ISSUE DATE: December 11, 2024

DEADLINE FOR QUESTIONS: January 8, 2025, 4:30 PM WAT

CLOSING DATE AND TIME: January 24, 2025, 4:30 PM WAT

PROGRAM TITLE: USAID Community Health Activity

SUBJECT: Notice of Funding Opportunity Number (NOFO): 72062025RFA00003

Dear Interested Parties,

The United States Government, as represented by the U.S. Agency for International Development (USAID)/Nigeria seeks applications from qualified entities to implement the USAID Community Health Activity. Eligibility for this award is restricted to local Nigerian organizations.

USAID intends to issue one or more awards to the applicant(s) who best meet the objectives of this funding opportunity based on the merit review criteria described in this NOFO. Eligible parties interested in applying for the USAID Community Health Activity are encouraged to thoroughly read this NOFO.

To be eligible for award, the applicant must provide all information as required in this NOFO and meet eligibility standards in Section B of this NOFO. This funding opportunity is posted on www.grants.gov and may be amended. It is the responsibility of the applicant to regularly check the website to ensure they have the latest information pertaining to this NOFO and to ensure that it has been downloaded from the internet in its entirety. USAID bears no responsibility for data errors resulting from transmission or conversion process.

USAID/Nigeria encourages all interested organizations to register in the USAID Partner Directory (https://www.workwithusaid.gov/partner-directory). The USAID Partner Directory is a listing of development organizations working to make sustainable changes in their communities and around the world. Showcasing your organization increases your visibility among USAID Headquarters, Missions, and current partners looking for collaboration opportunities. It also provides a space for applicants to search for other organizations that may complement their expertise to form a strong technical approach in response to this solicitation.

Questions regarding this funding opportunity must be sent electronically to abujasolicitations@usaid.gov. The deadline for receipt of questions is shown above. Responses to questions received prior to the deadline will be furnished to all potential applicants through an amendment to this NOFO posted to www.grants.gov.

Issuance of this NOFO does not constitute an award commitment on the part of the Government nor does it commit the Government to pay for any costs incurred in preparation or submission of 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.

Thank you for your interest in USAID programs.

Sincerely,

MARVA MICHELLE BUTLER (affiliate)
Digitally signed by MARVA MICHELLE BUTLER (affiliate)
Date: 2024.12.11 17:09:46 +01'00'

Marva Butler
Agreement Officer

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SECTION A: FEDERAL AWARD INFORMATION

A.1 Estimate of Funds Available and Number of Awards Contemplated

USAID intends to award one or more Cooperative Agreements pursuant to this Notice of Funding Opportunity (NOFO).

USAID intends to provide up to $35,000,000 for the USAID Community Health Activity. Actual funding amounts are subject to the availability of funds. USAID reserves the right to fund any or none of the applications submitted.

A.2 Start Date and Period of Performance for Federal Awards

The anticipated period of performance is five (5) years, with an estimated start date upon the Agreement Officer's signature.

A.3 Substantial Involvement

As per ADS 303.3.11, USAID/Nigeria will remain substantially involved during award implementation. The substantial involvement envisaged under the resulting awards will include the following:

a) The Agency's approval of the recipient's implementation plans during performance. USAID generally only requires approval of implementation plans annually; however, where changed contexts or new information require a pivot in the activity, USAID may consider changes to an implementation plan. These plans include:

    1. Annual Work Plans
    2. Annual Monitoring and Evaluation Plan

b) Approval of Key Personnel. The recipient must obtain prior USAID approval of Key Personnel positions, which are deemed essential to the successful implementation of the activity. USAID reserves the right to determine the relevance of education and experience for all Key Personnel positions.

c) The Agency's ability to immediately halt an activity if the recipient does not meet identified performance targets.

d) The Agency's review and approval of substantive provisions of proposed subawards or contracts. The Recipient must obtain Agreement Officer approval prior to the issuance of any subawards or the transfer or contracting out of any work under an award.

e) Agency and recipient collaboration or joint participation, including USAID involvement as a member of advisory committees, when the recipient's successful accomplishment of program objectives would benefit from USAID's technical knowledge. This includes USAID participation in specific meetings with partners, donors and the GON.

f) Agency monitoring to permit specific kinds of direction or redirection of the work because of the interrelationships with other USAID or donor programs, alignment with U.S. Foreign Policy objectives, and USAID/Nigeria strategy.

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

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

A.4 Authorized Geographic Code

The geographic code for the procurement of commodities and services under this program is Code **937**, this is defined as the United States, the recipient country, and developing countries other than advanced developing countries, but excluding any country that is a prohibited source.

Procurement of vehicles and pharmaceuticals, and other restricted commodities are subject to the limitations in 22 CFR 228, ADS 312, and ADS 310 and may require a waiver or Agreement Officer's approval.

A.5 Nature of the Relationship between USAID and the Recipient

The principal purpose of the relationship with the Recipients and under the subject program is to transfer funds to accomplish a public purpose of support or stimulation of the USAID Community 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.

[END OF SECTION A]

SECTION B: ELIGIBILITY

B.1 Eligible Applicants

Eligibility for this NOFO is restricted to local organizations.

USAID defines a "local entity" as an individual, a corporation, a nonprofit organization, or another body of persons that:

1. Is legally organized under the laws of; and
2. Has as its principal place of business or operations in; and
3. Is
    a. majority owned (51% or more) by individuals who are citizens or lawful permanent residents of the recipient country (Nigeria); and

    b. managed by a governing body the majority of who are citizens or lawful permanent residents of the country receiving assistance (Nigeria).

For purposes of this definition, 'majority owned' and 'managed by' include, without limitation, beneficiary interests, and the power, either directly or indirectly, whether exercised or exercisable, to control the election, appointment, or tenure of the organization's managers or a majority of the organization's governing body by any means.

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

Faith-based organizations are eligible to apply for federal financial assistance on the same basis as any other organization and are subject to the protections and requirements of Federal law.

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. Non-discrimination includes equal treatment without regard to race, religion, ethnicity, gender, and political affiliation. Applications will not be accepted from individuals.

B.2 Cost Sharing

Cost Sharing is not required for this activity.

B.3 Other

An organization may submit only one (1) application as the prime applicant under this notice of funding opportunity. However, organizations participating as a member of a consortium may elect to participate as a sub-awardee in another consortium under a different application.

In support of the Agency's interest in fostering a larger assistance base and expanding the number and sustainability of development partners, USAID encourages applications from potential new and underutilized implementing partners who may not have previously received financial assistance from USAID. Any resultant award to a new organization may require a pre-award review of the organizations as part of a "risk assessment" of a potential recipient.

A new partner is defined as an organization that has never received direct or indirect awards from USAID. An underutilized partner is defined by the Agency as an organization that has received less than $25 million in direct or indirect awards from USAID over the past five years. The five years is relative to when the organization is applying to a USAID procurement/funding opportunity.

[END OF SECTION B]

SECTION C: PROGRAM DESCRIPTION

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

C.1 Introduction

The USAID Community Health activity, hereafter referred to as "the Activity", will support priority populations and communities, community organizations and networks, and public- or private-sector actors that work in partnership with civil society at the community level, in the design, delivery, monitoring and evaluation of activities aimed at achieving the purpose of increasing the adoption and sustained uptake of priority health behaviors, services, and products.

The Activity will achieve its purpose through the following results:

IR 1: Adoption and sustained practice of healthy behaviors improved
IR 2: Nigeria's community-based health worker program operationalized to improve equitable access to quality community-based health services, Social Behavior Change (SBC) and risk communication and community engagement (RCCE) interventions.
IR 3: Community-led systems for health governance and accountability strengthened.
CCR: Leadership, visibility and voice of underrepresented and affected groups, including women in delivery and accountability of health services enhanced.

C.2 Background and Problem Analysis

Nigeria accounts for 2.4 percent of the world's population but is responsible for 10 percent of global maternal deaths with a Maternal mortality ratio (MMR) of 512/100,000 live births[1]. Many of these deaths occur outside of a health facility, as nearly 6 in 10 births (61 percent) happen at home (NDHS 2018). Each year, approximately 262,000 babies die at birth, the world's second highest national total. More than half of the under-five deaths – 64 percent – result from malaria, pneumonia or diarrhea (UNICEF, Situation of women and children in Nigeria). This dismal performance in RMNCAH+NM indices is attributed to gross limitations of both the supply and demand factors in the causal pathways for these deaths and worsened by the high burden of

[1]https://www.unicef.org/nigeria/situation-women-and-children-nigeria#:~:text=Nigeria's%2040%20million%20women%20of,global%20deaths%20for%20pregnant%20mothers.

communicable and non-communicable diseases. Additionally, even though Nigeria has recorded unprecedented increases in tuberculosis treatment coverage in the last five years moving from 24% to 74%, gaps still exist among key populations, such as children and men who make up 10% and 54% of those notified, respectively.

On the supply side, a shortage of healthcare workers in Nigeria limits coverage of health services for Nigeria's population. This is particularly felt by communities who face long travel and poor access to formal health facilities. A strong community-level health system can increase access to care and can improve health outcomes. However, many national attempts to improve the community component of primary health care (PHC) have not achieved their intended goals. In 2018, the implementation of the Community Health Influencers Promoters and Service (CHIPS) program commenced with a goal to integrate and harmonize all community-based health worker programs into one category for improved and equitable delivery of basic PHC services, increasing coverage and contributing to the reduction of maternal and child morbidity and mortality. As of February 2024, an assessment by the National Primary Health Care Development Agency (NPHCDA) documented that poor political commitment and ownership at the subnational level, grossly inadequate funding, capacity gaps and poor motivation of the CHIPS personnel, gaps in the supply chain for commodities and inadequate supportive supervision systems contributed to the uneven progress with the implementation of the CHIPs program across states. Accordingly, and in line with the National Health Sector Renewal Investment, the NPHCDA led the redesign of the community-based health workers (CBHW) program, addressing gaps and building on gains of the CHIPS program. This Activity will support the operationalization of the GoN's redesigned CBHW program, as the primary human resource vehicle for increasing access to health services, improving uptake of behaviors and community-based disease surveillance.

See Attachment 1: for detailed country and health context (part A), description of development challenges (part B), key USAID and GoN health strategies (part C) and summary of USAID's historical investments in community health, SBC and RCCE (part D).

C.3 Activity Description

The purpose of this Activity is to increase the adoption and sustained uptake of priority[2] health behaviors, services, and products. This Activity will achieve these through **three core areas of work**:

First, this activity will lead the **design and implementation** of theory-informed, evidence-based, locally-led SBC and risk communication and community engagement (RCCE) programming. SBC

[2] Data-informed consultative and iterative process, involving this Activity, other USAID-funded Activities, USAID, GoN, and other stakeholders, to prioritize and select a range of clearly defined behaviors, which will ideally vary for different states or geographical regions or sub-populations.

programming is intended to foster positive health practices in households and communities and support changes in social, gender and cultural norms that will reinforce and maintain these practices. SBC is defined as the coordinated use of a range of communication and noncommunication approaches - including mass media, community-level activities, nudging and interpersonal communication - to change individual and family behaviors, and improve social and gender norms in support of improved health outcomes. High-quality SBC is evidence- and theory-driven and identifies and addresses specific drivers of health beliefs and behaviors at individual, interpersonal and collective levels. It follows a proven model for planning, creative development, implementation, and evaluation, and emphasizes ongoing engagement and participation of the primary audience and other stakeholders.

Accessibility and convenience factors are known barriers to translating behavioral intention to action hence the **second core area of work** that this activity will advance to achieve the stated result and purpose is to **facilitate the operationalization and scale-up of community health workers** to expand access to essential community-based health services, and drive demand for facility-based health services. These efforts will be guided by the program guide for CBHWs, the package of interventions, and other relevant national policies listed in Attachment 1 part C. Under this component, this Activity will: i) bridge the gaps in access to health information, products, and services through direct implementation of the community component of PHC, critical to attaining Universal Health Coverage (UHC); ii) improve the community-PHC continuum of care by linking individuals and households to the primary health facilities (public and private) and higher-level care (where needed) and iii) support behavior maintenance and enhance follow-up through interventions that support individuals and households to stay connected to the primary health systems that deliver services.

Led by the NPHCDA, the Nigerian government has proposed recommendations for the redesign of the country's CBHW model. The major thrust is the proposition of a two-cadre model (see figure 1 below), including skilled and formally trained Junior Community Health Extension Workers (JCHEWs) and less skilled but trained auxiliary/lay health workers. Both tiers of CBHWs will work collaboratively to deliver a broad set of services, products and SBC interventions in communities. Applicants will support operationalization of the redesigned CBHW program in select geographic areas to be determined with GoN and USAID/Nigeria. Efforts may include state context specific adaptation of the program, including support for mapping, recruitment (including transition of current community health workers/volunteers to government payroll), training and deployment of community health workers.

Given the fluidity of the national roll-out of CBHW redesign, successful applicants may be asked to pay for the salaries for CBHWs in the short-term, within government approved rates, which

may vary by state, while developing transition models with GoN leadership. Based on the estimated costing of the national CBHW guide, an average cost of $1,580 is required for kitting, salaries and incentives per CBHW on an annual basis. This estimated average cost does not include training, supervision, or other recurring costs. Support for strengthened supportive supervision, data collection, routine on the job training and mentoring are other areas that the applicant can be expected to support. Technical assistance to support institutionalization of the community health workers may include supporting the evidence base to guide adaptive management/scale of the CBHW program and or policy development. With support from USAID/Nigeria, it is expected that the applicant will work in partnership with other development partners, GoN and other implementing partners to support coordination of the national CBHW roll-out/monitoring.

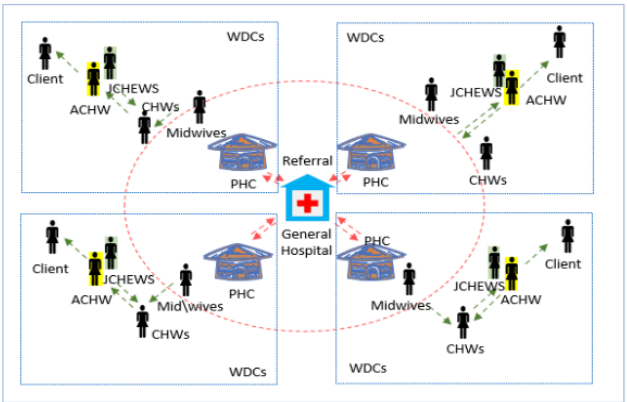


Figure 1: Proposed two-cadre CHW. Culled from the NPHCDA CBHW Guide

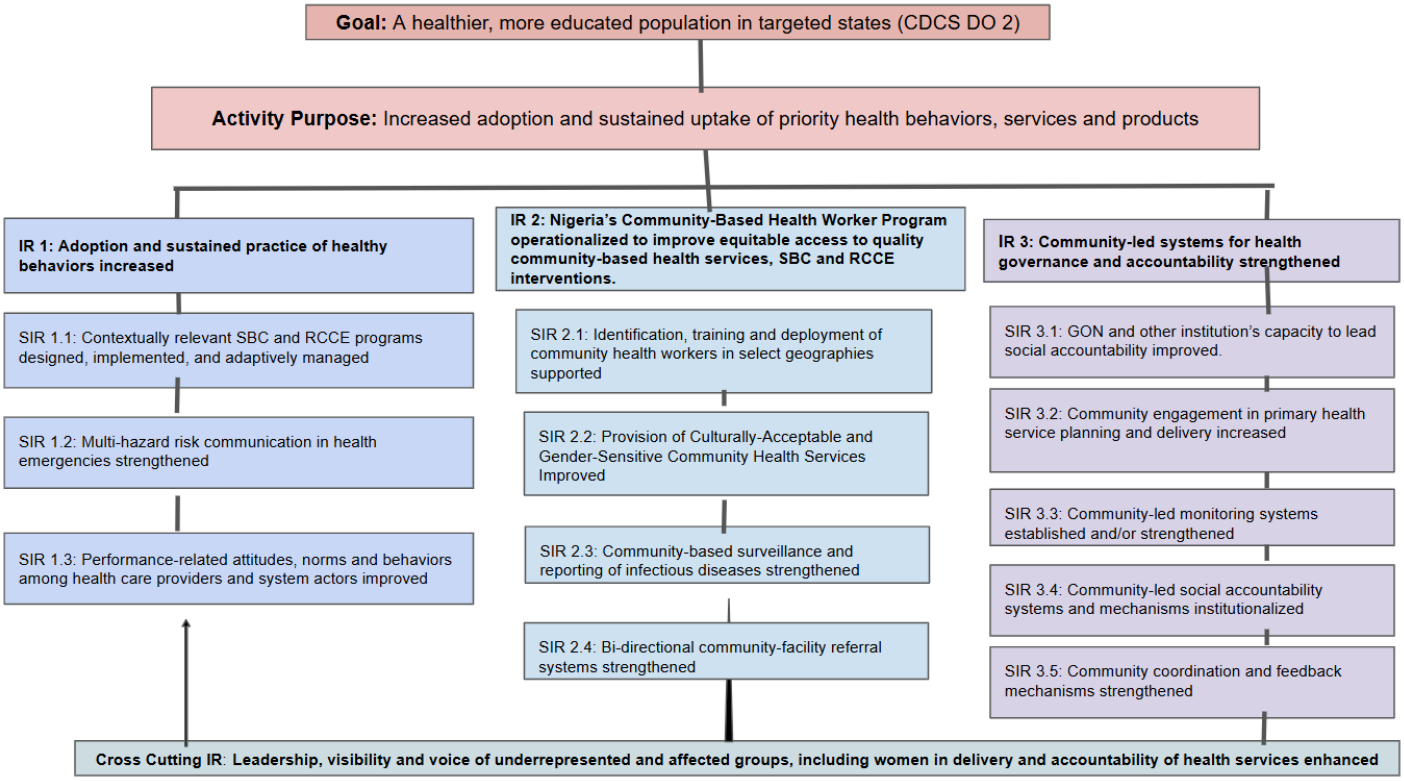
The **third core area of work** that this Activity will advance is the **strengthening of social accountability and governance for health** at the local government and ward levels. This result will improve community knowledge and understanding of health and will engage individuals, households, and communities to make informed decisions in managing their own health. Building the capacity of civil society organizations (CSOs), such as community-based organizations (CBOs) and faith-based organizations (FBO), other community platforms, etc. will be critical to advocate for more transparent and responsive health services (e.g., serving as a bridge between clients and health service providers). With explicit focus at community level, engagement of local CSOs will improve health system functionality, increase community health behaviors and care-seeking practices and ensure high-quality, client-centered health services at all levels. Through these results, it is expected that the apparently successful applicant will: 1) Improve community engagement, ownership, and ability to make informed decisions about its own health; 2) Enhance CSO capacity to advocate for improved health system accountability,

transparency, and responsiveness and 3) Strengthen accountability systems and platforms to improve the health outcomes.

With recent government reforms to achieve full autonomy for, and directly fund local government areas (LGAs), efforts would include those that empower LGA health teams, ward and community health governance structures such as Ward and Village/Community Development Committees (WDCs and V/CDCs) to take responsibility to improve their communities' health through enhanced ownership and accountability systems and platforms for health. This Activity will also engage and strengthen the capacity of existing coalitions of health (and non-health) CSOs, FBOs and CBOs and other health allies such as the media to foster greater community engagement and informed participation in PHC service planning, delivery and monitoring through existing platforms such as facility management committees or new innovative platforms. Community feedback mechanisms, including community score cards, citizen voice surveys, etc. could be considered.

C.4 Result Framework and Expected Results

Figure 2 below depicts the Results Framework for the Community Health and Behavior Change activity.



Applicants will propose interventions that will achieve the expected results (as measured by indicators and targets) for each sub-IR and will provide the rationale in the activity monitoring, evaluation and learning plan (MELP).

IR 1: Adoption and sustained practice of healthy behaviors improved.

Health promoting behaviors and healthy lifestyle patterns are a fundamental concept and determinant of general health status. Evidence supports that when uptake of the accelerator behaviors (outlined in Table 1) is high, they have the potential to greatly reduce maternal and child deaths, prevent the occurrence and progression to chronic diseases. To adopt health behaviors, individuals should understand the benefits of practicing them, and have both the intention and ability to practice them and consequently seek health services. The applicant's approach should be informed by addressing the various factors that prevent the adoption or sustainment of positive individual and household health behaviors. Applicants are expected to define strategies based on data and evidence, test and then scale[3] behavior change approaches.
Table 1 below summarizes current uptake of key health behaviors, not exhaustive list, within the purview of this activity. Applicants should be prepared to provide innovative solutions that will help accelerate uptake of these behaviors among priority populations, in targeted states.

TABLE 1 **Behavior**	**Uptake (NDHS 2023-24)**
Pregnant women attend a complete course of antenatal care (MH)	52 percent
Pregnant women deliver with the assistance of a skilled provider (MH)	46 percent
New mothers' complete postnatal appointments with a skilled provider (MH)	43 percent
Pregnant women take at least three or more doses of intermittent preventive treatment of malaria (IPTp) during ANC visits (Malaria/MH)	26 percent
Mothers initiate breastfeeding within one hour after delivery (NH/Nutrition)	36 percent

[3] Defined as reaching the proportion of primary and secondary audiences required to achieve and sustain population-level behavior change within target populations.

Caregivers provide essential newborn care immediately after birth (NH)	42 percent i.e. PNC for babies within 2 days
Mothers breastfeed exclusively for six months after birth (NH/Nutrition)	29 percent
Caregivers seek full course of timely vaccinations for infants and children under 2 years (N/CH)	39 percent
Caregivers seek prompt and appropriate care for fever (Malaria/CH)	60 percent[4]
Caregivers provide appropriate treatment for children with diarrhea, as well as symptoms of acute respiratory infections (ARI) at onset of symptoms (CH)	60 percent
Infants 6-24 months fed with adequate amounts of nutritious, age-appropriate foods to children from 6 to 24 months of age, while continuing to breastfeed (CH/Nutrition).	12 percent
After a live birth, women or their partners use a modern contraceptive method, including Long Acting Reversible Contraceptives, to avoid pregnancy for at least 24 months (FP/RH)	15 percent
Individuals sleep under an insecticide-treated net (ITN) (Malaria)	60/66 percent (CU5/PW[5])
Caregivers demand test before treatment (Malaria)	20 percent[6]
Tuberculosis	
Correct beliefs and knowledge about TB stigma (women, men)	26 and 23 percent
Knowledge of common symptoms of TB (women, men)	64 and 70 percent

This activity will maintain a focus on Preventing Child and Maternal Death accelerator behaviors as outlined in the table above. Other priority behaviors include:

[4] This is percent of caregivers who sought care for sick children and not those who sought prompt care i.e. care within 48 hours of onset of symptoms
[5] Children Under 5/Pregnant Women
[6] Percentage of children under age 5 with a fever in the 2 weeks before the survey who had blood taken from a finger or heel for testing. This is a proxy measure of diagnostic testing for malaria

- Individuals seek prompt and appropriate care for signs and symptoms of TB (persistent cough lasting more than two weeks) (TB)
- Individuals seek timely testing and adhere to TB treatment, as prescribed (TB)
- Community members treat individuals affected by TB with the same dignity as anyone else (TB)
- Caregivers wash hands with soap under running water at four (4) critical times [after defecation, after changing diapers, before food preparation and before eating] (GHS/Cross-cutting)

Upon determination of states post award, Applicants will propose data-informed, geographically differentiated mix of priority behaviors and a package of SBC interventions to improve uptake, among priority populations, in targeted states. Sound understanding of local context, local and global best practices/solutions, innovations, and measurement and demonstration of results are expected. When results are not changing, adaptive management principles should be deployed to refine solutions. Accelerating and sustaining the achievements of SBC programming hinges on three critical factors: 1) consistent application of theory and data by local partners; 2) strong monitoring and evaluation (M&E) of behavioral determinants and outcomes to continue learning and building evidence for effective SBC interventions and 3) local leadership, policy support, and financial investments. USAID seeks creative and technically sound leadership from Applicants in proposing the best solutions to these critical factors.

Approaches should demonstrate alignment with USAID's localization vision to "place local communities in the lead to either co-design a project, set priorities, drive implementation, or evaluate the impact of programs." This Activity will incorporate elements from USAID's locally-led programs indicator which lays out four categories of good practices in local leadership. Activities under this IR will emphasize rapid, robust, and programmatically useful formative research, concept- and pre-testing, and monitoring.

Given the multiple outbreaks of public health interest in Nigeria, this Activity will support the systematic detection and reporting of events that are led by community members. The role of communities in preventing, detecting and responding to local health threats is critical in improving the lives of Nigerians. One of the principal advantages of community-based surveillance is that it ensures effective communication of unusual events or changes in the health status of residents in a community to authorities and, importantly, gives a voice to communities, enabling early detection and response to potential epidemics, making it possible to stop them before they start.

The three sub-intermediate results under IR 1 are:

SIR 1.1: Contextually relevant SBC and RCCE programs designed, implemented and adaptively managed
SIR 1.2: Multi-hazard risk communication in health emergencies strengthened
SIR 1.3: Performance-related attitudes, norms and behaviors among health care providers and system actors improved

SIR 1.1: Contextually relevant SBC and RCCE programs designed, implemented and adaptively managed.

Recent behavioral sentinel surveys as well as evaluations of USAID-funded SBC interventions have increased the understanding of programmatic determinants of success. These determinants include but are not limited to i) the use of formative research; ii) grounding approaches and interventions in behavioral theory; iii) audience or population segmentation and behavioral objectives; iv) continued engagement of stakeholders in design, implementation, and monitoring; and v) use of multiple channels and strategies to influence key determinants of behaviors. Careful considerations of these determinants in the design of SBC programs are important to improve uptake of live-saving behaviors and services at the community level to ultimately drive down maternal and child morbidity and mortality. This Activity will pay close attention to the existing evidence on the effectiveness of various intervention types to influence uptake of behaviors and how this effectiveness varies across behaviors in proposing appropriate levels of effort across intervention types, behaviors and subpopulations. This activity will also contribute to measurable shifts in the underlying social norms[7] and beliefs that constrain the practice of priority health behaviors. Other critical considerations for this activity will be the promotion of newer tools and/or behaviors e.g. uptake of recommended doses of the malaria vaccine. Approaches will also carefully examine the evidence on approaches to SBC integration and should clearly demonstrate opportunities for both heightened impact and economies of scale in programming.

Widespread access to mobile phones, social media and digital technology has transformed the communication landscape in Nigeria, enhancing interpersonal connectivity, and accelerating the spread of new ideas and norms as well as misinformation/disinformation. This Activity will consider recommendations in the USAID digital divide learning brief as well as those from other existing literature to increase gender equitable access to, and use of digital tools for SBC programming. Finally, this Activity will employ co-creation[8] approaches that elevates diverse local voices, including of people living with disabilities, across the program cycle and facilitate joint

[7] May include improving women's decision-making power; addressing cultural taboos around sex and sexuality; reducing social tolerance for forms of gender-based violence or addressing TB-related stigma and its impact on uptake of behaviors along the continuum of care; testing to treatment adherence

[8] Defined by USAID as an intentional design approach to address a specific problem, challenge, question, or to gain further insight on a topic of interest through a participatory process whereby participants share power and decision-making.

ownership of USAID's investment while addressing ways in which gender and power inequalities can limit certain people's access to, equitable participation in, and benefit from SBC interventions.

SIR 1.2: Multi-hazard risk communication in health emergencies strengthened.

In addition to proactively mainstreaming risk communication interventions, as maybe needed, into routine SBC programming implemented (IR 1.1), this Activity will provide agile[9] risk communication design and implementation support as part of response to outbreaks or emerging pandemic threats. This Activity, working closely with affected populations and communities, governments, and other partners, will design and implement interventions focusing on pre- and post-event strategic preparedness and response. The Activity will i) demonstrate the value of investing in "preparedness and readiness" and "response" loops through shifts from reactive to proactive RCCE programming ii) facilitate coordinated engagement of communities prior to, throughout the duration of and recovery from an event or emergency; and iii) foster community ownership by leveraging systems and structures. This Activity will use data to guide the design of interventions for any of Nigeria's prioritized zoonotic diseases[10] and other known threats (cholera, meningitis etc.). This Activity will leverage climate and disease data for the pre-positioning of messages to break transmission chains for recurrent zoonotic diseases like Lassa fever and waterborne outbreaks like cholera.

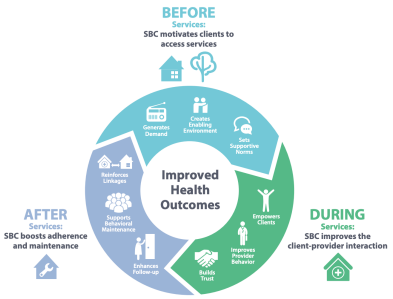


Figure 3: Circle of Care Model

This Activity will continue to support GoN to strengthen the application of the One Health approach for readiness for outbreak response (with an increased focus on animal and environmental health sectors) and collaborate with local partners for proactive community engagement to promote the practice of preventive behaviors that encourage healthy living for humans and animals in their shared environment. Additionally, this activity will provide RCCE support for priority vaccines & reactive vaccinations during outbreaks; provide technical support for the development of RCCE strategies, policies, and guidelines, that address gaps and provide a framework for health security; increase investments in subnational capacity strengthening for RCCE and strengthen partner coordination and collaboration within the RCCE and One Health ecosystem.

[9] Agility here refers to the ability to mobilize expertise (or man) and material resources in support of rapid response teams to affected states and communities.

[10] Lassa fever, yellow fever, rabies, mpox, highly pathogenic avian influenza and bovine TB

SIR 1.3: Performance related attitudes, norms and behaviors among health care providers and system actors improved.

Health system actors, especially health care providers, are both a priority audience for behavior change efforts and key change agents for affecting clients' behaviors. Strengthening the health system to support health care providers and other health systems actors more effectively improves the enabling environment for behavior change in individuals, communities, and institutions. Poor communication and counseling can erode community trust in the health system. This Activity will leverage growing evidence on strategies, tools, and approaches for strengthening "service communication" by improving linkages between SBC and service delivery partners and carefully consider ways to effectively integrate SBC at three stages of the service delivery process - see figure 3. This Activity will advance health systems' or ecosystems approach to changing behaviors of health providers through attention to the complex set of factors that are both internal and external, how these factors interact with each other and how they influence provider behavior, and within service delivery contexts such as facility or community-based. Interventions under this IR will be directed at facility-based health workers as well as CBHWs. This Activity will drive broader application of successful solutions across health areas, work closely with USAID service delivery activities (PHC Improvement Program and TB Service Delivery) to improve provider attitude and client management skills. This Activity will enhance engagement with relevant providers to create shared norms and peer-led approaches, explore client's expectations on the quality of care; clients experience of care and elements of respectful care.

IR 2: Nigeria's Community-Based Health worker (CBHW) Program operationalized to improve equitable access[11] to quality community-based health services, SBC and RCCE interventions.

As part of broader efforts to achieve UHC, there is recognition and evidence, globally and in Nigeria[12] that Community-based Health Resource Persons (CHRPs)[13] can effectively deliver a range of preventive, promotional and curative primary health services and thus, contribute to reducing inequities in access to healthcare information and products. In Nigeria the CBHW program is working to professionalize, sustain, and integrate CHWs within the health workforce and health systems. The Activity will harness the potential of a cadre, loosely referred to, for the purpose of this solicitation, as CHRPs to enhance the delivery of fit-for-purpose primary health including TB services, SBC interventions and products at community level to increase equitable

[11] Affording every individual a fair opportunity to attain their highest level of health regardless of social or demographic factors, with particular emphasis on underserved, socially excluded, and vulnerable populations (USAID HSS Vision 2030)

[12] Nigeria's task shifting and task sharing policy for essential health care services.

[13] For this Activity, CHRPs refer to a range of public and private sector actors including but not limited to community health volunteers; Junior Community Health Extension Workers (JCHEWS); Community Health Influencers and Promoters (CHIPS); Volunteer Community Mobilizers (VCMs); home-based care volunteers; health educators; health promoters; Community Based Organizations (CBOs) that provide health services; Proprietary and Patent Medicine Vendors (PPMVs); community pharmacists; community informants; community orientation and mobilization officers (COMOs) and Traditional or Mission Birth Attendants (TBAs/MBAs).

coverage, reduce maternal and child illnesses and deaths and contribute to lower disease burdens.

This Activity will provide support ranging from community mobilization, selection of CHRPs, cascade training, mapping, house numbering and assignment of workload, kitting, and tooling. Interventions will intentionally focus on equity through approaches such as the use of population[14] and health coverage[15] data to identify and deploy community-based services to "hard-to-reach", underserved and unserved populations, including but not limited to people with disabilities (PWDs), unmarried adolescents and youth etc. This Activity will support the operationalization of the revised CBHW program to enhance access to a range of quality community-based health services. This Activity will support efforts at the subnational level, to develop or adapt existing implementation guidelines to the context of states. This will entail efforts to increase the participation of relevant community structures and representatives in state-led planning of set priorities, and selection of CHRPs, using predefined government criteria as well as those that support the co-development of modalities for performance monitoring and problem solving.

The scope of preventive, promotive and curative services provided by CHRPs will be guided by the national CBHW guide, the FMOH strategic blueprint for the community service component of the NSHRII, as well as other relevant policies. Select services will include but not limited to a **range of testing services** e.g. rapid diagnostic tests for malaria and screening services e.g. presumptive TB case identification and referral, Middle Upper Arm Circumference screening in children under 5 for moderate to severe malnutrition, self-care diagnostics, etc.; **provision of non-prescriptive services** e.g. short term FP methods, treatment of uncomplicated malaria and diarrhea etc.; **disease surveillance and reporting** as well as **referral management** and linkages to formal public and private sector service delivery platforms (including facility-led community outreaches) – detailed here.

Applicants will propose models to clearly focus on community-level delivery of the defined package of interventions such as home visits or community dialogues and draw applicable lessons from successful and promising approaches for the integrated community case management of illnesses in children in Nigeria. Applicants will also clearly demonstrate linkages between proposed models and those led by facility-level actors such as PHC-led outreaches to communities, mobile clinics etc.

The four sub-intermediate results under IR 2 are:

[14] Population coverage refers to "catchment" or share of population eligible for a core set of health services.
[15] Proportion of eligible population or catchment reached with defined/core set of health services.

SIR 2.1: Capacity[16] for delivery of quality community-based health services, SBC interventions and disease surveillance improved.

SIR 2.2: Provision of culturally acceptable and gender-sensitive community-based health services improved.

SIR 2.3: Community-based surveillance (CBS) and reporting of infectious diseases strengthened.

SIR 2.4: Bi-directional community-facility referral systems strengthened.

SIR 2.1: Identification, training and deployment of community-based health workers in select geographies supported.

Successful community-based health worker programs require building local capacity[17] by meaningfully engaging local communities to define needs, selection of, and ongoing support to CHRPs. This Activity will support efforts at the subnational level, to develop or adapt existing implementation guidelines, increasing the participation of relevant community structures and representatives in state-led planning of set priorities, and selection of CHRPs, using predefined government criteria as well as those that support the co-development of modalities for performance monitoring and problem solving. This Activity may leverage existing resources such as the national CBHWs training manual (currently being revised), to support the development of training plans, deployment of cascade trainings to enable the acquisition of competencies necessary for the delivery of expected preventive, promotive, diagnostic, and curative primary health services, identification of danger signs as well as quality two-way referrals.

Training will incorporate community components of the integrated disease surveillance and reporting module to increase capacity for the identification or detection and reporting of suspected cases for priority zoonotic diseases (PZDs); improve capacity for the use of service and commodity data and referral management tools; improve capacity for personal, infection prevention and control and build skills to support the unique health needs of PWDs. Where epidemiological needs require it, CHRPs will be trained to deliver disease outbreak or epidemic-specific interventions. Applicants will propose innovations to incentivize CHRPs including but not limited to social marketing approaches that provide sales commissions or cash vouchers based on pre-negotiated performance milestones. Applicants will also propose criteria and systems for assessing functional capacity/capability of engaged CHRPs in line with national standards/expectations. Additionally, this Activity will support kitting and tooling of trained CHRPs with job aids, stock and service data management tools, personal protective tools and other items as suited to the scope of services delivered and assigned tasks.

[16] Refers to support to training, tooling, kitting, mentoring, supportive supervision, where applicable

[17] Refers to support to training, tooling, kitting, mentoring, supportive supervision, where applicable

SIR 2.2: Provision of Culturally Acceptable and Gender-Sensitive Community Health Services Improved.

To improve access to quality health services in the selected geographic areas, integrated outreach and mobile services should be provided in addition to static PHC facility service support that will be identified through the service delivery awards. Similar to the CBHWs, health services should be contextualized to be culturally-acceptable and gender-sensitive in targeted geographies. Innovative and/or proven approaches should be used to strengthen community-based service delivery, including facility-led outreaches, maternal and child health week, supplementary immunization campaigns etc. This activity will optimize service uptake for all outreaches including those led by both public and private (civil society and faith based) entities. This Activity will adapt and/or develop specific gender-transformative tools and/or checklists to critically analyze and improve service provision and associated health and nutrition outcomes with respect to men and women. This Activity will explore differentiated service delivery models, including those that can maximize the knowledge, practices and use of mission and traditional birth attendants (in non-delivery roles) and other locally valued health personnel within targeted communities. Where there are geographical overlaps, this Activity will ensure complementarity of proposed support to community-based health services with those led by other non-USAID funded donors or private organizations. Service provision and utilization should be monitored for any obstacle, deterrence and disenchantment to any particular group of persons.

SIR 2.3: Community-based surveillance and reporting of infectious diseases strengthened.

Nigeria's health system continues to be challenged by multiple disease outbreaks, including but not limited to PZDs such as Lassa fever, rabies, and diseases of public health importance such as cholera, meningitis etc. In 2023 alone, Nigeria experienced multiple disease outbreaks across several states including Lassa fever, mpox, meningitis, diphtheria, cholera, Marburg, and yellow fever and was in the recovery phase for COVID-19. Coordinating surveillance systems, including at community level for the early detection and reporting of suspected cases of zoonotic diseases and other diseases of public health importance is a core objective of the revised National Action Plan for Health Security (NAPHS). Strengthening CBS is a priority in underserved communities, where geographical access barriers or high cost of healthcare pose challenges to utilization, and health facility-based surveillance will remain an underestimation of the true burden of disease in these areas. This Activity will strengthen the capacity of CHRPs to identify and report suspected cases through appropriate and established government channels. Support will include developing CHRPs skills for the use of Nigeria's Auto Visual Alert Detection and Reporting. Community level providers will be supported to routinely, identify and report suspected cases, and may be primed for time and/or event-based surveillance informed by historical climate and disease burden data.

SIR 2.4: Bi-directional[18] community-facility referral systems strengthened.

Effective two-way referrals, across all levels of care, are an essential component of accessible health care systems and are essential to save lives and ensure quality and a continuum of care. Strengthening bi-directional or "two-way" community to facility referrals", will be a core focus of this Activity. Efforts will be complementary to those of the USAID Health Data Initiative Activity which will be directed at system-level efforts to establish, strengthen, and scale Nigeria's Community Health Management Information Systems. This Activity's efforts will operationalize[19] system level efforts (including policy, standard operational procedures [SOPs] etc.) by training CHRPs and enhancing efficiencies in their use of such tools, through collection of user experience in support of refinement. Support to GoN for refinement will be led by the USAID Health Data Initiative. This Activity will build on lessons learned from programming investments and existing literature to clearly define parameters for documenting a "completed referral", define the procedure or modalities for household level follow-up visits following service referral by a CHRP (e.g. for which services, how frequently, duration between visits etc.), and strengthen the intermediate role of CHRPs in the circle of care continuum. Finally, this Activity will establish internal monitoring systems (database), data sharing agreements or partnerships that enable documentation and reporting of reach, referrals, and contributions to facility client volume (by CHRP cadre, service type, age, sex, location etc.).

IR 3: Community-led systems for health governance and accountability strengthened.

Nigeria's community health ecosystem includes many formal and informal actors, structures and/or platforms. Effective community engagement will require optimal coordination of all actors within the community health ecosystem towards achieving shared objectives. This activity will identify, engage and strengthen the capacity of community stakeholders such as Ward Development Committees (WDCs) and village/community development committees (V/CDCs) and LGA Health teams. Adequate coordination and engagement between these community stakeholders and civil actors such as faith and community leaders, coalitions or networks, community-based health organizations, local media, youth associations and leaders of relevant trade unions[20] is key to catalyzing action for health governance and accountability. The goal is to increase community engagement and participation in primary health service planning and

[18] Bi-directional referral, means referring clients to health care facilities (public and private) from communities and following up with such clients to ensure referral completion, ensure treatment adherence or behavior sustenance post referral completion

[19] refers to building skills on the use of tools, SOPs such as those that provide indications for referrals (for conditions beyond the scope of CHRPs capacity), consent seeking for, and communication during referrals etc.; planning support e.g. work plan development for CHRPs and referral planning including but not limited to referral mapping# (including private sector facilities for TB or higher-level care for severe acute malnutrition (SAM) treatment, diarrhea, febrile illness, etc.), facilitating referral completion (e.g. through accompaniment or leveraging community transport systems), referral documentation and follow up visits.

[20] For example, associations of Patent Proprietary Medicine Vendors (PPMVs), traditional birth attendants, community barbers etc.

delivery as well as increased community ownership[21] of their health.

This Activity will strengthen the capacity and enhance the processes of local government authorities, ward and community-led platforms and structures, and LGA health teams supported by the PHC Act and established by the NPHCDA, to execute duties of health governance and accountability. The Ward Health System represents the national strategic thrust for the delivery of PHC services and utilizes the electoral ward as the basic operational unit for PHC service delivery and health governance. Nigeria's minimum standards for PHC identifies management and governance functions for V/CDCs and WDCs across the country's tiered PHC delivery, as well as required membership composition and operational guidelines for both levels of development committees.

This Activity will build off lessons learnt and good practices for capacity strengthening of WDCs and CDCs as summarized in Part D, Attachment 1 to propose a mix of interventions that strengthen existing platforms or establish and capacitate new ones (especially for the coordination of formal and informal actors). It will enhance internal processes within these structures or platforms with the ultimate goal of increasing community ownership for their health, and engagement with primary health systems actors to influence decisions that affect health in their communities, improve quality of, governance and accountability for services provided.

The five sub-intermediate results under IR 3 are:

SIR 3.1: GON and other institution's capacity to lead social accountability[22] improved.
SIR 3.2: Community engagement in primary health service planning and delivery increased.
SIR 3.3: Community-led monitoring systems established and/or strengthened.
SIR 3.4: Community-led social accountability systems and mechanisms institutionalized.
SIR 3.5: Community coordination and feedback mechanisms for strengthened.

SIR 3.1: GON and other institution's capacity to lead social accountability improved.
USAID's local capacity strengthening (LCS) policy emphasizes the importance of partnerships to strengthen local communities through the implementation of demand driven[23] capacity

[21] Sarriot, Eric; Shaar, Nashat, Ali. Global Health: Science and Practice. 2020 | Volume 8 | Number 3. Community Ownership in Primary Health Care—Managing the Intangible. https://www.ghspjournal.org/content/ghsp/8/3/327.full.pdf. Community ownership can be defined as the point when community members have the capacity, agency, leadership and find value in the provision of health services and are active participants, drivers of influence, exercising direct accountability for responsive health services.
[22] Social accountability is an approach that relies on citizens' (individuals and groups) engagement to exact accountability from service providers and relevant government authorities so that those respond to community health needs.
[23] Demand driven implies beneficiaries of capacity strengthening interventions define their own vision for success and determine the best ways to achieve and sustain success

building[24] approaches. This Activity will work to strengthen the capacity of V/CDCs and WDCs within targeted states as well as key operating units[25] of the ministry of health at the national and subnational levels to execute the governance functions as defined in the minimum standards for PHC in Nigeria. This Activity will work with these actors[26] to co-define competency and capacity gaps, co-determine which capacities to strengthen and which methods can be most effective, and co-create performance improvement targets and methods to track results.

SIR 3.2: Community engagement in primary health service planning and delivery increased.

Community engagement for health is a process by which communities develop relationships with service providers and work together to address issues (such as those related to access, quality, or utilization) to achieve positive outcomes. The UN's Global Strategy[27] identifies community engagement as one of the nine action areas required to improve health systems ownership. This Activity will foster improved relationships between community coalitions and health system actors to ensure that primary health services are appropriately tailored to community needs and preferences through contextually relevant participatory learning approaches. This Activity will support ward and community health structures as well as civil actors to work collaboratively with health system managers to diagnose persistent challenges and barriers to access, provision of quality client-centered services, and utilization of services, and then co-design and implement locally funded solutions to address prioritized barriers. The Activity will support actors to effectively engage in decision making, for health service planning and delivery; support community engagement that facilitates checks and balances in primary health service delivery ensuring that they are responsive to the needs of all community beneficiaries, including men, women, girls, youth, minority ethnic groups, and disadvantaged members of the community. Finally, this Activity will enhance the role of community structures in the collaborative design and implementation of specific components of the GoN's Basic Health Care Provision Program (BHCPP) 2.0 including but not limited to development and execution of business plans, and management of drug revolving schemes. This Activity will consider the existing evidence on proven and promising community group engagement approaches, with a keen focus on answering questions on scalability and costing.

SIR 3.3: Community-led monitoring (CLM) systems established and/or strengthened.

CLM promotes meaningful and systematic participation of community structures and civil actors

[24] Capacity here refers to knowledge, skills, motivations, and relationships that enable beneficiaries (individual, organization, or a network of organizations) to act, to learn and adapt from that action, and to innovate and transform over time.
[25] This refers to relevant GoN ministries, department and agencies at national and sub-national levels
[26] Faith and community leaders, coalitions or networks of faith and community-based health and youth organizations, local media, relevant trade unions
[27] WHO global strategy on integrated people-centered health services 2016-2026

(defined above) as well as beneficiaries in long-term, decision-making roles as co-managers in the design, implementation, and/and management of monitoring processes. The Activity will catalyze CLM processes such as co-defining metrics of success, jointly shape learning questions, co-creating monitoring tools, compiling evidence on what works well, what is not working, and what needs to be improved (e.g. service quality across RMNCH+NM and TB). The Activity will examine the evidence on best practice for applying CLM such as for malaria interventions[28] as well as HIV prevention, care and treatment programs[29]. Often, the scope and process of CLM are tailored to the needs of local communities. The Activity will support CLM activities such as establishing rapid feedback loops with service providers and LGA health teams, providing suggestions for targeted action to improve processes and outcomes, participating in pause-and-reflect sessions monitoring implementation of recommendations as part of efforts to hold system actors accountable. The Activity will ensure CLM is both owned and conducted by the community structures, civil actors, and beneficiaries, free from undue external influence. Part of the GoN's health sector renewal initiative and BHCPP 2.0 includes performance-based incentives or payment for results. This Activity will support CLM efforts for the verification of results related to disbursement-linked indicators. This Activity's role will primarily be capacity enhancement and technical assistance to organize community coalitions in support of CLM.

SIR 3.4: Community-led Social Accountability systems and mechanisms institutionalized.

Over the past decade, there has been a growing consensus that stronger accountability mechanisms are critical for improving the health outcomes. The structures to support social accountability are frequently in place but are badly neglected[30]. In recognition of the role of local accountability, the GoN's health sector renewal initiative includes a focus on social accountability – both on the demand and supply sides. This Activity will strengthen community structures (V/CDCs and WDCs) and support the establishment and institutionalization of feedback loops for continued client feedback for service improvement, improve two-way communication of service availability and readiness to improve beneficiary perceptions as well as expectations of health services. Hence fostering accountability at local levels. Additionally, the Activity will establish or revitalize anonymous channels for reporting or grievance resolution e.g. accountability hotlines. This Activity will support GoN's efforts to amplify citizen's voices and hold health system actors accountable for quality, responsive, client-centered, and accessible health services. Finally, this Activity will improve capacity of community structures and civil actors for health advocacy, engagement, and increase the functionality of community systems/coordination platforms to

[28]https://cs4me.org/wp-content/uploads/2022/11/Community-Led-Monitoring-Guide-For-Key-Malaria-Programmes-RT-2.pdf
[29]https://www.hivresearch.org/news/news/walter-reed-program-nigeria-pilots-community-led-monitoring-improve-hiv-prevention-care
[30] Strengthening social accountability in ways that build inclusion, institutionalization, and scale: reflections on Future Health System experience,2020.

drive greater social accountability and ultimately, improved health outcomes in target communities.

SIR 3.5: Community coordination and feedback mechanisms for Community Health services, SBC and RCCE programs strengthened.

This Activity will support the establishing of community feedback loops e.g. through community listening, rapid perception surveys, media monitoring or social listening etc. as well as ongoing capacity-strengthening support for rumor collection, analysis, and use of data for continued program and health planning decision-making. Effective response in a health emergency is dependent on agile systems for rapid learning and adaptation of messages and other interventions to keep up with information needs, dispel rumors, and address dis/misinformation. This Activity will support Nigeria's nascent infodemic management system, managed by the NCDC at the national level through capacity strengthening and dedicated mentoring. This Activity will work with key stakeholders (including affected communities and experts) to design, conduct and analyze data from periodic rounds of surveys (including phone surveys, social media surveys, short message service surveys etc.) and feed insights into the development of SBC materials and strategic documents for RCCE programming.

Cross Cutting Result Area: Leadership, visibility and voice of underrepresented and affected groups, including women in delivery and accountability of health services enhanced.

This activity will focus on strengthening understanding, ownership, accountability and quality of health services. Therefore, for RMNCH services for instance, having women at the center of planning all solutions is critical. This includes having women in leadership positions/roles to advocate for other women, bringing their experiences (visibility) and voice to drive solutions. For TB services, involving men and boys in affected communities will be key. This activity should identify opportunities and solutions to strengthen women and girls' involvement in decision making that affect how health services are delivered or adapted. The applicant should consider working with all stakeholders to ensure equal representational opportunities for marginalized, underrepresented and affected populations or groups of people which may include youth, women, persons living with physical and cognitive disabilities etc.

Establishment and Implementation of Technical Assistance (TA) Fund for responsive technical assistance (up to $3.5 million).

Up to $3.5 million dollars of the award, or ten percent of the TEC, will be set aside for adaptive, responsive RMNCH+N, malaria and TB related TA to address gaps identified at subnational levels.

During the course of implementation, the successful applicants may identify gaps and propose supplemental technical assistance to fill them. The applicant will also ensure accountability by all parties including MOH and recipients of the TA with respect to the quality of TA services or products delivered under this award. These funds, from the TEC, will be ringfenced to address gaps that pose a significant threat to successful activity outcomes.

The Ministry of Health and other development partners are currently doing statewide capacity assessments and establishing procedures for more transparency and equitable distribution of TA across the country. Additionally, a Joint Technical Assistance Fund (JTAF) and protocols are being established to deliver on clear oversight and demand driven TA procedures from the states to the federal level. The successful applicants will be tapped to support TA needs that may arise from this national JTAF model. It is expected that TA under this award, if provided, will be catalytic and responsive to improving community-based health services, SBC, and social accountability with the ultimate goal of improved health outcomes in select geographic areas.

Requests for the TA funds will be approved by USAID with concurrence from the MOH and observers from the development partner community where applicable. This approach to approval is to maximize external investments to the health sector and ensure streamlined TA for unified support to the MOH. The TA may include but are not limited to some of the following illustrative examples:

- Supporting improved health care provider interpersonal communication tools
- Standing up new technical systems or processes identified by USAID, MOH Federal or State Ministries of Health, State Primary Healthcare Development Agencies, LGAs, communities;
- Expanding the number or type of technical assistance interventions and/or training activities provided by the recipient; or
- Developing behavioral sentinel surveys, telephone polling for insights generation, monitoring, analysis, and assessments.

C.5 Strategic Alignment

USAID Alignment

This Activity will align with relevant Government of Nigeria (GoN) health strategies and contribute to the Development Objective (DO) 2 of USAID/Nigeria's Country Development Cooperation Strategy (CDCS) 2020-2025 of "a healthier, more educated population in targeted states". This Activity will lead in the implementation and support to all interventions that will be deployed at the community level. This activity will complement other USAID investments in the

human and animal health sectors in targeted geographic areas to reduce health gaps associated with geo-location, differences in income, education level, health seeking preference (i.e. assisted delivery by traditional birth attendants) among other factors. Through this activity, USAID will increase access to quality health including TB and nutrition services and increase capacity for early detection and reporting of priority diseases through trained, supervised, and motivated community health workers. This activity will ensure community health workers can confidently provide quality diagnostic and treatment services through robust training and supervision, using the required tools and supplies.

The apparently successful applicant(s) will be required to do joint annual work plan development and coordinate implementation with other USAID awards including the USAID Primary Health Improvement Program (UPHIP), USAID Digital Health Initiative (UDHI), USAID Human resources for health (HRH) and healthcare financing activity, USAID Integrated Delivery of TB Services (iDOTS) activity; USAID Malaria Service Strengthening activity; and upcoming Global Health Security (GHS) activities to leverage additional financing through those mechanisms for joint results reporting to USAID/Nigeria.

This Activity will be expected to provide a high-caliber technical support and advisory services to other USAID-funded health activities on SBC related products and deliverables. For example, through current investments, USAID's SBC and health systems activities collaborated to design a national campaign to drive health insurance enrollment numbers. Additionally, this Activity will provide demand-driven and need based technical assistance (TA) support to relevant GoN or private institutions, directly responsible for community health, SBC or health promotion and risk communication. Support will be prioritized for institutions/stakeholders that will be the closest to delivering community based health services, i.e. PHCs, LGAs and States. Such support may include the joint[31] identification and prioritization of technical assistance needs that are met through short- to -long term secondments of advisors, experts consultants or other TA approaches that deliver measurable results.

GoN Alignment

This Activity will align with relevant GoN health strategies The GoN, under its National Health Sector Renewal Initiative (NHSRI) seeks to strengthen the delivery and coverage of community-based services. Additionally, social accountability and citizen engagement are core to the NSHRI to ensure citizen responsive services and a continuous feedback loop with citizens and community members (Figure 4).

[31] Alongside government stakeholders, other development and implementing partners to assure alignment and non-duplication of assistance

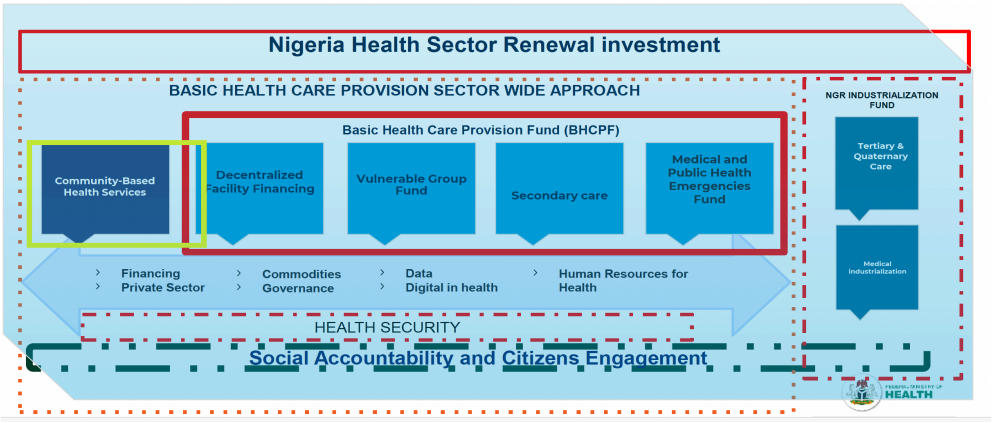


Figure 4: NHSRI Schema highlighting community-based health services, social accountability and citizen engagement components

As part of this vision, the GoN is actively redesigning a community-based health worker (CBHW) program. The redesigned CBHW program is envisioned to be a systemic approach to the delivery of health services at the community level with the frontline health worker serving as a link between the health facility and the community, and working in synergy with other community health system actors to drive social accountability and community ownership for health (Figure 5). This award will be USAID's investment to support delivery of the GoN's ambitions for community-based health services and social accountability, citizens engagement and health security through community-based surveillance (CBS).

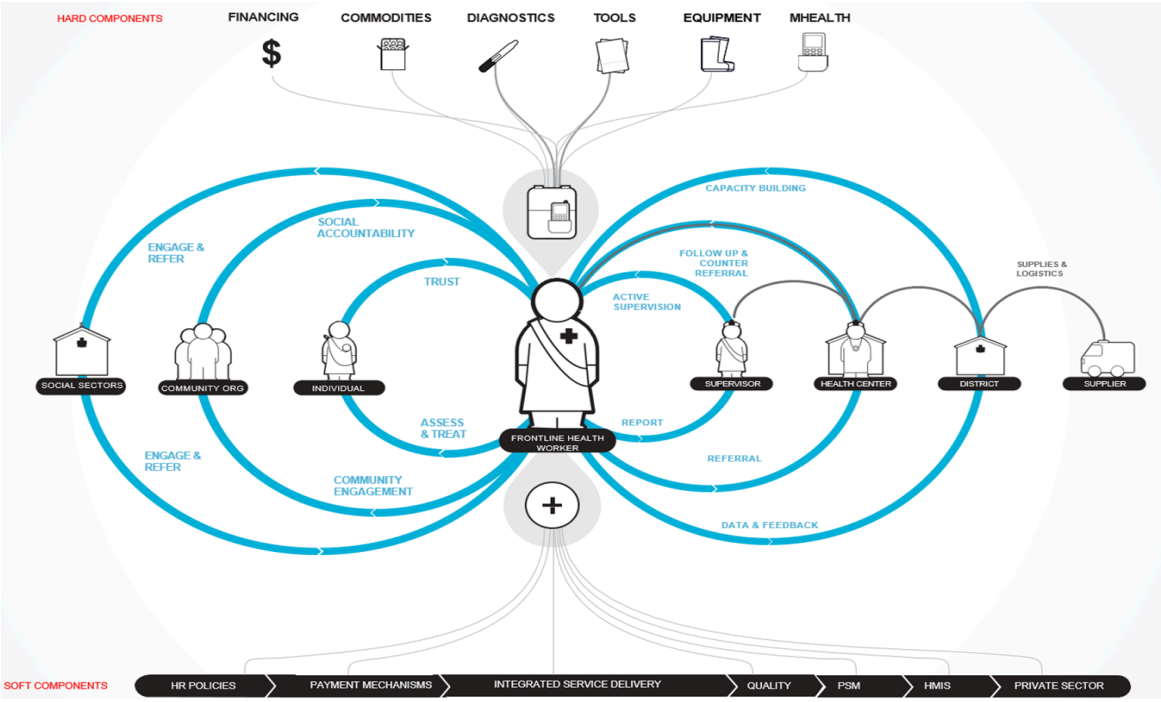


Figure 5: UNICEF's PHC and Community Health Systems Strengthening Schema

C.6 Activity Monitoring, Evaluation, and Learning (MEL)

Data is key to designing and refining evidence-based messaging, adapting and scaling community health worker programs and social accountability. Therefore, this Activity will work closely with other bilateral health and TB activities to design tools and apply approaches for rigorous program monitoring over the course of implementation. Monitoring will include complexity-aware methods to assess the effectiveness of interventions on an ongoing basis. This activity will develop and institutionalize course-correcting mechanisms as a standard of practice through innovative monitoring tools developed with local stakeholders. This approach will entail gathering real-time data including sex- and age-disaggregated population-level data. Sex-disaggregated data related to CHRPs recruitment, training and deployment shall be reported. Monitoring activities will facilitate the collection of outcome indicators and may be data points during external evaluation. This Activity will conduct analysis and triangulation of data sources e.g. demand, service uptake and commodity consumption data to inform coverage of community health and SBC interventions. This Activity will also triangulate climate, disease burden and service uptake data to inform proactive deployment of prevention messaging in advance of outbreaks or care seeking messaging for seasonal diseases like malaria.

C.6.1 Adaptive Management

Adaptive management is a structured, iterative process of robust decision-making in the face of uncertainty, with an aim to reduce uncertainty over time via system monitoring. This Activity will employ an adaptive management approach at all levels of programming, to ensure the activity remains flexible, responsive and effective in addressing the dynamic healthcare landscape and evolving needs of the communities it serves. This approach will facilitate continuous learning and improvement, enabling the program to achieve its goals more efficiently. Key principles of adaptive management include:

1. **Flexibility and responsiveness** demonstrated through *dynamic planning* - developing and maintaining a flexible work plan that can be adjusted based on real-time feedback and changing conditions on the ground as well as *agile implementation* - activity implementation in a phased manner, allowing for course corrections based on ongoing M&E;

2. **Continuous** l**earning and** i**mprovement** demonstrated through the establishment of *feedback loops* - mechanisms for regular feedback from beneficiaries, community gatekeepers and other stakeholders to inform program adjustments as well as through the cultivation of a *learning culture* **-** promoting learning within the program team and among partners, encouraging experimentation and sharing of lessons learned;

3. **Evidence-based decision-making** demonstrated through the use of *data-driven insights* - utilization of rapid pulse or perception surveys and continuing feedback to monitor fidelity of interventions or messages, identify challenges, and make informed decisions to course correct as well as *evaluative thinking* **-** regularly assessing program strategies and interventions through both formative and summative evaluations to understand their effectiveness and

4. **Stakeholder engagement and collaboration** demonstrated through *inclusive participation* - engaging a diverse range of stakeholders, including government entities, local communities, and partner organizations, in decision-making processes and *establishment of collaborative networks* - fostering collaboration and partnerships to leverage additional resources, expertise, and support for adaptive management activities.

The successful applicant shall develop a robust data collection system that includes adequate data quality controls and complies with all USAID/Nigeria data quality requirements, as outlined in ADS 201.3.5.8[32]. Each indicator in the final MELP will have a performance indicator reference sheet that provides detailed description of the indicator, the baseline, numerator and denominator where proportion/per cent measures are used and a data collection plan. The MEL Plan shall specify approximate dates for data collection, the method, type, and source of information to be collected, and shall report on these indicators in line with existing and future USG guidance. USAID/Nigeria plans to conduct evaluations of individual interventions/approaches, target populations and the implementation environment at different times as well as a comprehensive external evaluation of the activity during the fifth year of implementation.

C.6.2 Technical and Strategic Considerations

Applicants are expected to clearly demonstrate how each of the considerations below are incorporated into their application and technical approaches:

[32] chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://2012-2017.usaid.gov/sites/default/files/documents/1870/201.pdf

- *Attention to patterns in the adoption, practice, or maintenance of different behaviors as well as the behavioral theories proposed as a pathway to change.* Health behaviors vary widely in how often they must be enacted; by whom; at what financial, logistical, or social cost; and with what interpersonal agreement or support. For example, two behaviors from divergent health areas may be more like each other, in part because the same factors (e.g., gender norms and inequality) shape the behavior. Analyzing differences and similarities across different behavioral typologies offers potential for improved impact and cost-effectiveness. Some behaviors require consistent or repeat performance, tending towards a habit. Applicants are required to propose innovations in behavioral theories that underpin the design of interventions. Such theories may include those that support habit formation, e.g. for behaviors that require repeat performance.

- *Advance USAID Gender and Inclusive Development principles and priorities*: The 2023 USAID/Nigeria health sector gender and inclusion analysis and activity design gender analysis report provides insights into the multiple dimensions (behavioral and structural) within which gender and inclusion issues affect peoples' lives at the micro and macro level. Evaluations of current USAID/Nigeria health SBC investments reveal variations in exposure to, and impact of interventions with populations in the lowest wealth and educational attainment quintiles least exposed to, or least impacted by interventions. As part of baseline assessment, this Activity will complete an activity-level gender and inclusion analysis within targeted implementation areas. Findings will inform an intersectional lens and the determination of prioritized interventions to identify and expand coverage for unserved, underserved and inadequately served populations; invest in robust monitoring systems to collect appropriately disaggregated data to inform adaptive management; disability-friendly or assistive technologies or approaches to expand coverage among PWDs.

- *Localization[33] and local capacity development:* USAID/Nigeria' prioritizes deepening its commitment to being transparent, inclusive, and responsive to and supportive of local actors in leading their own development. To achieve this, this Activity will fully consider, and integrate relevant aspects of localization objectives and best practices, and contribute to measurable results as outlined in USAID's locally-led development, local systems, local capacity strengthening and local capacity strengthening policy.

[33] Localization at USAID is defined as intentional changes to policies, processes, staffing, and funding decisions to support partnerships and programs that equitably empower local actors, strengthen local systems, and facilitate local leadership so that development and humanitarian assistance are more effective and sustainable.

- *Meaningful Youth Engagement:* An enhanced focus on adolescents and youth is vital to USAID/Nigeria's ability to achieve the health and development goals of the CDCS 2020-2025. This Activity will advance the goals of USAID's Youth in Development Policy (2022) including, increasing the meaningful participation of youth within their communities, enhancing their technical and soft skills; providing opportunities for them to contribute to communities including employment as CHRPs; and fostering healthy relationships and leveraging their collective leadership.

- *Conflict Sensitivity:* As outlined in the country context of Attachment 1, Nigeria continues to grapple with conflict tensions as well as recurring health outbreaks or epidemics which disrupts and have substantial impact on health systems and actors and their capacity to deliver quality and accessible services and products in an equitable manner. The Activity will adhere to principles of Do No Harm and design a conflict sensitive approach to minimize the negative effects and to maximize the positive impacts of its proposed interventions on conflict dynamics. To have a conflict sensitive approach, the Activity must be designed and implemented with a thorough understanding of the conflict, cultural and political concerns of all stakeholders, and it will be important to understand that in some cases an intervention, while seemingly relevant and appropriate, may not be possible. Drawing on lessons learnt from the COVID-19 pandemic, appropriate agility and flexibility that allows for pivoting to alternative delivery methods may be necessary. Coordination with USAID, GoN and other donor funded activities for conflict and health shock monitoring and increasing community resilience will be essential. In striving to reduce conflict and to exemplify Do No Harm principles, interventions must be designed and implemented in a manner consistent with a conflict sensitive approach. The applicant must: (1) demonstrate an understanding of the context in which the intervention is working; (2) recognize how the proposed interventions interact with the context and (3) continually revisit the programming approach to ensure that no harm is being done and that interventions have positive outcomes that contribute to increased community cohesion and resilience. A context or conflict analysis, including a mapping of key stakeholders and "dividers and connectors," should be completed at the outset of Activity implementation, usually within 90 days after award, and continuously updated as part of the ongoing CLA process. Regular analyses will need to be conducted to ensure activities are not exacerbating tensions within and between communities, or between communities and government and staff are encouraged to be familiar with conflict sensitivity principles.

- *Private Sector Engagement (PSE):* Strategic and proactive PSE strengthens the design and implementation of promising solutions to jointly defined challenges and opportunities

that align with the interest of private sector players and increases opportunities for local resource mobilization and sustainable impact of investments at community level. The Activity will work closely with the private sector to increase their contribution in improving communities' health and provision of relevant health services.

- *Environmental Consideration:* The Initial Environmental Examination (IEE) for USAID/Nigeria Health, Population and Nutrition (HPN) and HIV and TB offices prepared in June 2021 through September 2026 covers this Activity. USAID has determined that "Categorical Exclusions" and "Negative Determination with Conditions" applies to the proposed interventions. The USAID AOR, with the support of the Mission Environment Officer (MEO), will be responsible for ensuring that where necessary the applicant develops an Environmental Mitigation and Monitoring Plan and budget prior to activity implementation. The Applicant shall be responsible for implementing all IEE conditions pertaining to all interventions funded under this award.

C.7 Geographical Location

For RMNCH+NM health areas, intervention locations will be co-creatively determined, post award and will be largely influenced by, and aligned with other complementary activities with a focus on service delivery and quality of care, commodity logistics and supply chain management, health financing and HRH, health information management, global health security and other related health investments. Such selections will take into consideration data driven priority geographic locations such as for zero dose populations and MAMII intervention LGAs.

For TB Community Health and SBC interventions, implementation will be in Kano, Lagos, Oyo, Osun, Akwa Ibom, Cross River, Katsina, Kaduna, Bauchi, Benue, Anambra and Taraba states. Where there are geographical overlaps, the applicant will propose an integrated activity covering all health areas. And in TB-only states, the applicant will propose TB-specific community health and SBC intervention packages.

C.8 Expected Performance Indicators, Targets, Baseline Data, and Data Collection

The expected performance indicators will be suggested by applicants that will be used to measure success over the life of the program. It is expected that final performance indicators and corresponding annual targets will be developed during the annual work plan co-creation, jointly with USAID and other key stakeholders.

[END OF SECTION C]

SECTION D: APPLICATION CONTENT AND FORMAT

D.1 Agency Points of Contact

Name: Maryam Abdullahi
Title: Acquisition & Assistance Specialist
Email: mabdullahi@usaid.gov

Name: Caraline DiNunzio
Title: Agreement Officer
Email: cdinunzio@usaid.gov

D.2 Questions and Answers

Questions regarding this NOFO should be submitted as indicated on the cover letter. Any information given to a prospective applicant concerning this NOFO will be furnished promptly to all other prospective applicants as an amendment to this NOFO, if that information is necessary in submitting applications or if the lack of it would be prejudicial to any other prospective applicant.

D.3 General Content and Form of Application

Each applicant must furnish the information required by this NOFO. The application process will include the following two (2) phases:

Phase 1: Concept Submission, and Oral Presentation, if invited

In Phase 1, interested applicants must submit a concept in the form of a slide deck presentation. Highly ranked applicants will be invited to present their concept orally. The concepts will be evaluated in accordance with the merit review criteria under Section E. Oral presentations will be reviewed in accordance with the merit review criteria under Section E. Following the oral presentation of concepts, USAID will request a full application from the highest rated applicants.

USAID will not cover expenses associated with travel or incurred in the preparation and submission of the concept slide deck, oral presentation, or full application.

Phase 2: Submission of Full Applications

Upon completion of Phase 1, a Request for Application (RFA) will be sent to the Apparently Successful Applicant(s) and provide additional instructions and detail for the full technical and business application. Subsequently, USAID/Nigeria will initiate negotiations regarding the anticipated costs associated with implementing the Program Description. The Apparently Successful Applicant(s) must furnish the information required by this NOFO and the subsequent Request for Application.

These applications will be evaluated, and an award will be prepared and shared with the Apparently Successful Applicant(s) for their review. USAID may request additional information from the applicant regarding their technical approach, organizational capacity, management framework, past performance, cost application, and certifications if required.

USAID retains the right to cancel negotiations and the award process at no cost to the Government.

D.4 Submission Method

Applications in response to this NOFO must be submitted no later than the closing date and time indicated on the cover letter, as amended. Late applications may be considered at the discretion of the Agreement Officer. Applicants must retain proof of timely delivery in the form of system generated documentation of delivery receipt date and time.

Applications must be submitted by email to abujasolicitations@usaid.gov. Email submissions must include the NOFO number and applicant's name in the subject line heading. In addition, for an application sent by multiple emails, the subject line must also indicate the desired sequence of the emails and their attachments (e.g. "No. 1 of 4", etc.). Applications and any modifications thereof must be submitted via email. The submissions must include the following in the subject line:

"USAID Community Health Activity NOFO No. 72062025RFA00003 [Applicants Name] Phase 1 Submission"

There may be a problem with the receipt of *.zip files due to anti-virus software. Therefore, applicants are discouraged from sending files in this format as USAID/Nigeria cannot guarantee their acceptance by the internet server.

D.5 Concept Format

In Phase 1, interested applicants must submit a concept in the form of a slide deck. The concept must demonstrate the applicant's capabilities and expertise with respect to achieving the goals of this program and should consider the requirements of this activity and the merit review criteria found in this NOFO.

The concept slide deck must comply with the following requirements:

- Length - Not exceed **20** slides
- Format - PowerPoint presentation or similar slide deck presentation saved in PDF format
- Language – English
- Font Type and Size - Calibri, the font size may be varied but no smaller than 12 points
- Include slide numbers

Only text in the slide deck will be reviewed, no links/hyperlinked documents will be read/reviewed or scored. The concept slide deck presentation must have a cover page, containing the following information:

- Program title;
- NOFO reference number;
- Name of organization(s) applying for the agreement;
- Any partnerships;
- Primary Contact Person and Alternate Contact Person (name, title, organization, mailing address, telephone number and email address and corresponding signatures);
- Proposed sub-recipients, collaborating organizations or partnerships, if any.
- Total Estimated Amount of Funding Requested from USAID;
- Proposed Period of Performance;
- Unique Entity Identifier (UEI) Number, if known.

The slide deck should include the following sections:

- Cover Slide (up to two (2) slides, not included in the 20-slide limit)
- Section I: Technical Approach and Management Capacity
- Section II: Responses to Case Studies on Activity Objectives
- Section III: Supporting Information

Section I: Technical Approach and Management Capacity

This section of the concept should address each of the following:

- Strategy. Describe the strategy to be used to achieve the proposed results. Outline steps towards human-centered approaches that promote integrated and sustainable programming across health areas.
- Theory of Change (TOC). Develop the TOC, describing underlying assumptions and adaptive management approach.
- Activity description and timeline. Describe the activities that will be undertaken to achieve the proposed results. Provide a high-level timeline of activities.
- Illustrative indicators. Propose a list of suggested indicators that will be used to measure success over the life of the program.
- Social, cultural, and demographic issues. Describe any social, cultural, or demographic issues that should be factored into the planning and implementation of the project (e.g. gender, age, literacy, culture, religion, minority populations, conflict, government policies etc.)
- Management Capability Statement: Describe the applicant's capacity to deliver results and coordinate effectively with other USAID and non-USAID implementing partners, GoN and USAID.

Section II: Responses to Case Studies on Activity Objectives

This section of the concept should provide concise responses to each of the following case studies and scenarios related to priority behavioral outcomes in Table 1 of Section C: Program Description:

A. Innovations to improve consistent use of Insecticide Treated Nets (ITN)

Consistent use (defined as use every night, all year round) of ITN is a proven cost-effective and efficient malaria prevention behavior. ITN use is influenced by a range of barriers and facilitators, and these vary by geopolitical zones and sub-populations. ITN access (defined as the proportion of households with access to one ITN for every two persons) is an important determinant of use. Despite improvements in access, use: access ratio (i.e. proportion of the population using nets, among those that have access to one within their household) varies across geopolitical zones, by subpopulations, wealth quintiles, residence (rural areas have higher ratios than in urban areas) and seasons (rainy or dry). Use: Access ratio also varies by socio-demographics with children under five and pregnant women prioritized for ITN use in households that do not have enough ITNs while men and boys have the lowest use, in this context. Using an example of Nasarawa state with one of the lowest use: access ratio of 0.3 (Malaria Indicator Survey, 2021):

- What are some of the strategies to increase the ITN use: access ratio in Nasarawa state, addressing the specific socio-cultural and demographic disparities, over the life of the activity?

B. Addressing gaps along the TB continuum of care

Despite progress in increasing TB case notifications over the past few years and an above average treatment success rate, gaps persist along the TB continuum of care and among the general and specific sub-populations. Additionally, TB prevention is a key strategy to reduce transmission and disease progression however, Nigeria is yet to record similar success as in case finding.

- How might we maximize SBC investments to address these gaps and ensure that all vulnerable and key populations with TB are screened, diagnosed and successfully treated while also increasing uptake of TB prevention measures?

Section III: Supporting Information

Organizational Chart: No more than 1 slide providing an overview of how the application proposes to house this project within the organization, including a graphic illustration of the Applicant's project management structure.

D.6 In-Person Oral Presentation, if invited

Based on USAID's merit review of the concept submission, the highest rated applicants will be invited to present their concepts orally.

Oral presentations will be held in Abuja, Nigeria; the details of the logistics for any oral presentations will be provided with the invitation letter. USAID will not cover expenses associated with travel or the presentation. The audience for the Oral Presentation will consist of the Merit Review Committee, the Agreement Officer, and other observers. The Agreement Officer will chair the Oral Presentations.

Oral Presentation Participants

The selected applicants are encouraged to include up to five (5) participants to present the concept orally, with a balanced representation of consortium members, if any. Participants must be physically present at the specified venue on the designated date and time mentioned in the invitation letter.

D.7 Full Application Instructions

Upon completion of Phase 1, the highest rated applicant(s) will receive a Request for Application (RFA), which will provide specific details for a full Technical and Business (Cost Application). Applicants will be requested to provide more detail in the full application.

Subsequently, USAID/Nigeria will initiate negotiations regarding the anticipated costs associated with implementing the Program Description. USAID retains the right to cancel negotiations and the award process at no cost to the Government.

D.8 Other NOFO Requirements

D.8.1 Unique Entity Identifier (UEI) and SAM.gov Registration

Each applicant, that does not have an exemption under 2 CFR 25.110, is required to:

1. Be registered in SAM.gov before submitting an application.
2. Maintain a current and active registration in SAM.gov at all times during which it has an active Federal award as a recipient or an application under consideration by USAID. The applicant or recipient must review and update its information in SAM.gov annually from the date of initial registration or subsequent updates to ensure it is current, accurate, and complete. If applicable, this includes identifying the applicant's or recipient's immediate and highest-level owner and subsidiaries, as well as providing information on all predecessors that have received a Federal award or contract within the last three years; and
3. Include its UEI in each application it submits to USAID. A UEI is a unique, alpha-numeric 12-character identifier issued and maintained by SAM.gov that verifies the existence of an entity globally. The UEI is the official government-wide identifier used for Federal awards.

The SAM registration process may take many weeks to complete. Therefore, applicants are encouraged to begin the process early. If an applicant is unable to obtain a UEI and complete SAM registration before submitting an application, the applicant may request an exemption in accordance with the instructions below. 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. Applicants can find additional resources for obtaining a UEI and registering in SAM on a blog post on WorkwithUSAID.gov.

Note: First-tier subrecipients (i.e., direct subrecipients) must obtain a UEI in order to receive a subaward but are not required to complete full SAM registration.

Requests for UEI/SAM exemptions: An applicant may include in its application (or separately in writing to the Agreement Officer) a request to be exempted from the above UEI and/or SAM registration requirements, if the criteria for one of the exceptions in 2 CFR 25.110 apply. The applicant may be required to submit additional justification or information in support of the request for an exemption. In certain cases where an exemption is approved, the selected applicant may still be required to obtain a UEI and/or register in SAM.gov within thirty (30) days after receiving the award.

D.8.2 Funding Restrictions

- Profit is not allowable for recipients or subrecipients under this award. See 2 CFR 200.331 for assistance in determining whether a sub-tier entity is a subrecipient or contractor.

- Construction will not be authorized under this award.

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

D.9 Pre-Award Term

D.9.1 Conscience Clause

"CONSCIENCE CLAUSE IMPLEMENTATION (ASSISTANCE) – SOLICITATION PROVISION (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 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 Provision)

D.9.2 Conflict of Interest Pre-Award Term

CONFLICT OF INTEREST PRE-AWARD TERM (August 2018)

a. Personal Conflict of Interest

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

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

b. Organizational Conflict of Interest

The applicant must notify USAID of any actual or potential conflict of interest that they are aware of that may provide the applicant with an unfair competitive advantage in competing for this financial assistance award. Examples of an unfair competitive advantage include but are not limited to situations in which an applicant or the applicant's employee gained access to non-public information regarding a federal assistance funding opportunity, or an applicant or applicant's employee was substantially involved in the preparation of a federal assistance funding opportunity. USAID will promptly take appropriate action upon receiving any such notification from the applicant.

(END OF PRE-AWARD TERM)

[END OF SECTION D]

SECTION E: APPLICATION REVIEW INFORMATION

E.1 Merit Review Process

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.

Merit Review Factors will be evaluated relative to each other, as described here and prescribed by the Technical Application Format. The full application will be scored by a Merit Review Committee (SC) using the criteria described in this section.

E.2 Phased Selection Process

PHASE 1: Concept Submission, and Oral Presentation, if invited

Concept Slide Deck Presentation

The concept slide deck will be reviewed by a Merit Review Committee according to the criteria described in E.3 below. USAID anticipates two (2) possible results from the concept merit review process:

- UNACCEPTABLE: An applicant's concept is UNACCEPTABLE when evaluated against the merit review criteria, the applicant is found to propose an unsound approach, and USAID has **Low Confidence** that the applicant understands the requirements and the applicant(s) will be unsuccessful in implementing the program. If UNACCEPTABLE, USAID declines the applicant providing an oral presentation.

- CONDITIONALLY ACCEPTABLE – An applicant's concept is CONDITIONALLY ACCEPTABLE when the applicant proposes a sound approach and USAID has **Confidence** that the applicant understands the requirements and will be successful in performing with no government intervention. Applicants that are rated as CONDITIONALLY ACCEPTABLE after review of the oral presentation slides will be invited to participate in an oral presentation.

Oral Presentation Evaluation, if invited

The purpose of the oral presentation is to better understand the applicant's concept and technical approach, as well as provide USAID an opportunity to pose clarifying questions. After the oral presentations, USAID will use the Merit Review Criteria to assign a final rating to applicants and determine whether the oral presentation addressed the strategic objectives outlined in Section C of the NOFO. Only oral presentations that are acceptable will move forward to Phase 2.

- ACCEPTABLE – The oral presentation is ACCEPTABLE when the applicant proposes a sound approach and USAID has **Strong Confidence** that the applicant understands the requirements and will be successful in performing with no or limited government intervention.

PHASE 2: Full Application

Details regarding the evaluation of the full application will be provided along with any Request for Application (RFA).

E.3 Merit Review Criteria

PHASE 1: Concept and Oral Presentation, if invited

For Phase I, the criteria listed below are presented in the order of importance as follows: criteria 1 and 2 are of equal importance and are both more important than criteria 3 and 4.

The criteria below reflect the requirements of this particular NOFO. Applicants must note that these factors serve as the standard against which the concept slide decks and oral presentation will be reviewed and evaluated.

Criterion 1: Technical Approach and Management Capacity

- The extent to which the Applicant's technical approach demonstrates a clear understanding of the Activity purpose and results and presents a comprehensive, feasible and sustainable strategic approach to achieving them.
- The extent to which the Applicant's technical approach demonstrates a clear and detailed statement of logic, assumptions, causal relationships, challenges, opportunities, and risks within the health sector in Nigeria and how the applicant's approach addresses them in order to reach the proposed results.

- The extent to which Applicant's proposed interventions demonstrate a mix of context relevant, proven, promising and innovative approaches and appropriate indicators that will lead to the achievement of program results.
- The extent to which Applicant's approach includes feasible approaches to enhance geographic and program coordination as well as plans to leverage other USG health and non-health activities to maximize project output.

Criterion 2: Responses to Case Studies on Activity Objectives

The extent to which the Applicant demonstrates use of available data and proposes insightful, proven and promising solutions to the specified questions on the case studies and scenarios.

Criterion 3: Management Framework and Institutional Capabilities

- The extent to which the applicant's approach to award management at both national and subnational levels demonstrates meaningful, collaborative, effective engagement.
- The extent to which the application demonstrates the methodology to propose a mix of consortium member organization that reflects the technical approach

Criterion 4: Organizational Structure and Staffing Approach

- The extent to which the organizational charts support the proposed technical approach
- The extent to which the Applicant organizational and staffing approach demonstrates project management decision making power closest to the level of implementation (national, state and LGA) to support adaptive management.

E.4 PHASE 2: Full Application Merit Criteria

Details regarding the evaluation of the full application will be provided along with any Request for Application (RFA).

E.5 Cost Evaluation

Following the technical evaluation process, a cost application will be requested from the apparently successful applicant/s. A review of cost realism will be conducted on the summary budget application. Cost will not be assigned a score but will be evaluated for general reasonableness, allowability, allocability and cost effectiveness to the proposed activity. The applicant's cost application will be evaluated to ensure it is realistic as a financial expression of

the proposed activity and does not contain estimated costs which may be unreasonable, unallowable and unallocable.

Cost negotiations will only be conducted with the apparently successful applicant. If a mutually satisfactory award cannot be negotiated, the Agreement Officer will notify the applicant that negotiations have been terminated, and the Agreement Officer will initiate negotiations with the second most technically acceptable applicant. This procedure will continue until a mutually satisfactory award has been negotiated.

The final cost application may be adjusted, for purposes of evaluation, based on the results of the detailed budget review and its assessment of credibility, completeness and for:

- Allowable Costs (2 CFR 200.403)
- Reasonable Costs (2 CFR 200.404)
- Allocable Costs (2 CFR 200.405)

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

The AO will perform a risk assessment (2 CFR 200.206). The AO may determine that a pre-award survey is required to inform the risk assessment in determining whether the prospective recipient has the necessary organizational, experience, accounting and operational controls, financial resources, and technical skills – or ability to obtain them – in order to achieve the objectives of the program and comply with the terms and conditions of the award. Depending on the result of the risk assessment, the AO will decide to execute the award, not execute the award, or award with “specific conditions” (2 CFR 200.208).

[END OF SECTION E]

SECTION F: FEDERAL AWARD ADMINISTRATION INFORMATION

F.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. The Agreement Officer is the only individual who may legally commit the Government to the expenditure of public funds. No costs chargeable to the proposed Agreement may be incurred before receipt of either a fully executed Agreement or a specific, written authorization from the Agreement Officer.

Following selection for award and successful negotiations with the apparently successful applicant, an electronic copy of the notice of the award signed by the Agreement Officer will be sent to the successful applicant, which serves as the authorizing document. The Agreement Officer will only do so after making a positive responsibility determination that the applicant possesses, or has the ability to obtain, the necessary management competence in planning and carrying out assistance programs and that it will practice mutually agreed upon methods of accountability for funds and other assets provided by USAID.

The award will be issued to the contact as specified in the application as the Authorized Individual in accordance with the requirements in the Representations and Certifications.

USAID reserves the right to perform a pre-award survey which may include but is not limited to: (1) interviews with individuals to establish their ability to perform agreement duties under the project conditions; (2) a review of the prime recipient's financial condition, business and personnel procedures, etc.; and (3) site visits to the prime recipient's institution.

F.2 Administrative & National Policy Requirements

The resulting award from this NOFO will be administered in accordance with the following policies and regulations. For Non-U.S. organizations: 2 CFR 200 Subpart E and Standard Provisions for Non-U.S. Non-governmental Organizations. Further requirements for this section will be communicated to the apparent successful applicant.

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

F.3 Co-Design

USAID will invite the Recipient(s) to develop the USAID Community Health Activity Year One work plan through a multi-stakeholder co-creation workshop after award. The Recipient(s) will be responsible for coordinating and hosting this workshop, in consultation with USAID.

ADS 201.6 defines co-creation as "a design approach that brings people together to collectively produce a mutually valued outcome, using a participatory process that assumes some degree of shared power and decision-making." Co-creation is a design approach that brings people together to collectively produce a mutually valued outcome, using a participatory process that assumes some degree of shared ownership and decision-making. By involving local organizations, the private sector, traditional USAID implementing partners, local experts, host country government officials, and other international donors during the co-creation process, co-creation can greatly enhance opportunities for increasing local ownership of USAID programming. Moreover, co-creation can also lower the programmatic risk that USAID will not achieve the intended results, because the activity design and implementation will be informed by engagement with a broader array of stakeholders.

USAID envisages an open, creative back-and-forth process with external experts and implementers to:

- build a strong analysis rooted in multiple, diverse perspectives and forms of expertise;
- promote multiple viewpoints that will help to identify parameters, prioritize focus areas, or identify opportunities for system collaboration;
- solicit the feedback, validation, and buy-in of multiple stakeholders;
- better understand local needs and constraints and encourage local communities to act; and approach development through a more inclusive, collaborative, creative, and open process.

F.4 Reporting Requirements

The programmatic reporting requirements below may be made part of any award issued under this NOFO. If timelines for submissions are not identified below, they will be determined by the AOR. More detail on each reporting deliverable will be included in the eventual award. The recipient must also consult with the AOR on the format and expected content of all reports prior to submission.

Illustrative Financial Reporting:

For awards other than fixed amount awards, the Standard Form 425 (SF-425) must be submitted via email. The Recipient must also submit a copy of SF-425 to the Agreement Officer, Agreement Officer's Representative, and the cognizant USAID/Nigeria Financial Payments office. Electronic copies of the SF-425, along with instructions, can be found at https://www.grants.gov/forms/forms-repository/post-award-reporting-forms.

- Quarterly Financial Report: Quarterly Financial Reports shall be due within 30 days following the end of each quarter corresponding to USAID's fiscal year from October 1 through September 30.

- Final Financial Report: The Final Financial Report shall be due within 120 days following the expiration of the award. Financial Reports shall be in accordance with 2 CFR 700.

Illustrative Performance Reporting:

i. **Annual Work Plan:** The recipient will develop an Annual Work Plan based on fiscal year within 60 days of the effective date of the award. For subsequent years, the recipient will submit an Annual Work Plan for the following year of implementation 30 days prior to the end of the preceding fiscal year. In developing the work plans, the recipient will be required to outline all ongoing activities, targets and/or benchmarks, and results to be achieved over the course of the year within each of those activities. The recipient is expected to engage the key and relevant stakeholders both at the national and county levels for joint work planning. The co-creation of the work plan should ensure that the activities proposed are aligned to the government and key stakeholders' priorities and results in inclusion to the national or local government institution's annual work plan, with estimated budget from all the stakeholders. This strategy should be embraced to promote self-reliance. The work plans will be structured for continual learning and adaptive management, so that lessons learned in the course of implementation and best practices shared from experiences in other implementation programs can be used to make adjustments for program improvement.

ii. **Activity Monitoring, Evaluation, and Learning Plan (AMELP):** The recipient will submit the AMELP informed by the program description, using a standardized Mission AMELP template to be shared after award. The AMELP for the first year of the Activity will be due within 90 days of award. The AMELP will indicate benchmarks and

indicators to measure progress for all interventions, including methods of data collection and analysis of the same. Evaluations and studies will be used to assess the effectiveness and impact of interventions towards the achievement of the stated activity results. The recipient will use the collaborating, learning and adapting (CLA) approach during the Activity's implementation. The CLA approach is based on the understanding that development efforts yield more effective results if they are coordinated and collaborative; test promising, new approaches in a continuous yet also rapid, targeted research for generating improvements and efficiencies; and build on what works and eliminate what doesn't work. The recipient will identify and monitor research and/or learning questions or evidence gaps, especially as they relate to key programmatic assumptions and/or the influence of external contextual conditions on activity impact and apply learning and evidence gathered to make adjustments and adaptations as deemed necessary during the implementation. Application of the new knowledge to implementation decisions will be reflected in the Activity Work Plans and AMELPs.

iii. **Quarterly Progress Report:** The recipient will submit quarterly progress reports 30 days after each fiscal quarter. The fourth quarter report shall be a cumulative annual report (i.e. for the fiscal year). Quarterly progress reports will summarize progress in relation to agreed targets or milestones contained in the Work Plan and report on all indicators in the AMELP. The report will also include a narrative that describes the overall impact of program activities with respect to the higher-level goals of the Activity. The report will specify any problems encountered and indicate resolutions or proposed corrective actions (for each corrective action, the recipient will designate responsible parties and establish a timeframe for completion). The report will list activities proposed for the next reporting period, noting where they deviate from the approved Work Plan and will provide information on accrued expenditures to date. Each progress report will also include the following: i) at least one snapshot or success story; ii) content for social media, such as text and photos for tweets, iii) any innovative approaches supported by the Activity and their impact on achieving results; iv) a discussion of how the Activity is utilizing local expertise and strengthening local capacity to achieve health systems strengthening and sustainability goals or results; v) linkages with other USAID and other donor programs and their impact on the results of this Activity.

iv. **Annual Reports:** Within 45 days after the close of each USAID fiscal year, the Recipient will submit to the AOR a comprehensive annual report that reflects the progress of program activities over the last year. (This report would complement, not

replace, the relevant quarterly reports.) The report, based on the approved PMP but not necessarily limited to such, should indicate the results and impact the program is having on the target beneficiaries.

v. **Final Report:** The recipient will submit a final report that covers the entire period of the award. It will be submitted 90 days after the expiration of the award and will include the following: i) a description of the cumulative results achieved; ii) final data compared to baseline data for all indicators included in the AMELP; iii) an assessment of the impact of the Activity, disaggregated by gender and age, and potentially highlighting vulnerable groups, as well as a summary of problems/obstacles encountered during the implementation and how those obstacles were addressed and overcome if appropriate; iv) a presentation of life-of-activity results towards achieving the Activity's objectives and the performance indicators, as well as an analysis of how the indicators illustrate the Activity's impact on improvement of health systems outcomes; v) recommendations regarding unfinished work and/or future needs and directions for improvement of health systems outcomes; vi) recommendations for what issues no longer require donor assistance; and vii) a summary of lessons learned and any particularly important success stories.

vi. **Close-out and disposition plan:** One hundred and eighty (180) days or 6 months prior to the end of the Agreement, the Recipient shall submit a closeout plan to the AOR and the Acquisition and Assistance Office. The closeout plan shall include: brief program summary; brief program timeline; financial status report; final Financial Status Report timeline; latest NICRA or indirect cost rates; anticipated balance of federal funds after expiration of the instrument; final inventory of residual non-expendable property, which was acquired or furnished under the instrument; program and activity end date; recipient responsibilities during phase out; Subawardees and/or partnership phase out; status of all program audit reports per the instrument's provisions; final audit report timeline; final report timeline; personnel phase-out timeline; personnel phase-out plan; and job descriptions for personnel anticipated to serve during the closeout phase.

vii. **Branding and Marking Plan:** The Recipient shall include a branding and marking plan to be evaluated and approved by the Agreement Officer, in consultation with the Mission with concurrence from the Agreement Officer's Representative (AOR), due no later than 30 days after the award is made, in full compliance with ADS 320. Please refer to ADS 320, (http://www.usaid.gov/policy/ads/300/) specifically ADS 320.3.3.3 for more information. Additionally, marking shall comply with the USAID "Graphic

Standards Manual" available at: www.usaid.gov/branding, or any successor branding policy.

viii. **Development Experience Clearinghouse Requirements:** Development Experience Clearinghouse Requirements: The Recipient shall be required to submit any technical reports produced under this program, in English, to USAID's Development Experience Clearinghouse (DEC) according to the instructions found at https://dec.usaid.gov/dec/content/submit.aspx.

[END OF SECTION F]

SECTION G: FEDERAL AWARDING AGENCY CONTACT(S)

G.1 Agency Points of Contact

Any questions or comments concerning this NOFO must be submitted in writing by email to abujasolicitations@usaid.gov by the deadline for questions indicated at the top of this NOFO's cover letter. Please copy the below points of contact on any emails sent to abujasolicitations@usaid.gov.

Name: Maryam Abdullahi
Title: Acquisition & Assistance Specialist
Email: mabdullahi@usaid.gov

Name: Caraline DiNunzio
Title: Agreement Officer
Email: cdinunzio@usaid.gov

Any prospective applicant desiring an explanation or interpretation of this NOFO must request it in writing by the deadline for questions specified in the cover letter to allow a reply to reach all prospective applicants before the submission of their applications. Any information given to a prospective applicant concerning this NOFO will be furnished promptly to all other prospective applicants as an amendment of this NOFO, if that information is necessary in submitting applications or if the lack of it would be prejudicial to any other prospective applicants.

G.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

[END OF SECTION G]

SECTION H: OTHER INFORMATION

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

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

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

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

[END OF SECTION H]

ANNEX A - ABBREVIATIONS AND ACRONYMS

ADS	Automated Directory System
AMELP	Activity Monitoring, Evaluation, and Learning Plan
AO	Agreement Officer
AOR	Agreement Officer Representative
BHCPP	Basic Health Care Provision Program
BMP	Branding and Marking Plan
CBS	Community Based Surveillance
CBOs	Community Based Organizations
CBHW	Community-Based Health Workers
CBHRP	Community-based Health Resource Persons
CCR	Cross Cutting Results
CDC	Community Development Committee
CDCS	Country Development Cooperation Strategy
CFR	Code of Federal Regulations
CHMIS	Community Health Management Information Systems
CHIPS	Community Health Influencers Promoters and Service
CHW	Community Health Workers
CLM	Community-Led Monitoring
CLA	Continuous Learning and Adaptation
COP	Chief of Party
CRRP	Community-based Health Resource Persons
CSO	Civil Society Organizations
DEC	Development Experience Clearinghouse
DO	Development Objective
FBOs	Faith-Based Organizations
FP	Family Planning
GBV	Gender Based Violence
GFF	Global Financing Facility
GHS	Global Health Security
GHWI	Global Health Workforce Initiative
GoN	Government of Nigeria
HAT	HIV and TB
HMIS	Health Management Information System
HPN	Health Population and Nutrition
HRH	Human Resources for Health
HSS	Health System Strengthening

IEE	Initial Environmental Examination
IPT	Intermittent Preventative Therapy
IR	Intermediate Result
ITN	Insecticide Treated Nets
JCHEWs	Junior Community Health Extension Workers
JTAF	Joint Technical Assistance Fund
LGA	Local Government Areas
LOE	Level of Effort
MAMII	Maternal Mortality Reduction Innovation and Initiatives
MCH	Maternal and Child Health
MEAM	Monitoring, Evaluation and Adaptive Management
M&E	Monitoring and Evaluation
MEL	Monitoring Evaluation and Learning
MELP	Monitoring, Evaluation and Learning Plan
MEO	Mission Environmental Officer
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MUAC	Middle Upper Arm Circumference
NAPHS	National Action Plan for Health Security
NCDC	Nigeria Centre for Disease Control
NDHS	National Demographic Health Survey
NGOs	Non-Governmental Organizations
NMEP	National Malaria Elimination Program
NOFO	Notice of Funding Opportunity Number
NPHCDA	National Primary Health Care Development Agency
NSHRI	National Health Sector Renewal Initiative
NTBLCP	National Tuberculosis and Leprosy Control Program
PD	Program Description/Project Director
PHC	Primary Health Care
PPMV	Patent Proprietary Medicine Vendors
PSE	Private Sector Engagement
PWD	Persons living with Disabilities
PZD	Priority Zoonotic Diseases
Q&A	Question and Answer
QR	Quarterly Report
RCCE	Risk Communication and Community Engagement
RMNCAH+NM	Reproductive Maternal Newborn Child Adolescent Health, Nutrition and Malaria

SAM	System for Award Management
SBC	Social Behavior Change
SC	Selection Committee
SIR	Sub-Intermediate Result
SOP	Standard Operational Procedures
SWaP	Sector-Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TEC	Total Estimated Cost
TOC	Theory of Change
UDHI	USAID Health Data Initiative
UCHA	USAID Community Health and Social and Behavior Change
UEI	Unique Entity Identifier
UHC	Universal Health Coverage
UPHIP	USAID Primary Health Care Improvement Program
USAID	U.S. Agency for International Development
USG	United States Government
VDC	Village Development Committees
WAT	West Africa Time
WDC	Ward Development Committees
WHS	Ward Health System

[END OF ANNEX A]

ANNEX B - STANDARD PROVISIONS

The selected applicant will be required to comply with USAID's standard provisions. The standard provisions included in the resultant award will be dependent on the organization that is selected or, in the case of a fixed amount award, the type of award.

The full text of these provisions may be found on USAID's website here:

- Standard Provisions for non-U.S. Nongovernmental Organizations: https://www.usaid.gov/ads/policy/300/303mab, and

The resultant award will include the full text of current Mandatory Standard Provisions and the Required As Applicable Standard Provisions. **The required as applicable standard provisions will be required if checked below.**

Required as Applicable Standard Provisions for Non-U.S. Nongovernmental Organizations

Required	Not Required	REQUIRED AS APPLICABLE STANDARD PROVISIONS Non-U.S. NGOs
Determined at award		RAA1. Advance Payment and Refunds (August 2024)
Determined at award		RAA2. Reimbursement Payment and Refunds (August 2024)
Determined at award		RAA3. Indirect Costs – Negotiated Indirect Cost Rates Provisional & Final (August 2024)
Determined at award		RAA4. Indirect Costs – Charged As A Fixed Amount (Nonprofit) (August 2024)
Determined at award		RAA5. Indirect Costs – De Minimis Rate (August 2024)
	X	RAA6. Reserved
X		RAA7. Reporting Subawards and Executive Compensation (August 2024)
X		RAA8. Subawards (August 2024)
X		RAA9. Travel and International Air Transportation (December 2014)
X		RAA10. Ocean Shipment of Goods (June 2012)
X		RAA11. Reporting Host Government Taxes (December 2022)
X		RAA12. Patent Rights (December 2022)

Required	Not Required	REQUIRED AS APPLICABLE STANDARD PROVISIONS Non-U.S. NGOs
	X	RAA13. Reserved
	X	RAA14. Investment Promotion (December 2022)
	X	RAA15. Cost Sharing (August 2024)
	X	RAA16. Program Income (August 2024)
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 2022)
	X	RAA29. Reserved
	X	RAA30. Reserved
X		RAA31. Never Contract with the Enemy (August 2024)

[END OF ANNEX B]

[END OF NOFO NO. 72062025RFA00003]