applicant wishes to protect, as the concept papers may be shared with other organizations as part of the co-creation process. However, once potential partners have been invited to engage in further discussions, they will work with USAID to identify proprietary information that requires protection. Therefore, organizations submitting concept papers provide USAID a royalty free, non-exclusive, and irrevocable right to use, disclose, reproduce, and prepare derivative works, and to have, or permit others to have, use of any information contained in the concept paper submitted under each Component(s) of this APS. If USAID engages with the organization regarding its concept paper, the parties can negotiate further intellectual property protection for the organization's intellectual property. Organizations must ensure that any submission under all Component(s) of this APS is free of any third party proprietary data rights that would impact the license granted to USAID herein.

The goals of a co-creation workshop would likely be to explore and validate key challenges and problems, and then jointly develop promising solutions or adapt and expand upon existing solutions. Ideas described within the concept papers may be discussed and further developed in the workshop, but workshop thinking, and possible eventual full applications, will not be limited to these ideas.

Note: None of USAID's communication during the co-creation process in all Components of this APS should be interpreted as a commitment to making an award of USAID funding.

USAID envisages a product of the co-creation process to be a strong draft project description from each selected applicant/consortium for the full application phase, as well as quantitative and/or qualitative indicators or performance milestones. Note on additional partners/resources: Until full applications are submitted, both the applicant and USAID may identify and include potential additional technical partners and/or potential resource partners. All additional sub-partners may be included as part of a subsequent full application if there is an agreement to do so between the potential sub-partner, the original concept paper applicant, and USAID, but this is not guaranteed. Discussions with potential resource partners may continue throughout each Component's process and during implementation.

If an applicant does not succeed at the co-creation phase, the process ends for that applicant. USAID reserves the right to remove any co-creation participant from award consideration should the parties fail to reach agreement on activity concept, design, award terms, conditions, or cost/price within a reasonable time, the participant fails to provide requested additional information in a timely manner, or the U.S. Government believes it is in its best interest.

USAID also reserves the right to not conduct a co-creation phase and request full applications from successful applicants at the concept paper stage.

c) Full Application – Third Phase: If a proposed activity (submitted as a concept paper) meets the requirements of this APS as well as the Co-Creation requirements, an Applicant will be invited to submit a Full Application.

PHASE 3: FULL APPLICATION

Additional instructions and criteria for full application submissions will be provided after evaluation of concept papers and the co-creation workshop.

After the co-creation phase, if the Merit Review Committees decide full application(s) are warranted, full application instructions and criteria will be provided to the selected applicant(s). The NOFO/RFA will provide complete instructions for submission of a full application. The full application will detail and expand upon the concept(s) developed through co-creation. The full application also requires the applicant to complete specific USG forms and to provide additional information that USAID will need to move forward with an appropriate implementing instrument. All full applications will be reviewed for their technical merit against the full application merit review/evaluation criteria by the Merit Review Committee. Using its technical expertise, the Merit Review Committee may suggest revisions and additions to the proposed project as well as potential partners and resources. USAID will continue to have robust communication with applicants, potential partners, and other key stakeholders regarding the technical substance of the evolving approach, as well as the identity and roles of proposed or additional partners. USAID may request that key personnel of applicants deemed responsive and eligible deliver an oral presentation describing their proposed technical approach to inform the technical merit review.

If the Merit Review Committee selects application(s) for funding, its review will be shared with the Agreement Officer for cost analysis, final approval and award negotiation. During this stage, the Apparently Successful Applicant(s) and USAID can further refine the technical approach, and clarify general resource requirements, additional partner involvement, and management control of the project under the guidance of the Agreement Officer. The Apparently Successful Applicant(s) may also be asked to provide additional information about its technical approach, capacity, management and organization, proposed cost and budget, responsibility, and representations and certifications.

The Agreement Officer will engage in final review, negotiation, and determinations of award responsibility, and cost reasonableness, and will draft an assistance mechanism, to be reviewed by the Apparently Successful Applicant. Information regarding possible award provisions will be offered to the applicant, as well as the final award provisions when the award is drafted. USAID reserves the right to accept applications in their entirety or to select only portions of the application to award.

There are reasons why an applicant may be unsuccessful at the full application phase. For example:

- The application is not compliant with the request for full application, including (but not limited to) not adequately meeting the Merit Review Criteria
- The applicant refuses to sign the necessary certifications and representations, or does not agree to a mandatory provision, such as Protecting Life in Global Health Assistance;
- The applicant cannot provide evidence that it is a legal entity in the country or countries for which it is submitting an application; or
- USAID has other concerns after conducting due diligence or pre- award surveys.

USAID reserves the right to make no award under this APS or any Component at any stage of the process.

If requested to submit a full application, the applicant(s) (unless the applicant is an individual or Federal awarding agency that is excepted from those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the Federal awarding agency under 2 CFR 25.110(d)), is required to:

i. Be registered in SAM (System for Award Management) before submitting its application;

ii. Provide a valid DUNS (Data Universal Numbering System) number in its application; and

iii. Continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency.

USAID will not make a Federal award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time USAID is ready to make an award, USAID may determine that the

applicant is not qualified to receive a Federal award and use that determination as a basis for making a Federal award to another applicant.

Per 2 CFR Appendix I to Part 200, Full Text of the Notice of Funding Opportunity, Section E, 3, USAID informs all potential applicants:

i. That the Federal awarding agency [USAID], prior to making a Federal award with a total amount of Federal share greater than the simplified acquisition threshold, is required to review and consider any information about the applicant that is in the designated integrity and performance system accessible through SAM, currently Federal Awardee Performance and Integrity Information System (FAPIIS) (see 41 U.S.C. 2313);

ii. ii. That an applicant, at its option, may review information in the designated integrity and performance systems accessible through SAM and comment on any information about itself that a Federal awarding agency [USAID] previously entered and is currently in the designated integrity and performance system accessible through SAM;

iii. That the Federal awarding agency [USAID] will consider any comments by the applicant, in addition to the other information in the designated integrity and performance system, in making a judgment about the applicant's integrity, business ethics, and record of performance under Federal awards when completing the review of risk posed by applicants as described in CFR 200.205 Federal awarding agency review of risk posed by applicants."

Applicants must review, understand, and comply with all aspects of this APS. Failure to do so may be considered as being non-responsive and may be evaluated accordingly. Applicants should retain a copy of the application and all enclosures for their records.

4. Application Submission Procedures

Applications in response to this APS must be submitted no later than the closing date and time indicated on the cover letter, as amended. Late applications will not be reviewed nor considered. Applicants must retain proof of timely delivery in the form of system generated documentation of delivery receipt date and time/confirmation from the receiving office/certified mail receipt.

Email Submission:

Applications **must** be submitted by email to mroberto@usaid.gov and nawilane@usaid.gov with a copy to SenegalHealthAPS@usaid.gov. Email submissions must include the APS number and applicant's name in the subject line heading.

After submitting an application electronically, applicants should immediately check their own email to confirm that the attachments were indeed sent. If an applicant discovers an error in transmission, please send the material again and note in the subject line of the email or indicate in the file name if submitted via grants.gov that it is a "corrected" submission. Do not send the same

email more than once unless there has been a change, and if so, please note that it is a "corrected" email.

Applicants are reminded that e-mail is **NOT** instantaneous, and in some cases delays of several hours occur from transmission to receipt. Therefore, applicants are requested to send the application in sufficient time ahead of the deadline. For this APS, the initial point of entry to the government infrastructure is the USAID mail server.
There may be a problem with the receipt of *.zip files due to anti-virus software. Therefore, applicants are discouraged from sending files in this format as USAID/Senegal cannot guarantee their acceptance by the internet server.

Sample language for uploading to Grants.gov:

Applicants may upload applications to http://www.grants.gov. USAID bears no responsibility for data errors resulting from transmission or conversion processes associated with electronic submissions.

5. Technical Application Format

The information related to this section will be populated in the RFA (Full Application)]

6. Business (Cost) Application Format

The Business (Cost) Application must be submitted separately from the Technical Application. While no page limit exists for the full cost application, applicants are encouraged to be as concise as possible while still providing the necessary details. The business (cost) application must illustrate the entire period of performance, using the budget format shown in the SF-424A.

Prior to award, applicants may be required to submit additional documentation deemed necessary for the Agreement Officer to assess the applicant's risk in accordance with 2 CFR 200.205. Applicants should not submit any additional information with their initial application.

The Cost Application must contain the following sections (which are further elaborated below this listing with the letters for each requirement):

a) Cover Page (See Section D.3 above for requirements)

b) SF 424 Form(s)

The applicant must sign and submit the cost application using the SF-424 series. Standard Forms can be accessed electronically at www.grants.gov or using the following links:

Instructions for SF-424	http://www.grants.gov/web/grants/form-instructions/sf-424-instructions.html
Application for Federal Assistance (SF-424)	https://www.grants.gov/web/grants/forms/sf-424-family.html
Instructions for SF-424A	http://www.grants.gov/web/grants/form-instructions/sf-424a-instructions.html
Budget Information (SF-424A)	https://www.grants.gov/web/grants/forms/sf-424-family.html
Instructions for SF-424B	http://www.grants.gov/web/grants/form-instructions/sf-424b-instructions.html
Assurances (SF-424B)	https://www.grants.gov/web/grants/forms/sf-424-family.html

Failure to accurately complete these forms could result in the rejection of the application.

c) Required Certifications and Assurances

The applicant must complete the following documents and submit a signed copy with their full application/ upon request by the AO :

(1) "Certifications, Assurances, Representations, and Other Statements of the Recipient" document found at http://www.usaid.gov/sites/default/files/documents/1868/303mav.pdf
(2) Assurances for Non-Construction Programs (SF-424B)
(3) Certificate of Compliance: Please submit a copy of your Certificate of Compliance if your organization's systems have been certified by USAID/Washington's Office of Acquisition and Assistance (M/OAA).

d) Budget and Budget Narrative

The Budget must be submitted as one unprotected Excel file (MS Office 2000 or later versions) with visible formulas and references and must be broken out by project year, including itemization of the federal and non-federal (cost share) amount. Files must not contain any hidden or otherwise inaccessible cells. Budgets with hidden cells lengthen the cost analysis time required to make award, and may result in a rejection of the cost application. The Budget Narrative must contain sufficient detail to allow USAID to understand the proposed costs. The applicant must ensure the budgeted costs address any additional requirements identified in Section F, such as Branding and Marking. The Budget Narrative must be thorough, including sources for costs to support USAID's determination that the proposed costs are fair and reasonable.

The Budget must include the following worksheets or tabs, and contents, at a minimum:

- Summary Budget, inclusive of all program costs (federal and non-federal), broken out by major budget category and by year for activities implemented by the applicant and any potential sub-applicants for the entire period of the program.
- Detailed Budget, including a breakdown by year, sufficient to allow the Agency to determine that the costs represent a realistic and efficient use of funding to implement the applicant's program and are allowable in accordance with the cost principles found in 2 CFR 200 Subpart E.
- Detailed Budgets for each sub-recipient, for all federal funding and cost share, broken out by budget category and by year, for the entire implementation period of the project.

The Detailed Budget must contain the following budget categories and information, at a minimum:

1) Salaries and Allowances – Must be proposed consistent with 2 CFR 200.430 Compensation - Personal Services. The applicant's budget must include position title, salary rate, level of effort, and salary escalation factors for each position. Allowances, when proposed, must be broken down by specific type and by position. Applicants must explain all assumptions in the Budget Narrative. The Budget Narrative must demonstrate that the proposed compensation is reasonable for the services rendered and consistent with what is paid for similar work in other activities of the applicant. Applicants must provide their established written policies on personnel compensation. If the applicant's written policies do not address a specific element of compensation that is being proposed, the Budget Narrative must describe the rationale used and supporting market research.

2) Fringe Benefits – (if applicable) If the applicant has a fringe benefit rate approved by an agency of the U.S. Government, the applicant must use such rate and provide evidence of its approval. If an applicant does not have a fringe benefit rate approved, the applicant must propose a rate and explain how the applicant determined the rate. In this case, the Budget Narrative must include a detailed breakdown comprised of all items of fringe benefits (e.g., superannuation, gratuity, etc.) and the costs of each, expressed in U.S. dollars and as a percentage of salaries.

3) Travel and Transportation – Provide details to explain the purpose of the trips, the number of trips, the origin and destination, the number of individuals traveling, and the duration of the trips. Per Diem and associated travel costs must be based on the applicant's normal travel policies. When appropriate please provide supporting documentation as an attachment, such as company travel policy, and explain assumptions in the Budget Narrative.

4) Procurement or Rental of Goods (Equipment & Supplies), Services, and Real Property – Must include information on estimated types of equipment, models, supplies and the cost per unit and quantity. The Budget Narrative must include the purpose of the equipment and supplies and the basis for the estimates. The Budget Narrative must support the necessity of any rental costs and reasonableness in light of such factors as: rental costs of comparable property, if any; market conditions in the area; alternatives available; and the type, life expectancy, condition, and value of the property leased.

5) Subawards – Specify the budget for the portion of the program to be passed through to any subrecipients. See 2 CFR 200.330 for assistance in determining whether the sub-tier entity is a subrecipient or contractor. The subrecipient budgets must align with the same requirements as the applicant's budget, including those related to fringe and indirect costs.

6) Other Direct Costs – This may include other costs not elsewhere specified, such as report preparation costs, passports and visas fees, medical exams and inoculations, as well as any other miscellaneous costs which directly benefit the program proposed by the applicant. The applicant should indicate the subject, venue and duration of any proposed conferences and seminars, and their relationship to the objectives of the program, along with estimates of costs. Otherwise, the narrative should be minimal.

7) Indirect Costs – Applicants must indicate whether they are proposing indirect costs or will charge all costs directly. In order to better understand indirect costs please see Subpart E of 2 CFR 200.414. The application must identify which approach they are requesting and provide the applicable supporting information. Below are the most commonly used Indirect Cost Rate methods:

   Method 1 - Direct Charge Only
   Eligibility: Any applicant
   Initial Application Requirements: See above on direct costs

   Method 2 - Negotiated Indirect Cost Rate Agreement (NICRA)
   Eligibility: Any applicant with a NICRA issued by a USG Agency must use that NICRA
   Initial Application Requirements: If the applicant has a current NICRA, submit your approved NICRA and the associated disclosed practices. If your NICRA was issued by an Agency other than USAID, provide the contact information for the approving Agency. Additionally, at the Agency's discretion, a provisional rate may be set forth in the award subject to audit and finalization. See USAID's Indirect Cost Rate Guide for Non Profit Organizations for further guidance.

   Method 3 - De minimis rate of 10% of modified total direct costs (MTDC)
   Eligibility: Any applicant that has never received a NICRA
   Initial Application Requirements: Costs must be consistently charged as either indirect or direct costs, but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a non-Federal entity chooses to negotiate an indirect rate, which the non-Federal entity may apply to do at any time. The applicant must describe which cost elements it charges indirectly vs. directly. See 2 CFR 200.414(f) for further information.

   Method 4 - Indirect Costs Charged As A Fixed Amount
   Eligibility: Non U.S. non-profit organizations without a NICRA may request, but approval is at the discretion of the AO
   Initial Application Requirements: Provide the proposed fixed amount and a worksheet that includes the following:

- Indirect costs (common costs that benefit the day-to-day operations of the organization, including categories such as salaries and expenses of executive officers, personnel administration, and accounting, or that benefit and are identifiable to more than one program or activity, such as depreciation, rental costs, operations and maintenance of facilities, and telephone expenses) for the previous fiscal year and estimates for the current year
- Proposed method for prorating the indirect costs equitably and consistently across all programs and activities of using a base that measures the benefits of that particular cost to each program or activity to which the cost applies.

If the applicant does not have an approved NICRA and does not elect to utilize the 10% de minimis rate, the Agreement Officer will provide further instructions and may request additional supporting information, including financial statements and audits, should the application still be under consideration after the merit review. USAID is under no obligation to approve the applicant's requested method.

e) Prior Approvals in accordance with 2 CFR 200.407

Inclusion of an item of cost in the detailed application budget does not satisfy any requirements for prior approval by the Agency. If the applicant would like the award to reflect approval of any cost elements for which prior written approval is specifically required for allowability, the applicant must specify and justify that cost. See 2 CFR 200.407 for information regarding which cost elements require prior written approval.

e) Approval of Subawards

The applicant must submit information for all subawards that it wishes to have approved at the time of award. For each proposed subaward the applicant must provide the following:

- Name of organization
- DUNS Number
- Confirmation that the subrecipient does not appear on the Treasury Department's Office of Foreign Assets Control (OFAC) list
- Confirmation that the subrecipient does not have active exclusions in the System for Award Management (SAM)
- Confirmation that the subrecipient is not listed in the United Nations Security designation list
- Confirmation that the subrecipient is not suspended or debarred
- Confirmation that the applicant has completed a risk assessment of the subrecipient, in accordance with 2 CFR 200.331(b)
- Any negative findings as a result of the risk assessment and the applicant's plan for mitigation.

f) Dun and Bradstreet and SAM Requirements

USAID may not award to an applicant unless the applicant has complied with all applicable unique entity identifier (DUNS number) and System for Award Management (SAM) requirements. Each applicant (unless the applicant is an individual or Federal awarding agency that is exempted from requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the Federal awarding agency under 2 CFR 25.110(d)) is required to:

1. Provide a valid DUNS number for the applicant and all proposed sub-recipients;
2. Be registered in SAM before submitting its application. SAM is streamlining processes, eliminating the need to enter the same data multiple times, and consolidating hosting to make the process of doing business with the government more efficient (www.sam.gov).
3. Continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency.

The registration process may take many weeks to complete. Therefore, applicants are encouraged to begin the process early. If an applicant has not fully complied with the requirements above by the time USAID is ready to make an award, USAID may determine that the applicant is not qualified to receive an award and use that determination as a basis for making an award to another applicant.

DUNS number: http://fedgov.dnb.com/webform
SAM registration: http://www.sam.gov

Non-U.S. applicants can find additional resources for registering in SAM, including a Quick Start Guide and a video on how to obtain an NCAGE code, on www.sam.gov, navigate to Help, then to International Registrants.

g) History of Performance

The information related to this section will be populated in the RFA (Full Application)

h) Branding Strategy & Marking Plan

The apparently successful applicant will be asked to provide a Branding Strategy and Marking Plan to be evaluated and approved by the Agreement Officer and incorporated into any resulting award

Pre-Award Terms

1. Branding Strategy – Assistance (June 2012)

a. Applicants recommended for an assistance award must submit and negotiate a "Branding Strategy," describing how the program, project, or activity is named and positioned, and how it is promoted and communicated to beneficiaries and host country citizens.

b. The request for a Branding Strategy, by the Agreement Officer from the applicant, confers no rights to the applicant and constitutes no USAID commitment to an award.

c. Failure to submit and negotiate a Branding Strategy within the time frame specified by the Agreement Officer will make the applicant ineligible for an award.

d. The applicant must include all estimated costs associated with branding and marking USAID programs, such as plaques, stickers, banners, press events, materials, and so forth, in the budget portion of the application. These costs are subject to the revision and negotiation with the Agreement Officer and will be incorporated into the Total Estimated Amount of the grant, cooperative agreement or other assistance instrument.

e. The Branding Strategy must include, at a minimum, all of the following:

(1) All estimated costs associated with branding and marking USAID programs, such as plaques, stickers, banners, press events, materials, and so forth.

(2) The intended name of the program, project, or activity.

i. USAID requires the applicant to use the "USAID Identity," comprised of the USAID logo and brandmark, with the tagline "from the American people" as found on the USAID Web site at http://www.usaid.gov/branding, unless Section VI of the RFA or APS states that the USAID Administrator has approved the use of an additional or substitute logo, seal, or tagline.

ii. USAID prefers local language translations of the phrase "made possible by (or with) the generous support of the American People" next to the USAID Identity when acknowledging contributions.

iii. It is acceptable to cobrand the title with the USAID Identity and the applicant's identity.

iv. If branding in the above manner is inappropriate or not possible, the applicant must explain how USAID's involvement will be showcased during publicity for the program or project.

v. USAID prefers to fund projects that do not have a separate logo or identity that competes with the USAID Identity. If there is a plan to develop a separate logo to consistently identify this program, the applicant must attach a copy of the proposed logos. Section VI of the RFA or APS will state if an Administrator approved the use of an additional or substitute logo, seal, or tagline.

(3) The intended primary and secondary audiences for this project or program, including direct beneficiaries and any special target segments.

(4) Planned communication or program materials used to explain or market the program to beneficiaries.

i. Describe the main program message.

ii. Provide plans for training materials, posters, pamphlets, public service announcement, billboards, Web sites, and so forth, as appropriate.

iii. Provide any plans to announce and promote publicly this program or project to host country citizens, such as media releases, press conferences, public events, and so forth. Applicant must incorporate the USAID Identity and the message, "USAID is from the American People."

iv. Provide any additional ideas to increase awareness that the American people support this project or program.

(5) Information on any direct involvement from host-country government or ministry, including any planned acknowledgement of the host-country government.

(6) Any other groups whose logo or identity the applicant will use on program materials and related materials. Indicate if they are a donor or why they will be visibly acknowledged, and if they will receive the same prominence as USAID.

f. The Agreement Officer will review the Branding Strategy to ensure the above information is adequately included and consistent with the stated objectives of the award, the applicant's cost data submissions, and the performance plan.

g. If the applicant receives an assistance award, the Branding Strategy will be 4 included in and made part of the resulting grant or cooperative agreement

(END OF PRE-AWARD TERM BRANDING STRATEGY)

2. Marking Plan – Assistance (June 2012)

a. Applicants recommended for an assistance award must submit and negotiate a "Marking Plan," detailing the public communications, commodities, and program materials, and other items that will visibly bear the "USAID Identity," which comprises of the USAID logo and brandmark, with the tagline "from the American people." The USAID Identity is the official marking for the Agency and is found on the USAID Web site at http://www.usaid.gov/branding. Section VI of the RFA or APS will state if an Administrator approved the use of an additional or substitute logo, seal, or tagline.

b. The request for a Marking Plan, by the Agreement Officer from the applicant, confers no rights to the applicant and constitutes no USAID commitment to an award.

c. Failure to submit and negotiate a Marking Plan within the time frame specified by the Agreement Officer will make the applicant ineligible for an award.

d. The applicant must include all estimated costs associated with branding and marking USAID programs, such as plaques, stickers, banners, press events, materials, and so forth, in the budget portion of the application. These costs are subject to the revision and negotiation with the Agreement Officer and will be incorporated into the Total Estimated Amount of the grant, cooperative agreement or other assistance instrument.

e. The Marking Plan must include all of the following:

(1) A description of the public communications, commodities, and program materials that the applicant plans to produce and which will bear the USAID Identity as part of the award, including.

i. Program, project, or activity sites funded by USAID, including visible infrastructure projects or other sites physical in nature;

ii. Technical assistance, studies, reports, papers, publications, audiovisual productions, public service announcements, Web sites/Internet activities, promotional, informational, media, or communications products funded by USAID;

iii. Commodities, equipment, supplies, and other materials funded by USAID, including commodities or equipment provided under humanitarian assistance or disaster relief programs; and

iv. It is acceptable to cobrand the title with the USAID Identity and the applicant's identity.

v. Events financed by USAID, such as training courses, conferences, seminars, exhibitions, fairs, workshops, press conferences and other public activities. If the USAID Identity cannot be displayed, the recipient is encouraged to otherwise acknowledge USAID and the support of the American people.

(2) A table on the program deliverables with the following details:
i. The program deliverables that the applicant plans to mark with the USAID Identity;

ii. The type of marking and what materials the applicant will use to mark the program deliverables;

iii. When in the performance period the applicant will mark the program deliverables, and where the applicant will place the marking;

iv. What program deliverables the applicant does not plan to mark with the USAID Identity , and

v. The rationale for not marking program deliverables.

(3) Any requests for an exemption from USAID marking requirements, and an explanation of why the exemption would apply. The applicant may request an exemption if USAID marking requirements would:

i. Compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials. The applicant must identify the USAID Development Objective, Interim Result, or program goal furthered by an appearance of neutrality, or state why an aspect of the award is presumptively neutral. Identify by category or deliverable item, examples of material for which an exemption is sought.

ii. Diminish the credibility of audits, reports, analyses, studies, or policy recommendations whose data or findings must be seen as independent. The applicant must explain why each particular deliverable must be seen as credible.

iii. Undercut host-country government “ownership” of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, public service announcements, or other communications. The applicant must explain why each particular item or product is better positioned as host-country government item or product.

iv. Impair the functionality of an item. The applicant must explain how marking the item or commodity would impair its functionality.

v. Incur substantial costs or be impractical. The applicant must explain why marking would not be cost beneficial or practical.

vi. Offend local cultural or social norms or be considered inappropriate. The applicant must identify the relevant norm and explain why marking would violate that norm or otherwise be inappropriate.

vii. Conflict with international law. The applicant must identify the applicable international law violated by the marking.

f. The Agreement Officer will consider the Marking Plan's adequacy and reasonableness and will approve or disapprove any exemption requests. The Marking Plan will be reviewed to ensure the above information is adequately included and consistent with the stated objectives of the award, the applicant's cost data submissions, and the performance plan.

g. If the applicant receives an assistance award, the Marking Plan, including any approved exemptions, will be included in and made part of the resulting grant or cooperative agreement, and will apply for the term of the award unless provided otherwise.

(END OF PRE-AWARD TERM MARKING PLAN)

i) Funding Restrictions

Construction is not covered by an existing Initial Environmental Examination (IEE). Any proposed construction would require an update to the IEE. Relevant risk assessments must be completed before the awardee(s) can incur costs for any minor renovation work that does not qualify as construction. Also, USAID does not allow reimbursement of pre-award costs under any Round of this APS.

USAID will not allow the reimbursement of pre-award costs under this award without the explicit written approval of the Agreement Officer.

Except as may be specifically approved in advance by the AO, all commodities and services that will be reimbursed by USAID under this award must be from the authorized geographic code specified in Section B.4 of this NOFO and must meet the source and nationality requirements set forth in 22 CFR 228.

j) Conscience Clause

CONSCIENCE CLAUSE IMPLEMENTATION (ASSISTANCE) – PRE-AWARD TERM (February 2012)

(a) An organization, including a faith-based organization, that is otherwise eligible to receive funds under this agreement for HIV/AIDS prevention, treatment, or care—

1. Shall not be required, as a condition of receiving such assistance—

(i) to endorse or utilize a multisectoral or comprehensive approach to combating HIV/AIDS; or

(j) (ii) to endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the organization has a religious or moral objection; and

2. Shall not be discriminated against in the solicitation or issuance of grants, contracts, or cooperative agreements for refusing to meet any requirement described in paragraph (a)(1) above.

(b) An applicant who believes that this solicitation contains provisions or requirements that would require it to endorse or use an approach or participate in an activity to which it has a religious or moral objection must so notify the cognizant Agreement Officer in accordance with the Mandatory Standard Provision titled "Notices" as soon as possible, and in any event not later than 15 calendar days before the deadline for submission of applications under this solicitation. The applicant must advise which activity(ies) it could not implement and the nature of the religious or moral objection.

(c) In responding to the solicitation, an applicant with a religious or moral objection may compete for any funding opportunity as a prime partner, or as a leader or member of a consortium that comes together to compete for an award. Alternatively, such applicant may limit its application to those activities it can undertake and must indicate in its submission the activity(ies) it has excluded based on religious or moral objection. The offeror's proposal will be evaluated based on the activities for which a proposal is submitted, and will not be evaluated favorably or unfavorably due to the absence of a proposal addressing the activity(ies) to which it objected and which it thus omitted. In addition to the notification in paragraph (b) above, the applicant must meet the submission date provided for in the solicitation.

(END OF PRE-AWARD TERM CONSCIENSE CLAUSE)

k) Conflict of Interest Pre-Award Term

CONFLICT OF INTEREST PRE-AWARD TERM (August 2018)

a. Personal Conflict of Interest 1. An actual or appearance of a conflict of interest exists when an applicant organization or an employee of the organization has a relationship with an Agency official involved in the competitive award decision-making process that could affect that Agency official's impartiality. The term "conflict of interest" includes situations in which financial or other personal considerations may compromise, or have the appearance of compromising, the obligations and duties of a USAID employee or recipient employee.

2. The applicant must provide conflict of interest disclosures when it submits an SF-424. Should the applicant discover a previously undisclosed conflict of interest after submitting the application, the applicant must disclose the conflict of interest to the AO no later than ten (10) calendar days following discovery.

b. Organizational Conflict of Interest The applicant must notify USAID of any actual or potential conflict of interest that they are aware of that may provide the applicant with an unfair competitive advantage in competing for this financial assistance award. Examples of an unfair competitive advantage include but are not limited to situations in which an applicant or the applicant's employee gained access to non-public information regarding a federal assistance funding opportunity, or an applicant or applicant's employee was substantially involved in the

preparation of a federal assistance funding opportunity. USAID will promptly take appropriate action upon receiving any such notification from the applicant.

(END OF PRE-AWARD TERM CONFLICT OF INTEREST)

[END OF SECTION D]

SECTION E: APPLICATION REVIEW INFORMATION

1. Criteria

The information related to this section will be populated in the RFA (Full Application)]

2. Review and Selection Process

The information related to this section will be populated in the RFA (Full Application)]

a) Merit Review

The information related to this section will be populated in the RFA (Full Application)]

b) Business Review

The Agency will evaluate the cost application of the applicant(s) under consideration for an award as a result of the merit criteria review to determine whether the costs are allowable in accordance with the cost principles found in 2 CFR 200 Subpart E.

The Agency will also consider (1) the extent of the applicant's understanding of the financial aspects of the program and the applicant's ability to perform the activities within the amount requested; (2) whether the applicant's plans will achieve the program objectives with reasonable economy and efficiency; and (3) whether any special conditions relating to costs should be included in the award.

Proposed cost share, if provided, will be reviewed for compliance with the standards set forth in 2 CFR 200.306, 2 CFR 700.10, and the Standard Provision "Cost Sharing (Matching)" for U.S. entities, or the Standard Provision "Cost Share" for non-U.S. entities.

The AO will perform a risk assessment (2 CFR 200.205). The AO may determine that a pre-award survey is required to inform the risk assessment in determining whether the prospective recipient has the necessary organizational, experience, accounting and operational controls, financial resources, and technical skills – or ability to obtain them – in order to achieve the objectives of the program and comply with the terms and conditions of the award. Depending on the result of the risk assessment, the AO will decide to execute the award, not execute the award, or award with “specific conditions” (2 CFR 200.207).

[END OF SECTION E]

SECTION F: FEDERAL AWARD ADMINISTRATION INFORMATION

1. Federal Award Notices

Award of the agreement contemplated by this APS cannot be made until funds have been appropriated, allocated and committed through internal USAID procedures. While USAID anticipates that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for the award.

2. Administrative & National Policy Requirements

The resulting award from this NOFO will be administered in accordance with the following policies and regulations.

For US organizations: ADS 303, 2 CFR 700, 2 CFR 200, and Standard Provisions for U.S. Non-governmental organizations.

For Non US organizations: Standard Provisions for Non-U.S. Non-governmental Organizations.

See **Annex 2**, for a list of the Standard Provisions that will be applicable to any awards resulting from this NOFO.

3. Reporting Requirements

- **Financial Reporting:**

The Recipient shall submit quarterly financial reports using the SF 425 in keeping with 22 CFR 22T6.52. Electronic submission is preferred. The SF 425 shall be submitted to the Agreement Officer Representative (AOR).

The Recipient will submit electronic copies of Financial Reports in keeping with 2 CFR 200 and 2 CFR 700. The Financial reports must be submitted via electronic format to the cognizant Mission Financial Payments office at **dakarusaidofmfinancialanalysts@usaid.gov**. In addition, copies of all financial reports should be submitted to the Mission Controller, Agreement Officer (AO), and the Agreement Officer's Representative (AOR). The recipient will be expected to submit monthly financial reports. In addition, a complete quarterly, semi-annual and annual Expenditure Report .

Financial Reports	Quarterly: Before each contract modification; and in the first week of the last month of the fiscal year quarter	The Contractor must provide pipeline and financial reports to the COR: (i) on a quarterly basis; (ii) before each contract modification/incremental funding; and (iii) accruals information no later than the 15th of March, June, September and December of each year, covering the periods through the end of the reporting quarter. Financial and pipeline reports must separate by funding type (PEPFAR funding and other funding). The reports must show the fiscal year approved budget against actual and projected spend by quarter over the fiscal year and the remaining amount for the fiscal year. They must also show obligated funds against actual expenditures.

- **Performance Reporting**

Annual reports: The annual report is due within 90 calendar days after the reporting period the end of the first full USAID fiscal year and annually thereafter for each authorized year of performance. The Annual Performance Report follows the same format as the quarterly report, but with additional focus on cumulative accomplishments, progress and problems toward achievement of results, performance measures, indicators and benchmarks tied to the Annual Work Plan and the MEP targets, for the quarter and the entire previous fiscal year, which runs from October 1-September 30.

[END OF SECTION F]

SECTION G: FEDERAL AWARDING AGENCY CONTACT(S)

Questions regarding this APS should be submitted electronically through e-mail to: mroberto@usaid.gov and nawilane@usaid.gov with a copy to SenegalHealthAPS@usaid.gov no later than the date and time indicated on the cover letter of this APS or as amended.

[END OF SECTION G]

SECTION H: OTHER INFORMATION

USAID reserves the right to fund any or none of the applications submitted. The Agreement Officer is the only individual who may legally commit the Government to the expenditure of public funds. Any award and subsequent incremental funding will be subject to the availability of funds and continued relevance to Agency programming.

Concept Papers and Proprietary Data

Proprietary Data should not be included at the Concept Note Stage as USAID intends to discuss and share concepts notes during co-creation.

Full Applications and Proprietary Data

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

> "This application includes data that must not be disclosed duplicated, used, or disclosed – in whole or in part – for any purpose other than to evaluate this application. If, however, an award is made as a result of – or in connection with – the submission of this data, the U.S. Government will have the right to duplicate, use, or disclose the data to the extent provided in the resulting award. This restriction does not limit the U.S. Government's right to use information contained in this data if it is obtained from another source without restriction. The data subject to this restriction are contained in sheets {insert sheet numbers}."

Additionally, the applicant must mark each sheet of data it wishes to restrict with the following:

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

[END OF SECTION H]

ANNEX 1 - SUMMARY BUDGET TEMPLATE

The information related to this section will be populated in the RFA (Full Application)]

[END OF ANNEX 1]

ANNEX 2 - STANDARD PROVISIONS

(Note: the full text of these provisions may be found at: https://www.usaid.gov/ads/policy/300/303maa and https://www.usaid.gov/ads/policy/300/303mab). The actual Standard Provisions included in the award will be dependent on the organization that is selected. The award will include the latest Mandatory Provisions for either U.S. or non-U.S. Nongovernmental organizations**.** The award will also contain the following "required as applicable" Standard Provisions:

REQUIRED AS APPLICABLE STANDARD PROVISIONS FOR U.S. NONGOVERNMENTAL ORGANIZATIONS

Required	Not Required	Standard Provision
TBD		RAA1. NEGOTIATED INDIRECT COST RATES - PREDETERMINED (DECEMBER 2014)
		RAA2. NEGOTIATED INDIRECT COST RATES - PROVISIONAL (Nonprofit) (DECEMBER 2014)
		RAA3. NEGOTIATED INDIRECT COST RATE - PROVISIONAL (Profit) (DECEMBER 2014)
		RAA4. INDIRECT COSTS – DE MINIMIS RATE (MAY 2020)
		RAA5. EXCHANGE VISITORS AND PARTICIPANT TRAINING (JUNE 2012)
		RAA6. VOLUNTARY POPULATION PLANNING ACTIVITIES – SUPPLEMENTAL REQUIREMENTS (JANUARY 2009)
		RAA7. PROTECTION OF THE INDIVIDUAL AS A RESEARCH SUBJECT (APRIL 1998)
		RAA8. CARE OF LABORATORY ANIMALS (MARCH 2004)
		RAA9. TITLE TO AND CARE OF PROPERTY (COOPERATING COUNTRY TITLE) (NOVEMBER 1985)
		RAA10. COST SHARING (MATCHING) (FEBRUARY 2012)
		RAA11. PROHIBITION OF ASSISTANCE TO DRUG TRAFFICKERS (JUNE 1999)
		RAA12. INVESTMENT PROMOTION (NOVEMBER 2003)
		RAA13. REPORTING HOST GOVERNMENT TAXES (DECEMBER 2014)
		RAA14. FOREIGN GOVERNMENT DELEGATIONS TO INTERNATIONAL CONFERENCES (JUNE 2012)
		RAA15. CONSCIENCE CLAUSE IMPLEMENTATION (ASSISTANCE) (FEBRUARY 2012)
		RAA16. CONDOMS (ASSISTANCE) (SEPTEMBER 2014)
		RAA17. PROHIBITION ON THE PROMOTION OR ADVOCACY OF THE LEGALIZATION OR PRACTICE OF PROSTITUTION OR SEX TRAFFICKING (ASSISTANCE) (SEPTEMBER 2014)
		RAA18. USAID DISABILITY POLICY - ASSISTANCE (DECEMBER 2004)
		RAA19. STANDARDS FOR ACCESSIBILITY FOR THE DISABLED IN USAID ASSISTANCE AWARDS INVOLVING CONSTRUCTION (SEPTEMBER 2004)
		RAA20. STATEMENT FOR IMPLEMENTERS OF ANTI-TRAFFICKING ACTIVITIES ON LACK OF SUPPORT FOR PROSTITUTION (JUNE 2012)
		RAA21. ELIGIBILITY OF SUBRECIPIENTS OF ANTI-TRAFFICKING FUNDS (JUNE 2012)

		RAA22. PROHIBITION ON THE USE OF ANTI-TRAFFICKING FUNDS TO PROMOTE, SUPPORT, OR ADVOCATE FOR THE LEGALIZATION OR PRACTICE OF PROSTITUTION (JUNE 2012)
		RAA23. UNIVERSAL IDENTIFIER AND SYSTEM OF AWARD MANAGEMENT (July 2015)
		RAA24. REPORTING SUBAWARDS AND EXECUTIVE COMPENSATION (DECEMBER 2014)
		RAA25. PATENT REPORTING PROCEDURES (DECEMBER 2014)
		RAA26. ACCESS TO USAID FACILITIES AND USAID'S INFORMATION SYSTEMS (AUGUST 2013)
		RAA27. CONTRACT PROVISION FOR DBA INSURANCE UNDER RECIPIENT PROCUREMENTS (DECEMBER 2014)
		RAA28. AWARD TERM AND CONDITION FOR RECIPIENT INTEGRITY AND PERFORMANCE MATTERS (April 2016)
		RAA29. PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE (MAY 2017)
		RAA30. Program Income (August 2020)

REQUIRED AS APPLICABLE STANDARD PROVISIONS FOR NON-U.S. NONGOVERNMENTAL ORGANIZATIONS

Required	Not Required	Standard Provision
TBD		RAA1. ADVANCE PAYMENT AND REFUNDS (DECEMBER 2014)
		RAA2. REIMBURSEMENT PAYMENT AND REFUNDS (DECEMBER 2014)
TBD		RAA3. INDIRECT COSTS – NEGOTIATED INDIRECT COST RATE AGREEMENT (NICRA) (DECEMBER 2014)
		RAA4. INDIRECT COSTS – CHARGED AS A FIXED AMOUNT (NONPROFIT) (JUNE 2012)
		RAA5. INDIRECT COSTS – DE MINIMIS RATE (MAY 2020)
		RAA6. UNIVERSAL IDENTIFIER AND SYSTEM OF AWARD MANAGEMENT (July 2015)
		RAA7. REPORTING SUBAWARDS AND EXECUTIVE COMPENSATION (DECEMBER 2014)
		RAA8. SUBAWARDS (DECEMBER 2014)
		RAA9. TRAVEL AND INTERNATIONAL AIR TRANSPORTATION (DECEMBER 2014)
		RAA10. OCEAN SHIPMENT OF GOODS (JUNE 2012)
		RAA11. REPORTING HOST GOVERNMENT TAXES (JUNE 2012)
		RAA12. PATENT RIGHTS (JUNE 2012)
		RAA13. EXCHANGE VISITORS AND PARTICIPANT TRAINING (JUNE 2012)
		RAA14. INVESTMENT PROMOTION (NOVEMBER 2003)
		RAA 15. COST SHARE (JUNE 2012)
		RAA16. PROGRAM INCOME (AUGUST 2020)
		RAA17. FOREIGN GOVERNMENT DELEGATIONS TO INTERNATIONAL CONFERENCES (JUNE 2012)
		RAA18. STANDARDS FOR ACCESSIBILITY FOR THE DISABLED IN USAID ASSISTANCE AWARDS INVOLVING CONSTRUCTION (SEPTEMBER 2004)

		RAA19. PROTECTION OF HUMAN RESEARCH SUBJECTS (JUNE 2012)
		RAA20. STATEMENT FOR IMPLEMENTERS OF ANTI-TRAFFICKING ACTIVITIES ON LACK OF SUPPORT FOR PROSTITUTION (JUNE 2012)
		RAA21. ELIGIBILITY OF SUBRECIPIENTS OF ANTI-TRAFFICKING FUNDS (JUNE 2012)
		RAA22. PROHIBITION ON THE USE OF ANTI-TRAFFICKING FUNDS TO PROMOTE, SUPPORT, OR ADVOCATE FOR THE LEGALIZATION OR PRACTICE OF PROSTITUTION (JUNE 2012)
		RAA23. VOLUNTARY POPULATION PLANNING ACTIVITIES – SUPPLEMENTAL REQUIREMENTS (JANUARY 2009)
		RAA24. CONSCIENCE CLAUSE IMPLEMENTATION (ASSISTANCE) (FEBRUARY 2012)
		RAA25. CONDOMS (ASSISTANCE) (SEPTEMBER 2014)
		RAA26. PROHIBITION ON THE PROMOTION OR ADVOCACY OF THE LEGALIZATION OR PRACTICE OF PROSTITUTION OR SEX TRAFFICKING(ASSISTANCE) (SEPTEMBER 2014)
		RAA27. LIMITATION ON SUBAWARDS TO NON-LOCAL ENTITIES (JULY 2014)
		RAA28. CONTRACT PROVISION FOR DBA INSURANCE UNDER RECIPIENT PROCUREMENTS (DECEMBER 2014)
		RAA29. CONTRACT AWARD TERM AND CONDITION FOR RECIPIENT INTEGRITY AND PERFORMANCE MATTERS (April 2016)
		RAA30. PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE (MAY 2017)

[END OF STANDARD PROVISIONS]

[END OF ANNEX 2]

ANNEX 3 - ABBREVIATIONS AND ACRONYMS

AIDS - Acquired immunodeficiency syndrome
AO - Agreement Officer

AOR - Agreement Officer Representative

APS - Annual Program Statement

ASA - Apparently Successful Applicant

CBO - Community based Organizations

CDCS - Country Development Cooperation Strategy

CDP - Comite de Pilotage

CFDA - Catalog of Federal Domestic Assistance

CFR - Council on Foreign Relations

CHU - Cheick Anta Diop University Hospital Center

CLA - Collaborating, Learning, and Adapting

CMU - Universal Health Coverage

CRV - Regional Audit Committed

CSOs - Civil Society Organizations

DEC - Development Experience Clearinghouse

DG - Democracy and Governance

DHIS - District Health Information Systems

DIEM - Directorate for infrastructure, equipment and maintenance

DLP - Directorate for pharmacies and laboratories

DO - Development Objective

DRG - Democracy Human Right and Governance

DSDOM - Dispensateur de soins a domicile

DUNS - Data Universal Numbering System

ENA - Essential Nutrition Actions

EPPR - Effective Partnering and procurement reform

FAA - Foreign Assistance Act

FAPIIS - Federal Awardee Performance and Integrity Information System

FBO - Faith based Organizations

FGM/C - Female genital mutilation and cutting

FP - Family Planning

G2G - Government to Government Assistance

GBV - Gender based Violence

GHSA - Global Health Security Agenda

GLAAS - Global Acquisition and Assistance System

GOLD - Governance for local development

GOS - Government of Senegal

HHS - Department of Health and Human Services

HPNO - Health Population Nutrition Office

HRH - Human Resources for Health

IDH - Integrated District Health

IEE - Initial Environmental Examination

iHRIS - Integrated Human Resource Information System

IPS - Implementing Partners

IPTP - Intermittent preventive treatment in pregnancy

IR - Intermediate Result

JICA- Japanese International Cooperation Agency

LLIN - Long lasting insecticide treated nets

LOE - Level of effort

LuxDev - Luxemburg Development Agency

M - Malaria

MDSR - Maternal death surveillance response

MELP - Monitoring, Evaluation and Learning Plan

MRC - Merit Review Committee

MSM - Men who have sex with men

NCAGE - Code Request Tool

NOFO - Notice of Funding Opportunity

NPI GH - New partnerships initiative for global health

NTD - Neglected Tropical diseases

NTDs - Neglected Tropical Diseases

NUT - Nutrition

OFAC - Office of Foreign Assets Control

PAR - Participatory Action Research

PEPFAR: President's Emergency Plan For AIDS Relief

PMI - President Malaria Initiative

PNA - National Supply Pharmacy

PNDSS - Plan National de Development Sanitaire et Social

POC - Point of Contact

PSE - Plan Senegal Emergent

PTA - Plan de travail annuel

RFA - Request for Applications

RLO - Regional Legal Office

RMNCAH - Reproductive, Maternal, Newborn, Child and adolescent Health

SAM - System for Award Management

SBC - Social and behavior change

SC - Selection Committee

SMC - Seasonal malaria chemoprevention

SNEIPS - National service for health education and information

TA - Technical Assistance

UHC - Universal Health Coverage

UNICEF - United Nations Children Fund

USG - United States Government

VAT - Value Added Tax

WASH - Water, Sanitation and Hygiene

WHO - World Health Organization

[END OF ANNEX 3]

ANNEX 4 - APS SCHEMA

See Separate File

[END OF ANNEX 4]

ANNEX 5 - INITIAL ENVIRONMENTAL EXAMINATION

See Separate File

[END OF ANNEX 5]

ANNEX 6 - CLIMATE RISK MANAGEMENT

See Separate File

[END OF ANNEX 6]

----------[END OF APS]----------