Issue Date:	February 16, 2022
Question Due Dates:	February 24, 2022 at 08:00 AM GMT
Concept Paper Closing Date:	March 24, 2022 at 08:00 AM GMT
Subject:	**Request for Concept Notes: Round 1** under the Guinea Local Health System Strengthening (GLHSS), Annual Program Statement (APS) No.: 72067522APS00002
Opportunity Title:	Guinea Local Health System Strengthening Round No.: 1
Catalog of Federal Domestic Assistance:	98.001 Foreign Assistance for Programs Overseas

Dear Interested Applicants:

Pursuant to the authority granted in the Foreign Assistance Act of 1961, as amended, the United States Government (USG), represented by the United States Agency for International Development (USAID), the Guinea Mission is issuing this Annual Program Statement (APS) for USAID to use as a platform for obtaining concept papers, full applications and issuing awards

GLHSS APS Round 1 is a request for Concept Paper(s) to strengthen local health systems in targeted geographic areas so that Guineans can access a higher quality of health care in their communities and local public health facilities.

To be competitive, the Concept Paper submission must be fully responsive to all directions under this request as well as the GLHSS APS No.: 72067522APS00002. Based on the submitted Concept Paper, USAID will determine whether to request a Full Application from an eligible organization. Issuance of this round does not constitute an award or commitment on the part of the U.S. Government, nor does it commit the U.S. Government to pay for costs incurred in the preparation and submission of Concept Paper(s) or Application(s). Issuance of award is subject to the availability of funds and the interest and requirements of USAID, as well as the viability of eventual Full Application(s) received if successful in the concept paper round.

To be eligible for award, the Applicant must provide all information as required and meet eligibility standards of this APS. This funding opportunity is posted on www.grants.gov, and may be amended. It is the responsibility of the Applicant to ensure that the APS and Request for Concept

Papers has been downloaded from www.grants.gov in its entirety as USAID bears no responsibility for data errors resulting from transmission or conversion process. In case of difficulty registering on www.grants.gov or accessing the APS, please contact the grants.gov Helpdesk at 1-800- 518-4726 or via email at support@grants.gov for technical assistance.

USAID/Guinea will not award to an applicant unless the applicant has complied with all applicable unique entity identifier (DUNS Number) and System for Award Management (SAM) requirements detailed in **Section D**. The registration process may take many weeks to complete. Therefore, applicants are encouraged to begin registration early in the process.

All submissions (including questions) must be emailed to the undersigned at aasante@usaid.gov with a copy to conakryoaa@usaid.gov by the date and time indicated on this cover letter. Responses to questions received prior to the deadline will be furnished to all potential applicants through an amendment to this notice posted to www.grants.gov.

Issuance of this APS does not constitute an award commitment on the part of the Government, nor does it commit the Government to pay for costs incurred in the preparation and submission of comments/suggestions or an application. In addition, final award, if any, cannot be made until funds have been fully appropriated, allocated, and committed through internal USAID/Guinea procedures. Applications are submitted at the risk of the applicant; should circumstances prevent an award, all preparation and submission costs are at the applicant's expense.

Thank you for your interest in USAID programs.

Sincerely,

Albert Asante
Digitally signed by Albert Asante
Date: 2022.02.16 16:16:14 Z

Albert P. Asante
Regional Agreement Officer
Office of Acquisition and Assistance

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ABBREVIATIONS AND ACRONYMS

ADS Automated Directives System
AIDS Acquired Immunodeficiency Syndrome
ANAFIC Agence Nationale de Finance des Collectivités Locales
AO Agreement Officer
AOR Agreement Officer Representative
ASC Agent de Santé Communautaire (Community Health Worker)
BIP Branding Implementation Plan
CBO Community Based Organization
CDCS Country Development Cooperation Strategy
CFR Code of Federal Regulations
CHW Community Health Worker (Agent de Santé Communautaire – ASC)
CPA Certified Public Accountant
COP Chief of Party
COSAH Comité de Santé et d'Hygiène
COVID Coronavirus disease 2019
CSO Civil Society Organization
DCOP Deputy Chief of Party
DEC Development Experience Clearinghouse
DHIS2 District Health Information System, version 2
DHS Demographic Health Survey
DO Development Objective
EA Environmental Assessment
eLMIS Electronic Logistics Management Information System
EMMP Environmental Mitigation and Monitoring Plan
FAR Federal Acquisition Regulation
FBO Faith-based Organizations
FGM/C Female Genital Mutilation/Cutting
FP Family Planning
FP/RH Family Planning and Reproductive Health
GASS Generally Accepted Auditing Standards
GAVI The Global Alliance for Vaccines and Immunizations
GBV Gender Based Violence
GESI Gender Equality and Social Inclusion
GHSC Global Health Supply Chain
GFATM Global Fund to Fight AIDS, TB and Malaria
GNF Guinean National Francs
GOG Government of Guinea
HDI Human Development Index
HSD Health Service Delivery
IEE Initial Environmental Evaluation
IPC Infection Prevention and Control
KAP Knowledge, Attitudes and Practice
GLHSS Local Health System Strengthening Activity
LOE Level of Effort
MCH Mother and Child Health

MEL Monitoring, Evaluation and Learning
AMELP Activity Monitoring, Evaluation and Learning Plan
M&M Mitigation and Monitoring
MOH Ministry of Health
NFO Notice of Funding Opportunity
NGO Non-Governmental Organization
NICRA Negotiated Indirect Cost Rate Agreement
OMB Office of Management and Budget
PAO Plan d'Action Opérationnel
PCG Pharmacie Centrale de Guinée
PEV Programme Elargi de Vaccination (Expanded Vaccination Program)
PMI President's Malaria Initiative (U.S.)
PMP Performance Management Plan
PNDS Plan National de Développement Sanitaire (National Health Development Plan)
PNLP Programme National de Lutte contre le Paludisme (National Malaria Program)
PQM Promoting Quality of Medicines
PSA Public Service Announcement
PSE Private Sector Engagement
PSM Procurement and Supply Management
RECO Community Relays (Relais Communautaire)
RFA Request for Applications
RH Reproductive Health
SAM System for Award Management
SBC Social and Behavior Change
SC Selection Committee
TB Tuberculosis
UNDP United Nations Development Program
UNFP United Nations Population Fund
U.S. United States
USG United States Government
USD United States Dollar
USAID U.S. Agency for International Development
WASH Water, Sanitation and Hygiene
WHO World Health Organization

SECTION A: PROGRAM DESCRIPTION

The U.S. Agency for International Development (USAID) Mission in Guinea is pleased to issue this Round for the implementation of an activity designed to strengthen local health systems in targeted geographic areas so that Guineans can access a higher quality of health care in their communities and local public health facilities.

A.1. Guinea Local Health System Strengthening (GLHSS) Overview

USAID/Guinea's health office proposes the design of a new health sector activity entitled: Guinea Local Health System Strengthening (GLHSS). Its design involved USAID/Guinea, USAID/Washington, the Ministry of Health (MOH) and stakeholders working in the health sector. This co-engagement process will continue during the five-year implementation phase and will identify health topics on which additional information is needed.

The core development problem that GLHSS will address is poor health outcomes. This problem will be addressed by responding to key challenges to the efficient functioning of the health system, with a particular emphasis on the local level. These challenges can be categorized into the following seven broad areas: Accessibility, Affordability and Quality of Care; Supply Chain Management; Leadership, Management and Governance; Human Resources; Health Information System; Social and Behavior Change; and Funding for the Health Sector. GLHSS will result in improved delivery of integrated health services in targeted areas, establishment of health enhancing social norms, stronger democratic norms and processes, and increased use of strategic information for decision-making.

The co-engagement process will maximize the use of innovative approaches to addressing the challenges facing Guinea's health sector. This process will require the rigorous collection of relevant data and information, and close collaboration for the life-of-project with key stakeholders in Guinea, MOH officials at the national and local levels, other donor representatives and concerned community leaders.

Throughout this process, creativity and flexibility on the part of the selected implementation agent in achieving stated activity objectives will be encouraged. Preference will be given to the formation of an implementation consortium that includes sub-awards to qualified local organizations. Moreover, an important element is the manner in which issues concerning gender, youth and people with disabilities are addressed. Also, the implementing agent will be expected to involve USAID/Guinea's Democracy and Governance Office in the conduct of activities designed to strengthen democratic norms at the community level.

The activity will be implemented in the U.S. Presidential Malaria Initiative (PMI) target regions, namely the three regions of Boké, Kindia and Labé, and five communes of the capital city of Conakry. Together, these regions cover an estimated 50% of Guinea's total population. The activity will be designed and implemented with sufficient flexibility to allow changes as needed in its geographical focus zones so as to reflect Guinea's evolving political, social and health situations.

It will also have the flexibility to adjust its scope according to available funding resources and crisis situations.

GLHSS will contribute to sustainable improvements in the health status of target populations in these three regions and five Conakry communes. Thus, it directly supports the Mission's Development Objective (DO) 1: *Increased Capacity and Commitment of the Local Health System for Better Health Outcomes.* GLHSS will be the central pillar of USAID/Guinea's health service delivery and capacity building portfolio. It also consolidates two current USAID/Guinea bilateral health activities: Health Services Delivery (HSD) and Guinea's flagship PMI activity.

GLHSS will apply a systems approach that uses USAID resources to leverage and influence other actors, internal and external, working in Guinea's health sector. For example, USAID will collaborate closely with not only the MOH, but also with other donors such as the Global Fund to Fight AIDS, TB and Malaria (GFATM), United Nations Population Fund (UNFPA) and the World Bank. The aim will be to improve the accountability, management and decision-making capacity of local health system actors so that they are able to provide quality health services within targeted health districts. A strong emphasis will be placed on ensuring the integration of principles of equity, quality and resource optimization into the health delivery system at the community level.

A.2 Development Hypothesis

The overarching development hypothesis is that IF local health systems ensure quality and affordable health service provision; support norms and behaviors that enhance health; operate according to democratic norms and procedures; have sufficient funding, and use available data to inform decisions, THEN the local health systems will demonstrate increased capacity and commitment to better health outcomes, and, thereby, engender greater trust by communities in the health system.

Underlying this central hypothesis are the following points:

IF health facilities and human resources are managed more effectively and at the decentralized level; health facilities have the required equipment, tools, training, and medicines; and health services are delivered in a people-centered fashion, THEN the local health system will have ensured the availability of quality, affordable and gender- and youth-responsive health services.

IF the targeted population and health care workers have the knowledge and beliefs needed to practice health-enhancing behaviors; health care workers provide unbiased care according to protocols; and key social and behavior change messages are disseminated in an effective manner, THEN an enabling environment for health-enhancing social norms and behaviors will be established.

IF local government responsiveness to the male and female population's concerns can be improved; civil society and media advocacy strengthened; targeted national level institutions strengthened; and consensus building increased among local stakeholders, THEN democratic processes that support improved health outcomes will be strengthened.

Investments that support the increased capacity of local health systems and encourage local actors to demonstrate their commitment to improved health outcomes are crucial for Guinea to move along the path towards greater self-reliance. In particular, local government entities will be encouraged to include in their plan for funding needed to improve health services in their communities.

USAID/Guinea proposes to focus primarily on decentralized levels to strengthen the local health system to support improved health outcomes. The provision of quality services requires well-managed human resources within health service delivery points; necessary equipment, infrastructure, training, tools, and health consumables; and making health services available and affordable to all members of the population, including women, youth, marginalized and vulnerable groups.

Local health system actors are also critical in reinforcing positive social norms and governing the use of human and financial resources destined for the sector. Focusing on these areas, and using accurate information for decision-making across these areas, will create the necessary enabling environment for better health outcomes, particularly at the community level.

A.3 Critical Assumptions and Risk Factors

The critical assumptions that underpin this new activity include the following:

- The Government of Guinea (GOG) remains committed to both its decentralization and community health strategies.
- Current donor funding levels for Guinea's health sector do not decrease.
- USAID/Guinea will be able to identify effective incentives to strengthen the accountability of local health system actors.
- GOG and other relevant institutions are receptive to addressing any inequities in the health system which diminish the care provided to women and youth.
- USAID/Guinea's implementing partners will be able to identify positive change agents at the district, facility and the community level who can serve as models to other regions.
- The local health system will continue to function at a sufficient level to allow for the delivery of health services and the engagement of USAID.
- The Government of Guinea continues to provide funds to the health sector;[1] and
- No substantial changes in USAID funding to Guinea.

USAID/Guinea's Health Office has also identified the following possible health risks:

- Probability of outbreaks of other infectious diseases, as experienced during the 2014-2016 Ebola outbreak and in early 2021 with some Ebola cases reported in Guinea's Forest Region, and the Marburg case reported in 2021.

[1] The export of bauxite, diamonds and gold represents nearly 80 percent of the GOG's revenue.

- The advent of a new wave of the COVID-19 pandemic could increase economic and food security hardships for the Guinean people, especially girls, women, youth, the marginalized and the most vulnerable.
- Misappropriation of Government of Guinea health resources could occur, resulting in underfunding of health activities; and
- An upsurge in the COVID-19 pandemic could reduce the use and delivery of routine health services and disrupt the procurement of essential medicines, as well as regular childhood vaccination and mosquito bed net distribution campaigns.

Overall, the evolving situation in Guinea could increase its fragility. Already, Guinea is ranked 15th from the bottom of a list ranking 179 countries on the 2020 Fragile States Index. Except for Nigeria, Guinea was ranked as the most fragile country in West Africa.

The design of this new activity will take into account the assumptions and risks outlined above, incorporating sufficient flexibility so that implementation can readily be adjusted to reflect the realities of the evolving operational situation and unforeseen circumstances.

A.4 Problem Statement and Rationale

The GOG's MOH National Health Development Plan (PNDS), 2015-2024, characterizes Guinea's health system as being weak and, thus, its overall performance is poor.[2] The PNDS cites low coverage (estimated at about 50 percent) of the population with essential quality health services. It also cites low institutional health care capacity as a major handicap to improving the health status of Guinea's population. As indicated below, this new activity will be designed to respond to key shortcomings in Guinea's health status, particularly in targeted communities.

The PNDS describes Guinea's health status as follows: morbidity and mortality levels are still too high, especially among vulnerable groups, including mothers and newborns; weak coverage for most of the essential health services and the doubtful quality of those services; inefficient and inequitable provision of health services; and an operational environment constrained by important obstacles and constraints, notably in the areas of adequate equipment and infrastructure. It notes this environment was worsened by the 2014-2016 Ebola outbreak and the health system is still recovering from the devastating impact of this epidemic.

The 2018 DHS does show some progress over the previous 2012 DHS.[3] For example, in the 2018 DHS, 53 percent of women used maternity services available at their local health facilities whereas in 2012 it was reported that 40 percent of women used these services and 47 percent delivered their

[2] Minstère de la Santé, République de Guinée, Plan National de Développement Sanitaire (PNDS) 2015-2024, Mars 2015. https://mohs2017.files.wordpress.com/2017/06/guinea_plan_national_developpement_sanitaire_2015-2024_guinee_fin.pdf

[3] Enquête Démographique et de Santé et à Indicateurs Multiples (EDS-MICS 2012), Institut National de la Statistique, Ministère du Plan, Conakry, Guinée, Novembre 2013.

babies at home.[4] Therefore, progress is possible, but many barriers remain to be overcome to ensure that an adequate level of quality health care is available to all Guineans.

A high variability of health services provided at local facilities demonstrates that serious issues of accessibility, affordability, acceptability, equity and quality persist. Financial barriers remain the most cited reason (60 percent) that women do not seek care at a health facility. The limited number of available skilled health workers (e.g., physicians, nurses and midwives) is also a serious concern, particularly in rural areas. This shortage of skilled workers, especially women, is highlighted by the lack of competent health providers who are able to provide quality emergency obstetric and newborn care in many health facilities.

Family planning[5] (FP) is another area where much progress is needed. While the use of modern contraceptives is increasing, the unmet need for FP remains high at 22 percent and the overall demand is 33 percent. The persistent high unmet need for FP information and services reflects systematic obstacles to potential FP users.

The failure of the MOH to provide adequate vaccination coverage to children under five years of age against childhood diseases demonstrates one of the most important weaknesses of Guinea's health system. According to the DHS, immunization rates for this age group fell from 37 percent in 2012 to 24 percent in 2018, meaning almost one in four children in this age group has not received any of the recommended immunizations.

This low immunization rate has resulted in recurrent measles outbreaks in various regions. These outbreaks contribute to the continued high mortality rate of children under five years of age. The 2018 DHS reported 111 deaths per 1,000 live births. Neonatal births represented almost half of these deaths (48 percent). Other than these neonatal deaths, the key contributors to the deaths of children under five years of age are malaria, diarrhea and undernutrition.

The high incidence of malaria in Guinea is worthy of special note. According to the MOH, malaria is endemic in Guinea and the leading cause of clinical consultations, hospitalizations and hospital deaths. Malaria is the biggest killer of children under the age of five (over 14 percent in this age group). Pregnant women have a high risk of contracting malaria. In response, PMI is the largest USG health care investment in Guinea. PMI is the largest funding stream for GLHSS.

Sub-optimal health behaviors sustained by socio-cultural factors contribute to high rates of preventable child and maternal deaths and infectious diseases. There is also a range of poor health practices related to hygiene and nutrition. In addition, harmful traditional practices such as female

[4] Enquête Démographique et de Santé (EDS V) 2018, Institut National de la Statistique, Ministère du Plan et du Développement Economique, Conakry, Guinée, Juillet 2019.

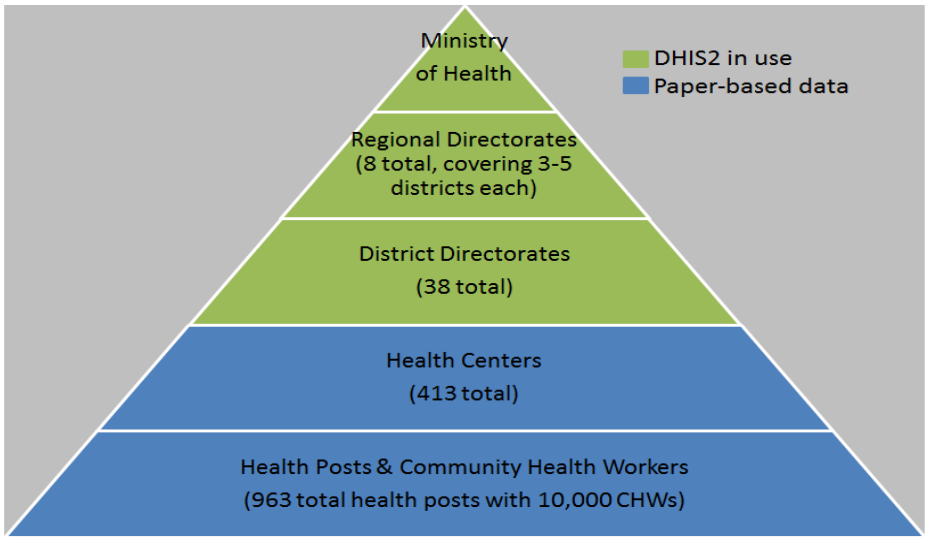
[5] At present, USAID family planning programming is restricted to activities that do not directly support the government due to Section 7008 restrictions invoked following the September 2021 coup. These restrictions will remain in place until officials of a duly elected government take office. Therefore, GLHSS will need to be adequately flexible to focus family planning efforts exclusively on the private sector and communities, while remaining prepared to also incorporate family planning support to the government at such time as this may be allowed.

genital mutilation and cutting (FGM/C), early marriage and the low educational attainment of women and girls contribute to poor health status.

The low level of health service utilization in Guinea is influenced by a number of factors, including a perceived low quality of health services and a general lack of confidence in the public health system. Other contributing factors include incorrect knowledge and attitudes about health behaviors and risks. Another factor is the inconsistent quality and scale of social and behavior change (SBC) programming.

A.5 Structure of Guinea's Health System and Key Challenges

The administrative structure of Guinea's health system is depicted in the pyramidal graphic shown below. At the top of the graphic, the MOH headquarters in the capital city of Conakry includes 10 national health directorates, six disease control programs and two university hospitals. At the next lower level are eight regional directorates, one for each of Guinea's eight governmental administrative regions. Each of these regional directorates covers three to five health districts. There are 38 health districts managed by their respective district directorates. Under these districts are 413 health centers which cover collectively 963 health posts. Altogether, the MOH is staffed nationally with about 12,000 paid employees and about 10,000 community health workers supported by partners.



The following analysis of the Guinean health system is based on the interrelated and mutually reinforcing components of the World Health Organization's (WHO) Health Systems Framework for Action for Strengthening Health Systems.[6] This framework emphasizes

[6] World Health Organization, Framework for Action for Strengthening Health Systems, 2007. https://www.who.int/healthsystems/strategy/en/

addressing bottlenecks in a collaborative, coordinated way, driven by desired health outcomes, to achieve sustainable system-wide effects. WHO also stresses that any effort to strengthen a health system must be a country-led process that is based on priorities set in a comprehensive national health strategy as has been done in the PNDS.

The design of GLHSS is also guided by the publications of USAID's Bureau for Global Health's Office of Health Systems. This office has noted the importance of the connection between formal health and community systems. This office describes the community health system as a set of local actors, relationships and processes engaged in producing, advocating for and supporting health in communities and households outside, but related to, the formal health system. This office also notes a growing recognition that effective partnerships between communities and health systems are needed to achieve and sustain positive health outcomes. In addition, a whole-of-society approach is considered an important factor that will contribute to the success of GLHSS. (See referenced USAID's 'Vision for Health System Strengthening 2030' released in April 2021.)

GLHSS focuses on making the health system work at the community level in its targeted geographic zones in order to expand universal primary health care on a sustainable basis. An underlying principle of this new activity is to develop a model which can be replicated in other regions of Guinea. The adoption of this model in other regions of Guinea will be an indicator of GLHSS' success.

SBC is an important element of GLHSS due to the pivotal role of behaviors on health outcomes, including behaviors of clients, health service providers, and health system managers. The USAID health program portfolio will focus on the community level, but also works at the central and operational (prefectural) levels to strengthen the health system at the local level. All work will be undertaken in close and constructive collaboration with concerned MOH officials, other donor representatives and stakeholders working in Guinea's health sector.

A summary description of seven key challenge areas facing Guinea's health sector is provided below. GLHSS will be designed to address to the maximum extent possible these formidable challenges and, thereby, improve the quality of health care and make Guinea's health system more resilient and sensitive to gender and youth issues at every level, especially at the household and community levels.

Challenge 1: Accessibility, Affordability and Quality of Care

Variations in the geographic distribution of the cost of services and standards of practice limit the Guinean population's access to skilled health personnel and quality health services. These variations are exacerbated by the fact that the Guinean health system relies heavily on international donor support. Donors may subsidize their priority technical areas, certain health districts and health facilities. In this context, effective donor coordination at the health district level is essential to provide targeted populations with all the health care services they need.

Although data on health financing is limited in Guinea, it is estimated, as previously noted, that households contribute the most (62 percent) to total health spending. Yet, the abject poverty of most Guineans means they cannot afford health care services. It is expected that Guinea's high level of poverty could deepen because of the prolonged COVID-19 pandemic. In spite of its vast mineral wealth, Guinea is ranked in the low human development category of the UN Development Program's (UNDP) annual Human Development Index (HDI). In 2020, Guinea was ranked 178 out of 189 countries on the HDI.

Multiple factors impact the quality of health services. Health workers are slow to implement new service delivery and treatment protocols. Too often, health workers lack the training or tools to provide quality care. This situation results in outdated procedures being used and poor service standards. Additionally, the lack of appropriate and properly maintained equipment, stable access to electricity, and safe and hygienic working conditions, undermines the quality of the services delivered at health facilities. The PNDS states that of the total 1,383 public health facilities in Guinea, half do not satisfy the MOH's minimal physical structure standards. Also, the MOH reports only 16 percent of facilities possess all the equipment it recommends.

It is also estimated that only nine percent of these facilities have potable water and three percent have electricity, a critical impediment to quality service delivery. It is also rare to find usable latrines, food services and an acceptable system for the disposal of bio-medical wastes. There is also a huge deficit in hospital beds. Guinea has one bed per 3,396 inhabitants whereas the WHO recommends one bed per 1,000 inhabitants.

Furthermore, most (at least 50 percent) rural Guineans do not have access to health facilities because they reside too far (five kilometers or more) from a health facility. The poor state of roads also makes it difficult to reach health facilities, even if transport is available and can be afforded. These barriers to accessing formal health facilities often cause people to consult local traditional healers. By strengthening accessibility and quality of the community health system, GLHSS will reduce this constraint and thus more people will be reached with quality health care.

Response: GLHSS will contribute to improved technical coordination among the various levels of the health system and with donors, CSOs, FBOs and private sector partners. This approach should help address issues related to uneven donor-provided service distribution. As donors and MOH authorities are more attuned to each other's needs and constraints, donors will be in a better position to fill existing gaps in health service delivery and avoid programmatic duplication.

Experience in Guinea and worldwide has demonstrated that introducing health service financing mechanisms can alleviate the direct cost burden on patients and, in the case of performance-based financing, can improve the quality of the services provided at health facilities. GLHSS will advocate, as appropriate and possible, health financing mechanisms such as vouchers, community health insurance, and/or savings schemes.

Building on the experience and lessons learned from the previous seven-year HSD project and over ten years of PMI implementation, GLHSS will explore opportunities to partner with the private sector (for- and not-for-profit entities), local authorities, CBOs and FBOs to address the

infrastructure, electrical, sanitation and equipment needs of health facilities. With an eye towards fostering local health system self-reliance, GLHSS could include, as appropriate, equipment or infrastructure support as an incentive for improving health facility performance.

Important strategies to increase accessibility to affordable, quality care include a highly motivated and well-trained health workforce, including community health workers, and mobile outreach which brings services from the health facility directly to remote communities. Both of these strategies will be supported by GHLSS to facilitate quality service delivery. GHLSS service delivery efforts will focus on the technical areas of malaria, family planning, and maternal and child health. In addition, if necessary and permissible with available funding streams, GHLSS will support COVID-related services and will be responsive to emerging pandemic threats and other shocks.

Challenge 2: Supply Chain Management

The supply chain system for essential medicines and commodities is plagued by poor planning, distribution, and stock management which leads to over or under stocking and wastage. The system for procuring and distributing essential medicines requires increased coordination and efficiency. Different donor and private sector procurement systems make it difficult to track the quantity, type and destination of drugs in Guinea.

Budgets for the procurement of essential medicines (both donor and government funded) are often non-transparent and commodity procurement is not based on reliable consumption information. Important logistical challenges (e.g., lack of roads and transportation, inadequate storage conditions, shortage of fuel and electricity to maintain cold chains for vaccines) reduce the availability of quality health commodities. According to a June 2018 audit report produced by GAVI (The Vaccine Alliance), an appropriate vaccine management procedure did not exist at Guinea's national storage warehouse. Moreover, data omissions and errors in inventory management records contributed to the expiration of vaccine doses provided by GAVI.

Response: GLHSS will be the main operational arm of USAID/Guinea's overall approach to strengthening commodity management at the health district level and below (health centers, health posts, and Community Health Workers). At this level, GLHSS will engage provincial and health facility managers in its targeted geographical zones in the management of these commodities as stipulated by national protocols. GLHSS will not introduce new tools, but will provide, as needed, training to concerned male and female health facility staff, making sure they use existing tools in an appropriate and transparent manner. GLHSS will facilitate the identification and implementation of sustainable solutions with local actors (mosques, churches, CSOs, FBOs, private businesses, community-based organizations (CBOs) and local leaders). In addition, stipends paid by USAID and other entities to CHWs facilitate delivery of commodities to the last mile, as CHWs use these stipends to travel to monthly health meetings where they submit data and replenish commodities. Reducing reliance on donors for these stipends will be an important goal over the life of GLHSS and a topic of co-engagement.

At the national level, the pharmaceutical procurement, storage and distribution agency of Guinea, Pharmacie Centrale de Guinée (PCG), is responsible for importing and delivering to all public health facilities at all levels in Guinea the medicines and medical equipment they need to function efficiently. Recent reforms in PCG operations and the issuance in August 2020 of its new legal statutes offer the promise of improvements in the timely delivery to all points within Guinea of essential drugs and medical equipment.

USAID support to the PCG and the MOH will continue under the Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) project. PSM will continue to manage the bulk procurement and distribution of USAID-funded malaria commodities and family planning commodities. It is also envisioned that PSM will advocate to ensure the procurement and delivery of essential medicines to the health facilities in the geographic areas where GLHSS will be working. PSM will also be USAID/Guinea's main interlocutor at the national level with the MOH and other donors to determine the best way to harmonize existing supply chain systems in favor of strengthening the national supply chain, including the PCG. Since 2017, PSM has been assisting the MOH to develop a waste management system for the disposal of damaged or expired medical products. PSM has also worked since 2016 in collaboration with PMI to strengthen Guinea's supply chain for malaria commodities. This effort has included the installation and use of a software program (eLMIS) to improve logistical management of medical products.[7]

In addition to coordinating with PSM, GLHSS will also coordinate with another USAID central buy-in mechanism, Promoting Quality of Medicines (PQM). PQM worked closely with the MOH from 2014 to 2019 and its National Directorate of Pharmacy and Medicine and National Medicines Quality Control Laboratory to strengthen their capacity to assure the quality of medicines. PQM also supported MOH efforts to improve the overall regulation of medicines and to build a quality control system for all essential medicines. The activities of PQM, like PSM, are expected to be coordinated by GLHSS.

Challenge 3: Leadership, Management and Governance

Effective regulation, oversight and performance monitoring of the health workforce are compromised by societal norms that encourage allegiances to social networks that guarantee promotions to higher paying posts, rather than to clients, managers and supervisors. This lack of accountability, combined with an arbitrary health facility fee-based system, and low to non-existent government salaries, create opportunities for health sector workers to find "other means" for supporting themselves, which can translate into corrupt activities (e.g., selling health commodities which are free and the addition of hidden costs to otherwise "free" services).

Despite these shortcomings, past and current USAID experiences in Guinea have shown there are competent, self-motivated personnel at all levels of Guinea's health system.

[7] eLMIS = Electronic Logistics Management Information System

They are often hampered by the lack of resources, as well as practical, applied skills in management, budgeting, planning and problem-solving. Another human resource constraint is the centralized and unilateral nature of decision-making at the top levels of the MOH.

In terms of overarching governance documents (e.g., regulatory guidelines and frameworks), the MOH does have a comprehensive list of appropriate and internationally recognized policies, strategies and protocols. A challenge for GLHSS will be the effective implementation of these plans and strategies at the local level. Much will depend on the effectiveness of the decentralization process and the active participation of stakeholders.

Response: GLHSS will work with health sector authorities and service providers to reinforce their leadership and management skills, as well as accountability to their main stakeholders and key clients. USAID/Guinea's health office will work in concert with the Mission's Democracy and Governance (D/G) Office to improve stakeholder involvement in health services management at the level of targeted communities and health facilities. The joint efforts of these two USAID/Guinea offices will improve citizen oversight of service fees collected and the quality of services provided at health facilities.

GLHSS will also support MOH efforts to implement its decentralization agenda via its Community Health Strategic Plan. GLHSS will work closely with prefectural MOH health officials to gain their support in its targeted geographic areas to ensure the successful implementation of the health care decentralization process. GLHSS assistance in this area could include material, logistical, and technical assistance to enable local health authorities to improve their coverage in zones where USAID is working.

Overall, GLHSS will work to empower communities to use and demand a higher level of health services. Key to the mobilization of communities will be an effort to galvanize community leaders around health improvement efforts. Community empowerment in order to achieve better health outcomes at the local level will be a central theme that will guide the implementation of GLHSS.

Challenge 4: Human Resources for Health

In general, Guinea's health workforce is ill-adapted to the needs of the population (i.e., too many of the wrong type of providers based on population need), inadequately paid, poorly trained and motivated, and inequitably distributed. Recognizing that health worker salaries are low, there is a temptation to provide salary supplements to individual health workers under the guise of performance-based financing in order to achieve program objectives (e.g., increases in immunization coverage, supervision visits and training sessions). There is a consensus among health donors and MOH officials that this practice of providing salary supplements creates perverse incentives, compromising the vision the MOH has for the health system.

A huge challenge to providing quality health care in Guinea is that the vast majority of trained health care professionals reside in the capital city, Conakry. According to the MOH's PNDS, over 50 percent of its employees live and work in Conakry. Another estimated 15 percent are based in

two regions, Kindia and Mamou. Therefore, about 35 percent (approx. 4,200) of the total of about 12,000 health care professional MOH employees are spread thinly over Guinea's remaining six administrative regions.

This inequitable distribution of MOH health personnel results in critical shortages of health professionals in rural areas. These shortages are exacerbated by limited training, low employee retention rates and an insufficient capacity to manage efficiently MOH human resources. The overall poor performance of health personnel discourages the local population and undermines trust in the quality of services provided by their local health facility.

A glaring observation is that there are insufficient women in Guinea's health workforce. Women serve as nurses, midwives and traditional birth attendants, but there are few women working as health facility managers. Also, there are few women medical doctors, particularly in rural areas. The latter may be due to the MOH taking gender into consideration when assigning health personnel (e.g., married women prefer working in urban areas so they can be near their families).

Response: Motivated Community Health Workers are critical to accessible, quality services at community level and therefore key to the success of GHLSS. GHLSS will provide technical assistance to propose sustainable solutions to advance the national Community Health Strategy. GHLSS will incentivize progressive local contributions to the financing of CHWs while providing limited stipends to CHWs in targeted regions as needed to ensure continuity of community services. USAID and the U.S. Embassy will continue to advocate for the full and timely payment of CHWs and other health cadres by the GoG. GLHSS and the entire USAID/Guinea Mission will support other donor efforts to rationalize health worker registries (e.g., identifying actual versus ghost workers) to enable the MOH to better comprehend the current status of its workforce.

At the regional, prefectural, district and community levels, GLHSS will improve technical and managerial skills, and raise the motivation of the health workforce. GLHSS will provide technical assistance and training support at the health district and community levels to reinforce the technical skills of community health workers and facility managers. GLHSS will also work to strengthen the administrative capacities of local health authorities. In addition to improving needed skills, non-material incentives such as training will help motivate workers to improve health service delivery and management.

GLHSS will work with health service providers and communities to identify other means of motivating health workers, paying attention to the different motivating factors for male and female health workers as well as youth. These means may include improving the physical working environment and introducing quality incentives. In the absence of direct salary payments, these activities will contribute to the body of knowledge on what factors motivate health workers. It would also be useful to examine what incentives health professionals based in Conakry need to work at other locations in Guinea.

Challenge 5: Health Information Systems

The current MOH systems to collect, enter, analyze and report health-related information are fragmented, impeding evidence-based decision-making. Nationally standardized tools for health data collection, analysis and transmission are not well disseminated. Donor and national disease-specific program priorities produce multiple data collection tools that result in duplicative data collection efforts. Data from private health facilities are not captured. Health center staff can spend approximately half of their time collecting and reporting data, thus reducing the amount of time they have to provide health care.

In 2016, USAID/Guinea assisted the MOH to begin the adoption of the DHIS2 software system to collect, analyze and report on pertinent health data.[8] Thus far, data recorded in DHIS2 cover HIV, infectious diseases, maternal and child health, child immunization, disease surveillance, service delivery, and a comprehensive listing of health facilities. Health workers in all national, regional and district hospitals have been trained in the use of DHIS2. The use of DHIS2 is being expanded to the health center level and some health centers have tried to use DHIS2, but, generally, health centers depend on monthly paper records and do little, if any, analysis of the data collected. Generally, there is rarely feedback from the central level about data submitted by health centers; consequently, quality control of data is lacking, and health districts seldom use the data collected to make decisions. Moreover, PMI is using DHIS2 to collect digital data pertinent to malaria at the community level.

Response: GLHSS will support the expansion of the use of DHIS2 to health centers in its geographic focus areas. At the same time, GLHSS will work to rationalize the current system of data collection and analysis at the regional and prefectural health levels. GLHSS will work closely with local health facility staff and higher-level health managers to strengthen routine data collection, analysis and reporting, ensuring that data entered is sex-disaggregated and of good quality. GLHSS will also champion the elimination of data collection tools still in use that duplicate the DHIS2 system. Overall, GLHSS will work to ensure that DHIS2 is recognized nationally and used correctly at all health facilities, including the private sector and non-public health facilities. In addition, GLHSS will support the use of eLMIS for reporting and data analysis in its geographic zones.

Challenge 6: Social and Behavior Change (SBC)

Traditional gender, cultural, and societal norms perpetuate harmful practices which prevent individuals, including service providers, from adopting health-promoting behaviors. Other best practices related to education, civic participation and good governance are also constrained by these practices. Current and past SBC interventions have neither systematically analyzed nor addressed the key determinants of the harmful gender, cultural and societal norms that underlie these practices, influencing negative health outcomes. Therefore, innovation is needed to guide future SBC efforts.

More research is needed to clarify the determinants of desired health behavior change within the larger societal context, including exploring deeply issues affecting gender and youth. A special focus will be on the power dynamics at play at the community level and

[8] DHIS2 = District Health Information System, version 2

the incentives that drive negative behaviors which hinder the delivery and management of quality health services.

Communication channels (e.g., mass media, interpersonal and group discussions) are under-utilized and, when used, they are not used effectively. For example, Community Health Workers (CHWs) who are responsible for disseminating key health messages in rural areas lack materials to raise the awareness of their communities about negative and positive health behaviors and practices. CHWs need to be able to motivate communities to adopt healthy behaviors. Moreover, there is a multiplicity of health information, education and communication materials of varying quality and utility that often do not adequately reflect gender and youth issues, the local culture, or the linguistic and societal context.

Response: Culturally appropriate SBC activities, delivered through effective communications channels that use materials relevant to the local situation and context are essential to increasing knowledge and shifting social norms and individual attitudes. SBC communications (SBCC) will be an important complement to activities designed to achieve general societal behavior change. New SBC research will be undertaken in GLHSS' target zones to identify the cultural realities, social norms, and general attitudes and beliefs that need to be changed to achieve favorable health outcomes. The results of this research will provide SBC activities and communication campaigns with the information they need to develop high impact programs that result in the positive changes in behavior which improve the health profile of Guineans.

GLHSS will also help develop innovative national health communication approaches, strategies and standardized messages, including where appropriate, for mass campaigns (e.g., national immunization days, mosquito bed net distribution and disease awareness campaigns). GLHSS will take steps to ensure that all health practice demonstrations and messages are adapted to the local context. GLHSS will also support beneficial community-level and interpersonal health communication activities.

At the same time, GLHSS will undertake activities with health care providers to address any negative beliefs and biases they may possess as well as gaps in their knowledge with regards to improved health-enhancing behaviors. The aim will be to make health care workers influential examples of healthy behaviors to be adopted by the general population. GLHSS will also endeavor to ensure that the MOH has the capacity to implement effectively nationwide a training program on health-enhancing behaviors for all concerned health care professionals, men and women, as well as traditional authorities, birth attendants and religious leaders.

As a part of its SBC operational research agenda, GLHSS will contribute to the design and testing of a mix of proven and innovative approaches to address the behavior change challenges facing its targeted populations. Emphasis will be placed on changing negative behaviors that affect the reduction of maternal and child under-five mortality (e.g., family planning, exclusive breastfeeding, FGM/C). The interactions between cultural norms and

service provider behavior, including appropriate counseling and service delivery practices, will also be examined as part of this SBC exercise.

This subject will be among the special topics to be explored in-depth by prospective applicants, USAID/Guinea, and concerned stakeholders during the implementation of GLHSS as part of an ongoing co-engagement process. This subject includes appraising the capacity of the MOH to design and conduct effective national SBC campaigns.

Challenge 7: Funding for the Health Sector

One main reason that Guinea's health system does not function well is because of the insufficiency of financial resources at every level. It is estimated that only up to eight percent of the GOG's national budget is for its health sector, although it was recommended at a conference of African heads of state in Abuja, Nigeria in 2001 that a minimum of 15 percent of national budgets be devoted to each country's respective health sectors. (Referred to as the Abuja Declaration.) In Guinea's case, the actual amount of funding disbursed annually by the MOH is much lower than the amount of its annual budget.

The lengthy MOH integrated operational action plan (PAO) issued in January 2020 reported that the MOH only disbursed 37 percent of its planned annual budget for 2019 of over 239.5 billion Guinean Francs (GNF), equaling in U.S. Dollars (USD) about $25 million.[9] It is estimated that about 27 percent of total national expenditures on health is provided by the MOH. It is also estimated that the USD value of donor contributions to Guinea's health sector was higher in 2019 than the actual budget amount disbursed by the MOH.

Guinea has one of the lowest per capita health expenditures in the world. It was estimated in 2016 that Guinea spent about $34 per capita on health expenditures. This compares to $31 and $66 spent per capita, respectively, in the neighboring countries of Mali and Sierra Leone. In this regard, Guinea is well below the Sub-Saharan Africa country average of $83 spent per capita on health-related expenditures.[10]

Without sufficient financial resources, it is difficult to train, staff and pay sufficiently well-qualified staff at Guinea's health facilities at every level. Thus, the number of trained health professionals working in Guinea's health system is greatly inferior to the recommended level. This lack of funding also means that much of the health infrastructure is in a poor state and under-equipped. As noted earlier, this includes the absence of clean water and latrines, and electricity (thus no Internet) in many health facilities. The misuse of funding received at all levels is common. There is a lack of competent leadership, accountability and transparency at every level of Guinea's health system.

The GOG's decision in October 2019 to provide 15 percent of mining revenues to local government entities (collectivités) via its Agence Nationale de Finance des Collectivités (ANAFIC) is

[9] République de Guinée, Ministère de la Santé, Bureau de Stratégie et de Développement, Plan d'Action Opérationnel (PAO) Intégré 2020 du Ministère de la Santé, Janvier 2020.
[10] World Health Organization Global Health Expenditure database (apps. who.int/nha/database)

promising. This GOG action is intended to support its decentralization process by providing local government collectivités (an elected community group) with needed funding for basic development activities. Part of these revenues should have gone to supporting the local health care system beginning in 2020. However, though these resources (the equivalent of about $100 million) were provided to Guinea's locally elected bodies, they were not utilized for CHWs as anticipated.

Response: USAID/Guinea will continue to advocate for an increase in the percentage of the GOG's annual national budget that is allocated to the MOH. USAID/Guinea's health office will also collaborate with the Mission's D/G office to monitor the effective and transparent use of any budgetary increases to remedy deficiencies in the GOG's health care system. In addition, USAID/Guinea will also urge the MOH to increase its capacity to fully disburse and use efficiently its annual budget.

USAID/Guinea will also collaborate with other donors to discuss frankly with the MOH any gross misuse of GOG funding budgeted for the health sector and urge the MOH to take corrective actions. The use and size of the MOH's annual budget will be monitored by USAID/Guinea and be the subject of ongoing discussions within the donor community and with the MOH. USAID/Guinea will also monitor the utilization of ANAFIC funding received by collectivités and its use, if any, to address local health problems, offering advice as appropriate. All concerned need to recognize that the rational use of increased funding is needed to raise the level and quality of health care in Guinea.

Furthermore, GLHSS will advocate in its target geographic zones for funds provided to local government entities to be used to improve health facility infrastructure. It will also work with the D/G office to have a dialog with the Chambre des Mines de Guinée about increasing the contribution of the mining industry to the health sector. As noted, all these efforts will involve close collaboration with the Mission's D/G Office.

A.6 Lessons Learned

The main lesson learned from the evaluation of the first five-years (2015-2020) of USAID/Guinea's flagship HSD project was that increased impact could be achieved by decreasing the breadth and increasing the depth of any follow-on project. This is one reason USAID/Guinea's health team decided to reduce the new activity's geographic coverage from the seven regions covered by the previous HSD project to three regions and five Conakry communes covered by PMI. This reduction in geographic focus will allow for a more in-depth and impactful approach as well as greater consolidation with the PMI program. At the same time, efforts will be intensified under GLHSS to reach more deeply into communities and related health facilities.

Following recommendations of the HSD evaluation, GLHSS will therefore focus its efforts on fewer regions in order to achieve the aims of its assistance to Guinea's health sector. Previously, by stretching its resources to cover a larger geographic territory, desired results were not achieved. Consequently, by concentrating resources on fewer regions and increased consolidation with PMI, GLHSS is expected to achieve a higher level of results.

Accordingly, under GLHSS, the regions of Faranah, Kankan and Mamou will not be covered. The MOH and other donors (e.g., the Global Fund, World Bank, EU, UN agencies (UNICEF, WHO, UNFPA, etc) will continue their health coverage of these regions. It is important to note that USAID/Guinea will work closely with HSD, other donors, and the MOH in the final year of HSD to facilitate a smooth transition.

It is believed that this integration of PMI activities with maternal/child health (MCH) and family planning/reproductive health (FP/RH) will result in greater impact at the community level and allow for a more holistic approach.

Estimated core funding level by health area, subject to availability of funds:

Family planning	20%
Maternal and child health	25%
Infectious disease (malaria and possibly COVID)	55%

It is also believed this geographic realignment will strengthen the PMI program as it coincides with those regions and Conakry communes covered by this program. Basically, under GLHSS previous assistance in the areas of MCH and FP/RH in the regions of Faranah, Kankan and Mamou will instead be focused on those regions and communes covered by the PMI program. This change in geographic coverage is deemed necessary in order for USAID/Guinea's overall health program to achieve lasting results.

The HSD evaluation report also emphasized the need to support the MOH's national Community Health Strategic Plan, as well as increased accountability, collaboration, leadership and ownership at every level of the health system. This evaluation also highlighted the need to focus on critical requirements (e.g., pre-service training and human resource management) of improving the quality of health care delivery, particularly stressing the continuum of integrated care and the need for an efficient referral system. In addition, this evaluation recommended exercising flexibility in the design and implementation of a new activity so that activities can adapt readily to changing contexts and needs and be responsive to evolving beneficiary needs and priorities. All the lessons learned in the previous HSD project will be taken into account in the design of GLHSS.

Lessons have also been learned from the implementation of PMI (Stop-Palu+) which has been active in Guinea since 2011. These lessons are of particular importance because as noted earlier malaria is endemic in all areas of Guinea and remains the number one health problem, particularly for pregnant women and children under five years of age. As also noted previously, malaria is the primary cause in Guinea of clinical consultations, hospitalizations and deaths. Obviously, reducing

the high incidence of malaria will relieve the health system of its biggest burden, as well as save thousands of lives.

Any USAID health program working in Guinea to roll back malaria is required to work closely with the MOH's National Malaria Control Program (PNLP). The goal stated in the PNLP's National Strategic Plan 2018-2022 is: Reduce Malaria Related Morbidity and Mortality by 75 percent from the 2016 level, bringing Guinea to pre-elimination status by 2022. The implementation of this new activity will require continued close collaboration with the PNLP and the demonstration of economical but effective ways of reaching communities with malaria control activities.

Perhaps the most valuable lesson learned by years of experience with the PMI program is the constructive quality of its relationship with host country health personnel at every level. This quality is especially evident in the collaboration exercised in the preparation of annual PMI operational plans (MOPs). Also, PMI's collaboration with the Global Fund to achieve a higher impact in terms of reducing the incidence of malaria is another good practice. PMI's efforts to have the PNLP take clear ownership of Guinea's malaria control program is also worthy of note.

The operational mechanism used by PMI in Guinea can well serve as a model to replicate in other regions of Guinea, particularly with regard to its use of data systems and its conduct of a Monitoring and Evaluation (M&E) system to plan and make decisions. The manner PMI is able to collaborate with community health agents to collect data and diagnose and treat malaria is a good example of how other health services can function at the community level. The regular meetings between PNLP and PMI staff are instructive on how to share any lessons learned and apply them in practice.

Closely associated with PMI are lessons learned by PSM's work in Guinea since 2011 and PQM's activities in Guinea in the 2011 to 2019 period. PSM activities and experiences have contributed to a better understanding of the PCG's procurement and supply chain mechanisms. The results of PQM's work in Guinea have highlighted the importance and challenges of installing an effective quality assurance program for the control and use of essential medicines.

The lessons learned on how to cope productively with the COVID-19 pandemic are instructive. Learning how to operate effectively from remote locations has been a revelation in terms of maintaining an acceptable level of achievement in spite of the limitations caused by the pandemic. A notable example of keeping the work moving in spite of the restrictions imposed by the pandemic was the ability of in-country partners to modify protocols so that a nationwide Seasonal Malaria Chemoprevention (SMC) program for young children could be conducted in 2020.

While the 2014-2016 Ebola epidemic in Guinea was different from the COVID-19 pandemic in terms of its mode of transmission, symptoms, lethality and geographic locations, it provides some useful lessons, as does the Ebola outbreak in early 2021 in the Forest Region. Ebola was similar to COVID-19 in that they both discourage the general populace from using public health facilities. The threat of a potential resurgence of Ebola and the current limitations imposed by the prolonged

COVID-19 pandemic contribute to a reduction in the use of health facilities.[11] Like Ebola, the COVID-19 pandemic also requires USAID/Guinea staff time, for example to provide personal protective equipment to health facility staff, deliver COVID vaccine donations to the MOH.

Activity Goal, Intermediate Results, Focus Areas and Performance Factors

Goal: Contribute to sustainable improvements in the health status of Guineans

The achievement of this goal will be measured by the following changes experienced by communities and local health facilities supported by USAID:

- Evidence of an improvement in governance practices of prefectural health authorities and health service providers.
- Increased improvement in the accessibility of quality health services in USAID-supported geographic zones.
- Clients and citizens report improved satisfaction with the health services they receive.
- Health service delivery points report increased use of essential services; and
- CSOs and FBOs provide increased oversight of local health services.

It is anticipated that by the end of GLHSS in 2027 it will have contributed to the achievement of a number of key health status indicators included in the MOH's PNDS. The PNDS aims for a reduction from their 2015 levels in the following key health indicators by the end of 2024:

- Child under-five mortality ratio from 123/1,000 live births to 47/1,000 live births.
- Maternal mortality ratio from 724/100,000 live births to 349/100,000 live births.
- Neonatal mortality ratio of 33/1,000 live births to 12.5/1,000 live births.
- Infant mortality ratio from 67/1,000 live births to 26/1,000 live births.
- Prevalence of chronic malnutrition among children under five years of age from 31 percent to 21 percent; and the
- Prevalence of acute malnutrition from nine to four percent.

Note. Progress toward the achievement of these indicators and others will be documented in the scheduled sixth five-year 2023 Demographic Health Survey (DHS) led by USAID.

GLHSS Intermediate Results (IRs)

Prospective applicants for the implementation of GLHSS shall propose illustrative activities which will support the achievement of each of the four IRs indicated below (see Annex A GLHSS Results Framework). These activities can be in the indicated implementation focus areas cited for each IR and others that the applicant considers relevant for the achievement of a respective IR. The applicant

[11] It is noted on page nine of the annual FY 2016 Malaria Operational Plan of Guinea's U.S. Presidential Malaria Initiative that the Ebola epidemic caused people to change their health-seeking behavior, often for fever symptoms, and this would result in increased morbidity and mortality due to unaddressed malaria infections.

will also be encouraged to provide sample performance indicators for each IR, or modification thereof, in addition to the sample indicators provided below.

Intermediate Result 1: Provision of Quality Maternal and Child Health, Family Planning/Reproductive Health and Malaria Services Assured

Three sub-results are:

- Decentralized human resources are managed effectively
- Health facilities have the appropriate commodities, infrastructure and equipment
- People-centered preventative, curative and rehabilitation services offered

IR 1 Proposed Focus Areas:

- CHWs motivated and capable of providing services in line with GoG expectations
- Timely delivery, storage and administration of pharmaceuticals
- Preventive malaria care and treatment provided to pregnant women, mothers and young children
- Seasonal Malaria Campaigns conducted annually in approximately seven prefectures
- Distribution of nets in an estimated four regions for the mass net campaign anticipated in 2025 and routine distribution in four regions throughout implementation
- Quality obstetric care provided to women and newborns, including any non-communicable diseases affecting pregnant women
- Quality family planning services provided to women and couples
- Pregnant women give birth in sanitary conditions
- Local CSOs, FBOS and private sector entities fill health system functional gaps
- Effective management and supervision of human resources for health

Proposed sample indicators could include the following:

- Increased availability of quality essential drugs
- Worker absenteeism
- Reduced delays in payment of salaries to local public health facility staff
- Rate of reduction for clients reporting negative reception at health facilities

Intermediate Result 2: Health-Enhancing Social Norms Established

Four sub-results are:

- Targeted population knowledge, attitudes and practices (KAPs) concerning key health behaviors increased
- Targeted health care providers and managers provide unbiased services according to established protocols
- Effective social and behavior change communication strategies implemented
- Target population(s) measurably increases health-enhancing behaviors

IR 2 Proposed Focus Areas:

- Ample consultations undertaken to compile a list of positive health behaviors to promote (such as breastfeeding, malaria prevention and use of contraceptives)

- Innovative approaches to dissuade the widespread practice of FGM/C
- Actions to prevent and respond to gender-based violence (GBV)
- Activities to prevent early marriage and mitigate its consequences
- Awareness of the behaviors and practices by health providers and their patients that reduce positive health outcomes (e.g., in the areas of IPC and WASH)[12]
- Effective communication strategy for the adoption of positive health behaviors at the community level.

Proposed sample indicators could include the following:

- Reduction in belief that FGM/C is an acceptable practice
- Percentage increase in positive health behaviors in targeted population
- Rate of positive change in behavior of targeted population before and after SBC campaigns, especially as concerns women and youth
- Percentage increase of caregivers who seek health care when their child has a fever

Intermediate Result 3: Democratic Norms and Processes Strengthened

The four sub-results are:

- Local government responsiveness to citizen health needs strengthened
- Civil society and independent media strengthened
- Targeted national-level institutions strengthened
- Consensus building promoted among key political stakeholders

IR 3 Proposed Focus Areas:

- Improve the management of local health systems
- Funding for the MOH's Community Health Strategic Plan
- Reasonable share of funds received by decentralized governance bodies go to support local health system operations
- Local CSOs, FBOs, private sector entities and other concerned parties work together for the efficient functioning of local health facilities[13]
- Role of elected officials strengthened to sustain health services at the community level
- Local leaders demonstrate high level of accountability in health management
- CSOs, FBOs and private media play strong role in collaborating with health facilities
- Journalists report regularly and effectively accurate information on key health subjects

Proposed sample indicators could include the following:

- Proportion of GOG funds reaching local health facilities
- Number of community recommendations adopted to improve health service delivery
- Number of media staff and journalists trained to report accurately on health subjects
- Number of USG-supported national organizations implementing improvements
- Increased local budget allocations for CHW salaries

[12] IPC = Infection Prevention and Control.
WASH = Water, Sanitation and Hygiene.
[13] PEV – Programme Elargi de Vaccination (Expanded Vaccination Program)

This IR is considered to be cross-sectoral and as such involves the participation of the Mission's Democracy, Rights and Governance (DRG) Office. GLHSS will jointly develop and implement a work plan with the implementing partner for the DRG portfolio that responds to this IR to strengthen democratic norms and improve health governance at the community level. This also represents an area of continuous co-engagement throughout the life of the activity.

Intermediate Result 4: Cross-Cutting: Use of Strategic Information for Decision-Making Increased

Four sub-results are:

- Regional, prefectural and local health committees are able to collect, analyze and correctly interpret the routine collection of health information (DHIS2)
- Access to routine health system information increased for non-health actors
- Operationality and linkages of key information systems (DHIS2, eLMIS, etc.) working in targeted health facilities
- Regular, interactive use of infectious diseases surveillance systems strengthened[14]

Proposed Focus Areas:

- Accurate sex-disaggregated data are generated and used correctly
- Routine health and logistics data is collected, analyzed and reported on accurately
- Data collection and reporting systems (e.g., DHIS2 and eLMIS) reinforced
- Two-way flow of health information for use by health personnel and non-health actors
- National infectious diseases surveillance system fully developed and operational

Proposed sample performance indicators could include the following:

- Number of local health committees that use data correctly for decision making
- Number of health workers, disaggregated by sex, able to collect and use data appropriately and competently
- Percentage of local radio stations using official MOH DHIS2 data reports in their health-related broadcasts
- Percentage of USG-supported health facilities with reliable access to internet[15]

This IR is considered cross-cutting as it concerns the implementation of all IRs.

All applicants will be encouraged to propose alternate focus areas and additional process, outcome and impact indicators. Innovative indicator and activity proposals are desired. Overall, proposed approaches to increasing knowledge and understanding of key behaviors, norms, beliefs and attitudes that impact upon health outcomes will be of high interest. Also, ways of collaborating constructively with USAID/Guinea's D/G Office will be welcome.

[14] The basis of this system will be according to WHO's 2005 guidelines for International Health Regulations, third edition as published in 2016. https://www.who.int/ihr/publications/9789241580496/en/.

[15] USG – United States Government

A.8 Hallmarks and Strengths of the Proposed Activity

A community, bottom-up approach will be followed by GLHSS to enlarge the number of beneficiaries and strengthen the promise of a sustainable health care system for all. In view of the many challenges facing public health facilities, the result of providing increased health care at the community level will be an increase in the number of Guineans reached. GLHSS' community approach also recognizes the ongoing decentralization process in Guinea that is moving to grant greater decision-making power to the prefecture level, communes and community levels. GLHSS will help strengthen this decentralization process. It will facilitate consideration of health concerns of communities in decentralized resource mobilization efforts and allocation decisions. In addition, it will give communities a greater say in the operations of their local health facility. GHLSS will apply a social and behavioral science lens to improve motivation and behavior of health workers, local officials, and community members.

GLHSS supports the MOH and is integrated, responsive to beneficiary needs and priorities, technically sound, and feasible. In many respects, it builds on the lessons learned of its predecessor projects, HSD and StopPalu+, but with increased technical and financial efficiencies as an integrated project GLHSS will build in its targeted geographic zones on the achievements of this former health project.

The final evaluation of the previous project recommended narrowing the focus of any follow-on project. Therefore, GLHSS will work in fewer geographic regions and concentrate on making health services work efficiently for more people at the community level. The goal of augmented assistance to improve health systems at the local level is to reinforce efforts to implement effectively the MOH's Community Health Strategic Plan.

While GLHSS will focus on the decentralized level, achieving the results desired will depend on maintaining existing, and forging new, strong and productive links between communities and their local public health service facilities. Therefore, this bottom-up approach will entail strengthening the functions and outreach capabilities of local public health facilities and, as appropriate and needed, higher levels of the health system, including the prefectural, regional and national levels. Community satisfaction with the improved performance of these links will help build needed trust in the local health system.

Important in building these links is the work of well-trained and -equipped CHWs and Community Relays (RECOs). CHWs and RECOs are the cornerstones of this community health approach.[16] Well-performing and well-supported local health facilities, CHWs and RECOs will increase community commitment to making the local health system work for them. Communities will become more motivated and involved in efforts to mobilize their fellow citizens, men and women, to undertake actions that improve their health conditions, including positive behavior changes and the adoption of healthier practices.

[16] CHW in French is Agent de Santé Communautaire (ASC) and RECO in French is Relais Communautaire.

Active community participation in the governance of the local health system is a necessary element in creating a consistent, productive and sustainable health care system which benefits equitably all concerned. By engaging communities more in the management of their health status, they become more resilient and vocal in demanding the health services they need, and should receive, from the GOG. This type of increased community participation supports the GOG's efforts to decentralize governance. A major aim of GLHSS will be to increase the capacity of communities, especially their health committees (e.g., Comité de Santé et d'Hygiène – COSAH), to participate actively in local health governance and the GOG's overall decentralization process. In this regard, the Mission's D/G office will be of assistance.

A main goal of GLHSS is to increase the number of beneficiaries reached with quality health care. As noted earlier, it is believed that greater numbers of people will be reached through this community approach. This increase in beneficiaries will reduce the cost per beneficiary and, consequently, lend itself to the sustainability of activities supported by GLHSS. The practice of cost efficiencies in the implementation of GLHSS will be applied. Attention will be exercised to not introduce recurrent costs that would be difficult to sustain by local and central government bodies after the end of GLHSS.

Coordination with and leveraging of other USG and donor efforts is an important hallmark of this activity. For example, USAID's economic growth office is designing a Global Development Alliance (GDA) award that would support electrification of health facilities. GHLSS will coordinate with this activity, for example, leveraging electrification as an incentive to motivate and reward high-performing facilities and their staff. Similarly, close collaboration with the DRG Office's governance activity will ensure that underlying local governance issues affecting the health sector will be addressed.

SECTION B: FEDERAL AWARD INFORMATION

Please see the Guinea Local Health System Strengthening (GLHSS) APS for award information. Additional information pertinent to the Guinea Local Health System Strengthening Round No.: 1 is provided below.

B.1 Funding

Subject to the availability of funds, under the Guinea Local Health System Round No. 1, USAID anticipates supporting approximately one new Cooperative Agreement of up to **$73.0 million over a period of performance of five years**. Under that total estimated cost and over the period of performance, USAID anticipates approximately the below funding levels by health area – subject to the availability of funds:

Estimated funding levels by health area, subject to availability of funds:

Family planning	20%
Maternal and child health	25%
Infectious disease (malaria and possibly COVID)	55%

For the award resulting from the Guinea Local Health System Round No. 1, USAID anticipates subawards. USAID strongly encourages substantive collaboration and partnerships with a wide range of local private sector actors and institutions for service delivery, technical assistance, innovation, and other relevant skills and expertise. Interested parties should seek to issue performance-based, capacity-building, and/or innovation sub-awards and sub-grants to local organizations. All sub-awards to local organizations should connect to specific national priorities with clear, achievable, and measurable outcomes mapped to priority health indicators.

All applicants require a cost-share of $5,840,000 in this Round. Leverage (1:1 match) is encouraged, and cost-share can count towards leverage in concept papers submitted under this APS. USAID anticipates the Applicant will leverage its financial and in-kind resources.

B.2. Substantial Involvement

Consistent with ADS 303.3.11, USAID/Guinea will be substantially involved in the implementation of GLHSS. The intended purpose of the Agreement Officer's Representative (AOR) involvement during the implementation of the program is to assist the recipient in achieving the supported objectives. It is expected that the USAID's Agreement Officer (AO) will delegate the following approvals to the AOR, except for changes to the Program Description, or the approved budget or key personnel, which may only be approved by the AO.

1) Approval of the Recipient's Implementation Plans

The annual Implementation Plan, and any subsequent revisions, are subject to approval by USAID AOR prior to implementing substantive work for each year of the Agreement. The AOR will ensure that the Implementation Plans align with GLHSS's stated goals, milestones, benchmarks and outputs, as well as fit within the scope, terms and conditions of the Cooperative Agreement.

2) Approval of Specified Key Personnel

USAID/Guinea has determined that the following five positions are key to the successful implementation of the program: the Chief of Party (COP), the Senior Malaria Advisor, the Senior Family Planning/Maternal and Child Health Advisor, the Monitoring, Evaluation, and Learning (MEL) Specialist and the Financial Manager.

3) USAID and Recipient Collaboration or Joint Participation

The following collaboration or joint participation of USAID and the recipient of the GLHSS award are authorized:

a) Collaborative involvement in selection of advisory committee members: The AOR will be involved in the selection of advisory committee members. The AOR, USAID Project Management Team, and the Recipient will participate as members of this committee together with relevant stakeholders jointly selected by the AOR and the Recipient. This committee will ensure continuous co-engagement throughout activity implementation. Co-engagement will include in-depth study and discussion on topics of critical interest, which may include but is not limited to: female genital mutilation/cutting, private sector engagement, capacity building and sustainability, accountability and transparent decision-making, community health approaches and governance, incentive schemes to improve health worker performance, affordability of public health care services, adoption of positive health behaviors and practices, health financing, and links between information systems.

b) USAID will approve sub-awards/sub-grants, pursuant to 2 CFR 200.308.

c) The AOR will approve the recipient's final Activity Monitoring & Evaluation Plan (AMELP) which will be developed in consultation with USAID/Guinea. The AMELP will be aligned with the monitoring and reporting framework and other relevant reporting mechanisms required by USAID/Guinea. During the initial project planning period, the Recipient shall work closely with USAID/Guinea to establish major milestones, activity performance monitoring indicators, as well as baseline data and performance targets which will demonstrate successful achievement of the results expected of this new activity.

d) The AOR will approve the Environmental Monitoring and Mitigation Plan (EMMP).

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

f) Agency monitoring to permit specific kinds of direction or redirection of the work because of requirements under the relevant USG annual Operational Plans (Malaria Operational Plan and Operational Plan) and/or the interrelationships with other projects or activities. All such direction or redirection must be within the program description budget, and other terms and conditions of the award.

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

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

SECTION C: ELIGIBILITY INFORMATION

Please see the Guinea Local Health System Strengthening (GLHSS), APS No.: 72067522APS00002 for eligibility information.

SECTION D: CONCEPT PAPERS SUBMISSION INFORMATION

Concept Paper Instructions

For questions on this document, please submit all questions via email to Mr. Albert P. Asante (aasante@usaid.gov) and cc (conakryoaa@usaid.gov) by the deadline specified on the Cover Page.

Applicants should submit Round No.: 1 concept papers that present their proposed approach to achieving the four intermediate results of the Guinea Local Health System Strengthening Round No.: 1. Applicants must address all IRs. Organizations may submit more than one concept paper if submitting as both an individual organization and as part of a consortium.

For Guinea Local Health System Strengthening Round No.:1, interested applicants should submit a concept paper via email to Mr. Albert P. Asante (aasante@usaid.gov) and cc (conakryoaa@usaid.gov). Under 5 CFR 1320, the Paperwork Reduction Action, only electronic copies of concept papers will be accepted. The concept papers must be received by the deadline on the cover page of this document for Round No.: 1 (demonstrated by the timestamp on the email when received by USAID).

When emailing a concept paper, the following must be in the subject line of the email; 72067522APS00002, Round 1 and attachment file name(s). USAID's email server cannot handle more than 25 MBs of attachments per email. If the applicant must divide the submission into more than one email, please number the emails in the subject line and indicate in the email's subject line the desired sequence of emails (Email 1 of 3 etc.). It is the applicant's responsibility to ensure that all necessary documentation is completed and received on time. In the event of technical difficulties, please contact Mr. Albert P. Asante (aasante@usaid.gov) and cc (conakryoaa@usaid.gov).

D.1. Concept Paper Content and Format

This section presents guidance for the structure of the concept paper. Organizations that wish to be considered for funding under the Guinea Local Health System Strengthening Round No.:1 must submit a concept paper via email. To facilitate the competitive review of the concept papers, USAID will only consider those concept papers that conform to the format prescribed below.

The concept paper must be written in English and must adhere to a page limit of no more than five **(5) pages** for the Technical Section (includes Introduction, Program Approach, Organizational Capacity and Partner Roles). This page limit does not include the cover page, the estimated cost summary. The number of pages indicated for each part of the Technical Section are illustrative, but the total number of five pages must not be exceeded. Concept papers must use standard 8.5" x 11", single-spaced, 1" margins on each page with 12 point Times New Roman font and single spacing. 10 point font can be used for graphs and charts. Tables must comply with the 12 point Times New Roman requirement. Any submissions over the page limit will not be evaluated. The concept paper needs to be in either PDF (.pdf) or Microsoft Word format (.docx).

The concept paper must be prepared according to the following structural format set forth below:

1. Cover Page: The cover page must include the APS number, Round number, name of applicant or consortium members, title, and results being addressed in the concept paper. In addition, the Cover Page must include full contact information for the prime applicant or consortium. Including the name of any proposed sub-recipients or partnerships (identify if any of the organizations are local organizations, per USAID's definition of 'local entity' under ADS 303).

2. Technical Section:
    a. **Concept Introduction and Context** (1 page): Describe the problem your organization will address, linking it to the Program Description's intermediate results (IRs) and briefly describe your organization's approach to tackling this problem. What are the biggest challenges and opportunities? Describe why there is a strategic need for your organization's concept, how it differs from alternatives, and any relevant partner-specific considerations for the problem or solution.
    b. **Program Approach** (3 pages)**:** Building on the introduction, expand on your approach and its innovations for achieving the desired impact. The program approach must provide a clear approach to sustainably achieving the Intermediate Results (IRs) and addressing key challenges outlined in the Program Description. This section should include illustrative activities for all IRs and for at least five (5) of the seven (7) key challenges. In addition, present the anticipated outputs the Applicant will support to achieve the four Intermediate Results.
    c. **Organizational Capacity and Partner Roles** (1 page)**:** Define the role of each entity in the partnership. This must include a description of sub-awardees and their role. Subawards should reflect the value of diverse perspectives and capabilities, including emphasis on engaging and collaborating with local partners. Provide a clear and succinct description of relevant organizational capability and technical expertise of each entity in the partnership, including specific strengths, in relation to their role in the partnership. Briefly describe programs of similar size and scope that the organization and its sub-awardees have implemented.

3. Estimated Cost Summary (approx. 1- page)

Summary Budget	
Cost Elements	Amount
Proposed cost to be managed by the prime recipient	$ 0.00
Proposed sub-awards (list each sub-awardee and program area)	$ 0.00
Cost Sharing	**$ 5,840,000.00**
Total Award Budget	$ 0.00

Additional instructions and criteria for full application submissions will be provided after evaluation of concept papers when full applications are requested from selected applicant(s). Please see Section D of the APS document for information on the concept paper and full application process. Also, applicants must follow the Standard Provisions for either U.S.Nongovernmental Orginizations and Non-U.S. Nongovernmental Organizations.

D.2. Concept Paper Submission

Concept papers received under the Guinea Local Health System Strengthening Round No.: 1 will be reviewed based on full and open competition and under the procedures and criteria identified in Section E. After a concept paper is received, USAID reserves the right to pose clarifying questions to applicants but may opt to not do so if it believes it has sufficient information in the concept paper itself.

For applicants seeking to receive USAID funding to implement proposed activities under the Guinea Local Health System Strengthening Round No.: 1, USAID's discussions with those applicants will take place within the parameters of publicly available information. These parameters provide ample room for extensive, robust discussions regarding the development problem/goal in question (Section A of this APS, and specified in each Round), best practices, lessons learned in the relevant technical sectors, and pertinent research and evaluations and various other matters. After concept papers have been submitted, USAID personnel can have highly specific, detailed activity design discussions with the applicants throughout the remainder of the process, e.g., up to and through any award that might be issued under the Guinea Local Health System Strengthening Round No.:1 of this APS. USAID also reserves the right to make an award without discussions if determined to be in the Government's best interest.

Concept papers are not evaluated against other concept papers, but rather against the criteria stated in Section E. The evaluation of the content in the concept papers against the Guinea Local Health System Strengthening Round No.: 1 criterion will allow USAID to determine if an organization should be asked to complete a full application.

No additions or modifications to concept papers will be accepted after the submission date for this Round. Concept papers that are submitted late or are incomplete may not be considered for a request for full applications.

Not every organization that submits a concept paper through the Guinea Local Health System Strengthening Round No.: 1 will be asked to submit a full application. Due to the number of concept papers received, USAID is not able to provide details on why concept papers were not selected. USAID may limit the number of submitted concept notes selected to move forward based on efficiencies.

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

1. Be registered in SAM (System for Award Management) before submitting its application.
2. Provide a valid DUNS (Data Universal Numbering System) numbers in its application.
3. Continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a federal awarding agency.

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

Per 2 CFR Appendix I to Part 200, Full Text of the Notice of Funding Opportunity, Section E,

3, USAID informs all potential applicants:

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

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

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

SECTION E: APPLICATION REVIEW INFORMATION

E.1. Review of Concept Papers and Full Applications

Once a Concept Paper has been submitted in response to the Local Health System Strengthening Round No. 1 announcement, USAID will conduct an initial review of the Concept Paper using the criteria outlined below.

The purpose of the initial review is to determine whether USAID wishes to engage in further discussions regarding the proposed approach and activities. The initial review and communication will result in one of three outcomes:

- a decision to forego further consideration of the approach proposed in the Concept Paper.
- a decision to provide the Applicant an opportunity to submit a revised Concept Paper (this is very rare) OR
- an invitation to submit a Full Application.

E.2. Full Application Review Process

If the Merit Review Committee decides a full application(s) is warranted, full application instructions and criteria will be provided to the selected applicant(s) or groups of applicants that are proposing to work together. At this point, USAID will issue a Request for Application (RFA), which should not be interpreted as a commitment to funding or guaranteed issuance of the award.

The Merit Review Criteria below is applicable at the Concept Paper stage. Additional instructions and criteria for full application submissions will be provided after evaluation of concept papers, and when full applications are requested from selected applicant(s).

Using its technical expertise, the Merit Review Committee may suggest revisions and additions to the proposed activity as well as potential partners and resources. USAID will continue to have robust communication with applicants, potential partners, and other key stakeholders regarding the technical substance of the evolving approach, as well as the identity and roles of proposed or additional partners.

Agreement Officer Determination. If the Merit Review Committee recommends application(s) for funding, its review will be shared with the Agreement Officer for cost analysis, final approval and award negotiation. During this stage, USAID may invite the Apparently Successful Applicant(s) to a co-engagement workshop and/or provide comments in writing to further design the technical approach, and clarify general resource requirements, additional partner involvement, and management control of the project under the guidance of the Agreement Officer. The Apparently Successful Applicant(s) may also be asked to provide additional information about its technical approach, capacity, management and organization, proposed cost and budget, responsibility, and representations and certifications.

The Agreement Officer will engage in final review, negotiation, and determinations of award responsibility, and cost reasonableness, and will draft a cooperative agreement, to be reviewed by the Apparently Successful Applicant(s). The standard provisions for awards are generally prescribed by law and regulation for cooperative agreements. Information regarding possible award provisions will be offered to all selected applicants that are invited to submit a full application, as well as the final award provisions to the Apparently Successful Applicant(s) when the cooperative agreement is drafted. USAID reserves the right to accept applications in their entirety or to select only portions of the application to award. If the Apparently Successful Applicant(s) and USAID cannot arrive at a mutually agreeable arrangement, the Agreement Officer will not make the award(s), which will be at no cost to the Government.

E.3. Merit Review Criteria and Considerations

USAID will use the following criteria to assess Concept Papers in response to the Guinea Local Health System Strengthening Round No.: 1. These criteria reflect the core principles outlined above and are applied to all Concept Paper submissions.

Concept Papers will be assessed according to the following merit review criteria on an adjectival system: Exceptional, Very Good, Satisfactory, Marginal, and Unsatisfactory. The definitions will be provided at the RFA stage. The Criteria 1-3 are listed in descending order of importance.

Additional instructions and criteria for full application submissions will be provided after evaluation of concept papers, and when full applications are requested from selected applicant(s).

<u>Evaluation Criteria #1: Program Approach</u>

The extent to which the concept paper proposes effective technical approaches that are:

- responsive to the Program Description and its Intermediate Results
- responsive to at least five of the seven key challenges in the Program Description
- technically sound, well-defined, and achievable

Evaluation Criteria #2: Organizational Capacity

The extent to which the Applicant and its sub-awardees demonstrate the organizational capacity and experience to implement their proposed approaches to achieve the Intermediate Results, including:

- appropriate institutional capacity to implement the proposed program effectively
- appropriate technical capacity to implement the proposed program effectively
- proposed consortium demonstrates a commitment to working with underutilized and locally established partners

Evaluation Criteria #3: Sustainability

The extent to which the proposed approach will facilitate sustainable progress such that the interventions and/or achievements will continue beyond the life of the Program without funding from USAID, including a clear strategy to:

- increase government ownership of and funding for the health sector including Community Health Workers
- increase accountability in the health sector