



To: All Interested Organizations

Subject: Uganda Health Activity Draft Notice of Funding Opportunity (NOFO)

The United States Government, represented by the U.S. Agency for International Development Mission in Uganda (USAID/Uganda), seeks to inform interested organizations of the release of the draft Notice of Funding Opportunity for the planned integrated health funding activity, titled the *Uganda Health Activity*. The proposed Uganda Health Activity aims to increase access to and use of quality healthcare services and improve the performance of the health system at subnational levels in priority districts. A draft NOFO is provided as Attachment 1.

Interested organizations are invited to provide comments on the whole NOFO but with special emphasis on Section D – Application and Submission Information, Section E – Application Review Information, and Section F Federal Award Administration Information.

The draft NOFO does NOT commit USAID to consider or incorporate any received comments, issue a Notice of Funding Opportunity or make an award on the basis of this draft NOFO. All response costs incurred in providing feedback to this NOFO are at the respondent's expense. Please note that responding to this draft NOFO will not give any advantage to or preclude any organization or individual from responding to any Notice of Funding Opportunity (NOFO) that may be subsequently issued. If USAID releases a NOFO, it will be posted on www.grants.gov. It is the potential applicant's responsibility to monitor these websites for the release of further information and updates.

Applicants may submit up to **three** pages of responses or questions in Microsoft Word to this draft NOFO by email to kampalausaidsolicita@usaid.gov no later than the date and time shown below;

Issuance Date: April 4, 2022

Response Due Date and Time: April 15, 2022, 5:00 p.m. Washington, D.C. time (EST)10:00 a.m.
Kampala time

Response Email Address: kampalausaidsolicita@usaid.gov

Do not submit any applications at this time. Information received in response to this draft NOFO will become the property of USAID. Therefore, information that cannot be shared should not be sent. Please note that respondents will not receive individualized feedback on their submission. USAID may revise the draft NOFO based on comments received but is not obligated to do so. Thank you for your interest in USAID programs and we look forward to receiving your feedback on the draft NOFO.

Sincerely,

Brian Aaron
Supervisory Agreement Officer

Attachment 1: Draft Notice of Funding Opportunity USAID/Uganda Health Activity



USAID
FROM THE AMERICAN PEOPLE

Subject: Draft Notice of Funding Opportunity (NOFO) USAID/Uganda Health Activity
Program Title: USAID/Uganda Health Activity (UHA)

Federal Assistance Listing Number: 98.001-- USAID Foreign Assistance for Programs Overseas

To all interested Organizations:

This is a DRAFT Notice of Funding Opportunity. See the cover letter for feedback submission details. An official Notice of Funding Opportunity will be published with associated due dates at a later time.

The United States Agency for International Development (USAID) Mission in Uganda (USAID/Uganda) is seeking applications for a cooperative agreement from qualified entities to implement the Uganda Health Activity (UHA).

This **draft** funding opportunity is authorized under the Foreign Assistance Act of 1961, as amended. The resulting award will be subject to 2 CFR 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, and USAID’s supplement, 2 CFR 700, as well as the additional requirements found in other Sections of this NOFO.

Subject to the availability of funds, USAID intends to provide up to \$170 million, to be allocated over the five-year period. USAID reserves the right to fund any or none of the applications submitted. Eligibility for this award is not restricted.

USAID intends to make an award to the applicant(s) who best meet(s) the objectives of this funding opportunity based on the merit review criteria described in this NOFO and subject to a risk assessment. Eligible parties interested in submitting an application are encouraged to read this NOFO thoroughly to understand the type of program sought, application submission requirements, and selection process.

To be eligible for award, the Applicant must provide all information as required in this NOFO and meet eligibility standards in Section C of this NOFO. This funding opportunity is posted on www.grants.gov, and may be amended. This NOFO and any future amendment can be downloaded from <https://www.grants.gov>. Select “Find Grant Opportunities,” then click on “Browse Agencies,” and select the “Agency for International Development” and search for the NOFO. It is the responsibility of the Applicant to regularly check the website to ensure they have the latest information pertaining to this notice of funding opportunity and to ensure that the NOFO has been received from the internet in its entirety. USAID bears no responsibility for

data errors resulting from transmission or conversion process. If you have difficulty registering on www.grants.gov or accessing the NOFO, please contact the Grants.gov Helpdesk at 1-800-518-4726 or via email at support@grants.gov for technical assistance.

Any questions regarding this NOFO must be submitted in writing to KampalaUSAIDSolicita@usaid.gov. Questions sent to any other email address will not be answered. **The email transmitting the questions must reference the NOFO number and title on the subject line of the e-mail.** Responses to questions received prior to the deadline will be furnished to all potential Applicants through an amendment to this notice posted on <https://www.grants.gov>.

If you decide to submit an application, please note that electronic submission is required. Applications are to be sent as email attachments to KampalaUSAIDSolicita@usaid.gov, to the attention of Agreement Officer, Ms. Andreea Surdu. Late applications will not be considered for award. Hard copy or fax applications are not authorized for this NOFO and will not be accepted.

USAID may not award to an Applicant unless the Applicant has complied with all applicable unique entity identifier and System for Award Management (SAM) requirements detailed in Section D. The registration process may take many weeks to complete. Therefore, Applicants are encouraged to begin registration early in the process. An Applicant under consideration for an award that has never received funding from USAID may be subject to a pre-award survey to determine financial responsibility, capacity, and ensure the adequacy of financial controls.

Issuance of this notice of funding opportunity does not constitute an award commitment on the part of the United States Government (USG) nor does it commit the USG to pay for any costs incurred in preparation or submission of comments/suggestions or an application. Applications are submitted at the risk of the applicant. All preparation and submission costs are at the applicant's expense. In addition, the final award of any resultant grant cannot be made until funds have been fully appropriated, allocated, and committed through internal USAID procedures. While it is anticipated that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for the award.

Thank you for your interest in the USAID/Uganda Health Activity.

Sincerely,

Andreea Surdu
Agreement Officer
USAID/Uganda

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SECTION A: PROGRAM DESCRIPTION

Acronyms

AGYW	Adolescent Girls and Young Women	IYCD	Integrated Child and Youth Develop. Activity
AMELP	Activity Monitoring and Evaluation Plan	KCHS	Keeping Children Healthy & Safe
ANC	Antenatal Care	LARC	Long Acting and Reversible Contraception
AOR	Agreement Officer's Representative	LMIS	Logistics Management Information System
ARV	Antiretroviral	M&E	Monitoring and Evaluation
CBO	Community-Based Organization	MCHN	Maternal, Child Health, and Nutrition
CCA	Clean Clinic Approach	mCPR	Modern Contraceptive Prevalence Rate
CDCS	Country Development and Cooperation Strategy	MEL	Monitoring, Evaluation, and Learning
CHEW	Community Health Extension Worker	MIYCAN	Maternal, Infant, Young Child, and Adolescent Nutrition
CHW	Community Health Worker	MNCH	Maternal, Newborn, and Child Health
CLA	Collaborating, Learning, and Adapting	MOH	Ministry of Health
COP	Chief of Party	MPDSR	Maternal and Perinatal Death Surveillance and Response
CQI	Continuous Quality Improvement	NDP III	National Development Plan III
DHO	District Health Office	NGO	Non-Governmental Organization
DHMT	District Health Management Team	NHP III	National Health Policy III
DO	Development Objective	NOFO	Notice of Funding Opportunity
DRM4D	Domestic Resource Mobilization for Development	PHC	Primary Healthcare
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe	PMI	President's Malaria Initiative
EBF	Exclusive Breastfeeding	PNC	Postnatal Care
ECD	Early Childhood Development	PNFP	Private Not-for-Profit
EMR	Electronic Medical Record	PUMRA	PMI Uganda Malaria Reduction Activity
F&A	Finance and Administration	QI	Quality Improvement
FBO	Faith-Based Organization	RBF	Results-Based Financing
FP	Family Planning	RH	Reproductive Health
FPA	Family Planning Activity	RHITES	Regional Health Integration to Enhance Services
G2G	Government-to-Government	RMNCAH	Reproductive, Maternal, Newborn, and Adolescent Health
GBV	Gender-Based Violence	RRH	Regional Referral Hospitals
GF	Global Fund	SBC	Social and Behavioral Change
GOU	Government of Uganda	SBCA	Social and Behavioral Change Activity
HC	Health Center	SCAPP	Standards, Compliance, Accreditation, and Patient Protection
HCW	Healthcare Worker	SITES	Strategic Information Technical Support
HMIS	Health Management Information System	TA	Technical Assistance
HRH	Human Resources for Health	TB	Tuberculosis
HRIS	Human Resource Information System	TBD	To Be Decided
HSS	Health Systems Strengthening	UDHS	Uganda Demographic and Health Survey
HUMC	Health Unit Management Committee	UHA	Uganda Health Activity
ICARE	Improving Care and Resilience for Children and Youth in Eastern Central	UHSS	Uganda Health Systems Strengthening
iCCM	Integrated Community Case Management	ULA	Uganda Learning Activity
IEE	Initial Environmental Examination	UNHLDS	Uganda National Health Laboratory & Diagnostics Services
IFMS	Integrated Financial Management System	USAID	U.S. Agency for International Development
IHSD	Integrated Health Service Delivery	USG	United States Government
IP	Implementing Partner	VHT	Village Health Team
IPC	Infection Prevention and Control	WASH	Water, Sanitation, and Hygiene
IR	Intermediate Result		

SECTION A: PROGRAM DESCRIPTION

A1. Introduction

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

- 1) Improved access to and use of quality health services at the community and health facility levels.
- 2) Enhanced local ownership and leadership for sustainable health outcomes.
- 3) Strengthened health systems at the regional, district, facility, and community levels.

UHA will focus its activities primarily at the regional level and below, strengthening the quality and availability of maternal, newborn, and child health (MNCH), family planning (FP)/reproductive health (RH), nutrition, and facility-level water, sanitation, and hygiene (WASH) services in a subset of up to 30 focal districts surrounding the seven regional referral hospitals (RRHs) in Gulu, Jinja, Kabale, Lira, Mbale, Mbarara, and Moroto, building on the investments in HIV/AIDS services made by PEPFAR and other USG investments to date. HIV/AIDS services are a large part of UHA. They feature prominently under IR1 (under quality improvement [QI] efforts) and IRs 2 and 3, where UHA will provide additional district-level health systems strengthening (HSS) technical assistance (TA) in a further 72 districts and cities/municipalities where PEPFAR local implementing partners (IPs) operate. UHA will provide TA to local IPs to help enhance HIV/AIDS outcomes and their sustainability. UHA marks a strategic shift in USAID's previous integrated health support. It builds on promising practices identified from recent USAID Regional Health Integration to Enhance Services (RHITES) programming, while incorporating new elements of integration and local ownership.

Community-led and locally owned service delivery is a core element of UHA. The activity includes a greater focus on building the capacity, sustainability, and resilience of local governments and local partner institutions to deliver evidence-based and high quality MNCH, FP/RH, nutrition, facility-level WASH, and HIV/AIDS services at both facility- and community-levels. This greater focus reflected in part through UHA's concentration on strengthening the capacity of RRHs to fulfill their technical oversight and health QI mandate in line with Government of Uganda (GOU) objectives and to coach local PEPFAR IPs to more effectively lead epidemic control responses.

Increased coordination and functional collaboration will be critical to success in implementing UHA, given the interlocking nature of USG health investments. As detailed in Section A5, expected collaboration includes work with 1) Specific PEPFAR local IPs and GOU RRHs in priority sub-regions (leveraging USG government-to-government [G2G] investments); 2) Above-site USAID national health mechanisms; and 3) Allied multi-sectoral development programming, such as food security, livelihoods, resilience, and women's empowerment activities. UHA fully aligns with and supports the GOU's ambitious goals for improved health outcomes and decentralization, as outlined in the new third National Health Policy (NHP III). The activity will also accelerate progress toward three Development Objectives within USAID/Uganda's Country Development Cooperation Strategy (CDCS) (see Section A3).

A2. Background

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

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

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

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

Yet despite the momentum, MNCH, FP/RH, and nutrition progress remains far below National Development Plan III (NDP III) 2024/25 targets. Maternal mortality remains very high at 336 deaths/100,000 live births.⁴ Neonatal mortality is largely stagnant and accounts for 42 percent of all under-five deaths. Only 31 percent of health centers have basic water services and 12 percent have basic sanitation, inhibiting effective infection prevention and control (IPC) and quality of care outcomes.⁵ Nearly half of children under five years and a third of women of reproductive age are anemic,⁶ increasing their respective risk for impaired cognitive and social functioning and adverse pregnancy and birth outcomes. Little progress has been made on increasing exclusive breastfeeding and dietary diversity of children.⁷

While the modern contraceptive prevalence rate (mCPR) increased from 24.6 percent to 30.4 percent among all women between 2015 and 2020,⁸ adolescent childbearing has decreased little due to harmful gender and sociocultural norms and economic challenges. The COVID-19 pandemic threatens to reverse progress. Studies showed sharp declines in MNCH, FP/RH, and nutrition service delivery and uptake and corresponding increases in maternal and under-five morbidity and mortality, likely due to delayed care-seeking behavior.⁹

HIV in Uganda is on track to epidemic control in the 90-90-90 cascade. While there are still areas of improvement needed—particularly in HIV prevention, case finding, and viral load suppression—Uganda has made significant HIV progress and is now considered to be one of six countries globally close to achieving epidemic control. PEPFAR and the GOU are now focused on sustaining this progress.

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

Context of USAID Support

² UBOS and ICF. [Uganda Demographic and Health Survey 2016](#). 2018.

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

⁴ UBOS and ICF. [Uganda Demographic and Health Survey 2016](#). 2018.

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

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

⁷ UBOS and ICF. [Uganda Demographic and Health Survey 2016](#). 2018.

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

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

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

USAID expects that the UHA awardee will incorporate and build upon lessons learned from the past five-plus years of implementation of its suite of five RHITES activities, implemented in Southwest, East, East-Central, North-Lango, and North-Acholi regions. These activities, which will reach completion in 2023, aim to enhance integrated health services for HIV, malaria, TB, MNCH, FP/RH, and nutrition. The RHITES activities also supported the transition of HIV epidemic control service delivery activities to new local IPs in each region to increase sustainability. USAID/Uganda expects that UHA will successfully transition relevant RHITES activities, while adding new elements.

In July 2021, USAID/Uganda's Office of Health and HIV commissioned the Uganda Learning Activity (ULA) to conduct an in-depth desk review of the RHITES activities to inform UHA design. The review identified five key barriers and five key facilitators to success, which USAID/Uganda expects the UHA awardee will adopt or scale-up in UHA. Among the expectations, UHA should:

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

Please see **Attachment A** for the full list of ten barriers and facilitators identified through the RHITES program review. Relevant additional bottlenecks to be addressed by UHA include:

1) Challenge: One-size-fits-all TA fails to help districts adapt and deploy health interventions appropriate for their local context. UHA priority sub-regions each feature unique epidemiological, health system, socio-cultural, economic, and environmental characteristics that necessitate customized TA. Karamoja and Acholi sub-regions, for example, each feature higher stunting rates than their counterparts nationally, indicating need for increased attention to multi-sectoral interventions. Districts require more tailored mentorship based upon their local needs. This will ensure districts can use data more effectively to customize and resource their annual work plans based upon local context.

2) Challenge: Health facilities struggle to operationalize QI and achieve improved quality of care. USAID and GOU programs have succeeded in building health care worker (HCW) skills in MNCH, FP/RH, nutrition, and IPC. Yet prematurity, sepsis, and asphyxia still remain leading causes of maternal and infant death in most regions. Districts and health facilities require support in scaling-up and institutionalizing HIV QI efforts and expanding them to address quality of care gaps in MNCH, FP/RH, nutrition, and facility-level IPC performance. In addition, many facilities require support in the development of a local QI culture and in operationalizing innovative local quality of care change ideas.

3) Challenge: Priority sub-regions and their surrounding districts vary in their ability to fully plan, coordinate, resource, and sustain PHC interventions. Hands-on clinical skills building alone is insufficient to create lasting improvements in service availability and quality of care. Target sub-regions and districts require high-impact HSS TA to accelerate progress toward and sustain health outcome achievement. While decentralization reforms are underway via the MOH's RRH-focused Hub and Spoke

Model,¹⁰ most RRHs and their corresponding districts do not have the planning, data, or domestic financing capacity to lead a PHC response in the absence of partners, impeding progress toward the full health leadership envisaged by the NDP III. Critical district sustainability barriers include gaps in 1) planning and coordination; 2) supply chain management; 3) data collection, analysis, and use to drive decision-making; 4) health workforce performance and management; and 5) health financing. In addition, many health facilities require remodeling and refurbishment to meet minimum MNCH and facility-WASH infrastructure standards and reinforce quality of care.

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

5) Challenge: Community PHC service delivery requires scale-up. Community service delivery and self-care interventions offer great promise for increased coverage and promotion of positive health behaviors. Yet community health service delivery challenges are acute, including in the motivation, remuneration, training, and supervision of community volunteers. Despite a goal of two functioning village health teams (VHTs) per village, many districts fail to reach that threshold. While the President's Malaria Initiative (PMI) has begun scaling-up integrated community case management (iCCM) in 13 high burden districts, coverage is uneven.¹¹ Those VHTs that do exist must deliver an ever-expanding menu of integrated health services and messages. To address these issues, the MOH has announced the planned roll out of a Community Health Extension Worker (CHEW) program and has increasingly prioritized community health activities.

6) Challenge: PEPFAR local IPs require tailored technical support to realize their full program management and service delivery functions. While the RHITES activities are transitioning out of direct service delivery, many recipients local IPs (see Sub-IR 2.5) possess varied organizational management, technical capacity, and operational gaps that will impede them from achieving and sustaining their targets. PEPFAR local IPs generally work in geographic silos, due in part to the nature of the segmented RHITES awards. This prevents the sharing of local HIV innovations across geographies and IPs.

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

- Leveraging the RRH platform to play a critical role in decentralizing health services and providing technical supportive supervision, in alignment with GOU strategy¹² and PEPFAR G2G investments.
- Enhancing functional collaboration between UHA and USAID's above-site health investments and district-level multi-sectoral programming, including the new Parish Development Model.
- Facilitating active collaboration, learning, and adapting (CLA) among local IPs to ensure best practices are shared across different regions.

¹⁰ USAID-SITES. *Reviewing Uganda's Health System Hub and Spoke Models: September 2018*. Unpublished manuscript.

¹¹ MOH/GF/PACE. *Implementation of iCCM Study in Uganda*. PowerPoint. Jan. 2021.

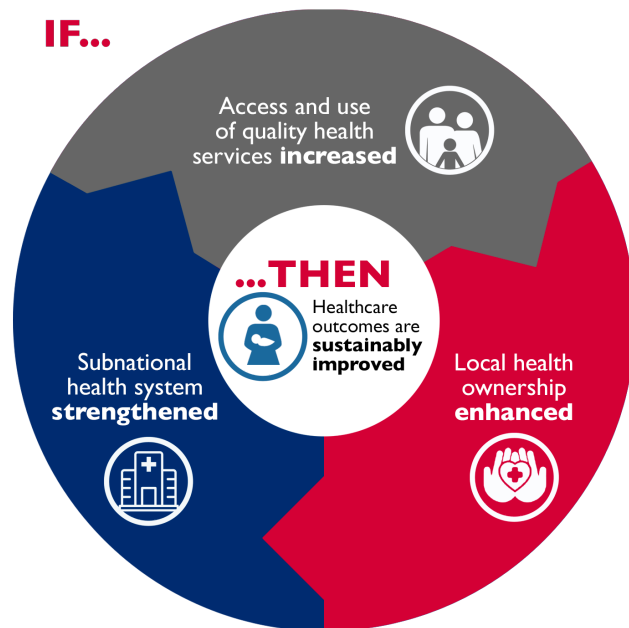
¹² MOH. *Comprehensive Supportive Supervision Strategy for the Health Sector, July 2020-June 2025*. 2020.

- Leveraging results-based financing (RBF) and Global Fund (GF) funding and domestic resource mobilization efforts to meet infrastructure, human resource, and supply chain gaps, gradually transitioning away from reliance on donor and out-of-pocket funding.
- Scaling successful COVID-19 adaptations and innovations that enhanced continuity of MNCH, FP/RH, nutrition, facility-level WASH, and HIV services.
- Increasing the use of proven digital tools and innovations that improve health access, quality of care, health worker performance, and citizen participation, in line with the GOU’s Health Information and Digital Health Strategic Plan.

A3. Intended Results

Inadequate access to and use of quality health care, combined with poor health-seeking behaviors and a sub-optimally performing PHC system, leads to inequitable health and nutrition outcomes. This compromises Uganda’s ability to scale quality health care and sustainably improve the health of its population. UHA seeks to address these challenges and achieve its activity **purpose** to improve health system resilience in priority districts and to increase the survival and well-being of vulnerable populations. USAID’s **vision** is that the Ugandan government, local partners, and communities achieve and sustain transformative health outcomes for Uganda’s most vulnerable. This is reflected in the UHA theory of change (Figure 1), which articulates a change pathway that will contribute to the achievement of the UHA purpose.

Figure 1: UHA Theory of Change



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

- UHA coordinates with and collaborates successfully with national-level health mechanisms and with IPs and RRHs in priority districts to scale-up high impact interventions (see Section A5).

- PEPFAR local IPs and RRHs, districts, facilities, and communities demonstrate readiness and commitment to assume ownership and financing of UHA interventions.
- RRHs and district health offices (DHOs) understand and operationalize their roles and accountabilities related to continuous quality improvement (CQI), reporting, governance, and supportive supervision.
- USAID’s technical and financial support enhances the enabling environment for health improvements, including local health governance.
- The GOU maintains its commitment to and investment in HIV, MNCH, FP/RH, nutrition, and facility-level WASH service delivery.
- Uganda’s political, economic, and COVID-19 epidemiologic situation remains stable.

Results Framework

Aligned to the theory of change, the UHA Results Framework (Figure 2) depicts the three foundational IR and sub-IRs required to achieve the UHA purpose. UHA’s IRs and sub-IRs are intended to be mutually reinforcing. Each proposed IR and associated interventions at the regional, district-, facility- and community-levels will contribute to the increased survival and well-being of priority populations and improved health system resilience.¹³ For example, TA under IR 3 will support the development of more resilient and responsive local health care systems that are increasingly capable of planning, financing, and implementing high quality and integrated HIV, MNCH, FP/RH, nutrition, and facility WASH/IPC health interventions (supporting IR 1). USAID/Uganda expects continual interplay across IRs and sub-results to inform UHA implementation. *For the purposes of planning and budgeting, USAID/Uganda estimates the following levels of effort across IRs: IR 1 (50%), IR 2 (20%), and IR 3 (30%).*

UHA will contribute to relevant MNCH, FP/RH, nutrition, facility-level WASH, HIV, and HSS efforts outlined by the GOU to meet the ambitious goals outlined in the NHP III. As such, its interventions must align to relevant MOH national strategies and evidence-based approaches for PHC, including, but not limited to its NHP III; Draft Reproductive, Maternal, Newborn, Child, Adolescent, and Healthy Aging Sharpened Plan for Uganda (2020/21-2025/26); National FP Costed Implementation Plan 2020/21-2024/25; Uganda Nutrition Action Plan II 2020/2021–2024/2025, and National QI Framework & Strategic Plan (2021-2025).

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

Alignment with USAID/Uganda CDCS (2016-2021)

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

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

¹³ Please review USAID’s Vision for Health Systems Strengthening 2030 for additional information on guidance on USAID’s objectives and approaches in relation to health system resilience.

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

Implementation Approach and Geographic Focus

UHA will operate primarily at the sub-national level¹⁴ to support achievement of its objectives, providing TA to RRHs and districts to scale-up priority high-impact health interventions and HSS initiatives in priority districts. Specifically, UHA will assist the MOH to operationalize its “Hub and Spoke” model for health systems decentralization. Under this strategy, RRH, Community Health Departments provide technical supportive supervision to lower-level health facilities (especially to Health Center [HC] IV and general hospitals), serve as hubs for skills transfer, and as referral hubs from lower levels for tertiary and specialized care. UHA will center its service delivery and HSS TA on supporting **seven priority RRHs** to fulfill their health supervision mandate as part of the GOU’s health decentralization strategy, improving HIV, MNCH, FP/RH, nutrition, and facility WASH/IPC access and outcomes in a subset of priority surrounding districts. UHA priority RRHs are:

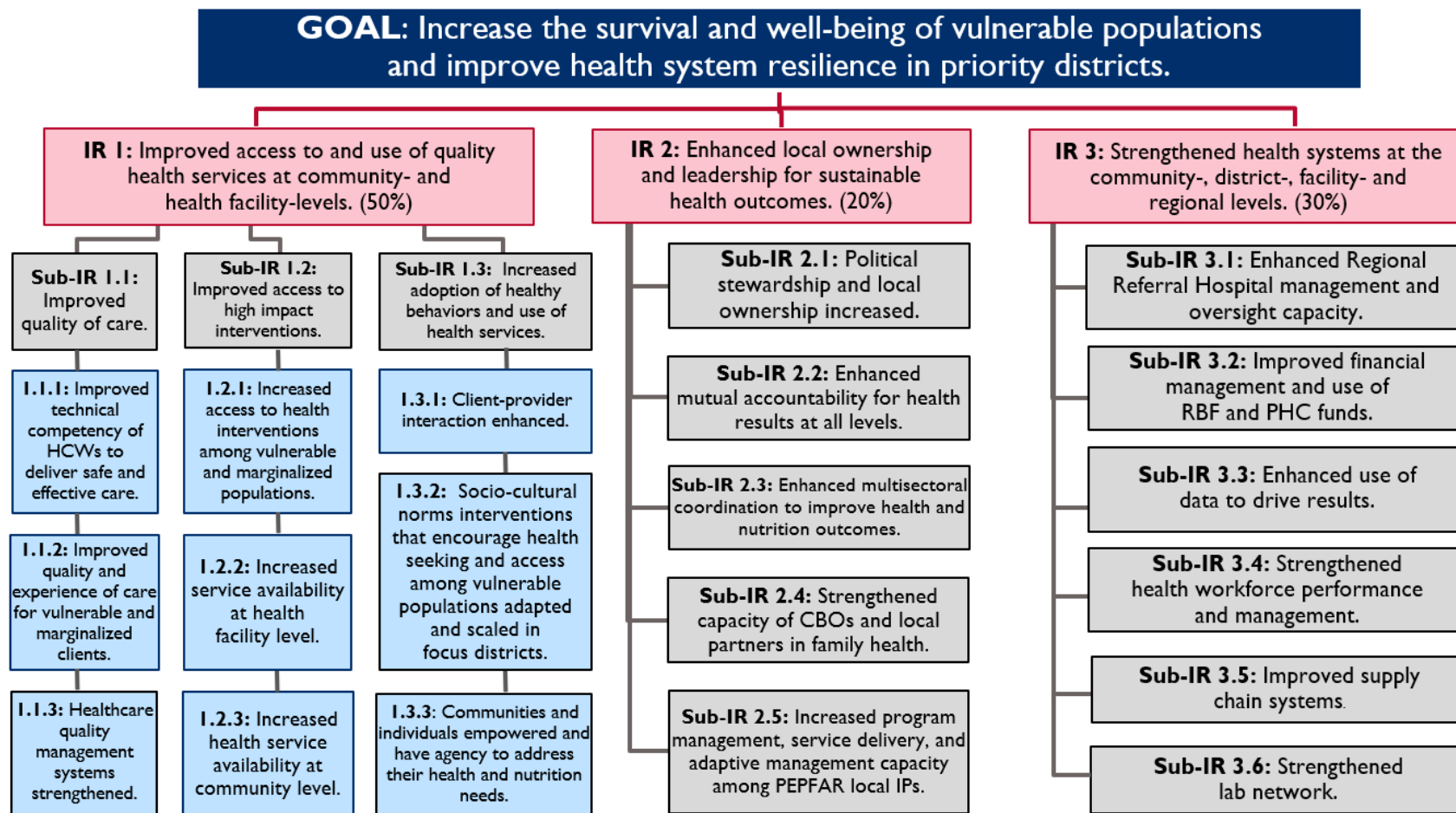
- 1) Gulu RRH (Gulu District, Acholi Sub-Region)
- 2) Jinja RRH (Jinja District, Busoga Sub-Region)
- 3) Kabale RRH (Kabale District, Kigezi Sub-Region)
- 4) Lira RRH (Lira District, Lango Sub-Region)
- 5) Mbale RRH (Mbale District, Bugisu Sub-Region)
- 6) Mbarara RRH (Mbarara District, Ankole Sub-Region)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

USAID/Uganda selected these priority RRHs for UHA in consultation with the MOH and based on several factors, including USG investment synergy that could be leveraged for enhanced impact and cost-effectiveness. UHA will focus its direct service delivery support primarily at the regional level and below, in up to 30 districts surrounding the seven RRHs where PEPFAR provides government-to-government (G2G) support. UHA has deliberately consolidated and significantly reduced the number of districts so that it can intervene more intensely and saturate districts with community services that reach clients as close to their homes as possible.

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¹⁴ With the exception of Sub-IR 1.1.3, which calls for national QI systems strengthening support (*see Sub-IR 1.1.3 for details*).

Figure 2: UHA Results Framework



The UHA awardee will provide TA for IR 1 activities (MNCH, FP/RH, nutrition, facility-level WASH/IPC, and QI for all integrated health areas, including HIV) to each of these seven RRH and their home DHOs. In addition, the awardee will provide IR 1 TA to a further sub-set of two to four proposed priority “spoke” districts linked to the hub RRH district, with a maximum of 30 total districts supported.

Applications should list the total number and names of initial priority districts on which to target for Intermediate Result 1. The application should describe how the applicant will select priority districts in support of the MoH’s RRH Hub and Spoke approach. Applicants should propose and justify UHA priority spoke districts based on criteria that they believe will accelerate the achievement and sustainability of UHA results, such as epidemiology, geographic proximity, HSS needs, presence of other USAID IPs, and operational considerations. Applicants should also detail their approach to scale-up and saturation of UHA TA within priority districts (IR 1 and 2 integrated family health districts +72 IR 3 HSS districts).

The UHA awardee will work with priority RRHs to develop a differentiated TA package for each priority hub and spoke district under UHA based upon local context rather than a one-size-fits-all package. This is critical both to increase effectiveness and to enhance local ownership for sustainability, given limited resources. Proposal technical approaches should reflect an in-depth understanding of the sub-regional epidemiological, socio-cultural, and development challenges and opportunities that may impact achievement of UHA intermediate results in priority districts. The description must explain how the Applicant’s approach will enable differentiated TA based upon local health and HSS capacity needs within priority districts. The plan should describe how the applicant will leverage and coordinate district-level TA in districts where PEPFAR local IPs are also operating and providing HIV service delivery support.

An important element across all IRs will be providing mentorship and TA in identifying, adapting, and implementing the most effective interventions based upon local transmission, socio-cultural, and health system dynamics. UHA will be expected to use a whole-of-district approach to its TA, ensuring its activities cover all sub-counties, public HC IVs, and their catchment communities within a given priority district. This, along with a much smaller number of potential priority districts under UHA as compared to RHITES activities, reflects a desire by USAID/Uganda to increase the overall saturation of facility- and community-level activities and spur more frequent and intense engagement between UHA and district leadership.

HSS support: In addition to the focal IR 1 service delivery districts identified above, UHA will provide additional targeted HSS support as detailed in IR 3 to 72 focal districts and cities/municipalities¹⁵ (see **Attachment B** for list of districts). These IR 3 HSS districts may overlap with IR 1 priority integrated family health districts to enhance coordination and synergy.

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

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

¹⁵ Please note the list of 72 districts includes five major cities/municipalities that host PEPFAR-supported GOU HIV service delivery sites and are supported by PEPFAR local IPs.

Expected Outcomes

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

- Accelerated improvements in MNCH, FP/RH, nutrition, facility WASH, and HIV outcomes in up to 30 high-need priority districts, resulting in reduced death and disability among pregnant women, children, infants, and people living with HIV.
- Measurably strengthened health systems capacity in PEPFAR priority districts, bolstering the GOU ability to lead, finance, and sustain primary healthcare services.
- Improved capacity in seven regional referral hospitals (RRHs) to help them oversee lower-level health facilities and focus on delivery of higher quality health care closer to citizens.
- Fully realized transitions of PEPFAR service delivery activities to six or more new local Ugandan partners, supporting their ability to lead and sustain Uganda's HIV response.

In addition, USAID/Uganda expects that UHA will contribute to high-level draft Reproductive, Maternal, Newborn, and Adolescent Health (RMNCAH) Sharpened Plan impact indicators, including Maternal Mortality Ratio, neonatal mortality rate, infant mortality rate, under-five mortality rate, total fertility rate, teenage pregnancy rate, unmet need for FP, mCPR, and under-five stunting prevalence. UHA will indirectly contribute to achievement of 95-95-95 HIV service delivery targets through TA to local IPs (as detailed under Sub-IR 2.5).

Please note that illustrative activities and indicators for potential consideration are included below in the intended results to guide development of the draft AMELP and technical application. These activities are not required except where indicated, and applicants are encouraged to suggest additional interventions that will support achievement of UHA results.

Proposals should include evidence-based, technically-sound and contextually appropriate interventions and activities likely to achieve the three intermediate results and cross-cutting area objectives (gender, youth, local capacity development, local ownership and accountability, and sustainability) based upon the challenges identified above. Applicants should highlight where proposed technical assistance builds on evidence or previous learning from Uganda-based programming and/or regional or global MNCH, FP/RH, nutrition, facility-level WASH/IPC, HIV, or HSS activities.

IR 1: Improved access to and use of quality health services at community- and health facility-levels.

IR 1 will improve MNCH, FP/RH, nutrition, and facility-level WASH/IPC in up to 30 priority spoke districts, RRH hub districts, and their catchment communities identified above. It will also support improved QI across all priority health areas, including HIV.

IR 1 Illustrative Indicators:

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

Sub-IR 1.1: Improved Quality of Care

Context: Though access to PHC has increased in recent years, the quality of that care remains inadequate to prevent maternal and child deaths. Just over half (52 percent) of Ugandan health facilities meet general service standards according to a 2019 service availability and readiness assessment. The maternal mortality ratio remains high despite improvement in service coverage. Many women and infants still die after reaching public health facilities due to slow emergency care and poor adherence to emergency obstetric and newborn care and emergency triage and treatment standards.¹⁶ Uganda also experiences HIV-related quality of care gaps around antiretroviral therapy treatment retention among young men, children, and

¹⁶ MOH. Reproductive, Maternal, Newborn, Child, Adolescent, and Healthy Aging Sharpened Plan (2020/21-2025/26). *Draft*.

adolescents and in reaching the most vulnerable, including adolescent girls and young women (AGYW), orphans and vulnerable children, and key populations. Throughout, quality of care outcomes is even worse for vulnerable and marginalized groups. Overall client satisfaction with Uganda's health sector remains low, with only one quarter of people satisfied with the quality of services received.¹⁷ This low satisfaction contributes in part to high client dropout rates after first ANC contact.

Multiple health system issues contribute to poorer quality of care. These include fragmented delivery of services, inadequate resource commitments to preventive and promotive care, and near constant HCW turnover at all levels of the health system. Data collection and use remains a challenge. Maternal and perinatal death surveillance and response (MPDSR) is still not widely applied: Only 65 percent of maternal deaths and fewer than 10 percent of perinatal deaths were reviewed in 2019/20.¹⁸ Health care-associated infections remain a major contributor of maternal and newborn deaths through sepsis. A 2019 national IPC survey ranked 38 percent of health facilities as possessing inadequate or basic IPC.¹⁹ Quality of care challenges remain a top priority of the MOH, as reflected within the new NHP III and its recently-approved National QI Framework & Strategic Plan (2021 – 2025). To date, most quality-of-care improvement efforts have been concentrated on HIV and MNCH, with FP/RH and nutrition requiring additional support.

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

Sub-IR 1.1.1 Illustrative Activities:

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

Sub-IR 1.1.1 Illustrative Indicators:

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

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

Sub-IR 1.1.2 Illustrative Activities:

Regional-Level QI:

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

District-Level QI:

- Provide TA to district staff in using data to analyze key quality of care gaps across all technical areas to drive technical supportive supervision and mentorship.

¹⁷ MOH. [National Quality Improvement Framework & Strategic Plan \(2021 – 2025\)](#). 2021

¹⁸ MOH. [Annual Health Sector Performance Report, Financial Year 2019/20](#).

¹⁹ MOH/MTaPS/USAID. *National IPC Survey Report*. Oct. 2019.

- Enhance the functioning of district QI Committees to fulfill their role and mandate.
- Support district-based QI coaches to provide facility-level QI coaching, mentorship, and supportive supervision to address quality of care gaps.
- Work with districts and health facilities to ensure that facility health care waste collection, separation, and disposal is in compliance with national guidelines (*required activity*).

Facility-Level QI:

- Strengthen existing hospital and health center QI Committees to ensure that each facility monitors quality of care indicators and improves standards of care.
- Encourage the identification of local QI priorities and locally appropriate solutions to address these gaps in service delivery to enhance the culture of QI at facilities.
- Introduce and integrate new FP/RH, nutrition, and facility WASH QI guidelines and tools into current QI capacity strengthening activities and structures.
- Scale-up the Clean Clinic Approach (CCA)²⁰ at high-volume sites to improve facility IPC (*required activity*).
- Remodel or refurbish relevant facility-level infrastructure based on facility need to meet minimum infrastructure standards and improve quality of care, e.g., renovations of maternity ward, obstetric theater, Kangaroo Mother Care rooms, improving patient flow, etc. (Note: Applicants should allocate \$7.5 million as a plug figure for remodeling or refurbishment in the cost application.)

Sub-IR 1.1.2 Illustrative Indicators:

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

Sub-IR 1.1.3: Health care quality management systems strengthened at all levels.

Please note that while the majority of UHA focuses on the sub-national level, the activity will include national-level support for QI efforts building on and continuing national- and regional-level QI investments supported under RHITES-N. Acholi.

Sub-IR1.1.3 Illustrative Activities:

- Provide TA to the MOH Standards, Compliance, Accreditation, and Patient Protection (SCAPP) department to operationalize National QI Framework & Strategic Plan.
- Support five staff seconded to the SCAPP department to provide TA to subnational QI staff and structures (*required activity*).
- Increase the utility and routine use of national-level QI learning platforms and collaboration fora for quality-of-care improvements.
- Ensure the functionality and use of the comprehensive national MOH QI database at sub-national level.
- Expand the use of the learning platforms for MNCH, FP/RH, and TB QI efforts.
- Provide TA to the SCAPP department to articulate, develop, and implement a community QI approach to improve quality of community services.

Sub-IR1.1.3 Illustrative Indicators:

²⁰ CCA is an evidence based CQI approach that encourages health facilities to set WASH goals toward incremental improvements to achieve Clean Clinic status. While ideal WASH conditions at a health facility require increased funding, staff, and infrastructure, lesser improvements like improving the waste management system, ensuring functional hand-washing stations, assigning roles for maintenance, and monitoring individual and collective progress can make a difference.

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

Sub-IR 1.2: Improved access to high-impact interventions.

Maternal and newborn health: Nearly all pregnancy, birth, and child health access indicators improved during 2016-2019, but remain below 2020 RMNCAH Sharpened Plan targets.²¹ The COVID-19 pandemic has unfortunately further slowed progress: Health facility deliveries declined by 62 percent during the pandemic, due in part to lockdowns and fears of visiting health facilities. Good progress has been made in reducing facility-based maternal deaths. GOU fiscal year data shows a 17 percent reduction in maternal deaths among 100,000 facility deliveries and a 77 percent increase in the maternal death reviews conducted between 2015/16 and 2019/20. Bunyoro, Kampala, and Bugisu regions have the highest institutional Maternal Mortality Rate. Postpartum hemorrhage remains the leading cause of death for women delivering in health facilities, with infections, HIV, anemia, and hypertension also contributing to preventable mortality. There is an urgent need to address the health system factors leading to maternal death. These include lack of blood products for transfusion, absence of critical human resources, and inadequate number of staff. Among infants, there was a 20 percent reduction in the number of perinatal deaths reported between 2019 and 2020. Fresh stillbirths and newborn deaths (0-7 days) constitute 63 percent of the perinatal deaths. Improving neonatal and prematurity care can significantly reduce under five deaths in Uganda.

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

FP/RH: While uptake of modern contraception has increased in Uganda, improvements have been largely unequal, with significant contrasts between urban and rural settings and richer and poorer households. The method mix is slowly expanding and increasing, with long-acting reversible contraception (LARC) accounting for 23 percent of contraceptives accessed. Short-term injectables remain the most popular FP method. Adolescent pregnancy remains high at 29 percent, with little change over time. It continues to be a leading cause of death for AGYW. Provider biases for certain FP methods, combined with FP/RH commodity stockouts, impacts the FP method mix. In addition, unreceptive service provider attitudes deter married and unmarried adolescents from seeking FP/RH services or ANC. Only 7 percent of clients accessed FP commodities through community-based distribution in 2019/20.

Nutrition: Malnutrition is one of the greatest bottlenecks to prosperity in Uganda, though the country is making progress, with stunting dropping from 40 percent to 29 percent between 2000-2016 (Uganda Demographic and Health Survey [UDHS]). There are, however, large variations in child stunting prevalence by district and region, ranging from 14.3 percent in Teso sub-region to 40.6 percent in Tooro sub-region.²² An estimated 44/112 districts possess stunting rates higher than the national average, with chronic malnutrition notably high in Northern and Western regions. Myriad multi-sectoral factors impact child nutrition, including household education, income, gender, and geography.

²¹ All sources of data in Sub-IR 1.2 sources from: MOH, [Endline Review of the Investment Case for RMNCAH Sharpened Plan in Uganda, 2015/16-2019/20](#). June 2020 and MOH, [Annual Health Sector Performance Report, Financial Year 2019/20](#) unless otherwise noted.

²² USAID/Uganda MEL Program (QED Group). Uganda Nutrition Assessment: National and Sub-Regional Nutrition Landscapes and Strategic Opportunities. Report. Sept. 2017.

The proportion of children receiving the minimum acceptable diet (those achieving minimum meal frequency and minimum dietary diversity) was alarmingly low, at 15% in the most recent UDHS, with regional variation in the proportion of children aged 6-23 months receiving the minimum acceptable diet, from 3% in Acholi region to 27% in Ankole region (UDHS, 2016). At health facility-level, RHITES data showed that fewer than half of children ages 6-59 months received nutritional screening during facility visits, a missed opportunity for nutrition interventions.²³ This is due in part to inadequate training in nutrition assessment and counseling HCWs receive, overwhelming HCW workloads, human resource gaps, and the under-prioritization of nutrition compared to other health services. Although nearly 90 percent of women took iron supplements at least once during their most recent pregnancy, fewer than 25 percent took them for the recommended 90 days or more according to the 2016 UDHS. Improved nutrition screening and quality services are at the facility and community level for women and children are still needed, including integration within other MNCH, FP/RH, and HIV services.

The GOU's new NHP III calls for re-invigorated PHC, a promising opportunity to scale-up community-based approaches to preventive health care and achieve a more integrated health system. In addition, the scale-up of the GF- and PMI-supported iCCM has reduced malaria-related deaths in children under five in the PMI- and the GF-supported districts.²⁴ VHTs are now often the first stop for children with fever in rural communities with trained VHTs. Self-care innovations, such as subcutaneous depot medroxyprogesterone acetate (DMPA-SC) and the Family Mid Upper Arm Circumference Approach are also increasing access to MNCH, FP/RH, and nutrition among marginalized and high-need rural populations. UHA will capitalize on this movement toward increased community service delivery access, while strengthening the availability of high-impact interventions for MNCH, FP/RH, and nutrition at facility- and community-level.

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

Sub-IR 1.2.1 Illustrative Activities:

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

Sub-Result 1.2.1 Illustrative Indicators:

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

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

Sub-IR 1.2.2 Illustrative Activities:

- Work with districts to roll out and increase access to priority high impact interventions and practices at facility-levels.
- Identify opportunities to optimize integration of MNCH, FP/RH, nutrition, and HIV services for improved client satisfaction and health outcomes.
- Strengthen referral system functionality from HC II and III to district hospitals and RRHs.

Sub-Result 1.2.2 Illustrative Indicators:

²³ USAID/Uganda. FY21 Q2 Implementing Partner Performance Review. PowerPoint. July 2021.

²⁴ MOH/GF/PACE. *Implementation of iCCM Study in Uganda*. PowerPoint. Jan. 2021.

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

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

Sub-IR 1.2.3 Illustrative Activities:

- Identify and build capacity of community health workers (CHWs) to provide health services and report on their activities.
- Link CHWs to CHEWs where applicable and GOU structures to ensure CHEWs integration, supportive supervision, and sustainability. Please note that UHA will not pay CHEW salaries; rather UHA will support priority districts with CHEW training, supportive supervision, and tools as applicable based upon district plans.
- Work with districts to conduct routine and targeted/data-driven mobile integrated health outreaches and Child Health Days.
- Collaborate with USAID Uganda PMI Malaria Reduction Activity (PUMRA) to increase coverage of malaria-related iCCM components in priority districts that overlap with UHA by supporting pneumonia and child health training/aspects of iCCM.
- Support integrated iCCM training, supportive supervision, and commodities (RCTs, ACTs) in high burden/hotspot sub-counties of five UHA districts where the Malaria Reduction Activity is not currently working.
- Increase community-based distribution of MNCH, FP/RH, and self-care commodities.
- Collaborate with relevant district-level multi-sectoral activities to integrate relevant community service delivery interventions, with an emphasis on nutrition-sensitive interventions.

Sub-IR 1.2.3 Illustrative Indicators:

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

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

Context: Ugandan women and adolescents in priority sub-regions face religious, patriarchal, and gender norms that undermine their ability to adopt positive MNCH, FP/RH, and nutrition behaviors and make a timely decision to seek medical care. These challenges create the *first delay*. Pregnant women in Lango and West Nile, for example, often require permission from partners to travel to health clinics. Early ANC remains far short of targets, due to sociocultural issues (e.g., early pregnancy concealment), gender norms,

and distance to health facilities. Micronutrient adequacy of diets of women of reproductive age is poor, with fewer than 10 percent of women nationally, and 7 percent in rural areas, meeting a minimum dietary diversity. This is a missed opportunity to manage early pregnancy complications, integrate prevention of mother-to-child transmission services, and move toward achieving the World Health Organization-endorsed eight ANC visits. These challenges continue with the *second delay*, where women in active labor and severely ill children in distress cannot reach a facility in time for life-saving treatment. Similarly, numerous sociocultural factors and norms impact FP demand and use, limiting women's ability to achieve their desired family size. Secrecy around sexual relationships increases risk of pregnancy among AGYWs.

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

Sub-IR 1.3.1: Client-provider interaction enhanced.

Sub-IR1.3.1 Illustrative Activities:

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

Sub-Result 1.3.1 Illustrative Indicators:

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

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

Sub IR1.3.2 Illustrative Activities:

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

Sub-IR 1.3.2 Illustrative Indicators:

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

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

Sub-Result 1.3.3 Illustrative Activities:

- Mentor districts and facilities to strengthen capacity of VHTs and volunteers to promote adoption of ten accelerator behaviors for ending preventable child and maternal deaths.²⁵
- Provide TA to districts to adapt and scale-up innovative empowerment, male engagement, and preventive behavior SBC models to their local context.
- Provide TA to CBOs and key influencers to implement and manage community SBC interventions.
- Leverage small grants to test and scale effective self-care and empowerment interventions.

Sub-Result 1.3.1 Illustrative Indicators:

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

IR 2: Enhanced local ownership and leadership for sustainable health outcomes.

IR 2 will focus on improving local ownership and accountability for health in the 72 priority PEPFAR districts and cities/municipalities and their catchment communities, collaborating with integrated health activities (IR 1) in the sub-set of districts where implementation overlaps. The technical approach should include a description of how the applicant will strengthen the technical and managerial capacity of RRHs, DHOs, PEPFAR local IPs, small grantees to provide and sustain high quality health services and promote adoption of positive health behaviors.

IR 2 Illustrative Indicators:

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

Sub-IR 2.1: Political stewardship and local ownership increased.

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

Sub-IR 2.1 Illustrative Activities:

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

Sub-IR 2.1 Illustrative Indicators:

²⁵ USAID. [USAID Social and Behavior Change Programs for Ending Preventable Child and Maternal Deaths](#). 2016.

- District budget utilization rate.

Sub-IR 2.2: Enhanced mutual accountability for health results at all levels.

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

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

Sub-IR 2.2 Illustrative Activities:

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

Sub-IR 2.2 Illustrative Indicators:

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

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

Context: Strengthening multi-sectoral coordination and program integration improves the well-being of families across a range of dimensions, including health, nutrition, agriculture, livelihoods, and resilience.²⁶ Integrating FP education and products into community-based agribusiness and income generating activities, for example, may increase new FP acceptors and generate cost savings as compared to standalone service provision.²⁷ Yet despite its potential to improve health outcomes, Uganda has struggled to operationalize subnational multi-sectoral coordination. Health and development activities largely operate in silos, working in parallel to and within government and contributing to duplication of interventions in some areas and “service overload” in others. The planned coordination meetings and processes that do exist often occur irregularly due to lack of funds, commitment, and competing interests. This creates a missed opportunity to more strategically share resources and address underlying social determinants of health.

²⁶ USAID/FHI 360. [Desk Review of Programs Integrating FP with Food Security and Nutrition](#). 2015.

²⁷ USAID Advancing Partners and Communities. [The Added Value of Integrating FP into Community-Based Services](#). 2017.

UHA will capitalize on recent GOU momentum toward enhancing multi-sectoral collaboration, as reflected in NHP III Policy Objective 2, its accompanying draft multi-sectoral coordination framework, and the GOU’s “Health-in-All Policies” directive and Uganda Nutrition Action Plan II. Similarly, Uganda’s recent National Integrated Early Childhood Development (ECD) Policy Action Plan (2016-2021) provides guidance on integrating multi-sectoral nurturing care interventions with MNCH and other interventions to ensure women and children are surviving and thriving. The evolving Parish Development Model offers the opportunity to enhance multi-sectoral collaboration further at sub-county level and below as Parish Development Committees increase coordination across partners and community political and development structures, such as the Local Council Executive Committee and VHTs.

Sub-IR 2.3 Illustrative Activities:

- Strengthen the functioning of relevant UHA-related coordination structures, including district social services committee, nutrition committees, and sub-county health committees.
- Work with district Chief Administrative Officers to ensure regular partner meetings occur and activities are integrated within One District Health Plan.
- Provide TA and training to DHOs and priority districts in operationalizing relevant coordination aspects of the Parish Development Model as it evolves.
- Leverage ECD platforms to increase access to MNCH, FP/RH, and nutrition services and messaging.

Sub-IR 2.3 Illustrative Indicators:

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

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

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

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

Sub-Result 2.4 Illustrative Activities:

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

Sub-IR 2.4 Illustrative Indicators:

- Percentage/number of USG-assisted organizations with increased performance improvement.

- Number of national and local organizations provided with a minimum package of technical and management capacity development assistance.
- Percentage of local partner's financial and program reports submitted on time and complete.

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

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

USAID/Uganda initiated transition awards to high-performing local health-focused NGOs beginning in 2020 on a rolling basis under RHITES. Lead RHITES IPs have since provided intensive technical and program management support aimed at fully transitioning service delivery and program management functions to local IPs. Today, these local IPs feature strong HIV/AIDS technical capacity but possess varying levels of program management and adaptive management capacity. Similarly, USAID/Uganda also began providing G2G assistance to select RRHs in 2021 to support the MOH's vision for decentralization and to increase sustainability as part of epidemic control. These G2G awards support HIV service delivery, regional continuous quality improvement, training and mentorship to lower-level health facilities, lab coordination, supply chain TA, human resources for health (HRH), financial management, and governance. As with the RHITES IPs, RRHs feature varying levels of technical and management capacity.

Table 1: Priority Local PEPFAR IPs for UHA TA

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

		Central, and Southwestern regions	Kanungu, Kazo, Kibuku, Kiruhura, Kisoro, Kitgum, Kotido, Kwania, Lamwo, Lira, Manafwa, Mayuge, Mbale, Mbarara, Mitooma, Moroto, Namayingo, Namisindwa, Namutumba, Ntungamo, Omoro, Otuke, Oyam, Pallisa, Rubanda, Rubirizi, Rukiga, Rukungiri, Sheema, Sironko, Tororo)
<i>Regional G2G Awards</i>			
Gulu RRH Strengthening Activity		Acholi	Gulu
Jinja RRH Strengthening Activity		Busoga	Jinja
Kabale RRH Strengthening Activity		Kigezi	Kabale
Lira RRH Strengthening Activity		Lango	Lira
Mbale RRH Strengthening Activity		Bugisu	Mbale
Mbarara RRH Strengthening Activity		Ankole	Mbarara
Moroto RRH Strengthening Activity		Karamoja	Moroto

UHA will consolidate gains from RHITES-supported capacity strengthening efforts, while providing customized TA to address local IP and RRH program management, service delivery, and adaptive management needs. Specifically, UHA will strengthen local partner technical and programmatic capacity to meet and sustain HIV 95-95-95 goals and TB targets and effectively implement GOU and USAID program priorities and requirements.

USAID/Uganda expects that Sub-IR 2.5 TA activities will gradually decrease over the life of UHA as local IPs and RRHs achieve capacity performance milestones and sustain service delivery targets. *Please note that UHA support is not focused on core organizational capacity building functions, such as Non-U.S. Organization Pre-Award Survey criteria. The UHA awardee should link local IPs and G2G entities to additional USAID/Uganda local organizational capacity building activities such as the Organizational Development Activity if additional support is needed in these areas.*

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

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

Sub-Result 2.5 Illustrative Indicators:

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

- Number of HIV service delivery points at a site supported by PEPFAR that are providing integrated voluntary FP services.
- Program successfully transitioned to PEPFAR local IPs (Yes/No).

- Percentage of UHA-supported organizations that demonstrate improvement in capacity across at least one domain.

IR 3: Strengthened health systems at the regional, district, facility, and community levels. IR 3 will focus on improving health system resilience in the 72 priority PEPFAR districts and cities/municipalities and their catchment communities, collaborating closely with integrated health activities (IR 1) in the subset of districts where implementation overlaps. UHA will collaborate closely with USAID above-site HSS-related activities to tailor and cascade district systems strengthening packages in the core areas of leadership and governance, health financing, information systems, HRH, supply chain, and lab network coordination.

IR 3 Illustrative Indicators:

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

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

Context: Priority sub-region RRHs and surrounding districts vary in their ability to provide the strategic oversight, guidance, and regulation of health services at all levels envisaged by the new NHP III. This is a critical gap that both impacts health service delivery quality in the near-term, as well as progress toward health decentralization in the longer-term. The profusion and frequent addition of new districts has complicated MOH decentralization efforts by adding new health leaders who require additional leadership and capacity building. UHA will strengthen the health leadership, planning, and coordination functions of the seven RRH Community Health Departments and priority DHOs to accelerate achievement of health outcomes both at community and facility levels. The activity will leverage and build upon above-site USAID health investments, including the Uganda HSS Activity (UHSS) and G2G support, to strategically address identified subnational leadership and governance capacity gaps at district and health sub-district level under this Sub-IR.

Sub-IR 3.1 Illustrative Activities:

- Assess leadership and governance capacity within priority RRHs, DHOs/DHMTs, and health sub-districts, building on previous assessments and capacity strengthening work conducted via UHSS, G2G support, or other above-site investments (as applicable).
- Strengthen RRH and district/sub-district leadership and governance capacity through training and mentorship, linking to UHSS (or the equivalent above-site HSS activity) and G2G mechanisms as relevant.
- Provide TA to develop data driven annual district work plans and budgets in priority districts and review them to ensure that work plans are aligned MOH and UHA primary health care priorities and sub-national targets.
- Advocate for the inclusion of and/or mentor districts on effectively integrating community engagement and service delivery activities into their work plans and budgets.
- Ensure that in each district there is at least one high quality health facility to serve as a model for service delivery and management systems.

Sub-IR 3.1 Illustrative Indicators:

- Percentage of districts submitting timely comprehensive quarterly and annual district health plans and performance reports to their designated MOH office.
- Percentage of districts that support community health services in annual budgets.
- Percentage of districts with at least one model service delivery site.
- Percentage of health sub-districts conducting quarterly support supervision visits.

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

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

The GOU/World Bank-funded RBF funding mechanisms serve as a bright spot in Uganda's health funding landscape. RBF funding has stimulated successful supply-side incentives, QI measures, and direct facility financing that has provided critically needed local autonomy to address district and facility level needs.²⁸ Under USAID's RHITES activities, health facilities used RBF to develop creative solutions to service delivery challenges, such as procuring buffer stocks of life-saving commodities and leveraging funding for community-level VHT nutrition activities. At the same time, many districts and facilities possess serious bottlenecks that have impacted their ability to access timely RBF funding. These include a need for increased capacity in RBF financial and technical reporting requirements to ensure timely receipt of funds, strengthened understanding in how RBF funds may be legally and creatively used, and a need for increased transparency by HUMCs in sharing how RBF funds are deployed.

UHA will require close collaboration with USAID's health financing and public financial management investments to scale and maximize domestic resource mobilization and optimization approaches in priority districts and at priority sites, including with: UHSS, which has served as a key coordinating body for RBF with the MOH as well as strengthened IFMS reporting; PEPFAR's G2G support to RRHs, which supports hospital financial management systems and monitoring; and USAID's Domestic Revenue Mobilization for Development Activity (DRM4D), which is increasing health budget advocacy and monitoring of health expenditures/allocations.

Sub-Result 3.2 Illustrative Activities:

- Strengthen RRH, DHMT, and health facility in-charge capacity in financial management and budget execution for improved service delivery.
- Build the capacity of health facilities and districts in activity planning, implementation and monitoring for timely utilization of both GOU and donor resources.
- Build RRH and district capacity to conduct RBF readiness audits and support supportive supervision to ensure facilities qualify and maintain their qualification for continued RBF funding.
- Provide TA to RRHs and districts to strengthen finance-related documentation and reporting skills of lower-level clinical and HF staff to reduce delays in RBF funds.
- Provide TA to the RRH Internal Audit unit to strengthen monitoring, oversight, and collaboration with the Chief Administrative Officer and HFs for improved financial management.
- Leverage and/or scale innovative health financing mechanisms or approaches from above-site activities in priority districts.
- Link RRHs and districts to above-site health financing mechanisms and MOH to address financial management and PFM gaps outside of the scope of UHA as needed.

Sub-IR 3.2 Illustrative Indicators:

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

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

Context: The timeliness, quality, and use of data at the community, facility, and district level remains weak due to multiple factors. Uganda's hybrid paper/digital system, for example, creates a massive reporting

²⁸ MOH and ThinkWell. [National Health Insurance in Sub-Saharan Africa: Insights for Uganda](#). Kampala. 2021.

burden through dozens of paper forms and registers that require manual aggregation by over-burdened HCWs. While an increasing data volume is reported through the country's electronic DHIS2 system, most improvements have been seen in HIV data. FP/RH, nutrition, and facility-level WASH data is often not routinely reported. While most districts have trained DHIS2 users, gaps remain in improving the use of data for decision-making and informing annual work plans. At a practical level, most districts cannot use data effectively to guide their health planning, budgeting, and intervention targeting without IP support. This creates real-world consequences, with some facilities failing to qualify for critical RBF funding or experiencing delays in disbursement.

COVID-19 has exacerbated many of these existing data challenges: timeliness of monthly outpatient department reporting declined from 97.5 percent to 85 percent from 2019-2020, largely due to district involvement in pandemic response.²⁹ Throughout, there is little ownership of data at facility- and community-level, with notable gaps in the inclusion and use of community-level data.

Sub-IR 3.3 Illustrative Activities:

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

Sub-IR 3.3 Illustrative Indicators:

- Timeliness of HMIS 105 reporting.
- Completeness of HMIS 105 reporting.
- Percentage districts/facilities with community members participating in data review meetings.
- Number of districts/facilities submitting complete iCCM/VHT quarterly reports in DHIS2.
- Number of PEPFAR-supported facilities that have an electronic medical record (EMR) system within the following service delivery areas: HIV Testing Services, Care & Treatment, Antenatal or Maternity Services, Early Infant Diagnosis or Under Five Clinic, and TB/HIV Services (EMR_SITE).

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

Context: High HCW turnover, absenteeism, and maldistribution often means rural communities are left with minimally trained and supervised PHC workers.³⁰ This HRH situation impacts maternal and child survival, with pregnant women sometimes turning to traditional birth attendants or healers to meet their care needs. Devolution, coupled with MOH health facility and district expansion, strains the health workforce even further. New skills are required by RRH and newly appointed district health managers at all levels to operate successfully in the recently devolved environment, including in HRH budgeting, planning, and forecasting. The MOH's current restrictive staffing structure, which has not been reviewed in more than ten years, further contributes to HCW shortages.

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

²⁹ MOH, [Annual Health Sector Performance Report, Financial Year 2019/20](#).

³⁰ MOH, [HRH Strategic Plan 2020-2030, Operational Plan 2020/21-2024/25](#).

Sub-IR 3.4 Illustrative Activities:

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

Sub-IR 3.4 Illustrative Indicators:

- Percent of approved posts filled with qualified personnel in public health facilities.
- Health care worker absenteeism rate.
- Percentage of districts with functional HRIS.
- Percentage of HCWs that have developed/implemented an annual individual performance plan.
- Number of new health workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts, within the reporting period, by select cadre (HRH_PRE).

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

Context: Persistent stockouts of essential medicines and health supplies continue to plague service delivery in Ugandan public health facilities. A 2018 USAID supply chain assessment found that more than 90 percent of health centers and hospitals reported stockouts in one or more tracer commodities across the system.³¹ Such stockouts frequently result in sub-optimal clinical care, cause unaffordable out-of-pocket expenditures, and drive clients to loosely regulated private sector care. These challenges are even more acute at community level: only 9 percent of VHTs nationally possessed all three required iCCM commodities to treat malaria, pneumonia, and diarrhea in a recent MOH study.³²

While central-level GOU commodity forecasting, and inventory management capabilities are strong, subnational capacity in facility-level planning, quantification, and ordering varies. Weak data collection, analysis, and use underpins nearly all supply chain challenges. Numerous logistics management information systems (LMIS) have been rolled out including the National Medical Stores' Client Self Service Portal (CSSP), but in many cases the systems are siloed and do not share data. RRHs in particular often have significant deviations between stock on hand and LMIS values.³³ As a result, facilities fail to access adequate and timely supplies, and sometimes hoard their commodities to avoid stockouts. Yet despite these challenges, recent supply chain strengthening efforts offer great opportunities to improve availability of essential medicines and supplies. PEPFAR and GF investments in supply chain strengthening have increased the availability of LMIS and associated infrastructure and connectivity that can be leveraged to improve supply chain reporting, data use, and oversight for MNCH, FP/RH, nutrition, and facility WASH/IPC commodities. The newly-launched 10-Year Road Map for Government of

³¹ USAID/GHSC-PSM. [Uganda National Supply Chain Assessment: Capability and Performance](#). Aug. 2018.

³² MOH/GF/PACE. *Implementation of iCCM Study in Uganda*. PowerPoint. Jan. 2021.

³³ USAID/GHSC-PSM. [Uganda National Supply Chain Assessment: Capability and Performance](#). Aug. 2018.

Uganda's Health Supply Chain Leadership and Ownership 2021/2022 – 2031/2032 provides a vision and blueprint for increasing local ownership and financing of Uganda's essential medicines and supplies.

Sub-IR 3.5 Illustrative Activities:

- Strengthen RRH and district-level LMIS and activities for planning, managing, ordering, and monitoring the availability and use of essential medicines and supplies.
- Assist districts to operationalize the Supervision, Performance, Assessment, and Recognition Strategy to guide supervision and resource allocation.
- Provide TA to medicine management supervisors and facilities to ensure functioning and use of digital stock management tools, including RxSolution, the Pharmaceutical Information Portal (PIP), the real-time stock status monitoring dashboard (RASS), and the CSSP.
- Strengthen district and facility capacity to increase community-level HIV, MNCH, FP/RH, and nutrition supply chain commodity availability and reporting efforts.

Sub-IR 3.5 Illustrative Indicators:

- Percentage of HF that had 95 percent of the essential commodities basket in the previous quarter.
- Average stockout rate of contraceptive commodities at FP service delivery points.
- Number of adult and pediatric antiretroviral (ARV) bottles (units) dispensed by ARV drug category at the end of the reporting period (SC_ARVDISP).
- Number of ARV drug units (bottles) at the end of the reporting period by ARV drug category (SC_CURR).

Sub-IR 3.6: Strengthened national laboratory network with improved access to high-quality laboratory services in 72 districts.

- Support district local government to coordinate and oversee the improvement of the laboratory diagnostic capabilities in collaboration with Uganda National Health Laboratory and Diagnostic Services (UNHLDS) and RRHs.
- Support district local government to implement the latest UNHLDS policies and guidelines, including supporting laboratory network optimization.
- Strengthen regional lab supportive supervision, ensuring all regional labs have external quality assurance program in place and move toward accreditation.

Sub-IR 3.6 Illustrative Indicators:

- Proportion of labs with adequate diagnostic capacity.
- Proportion laboratories that are implementing the latest UNHLDS policies and guidelines.
- Proportion of laboratories reporting no stock-outs of lab commodities.
- Percent of USG-supported laboratories performing TB microscopy with 95 percent or higher rate of correct results.
- Number of PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing sites engaged in CQI and proficiency testing activities (LAB_PTCQI).

A4. Activity Monitoring, Evaluation, and Learning Plan

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

days of award. The Applicant is required to submit a draft AMELP and CLA plan as an annex with its application that describes how it will work with USAID to monitor progress toward UHA results in the Program Description. At a minimum, the draft AMELP will:

- Identify appropriate performance indicators and data sources for each level of the results framework. Note: Applicants should select appropriate illustrative performance indicators from Section A3 that will enable them to most feasibly and cost-effectively monitor progress toward results framework objectives, including sustainability. Applicants may also suggest additional custom indicators that reflect their technical approach.
- Provide preliminary five-year performance indicator targets for proposed draft indicators. Final targets will be reviewed and agreed upon in conjunction with USAID/Uganda during the development of the finalized AMELP following award.
- Describe how data will be collected, analyzed, and presented to regularly inform performance. This includes supporting external and/or conducting assessments and evaluations of UHA to enhance performance and learning.
- Detail data quality controls and processes to ensure that data collected meets MOH and USAID/Uganda data quality guidelines and requirements.
- Describe how UHA will support existing GOU data collection and reporting systems and processes to the extent possible rather than establish parallel systems to support sustainability.

The applicant should also include a brief summary draft CLA Plan that identifies its approach to integrating CLA throughout UHA implementation. The CLA plan should lay out the applicant's approach to adaptive management and how the applicant will use lessons generated during the course of activity implementation to further inform planning and implementation. It should also describe how it will advance UHA's key learning questions.

Performance Evaluations and Assessments

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

Baseline assessment: USAID/Uganda will commission an external contractor to conduct a mixed methods baseline assessment for UHA. The baseline assessment—to be completed no later than by the end of Year 1—will serve as the basis for measuring progress across IRs, along with activity-reported data. The baseline will collect new primary quantitative and qualitative data as well as draw from existing secondary data (such as that in the 2016 UDHS and Performance Monitoring and Accountability Survey 2021); the End-Line Review of the Investment Case for RMNCAH Sharpened Plan in Uganda; DHIS2 data within priority districts; Site Improvement through Monitoring System data; Lot Quality Assurance Sampling data; and reports from previous health programming.

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

CLA

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

- **Collaborating:** The awardee must engage in active collaboration with both USG- and non-USAID supported activities at national-, regional- and district-level to leverage resources, reduce overlap, and share learning around improving health outcomes and strengthening health system resilience. This entails coordinating with other key in-country partners to share knowledge around assessments, emerging research, lessons learned, etc.; identifying strategic opportunities to take advantage of other GOU, donor, and USG platforms to advance the activity’s goals or layer interventions in similar geographic areas as other USAID IPs; and conducting joint work planning sessions with other relevant activities. Please see Section A5 for details.
- **Learning:** The awardee will identify opportunities for generating and feeding new learning, health innovations, and performance information back into the UHA program strategy to inform program management, design, and resource allocations (see box below for UHA proposed learning agenda questions). Sources for learning include data from routine facility- and community-level data and service statistics; new digital data collection tools; portfolio and data visualization reviews; findings of research, evaluations, analyses conducted by USAID or third parties; and knowledge gained from experience (such as pause and reflect and shared learning moments stocktaking exercises). The awardee should also disseminate knowledge generated by learning to activity stakeholders, partners, and collaborators in an appropriate forum and format so that it may be translated into decisions and actions that enhance the success of approaches and interventions designed to achieve common intermediate results, particularly across PEPFAR local IPs.
- **Adapting:** The awardee will learn from and adapt implementation throughout the life of UHA, using learning to influence decision making and resource allocation to achieve results. This may entail engaging in periodic reflection activities using approaches such as after-action reviews and pause and reflect sessions to identify, capture, and act upon lessons learned; translating learning from within implementation experience and considering programmatic changes to achieve better results. Given shifting epidemiology and upsurges of infectious disease (such as COVID-19), the awardee will be expected to employ a flexible implementation model to respond to the local implementation context, including health and non-health shocks and stressors.

UHA Learning Agenda Questions

What are the most effective approaches for operationalizing the MoH’s Hub and Spoke model for decentralized service provision?
 How can the GoU capitalize on recent adaptations and innovations to enhance continuity of services in a post-COVID context?
 What are successful approaches for enhancing functional collaboration between UHA and USAID’s above-site health investments and district multisectoral development programming?
 How can UHA leverage PEPFAR-supported multi-month drug dispensing to also enhance MNCH, FP/RH, nutrition, and facility WASH health outcomes?
 How can the GoU better leverage RBF, domestic resources, and public-private partnerships to more effectively fill health infrastructure, human resource, and supply chain gaps?

A5. Implementation Approach

Use of Sub-Grants

This award will provide approximately \$10 million in grants over the life of the five-year activity to NGOs, CBOs, and non-state actors to contribute to the achievement of key activity and IRs as described in the activity description above.

The applicant should describe how it will use small grants strategically to advance UHA results and increase local ownership, engagement, and sustainability. Illustrative areas for sub-granting may include, but are not limited to:

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

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

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

Private Sector Engagement

UHA focuses primarily on strengthening the public sector as the largest provider of affordable health care to vulnerable populations. USAID/Uganda recognizes however that Uganda's private sector plays an important role in providing and financing essential MNCH and FP/RH health services, particularly in locations where clients cannot conveniently access public health services. USAID/Uganda therefore expects the awardee to strategically engage the private sector in priority districts to accelerate the achievement of improved MNCH, FP/RH, nutrition, and WASH/IPC health outcomes and ensure their sustainability. Specific planned private sector engagement approaches for UHA include:

- In consultation with USAID and DHOs, strengthen coordination and technical oversight of select high-volume MNCH and FP/RH PNFP or private facilities in IR 1 into DHO supportive supervision, reporting, and capacity strengthening efforts (e.g., Lacor Hospital in Gulu, St. Josephs in Kitgum, and Kalong Hospital in Pader).
- Increase functional collaboration within and outside the health sector to identify strategic public or private sector investment that may be leveraged to improve health and nutrition outcomes, such as agricultural programming that may be leveraged for nutrition improvements (Sub-IR 2.3).
- Enhance technical and program management capacity of PFNP HIV service delivery sites (Sub-IR 2.5).
- Improve how districts leverage and use GOU/World Bank's \$159 million RBF project, ongoing GF, and philanthropic foundation investments to incentivize improved health outcomes and domestic resource mobilization (Sub-IR 3.2).

- Collaborate with UHSS to scale private sector activities within priority districts, such as strengthening sub-national public-private partnerships and coordination structures.

Local Capacity Development and Sustainability

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

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

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

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

The applicant should describe a realistic approach to ensuring sustainability of project outcomes and health services following the cessation of UHA support as part of its application.

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

Program Coordination with the GOU, Other IPs, and Donors

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

Community- and household level health and development challenges are frequently inter-linked across sectors and mutually reinforcing. USAID/Uganda therefore also expects thoughtful and purposeful coordination with other USG- and non-USG multi-sectoral investments in education, child development, agriculture, WASH, nutrition, youth, resilience, and economic growth programming. The awardee should identify strategic opportunities to leverage relationships, resources, and service delivery interventions to enhance achievement of UHA results in districts and sub-regions where activities will be jointly implemented, per Table 2. While the level, frequency, and intensity of engagement with different activities will vary based upon real-time geographic and technical considerations, anticipated collaboration may include:

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

Table 2: Potential Institutions/Activities with which UHA Will Collaborate (IRs)			Subnational Areas of Co-Location
USG/health sector activities	MCHN Activity	<ul style="list-style-type: none"> • Scale-up high impact MCHN practices at facility/community level 	<ul style="list-style-type: none"> • National-level and relevant priority districts
	FPA	<ul style="list-style-type: none"> • Cascade high impact FP practices at facility and community level 	<ul style="list-style-type: none"> • Overlapping priority districts: e.g., Kyegegwa, Kyenjojo, Buliisa, Kibaale, Bundibugyo, Ntoroko, Kiryadongo, Butamabala, Rakai, Gomba, and Kyankwazi
	SBCA	<ul style="list-style-type: none"> • Localize/scale relevant MNCH, FP/RH, and nutrition SBC approaches 	<ul style="list-style-type: none"> • TBD priority districts
	PMI Malaria Reduction Activity (PUMRA)	<ul style="list-style-type: none"> • Coordinate district malaria and community-level iCCM efforts in co-located districts 	<ul style="list-style-type: none"> • TBD priority districts in Acholi, Lango, Karamoja, and Busoga
	PEPFAR local IPs (see Sub-IR 2.5)	<ul style="list-style-type: none"> • Provide TA under Sub-IR 2.5 based upon IP capacity needs 	<ul style="list-style-type: none"> • PEPFAR IP implementation districts.

Table 2: Potential Institutions/Activities with which UHA Will Collaborate (IRs)			Subnational Areas of Co-Location
	Integrated Community Agriculture and Nutrition (ICAN)	<ul style="list-style-type: none"> • Leverage existing ICAN FTF community platforms for improving household nutrition mothers and children 	<ul style="list-style-type: none"> • UHA priority districts withing ICAN priority sub-regions: Acholi, Kigezi, Karamoja, Gulu
	Uganda Sanitation for Health (USHA)	<ul style="list-style-type: none"> • Scale-up new WASH IPC guidelines and facility WASH practices 	<ul style="list-style-type: none"> • Priority UHA districts, including in Acholi and Busoga (USHA)
	UHSS	<ul style="list-style-type: none"> • Scale IR 2 and 3 interventions 	<ul style="list-style-type: none"> • In PEPFAR districts
	SSCS	<ul style="list-style-type: none"> • Increase access to EHMS via TA; scale-up SSCS training and tools 	<ul style="list-style-type: none"> • National-level and within priority PEPFAR districts
	ULA	<ul style="list-style-type: none"> • Conduct relevant UHA assessments 	<ul style="list-style-type: none"> • National level
	SITES (MEL),	<ul style="list-style-type: none"> • Strengthen DQA and EMR efforts 	<ul style="list-style-type: none"> • In PEPFAR districts
	Integrated Child and Youth Development Activity (IYCD)	<ul style="list-style-type: none"> • Identify vulnerable household members for UHA interventions • Leverage community platforms to reach priority populations with health information • Strengthen community referrals for health services 	<ul style="list-style-type: none"> • Relevant priority districts where UHA and activities overlap (ICYD: Gulu, Jinja, Kabale, Lira, Mbale, Mbarara; ICARE: Jinja; KCHS: Mbarara, Kabale)
	Improving Care and Resilience for Children and Youth in Eastern Central (ICARE)		
	Keeping Children Healthy & Safe (KCHS)		
	Inclusive Agricultural Markets Activity (IAM)	<ul style="list-style-type: none"> • Leverage IAM gathering platforms for youth, women, farmers for information/referrals 	<ul style="list-style-type: none"> • Relevant priority districts of overlap
	DRM4D	<ul style="list-style-type: none"> • Increase health budget advocacy, monitoring of public expenditures, and budget analysis 	<ul style="list-style-type: none"> • Relevant priority districts where UHA and DRM4D overlap (in Mbarara, Jinja, Mbale, Lira, Gulu)
Other donors	World Bank	<ul style="list-style-type: none"> • Leverage URMCHIP RBF 	<ul style="list-style-type: none"> • Priority DHOs and health facilities

Table 2: Potential Institutions/Activities with which UHA Will Collaborate (IRs)			Subnational Areas of Co-Location
	Global Fund	<ul style="list-style-type: none"> Collaborate/coordinate on iCCM and relevant HSS support 	<ul style="list-style-type: none"> Relevant priority districts
	GFF	<ul style="list-style-type: none"> Implement new RMNCAH Sharpened Plan 	<ul style="list-style-type: none"> Relevant priority districts
	FCDO/DFID	<ul style="list-style-type: none"> Coordinate and fill gaps to address the reduction of FP/RH and malaria funding 	<ul style="list-style-type: none"> Relevant priority districts
	UNFPA	<ul style="list-style-type: none"> Leverage FP/RH commodity distribution 	<ul style="list-style-type: none"> National level
	UNICEF	<ul style="list-style-type: none"> Amplify UNICEF investments in iCCM, nutrition, child health 	<ul style="list-style-type: none"> Relevant priority districts, especially within Karamoja
Govt.	MoH	<ul style="list-style-type: none"> TA around relevant IRs to SCAPP, DHOs, and RRHs Share results and jointly plan 	<ul style="list-style-type: none"> Seven RRH community health departments and ≤30 districts National level TA to SCAPP
	Allied non-health GoU Ministries	<ul style="list-style-type: none"> Coordinate on multisectoral interventions under IR 1.3 and 2.3 	<ul style="list-style-type: none"> National-level and where relevant sub-nationally
Private sector	PNFP/FBOs	<ul style="list-style-type: none"> Provide TA to priority high-volume PNFP sites as directed by GoU Coordinate service delivery interventions at district level 	<ul style="list-style-type: none"> In all priority districts where UHA works, especially the Local Service Delivery Activity.
	Umbrella private sector organizations	<ul style="list-style-type: none"> Identify potential areas of collaboration and PPPs 	<ul style="list-style-type: none"> TBD

Gender Considerations

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

USAID/Uganda reviewed key gender-related analyses³⁴ to strengthen UHA’s gender-responsiveness. This review found that women’s health decisions and behaviors are influenced significantly by gender, socio-cultural, and religious norms that limit their agency in MNCH, FP/RH, nutrition, and HIV decision-making. These norms—including early and child marriage, polygamy and multiple concurrent unprotected sexual partnerships, young age of sexual debut, and high rates of GBV—negatively impact women and girls’ health. At a practical level, this means women and girls are often unable to negotiate for safer sex, condom use, and or FP; access financial resources; or seek health services when needed. Men often act as gatekeepers around the use of income and health services, although they often lack access to accurate

³⁴ USAID/Uganda Gender Equality and Social Inclusion Analysis (2021, draft and 2017); RHITES Gender Action Plans.

knowledge about HIV, MNCH, FP/RH, and nutrition. The COVID-19 pandemic has exacerbated gender inequality and worsened reproductive health outcomes. Travel restrictions and lockdowns have compromised women and youth's ability to access health services, post-violence care, and impacted adherence to HIV treatment. Women have also experienced a significant escalation of GBV during the pandemic, with some calling it "a pandemic within the pandemic."

Despite these gender-related challenges, opportunities exist to enhance equitable access to and uptake of health services as well as reduce gender inequalities through UHA. These include amplifying positive social norms and scaling-up the adoption of evidence-based and innovative strategies for increasing uptake of health services.

Applicants should recommend innovations and interventions in their proposals likely to increase access to and quality of health services among marginalized and vulnerable population groups, including youth, women, and girls; persons with disabilities; those in hard-to-reach areas; and urban poor. The UHA recipient will be expected to incorporate gender-sensitive approaches into all aspects of the activity, including by:

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

Youth and Other Vulnerable Groups

Uganda features one of the world's youngest populations globally, with nearly 80 percent of the population below the age of 30. Reaching and supporting youth populations is therefore critical to achieving UHA outcomes, and in harnessing the potential of Uganda's young population to contribute to the country's development in the future. AGYW face particularly high biological and social risks that increase their risk of early marriages, early pregnancies, HIV acquisition, malnutrition, and poverty.³⁵ This manifests itself in part through engaging in high-risk behaviors, including alcohol use, multiple sexual partners, unsafe sex, and transactional sex. As a result, the teenage pregnancy rate is alarmingly high, standing at 25 percent at national level and as high as 31 percent in the Eastern sub-region. The COVID-19 pandemic has reportedly increased teenage pregnancy rates in some districts and intensified many of the stressors increasing AGYW health risk, such as poverty, school closures, and limited access to health services. Unfortunately, complications from pregnancy, childbirth, and unsafe abortion are a leading cause of AGYW death and

³⁵ Nabugoomu, J., Seruwagi, G.K. & Hanning, R. [What can be done to reduce the prevalence of teen pregnancy in rural Eastern Uganda?: multi-stakeholder perceptions](#). *Reprod Health* (2020).

school dropout. AGYW are also at an increased risk of malnutrition and giving birth to underweight babies, continuing the cycle of malnutrition that increases child mortality.

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

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

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

Environmental Considerations and Climate Risk Management

The Foreign Assistance Act of 1961, as amended, Section 117 requires that the impact of USAID's activities on the environment be considered, and that USAID includes environmental sustainability as a central consideration in designing and carrying out its development programs. This mandate is codified in Federal Regulations (22 CFR 216) and in USAID's Automated Directives System (ADS) Parts 211.3.2.b and 204 (<http://www.usaid.gov/policy/ads/200/>), which in part require that the potential environmental impacts of USAID-financed activities are identified prior to a final decision to proceed and that appropriate environmental safeguards are adopted for all activities. In line with this directive, *no activity funded under this cooperative agreement will be implemented unless an environmental threshold determination, as defined by 22 CFR 216, has been reached for that activity, as documented in an Initial Environmental Examination (IEE) or Environmental Assessment duly signed by the Bureau Environmental Officer. Hereinafter, such documents are described as "approved Regulation 216 environmental documentation."* In addition, the recipient must comply with host country environmental regulations unless otherwise directed in writing by USAID. In case of conflict between Ugandan and USAID regulations, the latter will govern.

Pursuant to 22 CFR 216, USAID/Uganda is in the process of updating all of its current IEEs, one of which will cover UHA. This IEE updating exercise is ongoing. While USAID/Uganda is releasing a notice of funding opportunity at this stage, funds for this activity will not be committed or obligated into an award until the respective environment documentation (IEE) is completed, and all approvals obtained. The updated IEE is expected to be in place by the end of June 2022. USAID's updated IEE shall recommend an appropriate Environmental Threshold Determination for the UHA i.e. A Categorical Exclusion, Negative Determination with Conditions, or Positive Determination for the different interventions; and state appropriate environmental management conditions. The Recipient will be given the opportunity to

realign their budget based upon any new environmental considerations or guidance once the IEE is finalized.

The recipient, in collaboration with the USAID AOR and Mission Environmental Officer or Bureau Environmental Officer, will review all ongoing and planned activities included within its work plans and performance reports under this cooperative agreement to determine if they are within the scope of the approved Regulation 216 environmental documentation. If the UHA plans any new activities outside the scope of the approved Regulation 216 environmental documentation, the recipient must prepare an amendment to the documentation for USAID review and approval. No such new activities may be undertaken prior to receiving written USAID approval of environmental documentation amendments. Any ongoing activities found to be outside the scope of the approved Regulation 216 environmental documentation will be halted until an amendment to the documentation is written and approved by USAID.

Cost and technical applications must reflect environmental documentation preparation costs and approaches where applicable. This may include costs towards the preparation of an environmental mitigation and monitoring plan (EMMP) during the post-award stage. The recipient will be expected to comply with all conditions specified in the approved IEE; and periodically report on implementation of the EMMP in all reports to USAID.

USAID anticipates that environmental compliance and achieving optimal development outcomes for the proposed activities will require environmental management expertise. The activity shall therefore include as part of their approach to achieving environmental compliance and management, the following:

- A. Approach to developing and implementing an EMMP.
- B. Illustrative budget for implementing the environmental compliance activities/EMMP.

The recipient must use Environmental Review Forms or an Environmental Review checklist to screen sub-grant applications to ensure that the funded applications will result in no adverse environmental impact, to develop necessary mitigation measures and to specify monitoring and reporting. Use of the Environmental Review Form or Checklist is called for when the nature of the grant applications to be funded is not known well enough, to make an informed decision about their potential environmental impacts, yet due to the type and extent of activities to be funded, any adverse impacts are expected to be easily mitigated. Implementation of sub-grant activities cannot go forward until the Environmental Review Form or Environmental Review Checklist is completed and approved by USAID. UHA will ensure that mitigation measures specified by the environmental review process are implemented and addressed in annual reports.

Climate Risk Management

USAID supports strengthening development outcomes by integrating climate change into Agency programming, learning, policy dialogues and operations. Under Climate Risk Executive Order 13677 on "Climate-Resilient International Development," USAID requires climate risk assessment for all new activities across sectors to analyze the potential impact of climate change on the activity as well as to develop climate risk management strategies. This ensures the effectiveness and sustainability of project and activity objectives in the face of extreme weather and climate events. Accordingly, USAID/Uganda conducted a climate risk assessment for the UHA. While the Climate Risk assessment concluded that low climate risks are anticipated from the types of activities conducted through UHA, the awardee will identify opportunities to strengthen climate resilience in activity implementation, where possible.

Authorizing Legislation

This activity is authorized in accordance with the Foreign Assistance Act of 1961. Resulting awards to U.S. Non-government Organizations will be administered in accordance with Chapter 303 of USAID's Automated Directives System (ADS 303), 2 CFR 200, 2 CFR 700, applicable OMB Circulars and Standard Provisions for Non-Governmental Organizations. 2 CFR 200 / 2 CFR 700 is applicable to an award to a U.S. organization made under this RFA.

(a) All provisions of 2 CFR 200 / 2 CFR 700 and all Standard Provisions attached to this agreement are applicable to the recipient and to sub recipients which meet the definition of "Recipient" in Part 200 unless a section specifically excludes a sub recipient from coverage. The Recipient shall assure that sub recipients have copies of all the attached standard provisions.

(b) For any sub awards made with non-US sub recipients the Recipient shall include the applicable "Standard Provisions for Non-US Nongovernmental Grantees."

(c) For U.S. organizations, 2 CFR 700, 2 CFR 200, and ADS 303maa, Standard Provisions for U.S. Non-governmental Organizations are applicable.; For non-U.S. organizations, ADS 303mab, Standard Provisions for Non-U.S. Non-governmental Organizations will apply.; The applicable Standard Provisions that will apply in any resulting award document can be viewed or downloaded from USAID's Web Site:

<https://www.usaid.gov/sites/default/files/documents/303.pdf>

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SECTION B: FEDERAL AWARD INFORMATION

1. Estimate of Funds Available and Number of Awards Contemplated

USAID intends to award **one** (1) cooperative agreement pursuant to this notice of funding opportunity. Subject to funding availability and at the discretion of the Agency, USAID intends to provide \$170 million in total USAID funding over a five-year period. USAID reserves the right to fund any one or none of the applications submitted.

2. Expected Performance Indicators, Targets, Baseline Data, and Data Collection

Please see Section A4. Activity Monitoring, Evaluation, and Learning Plan within the Program Description for guidance on expected performance indicators, targets, and baseline data.

3. Start Date and Period of Performance for Federal Awards

The period of performance anticipated herein is the date of the Agreement Officer's signature of the award. The entire period of performance is anticipated to be five years from the effective date of the award. The estimated start date is on or about November 1, 2022.

4. Substantial Involvement

Consistent with ADS 303.3.11, USAID/Uganda will be substantially involved in the implementation of the Uganda Health Activity. 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 results and objectives. USAID/Uganda will provide technical knowledge and guidance to the awardee on programmatic implementation and promote sharing and learning of successes and challenges among the USAID partners implementing this activity. USAID's substantial involvement is required during award administration, as listed below:

a. Approval of the Recipient's Annual Implementation Plans:

If at the time of award, the program description does not establish a timeline in sufficient detail for the planned achievement of milestones or outputs, USAID may delay approval of the recipient's implementation plan for a later date. Implementation plans include, but are not limited to, annual work plans, including planned activities for the following year and any subsequent revisions, international travel plans, planned expenditures, event planning/management, international meeting preparation.

USAID requires the approval of implementation plans to ensure alignment with stated goals, milestones, and outputs. The implementation plan communicates how and when the recipient will complete project activities and is drafted annually to describe new activities. The AOR's review will ensure that the implementation plans fit within the scope, terms, and conditions of the agreement.

USAID may consider changes to an approved implementation plan when changed contexts or new information require a pivot in the activity.

This includes the approval of the recipient's monitoring and evaluation plans during implementation. This describes USAID involvement in monitoring progress toward the achievement of program objectives during the performance of the project, including written guidelines for the content of annual reports and final evaluations.

During the initial project planning period, the awardee will work closely with USAID to establish major milestones, program monitoring indicators, as well as baseline data and performance targets which will demonstrate successful achievement of the results addressed in the cooperative agreement.

Please note: Construction is **not** eligible for reimbursement under this award.

b. Approval on the substantive provisions of sub-awards:

The recipient must obtain AO's prior approval of substantive provisions of proposed subawards (see definitions in 2 CFR 200). Substantive provisions go beyond existing policies on Federal review of recipient procurement standards and sole-source procurement.

Please note that any sub-awards (sub-agreements) to foreign governmental organizations or parastatals of any amount must be approved by the AO, and may warrant additional clearances in accordance with ADS 303.3.21.b &c.

c. Direct involvement to ensure compliance:

USAID will have direct operational involvement or participation to ensure compliance with statutory requirements, Congressional Earmarks and Directives, and other funding requirements.

e. Agency Monitoring to Permit Redirection:

Agency monitoring to permit specific kinds of direction or redirection of the work because of the interrelationships with other projects or activities. All such activities must be included in the program description, negotiated in the budget, and made a part of the award.

Note: The AOR will provide review of the proposed change, and the AO is the only individual who can provide approval for this element of substantial involvement.

f. Agency and Recipient Collaboration or Joint Participation:

USAID has determined that the Recipient's successful accomplishment of the program objectives would benefit from USAID's technical knowledge, and has authorized the joint participation of USAID and the Recipient in the following ways:

(1) **Collaborative involvement in selection of advisory committee members:** If the Activity establishes an advisory committee that provides advice to the recipient, USAID will participate in selection of such advisory committee members and participate as a member of this committee as well. Advisory committees must only deal with programmatic or technical issues and not routine administrative matters.

(2) **Approval of recipient's monitoring and evaluation plans:** USAID's involvement in monitoring progress toward the achievement of program objectives during the performance of the project, including written guidelines for the content of annual reports and final evaluations through AOR's approval of AMELP. During the initial project planning period, the awardee will work closely with USAID to establish major milestones, program monitoring indicators, as well as baseline data and performance targets which will demonstrate successful achievement of the results addressed in the Program Description.

(3) **Communication with GOU Officials:** The AOR must be present in all meetings with government-level officials at the Minister and General levels. All communication with GOU officials must be made by the Chief of Party and coordinated in advance with the USAID AOR. Exceptions may be granted but must be in writing and made prior to any meeting/communication.

g. Approval of Specified Key Personnel:

USAID may designate as key personnel only those positions that are essential to the successful implementation of the recipient's program. USAID's policy limits this to a reasonable number of positions, generally no more than five positions or five percent of recipient employees working under the award, whichever is greater. The Uganda Health Activity will require experts and specialists in a range of MNCH, FP/RH, nutrition, WASH, and HSS technical and operational areas as outlined in the Program Description.

For this activity, USAID determines the following five key personnel are essential for the successful implementation and achievement of activity results. All personnel require 100% level-of-effort throughout the duration of the award. In accordance with the Substantial Involvement clause of this award, these personnel are subject to the approval of the Agreement Officer:

Proposed Uganda Health Activity Key Personnel Requirements

1. Chief of Party (COP)

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

Chief of Party Qualifications, Experience, and Skills

Required:

- Master's degree or other advanced degree (PhD, MD). in a relevant field, such as medicine, public health, social sciences, or management.
- Minimum of ten years' progressively responsive experience in a senior role managing large and complex integrated health service delivery programs of similar scope and dollar value (\$30 million+) in Sub-Saharan Africa.
- Previous experience working on USG programs and working knowledge of USG regulations.
- Proven ability to work collaboratively with government, donors, the private sector, and community organizations to advance health objectives.
- Demonstrated experience successfully leading and managing multi-disciplinary teams to achieve health results in a fast-paced environment.
- Excellent interpersonal, writing, and English language oral presentation skills.

Desired:

- Five years' experience working in East Africa on development programming.
- Current relationships with relevant Uganda stakeholders (MOH, donors, IPs) and/or past experience working in Uganda.
- Previous experience working on and/or technical expertise in MNCH, FP, nutrition, WASH, HSS, or/and PEPFAR programming.

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

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

Technical Director, IHSD - Qualifications, Experience, and Skills

Required:

- Master's degree or other advanced degree (PhD, MD) in a relevant field, such as medicine, public health, or social sciences.
- At least seven years of experience in managing and/or implementing integrated health service delivery or TA programming addressing MNCH, FP/RH, nutrition, and WASH in a similar context, with at least three of those years working in Uganda as a senior advisor or staff member.
- Experience and expertise in evidence-based facility- or community-based MNCH, FP/RH, nutrition, and/or WASH service delivery approaches.
- Ability to interact effectively and collaboratively with a broad range of public and private sector counterparts, donors, and other key stakeholders.

Technical Director, IHSD - Qualifications, Experience, and Skills

- Experience supervising technical staff in the implementation of integrated health programming.
- Excellent interpersonal, writing, and English language oral presentation skills.

Desired:

- Clinical qualification (MD, clinical officer, nurse, midwife, or other cadres).
- Previous experience working on USG-funded health programming in Uganda.
- Expertise in strengthening quality of care and/or QI for MNCH, FP, nutrition, or WASH.

3. Technical Director, HIV and HSS

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

Technical Director, HIV and HSS - Qualifications, Experience, and Skills

Required:

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

Desired:

- Clinical qualification (MD, clinical officer, nurse, midwife, or other cadres).
- Previous experience working on USG-funded HIV programming in Uganda.
- Expertise in strengthening the program management, service delivery or adaptive management of Ugandan health organizations.
- Experience working with decentralized health systems.

4. Director, MEL

Reporting to the COP, the Director, MEL will oversee all monitoring, evaluation, learning, and components of this Activity, including the design and implementation of the AMELP and

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

Director, MEL - Qualifications, Experience, and Skills
<p>Required:</p> <ul style="list-style-type: none"> ● Master’s degree in a relevant field, such as public health, epidemiology, biostatistics, applied statistics, M&E, or social sciences. ● At least seven years of experience in managing and/or leading MEL activities for large-scale health service delivery or HSS programs in Sub-Saharan Africa, with at least three of those years working in Uganda as a senior advisor or staff member. ● Demonstrated experience in setting up and managing MEL systems that track performance as per the objectives of UHA. ● Knowledge of and experience with key MNCH, FP/RH, nutrition, WASH, and/or HIV/AIDS indicators and GOU and USG data collection systems (e.g., DHIS2, DATIM). ● Demonstrated ability to translate project objectives and vision into an evidence-based theory of change. ● Strong analytical skills to successfully use data and evidence to guide program adaptations. ● Excellent ability to articulate oral and written technical information clearly and effectively to both technical and non-technical audiences.
<p>Desired:</p> <ul style="list-style-type: none"> ● Previous experience supporting MEL on USG-funded health programming in Uganda. ● Familiarity with CLA approaches. ● Expertise in qualitative and quantitative research methods. ● Data visualization skills.

5. Director, Finance and Administration (F&A)

The Director, F&A will report to the COP and will be responsible for overseeing all aspects of budgeting, financial management, and reporting; sub-award management and procurements; human resources management; asset management; logistics; and prime award compliance with terms and conditions of the award. This individual will be responsible for managing the cooperative agreement budget and preparing financial reports for submission to USAID. The Director, F&A will also ensure funds expended are compliant with USG regulations and policies. This individual will ensure systems and processes are implemented effectively to support implementation of the award, including fraud and risk mitigation practices. The proposed candidate must fulfill the position requirements detailed below:

Director, F&A - Qualifications, Experience, and Skills

Required:

- Bachelor's degree in business, accounting, finance, or related field.
- Professional certification (CPA or ACCA).
- Minimum of ten years of experience in financial and administrative management for large donor-funded development projects (>\$30 million of total award size).
- Experience managing donor-funded sub-awards and subcontractors and procurements.
- Familiarity with USG financial reporting and compliance requirements.
- Experience in risk management and implementation of internal controls.
- Demonstrated supervisory experience.
- Professional level of oral and written fluency in English language.

Desired:

- Master's degree or other in business, accounting, finance, or related field.
- Experience in development and implementing small grants programs.
- Expertise and experience in one or more areas: operations, human resources, logistics, or IT.

NOTE: USAID reserves the right to determine the relevance of education and experience.

The five key personnel specified above are considered to be essential for successful achievement of goals and results under this Cooperative Agreement. Prior to replacing any of the specified individuals, the Recipient must immediately notify both the USAID/Uganda Agreement Officer and Agreement Officer's Representative with reasonable advance notice and submit written justification (including proposed substitutions' resume) in sufficient detail to permit evaluation of the impact on the Activity. No replacement of key personnel will be made by the Recipient without the written consent of the Agreement Officer

5. Subawards

In accordance with the USG regulations, 2 CFR 200 and 2 CFR 700, all sub awarding under this Agreement must receive prior approval of the Agreement Officer unless described in the application and funded in the approved budget of the award. In seeking approval, the Recipient must at a minimum, identify the sub-Recipient, the amount, and the purpose of award. Approval for the Recipient to award or enter into the following sub-agreements is granted with the signing of this Award by the Agreement Officer:

6. Title to Property:

Property title under the resultant agreement will vest with the cooperating country in accordance with the Requirements of 2 CFR 200.312 -Federally-owned and exempt property.

For Non-US Non-Government Organizations, ADS Standard provision - Title to and Use of Property (December 2014) - title to all Property financed under this award vests in the recipient upon acquisition unless otherwise specified in this award; applies.

7. Authorized Geographic Code

The geographic code for the procurement of commodities and services under this activity is 937 and must meet the source and nationality requirements set forth in 22 CFR 228.

8. Nature of the Relationship between USAID and the Recipient

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

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DRAFT NOFO

SECTION C: ELIGIBILITY INFORMATION

1. Eligible Applicants

Eligibility for this NOFO is not restricted. In response to this NOFO, any U.S. or non-U.S. organization, non-profit, or for-profit entity is eligible to apply. Organizations may submit applications individually or in partnership with other international or local organizations.

USAID/Uganda encourages applications from organizations that have not previously received financial assistance from USAID. USAID assistance instruments do not require prior USAID experience.

To be eligible for award of a Cooperative Agreement, in addition to other conditions of this NOFO, organizations must have a politically neutral humanitarian mandate, a commitment to non-discrimination with respect to beneficiaries and adherence to equal opportunity employment practices. Nondiscrimination includes equal treatment without regard to race, religion, ethnicity, gender, and political affiliation.

Applicants must have established financial management, monitoring and evaluation processes, internal control systems, policies, and procedures that comply with established U.S. Government standards, laws, and regulations. The apparently successful applicant(s) will be subject to a responsibility determination by the Agreement Officer (AO). The AO may determine that a pre-award survey might be necessary to assist in establishing the responsibility of the Recipient to receive U.S. Government funding.

2. Cost Sharing or Matching

USAID has established a cost share of 5% of the projected award amount for the recipient of the award. Such funds may be mobilized from the recipient; other multilateral, bilateral, and foundation donors; host governments; and local organizations, communities and private businesses that contribute financially and in-kind to implementation of activities at the country level. This may include contribution of staff level of effort, office space, or other facilities or equipment which may be used for the program, provided by the recipient. Cost sharing, once accepted, becomes a condition of payment of the federal share. The proposed cost share (cash and/or in-kind contributions) will be monitored in accordance with 2 CFR 200.306 and 2 CFR 700.1. For guidance on cost sharing in grants and cooperative agreements, see 2 CFR 200 and 700, and ADS 303.3.10.

NOTE: The 5% cost share will be in addition to the total estimated budget of \$170 million for this NOFO.

The Recipient agrees to expend an amount not less than _____ (TBD at Award) of the Total Estimated Amount if the award is fully funded or 5% of the of the cumulative obligated amount by the end of the award if the award is not funded to the full Total Estimated Amount. Upon mutual agreement, the Recipient may be requested to increase the cost share by a reasonable amount in case there is an increase in the Total Estimated Amount of this cooperative Agreement.

The AOR must monitor the recipient's financial reports to ensure that the Recipient meets the above stated cost share.

3. Limitations on number of applications

The number of applications an applicant may submit under this NOFO is limited to **ONE** per submitting organization. USAID/Uganda will not consider any application in excess of this limitation.

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DRAFT NOFO

SECTION D: APPLICATION AND SUBMISSION INFORMATION

1. Agency Point of Contact

Name: Ms. Andreea Surdu

Title: Agreement Officer

Email: KampalaUSAIDSolicita@usaid.gov

Mail Address: USAID/Uganda US Embassy Compound, Ggaba Road Kampala, Uganda

2. Questions and Answers

Any questions regarding this NOFO must be submitted in writing to KampalaUSAIDSolicita@usaid.gov to the attention of Ms. Andreea Surdu, Agreement Officer no later than the date and time indicated on the cover letter, as amended. Questions sent to any other email address will not be answered. **The email transmitting the questions must reference the NOFO number and title on the subject line of the email.** Responses to questions received prior to the deadline, and any other information necessary for submitting applications, will be furnished to all potential applicants through an amendment to this notice posted on <https://www.grants.gov>.

3. General Content and Form of Application

NOTE: Electronic submission of applications via e-mail is required. The applications must be compatible with MS WORD or PDF (Portable Document File) with Optical Character Recognition format in Microsoft Windows. Applicants must provide budgets as text accessible Excel spreadsheets.

There has been a problem with the receipt of *.zip files due to the anti-virus software. **APPLICANTS MUST NOT SUBMIT ZIPPED FILES.**

Applicants are expected to review, understand, and comply with all aspects of the NOFO.

Please submit your applications to the email address below and by the date as stated on the cover page. **Paper copies of the applications are not accepted.** The address for the receipt of applications is: KampalaUSAIDSolicita@USAID.gov, to the attention of Andreea Surdu, Agreement Officer Applications do not follow the instructions contained herein run the risk of not being considered in the review process.

Each applicant must furnish the information required by this NOFO. Applications must be submitted in two separate parts: the Technical Application and the Business (Cost) Application. This subsection addresses general content requirements applying to the full application. Please see subsections 5 and 6 below for information on the content specific to the Technical and Business (Cost) Applications. The Technical Application must address technical aspects only while the Business (Cost) Application must present the costs, and address risk and other related issues.

Both the Technical and Business (Cost) Applications must include a cover page containing the following information:

- Name of the organization(s) submitting the application.
- Identification and signature of the primary contact person (by name, title, organization, mailing address, telephone number and email address) and the identification of the alternate contact person (by name, title, organization, mailing address, telephone number and email address).
- Program name.
- Notice of Funding Opportunity number.
- Date of Application.
- 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).
- DUNS and Unique Entity Identifier number for primary applicant.
- System for Award Management (SAM) registration status.

Applications signed by an agent on behalf of the applicant must be accompanied by evidence of that agent's authority unless that evidence has been previously furnished to the issuing office.

Applicants may choose to submit a cover letter in addition to the cover pages, but it will serve only as a transmittal letter to the Agreement Officer. The cover letter will not be reviewed as part of the merit review criteria.

Applications must comply with the following:

- USAID will not review any pages in excess of the page limits noted in the subsequent sections. Please ensure that applications comply with the page limitations.
- The Application must be written in English.
- Use English Times New Roman, 11 pt., Single Spacing, MS Word and PDF (Adobe Acrobat) versions on standard 8 1/2" x 11" paper (210 mm by 297 mm paper), each page numbered consecutively and no less than 1" margins on all sides left justification and headers and/or footers on each page including consecutive page numbers, date of submission, and Applicant's name.
- Legible fonts must be used for graphs, charts/diagrams, tables, and text boxes.
- The Application must be submitted via Microsoft Word or PDF formats, except budget files which must be submitted in Microsoft Excel.
- The estimated start date identified in Section B of this NOFO must be used in the cost application.
- The technical application must be a searchable and editable Word or PDF OCR format as appropriate.
- The Cost application must include an Excel spreadsheet with all cells unlocked and no hidden formulas or sheets. A PDF version of the Excel spreadsheet may be submitted in addition to the Excel version at the Applicant's discretion, however, the official cost application submission is the unlocked Excel version.

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

4. Application Submission Procedures

Each Applicant must furnish the information required by this NOFO. Applications must be submitted in two separate parts (a) Technical Application and (b) Cost/Business Application.

Please note that the Technical and Cost Applications must be kept separate.

For an application sent by multiple emails, please indicate in the subject line of the email whether the email relates to the technical or cost application, and the desired sequence of multiple emails (if more than one is sent) and of attachments (e.g., “No. 1 of 4”, etc.). For example, if your cost application is being sent in two emails, the first email should have a subject line which says: “[organization name], Cost Application, Part 1 of 2”. All emails must also contain the NOFO number in the subject line.

USAID’s preference is that the technical application and the cost application each be submitted as a single email attachment, e.g., that you consolidate the various parts of a technical application into a single document before sending them. If this is not possible, applications may be submitted via email with up to 10 attachments (4MB limit) per email.

Applicants are encouraged to provide clear instructions on how to collate the attachments. USAID will not be responsible for errors in compiling electronic applications if no instructions are provided or are unclear. All applications received by the submission deadline will be reviewed for responsiveness to the NOFO and the application format. No addition or modifications will be accepted after the submission date.

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

Applicants are reminded that email is NOT instantaneous, and in some cases delays of several hours occur from transmission to receipt. Therefore, applicants are requested to send the application in sufficient time ahead of the deadline. For this NOFO, the initial point of entry to the government infrastructure is the USAID mail server.

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

All applications received by the submission deadline will be reviewed for responsiveness to the NOFO and the application format. No additions or modifications will be accepted after the submission date. It is the Applicant’s responsibility to ensure that all necessary documentation is complete and received on time. USAID bears no responsibility for data errors resulting from transmission or conversion processes associated with electronic submissions.

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

“This application includes data that shall not be disclosed outside the U.S. Government and shall not be duplicated, used, or disclosed – in whole or in part – for any purpose other than to evaluate this application. If, however, a grant is awarded to this Application as a result of – or in connection with – the submission of this data, the U.S. Government shall have the right to duplicate, use, or disclose the data to the extent provided in the resulting grant. This restriction does not limit the U.S. Government’s right to use the information contained in this data if it is obtained from another source without restriction. The data subject to this restriction are contained in sheets [insert sheet numbers]” and, mark each sheet of data it wished to restrict with the following legend: *“Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this application.”*

5. Technical Application Format

The technical application must be specific, complete, and presented concisely. The application should demonstrate the applicant's capabilities and expertise with respect to achieving the goals of UHA. The application should take into account the requirements of the program description (Section C) and merit review criteria (Section E) found in this NOFO.

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

The Technical Application is limited to a maximum of 30 pages (excluding cover sheet, table of contents, acronyms, executive summary, and annexes). It must include the following sections in the prescribed order:

- a) **Cover Sheet:** See section above for requirements—not to exceed 1 page; *does not count against overall 30-page technical application page limit.*
- b) **Table of Contents:** Include major sections and page numbering to easily cross-reference and identify merit review criteria—not to exceed 1 page; *does not count against overall 30-page technical application page limit.*
- c) **Acronyms:** Not to exceed 2 pages; *does not count against overall 30-page technical application page limit.*
- d) **Executive Summary:** Provides a high-level overview of the key elements of the Technical Application (Technical Approach, Staffing Plan and Management Approach, Key Personnel, and Organizational Technical Capacity)—not to exceed 2 pages; *does not count against the overall 30-page technical application page limit.*

e) **Technical Approach** (*Merit Review Criterion 1*): Applicants must prepare an evidence-based and innovative technical approach and Annex 1 for achieving the intermediate results and outcomes described within Program Description.

f) **Staffing Plan and Management Approach** (*Merit Review Criterion 2*)

Applicants should detail their staffing plan and management approaches to facilitate effective achievement of UHA results within a complex, decentralized implementation environment.

Within the **staffing plan**, applicants should describe the proposed staffing structure that will enable effective implementation and integration across staff members, teams, and offices across sub-regions. The staffing plan should describe and ensure an appropriate and efficient skills mix to meet UHA's technical and managerial needs, including the use of Ugandan experts. Applicants may reference or refer to Annex 2 (Organizational Chart and Staffing Plan Matrix) in their application narrative descriptions. The staffing plan should detail the clear roles and responsibilities and skills of each proposed staff, including home office support.

Within the **management approach**, applicants should describe the following:

- The proposed geographic location of all offices and how the locations facilitate continuous and tailored TA to RRHs and district health offices and coordination within the activity and with key external stakeholders.
- The roles and responsibilities of proposed consortium members and how they will complement each other and enable the Applicant to cover all required skills by the program description. Describe how the Applicant plans to formally engage local entities within its consortium/team with relevant scopes of work, if applicable.
- Proposed lines of authority and management oversight among key staff, partners, and consortium members to ensure delivery of high-quality technical assistance and program results.
- Mechanisms and/or structures to promote coordination and knowledge sharing across UHA staff members, sub-partners, offices, and key stakeholders (GoU representatives, other USG implementers, health donors, etc.).
- A feasible timeline and approach to ensure rapid start-up and achieving Year 1 milestones, as detailed in Annex 3 (Rapid Mobilization and Year 1 Work Plan).
- Effective strategies for cost containment and mitigating fraud, waste, and abuse. This includes a description of how the Applicant would effectively manage the small grants program and ensure subgrantee adherence to USAID rules and regulations.

g) **Key Personnel** (*Merit Review Criterion 3*)

Key personnel are individuals whose performance is critical to the success of the UHA activity. Qualifications and skills required for the Key Personnel are stated in Section B of this NOFO. USAID/Uganda has determined that these five positions are: Chief of Party (COP); Technical Director, Integrated Health Service Delivery (IHSD); Technical Director, HIV and HSS; Director, MEL; and Finance and Administration Director.

Applicants should provide a summary of the proposed candidates for these positions and describe how their respective technical expertise, education, and experience will contribute to the achievement of UHA results in their application. The description should also summarize how key personnel meet or exceed the requirements set forth in the Section B, including experience in their relevant technical and managerial areas and experience implementing comparable activities in similar contexts. The key personnel sub-section must demonstrate that as a group, the proposed key personnel complement each other in management, design, evaluation, technical and implementation skills necessary to successfully and effectively implement the proposed technical approach. Refer to Annex 4 for Key personnel resumes and letters of commitment.

h) Organizational Technical Capacity (*Merit Review Criterion 4*)

This section of the application provides information about the prime applicant's and partners'/sub-awardees' technical capacity to implement the proposed project activities. The applicant must describe:

- The array of existing technical skills and capacity of the prime and partners/sub-awardees in Sub-Saharan Africa that will support the effective achievement of UHA's three intermediate results and intended outcomes, and how these combined capabilities complement each other to ensure coverage of all technical areas of the program description.
- Sufficient technical capacity in relevant cross-cutting areas to support UHA, including gender- and youth-sensitive programming, SBC interventions, and local capacity development.
- Demonstrate expertise in monitoring and evaluation of integrated health, nutrition, WASH/IPC, and HIV programming and in applying CLA to improve program management and outcomes.

i) Technical Application Annexes: The following annexes must be submitted with the technical application. These annexes are excluded from the 30-page technical application limit, but they include individual page limits for each annex. Any pages exceeding the limits for each annex below will not be reviewed.

a. Annex 1: Draft AMELP and CLA Plan (*not to exceed 6 pages*)

The Applicant is required to submit a draft AMELP and CLA plan with its application that describes how it will work with USAID to monitor progress toward UHA results in the Program Description and how they intend to learn from the evidence and knowledge generated throughout the program execution. (See Section A4; *Note: Applicants may use a smaller size font in these plans but must ensure that information is legible*).

b. Annex 2: Organizational Chart and Staffing Plan Matrix (*not to exceed 4 pages*)

Applicants must submit an organizational chart sufficient to illustrate the complete human resources needed given the program's technical complexity. The organizational chart should indicate or include staff reporting lines and relationships between positions; indication of

approximate LOE for each position; locations/offices where proposed staff will work (if applicant proposes multiple offices); and indicate under which organization the staff member will be employed (if applicable, e.g., the prime applicant proposes sub-awardee consortium members who have assigned staff).

This annex should also include a summary Staffing Plan Matrix that includes the following information for non-key personnel to illustrate their staffing plan: Position title, Position role/responsibilities, qualifications/expertise, organization, location, and assigned LOE. Please note that this matrix should include both long-term staff and short-term technical assistance and home office support (if any). *Note: Applicants may use a smaller size font in this table/matrix, but must ensure that information is legible*

c. Annex 3: Rapid Mobilization Plan and Draft Year 1 Work Plan *(not to exceed 5 pages for both components)*

Applicants must submit a Rapid Mobilization Plan that illustrates the critical tasks and timelines for ensuring successful rapid start-up. This plan will include at a minimum: a timeline for mobilization of key personnel and technical leads, plan for hiring other proposed TBD staff, startup of office (s), issuance of sub-awards to consortium members (if applicable), major equipment procurement, and engagement/communication with key stakeholders.

The Draft Year 1 Work Plan submitted must summarize the key tasks, actions and/or milestones necessary to achieve the results in Year 1, such as (but not limited to): development of key relationships, mobilization of activity personnel, opening of offices, and procuring vehicles and equipment necessary to open the offices, required deliverable development and approval, and major activities in support of the program description across the three intermediate results. The Draft Year 1 Work Plan should be presented as a table and include the following: Activity/task, responsible staff member(s), and projected implementation and completion month(s). *Note: Applicants may use a smaller size font in these plans but must ensure that information is legible.*

d. Annex 4: Key Personnel Resumes and Letters of Commitment *(not to exceed 20 pages total)*

Applicants must provide resumes for each proposed key personnel candidate. Resumes must not exceed three (3) pages in length and should present the candidate's experience in chronological order starting with the most recent experience.

Resumes for all key personnel must include three (3) past performance references with the references name, job title, organization, and up-to-date telephone numbers and email contact information for their most recent supervisors. Please note that USAID/Uganda reserves the right to carry out reference checks for all proposed key personnel before award, including other references not provided by the Applicant.

Applicants should also include a signed commitment letter (not exceeding one page) from each candidate indicating his or her: a) intention to serve in the stated position, b) present availability to serve in the stated position and the number of days from cooperative agreement award date

needed to assume responsibilities, c) length of time they are committing to serve in the position, and d) agreement to the compensation levels set forth in the cost application.

6. Business (Cost) Application Format

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

Prior to award, applicants may be required to submit additional documentation deemed necessary for the Agreement Officer to assess the applicant's risk in accordance with 2 CFR 200.206. Certain documents are required to be submitted by an Applicant in order for the Agreement Officer to make a determination of responsibility. However, it is USAID policy not to burden Applicants with undue submission requirements if that information is readily available through other sources. Applicants should not submit any additional information with their initial application.

If the Applicant has established a consortium or another legal relationship among its partners, the Cost/Business application must include a copy of the legal relationship between the parties. The agreement should include a full discussion of the relationship between the Applicant and SubApplicant(s) including identification of the Applicant with whom USAID will work with for purposes of Agreement administration, the identity of the Applicant which will have accounting responsibility, how Agreement effort will be allocated and the express agreement of the principals thereto to be held jointly and severally liable for the acts or omissions of the other.

Pursuant to 2 CFR 200 Contract means a legal instrument by which the Applicant purchases property or services needed to carry out the project or program under a resulting award. The term does not include a legal instrument when the substance of the transaction meets the definition of a federal award or sub-award (see § 200.92 Sub-award), even if the Applicant considers it a contract. The Applicant must describe the work to be performed, the risk borne by the contractor, the contractor's investment, the amount of subcontracting proposed by the contractor, and the quality of its record of past performance for similar work. For-profit contract organizations that work under the award and do not meet the above definition of a sub-awardee are eligible for profit/fee.

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

a) Cover Page (See above for requirements)

b) SF 424 Form(s)

The Applicants must provide a budget for each program year with an accompanying detailed budget narrative which provides in detail the total costs for implementation of the program. The cost application must be signed and submitted using Standard Form 424. Standard Forms can be accessed electronically at www.grants.gov or using the following links:

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

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

c) Required Certifications and Assurances

The applicant must complete the following documents and submit a signed copy with their business (cost) application

- (1) “Certifications, Assurances, Representations, and Other Statements of the Recipient” ADS 303mav document found at <http://www.usaid.gov/sites/default/files/documents/1868/303mav.pdf>
- (2) Assurances for Non-Construction Programs (SF-424B)
- (3) Evidence of responsibility the Agreement Officer can use to determine that the Applicant:
 - has adequate financial resources or the ability to obtain such resources as required during the performance of the award.
 - has the ability to comply with the award conditions, taking into account all existing and currently prospective commitments of the Applicant.
 - has a satisfactory record of performance. Past relevant unsatisfactory performance is ordinarily sufficient to justify a finding of non-responsibility unless there is clear evidence of subsequent satisfactory performance.
 - has a satisfactory record of integrity and business ethics; and
 - is otherwise qualified and eligible to receive a Cooperative Agreement under applicable laws and regulations (e.g., EEO).
- (4) Statutory and Regulation Certifications

The Applicant must complete the certifications in Section D) Required Certifications and sign and date in the signature space provided for both the prime and each of its proposed partners. The signed and dated printout must then be submitted with the application as an annex to the cost application. The Applicant must also complete and submit the certification in Section D for each of its proposed sub-applicants as an annex to the cost application.

Potential Request for Additional Documentation: Upon consideration of award or during the negotiations leading to an award, the Applicant may be required to submit additional documentation deemed necessary for the Agreement Officer to make an affirmative determination of responsibility. Applicants should not submit the information below with their applications. The information below is provided so that Applicants may become familiar with additional documentation that may be requested by the Agreement Officer:

The information that may be requested should substantiate:

1. Bylaws, constitution, and articles of incorporation, if applicable.
2. Whether the organization's travel, procurement, financial management, accounting manual and personnel policies and procedures, especially regarding salary, promotion, leave, differentials, etc., submitted under this section have been reviewed and approved by any agency of the Federal Government, and if so, provide the name, address, and phone number of the cognizant reviewing official. The Applicant should also provide copies of the same.

d) Budget and Budget Narrative

The Budget must be submitted as one unprotected Excel file (MS Office 2000 or later versions) with visible formulas and references and must be broken out by project year, including itemization of the federal and non-federal (cost share) amount. Files must not contain any hidden or otherwise inaccessible cells. Budgets with hidden cells lengthen the cost analysis time required to make award and may result in a rejection of the cost application. The Budget Narrative must contain sufficient detail to allow USAID to understand the proposed costs for each line item, including reference to sources used to substantiate the cost estimate (e.g., organization's policy, payroll documents, and vendor quotes, etc.) to allow USAID to understand the proposed costs and to support USAID's determination that the proposed costs are fair and reasonable. The applicant must ensure the budgeted costs address any additional requirements identified in Section F, such as Branding and Marking. The Budget Narrative must be thorough, including sources for costs to support USAID's determination that the proposed costs are fair and reasonable. The required budget format is found in **Attachment C** of this NOFO. Note: Cost Line Items are indicative & should therefore be adjusted as appropriate/applicable. Applicants should add rows that will cater to the proposed costs under each CLIN

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

- Summary Budget, inclusive of all program costs (federal and non-federal), broken out by major budget category and by year for activities implemented by the applicant and any potential sub-applicants for the entire period of the program. See Section H, Attachment C for Budget Template
- Summary Budgets - separate tab for the Prime Applicant and for each sub-recipient. Applicants who intend to utilize contractors or sub-awardees/sub-recipients should indicate the extent intended and a complete cost breakdown. Extensive contracts/agreement financial plans should follow the same cost format as submitted by the primary Applicant. A breakdown of all costs according to each partner organization, contract or sub-awardee involved in the program should be provided.

- Detailed Budget, including a breakdown by year of all costs associated with the program, if applicable, headquarters, regional and/or country offices, sufficient to allow the Agency to determine that the costs represent a realistic and efficient use of funding to implement the Applicant's program and are allowable in accordance with the cost principles found in 2 CFR 200 Subpart E.

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

- 1) Salaries and Allowances – Must be proposed consistent with 2 CFR 200.430 Compensation - Personal Services. The applicant's budget must include position title, salary rate, level of effort, and salary escalation factors for each position. Allowances, when proposed, must be broken down by specific type and by position. Applicants must explain all assumptions in the Budget Narrative. The Budget Narrative must demonstrate that the proposed compensation is reasonable for the services rendered and consistent with what is paid for similar work in other activities of the applicant. Applicants must provide their established written policies on personnel compensation. If the applicant's written policies do not address a specific element of compensation that is being proposed, the Budget Narrative must describe the rationale used and supporting market research.
- 2) Fringe Benefits – (if applicable) If the applicant has a fringe benefit rate approved by an agency of the U.S. Government, the applicant must use such rate and provide evidence of its approval. If an applicant does not have a fringe benefit rate approved, the applicant must propose a rate and explain how the applicant determined the rate. In this case, the Budget Narrative must include a detailed breakdown comprised of all items of fringe benefits (e.g., superannuation, gratuity, etc.) and the costs of each, expressed in U.S. dollars and as a percentage of salaries.
- 3) Travel and Transportation – Provide details to explain the purpose of the trips, the number of trips, the origin and destination, the number of individuals traveling, and the duration of the trips. Per Diem and associated travel costs must be based on the applicant's normal travel policies. When appropriate please provide supporting documentation as an attachment, such as company travel policy, and explain assumptions in the Budget Narrative.
- 4) Equipment – Must include information on estimated types of equipment, models, supplies and the cost per unit and quantity. The Budget Narrative must include the purpose of the equipment and supplies and the basis for the estimates. The Budget Narrative must support the necessity of any rental costs and reasonableness in light of such factors as: rental costs of comparable property, if any; market conditions in the area; alternatives available; and the type, life expectancy, condition, and value of the property leased.
- 5) Supplies – Supplies include all tangible personal property other than those described as Equipment. Provide information on types of supplies and the cost per unit and quantity. The Budget Narrative must include the purpose of the supplies and the basis for the estimates for determining cost allowability and reasonableness.

- 6) Subawards – This may include costs for all sub-awards. Specify the budget for the portion of the program to be passed through to any subrecipients. See 2 CFR 200 for assistance in determining whether the sub-tier entity is a subrecipient or contractor. The subrecipient budgets must align with the same requirements as the applicant’s budget, including those related to fringe and indirect costs.

Note: This does not imply that the prime applicant and each sub-recipient must follow the same indirect cost structure. Note: Pursuant to 2 CFR 200 Contract means a legal instrument by which the Applicant purchases property or services needed to carry out the project or program under a resulting award. The term does not include a legal instrument when the substance of the transaction meets the definition of a federal award or subaward (see 2 CFR 200.92 Subaward), even if the Applicant considers it a contract. The Applicant must describe the work to be performed, the risk borne by the contractor, the contractor's investment, the amount of subcontracting, the quality of its record of past performance, and industry profit rates in the surrounding geographical area for similar work. The cost principles do not address profit or fee; A profit or fee under a grant is not a cost but is an amount in excess of actual allowable direct and indirect costs. A fee cannot be paid by a recipient to a consortium participant, including a for-profit organization. However, a fee (profit) may be paid to a contractor/vendor providing routine commercial goods or services under a grant in accordance with normal commercial practice.

This award will provide grants over the life of the five-year activity to NGOs, CBOs, and non-state actors to contribute to the achievement of key activity and IRs as described in the activity description. **Applicants should allocate \$10 million as a plug figure for grants.**

- 7) Refurbishing and Remodeling - Applicants should allocate \$7.5 million as a plug figure for remodeling/refurbishment in the cost application.
- 8) Other Direct Costs – This may include other costs not elsewhere specified, such as report preparation costs, passports and visas fees, medical exams, and inoculations, as well as any other miscellaneous costs which directly benefit the program proposed by the applicant. The applicant should indicate the subject, venue and duration of any proposed conferences and seminars, and their relationship to the objectives of the program, along with estimates of costs.
- 9) Indirect Costs – Applicants must indicate whether they are proposing indirect costs or will charge all costs directly. In order to better understand indirect costs please see Subpart E of 2 CFR 200.414. The application must identify which approach they are requesting and provide the applicable supporting information. Below are the most commonly used Indirect Cost Rate methods:

Method 1 - Direct Charge Only

Eligibility: Any applicant

Initial Application Requirements: See above on direct costs

Method 2 - Negotiated Indirect Cost Rate Agreement (NICRA)

Eligibility: Any applicant with a NICRA issued by a USG Agency must use that NICRA

Initial Application Requirements: If the applicant has a current NICRA, submit your approved NICRA and the associated disclosed practices. If your NICRA was issued by an Agency

other than USAID, provide the contact information for the approving Agency. Additionally, at the Agency's discretion, a provisional rate may be set forth in the award subject to audit and finalization. See [USAID's Indirect Cost Rate Guide for Non Profit Organizations](#) for further guidance.

Method 3 - De minimis rate of 10% of modified total direct costs (MTDC)

Eligibility: Any applicant that does not have a current NICRA

Initial Application Requirements: Costs must be consistently charged as either indirect or direct costs but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a non-Federal entity chooses to negotiate an indirect rate, which the non-Federal entity may apply to do at any time. The applicant must describe which cost elements it charges indirectly vs. directly. See 2 CFR 200 for further information.

Method 4 - Indirect Costs Charged as A Fixed Amount

Eligibility: Non-U.S. non-profit organizations without a NICRA may request, but approval is at the discretion of the AO.

Initial Application Requirements: Provide the proposed fixed amount and a worksheet that includes the following:

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

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

- 9) Cost Sharing – The applicant should estimate the amount of cost-sharing resources to be provided over the life of the agreement and specify the sources of such resources, and the basis of calculation in the budget narrative. Applicants should also provide a breakdown of the cost share (financial and in-kind contributions) of all organizations involved in implementing the resulting award.

e) Prior Approvals in accordance with 2 CFR 200.407

In order to avoid subsequent disallowance or dispute based on unreasonableness or non-allocability, the recipient may seek the prior written approval of USAID for indirect costs or in advance of the incurrence of special or unusual costs. The absence of prior written approval on any element of cost will not, in itself, affect the reasonableness or allocability of that element, unless prior approval is specifically required for allowability as described under certain circumstances in the 2 CFR 200.407

f) Approval of Subawards

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

- Name of organization
- DUNS Number
- Confirmation that the subrecipient does not appear on the Treasury Department's Office of Foreign Assets Control (OFAC) list
- Confirmation that the subrecipient does not have active exclusions in the System for Award Management (SAM)
- Confirmation that the subrecipient is not listed in the United Nations Security designation list
- Confirmation that the subrecipient is not suspended or debarred
- Confirmation that the applicant has completed a risk assessment of the subrecipient, in accordance with 2 CFR 200.332(b)
- Any negative findings as a result of the risk assessment and the applicant's plan for mitigation.

g) Dun and Bradstreet and SAM Requirements

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

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

The registration process may take many weeks to complete. Therefore, applicants are encouraged to begin the process early. If an applicant has not fully complied with the requirements above by the time USAID is ready to make an award, USAID may determine that the applicant is not

qualified to receive an award and use that determination as a basis for making an award to another applicant.

DUNS number: <http://fedgov.dnb.com/webform>

SAM registration: <http://www.beta.sam.gov>

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

h) Funding Restrictions

USAID policy is not to award profit under assistance instruments. Therefore, profit is not allowable for recipients or subrecipients under this award. However, all reasonable, allocable, and allowable expenses, both direct and indirect, which are related to the agreement program and are in accordance with applicable cost principle under 2 CFR 200 Subpart E. of the Uniform Administrative Requirements may be paid under the anticipated award. See 2 CFR 200.330 for assistance in determining whether a sub-tier entity is a subrecipient or contractor.

USAID will not allow the reimbursement of pre-award costs under this award without the explicit written approval of the Agreement Officer. Except as may be specifically approved in advance by the AO, all commodities and services that will be reimbursed by USAID under this award must be from the authorized geographic code 937 and must meet the source and nationality requirements set forth in 22 CFR 228.

j) Required certifications, assurances, representations, and other statements of the Recipient

Completed Certifications, Assurances, Representations, and Other Statements of the Recipient. [See **Attachment D**]. This is also noted in part C of this section above.

k) History of Performance: Past Performance References and Information

Past Performance References and Information required for Applicant's mandatory risk assessment in accordance with ADS 303.3.9 and 2 CFR 200.205 and determination of responsibility by the Agreement Officer.

The Applicant must provide information regarding their recent history of performance. The Applicant must provide not more than five (5) of the most recent and relevant cost-reimbursement contracts, grants, or cooperative agreements involving similar or related programs, and up to three (3) of the most recent and relevant cost-reimbursement contracts, grants, or cooperative agreements involving similar or related programs for each sub-awardee, not to exceed the past 3 years. A major sub awardee is one whose proposed cost equals 20% or more of the Applicant's total proposed cost or any sub awardee, which will have principal responsibility for implementing one or more of the program components/deliverables or results area regardless of dollar value) in accordance with the following:

Applicants must provide for each of the contracts/grants listed the following information regarding its past or current performance: (1) a brief description of the work performed and key project accomplishments/results achieved to date; (2) primary performance location of work; (3) contract/award amount; (4) name of the technical contact person and (5) current telephone number and email address of responsible representative from the organization for which the work was performed and (6) beginning and end dates (with specification of whether the work was being done as a prime or a sub). Applicants/sub awardees must either provide this information or affirmatively state that it possesses no information directly relevant to similar past performance.

If the Applicant encountered problems on any of the referenced Awards, it may provide a short explanation and corrective action taken. The Applicant should not provide general information on its performance. USAID reserves the right to obtain relevant information concerning an Applicant's history of performance from any sources and may consider such information in its review of the Applicant's risk.

The Agency may request additional information and conduct a pre-award survey if it determines that it is necessary to inform the risk assessment.

The Government reserves the right to verify the experience and past performance record of cited projects or other recent projects by reviewing Contractor Performance Assessment Reports (CPAR's), other performance reports, or to interview cited references or other persons knowledgeable of the Applicant's performance on a particular project. The Government may check any or all cited references to verify supplied information and/or to assess reference satisfaction with performance. References may be asked to comment on items such as: Quality of Product or Service, Cost Control, Timeliness of Performance, Customer Satisfaction, and Key Personnel, non-discrimination in the delivery of services. The Agreement Officer may also consult other resources and references not provided by the Applicant related to the Applicant's past performance.

Applicants should use the format provided in **Attachment E: Past Performance Information** of the NOFO to document the detailed information as requested. The completed forms should be included as an annex to the cost application. There is no page limitation for the Past Performance Information.

1) Branding Strategy & Marking Plan

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

1. Branding Strategy – Assistance (June 2012)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Describe the main program message.

- (ii) Provide plans for training materials, posters, pamphlets, public service announcement, billboards, Web sites, and so forth, as appropriate.
- (iii) Provide any plans to announce and promote publicly this program or project to host country citizens, such as media releases, press conferences, public events, and so forth. Applicant must incorporate the USAID Identity and the message, “USAID is from the American People.”
- (iv) Provide any additional ideas to increase awareness that the American people support this project or program.

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

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

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

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

(END OF PRE-AWARD TERM)

2. Marking Plan – Assistance (June 2012)

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

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

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

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

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

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

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

(ii) Technical assistance, studies, reports, papers, publications, audio- visual productions, public service announcements, Web sites/Internet activities, promotional, informational, media, or communications products funded by USAID.

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

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

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

(2) A table on the program deliverables with the following details:

(i) The program deliverables that the applicant plans to mark with the USAID Identity.

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

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

(iv) What program deliverables the applicant does not plan to mark with the USAID Identity and

(v) The rationale for not marking program deliverables.

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

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

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

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

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

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

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

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

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

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

(END OF PRE-AWARD TERM)

h) Conscience Clause

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

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

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

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

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

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

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

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

(END OF PRE-AWARD TERM)

i) Conflict of Interest Pre-Award Term

CONFLICT OF INTEREST PRE-AWARD TERM (August 2018)

a. Personal Conflict of Interest

1. Agency official involved in the competitive award decision-making process that could affect that Agency official’s impartiality. The term “conflict of interest” includes situations in which financial or other personal considerations may compromise, or have the appearance of compromising, the obligations and duties of a USAID employee or recipient employee.

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

b. Organizational Conflict of Interest

The applicant must notify USAID of any actual or potential conflict of interest that they are aware of that may provide the applicant with an unfair competitive advantage in competing for this financial assistance award. Examples of an unfair competitive advantage include but are not limited to situations in which an applicant or the applicant’s employee gained access to non-

public information regarding a federal assistance funding opportunity, or an applicant or applicant's employee was substantially involved in the preparation of a federal assistance funding opportunity. USAID will promptly take appropriate action upon receiving any such notification from the applicant.

(END OF PRE-AWARD TERM)

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DRAFT NOFO

SECTION E: APPLICATION REVIEW INFORMATION

1. Criteria

The merit review criteria prescribed here are tailored to the requirements of this particular NOFO. Applicants should note that these criteria serve to a) identify the significant matters which the Applicants should address in their applications, and b) set the standard against which all applications will be evaluated. To facilitate the review of applications, applicants must organize the narrative sections of their applications with the same headings and in the same order as the selection criteria. Please note that, per USAID policy, all criteria listed below will take account of the applicants' consideration of the role of gender and climate risk mitigation in all program activities.

2. Merit Review

USAID will conduct a merit review of all applications received that comply with the instructions in this NOFO. Applications will be reviewed and evaluated in accordance with the following criteria shown in descending order of importance as listed in the table below (e.g., Criterion 1 is more important than Criterion 2, 3 and 4; Criterion 2 is more important than Criterion 3 and 4, Criterion 3 is more important than Criterion 4).

Summary Matrix of Merit Review Criteria		
<i>Criterion</i>	<i>Criterion Name</i>	<i>Importance</i>
Criterion 1	Technical Approach	Most important
Criterion 2	Staffing Plan and Management Approach	2 nd most important
Criterion 3	Key Personnel	3 rd most important
Criterion 4	Organizational Technical Capacity	4 th most important

Criterion 1: Technical Approach

USAID will evaluate the Applicants' Technical Approach based on the extent to which their technical approach and Annex 1 (Draft AMELP and CLA Plan) demonstrates an evidence-based and innovative technical approach for achieving the intermediate results and outcomes described within Program Description.

Criterion 2: Staffing Plan and Management Approach

USAID will evaluate the Applicants staffing plan and management approaches based on the extent to which they facilitate effective achievement of UHA results within a complex, decentralized implementation environment.

USAID will evaluate the Applicants' Staffing Plan and Annex 2 (Organizational Chart and Staffing Plan Matrix based on the extent to which it successfully describes the proposed staffing structure that will enable effective implementation and integration across staff members, teams,

and offices across sub-regions. The staffing plan describes and ensures an appropriate and efficient skills mix to meet UHA's technical and managerial needs, including the use of Ugandan experts. The staffing plan details the clear roles and responsibilities and skills of each proposed staff, including home office support.

Within the management approach, USAID will evaluate how successfully the applicants describe the following:

- The proposed geographic location of all offices and how the locations facilitate continuous and tailored TA to RRHs and district health offices and coordination within the activity and with key external stakeholders.
- The roles and responsibilities of proposed consortium members and how they will complement each other and enable the Applicant to cover all required skills by the program description. Describes how the Applicant plans to formally engage local entities within its consortium/team with relevant scopes of work, if applicable.
- Proposed lines of authority and management oversight among key staff, partners, and consortium members to ensure delivery of high-quality technical assistance and program results.
- Mechanisms and/or structures to promote coordination and knowledge sharing across UHA staff members, sub-partners, offices, and key stakeholders (GoU representatives, other USG implementers, health donors, etc.).
- A feasible timeline and approach to ensure rapid start-up and achieving Year 1 milestones, as detailed in Annex 3 (Rapid Mobilization and Year 1 Work Plan).
- Effective strategies for cost containment and mitigating fraud, waste, and abuse. This includes a description of how the Applicant would effectively manage the small grants program and ensure subgrantee adherence to USAID rules and regulations.

Criterion 3: Key Personnel

USAID will evaluate the Applicants' key personnel in Annex 4 based on the extent to which: Applicants' summary of the proposed candidates for these positions describes how their respective technical expertise, education, and experience will contribute to the achievement of UHA results in their application. The description successfully summarizes how key personnel meet or exceed the requirements set forth in the Section B, including experience in their relevant technical and managerial areas and experience implementing comparable activities in similar contexts. The key personnel sub-section demonstrates that as a group, the proposed key personnel complement each other in management, design, evaluation, technical and implementation skills necessary to successfully and effectively implement the proposed technical approach.

Criterion 4: Organizational Technical Capacity

USAID will evaluate the Applicants' organizational capacity based on the extent to which the technical application demonstrates that the applicants and sub-partners (if applicable) collectively possess:

- The array of existing technical skills and capacity of the prime and partners/sub-awardees in Sub-Saharan Africa that will support the effective achievement of UHA's three intermediate results and intended outcomes, and how these combined capabilities

complement each other to ensure coverage of all technical areas of the program description.

- Sufficient technical capacity in relevant cross-cutting areas to support UHA, including gender- and youth-sensitive programming, SBC interventions, and local capacity development.
- Demonstrates expertise in monitoring and evaluation of integrated health, nutrition, WASH/IPC, and HIV programming and in applying CLA to improve program management and outcomes.

4. Business Review

The AO will review the apparently successful applicant's budget to ensure that costs, including cost sharing, are in compliance with OMB's and USAID's policies. This will consist of a review of the cost application budget breakdown; and evaluate and analyze specific elements of costs for reasonableness and allocability of costs in the budget, and allowability of the costs under the applicable cost principles found in 2 CFR 200 Subpart E.

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

5. Pre-Award Risk Assessment

In accordance with ADS 303.3.9, the Agreement Officer will perform a risk assessment (2 CFR 200.205) of the apparently successful applicant.

Past performance reviews will be initiated of the "apparent successful applicant" as part of the applicant's risk assessment and responsibility determination. The Selection Committee chair will validate the applicant's past performance reference information based on existing evaluations to the maximum extent possible, and may contact all references to verify or corroborate the following:

- How well an applicant performed
- The relevancy of the work performed under the program
- Instances of good performance and/or significant achievements
- Instances of poor performance and/or significant problems
- Significant achievements
- Significant problems, and
- Any indications of excellent or exceptional performance in the most critical areas.

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

If criteria found in ADS 303.3.9.1 applies to the apparently successful applicant, the AO may determine that a pre-award survey is required to inform the risk assessment before making a risk assessment decision. This assessment assists in determining whether the prospective recipient has the necessary organizational experience, accounting and operational controls, financial resources, and technical skills – or ability to obtain them – in order to achieve the objectives of the program and comply with the terms and conditions of the award. Depending on the result of the risk assessment, the AO may either decide to execute the award, not execute the award, or award with “specific conditions” (2 CFR 200.208).

6. Cost Share

Cost sharing is an important element of the USAID-recipient relationship and the applicant’s compliance with Section C will be a consideration for award. Applicants that do not meet the minimum 5% cost share requirement are not eligible for award consideration and their application will not be evaluated. Proposed cost share will be reviewed for compliance with the standards set forth in 2 CFR 200.306, 2 CFR 700.10, and the Standard Provision "Cost Sharing (Matching)" for U.S. entities, or the Standard Provision "Cost Share" for non-U.S. entities.

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SECTION F: FEDERAL AWARD ADMINISTRATION INFORMATION

1. Federal Award Notices

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

USAID may notify the apparently successful Applicant of their recommendation for funding, but only a signed and executed award will constitute an obligation by USAID Agreement Officer to reimburse any costs incurred in the performance and implementation of a project/program. The signed and executed award will be e-mailed to the apparently successful Applicant.

The Agreement Officer is the only individual who may legally obligate USAID to the expenditure of public funds. The Agreement Officer may authorize pre-award costs in accordance with 2 CFR 200.209, but such pre-award costs will be incurred at the Applicant's sole risk in the event the award is not signed by the Agreement Officer or is denied or is less than the amount proposed by the apparently successful Applicant.

USAID will notify all unsuccessful Applicants that will not be considered for award explaining briefly why USAID did not select their application. Requests for additional information will not be considered from unsuccessful applicants.

2. Administrative & National Policy Requirements

Resulting awards to U.S. non-governmental organizations will be administered in accordance with Chapter 303 of USAID's Automated Directives System (ADS-303), 2 CFR 200, 2 CFR 700, and ADS 303maa Standard Provisions for U.S. Nongovernmental Organizations. Standard Provisions for U.S. Nongovernmental organizations are available at: <https://www.usaid.gov/sites/default/files/documents/1868/303maa.pdf>

Resulting awards to non-U.S. non-governmental organizations will be administered in accordance with Chapter 303 of USAID's Automated Directives System (ADS-303), 2 CFR 200, 2 CFR 700, and ADS 303mab Standard Provisions for non-U.S. Nongovernmental Organizations. Standard Provisions for Non-U.S. Nongovernmental organizations are available at: <http://www.usaid.gov/policy/ads/300/303mab.pdf>

2 CFR 200: http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title02/2cfr200_main_02.tpl

CFR 700 is available at: http://www.ecfr.gov/cgi-bin/textidx?SID=74c9b031753603ccb31812ebb90e203a&tpl=/ecfrbrowse/Title02/2cfr700_main_02.tpl

Applicable OMB Circulars are available at: http://www.whitehouse.gov/omb/circulars_default

Mandatory Standard Provisions for U.S. Nongovernmental Recipients can be accessed through USAID’s website: <https://www.usaid.gov/sites/default/files/documents/1868/303maa.pdf>

Resulting award to Public International Organizations (PIOs, or IOs) will be administered in accordance with Chapter 308 of USAID’s ADS including the Standard Provisions set forth in ADS 308.5.15. ADS 308 is available at: <https://www.usaid.gov/sites/default/files/documents/1868/308.pdf>

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

The USAID Inspector-General’s “Guidelines for Financial Audits Contracted by Foreign Recipients” is available at: <http://www.usaid.gov/sites/default/files/documents/1868/591maa.pdf>

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

3. Reporting Requirements

The types and frequency of financial and programmatic reports must be strictly limited to those detailed in 2 CFR 200.

This award follows the U.S. Government fiscal year for reporting, which runs from October 1 to September 30. References to quarters or years in reporting relates to the U.S. Government calendar below:

Quarter 1: October 1 - December 31

Quarter 2: January 1 - March 31

Quarter 3: April 1 - June 30

Quarter 4: July 1- September 30

The Recipient(s) will submit the following documents to the AOR electronically within the time period noted/specified in the award. Reports will be timed and formatted so that they can provide USAID with useful information needed for the reporting requirements.

a. Annual Implementation/Work Plan

Based on the program description, the Recipient shall prepare and submit a detailed annual work plan to guide the implementation process with a breakdown of activities and timelines and anticipated progress in the achievement of the activity results (consistent with the Activity M&E and Learning Plan), as well as the associated costs. The Recipient shall ensure a collaborative process in work plan development, consulting beneficiaries, partners, USAID, and other relevant stakeholders in preparing the annual work plan to ensure complementarity and shared ownership. In addition, the AOR may work with the Recipient to define particularly relevant sections of the

work plan that would enhance implementation, such as key assumptions and risks (as well as plans to mitigate and update these), lessons learned and work plan adjustments going forward.

CLA section must address:

- Any proposed actions to strategically collaborate internally and with other implementing partners to conduct joint targeting, collaborative research, etc.
- How knowledge gaps in the theory of change, the technical implementation approach, operating environments, assumptions, and risks, will be filled using activities such as, but not limited to, monitoring, research, evaluation, and analytical studies.
- How knowledge generated by learning will be used to increase efficiency; and
- How/which approaches, and activities will change based on CLA.

b. Quarterly Performance Reports

The Recipient shall submit quarterly reports that include narratives of quarterly achievements, and progress against the work plan, and agreed upon performance indicators. The quarterly report shall describe and assess the overall progress to date based upon agreed performance indicators. The reports will also describe the accomplishments of the Recipient and the progress made during the past quarter; including information on key activities, both ongoing and completed during the quarter (e.g., meetings, trainings, workshops, significant events, subcontracts, and grants). The quarterly reports must provide information on the extent to which gaps between males and females were closed; what new opportunities for men and women were created; what differential negative impacts on males/females were addressed or avoided; and what needs, and gender inequalities emerged or remained. Recipients must notify USAID of developments that have a significant impact on the award-supported activities.

The quarterly report provides the opportunity to discuss impacts of learning on the program, updates in key assumptions and the underlying development hypotheses. Also, notification shall be given in the case of problems, delays, or adverse conditions which materially impair the ability to meet the objectives of the award, or which may have an impact on the development hypothesis or theory of change for the activity, and/or other activities (USG-funded or not) which might be informed by such learning. This notification shall include a statement of the action taken or contemplated, and any assistance needed to resolve the situation.

The quarterly report will also include GIS data when relevant. Text and specific information to include will be identified with the AOR and in consultation with the program office as needed.

With regards to CLA, the Recipient must address:

- The products and results of collaboration that improve implementation approaches and development practice broadly.
- Include performance indicators to measure CLA.
- Increased ability of USAID's implementing partners to respond to the needs of target groups through learning.
- Instances of learning applied to influence decision making, resource allocation, and contextual shifts; and
- Increased efficiency in activity implementation.

c. Annual Performance Report

Annual performance reports on the project activities and progress against indicators are the responsibility of the Recipient and are needed by USAID/Uganda to provide timely input to the USG's Operational Plan. To the extent possible, the annual performance report should cover activities and results through the end of the fiscal year, and should review the cumulative experience, learning, adaptations, and the implications of these for the year.

With regards to CLA, the Recipient must address:

- The products and results of collaboration that improve implementation approaches and development practice broadly.
- Increased ability of USAID implementing partner to respond to the needs of target groups by using learning.
- Instances of learning applied to influence decision making, resource allocation, and contextual shifts; and
- Increased efficiency in activity implementation.

d. Final Performance Report

The report shall summarize the accomplishments of the agreement, methods of work used, and recommendations regarding unfinished work and/or program continuation, as well as key learnings from the total implementation experience. In addition, the report must specifically address how the Activity addressed gaps between males and females were closed; what new opportunities for men and women were created; what differential negative impacts on males/females were addressed or avoided; and what needs, and gender inequalities emerged or remained. It shall cover the entire period of the award and include the cumulative results achieved, an assessment of the impact of the program, lessons learned and recommendations, any particularly notable impact stories (or challenges), and detailed financial information. It should be grounded in evidence and data. The final completion report shall also contain an index of all reports and information products produced under the award.

e. Financial Reporting

Financial reporting requirements will be in accordance with 2 CFR 200.327. The Recipient must submit the Federal Financial Form (SF-425) on a quarterly basis via electronic format completed by the Recipient and emailed to the Agreement Officer Representative (AOR) and KampalaUSAIDVouchers@usaid.gov.

Accrual reports must be submitted at least 3 weeks before the end of each quarter or as requested on an ad hoc basis. The Recipient must also submit a copy of the Federal Financial Report (FFR) to the AOR. For non-U.S. Nongovernmental Organizations, financial reporting requirements will be in accordance with the procedures set forth in: Standard Provision "Advance Payment and Refunds (December 2014) or Standard Provision "Reimbursement Payment and Refunds (December 2014)."

Quarterly Financial Reports will include a report on expenditures incurred during the report period and activity projected expenditures for the next quarter, against award line items. Reports should breakout funds by funding stream and budget-line.

Reports are due as noted below:

Reporting Quarter	SF-425 Due Date
January 1 – March 31	April 30
April 1 – June 30	July 30
July 1 – September 30	October 30
October 1 – December 31	January 30

f. PEPFAR Reporting

Recipients implementing PEPFAR funded projects must report annually on program expenditures. Specifically, Recipients must use the form PEPFAR Program Expenditures (DS-4213 OMB 1405-0208) as a part of completing the PEPFAR Annual Progress Report at the end of each USG fiscal year (September 30).

Indicators: To balance the need for data with the ability to collect and analyze it, a current set of required indicators are listed below. USAID country teams may also collect additional indicators that are useful to monitoring their programs.

- Number of PEPFAR-supported facilities that have an electronic medical record (EMR) system within the following service delivery areas: HIV Testing Services, Care & Treatment, Antenatal or Maternity Services, Early Infant Diagnosis or Under Five Clinic, and TB/HIV Services (EMR_SITE).
- Number of new health workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts, within the reporting period, by select cadre (HRH_PRE).
- Number of adult and pediatric antiretroviral (ARV) bottles (units) dispensed by ARV drug category at the end of the reporting period (SC_ARVDISP).
- Number of ARV drug units (bottles) at the end of the reporting period by ARV drug category (SC_CURR).
- Number of PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing sites engaged in CQI and proficiency testing activities (LAB_PTCQI).

g. Activity Monitoring Evaluation and Learning Plan (AMELP) and CLA Plan

The AMELP is a management tool that enables the Recipients and USAID to track whether the desired results are being achieved and project implementation is being adapted to changing conditions. CLA planning involves strategic collaboration, continuous learning, and adaptive management. Activity monitoring, evaluation and CLA focuses on whether an activity is achieving programmatic results and generating learning to inform the adaptation of activities based on evidence. The Recipient will work closely with SITES, Uganda Learning Activity (ULA) and any assigned partner responsible for the collection and analysis of USAID data.

Adaptive management, weekly reporting, intensive program monitoring, scrupulous data analysis and short learning cycles will be a pillar approach in the implementation of this activity. Partners and facilities will be required to report progress on select assigned targets weekly through an established dashboard. This will enable USAID to maintain a pulse check on the performance and undertake course correction interventions where needed. In addition, the Recipient will ensure complete reporting by facilities and partners of performance data against national targets into the HMIS system, DHISII and additional PEPFAR data into HIBRID.

The Activity will have a rigorous system for performance management. The recipient will submit a draft M&E plan (AMELP) that describes how the recipient will monitor progress towards the results and use the information to adjust. At a minimum, the draft M&E plan will identify appropriate indicators for each level of the results framework; show data sources and describe how data will be collected/collated/acquired, analyzed, and presented to regularly inform performance. The plan will identify core indicators for every result and intermediate results/outcomes and provide preliminary five-year performance indicator targets.

Upon award, the USAID/Uganda AOR will provide guidance for completion of a detailed M&E plan to ensure that program monitoring and reporting requirements are in line with USAID's PMP and PEPFAR targets. The Recipient will also consult with other relevant IPs and MOH M&E Technical Working Group in developing the final M&E plan.

Each indicator in the final M&E plan will have a performance indicator reference sheet that provides a detailed description of the indicator, numerator, and denominator where percent measures are used and a data collection, analysis, and presentation plan. Where appropriate, indicator baselines should draw on and harmonize with UAIS, UMIS, HMIS and UDHS results as well as other studies and surveys.

The AMELP is a living document, and the recipient will make revisions to it in response to changing conditions and emerging lessons in consultation with the AOR.

The AMELP report will, at a minimum, but not limited to:

- Include all performance indicators, with targets and baseline figures needed to measure achievement of stated goals and results as well as other indicators the Recipient believes to be necessary to adequately track progress and impact of activities.
- Describe a clear data collection system, which includes adequate data quality controls and complies with all USAID data quality requirements and specify the approximate dates for data collection, the method, type, and source of information to be collected.
- Data analysis methodologies, including suggestions for data segregation by district, segregated, gender and others.
- Collaborate with data collection and M&E activities of other USG implementing partners, SITES, USAID/Uganda Learning Activity (ULA), the National HMIS, LQAS, Facility Assessment, and other national surveillance systems to avoid duplication in data collection and analysis.
- Include clear milestones and indicators for measuring sustainability of supported interventions.
- Dedicate a section of the M&E plan to describing how the Recipient will use lessons generated during Activity implementation or operations research results to further inform

- planning and implementation of activities.
- Use Geographical Information Systems (GIS) to map health outcomes, key population groups, disease patterns, service coverage, and available resources in order to enhance analysis and interpretation of Activity results.
 - A clear learning agenda and platform for integrating CLA in assessment, planning, implementation, and monitoring.

USAID/Uganda expects the recipient to be innovative and creative in their efforts, capturing, documenting, and reporting all the outcomes of USAID assistance including success stories and failures.

h. Baseline Assessment

USAID/Uganda will commission an external contractor to conduct a mixed methods baseline assessment for UHA. The baseline assessment—to be completed no later than by the end of Year 1—will assist in identifying approaches to achieve UHA’s targets and serve as the basis for measuring progress across IRs, along with activity-reported data. The baseline will collect new primary quantitative and qualitative data as well as draw from existing secondary data. The recipient will participate as necessary.

i. Sustainability Plan

The Recipient is expected to submit a sustainability plan for this Activity. The Recipient will avoid creation of new implementation and reporting structures and instead work within currently existing ones at national, district and community level, including working with existing platforms, networks, and groups. Building local capacity to effectively plan, design, implement, monitor, and maintain UHA improvements will be crucial for sustainability.

j. Gender, Youth and Social Inclusion Analysis

The recipient will need to conduct a Gender, Youth, and Social Inclusion Analysis to determine how best to reach these key sub-populations and integrate the findings into work plans and interventions.

k. Close-Out and Disposition Plan

Close-out and disposition plan in accordance with 2 CFR 200.343 and 2 CFR 200.313, 2 CFR 200.314 and 2 CFR 200.315 will be submitted six months before the activity end date for USAID approval. The plan should include but not be limited to:

- Dates for the final delivery of all goods and services for grants.
- A property disposition plan for the Recipient, sub-recipients where applicable in accordance with government regulations reviewed by the AOR and approved by the Agreement Officer.
- Review of the award and/or grant files for audit purposes and final billing to USAID.
- A schedule to address office leases, bank accounts, utilities, cell phones, personnel notification, health insurance, outstanding travel, social payments, household shipments,
- severance for local staff (if appropriate), vehicle leases/disposition, phone subscriptions.

- Receipt of all final invoices and grant performance reports.
- Report the use of funds not required for the completion of the award.
- Report on compliance with all local labor laws, tax clearances, etc.

I. Quarterly VAT Reports

Pursuant to bilateral agreements with the Government of Uganda (GOU), all imports and expenditures under this agreement by the Recipient and by non-local subcontractors/sub-recipients (as defined below) are exempt from Value-Added Tax (VAT) and Customs Duties imposed by the GOU. The GOU does not permit tax exemption at the point of sale. Therefore, the Recipient must budget and bill USAID for expenses inclusive of 18% VAT.

The Recipient must submit original VAT tax invoices/receipts, original certified summary (using a format provided by USAID) and 1 copy of all documents to USAID by the 25th of the month after the calendar year quarter end. For example, taxes and receipts for the period January to March are due April 25.

USAID will seek a VAT refund from the Government of Uganda. The refund will not be returned to the Recipient. The Recipient is responsible for ensuring that subcontractors, sub awardees, and grantees comply with this requirement. All VAT claims, for the Recipient, subcontractors, sub awardees and grantees, must be submitted to USAID through the prime Awardee.

The USAID point of contact for submission of quarterly VAT information is kampalavatusaid@usaid.gov Office of Financial Management, USAID/Uganda.

m. Foreign Tax Report

The recipient must submit a report containing:

- (i) Recipient name.
- (ii) Recipient name with phone, fax, and email.
- (iii) Agreement number(s).
- (iv) The total amount of value-added taxes and customs duties (but not sales taxes) assessed by the host government (or any entity thereof) on purchases in excess of \$500 per transaction of supplies, materials, goods, or equipment, during the 12 months ending on the preceding September 30, using funds provided under this contract/agreement.
- (v) Any reimbursements received by April 1 of the current year on value-added taxes and customs duties reported in (iv).
- (vi) Reports are required even if the recipient did not pay any taxes or receive any reimbursements during the reporting period.
- (vii) Cumulative reports may be provided if the recipient is implementing more than one program in a foreign country.

n. Annual Certification for Human Trafficking

The recipient must submit to the Agreement Officer, the annual “Certification regarding

Trafficking in Persons, Implementing Title XVII of the National Defense Authorization Act for Fiscal Year 2013” as required prior to this award, and must implement a compliance plan to prevent the activities described above in section (a) of the provision (Schedule C, Mandatory Standard Provisions “TRAFFICKING IN PERSONS (April 2016)”). The recipient is required to annually certify that neither the recipient nor subawardee, or contractor, at any tier, or their employee, labor recruiters, brokers or other agents are engaged in any of the activities stated in mandatory provision mentioned above. The recipient must provide a copy of the compliance plan to the Agreement Officer upon request and must post the useful and relevant contents of the plan or related materials on its website (if one is maintained) and at the workplace.

The first Certification should be submitted at the start of award. The concurrent certifications should be submitted within 30 calendar days following the end of each fiscal year. The draft certificate is accessible at the link below:

https://www.usaid.gov/sites/default/files/documents/1866/USAID_Trafficking_Persons_Annual_Certification.pdf xiv

o. Other Reports

The Recipient will prepare and disseminate, as directed by the AOR, other reports needed to accomplish the purpose of this award, such as assessments, including but not limited to, gender and youth assessments, studies, and other analytical products. These reports will include activity reports; technical reports; data quality assessment reports, portfolio review and performance plan and report analytical products, evaluation, review, and other operational research reports. The reports required and the number of copies will be determined at the time of the Annual Work plan.

4) Synopsis of Reports/Plans

Type of Document/Report	Due Date	Distribution
First Year Implementation/Work Plan	First draft due no later than 45 calendar days after the effective date of the award.	AOR
Quarterly Performance Reports	1.Submission of this report will be no later than 30 days after the end of each fiscal quarter. 2. This includes reporting on the recipient quarterly and annual indicators in the respective Performance Management Information System.	AOR
Annual Performance Report	30 calendar days following the end of the fiscal year	AOR
Final Performance Report	Draft of this report will be submitted 30 calendar days after the end date of award. Final due 90 calendar days after the award end date.	AOR
Financial Reporting	Accrual reports - 3 weeks before the end of each quarter or as requested on an ad hoc basis. Quarterly Financial Reports - 30 days after the end of each	AOR

	calendar quarter AOR.	
Activity Monitoring Evaluation and Learning Plan (AMELP)	First draft due no later than 90 calendar days after the effective date of the award. The date of the final submission plan will be discussed with the AOR and Health Office Strategic Information (SI) Unit team.	AOR, SI, PPD
Sustainability plan	First draft due no later than 45 calendar days after the effective date of the award. Final due no later than 60 days after the effective date of the award.	AOR, PPD
Gender, Youth and Social Inclusion Analysis	No later than 6 months after the effective date of the award	AOR, PPD
Environmental Mitigation and Monitoring plan (EMMP)	First draft due no later than 30 calendar days before the beginning of each fiscal year	AOR, MEO
Annual Certification for Human Trafficking	30 calendar days following the end of the fiscal year	AO, AOR
Close out & Disposition plan	Six months before the end of the award	AOR & AO
Quarterly VAT Reports	25th of the month after the calendar year quarter end. For example, taxes and receipts for the period January to March are due April 25.	AOR & Controller
Foreign Tax Reports	November 30. This will enable the mission to meet the April 16 deadline.	AOR & Controller

5) Special Provisions

The following special provisions may be made part of the resulting award.

1. Geographic Information Systems (GIS): There are three types of geographic data that the Mission would like to collect in a standardized manner:

Project and Activity Location Data: In consultation with the AOR, project and activity location data when utilized should be submitted according to the geographic precision defined by the Mission's data requirements. Capturing a discreet location for project and activity locations is an essential step towards establishing an effective method of managing and communicating project and activity information.

Thematic Data: This includes information such as demographic indicators, built infrastructure, environmental features, and any other thematic data. When created or acquired using USAID funds, these datasets are considered the property of USAID and when utilized should be submitted to the AOR.

Project-Specific Data: This includes data that is created during a project and may be useful to the Mission’s own strategic planning and design purposes. When created or acquired using USAID funds, these datasets are considered USAID’s property and when utilized should be submitted to USAID.

Recording a discreet location for project and activity locations is essential in establishing an effective method of managing, analyzing, and communicating project and activity information. The Recipient will work closely with the AOR to determine necessary information to collect, which may include:

- Type of activity
- Estimated cost of activity
- Photograph of activity
- Location of activity
 - Point features (latitude, longitude) such as public institutions with hand washing facilities, etc.
 - Area features (polygon) such as boundaries
- Location, including name of the village
- District name for activity location
- Facility type (home, school, health facilities, etc.)

Geographic Data should be projected to the Geographic Coordinate System World Geodetic System 1984 (GCS WGS 1984). All data should use the World Geodetic System 1984 (WGS 1984) datum.

The location and activity specific data would be recorded and managed by the Grantee. It would be submitted to the AOR and GIS Specialist in any of the following formats: .CSV file, MS Excel spreadsheet, MS Access database, or GIS-ready shapefile (.shp)/geodatabase.

As defined in the USAID Policy Framework (2011-2015), USAID is committed to geographically targeting aid investments, monitoring & evaluating overall aid effectiveness, and upholding the Agency’s open data and transparency goals. Utilizing GIS technology, geographic data and analysis is integral to effectively achieving all of these objectives. Geospatial analysis is a top priority of the USAID/Uganda to be incorporated into the learning agenda and M&E work to build resilience. In alignment with the US Government commitment to transparency and open data, as well as with USAID Data Policy (ADS 579), geographical data collected and the resulting maps produced as part of this program will be shared with the affected communities, district local governments, and the general public. All efforts will be made to protect Personally Identifiable Information (PII).

[End of Provision]

2. Utilization of Science, Innovation, Technology, and Partnership (SITP) for Collaboration

The recipient is strongly encouraged to utilize science, innovation, technology, and partnership (SITP) to:

- Do business differently to enhance the lives of Ugandan beneficiaries and share best

practices.

- Integrate change management practices to allow for program adaptation and realignment.
- Utilize project management tools/software for enhanced partnership and synergy with USAID and other programs and allow for reporting on multiple funding streams.

[End of Provision]

3. Value Added Tax and Customs Duties

Pursuant to bilateral agreements with the Government of Uganda (GOU), all imports and expenditures under this contract by the Recipient and by non-local Subrecipients (as defined below) are exempt from Value-Added Tax (VAT) and Customs Duties imposed by the GOU.

The GOU does not permit tax exemption at the point of sale. Therefore, the Recipient must bill USAID for 18% VAT inclusive expenses from VAT registered and compliant vendors only.

The Recipient must submit original electronic tax invoices (e-invoices) and receipts, original certified summary (using a format provided by USAID) and one copy of all documents to USAID by the 25th of the month after the calendar year quarter end. For example, taxes invoices and receipts for the period January to March are due April 25.

USAID will seek a VAT refund from the Government of Uganda. The refund may be returned to the Recipient through a direct credit to the award.

The Recipient is responsible for ensuring that Subrecipients and grantees comply with this requirement. All VAT claims, for the Recipient, subrecipients and grantees, must be submitted to USAID through the prime Recipient.

The USAID point of contact for submission of quarterly VAT information is kampalavatusaid@usaid.gov Office of Financial Management, USAID/Uganda.

[End of Provision]

4. Procurement Executive's Bulletin No. 2014-06: Electronic Payments System

Definitions: "Cash Payment System" means a payment system that generates any transfer of funds through a transaction originated by cash, check, or similar paper instrument. This includes electronic payments to a financial institution or clearing house that subsequently issues cash, check, or similar paper instruments to the designated payee.

"Electronic Payment System" means a payment system that generates any transfer of funds, other than a transaction originated by cash, check, or similar paper instrument that is initiated through an electronic terminal, telephone, mobile phone, computer, or magnetic tape, for the purpose of ordering, instructing, or authorizing a financial institution to debit or credit an account. The term includes debit cards, wire transfers, transfers made at automatic teller machines, and point-of-sale terminals.

2. The recipient agrees to use an electronic payment system for any payments under this award to

beneficiaries, sub recipients, or contractors.

3. Exceptions. Recipients are allowed the following exceptions, provided the recipient documents its files with the appropriate justification:

- Cash payments made while establishing electronic payment systems, provided that this exception is not used for more than six months from the effective date of this award.
- Cash payments made to payees where the recipient does not expect to make payments to the same payee on a regular, recurring basis, and payment through an electronic payment system is not reasonably available.
- Cash payments to vendors below \$3,000, when payment through an electronic payment system is not reasonably available.
- The Recipient has received a written exception from the Agreement Officer that a specific payment or all cash payments are authorized based on the Recipient's written justification, which provides a basis and cost analysis for the requested exception.

4. More information about how to establish, implement, and manage electronic payment methods is available to recipients at <http://solutionscenter.nethope.org/programs/c2etoolkit>.

[End of Provision]

5. Non-Discrimination in Implementation of USAID-Funded Programs

In the implementation of USAID-funded programs, the Recipient or Sub-Recipient shall not discriminate against any beneficiary or potential beneficiary, such as but not limited to, by capriciously or selectively withholding or denying assistance or benefits under the project, on the basis of any non-merit factor, including one or more of the following bases: race, color, religion, sex (including gender identity or perceived gender non-conformity, and pregnancy) national origin, disability, age, sexual orientation, genetic information, marital status, parental status, political affiliation, veteran's status, or other factors that adversely impact the beneficiaries' access to, or participation in, services provided under the award. Nothing in this provision is intended to limit the ability of a Recipient to target assistance to certain populations as defined in the approved work plan of a USAID-funded program.

[End of Provision]

6. Acquisition & Assistance Policy Directive No: 14-03: Representation by Organization Regarding a Delinquent Tax Liability or a Felony Criminal Conviction (AUGUST 2014)

(a) In accordance with section 7073 of the Consolidated Appropriations Act, 2014 (Pub. L. 113-76) none of the funds made available by that Act may be used to enter into an assistance award with any organization that:

1. Was "convicted of a felony criminal violation under any Federal law within the preceding 24 months, where the awarding agency has direct knowledge of the conviction, unless the agency has considered, in accordance with its procedures, that this further action is not necessary to protect the interests of the Government"; or
2. Has any "unpaid Federal tax liability that has been assessed for which all judicial and

administrative remedies have been exhausted or have lapsed, and that is not being paid in a timely manner pursuant to an agreement with the authority responsible for collecting the tax liability, where the awarding agency has direct knowledge of the unpaid tax liability, unless the Federal agency has considered, in accordance with its procedures that this further action is not necessary to protect the interests of the Government.”

For the purposes of section 7073, it is USAID’s policy that no award may be made to any organization covered by (1) or (2) above, unless the M/OAA Compliance Division has made a determination that suspension or debarment is not necessary to protect the interests of the Government.

[End of Provision]

7. Program Income

Program Income is not anticipated to be generated under this award. If generated, program income earned during the Activity’s period of performance must be added to the total program amount and used to further eligible objectives for the Activity. In accordance with 2 CFR 200.307(e), program income that the recipient did not anticipate at the time of the Federal award must be used to reduce the Federal award and recipient contributions rather than to increase the funds committed to the project.

8. Environmental Compliance

The UHA environmental compliance obligations under the FAA Sec 117 and 22 CFR 216 regulations and procedures are specified in Section A5 of this NOFO.

9. ADS. 303.3.35.2 Covered Telecommunication and Video Surveillance Equipment or Services Effective Date: 08/18/2020

Effective August 13, 2020, a recipient may not procure covered telecommunication equipment or services for the implementation of their program using award funds. 2 CFR 200.216, applicable to US organizations, and the standard provision “Prohibition on Certain Telecommunication and Video Surveillance Services or Equipment” applicable to non-US NGOs, implement Section 889(b) of the John S. McCain National Defense Authorization Act (NDAA) for Fiscal Year 2019 (Pub. L. 115-232) that prohibits the use of award funds, including direct and indirect costs, cost share and program income, to procure covered telecommunication and video surveillance services or equipment. The statute covers certain telecommunications equipment and services produced or provided by Huawei Technologies Company or ZTE Corporation, Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities). Such covered telecommunication equipment or services must not be reimbursed to the recipient as a direct or indirect cost or accepted as part of cost share. Additionally, the recipient must not use any program income generated under the award to purchase covered telecommunication equipment or services.

10. Shock Modifier

USAID intends to leverage existing programming for cross cutting support such as: Infection Prevention and Control, community engagement for adoption of health behaviors and general health systems improvement with cross-cutting health benefits including Ebola prevention, detection, and response. Adaptive management will be required to respond in implementation of the shock modifier while maintaining development gains achieved through normal activity implementation.

This clause may be enacted in the event of Ebola Outbreak, pandemic threat, or other natural disaster.

- A. Data indicates that there is a high probability of a crisis developing in the operating environment during the life of this activity. If a crisis develops, it is imperative to use adaptive management principles to respond immediately to the crisis as well as maintain development gains achieved through activity implementation up until the crisis.
- B. When the Mission Director has formally declared the need in writing, the Agreement Officer will, through oral or written communication, solicit a crisis response for adjustment from the recipient to respond to the crisis.
- C. The recipient will submit the crisis response application for adjustment to the Agreement Officer in the time period indicated by the Agreement Officer.
- D. If through negotiation the parties agree on a crisis response which increases or decreases the cost of, or time required for performing the work, the Agreement Officer shall make an equitable adjustment upon submittal of a final crisis response application for adjustment before final payment under the assistance.
- E. Notwithstanding the terms and conditions of paragraphs (a) through (d) of this clause, as this award is incrementally funded, the funds allotted for performance of this agreement, shall not be increased, or considered to be increased except by specific written modification. Until this modification is made, the Recipient shall not be obligated to continue performance or incur costs beyond the point established in A.3(2) Amount of Award and Payment.
- F. Failure to agree to any adjustment shall be a dispute under the Disputes clause.

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SECTION G: FEDERAL AWARDING AGENCY CONTACT(S)

1. Point of Contact Information:

Only the Agreement Officer is authorized to make commitments on behalf of USAID. The Agreement Officer is listed below:

Andreea Surdu
Agreement Officer
USAID/Uganda
US Embassy Compound Plot 1577
Ggaba Road, Kampala
Uganda
Generic Email: KampalaUSAIDSolicita@usaid.gov

Any questions while the funding opportunity is open may be submitted to the attention of Ms. Andreea Surdu in the above email.

2. Acquisition and Assistance Ombudsman

The A&A Ombudsman helps ensure equitable treatment of all parties who participate in USAID's acquisition and assistance process. The A&A Ombudsman serves as a resource for all organizations who are doing or wish to do business with USAID. Please visit this page for additional information: <https://www.usaid.gov/work-usaid/acquisition-assistance-ombudsman>

[The A&A Ombudsman may be contacted via: Ombudsman@usaid.gov](mailto:Ombudsman@usaid.gov)

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SECTION H: OTHER INFORMATION

1) Other Information

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

2) Applications with Proprietary Data

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

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

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

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

3) List of Attachments

Attachment A: Applying Lessons Learned from the Regional Health Integration to Enhance Services (RHITES) Desk Review to Uganda Health Activity Design

Attachment B: Priority PEPFAR Districts for IR 3 HSS Support

Attachment C: Budget Template

Attachment D: Certifications, Assurances, Representations, and Other Statements of the Recipient

Attachment E: Past Performance Information

Attachment F: Standard Provisions

Attachment G: USAID/Uganda Local Compensation Plan (LCP)

Attachment H: LDPG revised Schedule of Allowances (Feb. 2019)

Attachment I: Uganda Health Activity References

4) Other Resources

SAM: Quick Start Guide for New Grantee Registration

https://www.sam.gov/sam/transcript/Quick_Guide_for_Grants_Registrations.pdf

SAM: Quick Start Guide for International Registrants

https://www.sam.gov/SAM/transcript/Quick_Guide_for_International_Entity_Registration.pdf

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ATTACHMENT A: APPLYING LESSONS LEARNED FROM THE REGIONAL HEALTH INTEGRATION TO ENHANCE SERVICES (RHITES) DESK REVIEW TO UGANDA HEALTH ACTIVITY DESIGN

USAID/Uganda Health Activity (UHA)

*Applying Lessons Learned from the Regional Health Integration to Enhance Services (RHITES)
Desk Review to New Project Design*

Purpose: In July 2021 USAID/Uganda commissioned the Uganda Learning Activity (3ie) to conduct an [in-depth desk review](#) of the RHITES integrated health activity portfolio. The purpose was to identify the primary facilitators and barriers to achieving improved health outcomes and implementation success within RHITES so that the new UHA design team could systematically incorporate relevant learning and recommendations.

High-level suggestions included: 1) Ensuring that UHA design addresses known barriers to positive health outcomes, while capitalizing on potential facilitators to success; 2) Supporting health system strengthening (HSS) interventions in addition to facility-level interventions; 3) Scaling-up the use of gender-specific and -transformative interventions to address underlying health inequities; and 4) Expanding evidence-based health worker training and leadership/governance interventions. Below, we summarize the desk review findings and how we will address them in new project design.

3ie RHITES Desk Review Findings
BARRIERS
<p>1. Health system leadership and governance: RHITES implementers primarily focused on scaling and implementing facility-level health interventions in lieu of district-level managerial capacity strengthening (p.7)³⁶. This undermined the health system’s ability to fully own and sustain outcomes in some RHITES districts (p.8).</p>
<p><i>How UHA Will Address:</i></p> <ul style="list-style-type: none"> Adopts a systems lens to achieving and sustaining improved health outcomes; this is reflected through its proposed results framework <i>IR 2 Increased sustainability, ownership and enhanced enabling environment</i> and <i>IR 3 Strengthened health systems at the community- and district-levels</i>. Builds the leadership and governance capacity of target Regional Referral Hospitals (RRH) to fulfill their coordination and oversight mandates, increasing sustainability and maximizing USAID’s government-to-government (G2G) investments. In line with USAID’s Vision for HSS 2030, the results framework calls for HSS technical assistance (TA) in equity (<i>Sub-IR 1.2</i>), resource optimization (<i>Sub-IR 3.1</i>), and quality (<i>Sub-IR 1.1</i>) to improve health outcomes.
<p>2. Medical products and technology: Sub-optimal availability of essential medicines and supplies impacted health service quality many RHITES districts (p.7). Supply chain strengthening activities require greater coordination and focus to address frequent stockouts (p.8).</p>
<p><i>How UHA Will Address:</i></p> <ul style="list-style-type: none"> <i>Sub-IR 3.4: Improved supply chain management</i> requires interventions designed to increase access to quality medicines and supplies at district- and community-level. Strengthens collaboration between RRHs and USAID’s Strengthening Supply Chain Systems activity to ensure regions access supply chain TA; UHA <i>IR 2</i> reinforces TA by improving resource optimization and use of G2G funding, budget advocacy, and accountability on medicines availability at sub-national level.

³⁶ All page number references in this document refer to specific pages within the [3ie RHITES review](#).

<p>3. Data collection, analysis, and reporting: Gaps in in data availability and quality at all levels posed a significant barrier to RHITES implementation (p.7). Data was not shared effectively or routinely between RHITES implementers, development partners, or the government, impacting effectiveness and collaboration (p.12).</p>
<p><i>How UHA Will Address:</i></p> <ul style="list-style-type: none"> Proposed <i>Sub-IR 3.2: Improved data quality, collection, and use at all levels</i> prioritizes district- and community level capacity strengthening for data collection and use to address current gaps, such as improving the integrating community data within Uganda’s health management information system (HMIS). Scales-up proven community-level data collection and use interventions, per Facilitator 4 below.
<p>4. Equity and social determinants of health: While RHITES collected gender-disaggregated data and implemented some gender-specific interventions, these varied in effectiveness and scale by implementing partner (IP) (p. 7, 8). Local partners and district staff require additional capacity strengthening support in analyzing evidence to design/adapt locally appropriate gender-transformative interventions. In addition, the review found that non-health environmental factors, such as education and poverty, hindered progress toward outcomes (p.7).</p>
<p><i>How UHA Will Address:</i></p> <ul style="list-style-type: none"> Mandates identifying/addressing of social norms that constrain health-seeking behavior (<i>Sub-IR 1.3.2</i>). Encourages community and provider behaviors that encourage health seeking behavior, such as respectful care, youth-friendly services (<i>Sub-IR 1.1.3: Experience of care</i> [Community; respect/dignity; communication]). Increases functional collaboration between UHA and non-health activities (food security, economic growth, EYCD, etc.) at community level to enhance health outcomes and household resilience. Scales-up successful RHITES approaches to address inequities, such as leveraging village SACCOs (savings cooperatives) for health information, community dialogues with cultural leaders on girls’ education, etc.
<p>5. COVID-19: The pandemic contributed to increased stockouts at target health facilities due to global supply chain disruptions. It also decreased health service delivery uptake and retention due to social distancing and restrictions on movement within districts and other factors (p.7).</p>
<p><i>How UHA Will Address:</i></p> <ul style="list-style-type: none"> Including adaptive management and collaborating, learning, and adapting (CLA) as part of NOFO guiding principles, ensuring implementers develop approaches to pandemic-related shocks and stressors. Provide TA to the Ministry of Health and local partners to adopt evidence-based adaptations to maternal and child health and family planning service delivery continuity during COVID-19 pandemic, including RHITES learning (such as addressing transportation issues) and emerging global technical guidance.
<p>FACILITATORS</p>
<p>1. Community engagement: Establishing strong local partnerships with influential community leaders and groups improved the reach and success of community health interventions (p.6). For example, community engagement interventions that mobilized male community activists and leaders in social behavioral change campaigns helped shift norms that allowed men to prevent women from accessing reproductive health services (p.8).</p>
<p><i>How UHA Will Address:</i></p> <ul style="list-style-type: none"> Requires strong community engagement interventions, including <i>Sub-IR 1.3.3: Communities and clients are empowered and have the agency to address their health needs</i>; and <i>Sub-IR 2.3: Community ownership improved</i>.
<p>2. Participatory approaches: Engaging priority populations to design, implement, and oversee activities was “key to success” in RHITES (p.5). The review noted that participatory approaches supported both the supply of and demand for health services across multiple health areas (p.7).</p>
<p><i>How UHA Will Address:</i></p> <ul style="list-style-type: none"> <i>Sub IR 1.3 Improved health-seeking behaviors</i> requires implementers to adopt evidence-based approaches and innovative approaches, such as human-centered design, behavioral economics, and co-creation.

<p>3. Continuing medical education (CME): Scale-up of quality continuing medical education and mentorship contributed to improved service quality and availability at RHITES sites (p.5).</p>
<p><i>How UHA Will Address:</i></p> <ul style="list-style-type: none"> • Strengthens capacity of RRHs provide supportive supervision and mentorship lower-level health facility staff; establishes high-volume regional skills transfer hubs for CME, professional development, and mentorship for HCWs from lower-level facilities; and helps the RRHs create regional Centers for Excellence.
<p>4. Community-level data collection and use: Local data collection by RHITES helped supplement weaker district reporting systems and improved understanding of community health progress in these districts (p.7).</p>
<p><i>How UHA Will Address:</i></p> <ul style="list-style-type: none"> • To increase sustainability, provide TA to RRHs and districts to increase locally led data collection and review, moving from an IP-led to locally led approach to data reporting and use. • Prioritizes community monitoring and evaluation strengthening, including integration of community data into HMIS, under <i>Sub-IR 3.2 Improved data collection, quality, and use at all levels.</i>
<p>5. Service layering: Health integration – which ensures clients can access a holistic, “one stop” package of quality preventive and curative primary healthcare services at community level – helped to increased uptake of health services in some RHITES sites, especially among vulnerable priority populations (p.7).</p>
<p><i>How UHA Will Address:</i></p> <ul style="list-style-type: none"> • Under <i>IR 1</i> increases access to community health services and self-care. • Strengthens integrated primary healthcare services at lower-level health facilities through technical assistance to Regional Referral Hospitals under MOH “Hub and Spoke” approach.

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**ATTACHMENT B: PRIORITY PEPFAR DISTRICTS AND CITIES/MUNICIPALITIES
FOR IR 3 HSS SUPPORT**

1	Mbarara City	37	Ibanda District
2	Kabale District	38	Bugweri District
3	Kanungu District	39	Iganga District
4	Kisoro District	40	Buyende District
5	Rubanda District	41	Isingiro District
6	Rukiga District	42	Kaabong District
7	Rukungiri District	43	Butaleja District
8	Jinja City	44	Agago District
9	Kwania District	45	Kamuli District
10	Oyam District	46	Kotido District
11	Mbale City	47	Abim District
12	Alebtong District	48	Pallisa District
13	Apac District	49	Omoro District
14	Otuke District	50	Namisindwa District
15	Kibuku District	51	Tororo District
16	Amolatar District	52	Ntungamo District
17	Lira City	53	Budaka District
18	Amuru District	54	Kitgum District
19	Bushenyi District	55	Rubirizi District
20	Bududa District	56	Gulu City
21	Namayingo District	57	Lamwo District
22	Mitooma District	58	Moroto District
23	Sironko District	59	Bugiri District
24	Namutumba District	60	Lira District
25	Bukwo District	61	Kole District
26	Mayuge District	62	Dokolo District
27	Mbale District	63	Kween District
28	Buhweju District	64	Bulambuli District
29	Manafwa District	65	Kapchorwa District
30	Jinja District	66	Karenga District
31	Kaliro District	67	Mbarara District
32	Busia District	68	Rwampara District
33	Kazo District	69	Pader District
34	Kiruhura District	70	Nwoya District
35	Butebo District	71	Gulu District
36	Sheema District	72	Luuka District

ATTACHMENT C: BUDGET TEMPLATE - See separate attachment.

ATTACHMENT D: CERTIFICATIONS, ASSURANCES, REPRESENTATIONS, AND OTHER STATEMENTS OF THE RECIPIENT

Can be downloaded from:

<https://www.usaid.gov/sites/default/files/documents/1868/303mav.pdf>

ATTACHMENT E: PAST PERFORMANCE INFORMATION - See separate attachment.

ATTACHMENT F: STANDARD PROVISIONS

(Note: the full text of these provisions may be found at:

<https://www.usaid.gov/ads/policy/300/303maa> and

<https://www.usaid.gov/ads/policy/300/303mab>). The actual Standard Provisions included in the award will be dependent on the organization that is selected. The award will include the latest Mandatory Provisions for either U.S. or non-U.S. Nongovernmental organizations. The award will also contain the following “required as applicable” Standard Provisions:

Please note that the resulting award will include all standard provisions (both mandatory and required as applicable) in full text.

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

Required	Not Required	Standard Provision
TBD		RAA1. NEGOTIATED INDIRECT COST RATES - PREDETERMINED (NOVEMBER 2020)
		RAA2. NEGOTIATED INDIRECT COST RATES - PROVISIONAL (Nonprofit) (NOVEMBER 2020)
		RAA3. NEGOTIATED INDIRECT COST RATE - PROVISIONAL (Profit) (DECEMBER 2014)
		RAA4. INDIRECT COSTS – DE MINIMIS RATE (NOVEMBER 2020)
	X	RAA5. EXCHANGE VISITORS AND PARTICIPANT TRAINING (JUNE 2012)
X		RAA6. VOLUNTARY POPULATION PLANNING ACTIVITIES – SUPPLEMENTAL REQUIREMENTS (JANUARY 2009)
	X	RAA7. PROTECTION OF THE INDIVIDUAL AS A RESEARCH SUBJECT (APRIL 1998)

	X	RAA8. CARE OF LABORATORY ANIMALS (MARCH 2004)
X		RAA9. TITLE TO AND CARE OF PROPERTY (COOPERATING COUNTRY TITLE) (NOVEMBER 1985)
X		RAA10. COST SHARING (MATCHING) (FEBRUARY 2012)
	X	RAA11. PROHIBITION OF ASSISTANCE TO DRUG TRAFFICKERS (JUNE 1999)
	X	RAA12. INVESTMENT PROMOTION (NOVEMBER 2003)
X		RAA13. REPORTING HOST GOVERNMENT TAXES (DECEMBER 2014)
X		RAA14. FOREIGN GOVERNMENT DELEGATIONS TO INTERNATIONAL CONFERENCES (JUNE 2012)
X		RAA15. CONSCIENCE CLAUSE IMPLEMENTATION (ASSISTANCE) (FEBRUARY 2012)
X		RAA16. CONDOMS (ASSISTANCE) (SEPTEMBER 2014)
X		RAA17. PROHIBITION ON THE PROMOTION OR ADVOCACY OF THE LEGALIZATION OR PRACTICE OF PROSTITUTION OR SEX TRAFFICKING (ASSISTANCE) (SEPTEMBER 2014)
X		RAA18. USAID DISABILITY POLICY - ASSISTANCE (DECEMBER 2004)
	X	RAA19. STANDARDS FOR ACCESSIBILITY FOR THE DISABLED IN USAID ASSISTANCE AWARDS INVOLVING CONSTRUCTION (SEPTEMBER 2004)
	X	RAA20. STATEMENT FOR IMPLEMENTERS OF ANTI-TRAFFICKING ACTIVITIES ON LACK OF SUPPORT FOR PROSTITUTION (JUNE 2012)
	X	RAA21. ELIGIBILITY OF SUBRECIPIENTS OF ANTI-TRAFFICKING FUNDS (JUNE 2012)
	X	RAA22. PROHIBITION ON THE USE OF ANTI-TRAFFICKING FUNDS TO PROMOTE, SUPPORT, OR ADVOCATE FOR THE LEGALIZATION OR PRACTICE OF PROSTITUTION (JUNE 2012)
X		RAA23. UNIVERSAL IDENTIFIER AND SYSTEM FOR AWARD MANAGEMENT (NOVEMBER 2020)
X		RAA24. REPORTING SUBAWARDS AND EXECUTIVE COMPENSATION (NOVEMBER 2020)
	X	RAA25. PATENT REPORTING PROCEDURES (NOVEMBER 2020)
	X	RAA26. ACCESS TO USAID FACILITIES AND USAID'S INFORMATION SYSTEMS (AUGUST 2013)
X		RAA27. CONTRACT PROVISION FOR DBA INSURANCE UNDER RECIPIENT PROCUREMENTS (DECEMBER 2014)

X		RAA28. AWARD TERM AND CONDITION FOR RECIPIENT INTEGRITY AND PERFORMANCE MATTERS (April 2016)
		RAA29. RESERVED
X		RAA30. PROGRAM INCOME (AUGUST 2020)
X		RAA31. NEVER CONTRACT WITH THE ENEMY (NOVEMBER 2020)

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

Required	Not Required	Standard Provision
TBD		RAA1. ADVANCE PAYMENT AND REFUNDS (NOVEMBER 2020)
		RAA2. REIMBURSEMENT PAYMENT AND REFUNDS (DECEMBER 2014)
TBD		RAA3. INDIRECT COSTS – NEGOTIATED INDIRECT COST RATE AGREEMENT (NICRA) (NOVEMBER 2020)
		RAA4. INDIRECT COSTS – CHARGED AS A FIXED AMOUNT (NONPROFIT) (JUNE 2012)
		RAA5. INDIRECT COSTS – DE MINIMIS RATE (NOVEMBER 2020)
X		RAA6. UNIVERSAL IDENTIFIER AND SYSTEM OF AWARD MANAGEMENT (NOVEMBER 2020)
X		RAA7. REPORTING SUBAWARDS AND EXECUTIVE COMPENSATION (NOVEMBER 2020)
X		RAA8. SUBAWARDS (DECEMBER 2014)
X		RAA9. TRAVEL AND INTERNATIONAL AIR TRANSPORTATION (DECEMBER 2014)
X		RAA10. OCEAN SHIPMENT OF GOODS (JUNE 2012)
X		RAA11. REPORTING HOST GOVERNMENT TAXES (JUNE 2012)
	X	RAA12. PATENT RIGHTS (JUNE 2012)
X		RAA13. EXCHANGE VISITORS AND PARTICIPANT TRAINING (JUNE 2012)
	X	RAA14. INVESTMENT PROMOTION (NOVEMBER 2003)
X		RAA 15. COST SHARE (JUNE 2012)
X		RAA16. PROGRAM INCOME (AUGUST 2020)

X		RAA17. FOREIGN GOVERNMENT DELEGATIONS TO INTERNATIONAL CONFERENCES (JUNE 2012)
	X	RAA18. STANDARDS FOR ACCESSIBILITY FOR THE DISABLED IN USAID ASSISTANCE AWARDS INVOLVING CONSTRUCTION (SEPTEMBER 2004)
	X	RAA19. PROTECTION OF HUMAN RESEARCH SUBJECTS (JUNE 2012)
	X	RAA20. STATEMENT FOR IMPLEMENTERS OF ANTI-TRAFFICKING ACTIVITIES ON LACK OF SUPPORT FOR PROSTITUTION (JUNE 2012)
	X	RAA21. ELIGIBILITY OF SUBRECIPIENTS OF ANTI-TRAFFICKING FUNDS (JUNE 2012)
	X	RAA22. PROHIBITION ON THE USE OF ANTI-TRAFFICKING FUNDS TO PROMOTE, SUPPORT, OR ADVOCATE FOR THE LEGALIZATION OR PRACTICE OF PROSTITUTION (JUNE 2012)
X		RAA23. VOLUNTARY POPULATION PLANNING ACTIVITIES – SUPPLEMENTAL REQUIREMENTS (JANUARY 2009)
X		RAA24. CONSCIENCE CLAUSE IMPLEMENTATION (ASSISTANCE) (FEBRUARY 2012)
X		RAA25. CONDOMS (ASSISTANCE) (SEPTEMBER 2014)
X		RAA26. PROHIBITION ON THE PROMOTION OR ADVOCACY OF THE LEGALIZATION OR PRACTICE OF PROSTITUTION OR SEX TRAFFICKING(ASSISTANCE) (SEPTEMBER 2014)
	X	RAA27. LIMITATION ON SUBAWARDS TO NON-LOCAL ENTITIES (JULY 2014)
X		RAA28. CONTRACT PROVISION FOR DBA INSURANCE UNDER RECIPIENT PROCUREMENTS (DECEMBER 2014)
X		RAA29. CONTRACT AWARD TERM AND CONDITION FOR RECIPIENT INTEGRITY AND PERFORMANCE MATTERS (April 2016)
		RAA30. RESERVED
X		RAA31. NEVER CONTRACT WITH THE ENEMY (NOVEMBER 2020)

ATTACHMENT G: USAID/UGANDA LOCAL COMPENSATION PLAN (LCP)- attached separately.

ATTACHMENT H: LDPG REVISED SCHEDULE OF ALLOWANCES (March. 2019) - attached separately.

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ATTACHMENT I: UGANDA HEALTH ACTIVITY REFERENCES

Please find links below to documents referenced within **Section A: Program Description**.

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