Attachment II: Proposed Draft Uganda Health Activity (UHA) Program Description and Key Personnel Requirements

A1. Introduction

USAID/Uganda seeks to award a five-year, approximately $170 million cooperative agreement to increase the survival and well-being of vulnerable populations and improve overall health system resilience in priority districts. UHA will achieve this goal through three intermediate results (IRs):

1) Improved access to and use of quality maternal, newborn, and child health (MNCH); family planning (FP)/reproductive health (RH); nutrition; and water, sanitation, and hygiene (WASH) health services at community- and health facility-levels.
2) Enhanced local ownership and leadership for sustainable health outcomes.
3) Strengthened health systems at the regional-, district-, facility-, and community-levels.

UHA will focus its activities primarily at the regional level and below, strengthening the quality and availability of MNCH, FP/RH, nutrition, and facility-level WASH services in a subset of focal districts surrounding seven regional referral hospitals (RRHs) in Gulu, Jinja, Kabale, Lira, Mbale, Mbarara, and Moroto. UHA will also provide additional district-level health systems strengthening (HSS) technical support in a further 72 districts where PEPFAR local implementing partners (IPs) operate nationally to enhance and leverage HIV/AIDS outcomes and sustainability. UHA marks a strategic shift in USAID's previous integrated health support. It builds on promising practices identified from recent USAID Regional Health Integration to Enhance Services (RHITES) programming, while incorporating new elements of integration and local ownership. The activity includes a greater focus on building the capacity, sustainability, and resilience of local governments and local partner institutions to deliver evidence-based and high quality MNCH, FP/RH, nutrition, facility-level WASH, and HIV/AIDS services at both facility- and community-levels. This is reflected in part through UHA's focus on strengthening the capacity of RRHs to fulfill their oversight and health quality improvement mandate, in line with Government of Uganda (GoU) objectives and coaching local PEPFAR IPs to more effectively lead epidemic control responses.

Increased coordination and functional collaboration will be critical to success in implementing UHA, given the interlocking nature of U.S. government (USG) health investments. As detailed in Section A5, expected collaboration includes work with: 1) Specific PEPFAR local IPs and GoU RRHs in priority regions (leveraging USG government-to-government [G2G] investments); 2) Above-site USAID national health mechanisms; and 3) Allied multi sectoral development programming, such as food security, livelihoods, resilience, and women's empowerment activities. UHA fully aligns with and supports the GoU's ambitious goals for improved health outcomes and health decentralization, as outlined in the new third National Health Policy (NHP III). The activity will also accelerate progress toward three Development Objectives within USAID/Uganda's Country Development Cooperation Strategy (CDCS).

A2. Background

Uganda has succeeded in accelerating reductions in maternal, newborn, and child mortality during the past decade, despite resource gaps and health systems stressors. The Ministry of Health (MoH) expanded coverage of high-impact primary healthcare (PHC) interventions in all regions during this period. Nearly all pregnancy and birth-related indicators improved during 2016-2019, including uptake of antenatal care (ANC), facility-based delivery, and post-natal care (PNC).[1] Full immunization coverage

[1] MoH. *Endline Review of the Investment Case for RMNCAH Sharpened Plan in Uganda, 2015/16-2019/20*. June 2020.

also increased from 59% to 64%. As a result, under-five mortality declined from 90/1,000 live births to 64/1,000 live births from 2011-2016,[2] and institutional maternal mortality appears to be falling.[3]

The MoH's vision for universal health coverage and health sector decentralization has helped enable this progress, spurring GoU commitments to increase the availability of quality healthcare at the community-level. The GoU's new Parish Development Model offers further potential for achieving health and socio-economic transformation among households living in the last mile. USAID's accompanying MNCH, FP/RH, nutrition, WASH, and HIV/TB health investments–including RHITES and above-site HSS activities–have helped drive concurrent service delivery and systems-focused improvements.

Yet despite the momentum, MNCH, FP/RH, and nutrition progress remains far below National Development Plan III (NDP III) 2024/25 targets. Maternal mortality remains very high at 336 deaths/100,000 live births.[4] Neonatal mortality is largely stagnant and accounts for 42% of all under-five deaths. Only 31% of health centers have basic water and 12% have basic sanitation, inhibiting effective infection prevention and control (IPC) and quality of care outcomes.[5] Nearly half of children under five years and a third of women of reproductive age are anemic,[6] increasing their respective risk for impaired cognitive and social functioning and adverse pregnancy and birth outcomes. Little progress has been made on increasing exclusive breastfeeding and dietary diversity of children.[7] While the modern contraceptive prevalence rate (mCPR) increased from 24.6% to 30.4% among all women between 2015-2020,[8] adolescent childbearing has decreased little due to harmful gender and sociocultural norms and economic challenges. The COVID-19 pandemic threatens to reverse progress. Studies showed sharp declines in MNCH, FP/RH, and nutrition service delivery, uptake and corresponding increases in maternal and under-five morbidity and mortality, likely due to delayed care-seeking behavior.[9]

Throughout, progress also remains uneven and fragile across UHA sub-regions, reflecting inequities in access to quality care and largely dysfunctional subnational health systems. Health improvement efforts remain largely fragmented at district level and with different providers working in parallel to the MoH. Rising internal insecurity, coupled with the continued threat of COVID-19 resurgences, may further strain Uganda's heavily donor-dependent health system and contribute to backsliding.

Context of USAID Support

USAID/Uganda is committed to supporting the GoU to successfully operationalize and achieve its transformative vision of a healthy and productive population that contributes to socio-economic growth and national development. Aligned to the five NHP III priority areas, UHA is designed to help communities and the GoU increase access to evidence-based preventive and curative PHC services.

USAID expects that the UHA implementer will incorporate and build upon lessons learned from the past five-plus years of implementation of its suite of five RHITES activities, implemented in Southwest, East, East-Central, North-Lango, and North-Acholi regions. These activities, which have reached or will reach completion in 2023, aimed to enhance integrated health services for HIV, malaria, TB, MNCH, FP/RH, and nutrition. The RHITES activities also support the transition of HIV epidemic control service

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[2] UBOS and ICF. *Uganda Demographic and Health Survey 2016*. 2018.

[3] Institutional maternal mortality was below 100 per 100,000 health facility deliveries in 2019 according to DHIS2 data, but data on maternal death audits showed higher mortality.

[4] UBOS and ICF. *Uganda Demographic and Health Survey 2016*. 2018.

[5] WHO and UNICEF. WASH in health care facilities: Global Baseline Report. 2019.

[6] MoH. *Endline Review of the Investment Case for RMNCAH Sharpened Plan in Uganda, 2015/16-2019/20*. June 2020.

[7] UBOS and ICF. *Uganda Demographic and Health Survey 2016*. 2018.

[8] FP2020. *Uganda Core Indicator Summary Sheet: 2019-2020 Annual Progress Report*. 2020.

[9] Burt JF, et al. *Indirect effects of COVID-19 on maternal, neonatal, child, SRH services in Kampala*. BMJ Global Health. 2021.

delivery activities to new local IPs in each region to increase sustainability. USAID/Uganda expects that UHA will successfully transition relevant RHITES activities, while adding new elements per below. In July 2021 USAID/Uganda's Office of Health and HIV commissioned the Uganda Learning Activity (ULA) to conduct an in-depth desk review of the RHITES integrated health activity portfolio to inform UHA design. The review identified five key barriers and five key facilitators to success, which USAID/Uganda expects the awardee will adopt/scale-up in UHA. Among the findings, UHA should:

- Adopt a HSS focus to complement facility-level interventions, including interventions to strengthen supply chain management and coordination at district- and community level.
- Improve district- and community-level data quality, collection, and use capacity, including integrating community data within the health management information system (HMIS).
- Strengthen local capacity to design and scale-up the implementation of gender-sensitive and -transformative interventions to address underlying health inequities.
- Stimulate community and provider behaviors that encourage health-seeking behaviors.
- Expand subnational leadership/governance interventions at RRHs and district-level.
- Increase functional collaboration at community level between UHA and non-health activities (e.g., food security, economic growth, education, youth, etc.).

Relevant additional bottlenecks to be addressed by UHA include:
1) Challenge: One-size-fits-all technical assistance (TA) fails to help districts adapt and deploy health interventions appropriate for their local context. UHA priority sub-regions each feature unique epidemiological, health system, socio-cultural, economic, and environmental characteristics that necessitate customized TA. Karamoja and Acholi sub-regions, for example, each feature higher stunting rates than their counterparts nationally, indicating needs for increased attention to multisectoral interventions. Districts require more tailored mentorship that will enable them to use data to effectively customize and resource work plans based upon local context to address equity gaps.

2) Challenge: Health facilities struggle to operationalize quality improvement (QI) and achieve improved quality of care. USAID and GoU programs have succeeded in building healthcare worker (HCW) skills in MNCH, FP/RH, nutrition, and IPC. Yet prematurity, sepsis, and asphyxia still remain leading causes of maternal and infant death in most regions. Districts and health facilities require support in scaling-up and institutionalizing QI efforts to address the most intractable challenges to quality of care. To date, most district- and facility-level QI efforts have focused primarily on HIV, leaving gaps in MNCH, FP/RH, nutrition, and facility-level IPC performance. QI initiatives also remain primarily "top down," with QI priorities mandated from national level to sites. This suppresses the development of a local QI culture at facilities and the development of innovative local quality of care change ideas.

3) Challenge: Priority sub-regions and their surrounding districts vary in their ability to fully plan, coordinate, resource, and sustain PHC interventions. Hands-on clinical skills building alone is insufficient to create lasting improvements in service availability and quality of care. Target sub-regions and districts require high-impact HSS TA to accelerate progress toward and sustain health outcome achievement. While decentralization reforms are underway via the MOH's RRH-focused Hub and Spoke Model, most RRHs and their corresponding districts do not have the planning, data, or domestic financing capacity to lead a PHC response in the absence of partners, impeding progress toward the full health leadership envisaged by the NDP III. Critical district sustainability barriers include gaps in: 1) planning and coordination; 2) supply chain management; 3) data collection, analysis, and use to drive decision-making; 4) health workforce performance and management; and 5) health financing. In addition, many health facilities require remodeling and refurbishment to meet minimum MNCH and facility-WASH infrastructure standards and reinforce quality of care.

4) Challenge: Districts struggle to engage communities effectively in health promotion, service delivery, and oversight. Despite recent robust policies, districts face challenges in delivering

health services that are accountable and responsive to client needs. Community participation is frequently absent in district and health facility planning and review processes, weakening accountability and feedback on health service delivery. Health Unit Management Committees (HUMCs) are promising mechanisms to facilitate community engagement, but they face representation, capacity, and funding limitations. In addition, districts require greater TA in designing, adapting, and scaling social and behavioral change (SBC) interventions that increase uptake of positive health behaviors and drive facility-level care seeking.

5) Challenge: Community PHC service delivery requires scale-up. Community service delivery and self-care interventions offer great promise for increased coverage and promotion of positive health behaviors. Yet community health service delivery challenges are acute, including in the motivation, remuneration, training, and supervision of community volunteers. Despite a goal of two functioning village health teams (VHTs) per village, many districts fail to reach that threshold. While PMI has begun scaling-up integrated community case management (iCCM) in 13 high burden districts, coverage is uneven.[10] Those VHTs that do exist must deliver an ever-expanding menu of integrated health services and messages. To address these issues, the MoH has announced the planned roll out of a Community Health Extension Worker (CHEW) program and has increasingly prioritized community health activities.

6) Challenge: PEPFAR local IPs require tailored technical support to realize their full program management and service delivery functions. While the RHITES activities are transitioning direct service delivery, many recipients' local IPs possess varied organizational management, technical capacity, and operational gaps that will impede them from achieving and sustaining their targets. PEPFAR local IPs generally work in geographic silos, due in part to the nature of the segmented RHITES awards. This prevents the sharing of local HIV innovations across geographies and IPs.

Harnessing previous learning and the ingenuity, innovations, and persistence of Ugandan HCWs, local partners, and communities will be critical to surmounting the challenges above and creating a more responsive and resilient community health system. Leading opportunities under UHA include:

- Leveraging the RRH platform to play a critical role in decentralizing health services, in alignment with GoU strategy and PEPFAR G2G investments.
- Enhancing functional collaboration between UHA and USAID's above-site health investments and district-level multi-sectoral programming, including the Parish Development Model.
- Facilitating active collaboration, learning, and adapting (CLA) among local IPs to ensure best practices are shared across different regions.
- Leveraging results-based financing (RBF) and Global Fund (GF) funding and domestic resource mobilization efforts to meet infrastructure, human resource, and supply chain gaps, gradually transitioning away from reliance on donor and out-of-pocket funding.
- Scaling successful COVID-19 adaptations and innovations that enhanced continuity of MNCH, FP/RH, nutrition, facility-level WASH, and HIV services.

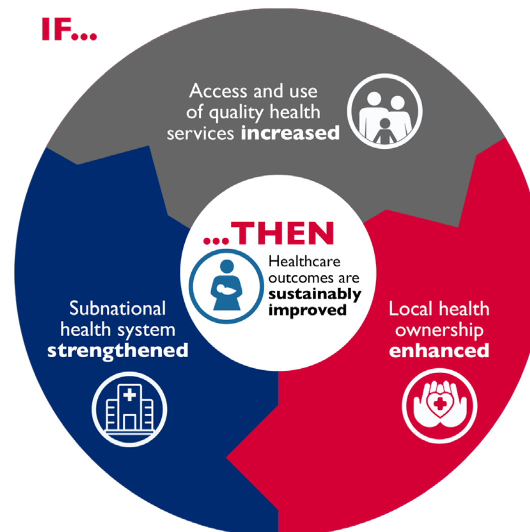
A3. Intended Results

Inadequate access to and use of quality healthcare, combined with poor health-seeking behaviors and a sub-optimally performing PHC system, leads to inequitable health and nutrition outcomes. This compromises Uganda's ability to scale quality healthcare and sustainably improve the health of its population. UHA seeks to address these challenges, and achieve its activity **purpose** to increase the survival and well-being of vulnerable populations and improve health system resilience in priority districts. USAID's **vision** is that the Ugandan government, local partners, and communities achieve and sustain transformative health outcomes for Uganda's most vulnerable. This is reflected in the UHA

[10] MoH/GF/PACE. *Implementation of iCCM Study in Uganda*. PowerPoint. Jan. 2021.

theory of change (Figure 1), which articulates a change pathway that will contribute to the achievement of the UHA purpose.

Figure 1: UHA Theory of Change



UHA's three foundational theory of change pillars–increased health access and quality, enhanced local ownership, strengthened local health systems–and their associated interventions will contribute to continual availability of respectful and patient-centered care for women, adolescents, and children at the both facility- and community-levels. The theory of change relies on several important assumptions:

- UHA coordinates with and collaborates successfully with IPs and RRHs in priority districts to scale-up high impact interventions and through national-level mechanisms (see Section A5).
- PEPFAR local IPs and RRHs, districts, facilities, and communities demonstrate readiness and commitment to assume ownership and financing of UHA interventions.
- USAID's technical and financial support enhances the enabling environment for health improvements, including local health governance.
- The GoU maintains its commitment to and investment in MNCH, FP/RH, nutrition, and facility-level WASH service delivery.
- Uganda's political, economic, and COVID-19 epidemiologic situation remains stable.

Results Framework

Aligned to the theory of change, the UHA Results Framework (Figure 2) depicts the three foundational IR and sub-IRs required to achieve the UHA purpose. UHA's IRs and sub-IRs are intended to be mutually reinforcing and work in tandem. Each proposed IR and associated interventions at the regional, district-, facility- and community-levels will contribute to increased survival and well-being of priority populations and improved health system resilience. For example, TA under IR 3 will support the development of more resilient and responsive local healthcare systems that are increasingly capable of planning, financing, and implementing high quality MNCH, FP/RH, nutrition, and facility WASH/IPC health interventions (supporting IR 1). USAID/Uganda expects continual interplay within and across IRs and sub-results to inform UHA implementation. *For the purposes of planning and budgeting, USAID/Uganda estimates the following levels of effort across IRs: IR 1 (50%), IR 2 (20%), and IR 3 (30%).*

UHA will contribute to relevant MNCH, FP/RH, nutrition, facility-level WASH, HIV, and HSS efforts outlined by the GoU to meet the ambitious goals outlined in the NHP III. As such, its interventions must align to relevant MoH national strategies and evidence-based approaches for PHC, including, but not limited to: its NHP III; Draft Reproductive, Maternal, Newborn, Child, Adolescent, and Healthy Aging

Sharpened Plan for Uganda (2020/21-2025/26); National FP Costed Implementation Plan 2020/21-2024/25; Uganda Nutrition Action Plan (UNAP) II 2020/2021–2024/2025, and National QI Framework & Strategic Plan (2021-2025).

Throughout, continuous **learning and adaptation** will be critical to ensuring UHA activities stay nimble, flexible, and pivot appropriately based on local operating context. UHA will support adaptive rigor by supporting health systems and communities to use available data for decision-making and to drive results and investment. It will also test and support the scale-up of innovative and impactful MNCH, FP/RH, nutrition, HSS, and local capacity building interventions as well as peer-to-peer learning to advance CLA, as described in Section A4.

Alignment with USAID/Uganda CDCS (2016-2021)
USAID's current CDCS strives to support Uganda in accelerating advancements in inclusive education, health, and economic development. UHA will support progress and results under each of the CDCS' three primary development objectives (DOs), strengthening Ugandan-led inclusive and sustainable development throughout. UHA interventions will contribute to following CDCS DOs:

- DO1: Community and household resilience in select areas and target populations increased (IR 1.3: Enhanced prevention and treatment of HIV, malaria, and other epidemics).
- DO2: Demographic drivers affected to contribute to long-term trend shift (IR 2.1: Adoption of healthy reproductive behaviors and practices increased; IR 2.2: Child well-being improved).
- DO3: Key systems more accountable and responsive to Uganda's development needs (IR 3.1: Leadership in development supported; IR 3.3: Key elements of systems strengthened).

As part of adaptive management, USAID/Uganda expects the UHA awardee will ensure implementation aligns with the forthcoming USAID/Uganda CDCS 2022-2025 upon its anticipated release in June 2022.

Implementation Approach and Geographic Focus

UHA will operate primarily at the sub-national level[11] to support achievement of its objectives, providing TA to RRHs and districts to scale-up priority high-impact health interventions and HSS initiatives in priority districts. Specifically, UHA will assist the MoH to operationalize its "Hub and Spoke" model[12] for health systems decentralization. Under this strategy, RRH's provide regional oversight to lower-level health facilities, serve as hubs for skills transfer, for tertiary and specialized care, and as referral hubs from lower levels. UHA will center its service delivery and HSS TA on supporting **seven priority RRHs** to fulfill their health oversight mandate as part of the GoU's health decentralization strategy, improving HIV, MNCH, FP/RH, nutrition, and facility WASH/IPC access and outcomes in a subset of priority surrounding districts. UHA priority RRHs are:

1) Gulu RRH (Gulu District, Acholi Sub-Region)
2) Jinja RRH (Jinja District, Busoga Sub-Region)
3) Kabale RRH (Kabale District, Kigezi Sub-Region)
4) Lira RRH (Lira District, Lango Sub-Region)
5) Mbale RRH (Mbale District, Bugisu Sub-Region)
6) Mbarara RRH (Mbarara District, Ankole Sub-Region)
7) Moroto RRH (Moroto District, Karamoja Sub-Region)

USAID/Uganda selected these priority RRHs for UHA in consultation with the MoH and based on several factors, including USG investment synergy that could be leveraged for enhanced impact and cost-effectiveness. This includes PEPFAR G2G investment in these respective RRHs, as well as additional non-health development programming in food security, livelihoods, resilience, youth, and child development.

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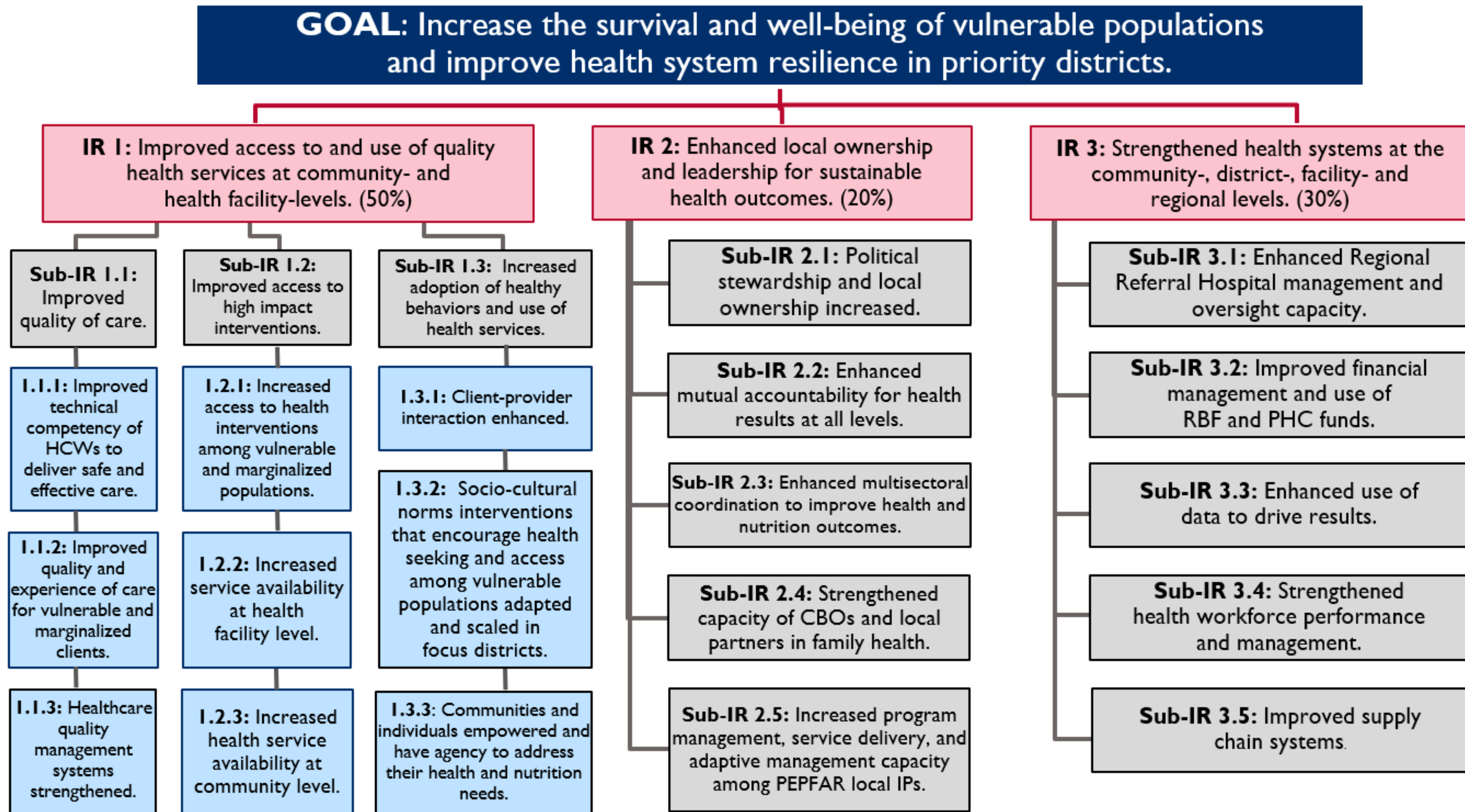
[11] With the exception of Sub-IR 1.1.3, which calls for national QI systems strengthening support (*see Sub-IR 1.1.3 for details*).

[12] USAID-SITES. *Reviewing Uganda's Health System Hub and Spoke Models: September 2018*. Unpublished manuscript.

Figure 2: UHA Results Framework



The UHA awardee will provide TA for IR 1 to each of these seven RRH and their home district health offices (DHOs). In addition, the implementer will provide IR 1 TA to a further sub-set of two to four proposed priority "spoke" districts linked to the hub RRH district, with a maximum of 30 total districts supported. Applicants should propose and justify UHA priority spoke districts based on criteria that they believe will accelerate the achievement and sustainability of UHA results, such as epidemiology, geographic proximity, HSS needs, presence of other USAID IPs, operational considerations, etc.

The UHA awardee will work with priority RRHs to develop a differentiated TA package for each priority RRH hub and spoke districts under UHA based upon local context rather than a one-size-fits-all package. This is critical both to increase effectiveness and to enhance local ownership for sustainability, given limited resources. An important element across all IRs will be providing mentorship and TA in identifying, adapting, and implementing the most effective interventions based upon local transmission, socio-cultural, and health system dynamics. UHA will be expected to use a whole-of-district approach to its TA, ensuring its activities cover all sub-counties, public HCIVs, and their catchment communities within a given priority district. This, along with a much smaller number of potential priority districts under UHA as compared to RHITES activities, reflects a desire by USAID/Uganda to increase the overall saturation of facility- and community-level activities and more frequent and intense engagement.

HSS support: In addition to the focal IR 1 service delivery districts identified above, UHA will provide additional targeted HSS support to 72 focal districts as detailed under IR 3 and Annex 1. These districts may overlap with IR 1 priority districts to enhance coordination and synergy.

National-level support: While UHA will primarily focus TA and resources at the sub-national level, the activity will also provide targeted national-level TA for QI systems strengthening efforts itself, described as detailed under Sub-IR 1.1.3. In addition, UHA will collaborate with USAID's above-site health mechanisms to cascade national-level health technical strategies, policies, and guidelines within priority districts (see Table 2, Collaboration).

Given the fluid operating context, please note that USAID/Uganda expects that the UHA implementer will adopt a flexible implementation model to be responsive to RRH and USAID needs during the life of the activity. As such, the implementer may be asked to adjust its priority districts based upon epidemiological or health system needs during implementation, with USAID concurrence and in discussion with the awardee.

Expected Outcomes

USAID will measure progress toward achievement of the overall purpose through an agreed-upon set of output and outcome indicators as detailed in the activity monitoring, evaluation, and learning plan (AMELP) (Section A4). Anticipated high-level measures of success to be achieved by UHA's end include:

- Accelerated improvements in MNCH, FP/RH, nutrition, and facility WASH in priority districts.
- Measurably strengthened health systems capacity in 72 priority districts.
- Improvements among RRHs to fulfill their GoU-mandated functions in technical oversight.
- Fully realized transitions of PEPFAR local partners in priority regions in program management, service delivery, and adaptive management dimensions (detailed in Sub-IR 2.5).

In addition, USAID/Uganda expects that UHA will contribute to high-level draft RMNCAH Sharpened Plan impact indicators, including: Maternal Mortality Ratio, neonatal mortality rate, infant mortality rate, under-five mortality rate, total fertility rate, teenage pregnancy rate, unmet need for FP, mCPR, and under-five stunting prevalence.

Please note that illustrative activities and indicators for potential consideration are included below in the intended results to guide development of the draft AMELP and technical application. These activities are

not required except where indicated, and applicants are encouraged to suggest additional interventions that will support achievement of UHA results.

IR 1: Improved access to and use of quality health services at community- and health facility-levels. IR 1 will improve MNCH, FP/RH, nutrition, and facility-level WASH/IPC in up to 30 priority RRH bub districts, spoke districts, and their catchment communities identified above.

IR 1 Illustrative Indicators:

- Overall service utilization rate among USAID-supported facilities implementing QI.

Sub-IR 1.1: Improved Quality of Care

Context: Though access to PHC has increased in recent years, the quality of that care remains inadequate to prevent maternal and child deaths. Just over half (52%) of Ugandan health facilities meet general service standards according to a 2019 service availability and readiness assessment (SARA). The maternal mortality ratio remains high despite improvement in service coverage. Many women and infants still die after reaching public health facilities due to slow emergency care and poor adherence to emergency obstetric and newborn care (EmONC) and emergency triage and treatment (ETAT) standards.[13] Uganda also experiences HIV-related quality of care gaps around antiretroviral therapy treatment retention among young men, children, and adolescents and in reaching the most vulnerable, including adolescent girls and young women (AGYW), orphans and vulnerable children, and key populations. Throughout, quality of care outcomes are even worse for vulnerable and marginalized groups. Overall client satisfaction with Uganda's health sector remains low, with one quarter of people satisfied with the quality of services received.[14] This contributes in part to high client dropout rates after first ANC contact.

Multiple health system issues contribute to poorer quality of care. These include fragmented delivery of services, inadequate resource commitments to preventive and promotive care, and near constant HCW turnover at all levels of the health system. Data collection and use remains a challenge. Maternal and perinatal death surveillance and response (MPDSR) is still not widely applied: Only 65% of maternal deaths and fewer than 10% of perinatal deaths were reviewed in 2019/20.[15] Healthcare-associated infections remain a major contributor of maternal and newborn deaths through sepsis. A 2019 national IPC survey ranked 38% of health facilities as possessing inadequate or basic IPC.[16] Quality of care challenges remain a top priority of the MoH, as reflected within the new NHP III and its recently-approved National QI Framework & Strategic Plan (2021 – 2025). To date, most quality of care improvement efforts have been concentrated on HIV and MNCH, with FP/RH and nutrition requiring additional support.

Sub-IR 1.1.1: Improved technical competency of HCWs to deliver safe and effective care.

Sub-IR 1.1.1 Illustrative Activities:

- Ensure districts regularly assess HCW competencies in MNCH, FP/RH, nutrition, and IPC and support district QI coaches to address HCW mentorship needs.
- Collaborate with USAID Maternal and Child Health and Nutrition (MCHN) Activity and Family Planning Activity (FPA) to conduct training on high impact interventions and technical guidance.
- Collaborate with PEPFAR G2G tele-mentoring RRH hubs to incorporate QI, MNCH, FP/RH, nutrition and WASH IPC content/skills labs.

Sub-IR 1.1.1 Illustrative Indicators:

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[13] MoH. Reproductive, Maternal, Newborn, Child, Adolescent, and Healthy Aging Sharpened Plan (2020/21-2025/26). *Draft.*

[14] MoH. Client Satisfaction Survey, 2019.

[15] MoH, Annual Health Sector Performance Report, Financial Year 2019/20.

[16] MoH/MTaPS/USAID. *National IPC Survey Report.* Oct. 2019.

- Number of individuals receiving nutrition professional training through USG-supported programs.
- Number/percentage of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs.
- Number/percentage of newborns not breathing at birth who were resuscitated in USG-supported programs.

Sub-IR 1.1.2: Improved quality and experience of care at subnational level.

Sub-IR 1.1.2 Illustrative Activities:

Regional-Level QI:

- Support seven seconded RRH-based Regional QI Coordinators to oversee district QI structures regional QI priorities, including integration of QI efforts (*required activity*).
- Support operationalization of the MoH regional referral strategy at seven RRHs.
- Conduct targeted virtual and on-site QI coaching and supervision visits to underperforming districts/facilities and support them to improve, working with Regional QI Coordinators.
- Improve the timeliness and completeness of QI data within the web-based QI database.

District-Level QI:

- Provide TA to district staff in using data to analyze key quality of care gaps across all technical areas to drive technical supportive supervision and mentorship.
- Enhance the functioning of district QI committees to fulfill their role/mandate.
- Support district-based QI coaches to provide facility-level QI coaching, mentorship, and supportive supervision to address quality of care gaps.
- Work with districts and health facilities to ensure that facility healthcare waste collection, separation, and disposal is in compliance with national guidelines (*required activity*).

Facility-Level QI:

- Strengthen existing hospital and health center QI Committees to ensure that each facility monitors quality of care indicators and improves standards of care.
- Encourage the identification of local QI priorities and locally-appropriate solutions to address these gaps in service delivery to enhance the culture of QI at facilities.
- Introduce and integrate new FP/RH, nutrition, and facility WASH QI guidelines and tools into current QI capacity strengthening activities and structures.
- Scale-up the Clean Clinic Approach (CCA) [17] at high-volume sites to improve facility IPC (*required activity*).
- Remodel/refurbish relevant facility-level infrastructure based on facility need to meet minimum infrastructure standards and improve quality of care, e.g., renovations of maternity ward, obstetric theater, Kangaroo Mother Care rooms; improving patient flow, etc.

Sub-IR 1.1.2 Illustrative Indicators:

- MPDSR reviews reported.
- Proportion of targeted health facilities with QI teams actively testing and implementing changes on MNCH and HIV.
- Average district quality of care score.
- Number of health facilities with improved infection prevention readiness scores.
- Proportion of Regional and District QI Committees functional.

[17] CCA is an evidence-based CQI approach that encourages health facilities to set WASH goals toward incremental improvements to achieve Clean Clinic status. While ideal WASH conditions at a health facility require increased funding, staff, and infrastructure, lesser improvements like improving the waste management system, ensuring functional hand-washing stations, assigning roles for maintenance, and monitoring individual and collective progress can make a difference.

Sub-IR 1.1.3: Healthcare quality management systems strengthened at all levels.
Please note that while the majority of UHA focuses at the sub-national level, the activity will include national-level support for QI efforts building on and continuing national- and regional-level QI investments supported under RHITES-N. Acholi.

Sub-IR1.1.3 Illustrative Activities:

- Provide TA to MoH Standards, Compliance, Accreditation, and Patient Protection (SCAPP) department to operationalize National QI Framework & Strategic Plan.
- Support five seconded staff to SCAPP to provide TA to subnational QI staff and structures (*required activity*).
- Increase the utility of and routine use of national-level QI learning platforms and collaboration fora for quality of care improvements.
- Ensure the functionality and use of a national QI database to guide decision-making.

Sub-IR1.1.3 Illustrative Indicators:

- Improved functionality of QI coordination structures.
- Improved data completeness and accuracy in QI reporting systems.

Sub-IR 1.2: Improved access to high-impact interventions.
Maternal and newborn health: Nearly all pregnancy, birth, and child health access indicators improved during 2016-2019, but remain below 2020 Sharpened Plan targets.[18] The COVID-19 pandemic has unfortunately further slowed progress: Health facility deliveries declined by 62% during the pandemic, due in part to fears of visiting health facilities and lockdowns. Good progress has been made in reducing facility-based maternal deaths. GoU fiscal year data shows a 17% reduction in maternal deaths among 100,000 facility deliveries and a 77% increase in the maternal death reviews conducted between 2015/16 and 2019/20. Bunyoro, Kampala, and Bugisu regions have the highest institutional Maternal Mortality Rate. Postpartum hemorrhage remains the leading cause of death for women delivering in health facilities, with infections/HIV, anemia, and hypertension also contributing to preventable mortality. There is an urgent need to address the health system factors leading to maternal death. These include lack of blood products for transfusion, absence of critical human resources, and inadequate number of staff. Among infants, there was a 20% reduction in the number of perinatal deaths reported between 2019 and 2020. Fresh stillbirths and newborn deaths (0-7 days) constitute 63% of the perinatal deaths. Improving neonatal and prematurity care can significantly reduce under five deaths in Uganda.

Child health: Malaria, pneumonia, diarrheal disease, and anemia remain leading causes of death in children under five. Full immunization coverage has increased to 20% of all districts in Uganda, but remains far below the 80% MoH target. During 2019/20, measles coverage for children under one years and DPT3 coverage decreased. Coverage of iCCM is slowly increasing, but requires significant scale-up to reduce child deaths. Vitamin A supplementation, one of the most cost-effective interventions for improving child survival, further declined by 9% to 21.4% from 30% in 2018/19 and is far below GoU targets.

FP/RH: While uptake of modern contraception has increased in Uganda, improvements have been largely unequal, with significant contrasts between urban/rural settings and poorer households. The method mix is slowly expanding and increasing, with long-acting reversible contraception (LARC) accounting for 23% of contraceptives accessed. Short-term injectables remain the most popular FP method. Adolescent pregnancy remains high at 29%, with little change over time. It continues to be a leading cause of death for AGYW. Provider biases for certain FP methods, combined with FP/RH

[18] All sources of data in Sub-IR 1.2 sources from: MoH. *Endline Review of the Investment Case for RMNCAH Sharpened Plan in Uganda, 2015/16-2019/20*. June 2020 and MoH, Annual Health Sector Performance Report, Financial Year 2019/20 unless otherwise noted.

commodity stockouts, impacts the FP method mix. In addition, unreceptive service provider attitudes deter married and unmarried adolescents from seeking FP/RH services or ANC. Only 7% of clients accessed FP commodities through community-based distribution in 2019/20.

Nutrition: Uganda features large variations in child stunting prevalence by district and region, ranging from 4.5% in Kween and 84.6% in Bududa districts. An estimated 44/112 districts possess stunting rates higher than the national average, with chronic malnutrition notably high in Northern and Western regions. Myriad multisectoral factors impact child nutrition, including household education, income, gender, and geography. At facility-level, RHITES data showed that fewer than half of children ages 6-59 months received nutritional screening during facility visits, a missed opportunity for nutrition interventions.[19] This is due in part to inadequate training in nutrition assessment and counseling HCWs receive. Although nearly 90% of women took iron supplements at least once during their most recent pregnancy, fewer than 25% took them for the recommended 90 days or more according to the 2016 Uganda Demographic and Health Survey (DHS). Improved nutrition screening and services are at the facility and community level for women and children are still needed, including integration within other MNCH, FP/RH, and HIV services.

The GoU's new NHP III calls for re-invigorated PHC, a promising opportunity to scale-up community-based approaches to preventive healthcare and achieve a more integrated health system. In addition, the scale-up of the GF- and PMI-supported iCCM has reduced malaria-related deaths in children under five in the PMI- and the GF-supported districts.[20] VHTs are now often the first stop for children with fever in rural communities with trained VHTs. Self-care innovations, such subcutaneous depot medroxyprogesterone acetate (DMPA-SC) and the Family Mid Upper Arm Circumference Approach are also increasing access to MNCH, FP/RH, and nutrition among marginalized and high-need rural populations. UHA will capitalize on this movement toward increased community service delivery access, while strengthening the availability of high-impact interventions for MCHN, FP/RH, and nutrition at facility- and community-level.

Sub-IR 1.2.1: Increased access to health interventions among vulnerable and marginalized populations.

<u>Sub-IR1.2.1 Illustrative Activities:</u>

- Strengthen district capacity in respectful maternity care for MNCH, FP/RH, and nutrition services and conduct effective oversight to ensure accountability.
- Scale-up innovations that increase access to MNCH, FP/RH, and nutrition services among vulnerable populations.
- Leverage Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe (DREAMS) groups and other platforms to increase access to and uptake of AGYW health interventions.
- Strengthen the functionality of the community-facility referral network.

<u>Sub-Result 1.2.1 Illustrative Indicators:</u>

- Number of individuals who received post gender-based violence (GBV) clinical care based on the minimum package.

Sub-IR 1.2.2: Increased service availability at health facility level.

<u>Sub-IR 1.2.2 Illustrative Activities:</u>

- Work with districts to roll out and increase access to priority high impact interventions and practices at facility-levels.

[19] USAID/Uganda. FY21 Q2 Implementing Partner Performance Review. PowerPoint. July 2021.

[20] MoH/GF/PACE. *Implementation of iCCM Study in Uganda*. PowerPoint. Jan. 2021.

- Identify opportunities to optimize integration of MNCH, FP/RH, nutrition, and HIV services for improved client satisfaction and health outcomes.
- Strengthen referral system functionality from HC II and III to district hospitals and RRHs.

Sub-Result 1.2.2 Illustrative Indicators:

- Number of women giving birth in a health facility receiving USG support.
- Early initiation of breastfeeding.
- Number of children who received their first dose of measles-containing vaccine by 12 months of age in USG-assisted programs.
- Percentage of children 6-59 months who received age-appropriate vitamin A supplementation in the last 12 months.
- Number of cases of child diarrhea treated in USG-supported programs.
- Number of cases of childhood pneumonia treated in USG-assisted programs.
- Percent of USG-assisted service delivery sites providing FP counseling and/or services.
- Contraceptive method mix by level.
- Percent of supported health facilities that offered a postpartum FP method within 6 weeks of delivery.
- Couple-years protection in USG-supported programs.
- Number of pregnant women reached with nutrition-specific interventions through USG-supported programs.
- Number of children under five (0-59 months) reached with nutrition-specific interventions through USG-supported programs.
- Percentage of children 6-59 months who received nutritional assessment and categorization at facility level.

Sub-IR 1.2.3: Increased health service availability at community level.

Sub-IR 1.2.3 Illustrative Activities:

- Identify and build capacity of community health workers (CHWs) to provide health services and report on their activities.
- Work with districts to conduct routine and targeted/data-driven mobile integrated health outreaches and Child Health Days.
- Increase coverage of iCCM in priority districts according to new guidelines.
- Increase community-based distribution of MNCH, FP/RH, and self-care commodities.
- Collaborate with relevant district-level multi-sectoral activities to integrate relevant community service delivery interventions, with an emphasis on nutrition-sensitive interventions.

Sub-IR 1.2.3 Illustrative Indicators:

- Number of USG-assisted CHWs providing FP information, referrals, and/or services.
- Number of children under two (0-23 months) reached with community-level nutrition interventions through USG-supported programs.

Sub-IR 1.3: Increased adoption of healthy behaviors and use of health services.

Context: Ugandan women and adolescents in priority sub-regions face religious, patriarchal, and gender norms that undermine their ability to adopt positive MNCH, FP/RH, and nutrition behaviors and make a timely decision to seek medical care (*first delay*). Pregnant women in Lango and West Nile, for example, often require permission from partners to travel to health clinics. Early ANC remains far short of targets, due to sociocultural issues (e.g., early pregnancy concealment), gender norms, and distance to health facilities. Micronutrient adequacy of diets of women of reproductive age is poor, with fewer than 10% of women nationally, and 7% in rural areas, meeting a minimum dietary diversity. This is a missed opportunity to manage early pregnancy complications, integrate prevention of mother-to-child transmission services, and move toward achieving the World Health Organization-endorsed eight ANC visits. These challenges continue with the *second delay*, where women in active labor and severely ill

children in distress cannot reach a facility in time for life-saving treatment. Similarly, numerous sociocultural factors and norms impact FP demand and use, limiting women's ability to achieve their desired family size. Secrecy around sexual relationships increases risk of pregnancy among AGYWs.

To promote sustainable change, UHA will adopt a community-led SBC strategy that maximizes existing community networks and structures. This approach will empower communities to identify their own health priorities and resources and develop activities to address these priorities using gender transformative approaches. Throughout, UHA will collaborate closely with the USAID SBC Activity (SBCA) to adapt and scale evidence-based SBC interventions.

Sub-IR 1.3.1: Client-provider interaction enhanced.

Sub-IR1.3.1 Illustrative Activities:

- Support districts to provide evidence-based training on respectful and responsive care and addressing and identifying biases that impact care.
- Mentor districts and facilities on tailoring SBC and models of differentiated care for priority populations, such as first-time parents, AGYW, rural populations, and GBV survivors.
- Leverage small grants to community-based organizations (CBOs) to identify and scale innovations that support incentivization of more responsive and respectful facility-based care.

Sub-Result 1.3.1 Illustrative Indicators:

- Proportion of clients allowed to have a companion of choice during delivery.
- Proportion of women reporting verbal or physical abuse at the health facility.

1.3.2: Socio-cultural norms interventions that encourage health-seeking and access among vulnerable populations adapted and scaled in focus districts.

Sub IR1.3.2 Illustrative Activities:

- Conduct training/mentorship to districts and CBOs/small grantees to scale-up relevant SBC interventions that increase demand for available health commodities and services.
- Leverage existing community health programs- and multisectoral platforms to promote awareness, demand creation, including gathering places/organizations for youth and men.
- Engage with key influencers, such as husbands, mothers-in-law, and religious and traditional leaders, to promote positive gender and social norms using evidence-based approaches.
- Identify and scale up innovative, community-level *second delay* approaches for helping women reaching facilities in time to deliver.

Sub-IR 1.3.2 Illustrative Indicators:

- Percentage of pregnant women who receive 4 ANC consultations (4th ANC visit coverage).
- Percentage of pregnant women received at least three doses of IPTp (IPTp3+).
- Percentage mothers who attended PNC visit within 6 weeks postpartum.
- Number of newborns who received PNC within 2 days of childbirth in USG-supported programs.
- Percentage of children under one year of age fully immunized.
- Number of children eating a diversified diet.

Sub-IR 1.3.3: Communities and individuals empowered and have agency to address their health and nutrition needs.

Sub-Result 1.3.3 Illustrative Activities:

- Mentor districts and facilities to strengthen capacity of VHTs and volunteers to promote adoption of 10 accelerator behaviors for ending preventable child and maternal deaths.[21]

[21] USAID. USAID Social and Behavior Change Programs for Ending Preventable Child and Maternal Deaths. 2016.

- Provide TA to districts to adapt and scale-up innovative empowerment, male engagement, and preventive behavior SBC models to their local context.
- Provide TA CBOs and key influencers to implement and manage community SBC interventions.
- Leverage small grants program to test/scale effective self-care and empowerment interventions.

Sub-Result 1.3.1 Illustrative Indicators:

- EBF of children for six months.
- Percentage of participants that view GBV as less acceptable after participating in or being exposed to USG programming.

IR 2: Enhanced local ownership and leadership for sustainable health outcomes. IR 2 will focus on improving local ownership and accountability for health in the 72 priority PEPFAR districts and their catchment communities, collaborating with integrated health activities (IR 1) in the sub-set of districts where implementation overlaps.

IR 2 Illustrative Indicators:

- Proportion of districts with previously highest mortality rates with increased budget allocations to high-impact interventions.
- Percentage of districts/facilities with community members participating in data review meetings.

Sub-IR 2.1: Political stewardship and local ownership increased.
Context: District-level political appointees, elected officials, and local health leaders play a crucial role in resourcing and overseeing PHC in Uganda. Yet at times some of these officials–including local parliament, district councilors, and others–may constrain health progress. Frequent turnover in local government through elections, political appointments, and creation of new districts means that new relationships between DHO staff and health technocrats and local government officials must be constantly established. New political appointees, while deeply experienced in some sectors, may have little experience in the health sector. District local council health sub-committees also require further technical support in realizing their envisaged oversight roles and responsibilities. UHA will advance efforts to bring political and health technical interests together and strengthen local health leadership capacity to improve local health outcomes, working closely with above-site mechanisms to access relevant governance and leadership TA.

Sub-IR 2.1 Illustrative Activities:

- Develop supportive relationships between regional- and district-level political actors, Chief Administrative Officer, and DHO and RRH staff to enhance health service delivery.
- Mentor and orient new political leaders and district health management team (DHMT) staff in newly-created districts on their health oversight responsibilities and strengthen their capacity to fulfill them.

Sub-IR 2.1 Illustrative Indicators:

- District budget utilization rate.

Sub-IR 2.2: Enhanced mutual accountability for health results at all levels.
Context: The GoU has made strong progress in advancing health accountability structures and processes during the past five years. The MoH has scaled-up MPDSR and MNCH scorecards, for example, which has increased accountability around the accessibility and quality of service delivery. Yet despite progress at national level, these governance structures and processes often remain weak locally. While some HUMCs and hospital boards are high functioning and can mobilize resources, many remain weak in their ability to fulfill their role in overseeing local health service delivery. This has practical ramifications: Strong HUMCs are required to ensure health facilities can access and account for critical RBF funding.

Community health accountability approaches and structures offer promise in reinforcing facility-based care-seeking through improving quality and availability of services. In reality, community participation is often absent in facility and district planning and oversight processes, limiting community input into service delivery. DHOs and facilities require skill building in participatory community engagement to effectively engage civil society in health service monitoring. Conversely, under-represented populations require capacity strengthening to participate in community platforms such as HUMCs and advocate effectively for their service needs. In recognition of these accountability gaps, the new draft RMNCAH plan aims to strengthen mutual accountability for RMNCAH outcomes, including through development of a new social accountability framework for health that will enhance rights-based community engagement. UHA will amplify these efforts in priority districts, scaling-up GoU facility and community structures and processes that enhance accountable relationships between communities and citizens.

Sub-IR 2.2 Illustrative Activities:

- Assist DHMTs to map and assess the functioning of HUMCs and provide TA and training to HUMCs and hospital management boards to address capacity gaps.
- Coach facilities in increasing representation and meaningful participation of adolescents, women, and other underrepresented groups on HUMCs and accountability structures.
- Introduce and scale-up innovative health social accountability interventions that build on existing community structures and enhance local ownership.
- Strengthen community participation in planning and budgeting for health facility funds.

Sub-IR 2.2 Illustrative Indicators:

- Percentage of facilities and RRHs with functional HUMCs with citizen representation.
- Number of community concerns received and responded to in a timely and consistent manner.

Sub-IR 2.3: Enhanced multi-sectoral coordination to improve health and nutrition outcomes.

Context: Strengthening multi-sectoral coordination and program integration improves the well-being of families across a range of dimensions, including health, nutrition, agriculture, livelihoods, and resilience.[22] Integrating FP education and products into community-based agribusiness and income generating activities, for example, may increase new FP acceptors and generate cost savings as compared to standalone service provision.[23] Yet despite its promise, Uganda has struggled to operationalize subnational multisectoral coordination. Health and development activities largely operate in silos, working in parallel to and within government and contributing to duplication of interventions in some areas and "service overload" in others. The planned coordination meetings and processes that do exist often occur irregularly due to lack of funds, commitment, and competing interests. This creates a missed opportunity to more strategically share resources and address underlying social determinants of health.

UHA will capitalize on recent GoU momentum toward enhancing multisectoral collaboration, as reflected in NHP III Policy Objective 2, its accompanying draft multisectoral coordination framework, and the GoU's "Health-in-All Policies" directive and UNAP II. The new Parish Development Model offers the opportunity to enhance multi-sectoral collaboration further at sub-county level and below as Parish Development Committees increase coordination across partners and community political and development structures, such as the Local Council Executive Committee and VHTs.

Sub-IR 2.3 Illustrative Activities:

- Strengthen the functioning of relevant UHA-related coordination structures, including district social services committee, nutrition committees, and sub-county health committees.

[22] USAID/FHI 360. *Desk Review of Programs Integrating FP with Food Security and Nutrition*. 2015.

[23] USAID Advancing Partners and Communities. *The Added Value of Integrating FP into Community-Based Services*. 2017.

- Work with district Chief Administrative Officers to ensure regular partner meetings occur and activities are integrated within One District Health Plan.
- Provide technical support and training to DHOs and priority districts in operationalizing relevant coordination aspects of the Parish Development Model.

Sub-IR 2.3 Illustrative Indicators:

- Number/percentage of new local partnerships leading to increased resources for MNCH, FP/RH, and nutrition programming in priority districts.
- Number/percentage of priority districts with well-functioning multi-sectoral partnership platforms to coordinate development partners.

Sub-IR 2.4: Strengthened capacity of CBOs and local partners in integrated health.

Context: Uganda features a robust landscape of local health non-governmental organizations (NGOs), faith-based organizations (FBOs), and universities who bring strong experience and local health solutions. In line with USAID's continued commitment to locally-led development and sustainability, UHA will include a small grants program for local partners working in priority districts designed to advance GoU health objectives at community level, while contributing to locally-led development and sustainability (see Section A5 for additional details on the small grants program).

UHA will strengthen the technical capacity of local partners in relevant integrated health sub-sectors based on their scopes of work. Given the relative shortage of organizationally mature non-HIV NGOs/CBOs, UHA may identify new or innovative high-performing local multi-sectoral organizations under the small grants program with the potential to add significant value to the primary healthcare landscape, such as youth development organizations. They will require this additional capacity strengthening support in MNCH, FP/RH, and nutrition. By prioritizing local partner technical capacity development, UHA will nurture the development of more locally-appropriate health solutions, increase local ownership and accountability, and help ensure community mobilization and service delivery continues beyond the end of UHA.

Sub-Result 2.4 Illustrative Activities:

- Assess local small-grantees technical capacity in relevant integrated health topics based upon scope of award and develop tailored capacity strengthening plans.
- Collaborate with the USAID/Uganda Civil Society Strengthening Activity and other Mission activities to access relevant capacity strengthening services for local partners.

Sub-IR 2.4 Illustrative Indicators:

- Percentage/number of USG-assisted organizations with increased performance improvement.
- Number of national and local organizations provided with minimum package of technical and management capacity development assistance.
- Percentage of local partner's financial and program reports submitted on time and complete.

Sub-IR 2.5: Increased program management, service delivery, and adaptive management capacity among PEPFAR local IPs and G2G RRHs.

Context: UHA will continue advancing a locally-led and sustainable HIV response by strengthening the functioning and technical performance of PEPFAR local IPs in priority sub-regions. This includes both local IPs who have received transition awards from international organizations under the RHITES activities, the local partners supporting private-not-for-profit health facilities, as well as new G2G recipient RRHs (see Table 1 for the full list of priority local IPs).

USAID/Uganda initiated transition awards to high-performing local health-focused NGOs beginning in 2020 on a rolling basis under RHITES. Lead RHITES IPs have since provided intensive technical and program management support aimed at fully transitioning service delivery and program management

functions to local IPs. Today, these IPs feature strong HIV/AIDS technical capacity, but possess varying levels of program management and adaptive management capacity. Similarly, USAID/Uganda also began providing G2G assistance to select RRHs in 2021 to support the MoU's vision for decentralization and to increase sustainability as part of epidemic control. These awards support HIV service delivery, regional continuous quality improvement, training and mentorship to lower-level health facilities, lab coordination, supply chain TA, human resources for health (HRH), financial management, and governance. As with the RHITES IPs, RRHs feature varying levels of technical and management capacity.

Table 1: Priority Local PEPFAR IPs for UHA TA

IP	Transition Award Name	Sub-Regions	Implementation Districts
Local NGO/CSO IPs			
African Network for the Care of Children Affected by HIV/AIDS (ANECCA)	LPHS - Karamoja	Karamoja	Abim, Kaabong, Karenga, Kotido, Moroto
Baylor College of Medicine Children's Foundation Uganda	LPHS – East	East (Mbale)	Budaka, Bududa, Bukwo, Bulambuli, Butaleja, Butebo, Kapchorwa, Kibuku, Kween, Manafwa, Mbale, Namisindwa, Pallisa, Sironko, Tororo
Joint Clinical Research Centre (JCRC)	LPHS – Kigezi and Lango	Kigezi and Lango	Lango: Alebtong, Amolatar, Apac, Dokolo, Kole, Kwania, Lira, Otuke, Oyam Kigezi: Kabale, Rukiga, Rubanda, Kisoro, Kanungu and Rukungiri
Makerere University Joint AIDS Program (MJAP)	LPHS- East Central	East Central (Jinja)	Bugiri, Bugweri, Busia, Buyende, Iganga, Jinja, Kaliro, Kamuli, Luuka, Mayuge, Namayingo, Namutumba
The AIDS Support Organization (TASO)	LPHS – Ankole and Acholi	Ankole and Acholi	Acholi: Agago, Amuru, Gulu, Kitgum, Lamwo Nwoya, Pader, Omoro Ankole: Buhweju, Bushenyi, Ibanda, Isingiro, Kazo, Kiruhura, Mbarara, Mitooma, Ntungamo, Rubirizi, Rwampara, Sheema
Uganda Protestant Medical Bureau (UPMB)	Local Service Delivery Activity	Multiple districts in Northern, Eastern, East Central, and South Western regions	Focusing on high-volume private not-for-profit (PNFP) facilities in 57 districts: Abim, Agago, Alebtong, Amolatar, Amuru, Apac, Budaka, Bududa, Bugiri, Bugweri, Buhweju, Bukwo, Bushenyi, Busia, Butaleja, Butebo, Buyende, Gulu, Ibanda, Iganga, Isingiro, Jinja, Kabale, Kaliro, Kamuli, Kanungu, Kazo, Kibuku, Kiruhura, Kisoro, Kitgum, Kotido, Kwania, Lamwo, Lira, Manafwa, Mayuge, Mbale, Mbarara, Mitooma, Moroto, Namayingo, Namisindwa, Namutumba, Ntungamo, Omoro, Otuke, Oyam, Pallisa, Rubanda, Rubirizi, Rukiga, Rukungiri, Sheema, Sironko, Tororo)
Regional G2G Awards			
Gulu RRH Strengthening Activity		Acholi	Gulu
Jinja RRH Strengthening Activity		Busoga	Jinja
Kabale RRH Strengthening Activity		Kigezi	Kabale
Lira RRH Strengthening Activity		Lango	Lira
Mbale RRH Strengthening Activity		Bugisu	Mbale
Mbarara RRH Strengthening Activity		Ankole	Mbarara
Moroto RRH Strengthening Activity		Karamoja	Moroto

UHA will consolidate gains from RHITES-supported capacity strengthening efforts, while providing customized TA to address local IP and RRH program management, service delivery, and adaptive management needs. USAID/Uganda expects that Sub-IR 2.5 TA activities will gradually decrease over the

life of UHA as local IPs and RRHs achieve capacity performance milestones and sustain service delivery targets. *Please note that UHA support is not focused on core organizational capacity building functions, such as Non-U.S. Organization Pre-Award Survey criteria.* UHA implementers should link local IPs and G2G entities to additional USAID/Uganda local organizational capacity building activities such as the Organizational Development Activity, if additional support is needed in these areas.

Sub-IR 2.5 Illustrative Activities (*all required activities*):

- Assess local PEPFAR IP/G2G capacity and develop and implement customized transition plans for a full range of program management and service delivery functions.
- Coach PEPFAR IPs/G2G recipients to address technical and adaptive management capacity needs among local IPs.
- Provide TA to PEPFAR local IPs and G2G sites in rolling out new guidelines on HIV prevention, care, and treatment at site-level.
- Standardize PEPFAR IP epidemic control support activities across regions.
- Assist G2Gs/RRHs to establish and/or strengthen tele-mentoring hubs to enhance HCW HIV service delivery knowledge and skills.
- Strengthen PEPFAR local IP capacity in adaptive management and use of data for performance improvement and program management.
- Promote peer-to-peer learning and virtual cross-learning exchanges on innovations for HIV epidemic control and program management across IPs.
- Ensure collaboration and integration with DHO family health and HSS activities under UHA IR 1 and 3 in districts of overlap.

Sub-Result 2.5 Illustrative Indicators:

**Please note: Local IPs will maintain responsibility for reporting on PEPFAR HIV prevention, care, and treatment service delivery targets and other priority indicators.*

- Number of HIV service delivery points at a site supported by PEPFAR that are providing integrated voluntary FP services.
- Program successfully transitioned to PEPFAR local IPs (Yes/No).
- Percentage of UHA-supported organizations that demonstrate improvement in capacity across at least one domain.

IR 3: Strengthened health systems at the regional, district, facility, and community levels.

IR 3 will focus on improving health system resilience in the 72 priority PEPFAR districts and their catchment communities, collaborating closely with integrated health activities (IR 1) in the sub-set of districts where implementation overlaps. UHA will collaborate closely with USAID above-site HSS-related activities to tailor and cascade district systems strengthening packages in the core areas of leadership and governance, HRH (including community health workforce), supply chain, health financing, and information systems.

IR 3 Illustrative Indicators:

- Average percentage service coverage gaps in: a) between ANC1 and ANC4; b) between Polio 1 and Polio 3 by HSS activities supported by USAID.

Sub-IR 3.1: Enhanced RRH and district health management and oversight capacity.

Context: Priority sub-region RRHs and surrounding districts vary in their ability to provide the strategic oversight, guidance, and regulation of health services at all levels envisaged by the new NHP III. This is a critical gap that both impacts health service delivery quality in the near-term, as well as progress toward health decentralization in the longer-term. The profusion and frequent addition of new districts has complicated MoH decentralization efforts by adding new health leaders who require additional leadership and capacity building. UHA will strengthen the health leadership, planning, and coordination functions of the seven RRH Community Health Departments and priority DHOs to accelerate

achievement of health outcomes both at community and facility levels. The activity will leverage above-site USAID health investments, including the Uganda HSS Activity (UHSS) and G2G support, to strategically address identified subnational leadership and governance capacity gaps at district and health sub-district level under this Sub-IR.

Sub-IR 3.1 Illustrative Activities:

- Assess leadership and governance capacity within priority DHOs/DHMTs and health sub-districts and RRHs.
- Strengthen RRH and district/sub-district leadership and governance capacity through training and mentorship, linking to UHSS (or the equivalent above-site HSS activity) and G2G mechanisms as relevant.
- Provide TA to develop data driven annual district work plans and budgets in priority districts and review them to ensure that work plans are aligned MOH and UHA primary healthcare priorities and sub-national targets.
- Advocate for the inclusion of and/or mentor districts on effectively integrating community engagement and service delivery activities into their work plans and budgets.

Sub-IR 3.1 Illustrative Indicators:

- Percentage of districts submitting timely comprehensive quarterly and annual district health plans and performance reports to designated MoH office.
- Percentage of districts that support community health services in annual budgets.

Sub-IR 3.2: Improved Financial Management and Use of RBF funds.

Context: While decentralization has increased the availability of funds at district level, it has also heightened public financial management challenges that threaten health service delivery. Many of Uganda's newly-created districts lack DHO staff with skills in budget analysis, planning, and financial management. At a practical level, this means that despite having the Integrated Financial Management System (IFMS) in place, the majority of districts submit their required financial reports late, delaying the timely receipt of funds.

The GoU/World Bank-funded Uganda Reproductive Maternal and Child Health Improvement Project (URMCHIP) serves as a bright spot in Uganda's health funding landscape. The RBF mechanism has stimulated successful supply-side incentives, QI measures, and direct facility financing that has provided critically-needed local autonomy to address district and facility level needs.[24] Under USAID's RHITES activities, health facilities used RBF to develop creative solutions to service delivery challenges, such as procuring buffer stocks of life-saving commodities and leveraging funding for community-level VHT nutrition activities. At the same time, many districts and facilities possess serious bottlenecks that have impacted their ability to access timely RBF funding. These include a need for increased capacity in RBF financial and technical reporting requirements to ensure timely receipt of funds, strengthened understanding in how RBF funds may be legally and creatively used, and a need for increased transparency by HUMCs in sharing how RBF funds are deployed. UHA will require close collaboration with USAID's health financing investments to scale and maximize domestic resource mobilization and optimization approaches in priority districts, including with: UHSS, which has served as a key coordinating body for RBF with the MoH as well as strengthened IFMS reporting; PEPFAR's G2G support to RRHs, which supports hospital financial management systems and monitoring; and USAID's Domestic Revenue Mobilization for Development (DRM4D), which is increasing health budget advocacy and monitoring of health expenditures/allocations.

Sub-Result 3.2 Illustrative Activities:

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[24] MoH and ThinkWell. *National Health Insurance in Sub-Saharan Africa: Insights for Uganda*. Kampala. 2021.

- Strengthen RRH, DHMT, and health facility in-charge capacity in financial management for improved service delivery.
- Build the capacity of health facilities and districts in activity planning, implementation and monitoring for timely utilization of both GOU and donor resources.
- Build RRH and district capacity to conduct RBF readiness audits and support supportive supervision to ensure facilities qualify and maintain their qualification for continued RBF funding.
- Provide TA to RRHs and districts to strengthen finance-related documentation and reporting skills of lower-level clinical and HF staff to reduce delays in RBF funds.
- Provide TA to the RRH Internal Audit unit to strengthen monitoring, oversight, and collaboration with the DHOs office and HFs for improved financial management.

Sub-IR 3.2 Illustrative Indicators:

- Percentage of districts submitting quarterly financial reports on time in IFMS (within 30 days).
- Percentage of DHOs with annual health budget execution rates greater than 90%.
- Percentage of RRHs with clean audits.

Sub-IR 3.3: Enhanced use of data to drive results.

Context: The timeliness, quality, and use at the community, facility, and district level remains weak due to multiple factors. Uganda's hybrid paper/digital system, for example, creates a massive reporting burden through dozens of paper forms and registers that require manual aggregation by over-burdened HCWs. While an increasing data volume is reported through the country's electronic DHIS2 system, most improvements have been seen in HIV data. FP/RH, nutrition, and facility-level WASH data is often not routinely reported. While most districts have trained DHIS2 users, gaps remain in improving the use of data for decision-making and informing annual work plans. At a practical level, most districts cannot use data effectively to guide their health planning, budgeting, and intervention targeting without IP support.

This creates real-world consequences, with some facilities failing to qualify for critical RBF funding or experiencing delays in disbursement. COVID-19 has exacerbated many of these existing data challenges: Timeliness of monthly outpatient department reporting declined from 97.5% to 85% from 2019-2020, largely due to district involvement in pandemic response.[25] Throughout, there is little ownership of data at facility- and community-level, with notable gaps in the inclusion and use of community-level data.

Sub-IR 3.3 Illustrative Activities:

- Provide technical support and training to improve the functioning and use of DHIS2 and new MoH HMIS tools at RRH-, district-, and facility-level.
- Mentor RRHs, districts, and lower-level facilities to improve data quality, reporting, and data use for decision making and resource allocation.
- Scale-up electronic medical record functionality at priority RRHs.
- Support districts to hold quarterly data validation meetings with community participation.
- Provide TA to districts, facilities, and VHTs to strengthen community data collection and use.

Sub-IR 3.3 Illustrative Indicators:

- Timeliness of HMIS 105 reporting.
- Completeness of HMIS 105 reporting.
- Percentage districts/facilities with community members participating in data review meetings.
- Number of districts/facilities submitting complete iCCM/VHT quarterly reports in DHIS2.

Sub-IR 3.4: Strengthened health workforce performance and management.

[25] MoH, Annual Health Sector Performance Report, Financial Year 2019/20.

Context: High HCW turnover, absenteeism, and maldistribution often means rural communities are left with minimally-trained and supervised PHC workers.[26] This HRH situation impacts maternal and child survival, with pregnant women sometimes turning to traditional birth attendants or healers to meet their care needs. Devolution, coupled with MoH health facility and district expansion, strains the health workforce even further. New skills are required by RRH and newly-appointed district health managers at all levels to operate successfully in the recently devolved environment, including in HRH budgeting, planning, and forecasting. The MoH's current restrictive staffing structure, which has not been reviewed in more than 10 years, further contributes to HCW shortages.

The MoH's recently-approved HRH Strategic Plan 2020-2030 offers an ambitious vision for the future, but requires TA and support in rolling out key priorities at district level. UHA will work closely with RRHs, priority DHO HRH focal persons, and UHSS to operationalize the new HRH strategic plan, with a specific focus on strengthening human resource management systems for MNCH health workforce performance and productivity and developing an adequate workforce to meet changing health needs.

Sub-IR 3.4 Illustrative Activities:

- Provide TA to districts in the development, review, and dissemination of quarterly and annual HRH implementation plans and budgets.
- Provide TA to health facilities to institute HRH performance management approaches, including work scheduling/rotation, attendance tracking, reward and sanctions.
- Provide TA to district HRIS focal persons to ensure HRIS is functioning within priority districts.
- Strengthen use of data for decision-making in HRH planning, budgeting, and recruitment among RRH and district HRH focal persons.
- Equip RRHs to train and coach districts to conduct their own local workload indicators of staffing need (WISN) analysis for efficient and equitable staff utilization.
- Mentor RRHs and DHOs to ensure that local IP PEPFAR-funded clinical and programmatic staff align to and are absorbed by the GoU payroll system to increase sustainability.

Sub-IR 3.4 Illustrative Indicators:

- Percent of approved posts filled with qualified personnel in public health facilities.
- Healthcare worker absenteeism rate.
- Percentage of districts with functional HRIS.
- Percentage of HCWs that have developed/implemented an annual individual performance plan.

Sub-IR 3.5: Improved supply chain systems within RRHs and priority districts.

Context: Persistent stockouts of essential medicines and health supplies (EMHS) continue to plague service delivery in Ugandan public health facilities. A 2018 USAID supply chain assessment found that more than 90% of health centers and hospitals reported stockouts in one or more tracer commodities across the system.[27] Such stockouts frequently result in sub-optimal clinical care, cause unaffordable out-of-pocket expenditures, and drive clients to loosely regulated private sector care. These challenges are even more acute at community level: Only 9% of VHTs nationally possessed all three required iCCM commodities to treat malaria, pneumonia, and diarrhea in a recent MoH study.[28]

While central-level GoU commodity forecasting and inventory management capabilities are strong, subnational capacity in facility-level planning, quantification, and ordering varies. Weak data collection, analysis, and use underpins nearly all supply chain challenges. Numerous logistics management information systems (LMIS) have been rolled out including the national medical stores Client Self Service

[26] MoH. *HRH Strategic Plan 2020-2030, Operational Plan 2020/21-2024/25*.

[27] USAID/GHSC-PSM. *Uganda National Supply Chain Assessment: Capability and Performance*. Aug. 2018.

[28] MOH/GF/PACE. *Implementation of iCCM Study in Uganda*. PowerPoint. Jan. 2021.

Portal (CSSP), but in many cases the systems are siloed and do not share data. RRHs in particular often have significant deviations between stock on hand and LMIS values.[29] As a result, facilities fail to access adequate and timely supplies, and sometimes hoard their commodities to avoid stockouts. Yet despite these challenges, recent supply chain strengthening efforts offer great opportunities to improve availability of EMHS. PEPFAR and GF investments in supply chain strengthening have increased the availability of LMIS and associated infrastructure and connectivity that can be leveraged to improve supply chain reporting, data use, and oversight for MNCH, FP/RH, nutrition, and facility WASH/IPC commodities.

Sub-IR 3.5 Illustrative Activities:

- Strengthen RRH and district-level LMIS and activities for planning, managing, ordering and monitoring the availability and use of EMHS.
- Assist districts to operationalize the SPARS to guide supervision and resource allocation.
- Provide TA to Medicine Management Supervisors and facilities to ensure functioning and use of digital stock management tools, including RxSolution, the Pharmaceutical Information Portal (PIP), the real-time stock status monitoring dashboard (RASS), and the NMS+ enterprise resource planning system (CSSP).
- Strengthen regional lab supportive supervision, ensuring all regional labs have external quality assurance program in place and move toward accreditation.
- Support the smooth functioning of the district lab sample transport network (*required activity*).
- Strengthen district and facility capacity to increase community-level MNCH, FP/RH, and nutrition supply chain commodity availability and reporting efforts.

Sub-IR 3.5 Illustrative Indicators:

- Percentage of HF that have 95% of essential commodities basket in the previous quarter.
- Average stockout rate of contraceptive commodities at FP service delivery points.
- Percent of USG-supported laboratories performing TB microscopy with 95 percent or higher rate of correct results.

A4. Activity Monitoring, Evaluation, and Learning

The Applicant is required to submit a draft AMELP with its application that describes how it will work with USAID to monitor progress toward UHA results. Upon award, the USAID/Uganda Agreement Officer Representative (AOR) and the Health Office Strategic Information Team will provide guidance for the detailed AMELP to ensure that indicators are aligned with the current Mission's CDCS and UHA IRs, contribute to USAID and PEPFAR health targets, and comply with Mission reporting and data quality requirements under all global health funding authorities. The successful Applicant will also consult with the Mission's monitoring and evaluation (M&E) contractors [Strategic Information Technical Support Activity (SITES), ULA], other relevant USAID and USG IPs, and MoH, M&E Technical Working Groups in developing the final AMELP. The successful applicant must obtain AOR's approval of final AMELP within 90 days of award.

Performance Evaluations and Assessments

Per ADS 201.3.5.13, USAID/Uganda will initiate evaluations at any point during activity implementation if new information arises indicating that an evaluation is appropriate for accountability or learning. Current anticipated evaluations for UHA are:

Baseline assessment: USAID/Uganda will commission an external contractor to conduct a mixed methods baseline assessment for UHA. The baseline assessment–to be completed no later than by the end of Year 1–will serve as the basis for measuring progress across IRs, along with activity-reported

[29] USAID/GHSC-PSM. Uganda National Supply Chain Assessment: Capability and Performance. Aug. 2018.

data. The baseline will collect new primary quantitative and qualitative data as well as draw from existing secondary data (UDHS [2016]; Performance Monitoring and Accountability Survey 2020); the End-Line Review of the Investment Case for RMNCAH Sharpened Plan in Uganda; DHIS2 data within priority districts; Site Improvement through Monitoring System data; Lot Quality Assurance Sampling data; and reports from previous health programming.

End of activity performance evaluation: USAID/Uganda will commission final performance evaluation of the UHA during its last year to assess overall activity performance, determine the purpose of UHA has been met, and provide USAID with lessons learned and recommendations about potential adjustments necessary to achieve sustainable health outcomes. The evaluation will draw from baseline assessment data, routine DHIS2 and other MoH data, UHA progress reports, and new household-level and other surveys, such as DHS 2022. While an external consultant will lead the evaluation to maintain its neutrality and integrity, USAID/Uganda's Country Office, USAID/Washington, and other external consultants may also be involved. The awardee must facilitate access to data, documentation, personnel, and key stakeholders as appropriate for the completion of an external evaluation. Following the completion of an evaluation, the Mission will share the draft and final evaluation reports with the awardee being evaluated and will coordinate on dissemination and utilization of evaluation findings.

CLA

This activity is expected to contribute to USAID/Uganda's CDCS's commitment to a multi-faceted CLA approach to achieve more effective development. Specifically, the UHA implementer will be expected to detail its CLA approach to enhance integrated health outcomes through the creation of a CLA plan in its draft AMELP that explains how it will approach strategic collaboration with the GoU and local PEPFAR IPs, fill knowledge gaps in the theory of change, seize opportunities to reflect on progress, use knowledge to adapt accordingly, and resource and facilitate the process of CLA. Key aspects include:

- **Collaborating:** The awardee must engage in active collaboration with both USG- and non-USAID supported activities at national-, regional- and district-level to leverage resources, reduce overlap, and share learning around improving health outcomes and strengthening health system resilience. This entails coordinating with other key in-country partners to share knowledge around assessments, emerging research, lessons learned, etc.; identifying strategic opportunities to take advantage of other GoU, donor, and USG platforms to advance the activity's goals or layer interventions in similar geographic areas as other USAID IPs; and conducting joint work planning sessions with other relevant activities. Please see Section A5 for details.

- **Learning:** This awardee will identify opportunities for generating and feeding new learning, health innovations, and performance information back into the UHA program strategy to inform program management, design, and resource allocations. Sources for learning include data from routine facility- and community-level data and service statistics; new digital data collection tools;

UHA Learning Agenda Questions

What are the most effective approaches for operationalizing the MoH's Hub and Spoke model for decentralized service provision?

How can the GoU capitalize on recent adaptations and innovations to enhance continuity of services in a post-COVID context?

What are successful approaches for enhancing functional collaboration between UHA and USAID's above-site health investments and district multisectoral development programming?

How can UHA leverage PEPFAR-supported multi-month drug dispensing to also enhance MNCH, FP/RH, nutrition, and facility WASH health outcomes?

How can the GoU better leverage RBF, domestic resources, and public-private partnerships to more effectively fill health infrastructure, human resource, and supply chain gaps?

portfolio and data visualization reviews; findings of research, evaluations, analyses conducted by USAID or third parties; and knowledge gained from experience (such as pause and reflect and shared learning moments stocktaking exercises). The awardee should also disseminate knowledge generated by learning to activity stakeholders, partners, and collaborators in an appropriate forum and format so that it may be translated into decisions and actions that enhance the success of approaches and interventions designed to achieve common intermediate results, particularly across PEPFAR local IPs.

- **Adapting:** The awardee will learn from and adapt implementation throughout the life of UHA, using learning to influence decision making and resource allocation to achieve results. This may entail engaging in periodic reflection activities using approaches such as after-action reviews and pause and reflect sessions to identify, capture, and act upon lessons learned; translating learning from within implementation experience and considering programmatic changes to achieve better results. Given shifting epidemiology and upsurges of infectious disease (such as COVID-19), the awardee will be expected to employ a flexible implementation model to respond to the local implementation context, including health and non-health shocks and stressors.

A5. Implementation Approach

Use of Sub-Grants

This award will provide approximately $10 million in grants over the life of the five-year activity to NGOs, CBOs, and non-state actors to contribute to the achievement of key activity and IRs as described in the activity description above. Illustrative areas for sub-granting may include, but are not limited to:

- Community HSS efforts, such as strengthening data collection, reporting, and analysis; the community-facility referral system; and community QI initiatives.
- Scaling-up innovative models of SBC and community engagement in support of Sub-IR 1.3, prioritizing the reduction of inequities in health access and outcomes among women and girls, persons with disabilities, refugees, indigenous, LGBTQI+, and other vulnerable populations.
- Strengthening the technical health capacity of high functioning HIV- or non-health focused development organizations such as youth development, education, or agriculture CBOs.
- Scale-up of community service delivery interventions, as described in Sub-IR 1.2.3.

UHA sub-grants may include performance-based or any other innovative approaches to giving grants to local partners that mitigates fraud, promotes accountability, and improved efficiency and effectiveness. In conjunction with USAID, the recipient will establish measures to mitigate the potential risks of mismanagement and misappropriation of the grant funds including, but not limited ,to due diligence assessments, utilization of existing accountability systems, and adhering to USAID regulations of financial management. Additional details regarding the sub-grants program include:

- The recipient must submit a request for the Agreement Officer approval for the proposed sub-grants, no later than 30 calendar days, detailing the process for identifying, evaluating, vetting, awarding, and monitoring sub-grant activities.
- Final selection of sub-grantees will be done in consultation with USAID to ensure compliance with USAID requirements for approval of sub-grants with non-governmental entities.
- Construction activities are prohibited under sub-grants.
- All sub-grants must be completed six months prior to the end of UHA.
- USAID retains the ability to terminate the sub-grants activities unilaterally in extraordinary circumstances.

Local Capacity Development and Sustainability

UHA aims to support the development and scale-up of locally-led health solutions. Key elements of UHA's local capacity development approach includes:

1) Focusing the majority of its technical capacity strengthening efforts and investments on RRH, local IPs, and the community health system.
2) Supporting GoU priorities, such as the decentralization of health services.
3) Scaling-up a community-led SBC strategy that emphasizes the role of communities and local partners in identifying their own health priorities, resources, and activities to address them.
4) Working with key local influencers (e.g., cultural, religious, other community role models) to create an enabling environment for health solution development and implementation.
6) Including a small grants program that will support the identification, seeding, and scaling up of cost-effective community health innovations and locally-led solutions from community-based and non-traditional Ugandan organizations in priority districts.

Sustainability: UHA uses a multi-prong approach designed to sustain health results beyond the life of USAID's engagement. Essential elements include:

- Adopting a systems lens that enhances the foundational health system elements required at subnational level to achieve improved health outcomes, such as the supply chain, health workforce, and governance. This contrasts with traditionally vertically-focused health programming that strengthens health service delivery at facility level.
- Prioritizing engagement of local stakeholders (GoU, NGOs, FBOs, communities, and the private sector) to narrow MNCH, FP/RH, and nutrition equity gaps; improve quality of care; and increase health system accountability.
- Building on existing local structures and community platforms and integrating with the GoU's existing national and district operational plans and guidelines.
- Scaling up a community-led SBC strategy that maximizes existing multi-sectoral community networks, emphasizing the role of communities and local partners in identifying their own health priorities, resources, and activities to address these priorities.
- Requiring the identification and use of low-cost and locally-driven solutions to health issues that are more cost effective and sustainable.

Increasing the availability of local resources: UHA includes a pronounced focus on identifying, facilitating, and optimizing the use of local resources to support increased sustainability of quality health services as USAID support sunsets. The activity will provide TA to RRHs, DHOs, and health facilities to maximize the use of MoH, URMCHIP, and Global Financing Facility (GFF) support to stimulate potential local private sector investments and optimize resource use under Sub-IR 3.2. Similarly, the UHA implementer is expected to collaborate with PEPFAR to ensure G2G investments spur local health investment at district level, while improving subnational capacity to manage and optimize those resources, including addressing transparency and accountability around resource expenditure for health.

Program Coordination with the GoU, Other IPs, and Donors

USAID/Uganda expects a high degree of cross-IP coordination to enhance achievement and reinforcement of UHA results, leveraging USAID's robust above-site/national and sub-national investments in the health sector. Specifically, UHA will work closely with the MoH and USAID/Uganda national/above-site mechanisms to cascade health policies, guidelines, and technical strategies to priority districts; test and scale new MNCH, FP/RH, nutrition- and facility WASH interventions; and establish feedback loops.

Community- and household level health and development challenges are frequently inter-linked across sectors and mutually reinforcing. USAID/Uganda therefore also expects thoughtful and purposeful coordination with other USG- and non-USG multisectoral investments in education, child development, agriculture, WASH, nutrition, youth, resilience, and economic growth programming. The awardee should identify strategic opportunities to leverage relationships, resources, and service delivery interventions to enhance achievement of UHA results in districts and sub-regions where activities will

be jointly implemented, per Table 2. While the level, frequency, and intensity of engagement with different activities will vary based upon real-time geographic and technical considerations, anticipated collaboration may include:

- Participating in relevant national-level technical working groups and sub-national GoU coordination fora, such as district partner meetings.
- Holding individual project planning and collaboration meetings with key USAID projects and sharing annual work plans; reporting on joint multi-sectoral results and objectives jointly.
- Where appropriate in joint implementation health districts, sharing resources where it is cost-effective to do so with other USAID- and donor-funded and GoU initiatives.
- Coordinating non-health specific meetings and progress reporting to local government officials (e.g non-health district and regional administrators).
- Engaging relevant regional and district health counterparts in joint work planning, sharing of reporting, and progress reviews, aligned to the extent possible with GoU processes.
- Ensuring UHA-supported sites report into MOH/GoU databases through existing channels/mechanisms, in addition to USAID reporting.
- Conducting joint supportive supervision to sites with different USAID projects.

Table 2: Potential Institutions/Activities with which UHA Will Collaborate (IRs)			**Subnational Areas of Co-Location**
USG/health sector activities	MCHN Activity	• Scale-up high impact MCHN practices at facility/community level	• National-level and relevant priority districts
	FPA	• Cascade high impact FP practices at facility and community level	• Overlapping priority districts: e.g., Kyegegwa, Kyenjojo, Buliisa, Kibaale, Bundibugyo, Ntoroko, Kiryadongo, Butamabala, Rakai, Gomba, and Kyankwazi
	SBCA	• Localize/scale relevant MNCH, FP/RH, and nutrition SBC approaches	• TBD priority districts
	PMI Malaria Reduction Activity (PUMRA)	• Coordinate district malaria and community-level iCCM efforts in co-located districts	• TBD priority districts in Acholi, Lango, Karamoja, and Busoga
	PEPFAR local IPs (see Sub-IR 2.5)	• Provide TA under Sub-IR 2.5 based upon IP capacity needs	• PEPFAR IP implementation districts.
	Integrated Community Agriculture and Nutrition (ICAN)	• Leverage existing ICAN FTF community platforms for improving household nutrition mothers and children	• UHA priority districts withing ICAN priority sub-regions: Acholi, Kigezi, Karamoja, Gulu
	Uganda Sanitation for Health (USHA)	• Scale-up new WASH IPC guidelines and facility WASH practices	• Priority UHA districts, including in Acholi and Busoga (USHA)
	UHSS	• Scale IR 2 and 3 interventions	• In PEPFAR districts
	SSCS	• Increase access to EHMS via TA; scale-up SSCS training and tools	• National-level and within priority PEPFAR districts
	ULA	• Conduct relevant UHA assessments	• National-level
	SITES (MEL),	• Strengthen DQA and EMR efforts	• In PEPFAR districts
	Integrated Child and Youth Development Activity (IYCD)	• Identify vulnerable household members for UHA interventions • Leverage community platforms to reach priority populations with health information	• Relevant priority districts where UHA and activities overlap (ICYD: Gulu, Jinja, Kabale, Lira, Mbale, Mbarara; ICARE: Jinja; KCHS: Mbarara, Kabale)
	Improving Care and Resilience for Children and Youth in Eastern Central (ICARE)		

	Keeping Children Healthy & Safe (KCHS)	• Strengthen community referrals for health services	
	Inclusive Agricultural Markets Activity (IAM)	• Leverage IAM gathering platforms for youth, women, farmers for information/referrals	• Relevant priority districts of overlap
	DRM4D	• Increase health budget advocacy, monitoring of public expenditures, and budget analysis	• Relevant priority districts where UHA and DRM4D overlap (in Mbarara, Jinja, Mbale, Lira, Gulu)
Other donors	World Bank	• Leverage URMCHIP RBF	• Priority DHOs and health facilities
	Global Fund	• Collaborate/coordinate on iCCM and relevant HSS support	• Relevant priority districts
	GFF	• Implement new RMNCAH Sharpened Plan	• Relevant priority districts
	FCDO/DFID	• Coordinate and fill gaps to address the reduction of FP/RH and malaria funding	• Relevant priority districts
	UNFPA	• Leverage FP/RH commodity distribution	• National level
	UNICEF	• Amplify UNICEF investments in iCCM, nutrition, child health	• Relevant priority districts, especially within Karamoja
Govt.	MoH	• TA around relevant IRs to SCAPP, DHOs, and RRHs • Share results and jointly plan	• Seven RRH community health departments and ≤30 districts • National level TA to SCAPP
	Allied non-health GoU Ministries	• Coordinate on multisectoral interventions under IR 1.3 and 2.3	• National-level and where relevant sub-nationally
Private	PNFP/FBOs	• Provide TA to priority high-volume PNFP sites as directed by GoU • Coordinate service delivery interventions at district level	• In all priority districts where UHA works, especially the Local Service Delivery Activity.
	Umbrella private sector organizations	• Identify potential areas of collaboration and PPPs	• TBD

Gender Considerations

Ugandan women and adolescent girls face religious, cultural, patriarchal, and gender and social norms that increases their maternal and child morbidity and mortality risk. In line with USAID's Gender Equality and Women's Empowerment 2020 Policy and the U.S. Strategy to Prevent and Respond to GBV 2016, UHA will mainstream and integrate gender issues to advance gender equality, address GBV, and promote female empowerment to accelerate achievement of the intended UHA results.

USAID/Uganda reviewed key gender-related analyses[30] to strengthen UHA's gender-responsiveness. This review found that women's health decisions and behaviors are influenced significantly by gender, socio-cultural, and religious norms that limit their agency in MNCH, FP/RH, nutrition, and HIV decision-making. These norms–including early and child marriage, polygamy and multiple concurrent unprotected sexual partnerships, young age of sexual debut, and high rates of GBV–negatively impact women and girls' health. At a practical level, this means women and girls are often unable to negotiate for safer sex, condom use, and or FP; access financial resources; or seek health services when needed. Men often act as gatekeepers around the use of income and health services, although they often lack access to accurate knowledge about HIV, MNCH, FP/RH, and nutrition. The COVID-19 pandemic has exacerbated gender inequality and worsened reproductive health outcomes. Travel restrictions and lockdowns have compromised women and youth's ability to access health services, post-violence care, and impacted

[30] USAID/Uganda Gender Equality and Social Inclusion Analysis (2021, draft and 2017); RHITES Gender Action Plans.

adherence to HIV treatment. Women have also experienced a significant escalation of GBV during the pandemic, with some calling it "a pandemic within the pandemic."

Despite these gender-related challenges, opportunities exist to enhance equitable access to and uptake of health services as well as reduce gender inequalities through UHA. These include amplifying positive social norms and scaling-up the adoption of evidence-based and innovative strategies for increasing uptake of health services. The UHA recipient will be expected to incorporate gender-sensitive approaches into all aspects of the activity, including by:

- Demonstrating a thorough understanding of the barriers and constraints to women and men, girls and boys and vulnerable groups participating and benefiting equally in the health system and developing strategies to address these barriers and constraints.
- Conducting gender youth, and social inclusion analysis and incorporating findings into the activity work plan.
- Providing TA to districts and local partners to implement culturally-sensitive, but transformational approaches to effectively address gender dynamics and socio-cultural norms that contribute to equity gaps in health for priority populations, including low parity parents/mothers, adolescent girls, young men, and those living in hard-to-reach rural areas.
- Providing TA to health service providers, districts, and local partners in the adaptation of evidence-based gender transformative approaches for diffusing positive norms and promoting uptake of reproductive health services.
- Exploring interventions that make existing health-care systems more inclusive and accessible to adolescent girls, women, people with disabilities, GBV survivors, and vulnerable populations.
- Facilitating engagement of civil society, FBOs, NGOs/CBOs, and other local institutions to narrow equity gaps at the regional, district, and community levels.
- Incorporating gender-sensitive indicators within the final AMELP and disaggregating data to enable the monitoring of UHA's differing impacts on women, girls, and other vulnerable groups.

Youth and Other Vulnerable Groups

Uganda features one of the world's youngest populations globally, with nearly 80% of the population below the age of 30. Reaching and supporting youth populations is therefore critical to achieving UHA outcomes, and in harnessing the potential of Uganda's young population to contribute to the country's development in the future. AGYW face particularly high biological and social risks that increase their risk of early marriages, early pregnancies, HIV acquisition, malnutrition, and poverty.[31] This manifests itself in part through engaging in high-risk behaviors, including alcohol use, multiple sexual partners, unsafe sex and transactional sex. As a result, the teenage pregnancy rate is alarmingly high, standing at 25% at national level and as high as 31% in Eastern sub-region. The COVID-19 pandemic has reportedly increased teenage pregnancy rates in some districts and intensified many of the stressors increasing AGYW health risk, such as poverty, school closures, and limited access to health services. Unfortunately, complications from pregnancy, childbirth, and unsafe abortion are a leading cause of AGYW death and school dropout. AGYW are also at an increased risk of malnutrition and giving birth to underweight babies, continuing the cycle of malnutrition that increases child mortality.

Adolescents currently lack access to high quality and youth-responsive services that meet their needs according to their life course. Newly married AGYW clients, for example, may benefit from health interventions aimed at delaying first pregnancy until age 18, while older/married youth may benefit from MNCH, postpartum FP, and LARC to contribute to healthy timing and spacing of pregnancy. Regardless of intervention, youth are vulnerable primarily because they depend on their parents or spouses and their decision to seek care still requires parental approval, particularly that of the father.

[31] Nabugoomu, J., Seruwagi, G.K. & Hanning, R. *What can be done to reduce the prevalence of teen pregnancy in rural Eastern Uganda?: multi-stakeholder perceptions*. Reprod Health (2020).

USAID/Uganda is committed to integrating and addressing the needs of youth and vulnerable populations into UHA, ensuring the incorporation of innovative mechanisms to promote youth engagement in implementation. This includes not only targeting the needs of adolescent girls and boys, but of their parents, partners, and community. Ensuring the inclusion of voices of vulnerable groups especially women, young people, and persons with disabilities requires special efforts and attention to positively influence service access and delivery and resulting health and social outcomes. UHA-supported youth and social inclusion interventions may include:

- Providing TA to adopt/scale up differentiated, inclusive, nondiscriminatory, and innovative models to better meet adolescent health needs, in alignment with the new National Adolescent Health Strategy 2021-2025.
- Supporting local partners and GoU to scale-up evidence-based individual and community SBC and facility interventions that reduce adolescent pregnancy and increase access to MNCH, FP/RH, nutrition, and HIV services.
- Increasing participation and engagement of youth and other vulnerable populations (people with disabilities, ethnic and sexual minorities) within social accountability platforms and approaches.
- Using age-disaggregated information to measure health impacts among adolescents.

Proposed Uganda Health Activity Key Personnel Requirements

1. Chief of Party (COP)

Role: The COP will oversee overall UHA implementation, providing strategic technical vision and managing the project team and consortium members. This leadership role liaises with USAID, the MoH, other health and development donors, and other IPs in Uganda on behalf of the UHA, cultivating open, productive, and collaborative relationships to advance activity objectives. The COP also ensures that the activity complies with cooperative agreement terms and conditions and USAID policies and regulations. The COP will be expected to identify issues and risks related to program implementation in a timely manner, suggest appropriate program adjustments, and ensure that systems are in place to mitigate the risk of fraud, waste, and abuse. The proposed COP candidate must fulfill the position requirements detailed below:

Chief of Party Qualifications, Experience, and Skills
Required: ● Master's degree or other advanced degree (PhD, MD). in a relevant field, such as medicine, public health, social sciences, or management. ● Minimum of 10 years' progressively responsive experience in a senior role managing large and complex integrated health service delivery programs of similar scope and dollar value ($30M+) in Sub-Saharan Africa. ● Previous experience working on USG programs and working knowledge of USG regulations. ● Proven ability to work collaboratively with government, donors, the private sector, and community organizations to advance health objectives. ● Demonstrated experience successfully leading and managing multi-disciplinary teams to achieve health results in a fast-paced environment. ● Excellent interpersonal, writing, and English language oral presentation skills.
Desired: ● 5 years' experience working in East Africa on development programming. ● Current relationships with relevant Uganda stakeholders (MOH, donors, IPs) and/or past experience working in Uganda. ● Previous experience working on and/or technical expertise in MNCH, FP, nutrition, WASH, HSS, or/and PEPFAR programming.

2. Technical Director, Integrated Health Service Delivery (IHSD)

Role: The Technical Director, IHSD will be responsible for technical oversight of integrated health service delivery and TA activities for MNCH, FP/RH, nutrition, and WASH at facility- and community-level. The Technical Director, IHSD reports directly to the COP and works in tandem with the Technical Director, HIV/AIDS and HSS. This position will take a leadership role in ensuring UHA meets stated integrated health service delivery goals, quality standards, and reporting requirements. The Technical Director, IHSD will also coordinate among USAID, donors, other health IPs, and numerous GoU institutions and representatives, particularly at the regional and district level for integrated health service delivery activities. The proposed candidate must fulfill the position requirements detailed below:

Technical Director, IHSD - Qualifications, Experience, and Skills

Required: ● Master's degree or other advanced degree (PhD, MD) in a relevant field, such as medicine, public health, or social sciences. ● At least seven years of experience in managing and/or implementing integrated health service delivery or technical assistance programming addressing MNCH, FP/RH, nutrition, and WASH in a similar context, with at least three of those years working in Uganda as a senior advisor or staff member. ● Experience and expertise in evidence-based facility- or community-based MNCH, FP/RH, nutrition, and/or WASH service delivery approaches. ● Ability to interact effectively and collaboratively with a broad range of public and private sector counterparts, donors, and other key stakeholders. ● Experience supervising technical staff in the implementation of integrated health programming. ● Excellent interpersonal, writing, and English language oral presentation skills.
Desired: ● Clinical qualification (MD, clinical officer, nurse, midwife, or other cadres). ● Previous experience working on USG-funded health programming in Uganda. ● Experience designing or implementing gender- or youth-sensitive health programming. ● Expertise in strengthening quality of care and/or QI for MNCH, FP, nutrition, or WASH.

3. Technical Director, HIV and HSS

Role: The Technical Director, HIV and HSS will be responsible for technical oversight of TA activities for strengthening PEPFAR local IPs and HSS (IR 3). The Technical Director, HIV and HSS reports directly to the COP and works in tandem with the Technical Director, IHSD. This position will take a leadership role in ensuring UHA meets stated HIV and HSS goals, quality standards, and reporting requirements. The Technical Director, HIV and HSS will also coordinate among USAID, other health IPs, and numerous GoU institutions and representatives, particularly at the regional- and district-level for HIV and HSS activities. The proposed candidate must fulfill the position requirements detailed below:

Technical Director, HIV and HSS - Qualifications, Experience, and Skills
Required: ● Master's degree or other advanced degree (PhD, MD) in a relevant field, such as medicine, public health, health system management, social administration, or social sciences. ● At least seven years of experience in managing and/or implementing integrated HIV prevention, care, and treatment and/or HSS programming in a similar context, with at least three of those years working in Uganda as a senior advisor or staff member. ● Experience and expertise in one or more of the following areas: facility- or community-based HIV approaches; health governance; HRH; supply chain strengthening; QI; MEL; capacity strengthening of local organizations. ● Ability to interact effectively and collaboratively with a broad range of senior and mid-level public and private sector counterparts, donors, and other key stakeholders. ● Experience supervising technical staff in the implementation of integrated health programming. ● Excellent interpersonal, writing, and English language oral presentation skills.
Desired: ● Clinical qualification (MD, clinical officer, nurse, midwife, or other cadres).

- Previous experience working on USG-funded HIV programming in Uganda.
- Experience designing or implementing gender- or youth-sensitive health programming.
- Expertise in strengthening the program management, service delivery or adaptive management of Ugandan health organizations.
- Experience working with decentralized health systems.

4. Director, MEL

Reporting to the COP, the Director, MEL will oversee all monitoring, evaluation, learning, and components of this Activity, including the design and implementation of the AMELP and corresponding information system to track delivery against targets. As part of this work, the Director, MEL will guide reporting processes among technical staff, ensuring timely, accurate, and complete reporting. The position will also promote learning and knowledge sharing of best practices, and dissemination of lessons learned and project outcomes as part of its CLA approach. The Director, MEL will mentor and support all the technical staff in MEL functions and will manage any MEL-related program staff. This position will also strengthen integrated health and HIV reporting capacity among local PEPFAR and GoU partners. The proposed candidate must fulfill the position requirements detailed below:

Director, MEL - Qualifications, Experience, and Skills
Required: ● Master's degree in a relevant field, such as public health, epidemiology, biostatistics, or social sciences. ● At least seven years of experience in managing and/or leading MEL activities for large-scale health service delivery or HSS programs in Sub-Saharan Africa, with at least three of those years working in Uganda as a senior advisor or staff member. ● Demonstrated experience in setting up and managing MEL systems that track performance as per the objectives of UHA. ● Knowledge of and experience with key MNCH, FP/RH, nutrition, WASH, and/or HIV/AIDS indicators and GoU and USG data collection systems (e.g. DHIS2, DATIM). ● Demonstrated ability to translate project objectives and vision into an evidence-based theory of change. ● Strong analytical skills to successfully use data and evidence to guide program adaptations. ● Excellent ability to articulate oral and written technical information clearly and effectively to both technical and non-technical audiences.
Desired: ● Previous experience supporting MEL on USG-funded health programming in Uganda. ● Familiarity with CLA approaches. ● Expertise in qualitative and quantitative research methods. ● Data visualization skills.

5. Finance and Administration Director

The F&A Director will report to the COP and will be responsible for overseeing all aspects of budgeting, financial management, and reporting; sub-award management and procurements; human resources management; asset management; logistics; and prime award compliance with terms and conditions of the award. This individual will be responsible for managing the cooperative agreement budget and preparing financial reports for submission to USAID. The F&A Director will also ensure funds expended are compliant with USG regulations and policies. This individual will ensure systems and

processes are implemented effectively to support implementation of the award, including fraud and risk mitigation practices. The proposed candidate must fulfill the position requirements detailed below:

Finance and Administration Director - Qualifications, Experience, and Skills
Required: ● Professional certification (CPA or ACCA). ● Minimum of 10 years of experience in financial and administrative management for large donor-funded development projects (>$30M of total award size). ● Experience managing donor-funded sub-awards and subcontractors and procurements. ● Familiarity with USG financial reporting and compliance requirements. ● Experience in risk management and implementation of internal controls. ● Demonstrated supervisory experience. ● Professional level of oral and written fluency in English language.
Desired: ● Master's degree or other in Business, Accounting, Finance, or related field. ● Expertise and experience in one or more areas: operations, human resources, logistics, or IT.

ANNEX 1: Priority PEPFAR Districts for IR 3 HSS Support

1	Mbarara City	37	Ibanda District
2	Kabale District	38	Bugweri District
3	Kanungu District	39	Iganga District
4	Kisoro District	40	Buyende District
5	Rubanda District	41	Isingiro District
6	Rukiga District	42	Kaabong District
7	Rukungiri District	43	Butaleja District
8	Jinja City	44	Agago District
9	Kwania District	45	Kamuli District
10	Oyam District	46	Kotido District
11	Mbale City	47	Abim District
12	Alebtong District	48	Pallisa District
13	Apac District	49	Omoro District
14	Otuke District	50	Namisindwa District
15	Kibuku District	51	Tororo District
16	Amolatar District	52	Ntungamo District
17	Lira City	53	Budaka District
18	Amuru District	54	Kitgum District
19	Bushenyi District	55	Rubirizi District
20	Bududa District	56	Gulu City
21	Namayingo District	57	Lamwo District
22	Mitooma District	58	Moroto District
23	Sironko District	59	Bugiri District
24	Namutumba District	60	Lira District
25	Bukwo District	61	Kole District
26	Mayuge District	62	Dokolo District
27	Mbale District	63	Kween District
28	Buhweju District	64	Bulambuli District
29	Manafwa District	65	Kapchorwa District
30	Jinja District	66	Karenga District

31	Kaliro District	67	Mbarara District
32	Busia District	68	Rwampara District
33	Kazo District	69	Pader District
34	Kiruhura District	70	Nwoya District
35	Butebo District	71	Gulu District
36	Sheema District	72	Luuka District