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| Issuance Date: | February 2, 2012 |
| Deadline for submission of Questions: | February 14, 2012 4pm EST (Washington, DC) |
| Anticipated date of response to Questions: | On or about February 20, 2012 |
| Closing Date for Application Submission: | March 9, 2012 |
| Closing Time: | 4pm EST (Washington, DC) |
| Anticipated Announcement and Award Dates: | April 2012 |
| Place of Performance: | Uganda |

**Subject: Request for Application (RFA) Number RFA-617-12-000005: "Northern Uganda– Health Integration To Enhance Services (NU-HITES)"**

The United States Agency for International Development (USAID) Uganda is seeking applications to fund one or more organizations through a Cooperative Agreement for a five-year USAID/Uganda health service integration program in Uganda as described in Section I of this RFA. The authority for the RFA is found in the Foreign Assistance Act of 1961, as amended. Subject to the availability of funds, USAID intends to provide approximately $50 million in total USAID funding to be allocated over the five-year period. USAID reserves the right to fund any or none of the applications submitted and expects one award as a result of this solicitation; however, more than one award may result.

This is a full and open competition, under which any type of organization, large or small, commercial (for-profit) firms, faith-based, and non-profit organizations in partnerships or consortia, are eligible to compete. In accordance with the Federal Grants and Cooperative Agreement Act, USAID encourages competition in order to identify and fund the best possible applications to achieve program objectives.

For the purposes of this RFA, the term "Grant" is synonymous with "Cooperative Agreement"; "Grantee" is synonymous with "Recipient"; and "Grant Officer" is synonymous with "Agreement Officer".

Pursuant to 22 CFR 226.81, it is USAID policy not to award profit under assistance instruments. However, all reasonable, allocable, and allowable expenses, both direct and indirect, which are related to the grant program and are in accordance with applicable cost standards (22 CFR 226, OMB Circular A-122 for non-profit organizations, OMB Circular A-21 for universities, and the Federal Acquisition Regulation (FAR) Part 31 for-profit organizations), may be paid under the grant.

This RFA and any future amendments can be downloaded from http://www.grants.gov. Select "Find Grant Opportunities," then click on "Browse by Agency," and select the "U.S. Agency for International Development" and search for the RFA. In the event of an inconsistency between the documents comprising this RFA, it shall be resolved at the discretion of the Agreement Officer. If you have difficulty registering or accessing the RFA, please contact the Grants.gov Helpdesk at 1-800-518-4726 or via e-mail at support@grants.gov for technical assistance.

Any questions concerning this RFA should be submitted in writing to KampalaUSAIDSolicita@usaid.gov, by the date stated above. Questions sent to any other e-mail address will not be answered. The e-mail transmitting the questions must reference the RFA number and title on the subject line of the e-mail. The deadline for receiving questions is

**February 14, 2012.** Applicants are requested to submit both Technical and Cost Proposals of their applications in separate volumes. Award will be made to that responsible applicant whose application offers the best value to the Government. Please note, however, that technical application will be significantly more important than cost.

If you decide to submit an application, please note that electronic submission is required. Applications should be sent as email attachments to KampalaUSAIDSolicita@USAID.gov, to the attention of Godfrey Kyagaba, A&A Specialist and Tracy Miller, Agreement Officer. Late applications will not be considered for award. Applications must be directly responsive to the terms and conditions of this RFA. Telegraphic or fax applications (entire proposal) are not authorized for this RFA and will not be accepted.

An applicant under consideration for an award that has never received funding from USAID may be subject to a pre-award survey to determine fiscal responsibility, capacity, and ensure adequacy of financial controls.

Award will be made to that responsible applicant whose application best meets the requirements of this RFA and the selection criteria contained herein.

Issuance of this RFA does not constitute an award commitment on the part of the Government, nor does it commit the Government to pay for costs incurred in the preparation and submission of an application. Further, the Government reserves the right to reject any or all applications received. In addition, final award of any resultant grant cannot be made until funds have been fully appropriated, allocated, and committed through internal USAID procedures. While it is anticipated that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for award. Applications are submitted at the risk of the applicant. Should circumstances prevent USAID from making an award, all preparation and submission costs are at the applicant's expense.

Sincerely,

Tracy J. Miller
Agreement Officer.

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## SECTION I – FUNDING OPPORTUNITY DESCRIPTION

## PROGRAM DESCRIPTION

### I.1 EXECUTIVE SUMMARY

With a new five-year Country Development Cooperation Strategy (CDCS) (2011-2015) in place, USAID/Uganda, in consultation with the Uganda Ministry of Health (MOH), Ministry of Local Government (MOLG), other development partners, and district-level stakeholders, is issuing this Request for Applications (RFA). The purpose of the NU-HITES is to continue technical assistance and capacity building support similar to that provided under the Northern Uganda Malaria, AIDS and Tuberculosis (NUMAT) project, integrate additional support in Maternal, Neonatal and Child Health (MNCH), Family Planning (FP) and nutrition; while prioritizing the strengthening of district-level health systems.

NU-HITES is envisioned to serve as USAID's key partner in the coming five years to support improvements for a health system able to meet the health needs of the northern Uganda population. As the north continues its transition from post-conflict to a more stable development setting, USAID is also transitioning its modes of support from humanitarian approaches that provide basic service provision to one of longer-term partnership with local structures and systems to ensure greater sustainability of social sector services. In this vein, the program will focus on supporting District governments to enable them to meet their primary responsibility for the provision of public sector health services. However, while public sector services and leadership are necessary, they are not sufficient to meet the population's health needs. Therefore, NU-HITES will also support the growth and acceleration of a vibrant and sustainable private health sector that aims to serve the health needs of the northern Uganda population through innovations in service provision while complementing the public sector. Underpinning this support of both the public and private sector to strengthen health services in the north will be a shift from the current NUMAT program's focus on infectious disease to an integrated focus on ensuring that quality primary health services are available, accessible, and affordable at different levels of the health system.

Specifically, NU-HITES goal is the improved and sustained health and nutritional status of northern Uganda population through strengthening a district-based integrated package of quality health services. The expected program objectives are as follows: 1) Increased use of quality health services at facility and community level by women, girls and children (Health Service Delivery); and 2) Strengthened systems for effective and sustainable delivery of quality health services (Health System Strengthening). This Program Description describes the geographic scope and strategic approach of this new project, its goal, objectives, and expected outcomes.

### I.2 GUIDING PRINCIPLES

NU-HITES will be challenged to work in the context of several overlapping initiatives and priorities of both the GOU and USG. First, NU-HITES will support strengthening the GOU's public health system, as USAID has committed to do through the signing of the International Health Partnership Plus Compact 2010-2015, which aligns donor support to the Health Sector Strategic and Investment Plan (HSSIP). This support to country

systems will be carried out while also ensuring adherence to the requirements of multiple U.S. Presidential Initiatives. However, the confluence of common goals and principles between both USG and GOU priorities offer tremendous opportunities to significantly improve the capacity and sustainability of the health system while concurrently improving the health status of the people of northern Ugandan via continuation and improvement of critical health services. In order to balance these demands, the following five guiding principles will be applied in the implementation of this program and will be demonstrated in approaches proposed by the Recipient:

**1) Enabling a country led, owned, planned and managed program.** The Recipient will coordinate and align with local governments and health officials in focus districts, taking a tailored approach to support of districts based on their capacity, leadership, and established processes to support the health system. This includes planning for inevitable changes in district leadership and capacity throughout the program across different districts. USAID staff in the Mission's Gulu field office will play a key role in facilitating this collaboration between USAID partners and district health management

**2) Flexibility and adaptability to collaborate with a variety of other partners focused on district-level health improvements and health system strengthening**. This includes strategic and logistical coordination among stakeholders and collaboration with other donors and development partners (DFID, JICA, UNICEF, World Bank, UNFPA, etc.), active collaboration with other USG partners in health system strengthening and service delivery working in both northern districts and at the national level where applicable, and seeking linkages and coordination where feasible with USG agriculture, democracy and governance programs working in northern Uganda districts and communities.

**3) Capacity and experience in technical assistance, quality improvement, and service delivery approaches aimed to maximize integration** of service delivery and programming based on the health needs of beneficiaries and services required at different levels of the established health system. A sound understanding of Uganda's health delivery system as well as strong technical competence across a wide array of infectious disease, primary health care, and key systems strengthening areas is required.

**4) Partnership-building strategies to engage the private sector and accelerate their role in northern Uganda's health system.** The Recipient will promote private sector engagement, forge public-private partnerships, and increases communication and collaboration across the public and private sectors to register a more comprehensive and collective response to facing the health systems challenges in northern Uganda.

**5) Inclusion of community involvement as a critical input to improving health outcomes and systems**. The Recipient will place the community at the core of leadership in addressing key preventive and care services at the local level, to serve as critical advocates within northern Uganda for improved health services, and to play a central role in improving key health seeking behaviors among communities in northern Uganda.

## I.3 DEVELOPMENT HYPOTHESIS AND PROGRAM OBJECTIVES

### I.3.1 Development Hypothesis

It is expected that supporting critical health systems in both the public and private sector that are essential to service delivery, while improving integration of HIV/AIDS, TB, malaria, MNCH, FP, and nutrition services at facility and community levels will improve the health and nutrition status of the population of northern Uganda.

The following development hypotheses will be tested during program implementation:

- Effective and efficient integrated health service delivery at facility and community level will improve health outcomes for individuals; and
- Strengthened health systems in and of themselves will result in improved health delivery and outcomes.

Also, in line with USAID/Uganda's CDCS, population growth is a game-changing issue in northern Uganda. Therefore, in addition to the needed continued focus on preventing and controlling infectious disease, special emphasis will be given to expand critical gaps in MNCH and FP services in northern Uganda.


*Map of target districts in northern Uganda*

### I.3.2 Geographic Focus

NU-HITES will be implemented in northern Uganda, comprising of 15 districts in Acholi and Lango sub region. These are Nwoya, Gulu, Amuru, Kitgum, Lamwo, Pader and Agago (Acholi sub region); Lira, Otuke, Oyam, Kole, Apac, Alebtong, Dokolo and Amolatar (Lango Sub region). The boundaries of the districts have been determined as per the new demarcation of July 2010.

According to population projections based on the 2002 Uganda Census, the target area has a population of about 3,390,100 (10% of the total Ugandan population). Estimates of target groups are as follows: 180,000 pregnant mothers, 780,000 women in child bearing age, 650,000 children under five years of age, and 280,000 HIV positive individuals.

### I.3.3 Planned Strategic Approach

In line with the Guiding Principles, as outlined below, and understanding the key

relationships needed across a variety of stakeholders, the Recipient will share their vision for the health sector in northern Uganda in the coming five years. The Recipient will describe a clear vision of the achievements possible in public sector service delivery, led by district leadership and management, the role the private sector will play in achieving sustainable health outcomes and systems, and the role that development partners such as USAID should plan to continue to serve after five years of this substantial investment. The program will include the following:

*1) District-Ownership*
Recipients are required to clearly state the level, including the tier of district structure at which the proposed interventions and activities are targeted, and how these enable the district administration to fulfill its primary responsibility to deliver quality health services, including:

a. District Health Officer and District health management team (DHMT)
b. Sub-districts and hospitals, if any
c. Health centers IV, III and II
d. Community-level health structures include Village Health teams (VHTs), other community resource persons and Community Based organizations (CBO).

Included in the strategic approaches related to district ownership, the Recipient will develop approaches to working with district health structures at different levels of functionality and possibly, overall commitment. For example, the Recipient may develop a tier of engagement with districts, illustratively described below:

a. Worst performing institution and / or poor cooperation: Only life-saving activities and prior commitments under various initiatives to continue (e.g. people on ARVs);
b. Average performing institution with activity based (partial) cooperation: All technical assistance to improved service delivery activities is supported; only limited support to the institutional management; and
c. High performing institution with full partnership: All technical assistance to improved service delivery activities supported; plus, targeted capacity building and funding for selected institutional priorities within the manageable interest.

*2) Private-sector engagement*
Recipients are required to demonstrate their approach to building the capacity of the private health sector to meet a greater share of the need for quality health services, in a sustainable manner that addresses issues of equity in accessing services. In addition to public-private partnerships as previously described, USAID is keenly interested in performance-based innovation, including but not limited to the following approaches: performance-based contracting, improved program effectiveness from Information and Communication Technology including M-Health. Inclusion of specific approaches to increase private sector engagement and innovation are expected.

### I.3.4 Gender

The Uganda Gender Policy (1997) is an integral part of the national development policies. It is a framework for redressing gender imbalances as well as a guide to all development practitioners. However, despite strong efforts made by the GOU and its development partners to address gender inequities, wide variations still remain between men and women and girls and boys with regard to access to health services, employment, nutrition, education and economic security. HIV prevalence for women is

nearly twice that of men nationwide, speaking to biological factors that increase the likelihood of transmission, but also social factors related to sexual behavior such as gender violence and alcohol use/abuse. 60% of women aged 15-49 experience physical violence, 39% sexual violence and 16% have experienced violence during pregnancy (UDHS 2006). The burden for family care placed on women and girls across an array of health issues from HIV to malaria to under-nutrition limits women and girls' time and independence. The high total fertility rate at 6.9 has a bearing on the rapidly increasing growth rates (3.3%) per annum, which in turn has negative consequences on provision of health services for women and increases the dependence ratio. The high incidence of teenage pregnancies is associated with high risks to health and life of both mother and child (The Uganda gender Policy 2007). As a signatory to the International Conference on Development and Population (ICDP) (1994), the U.S. Government is committed to promotion of sexual and reproductive health rights by putting gender relations at the center of health and population interventions. Sexual and Gender Based Violence (SGBV) and sexual exploitation appear to be widespread and increase the risk of young girls and women to HIV/AIDS, Sexually Transmitted Infections (STI)s, unintended pregnancies, and unsafe delivery. Men tend to occupy the vast majority of leadership and decision making positions in the home and the community. USAID/Uganda recognizes and accommodates the cultural realities that men seek health care and practice preventive care less often than women. The Recipient will propose approaches to deal with the burden women face in caregiving, their reduced decision-making authority in many settings, while also addressing the low uptake of health services by men, either for themselves or on behalf of their families and partners. Gender approaches should focus on increasing access to quality health services by women, girls and children.

### I.3.5 Youth

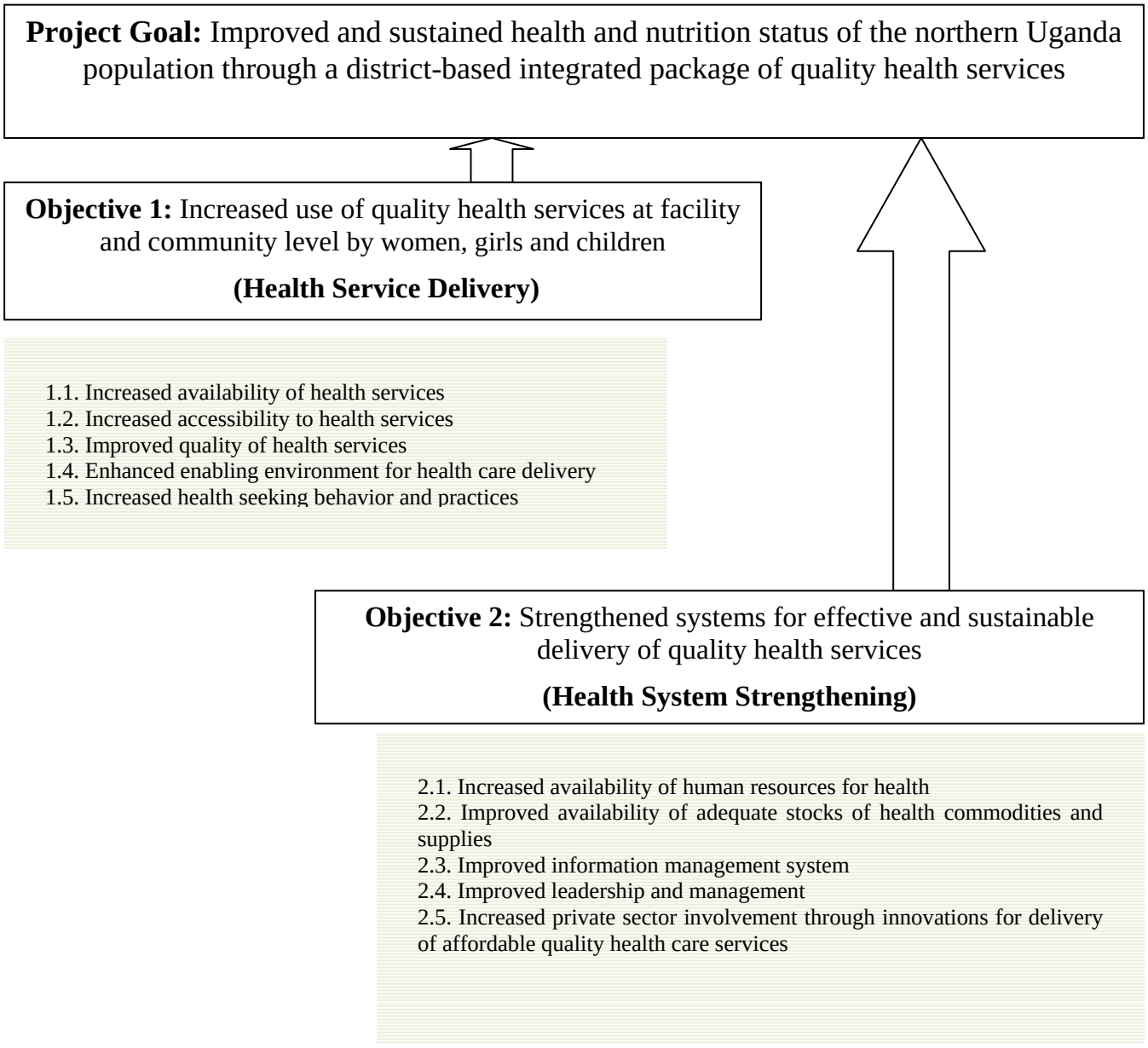
USAID/Uganda identified youth as one of three game-changing issues in the CDCS. The program should include, but not necessarily be limited to, addressing specific adolescent sexual and reproductive health information and services, in line with the GOU developed policies, structures, programs and partnerships to address the needs of youth.

### I.3.6 Project Framework

Interventions should focus on achieving the project goal and objectives laid out in the following "Project Framework" diagram. These goals and objectives are, in turn, intended to support the USAID/Uganda Country CDCS Health DO3 through achievement of the following Intermediate Results - IR 3.1: More effective use of sustainable health services, IR 3.1.1 Health seeking behavior increased, IR 3.1.3: Increased availability of health services, and IR 3.1.3.1: Enhanced enabling environment for health care.

While Recipients are required to focus on achieving the objectives specified in this RFA, Recipients are encouraged to think strategically and creatively about the best means to achieve these. USAID/Uganda is amenable to modifying the following Project Framework to align with the strategic approaches and activities laid out in the successful application. Recipients are reminded that the Project Framework forms the basis for the Cooperative Agreement's reporting and performance monitoring, including the Performance Monitoring Plan (PMP), which must feed directly into the DO3 PMP, and USAID's PMI, FTF and PEPFAR indicators.

**Project Framework Diagram**



### I.3.7 Project Goal, Results and Potential Activities

**Goal**
The Project goal is "the improved and sustained health and nutrition status of northern Uganda population through a district-based integrated package of quality health services, including system strengthening, integrated services for HIV/AIDS, tuberculosis, malaria, maternal, newborn and child health, reproductive health and family planning, and nutrition, for the fulfillment of the health sector's contribution to the National Development Plan and Millennium Development Goals (MDGs). It is expected that implementation of this program will contribute to reduced mortality and morbidity and further prevent occurrences of infectious diseases in the target area.

**Objective 1: Increased use of quality health services at facility and community level by women, girls and children**
This objective will be achieved through 5 sub-objectives. Achieving this objective will require collaboration with other USAID implementing partners.

**Sub-objective 1.1:** Increased availability of health services
**Expected outcomes**

- Increased availability of high-quality comprehensive package of preventive and curative health services at all levels of health facilities; and
- Increased availability of appropriate integrated high-impact interventions at community level.

**Sub-objective 1.2:** Increased accessibility to health services
**Expected outcomes**

- Improved capacity of health providers to deliver client-centered, customer-friendly services with dignity and respect;
- Client-centered, customer-friendly services through innovations and appropriate strategies; and
- Increased access of vulnerable groups and their families to prevention, care and treatment as well as wrap around services (household livelihoods, economic capacity and generate income, food supply and home garden, education and skill develop, clean water and sanitation, voluntary family planning, child health and nutrition).

**Sub-objective 1.3:** Improved quality of health care services
**Expected outcomes**

- Increased operation of national policies, procedures, guidelines and standard operating procedures for service provision;
- Increased effective capacity development, support supervision and mentoring at all levels; and
- Improved quality management approaches to health services at facility and community level.

**Sub-objective 1.4:** Enhanced enabling environment for health care delivery
**Expected outcomes**

- Increased advocacy by local communities and community organizations for better health service delivery; and

- Increased community participation and mobilization for health care services.

**Sub-objective 1.5:** Increased health seeking behavior and practices
**Expected outcomes**

- Improved appropriate health care-seeking behavior and increased adoption of positive health behaviors for risk reduction; and
- Improved home/community-based hygienic and preventive health practices with a special focus on the high impact interventions.

Specific considerations and requirements to achieve Result 1:

- The Recipient will not be expected to procure any of the following commodities, as they will be provided through existing USAID procurement mechanisms: ARVs and OI drugs, contraceptive commodities, ACTs and RDTs, bed-nets, and Ready to Use therapeutic foods (RUTF). NU-HITES will work with USAID, the GOU, and other partners as applicable to ensure adequate supplies of commodities to achieve stated results

In addition to consolidating upon achievements by the NUMAT program as previously stated, other specific program areas in Result 1 include:

- Nutrition: The USAID NuLife program (now completed) provided treatment for global acute malnutrition, including Ready-to-Use Therapeutic Foods (RUTF) at two (2) district hospitals in the target area. The supply for RUTF to these facilities will continue and the expectation is that the Recipient will continue to support treatment of malnutrition in these facilities, and propose limited geographic expansion of treatment sites. Community-level nutrition-related activities will be covered by the Community Connector and SCORE programs. The Recipient will need to closely align any proposed nutrition activities, particularly community-level activities in those districts with these implementing partners, and provide referrals (or receive referrals) where appropriate.

- OVC: If OVCs accessing healthcare services also require legal support (e.g. as a result of abuse), the Recipient will provide referrals to SUNRISE services in the nine (9) target districts covered by that project.

- Quality Management: HCI is currently implementing quality-management activities in five (5) target districts currently which will conclude in 2012. The Recipient will be expected to ensure continuity for these activities, by closely coordinating activities with the HCI implementing partner.

- Enhanced Enabling Environment: This program currently in design will bear large responsibility for improved enabling environment in collaboration with NU-HITES, requiring close collaboration between the two programs.

Health Seeking Behaviors: USAID's new Health Communications Program will provide technical assistance to the NU-HITES Recipient in implementing district-level BCC activities as this program works to harmonize BCC materials at the national level with the MoH. The Recipient will be required to use the materials and tools developed by the

current HCP program as well as the new Health Communications Program in executing BCC activities where feasible. Where an established UHMG franchised (Good Life) clinic exists, the Recipient will incorporate it into its HCT strategy for the area. The Recipient will also promote socially marketed products by coordinating community campaigns and other events with UHMG.

**Objective 2: Strengthened systems for effective and sustainable delivery of quality health services**

This objective will be achieved through 5 sub-objectives. Achieving this objective will require collaboration with other USAID partners implementing national and district-level service delivery activities.

**Sub-objective 2.1:** Availability of improved human resources for health (HRH) service delivery

**Expected outcomes**

- Improved HRH planning at district level to deliver effective and efficient quality health services;
- Improved recruitment, retention and motivation of health workers at service delivery levels;
- Improved health worker performance through performance management and support supervision; and
- Strengthened local training institutions/universities in pre-service/refresher/internship training for clinical staff.

**Sub-objective 2.2:** Improved availability of essential medicines and other health commodities

**Expected outcomes**

- Improved quantification and forecasting of medicines, supplies and other health commodities;
- Strengthened ordering, distribution, stock management and rational use of commodities at service delivery points; and
- Improved record keeping, reporting and accountability for medicines, supplies and other health commodities.

**Sub-objective 2.3:** Improved information management system

**Expected outcomes**

- Improved HMIS collection, management and reporting at district and facility level; and
- Increased utilization of strategic information at the district, facility, and community level for evidence based planning and programmatic decision making.

**Sub-objective 2.4:** Improved district/facility level leadership and management for health service delivery

**Expected outcomes**

- Enhanced capacity of district health teams to plan, implement, manage and monitor and evaluate health programs;
- Improved sector coordination and integration of HIV/AIDS, TB, Malaria Maternal and Child Health/Family Planning, nutrition, water and sanitation services at district level; and

- Increased the capacity of health management committees to take lead in management of facilities.

**Sub-objective 2.5:** Increased private sector involvement for innovations in delivery of affordable quality health care services

**Expected outcomes**

- Introduced appropriate innovations to expand and increase the range and types of health care services delivered by the private sector partners;
- Enhanced private sector capacity to provide high-quality health care services; and
- Increased access to affordable health care packages provided by the private sector to low-income vulnerable individuals.

Specific considerations and requirements to achieve Result 2:

- **HRH:** Annex 3 includes the expected role of the Recipient in implementing the HRH package in the target districts. The Uganda Capacity Program is currently implementing some activities in northern districts, which the Recipient will be expected to support and continue at the end of the UCP program.
- **Improved supply chain:** The USAID/Uganda SURE project is implementing the district Supply Chain support package in four (4) target area districts. NU-HITES will be responsible for implementing a standard district support package in collaboration with SURE in the remaining 11 districts using the same materials, tools, guidelines, and procedures. SURE will provide support to NU-HITES in some areas to ensure standardization and rapid start-up, including training of the Medicines Management Supervisors. Annex 4 includes more details about the district support package and SURE support.
- **Quality Improvement:** Annex 5 includes more details about the district Quality Improvement support package
- **Private Sector Engagement**: Avoiding duplication in this result area will require collaboration with USAID partners HIPS and UHMG, and with the new DFID implementing partner.

For both Objectives 1 and 2, the project-level outcomes are listed above. However, additional district-level outcomes will be determined as part of the consultation between the Recipient and the district-level health sector institutions after the award as district-level plans are developed.

## I.4 RELATIONSHIPS

NU-HITES implementation should be founded upon dynamic and productive partnerships between the Recipient, the MOH District Health leadership and management, private sector health providers and USAID/Uganda and its other relevant implementing partners. As outlined in the Guiding Principles, the project will also collaborate with other Health Development Partners, AIDS Development Partners NGOs and implementing partners working in the Health, Agriculture and governance sector, with the private sector, and with program beneficiaries at all levels.

### I.4.1 Government of Uganda/Ministry of Health and District Administrations

As is outlined in Guiding Principle 1, NU-HITES will directly contribute to GOU and MOH priorities for the health sector as stipulated in the MOH policies and guidelines as applicable. One of the objectives is to ensure equitable access by people in conflict and post-conflict situations to the Uganda National Minimum Health Care Package**.** This objective shall be achieved in two main ways: by strengthening health systems and revamping health services that collapsed during the conflict, and by gradually expanding coverage in areas, where access is limited. To that end, the Recipient will seek to fully integrate the program into district departments and work plans, implement activities within the HSSIP framework and promote strategic coherence and coordination among development partners. USAID will provide management oversight to this Cooperative Agreement through regular monitoring to provide leadership, guidance and quality assurance. NU-HITES program staff should, to a major extent, be physically located within the northern Uganda districts, where they will work together with local governments and stakeholders to design, plan, implement, and monitor program activities. The Recipient must develop strong communication and coordination mechanisms within the districts, using district structures whenever possible, through regular meetings, and dissemination of program activity reports.

A USAID Representative will participate along with the Recipient in quarterly review meetings with representatives of the District Administration to discuss progress towards agreed-upon results stipulated in the District Operation Plans (DOP) and under this Cooperative Agreement. Recipients will participate in relevant MOH national technical working groups, national policy discussions and provide technical assistance and leadership to working groups focused on the technical areas within their program and geographical areas, as appropriate.

### I.4.2 USAID/Uganda Implementing Partners, Other Health Development Partners

Northern Uganda is a major focus of USAID's development investments, resulting in several existing USAID-supported programs that are already active in the districts where NU-HITES is expected to operate. It is also expected that new USAID supported programs in northern Uganda will roll-out in these districts in the course of the NU-HITES program implementation. Brief summaries of these programs are available in Annex 2. As outlined in Guiding Principle 2, the Recipient will be expected to coordinate activities with all USAID health partners working in the region, work within the DOP and to collaborate whenever feasible with other development programs in agriculture, economic growth, democracy, and governance. In the area of democracy and governance in particular, which will dually support Guiding Principle 5 of community involvement, NU-HITES will work closely with a democracy and governance program in design, which seeks in part to improve local advocacy efforts with a focus on communities. NU-HITES collaboration with this program will be essential to strengthening community-level advocacy on pertinent health issues for populations in the north.

While district management structures will provide the basis for much of this coordination, additional communication and collaboration among USAID partners may be required on an ad hoc or ongoing basis. The NU-HITES AOR will provide guidance on additional coordination structures beyond support to district coordination efforts.

Beyond USAID, there are several development partners with programs in the NU-HITES

target areas. Although many health development partners provide direct support to the PRDP, several donor-specific projects are also active in northern Uganda. Among them, the United Kingdom's Department for International Development (DFID) currently implements a five-year, Post-Conflict Development Program in northern Uganda by improving the supply of essential medicines to public and private facilities. DFID's future plans include providing performance based subsidy to private providers in some of the NU-HITES target districts, to improve provisioning of quality maternal and child health services by providing a performance-based subsidy. The NU-HITES implementing partner will be required to ensure that there is no unnecessary duplication in providing medical commodities and/or technical assistance to private providers in the target districts. UNICEF supports therapeutic feeding for children 6 to 59 months and pregnant women with severe acute malnutrition in the Acholi sub-region of northern Uganda. The aim is to reach 80% of the caseload of children by 2013 in Acholi. UNICEF is also undertaking nutrition surveillance that includes health and food security indicators in the sub-region.

Beyond DFID and UNICEF collaboration, NU-HITES will collaborate with any additional donor-funded programs in the north. The AOR of the program may be able to assist in facilitating communication among development partners if challenges in collaboration on the ground persist.

### I.4.3 Private Sector Health Providers

'Uganda's current health system is not sustainable'. This is the conclusion of the *2010 Health Business Climate Legal and Institutional Reform Assessment* (2010 HealthCLIR). Donor funding currently accounts for over 30% of total health expenditures in Uganda, mainly supporting the public health system. However, according to the HealthCLIR, three out of four out-of-pocket shillings spent on the provision of health care in Uganda go to the private sector. The private health sector incudes the Private-Not-For-Profit (PNFP) facilities managed by the Catholic, Protestant and Muslim medical bureaus, non-government organizations (NGOs) focusing on specific aspects of health care delivery and health systems strengthening, and the commercially-run Private-For-Profit (PFP) facilities, including private pharmacies and drug shops. PFP providers range in scope from large corporations to individual private providers.

While the private sector accounts for a sizeable proportion of health service delivery in Uganda, they do face obstacles and barriers to further expansion of their reach and impact. The primary obstacle faced by the private health sector is fragmentation and undercapitalization. They tend to be divided into small local service centers using antiquated equipment. Lack of readily-available cash reserves inhibits opportunities for expansion and frequently leads to gaps in the availability of medications. In addition to this problem, the PNFPs face the additional burden of not being able to achieve full cost-recovery due to their subsidized user fees.

With the goal of promoting program sustainability, USAID's CDCS recognizes that both the public and private sector have an important role to play in a sustainable response to addressing Uganda's health issues. As is outlined in Guiding Principle 4, the Recipient will apply strategies to accelerate private sector investment and engagement in the health sector in northern Uganda. Public-Private partnerships are encouraged. Information about such partnerships, or Global Development Alliances (GDAs), can be found at www.usaid.gov/gda.

## I.5 PERFORMANCE MONITORING PLAN

The Recipient will be required to develop and maintain a performance monitoring system to track tangible, measurable progress toward Program Results, toward the strategic goals of the Uganda CDCS, PMI, FTF and PEPFAR. Recipient must report on required indicators in the USAID DO3 PMP, required PEPFAR Next Generation Indicators, FTF and PMI indicators. Alignment with MOH key indicators identified in the HSSIP is also encouraged. Additional indicators, especially impact, and outcome-level indicators designed to capture significant results attributed to this Cooperative Agreement at the district-level should also be included. All performance indicators and targets must be gender disaggregated by Male (M)/Female(F)/Total (T) where feasible. Once finalized, USAID requires a Data Quality Assessment for each indicator and semi-annual reporting of data. Please note that USAID may require the Recipient to report on additional performance indicators subject to changing Agency guidance and/or the requirements of specific funding sources.

## I.6 KEY PERSONNEL

The Recipient shall propose up to five Key Personnel under this Cooperative Agreement, including the Chief of Party, the Monitoring and Evaluation manager, the Finance Manager, and experts in the key technical areas of the Cooperative Agreement. For each Key Personnel position, provide a short Position Description including key management, technical, and supervisory responsibilities.

The Chief of Party will be responsible for all activities and results under the Cooperative Agreement, and will work on a daily basis with representatives of the highest levels of the MOH. Program success, therefore, depends on a skilled and experienced Chief of Party with demonstrated strong leadership, management, and technical skills. A minimum of fifteen years of relevant program management and supervisory experience are required, preferably in the field of Health and development. Outstanding interpersonal, communication, cross-cultural, collaboration and negotiation skills are essential. Excellent written communication in English is required.

Finance Manager: The Finance Manager is expected to have at least a Masters Level Degree in Business Administration, Finance or other relevant field and experience in logistics, procurement or supply management is highly preferred. S/he shall have at least eight years' experience in financial management of large international projects.

Monitoring and Evaluation Specialist: Will have demonstrated academic and practical skills in monitoring and evaluation of HIV/AIDS, RH/FP, and/or other relevant services, including maternal health, malaria and TB or related areas in developing countries.

The Key Personnel specified above are considered to be essential to the work being performed under this Cooperative Agreement. It is expected that Key Personnel will provide 100% Level of Effort to this USAID-funded Award. No replacement will be made by the Recipient without the written consent of the Agreements Officer. USAID reserves the right to adjust the level of key personnel during the performance of this Cooperative Agreement.

## I.7 ENVIRONMENTAL COMPLIANCE

The Foreign Assistance Act of 1961, as amended, Section 117 requires that the impact of USAID's activities on the environment be considered and that USAID include environmental sustainability as a central consideration in designing and carrying out its development programs. This mandate is codified in Federal Regulations (22 CFR 216) and in USAID's Automated Directives System (ADS) Parts 201.3.11.2.b and 204 (http://www.usaid.gov/policy/ads/200/), which, in part, require that the potential environmental impacts of USAID-financed activities are identified prior to a final decision to proceed and that appropriate environmental safeguards are adopted for all activities. Recipient environmental compliance obligations under these regulations and procedures are specified in the following paragraphs of this RFA.

1a) In addition, the recipient must comply with host country environmental regulations unless otherwise directed in writing by USAID. In case of conflict between host country and USAID regulations, the latter shall govern.

1b) No activity funded under this Cooperative Agreement will be implemented unless an environmental threshold determination, as defined by 22 CFR 216, has been reached for that activity, as documented in an Initial Environmental Examination (IEE), or Environmental Assessment (EA) duly signed by the Bureau Environmental Officer (BEO). Hereinafter, such documents are described as "approved Regulation 216 environmental documentation."

2) An Initial Environmental Examination (IEE) file name: Uganda FY08 S08 IIP IEE 091608.doc has been approved for the Program that will fund this cooperative agreement (CA). The IEE covers activities expected to be implemented under this CA. USAID has determined that a **NEGATIVE DETERMINATION WITH CONDITIONS** applies to the proposed activities. This indicates that if these activities are implemented subject to the specified conditions, they are expected to have no significant adverse effect on the environment. The recipient shall be responsible for implementing all IEE conditions pertaining to activities to be funded under this award.

3) As part of its initial Work Plan, and all Annual Work Plans thereafter, the recipient in collaboration with the USAID Agreement Officer's Representative and Mission Environmental Officer or Bureau Environmental Officer, as appropriate, shall review all ongoing and planned activities under this CA to determine if they are within the scope of the approved Regulation 216 environmental documentation.

3a) If the recipient plans any new activities outside the scope of the approved Regulation 216 environmental documentation, it shall prepare an amendment to the documentation for USAID review and approval. No such new activities shall be undertaken prior to receiving written USAID approval of environmental documentation amendments.

3b) Any ongoing activities found to be outside the scope of the approved Regulation 216 environmental documentation shall be halted until an amendment to the documentation is submitted and written approval is received from USAID.

4) When the approved Regulation 216 documentation is (1) an IEE that contains a Negative Determination with Conditions the recipient shall:

> Prepare an environmental mitigation and monitoring plan (EMMP) or project mitigation and monitoring (M&M) plan describing how the recipient will, in specific terms, implement all IEE and/or EA conditions that apply to proposed project activities within the scope of the award. The EMMP or M&M Plan shall include monitoring the implementation of the conditions and their effectiveness. If the approved Regulation 216 documentation contains a complete EMMP or project mitigation and monitoring (M&M) plan, the recipient does not need to complete a new plan. Guidance is available to assist with the EMMP and M&M process at http://www.encapafrica.org/meoEntry.htm.

4a) Integrate a completed EMMP or M&M Plan into the initial work plan.

4b) Integrate an EMMP or M&M Plan into subsequent Annual Work Plans, making any necessary adjustments to activity implementation in order to minimize adverse impacts to the environment.

5) A provision for sub-grants is included under this solicitation requiring the recipient to use the Environmental Review Form (ERF) or Environmental Review (ER) checklist to screen grant proposals to ensure the funded proposals will result in no adverse environmental impact, to develop mitigation measures, as necessary, and to specify monitoring and reporting. Use of the ERF or ER checklist is called for when the nature of the grant proposals to be funded is not well enough known to make an informed decision about their potential environmental impacts, yet due to the type and extent of activities to be funded, any adverse impacts are expected to be easily mitigated. Implementation of sub-grant activities cannot go forward until the ERF or ER checklist is completed by the recipient and approved by USAID. Recipient] is responsible for ensuring that mitigation measures specified by the ERF or ER checklist process are implemented and addressed in annual reports. Guidance is available to assist with the ERF and ER checklist process at http://www.encapafrica.org/meoEntry.htm

5a) The recipient will be responsible for periodic reporting to the USAID Contract/Agreement
Officer's Representative, as specified in the Program Description.

6) USAID anticipates that environmental compliance and achieving optimal development outcomes for the proposed activities will require environmental management expertise.

**(See Section IV of the RFA for detailed instructions regarding environmental considerations to be included in the technical and cost applications).**

## I.8 AUTHORIZING LEGISLATION

The authority for this RFA is found in the Foreign Assistance Act of 1961 and the resulting award(s) will be administered in accordance with OMB Circulars, 22 CFR 226,

and USAID's Automated Directives Systems (ADS) Chapter 303, "Grants and Cooperative Agreements with Non-Governmental Organizations" as applicable. These policies and regulations can be viewed or downloaded from USAID's Web Site http://www.usaid.gov/business/regulations/.

Pursuant to 22 CFR 226.81, it is USAID policy not to award profit under assistance instruments. However, all reasonable, allocable, and allowable expenses, both direct and indirect, which are related to this program and are in accordance with applicable cost standards (22 CFR 226, OMB Circular A-122 for non-profit organization, OMB Circular A-21 for universities, and the Federal Acquisition Regulation (FAR) Part 31 for-profit organizations), may be paid under the cooperative agreement. **USAID reserves the right to fund any or none of the applications submitted.**

[END OF SECTION I]

## SECTION II – BASIC AWARD INFORMATION

**II.1 ESTIMATED FUNDING**: The total estimated budget for this RFA is $50 million, subject to the availability of funds. The approximate breakdown for funding by program area is as follows: HIV/AIDS (PEPFAR) – 60%; TB - 8%, Malaria (PMI) – 8%; MCH – 7%; RH/FP – 7%; Nutrition – 10%

USAID may make one or more award(s) without discussions to responsible applicants whose applications offer the greatest value to the extent they are necessary, negotiations will be conducted with the apparently successful applicant(s). Award(s) will be made to the responsible applicant(s) whose application(s) offers the greatest value, cost and other factors considered. USAID reserves the right to fund any or none of the applications submitted.

**II.2 PERFORMANCE PERIOD**: The anticipated program start date is **April 2012 for a five-year period through April 2017.**

**II.3 AWARD TYPE**: USAID anticipates the award will be a **Cooperative Agreement**. **Substantial Involvement** under the award is expected to be as follows:

- Approval of the recipient's annual Implementation Plans and Performance Monitoring Plan;
- Approval of any changes to specified Key Personnel;
- *Monitoring (Site Visits and Periodic Program Reviews) and Direction and Redirection of Activities*: USAID may conduct site visits and organize and/or participate in periodic program reviews, and may direct or redirect activities because of interrelationships with other USG programs, program elements/activities. However, such directed or redirected activities must fall within the scope of activities outlined in the Program Description, negotiated in the budget, and made part of the Cooperative Agreement;
- Approval of sub-recipients;
- USAID participation as a member of any program advisory committee. The advisory committee will only deal with programmatic or technical issues, not routine administrative matters;
- Agency authority to immediately halt a construction activity, as applicable.

**II.4 AUTHORIZED GEOGRAPHIC CODE**: The Authorized Geographic Code is 935 for the procurement of goods and services. Reference ADS 308 for current information.

[END OF SECTION II]

## SECTION III – ELIGIBILITY INFORMATION

III.1. USAID policy encourages competition in the award of Grants and Cooperative Agreements. In response to this RFA, any U.S. or non-U. S. organisations, non-profit, or for-profit entity is eligible to apply.

III.2. USAID encourages applications from potential new partners.

III.3. There shall be cost share of 10% in all applications. Cost-sharing, once accepted, becomes a condition of payment of the federal share.

[END OF SECTION III]

## SECTION IV - APPLICATION AND SUBMISSION INFORMATION

### IV.1 Electronic Submission of Applications via E-mail is Required.

Applications are to be submitted via email. Please submit your applications to the email address below by **4pm EST (Washington, DC), March 2, 2012.** RECEIPT TIME IS WHEN THE APPLICATION IS RECEIVED BY THE AID/Washington INTERNET SERVER. **Paper copies of the applications are not accepted**. The address for the receipt of proposals is: KampalaUSAIDSolicita@USAID.gov , to the Attention of Godfrey Kyagaba and Tracy J Miller, Agreement Officer. Applications which are submitted late or do not follow the instructions contained herein run the risk of not being considered in the review process.

All applications received by the deadline will be reviewed for responsiveness to the specifications outlined in these guidelines and the application format. Note this RFA includes a mandatory minimum cost share percentage of 10% of the total proposed USAID contribution to the program. Per ADS 303.3.10.3, applications that do not meet this minimum cost sharing requirement are not eligible for award consideration.

Applications should take into account the evaluation criteria provided in **Section V** and must include the Representations and Certifications provided in **Attachment I**. In the event Representations and Certifications are not submitted with the Application, they must be completed before final award is made.

Please note that Technical and Cost Applications should be kept separate. USAID wants to leverage its assistance and applicants must make a clear commitment to provide cost sharing and a statement of how much (in percentage terms) of the budget they are going to raise from other sources. The Cost Application must contain a clearly identified section on cost sharing including sources for those funds.

Applicants should retain for their records one copy of the application and all enclosures which accompany their application. Erasures or other changes must be initialed by the person signing the application. To facilitate the competitive review of the applications, USAID will consider only applications conforming to the format prescribed below.

### IV.2 Technical Application Format

Applications must be submitted electronically in MS Word and .pdf (Adobe Acrobat) versions. In case of any conflicts between the MS Word and .pdf versions of the application, the .pdf version will govern as it will be the version presented to the Technical Evaluation Panel.

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

Applications must be legible and must *not* require **magnification** (!). Please be kind to the evaluators and keep the technical application clear, concise, easy to follow, while also in complete compliance with the instructions herein.

The technical application (**maximum 30 pages – not including annexes**) should clearly

and concisely outline how the Applicant proposes to meet the critical needs identified in the objective(s) and how the Applicant will achieve its expected results.

The application must include a detailed description of the management approach for implementing the proposed program, which includes specifying the composition and organizational structure of the entire implementation team (including home office support); describing each team member's role and level of effort.

The technical application must include your approach to achieving **environmental compliance and management**, to including:

- Approach to developing and implementing an IEE or EA or environmental review process for a grant fund and/or an EMMP or M&M Plan.
- Approach to providing necessary environmental management expertise, including examples of past experience of environmental management of similar activities.
- An illustrative budget for implementing the environmental compliance activities. For the purposes of this solicitation, applicants should reflect illustrative costs for environmental compliance implementation and monitoring in their cost proposal.

### IV.3 Annexes

The following six annexes should be submitted within the page limits indicated; any pages exceeding the limits for each annex will not be considered.

**Annex I. CVs for Key Personnel –** Three (3) pages maximum per CV.

A more detailed description of proposed key personnel including the Chief of Party and up to four additional key personnel, as well as any other personnel position for who the applicant wishes to provide CVs. For all Key Personnel, a CV and Contractor Biographical Data Sheet (USAID FORM 1420-17) including the candidate's employment history and past performance references for each long-term position held within the last ten years must be included for each proposed candidate. The use of local expertise is highly encouraged. Equal consideration should be given to equally-qualified women and men when recruiting for the project.

**Annex II. Draft Implementation** Plan (Max. 5 pages)

A draft implementation plan for all activities through the end of the current fiscal year, including milestones.

**Annex III. Draft Performance Monitoring Plan** (Max. 5 pages)

A draft PMP shall be submitted with the application, and shall include performance indicators, planned data sources, data collection and calculation methods, baseline data and annual targets directly linked to proposed activities.

**Annex IV. Past Performance References and** Information – ONE (1) page maximum per reference.

Please provide a list of current US Government and/or privately funded contracts, grants, cooperative agreements, etc., for similar or related programs during the past three years. Include the performance location, award number (if available), a brief description of the work performed, and a point of contact list with current telephone numbers.

**Annex V. Representations and Certifications, Assurances**: (See Attachment I for the required representations and certifications that are to be included as Annex V to the technical proposal).

NOTE: When these Certifications, Assurances, and Other Statements of Recipient are used for cooperative agreements, the term "Grant" means "Cooperative Agreement."

**Annex VI: Sustainability Plan** (Max. 5 pages)

The applicant will submit to USAID a sustainability plan as part of this application that includes milestones demonstrating full program sustainability by the time the award ends. This must include, but is not limited to, how NU-HITES will build sustainable services/leadership within the MOH/DHMT from its financial assistance, technical assistance and capacity building role, and what it will "leave behind" that may continue beyond the life of the program. The Recipient should describe the anticipated sustainable elements of the program, whether implemented by the public or private sector, and any specific approaches proposed to achieve more sustainable outcomes (e.g. recruitment, retention, and motivation of health workers; strengthening local training institutions and universities; increased logistics management and HMIS capacity; improved community level capacity and advocacy, etc.).

## IV.4 Cost Application Format

The Cost Application is to be submitted via a separate email from the Technical Application. Certain documents are required to be submitted by an applicant in order for the Agreement Officer to make a determination of responsibility. However, it is USAID policy not to burden applicants with undue reporting requirements if that information is readily available through other sources. A Cost Application consists of:

- **SF-424***, Application for Federal Assistance;
- **SF-424A***, Budget Information – Non-Construction Program;
- **SF-424B***, Assurances – Non-Construction Programs;
- a summary budget;
- a detailed/itemized budget; including illustrative costs for environmental compliance implementation and monitoring
- a budget narrative explaining costs to be incurred; and
- other administrative documentation as required.

*These forms may be downloaded from the following website: http://www.grants.gov/agencies/aforms_repository_information.jsp

The following sections describe the documentation that applicants for Assistance award must submit to USAID prior to award. While there is no page limit for this portion,

applicants are encouraged to be as concise as possible, but still provide the necessary detail to address the following:

The required budget format is found in Attachment J of this RFA.

Please be sure that the budget includes at least the following elements:

- the breakdown of all costs associated with the program according to costs of, if applicable, headquarters, regional and/or country offices;
- the breakdown of all costs according to each partner organization involved in the program, in the same detail and format as the budget template;
- potential contributions of non-USAID or private commercial donors to this Cooperative Agreement, including, the breakdown of the financial and in-kind contributions (cost sharing) of all organizations involved in implementing this Cooperative Agreement.

**NOTE: The award will not provide for the reimbursement of pre-award costs.**

Also include:

a) Information that confirms and ensures that the proposed cost sharing will materialize.

b) Details of sub-award arrangements to the extent they are known at the time of application development: In case there are multiple organizations and partners, please explain as clearly as possible the management structure and how the parties are going to interact. If there are formal legal arrangements such as sub awards or sub contracts please clearly explain how these are to be structured and list past experience between the organizations.

NOTE: If sub-awards are anticipated and not explained in the original application, the agreement officer's approval (after award) is required before the sub-agreement may be executed.

c) A copy of the self-certification for compliance with USAID policies and procedures for personnel, procurement, and travel.

d) A copy of the organization's U.S. Government Negotiated Indirect Cost Rate Agreement (NICRA), if applicable.

e) Applicants should submit additional evidence of responsibility they deem necessary for the Agreement Officer to make a determination of responsibility. The information submitted should substantiate that the Applicant:

1. Has adequate financial resources or the ability to obtain such resources as required during the performance of the award.

2. Has the ability to comply with the award conditions, taking into account all existing and currently prospective commitments of the applicant, non-governmental and governmental.

3. Has a satisfactory record of performance. Past relevant unsatisfactory performance is ordinarily sufficient to justify a finding of non-responsibility, unless there is clear evidence of subsequent satisfactory performance.

4. Has a satisfactory record of integrity and business ethics; and

5. Is otherwise qualified and eligible to receive a cooperative agreement under applicable laws and regulations (e.g., EEO).

## IV.5 Marking and Branding

**MARKING AND BRANDING:** Pursuant to ADS 303.3.6.3.f and ADS 320.3.1.2, the apparently Recipient will be requested to submit a Branding Strategy and Marking Plan that will have to be successfully negotiated before a cooperative agreement will be awarded. These plans shall be prepared in accordance with the guidance in ADS 320.3.3, 22 CFR 226.91 and the references therein. **Please note that the Branding Strategy and Marking Plan shall not be included with the original application but shall be provided only after a written request of the Agreement Officer.**

[END OF SECTION IV]

## SECTION V – APPLICATION REVIEW INFORMATION

### Overview

The Technical Evaluation Criteria are tailored to the requirements of this particular RFA and are set forth below. Applicants should note that these criteria serve to: (a) identify the significant matters which applicants should address in their applications and (b) set the standard against which all applications will be evaluated. To facilitate the review of applications, applicants must organize the narrative sections of their applications with the same headings and in the same order as the selection criteria.

USAID Uganda intends to evaluate the applications and award an agreement without discussions with the applicants. However, USAID reserves the right to conduct discussions if the latter is determined by the Agreement Officer to be necessary. Therefore, the initial offer should contain the applicant's best terms from a Technical and Cost/Price stand point.

The criteria by which the Grant Application will be assessed are as follows, in descending order of importance:

### Technical Criteria

(1) Technical Approach
(2) Institutional Capability
(3) Key Personnel and Staffing
(4) Past Performance

Assessment of each of these criteria will include the considerations described in the sections below.

### A. Technical Approach

The Technical Approach will be evaluated based on the following sub-criteria is descending order of importance:

- Extent to which the applicant demonstrates an understanding of the program complexities and the technical requirements detailed in Section I, and lays out an innovative, feasible and responsive approach to produce sustainable results.
- Extent to which the applicant clearly identifies measurable outputs, indicators and target outcomes within each component, as part of the illustrative Performance Management Plan, that provide specific mechanisms, procedures and a system for program monitoring and data collection, analyzing and reporting.
- Extent to which the applicant demonstrates understanding of gender roles in health, including constraints that may limit participation of men or women.

### B. Institutional Capability

- Corporate experience and capacity in technical areas relevant to this program.

### C. Key Personnel and Staffing

Key Personnel will be evaluated based on the following. The two sub-criteria are equally weighted:

- Extent to which the proposed personnel possess the appropriate technical and

management skills, as specified in Section I.

- Extent to which the applicant's proposed personnel plan demonstrates clearly how it will support the proposed technical approach to achieve results, and the extent to which they utilize local, well-qualified professional and administrative staff.

**D. Past Performance**

Past performance will be evaluated on:

- how well an applicant performed; relevancy of work performed by prime and any subs in implementing similar programs;
- instances of good and poor performance;
- significant achievements and problems; and any indications of excellent or exceptional performance in the most critical areas.

An applicant must provide a list of all its contracts, grants, or cooperative agreements involving similar or related programs during the past three years. The reference information for these awards must include the performance location, award number (if available), a brief description of the work performed, and a point of contact listed with current telephone number and email address. The Agreement Officer may also consult other resources and references not provided by the applicant related to the applicant's past performance. See Section IV.3, Annex IV for instructions for submission of past performance information.

**COST EVALUATION**

Cost has not been assigned a score but will be evaluated for cost reasonableness, allocability, allowability, cost effectiveness - including cost share - and realism, adequacy of budget detail and and cost sharing. While cost may be a determining factor in the final award(s) decision, especially between closely ranked applicants, the technical merit of applications is substantially more important under this RFA. Applications providing the best value to the Government, including cost share, will be more favorably considered for award. Applications will be ranked in accordance with the selection criteria identified above. USAID reserves the right to determine the resulting level of funding selected for award.

[END OF SECTION V]

## SECTION VI – AWARD ADMINISTRATION INFORMATION

1) Following selection for award, a Recipient will receive an electronic copy of the notice of award signed by the Agreement Officer which serves as the authorizing document. USAID will issue the award to the contacts specified by the applicant in its application documents and/or the Authorized Individuals submitted by the applicant.

2) The applicable Standard Provisions that will apply in any resulting award document can be viewed or downloaded from USAID's Web Site: http://www.usaid.gov/policy/ads/300/303.pdf.

3) The following programmatic reporting requirements shall be made part of any award issued under this RFA:

### Program Reporting

The Recipient shall submit one original, two (2) hard copies and an electronic copy of the following reports in English to the USAID/Uganda Agreement Officer Representative (AOR) for approval:

**1. Annual Implementation Plans and Budgets**

First Implementation Plan

- Due no later than **30 days after the effective date of this award**.
- Shall cover the period from the effective date of award through the end of the fiscal year in which the award was made.
- Shall describe planned activities arranged by the overall objectives of the Program Description and further broken down by sub-activities and tasks and by geographic location. Also include budgetary forecasts and notes tied to proposed activities.

Annual Implementation Plans

- Due no later than **30 days after the end of the fiscal year**.
- Shall contain the same information as described above covering the fiscal year.

**2. Performance Monitoring and Management Plan (PMP)**

- Due no later than **90 days after the effective date of this award**.
- Shall cover the entire period of performance of this Award and may be adjusted based on any changes in planned activities. Requires USAID approval.
- Shall include relevant indicators to measure performance annually and at the end of the program, with baselines and targets for each indicator. Indicators shall be quantitative and qualitative and used to track program impact, including related to stability, with less importance on tracking outputs. Where applicable, indicators should be disaggregated by gender, age cohorts, and geographical location. Program management and cross-cutting indicators are encouraged. The data collection process and tools to be used, and proposed

plans for periodic evaluations, assessments, studies, documentation on data source and quality etc. shall also be included.

- The Recipient is also required to fully collaborate with USAID/Uganda's third-party evaluation contractor. In line with USAID's Evaluation Policy, this Cooperative Agreement will be structured from the outset with the intent to conduct performance and impact evaluation. To this end, USAID/Uganda anticipates issuing a separate contract to an independent organization that will run parallel to this Cooperative Agreement. It is expected that the Recipient of this Cooperative Agreement will collaborate with the third-party evaluation contractor and USAID to develop a rigorous Evaluation Design at the outset of the program. At two points in the program (by the end of the second quarter of Year 3 and prior to the end of Year 5 of the Cooperative Agreement), the third-party evaluation contractor will conduct performance and impact evaluation of the program.

## 3. Reports

Quarterly Progress Reports

- Due to the AOR every three months, no later than **30 days after the end of each calendar quarter**.
- Shall be no longer than 20 pages summarizing, at minimum: (1) progress toward agreed upon Program Results; (2) identification of specific problems and delays and recommendations for adjustments and corrective action; (3) any high-level meetings held and field visits; (4) planned activities for the next reporting period; (5) assessment of the validity and efficacy of progress against the goal and results; (6) progress against cross-cutting issues, including but not limited to, any environmental compliance issues.
- Recipient may be required to present results un verbal and/or visual format
- *Accruals:* Shall be due **one week before the end of each quarter per year**; i.e. December 31, March 30, June 30, and September 30.
- *Quarterly Financial Reports:* 30 days after the end of each calendar quarter along with the progress report. Shall include a report on expenditures accrued during the report period and projected accrued expenditures for the next quarter, against Award line items.
- *Annual Financial Reports:* The July-September Quarterly Financial Report will constitute the Annual Financial Progress Report.

Final Performance Report

- Shall be submitted 90 days after the award end date. A draft shall be submitted 45 days after the award end date. The final report shall be in English. It shall cover the entire five-year period of the award and include the cumulative results achieved, an assessment of the impact of the program, lessons learned and recommendations, any particularly notable impact stories, and detailed financial information. It should be grounded in evidence and data. A copy of the final results shall be filed with the Development Experience Clearinghouse at: http://dec.usaid.gov or http://www.DocSubmit@usaid.gov.

[END SECTION VI]

## SECTION VII – AGENCY CONTACTS

Agreement Officer
USAID/Uganda
US Embassy Compound
Plot 1577 Ggaba Road
Kampala, Uganda

[END SECTION VII]

## SECTION VIII – OTHER INFORMATION

Resulting awards to U.S. Non-government Organizations will be administered in accordance with Chapter 303 of USAID's Automated Directives System (ADS 303), 22 CFR 226, applicable OMB Circulars (i.e., A-21 for Universities or A-122 for Non-Profit Organizations, and A-133), and Standard Provisions for Non-Governmental Organizations.

- ADS 303 is available at: http://www.usaid.gov/policy/ads/300/303maa.pdf.
- 22 CFR 226 is available at: http://www.access.gpo.gov/nara/cfr/waisidx_06/22cfr226_06.html. Applicable
- OMB Circulars are available at: http://www.whitehouse.gov/OMB/circulars/index.html.
- Standard Provisions for U.S. Non-Governmental Organizations are available at: http://www.usaid.gov/policy/ads/300/303maa.pdf.

Resulting award to Public International Organizations (PIOs, or IOs) will be administered in accordance with Chapter 308 of USAID's ADS including the Standard Provisions set forth in ADS 308.5.15.

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

Standard Provisions for Non-U.S. Non-Governmental Organizations are available at: http://www.usaid.gov/policy/ads/300/303mab.pdf. ADS 308 is available at: http://www.usaid.gov/policy/ads/300/308mab.pdf.
The USAID Inspector-General's "Guidelines for Financial Audits Contracted by Foreign Recipients" is available at: http://www.usaid.gov/oig/legal/audauth/rcapguid.pdf.

[END SECTION VIII]

**SECTION IX – REFERENCES AND ATTACHMENTS** (Attachments A – H are included in the RFA; Attachments I, J, and K are separate documents).

| | |
|---|---|
| **Attachment A** | **Acronyms** |
| **Attachment B** | **NU-HITES Background Information** |
| **Attachment C** | **DO3 Results Framework** |
| **Attachment D** | **Description of Relevant District-Level Activities of other USAID Implementing Partners in Target Districts** |
| **Attachment E** | **District HRH Package and Expected Role of District Implementing Partners** |
| **Attachment F** | **District Supply Chain Management Strengthening Package** |
| **Attachment G** | **Quality Management District Support Package** |
| **Attachment H** | **Reference Document List** |
| **Attachment I** | **Representations, Certifications & Assurances** |
| **Attachment J** | **Budget Template** |
| **Attachment K** | **Initial Environmental Examination** |

Attachment A - Acronyms

ACT - Artemisinin-based Combination Therapy
AIDS - Acquired Immune Deficiency Syndrome
AIM- AIDS/HIV Integrated Model
ANC - Antenatal Care
AOR - Agreement Officer's Representative
APHIA - AIDS Population and Health Integrated Assistance
ARI - Acute Respiratory Infection
ART - Anti-Retroviral Therapy
ARV - Anti-Retroviral
BCC - Behavior Change Communication
CA - Cooperative Agreement
CBO - Community Based Organization
CDCS - Country Development Cooperation Strategy
CDF- Community Development Fund
CFR - Code Of Federal Regulation
CHW - Community Health Worker
CSO - Civil Society Organization
CV - Curriculum Vitae
DEC - Development Experience Clearinghouse
DFID - Department for International Development
DHMT - District Health Management Team
DHS - Demographic and Health Survey
DO - Development Objective
DOC - Development Outreach and Communications
DOTS - Direct Observed Treatment (Short Course)
DOP - District Operational Plan
DSC - Districts Service Commissions
EmONC - Emergency Obstetric and Newborn Care
EID - Emergency Infectious Diseases
EMHS - Essential Medicines and Health Supplies
FBO - Faith Based Organization
FP - Family Planning
FSI - Food Security Initiative
FTF - Feed the Future
FY - Fiscal Year
GAPP - Governance, Accountability, Participation and Performance
GDA - Global Development Alliance
GOU - Government of Uganda
GPP - Good Pharmaceutical Practices
GHI - Global Health Initiative
HBB - Help Babies Breathe
HCI - Healthcare Improvement Project
HCP - Health Communications Partnership
HCT - HIV/AIDS Counseling and Testing
HIPS - Health Initiatives for the Private Sector
HIV - Human Immunodeficiency Virus
HMDC - Health Manpower Development Center
HMIS - Health Management Information Systems
HR - Human Resource
HRH - Human resources for health
HSSIP - Health Sector Strategic and Investment PLan
IDU - Injection Drug User
IEE - Initial Environmental Examination
IMR - Infant Mortality Rate
IP - Implementing Partner
IPT - Intermittent Preventive Treatment
IR - Intermediate Result
IT - Information Technology
ITN - Insecticide Treated bed Net
LLIN - Long Lasting Insecticide Treated Net
M&E - Monitoring and Evaluation
MARP - Most-At-Risk Population
MCH - Maternal Child Health
MDG - Millennium Development Goals
MMS - Medicines Management Supervisors
MNCH - Maternal, Neonatal & Child Health
MoLG - Ministry of Local Government
MoH - Ministry of Health
MOMS - Ministry of medical Services
MOPHS - Ministry of Public Health and Sanitation
MoU - Memorandum of Understanding
MSU - Marie Stoppes Uganda
NDA - National Drug Authority
NDP - National Development Plan
NGO - Non-Governmental Organization
NUMAT- Northern Uganda Malaria, AIDS and TB

OVC - Orphans and Vulnerable Children
PBC - Performance Based Contracting
PEPFAR - The President's Emergency Plan for AIDS Relief
PFP - Private For Profit
PMI - Presidents Malaria Initiative
PMP - Performance Monitoring Plan
PMTCT - Prevention of Mother to Child Transmission
PNFP - Private Not For Profit
QI - Quality improvement
RCE - Regional Center of Excellence
RDT - Rapid Diagnostic Tests
RFA - Request for Application
RH - Reproductive Health
RUTF - Ready to Use Therapeutic Food
SCM - Supply Chain Management
SCORE - Sustainable Responses for Improving the Lives of Vulnerable Children and their Households
SGBV - Sexual and Gender Based Violence
SO - Strategic Objective
SpO - Special Objective
STI - Sexually Transmitted Infections
SURE - Securing Ugandans' Right to Essential Medicines
SUSTAIN - Strengthening Uganda's Systems for Treating AIDS Nationally
TA - Technical Assistance
THALAS - The Targeted HIV/AIDS Laboratory Services
TB - Tuberculosis
TBD - To be determined
UCP - Uganda Capacity Program
UDHS - Uganda Demographic and Health Survey
UHMG - Uganda Health Marketing Groups
UPHOLD - Uganda Program for Human and Holistic Development
USG - US Government
VMMC - Voluntary Medical Male Circumcision
VHT - Village Health team
WISN - Workload Indicators of staffing Needs

Attachment B – Background for NU-HITES program

## I. The Health Context in northern Uganda

The prolonged armed conflict in northern Uganda had a devastating effect on the lives of Ugandans in Acholi and Lango sub-regions, affecting the functioning of the health systems and health service delivery. However, the situation in northern Uganda has improved over the last three years with current stability allowing about three quarters of the 1.8 million people who had been forced into displaced-persons camps to return to their homes. Despite this positive progress in a post-conflict setting, new challenges have arisen in the provision of basic social services as Internally Displaces Persons (IDPs) return home; inadequate or non-existent health infrastructure remains the reality, and poor health systems and services undermine health improvements.

The health system in northern Uganda, like the rest of the country, is decentralized with the Health Sector Strategic and Investment Plan 2010-2015 (HSSIP) serving as the overarching strategy and investment document that will guide health sector services in the coming years. Districts in northern Uganda also follow the Peace, Recovery and Development Plan (PRDP), which receives separate funding and support to rebuild infrastructure and rehabilitate basic social services in the wake of the prolonged conflict. Despite the special funding and focus that the PRDP provides, as well as considerable development partner focus on northern Uganda, health and nutrition status continues to be a challenge.

A 2010 household survey[1] conducted on health interventions in fifteen districts of northern Uganda - which have been the focus of USAID support to the health sector, including the NUMAT program - revealed that the performance of most HIV and malaria indicators had significantly improved from previous 2006/2008 survey findings. Other data sources revealed that the north central region is progressing in reaching national and international targets for Tuberculosis (TB), in part due to NUMAT support. However, significant challenges remain, including: a need to refocus HIV preventive interventions and to integrate them more within other health services; needed improvement in management of malaria in children; low family planning acceptance and declining uptake of family planning services. Furthermore, consultations with central government and Health Development Partners highlighted the inadequacy of quality health services for the population in northern Uganda. Large gaps in service delivery in the areas of reproductive health, maternal and child health, nutrition, and the prevention and control of infectious diseases persist. Health infrastructure in the region is insufficient, especially maternity wards and laboratory services. There are shortages and inappropriate distribution of critical human resources in the public health sector, lack of medicines and other essential supplies at service delivery units. There is limited household and community-level involvement in health management, as well as a lack of advocacy for delivery of quality health services in the Acholi and Lango subregions.

[1] LQAS Survey Report 2010: A household survey on Malaria, TB and HIV/AIDS interventions in nine districts of Uganda Uganda

## II. USAID Support to Health Programs in northern Uganda

Since 2001, USAID has supported northern Uganda through several health projects, including: The Uganda AIDS/HIV Integrated Model (AIM) District Program, the Uganda Program for Human and Holistic Development (UPHOLD) in scaling up HIV/AIDS, TB and malaria prevention and treatment services. Most recently, the NUMAT project provided technical assistance and financial support to local governments and civil society in the Acholi and Lango sub regions and has registered several achievements in strengthening service delivery systems for HIV/AIDS, TB and malaria. NUMAT comes to an end in June 2012. The Recipient will be expected to consolidate and build off of the progress and support provided under NUMAT.

Achievements in improved access and affordability and quality, of HIV/AIDS services, include:

- 31 Anti-Retroviral treatment (ART) sites supported with10,000 patients on treatment and care (9% children), 13,000 clients accessing cotrimoxazole and over 80 service providers trained on ART provision;
- Eight provider-initiated HIV/AIDS Counseling and Testing (HCT) facilities and over 100 HCT sites supported (including outreach) resulting in 450,000 individuals tested and 595 service providers trained in HCT;
- Lab strengthening with all the new clients having a baseline CD4 and over 9,820 CD4 tests conducted;
- Prevention scale-up including 100 sites supported for prevention of mother-to-child transmission (PMTCT), as well as initial scale-up of safe Voluntary Medical Male Circumcision (VMMC); and
- Home visits conducted to more than 40,000 people living with HIV/AIDS.

Achievements in improved access, affordability, and quality of TB services include:

- Coordinated Community-Based Direct Observed Treatment (DOTS) and TB /HIV collaborative activities in all the districts, resulting in a TB case detection rate constantly >70% and TB treatment success ranging 83% - 88%; and
- More than 16,600 TB patients tested for HIV cumulatively.

Achievements in improved access, affordability, and quality of malaria services include:

- 75,000 ITNs distributed and IPT-DOT supported through Antenatal Care (ANC) clinics;
- 5,586 Village Health Team members trained as Community Medicine Distributors and 7,258 Community Medicine Distributors trained on Home-Based Management of Fever for Malaria; and
- 65,786 Rapid Diagnostic Tests (RDT) for malaria distributed to 135 facilities with no lab capacity, and 163 health workers trained on RDT strategy.

Other systems strengthening achievements include:

- 64 labs provided with equipment, and 24 laboratories and counseling rooms in health units refurbished; and

- Health Management Information System (HMIS) in the districts supported, including computers to District Biostatisticians and provision of modems to district offices to support data transmission.

The Recipient will consolidate the gains made by NUMAT and previous USAID-supported programs. However, they will do so in the context of integrating infectious disease services with MNCH, family planning, and nutrition services as well as through approaches that strengthen the district health system's own leadership and ownership of services and catalyzing private sector contributions towards improved health services in northern Uganda.

## III. Alignment with USAID/Uganda Strategy and USAID global initiatives

**Country Development Cooperation Strategy (CDCS)**
President Obama's U.S. Global Development Policy directs USAID to formulate CDCS that are results-oriented and partner with host countries to focus investments. USAID/Uganda's CDCS implements this policy in the Ugandan context, making considered choices that focus and deepen programs and take closer account of the host country and donor context, while maintaining close coordination with USG partners.
The five-year CDCS Goal Statement, echoes the Government of Uganda's (GOU) vision for national development in Uganda, as outlined in the National Development Plan: Uganda's transition to a modern and prosperous country accelerated. This goal will be pursued through three Development Objectives (DOs) and one Special Objective (SpO):

- ***DO1: Economic growth from agriculture and the natural resource base expanded in selected areas and population groups.***
- ***DO2: Democracy and governance systems strengthened and made more accountable.***
- ***DO3: Improved health and nutrition status in focus areas and population groups.***
- ***SpO1: Peace and security improved in Karamoja.***

The NU-HITES program is designed to achieve DO3 in collaboration with all partners in northern Uganda contributing to USAID DOs wherever feasible for a more cohesive and collective approach to USAID assistance in the north.

The goals of the CDCS are operationalized through several new and ongoing Presidential Initiatives supported by the U.S. Government in Uganda:

**Feed the Future (FTF)** is the comprehensive global hunger, food security, and poverty reduction initiative. It invests in country-owned plans that support results-based programs and partnerships to promote inclusive agriculture sector growth and improved nutritional status, especially of women and children. It also features cross-cutting priorities of gender equality and expanded opportunities for women and girls, as well as environmentally sustainable and climate resilient agricultural development integrated into all FTF investments. Other key principles include strengthening strategic coordination, leveraging the benefits of multilateral organizations, and delivering on sustained and accountable commitments.

NU-HITES will address nutrition as a core component of Uganda's FTF Strategy in two ways: 1) by implementing nutrition interventions in the target districts with a major focus

on prevention of under-nutrition and a limited focus on treatment of severe acute malnutrition; and 2) by accepting referrals (or providing referrals, where appropriate) to the Community Connector (CC) and the Sustainable Responses for Improving the Lives of Vulnerable Children (SCORE) program in districts where they are operational, both of which focus on improving nutrition status through community and household-level interventions.

Similar to FTF, the **Global Health Initiative (GHI)** places women and children at the forefront of USG development efforts. By working with host countries to improve health outcomes through strengthened systems and integrated programming, focus is placed on improving the health of women and children through programs including infectious disease, nutrition, maternal and child health, family planning, and safe water. NU-HITES will contribute to the achievement of the USAID/Uganda GHI goal of achieving improved health outcomes by contributing to all seven core principles of the GHI: 1) focus on women, girls and gender equality; 2) encourage country ownership and invest in country-led plans; 3) build sustainability through health systems strengthening; 4) strengthen and leverage key organizations and partnerships with humanitarian and faith-based groups and the private sector; 5) increase impact through strategic coordination and integration; 6) improve metrics, monitoring and evaluation; and 7) promote research and innovation.

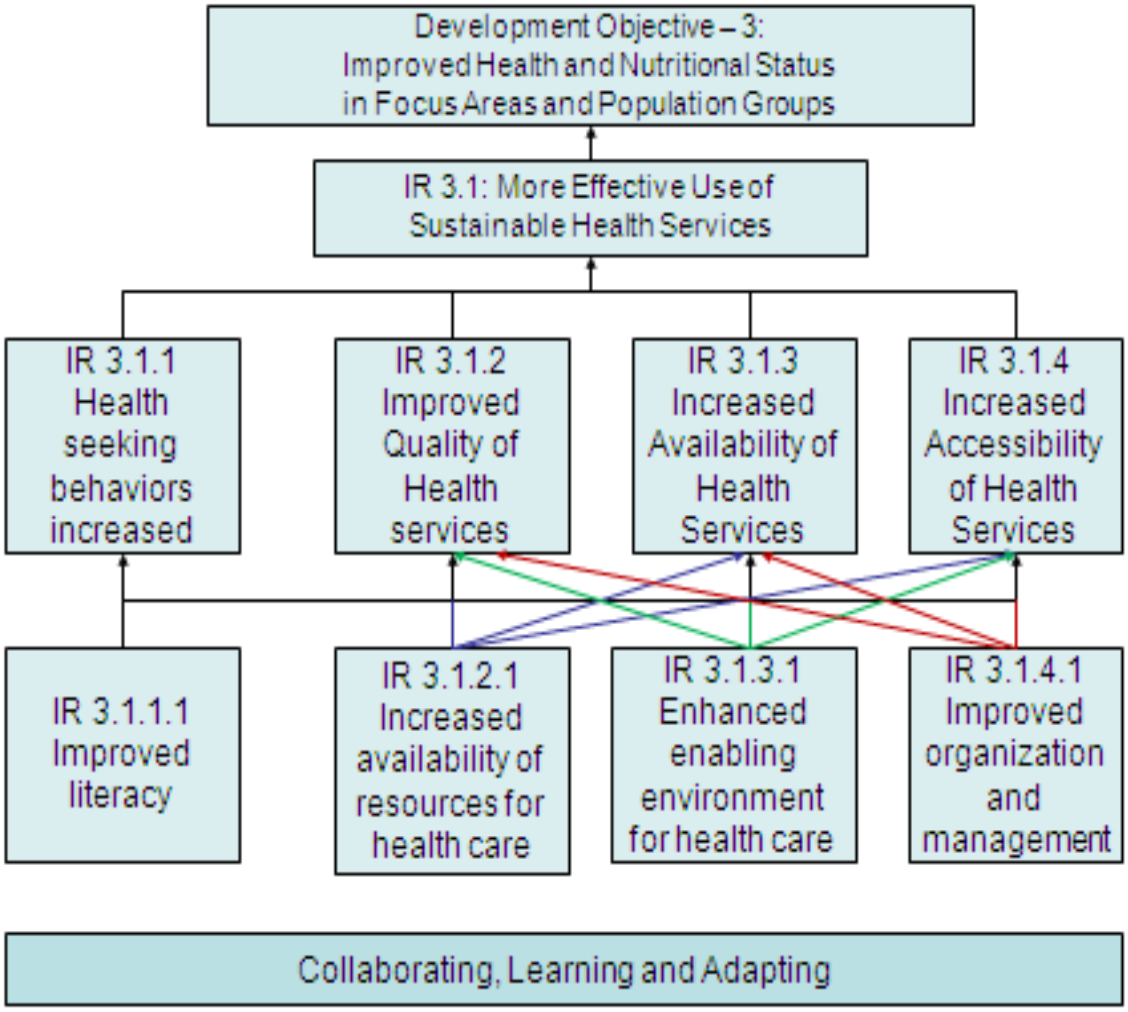
The President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative (PMI), and USAID's BEST Action Plan for Family Planning/MNCH/Nutrition in the Facility, Community, and Home are all included in the overall umbrella of the GHI principles.

**PEPFAR's** goal is to reduce HIV-related morbidity and mortality rates and slow the progression of HIV disease in affected communities through: 1) support to the prevention of more than 12 million new HIV infections; 2) providing direct support for more than 4 million people on treatment; and 3) supporting care for more than 12 million people, including 5 million orphans and vulnerable children. NU-HITES will utilize PEPFAR resources to support prevention, care and treatment of HIV/AIDS while strengthening health systems and integrating HIV/AIDS services with other critical primary health care services.

**PMI** aims to rapidly scale up malaria prevention and treatment interventions and reduce malaria-related mortality by 70% in 15 high-burden countries in sub-Saharan Africa by 2015. To support Uganda's national malaria control strategy, PMI provides funding to four major interventions to prevent and treat malaria: 1) distribution of Long-Lasting Insecticide-treated mosquito nets (LLINs); 2) indoor residual spraying (IRS); 3) intermittent preventive treatment for pregnant women (IPTp); and 4) case management of malaria, including proper diagnosis and treatment.

USAID/Uganda's **BEST Action Plan** for Family Planning, MNCH, and Nutrition in the Facility, Community, and Home prioritizes key evidence-based interventions for focus by USAID from 2011-2015 in order to more strategically focus FP, MNCH and nutrition resources. BEST also identifies opportunities for integration with PEPFAR, PMI, and other USG-supported health programs to optimize health outcomes through integrated services and strengthened systems.

Attachment C – DO3 Results Framework



Attachment D – Brief descriptions of relevant district-level activities of other USAID implementing partners in target districts

There are several projects, briefly described below, with activities relevant to the purpose of this RFA that might require the Recipient to work closely with the IPs implementing these activities.

***USAID Health Projects***

**The SUNRISE-Orphans and Vulnerable Children (OVC)** project, implemented by International HIV/AIDS Alliance is responsible for strengthening the capacity of districts and lower local governments and civil society organizations (CSOs) in planning, implementation and monitoring of OVC district responses, in nine (9) target districts.

**The SCORE** project implemented by Association of Volunteers in International Service Foundation strengthens capacity of the critically and moderately vulnerable households to access nutrition, economic strengthening and child protection services, through community based organizations in eight (8) target districts.

**Health Initiatives for the Private Sector (HIPS) Project** implemented by Cardeno/Emerging Markets Group works with the Ugandan business community to find cost-effective ways to ensure access to vital health services for company employees, their dependents and the surrounding community members. Specifically, the Project facilitates partnerships and provides technical assistance to design and implement comprehensive workplace health programs that maximize the accessibility of HIV/AIDS, TB & Malaria prevention and treatment services and improve use and knowledge of RH and Family Planning services and products. HIPS supports five (5) Private for Profit (PFP) clinics and several out-growers schemes (often involved in house hold testing) through Nile Breweries Limited in northern Uganda.

**The AFFORD/Uganda Health Marketing Group (UHMG)** project implemented by Johns Hopkins University works with communities, private sector service providers to social market, and increase visibility and demand for a range of HIV/AIDS, and MNCH/RH products and services. Promotional activities targeted at the community level, aim at sensitizing and engaging them to adopt healthy behaviors. Specifically, UHMG supports and builds the capacity of private sector service providers, to deliver health services and products. These services include family planning, HIV prevention and care, malaria prevention and child health services. UHMG has franchised two hundred (200) Good Life clinics across Uganda, including in the target districts.

**The Health Communications Partnership (HCP)** project implemented by Johns Hopkins University, works with USG partners to promote strategic, coordinated, multi-channel communication programs. In addition, HCP is supporting and building the capacity of public and private sectors to design and implement strategic health communication programs. Working with partners, they develop Behavior Change Communication/ Information Education and Communication (BCC/IEC) materials and job aides for use at community level and health units.

**The Securing Ugandans' Right to Essential Medicines (SURE) Program** implemented by Management Sciences for Health (MSH) supports the strengthening of the national pharmaceutical supply system. The MOH Pharmacy Division has endorsed

the national roll-out of a standard district support package designed to strengthen the capacity of districts and health facilities to effectively plan, manage and monitor their health commodities. The district support package, developed in collaboration with the SURE program, includes training of Medicines Management Supervisors (selected from district health team), routine performance monitoring of facilities in supply chain management, provision of motorcycles and fuel for supervision activities, training in pharmaceutical financial management, a performance-based reward scheme, computerization of hospital medical stores, and facility accreditation in Good Pharmaceutical Practices. SURE is implementing the district support package in four (4) target districts.

**The Uganda Capacity Program (UCP)** implemented by IntraHealth International seeks to strengthen the human resources needed to implement quality health programs through improved workforce planning, allocation and utilization, improved health worker skills, and strengthened systems for sustained health worker performance on the job to meet performance expectations and remain on the job. UCP implements activities in all target districts.

**The Targeted HIV/AIDS Laboratory Services (THALAS)** implemented by Joint Clinical Research Center project is a five year USAID supported program. The project successfully transitioned direct HIV/AIDS care and treatment activities to public sites that continue to receive technical assistance through Strengthening Uganda's Systems for Treating AIDS Nationally (SUSTAIN) project. Through its Regional Center of Excellence (RCE) in Gulu, THALAS continues to provide advanced lab services including CD4 count, viral load test, and DNA-PCR for early infant diagnosis for all HIV/AIDS care and treatment units in northern Uganda. THALAS will also build capacity and quality of selected Regional Referral Hospitals so that they implement good clinical laboratory practices and be able to conduct critical test for HIV/AIDS diagnosis and disease monitoring.

**The SUSTAIN** project implemented by University Research Council (URC) is focused on the provision of technical assistant to regional referral hospitals and selected district hospitals on comprehensive HIV/AIDS care, treatment and PMTCT services. SUSTAIN will coordinate with THALAS so that all supported facilities are linked to lab services provided by THALAS RCEs and work with THALAS to transfer skills and experience on laboratory management to selected public health facilities (including regional referral hospitals).

**The Healthcare Improvement (HCI)** Project implemented by URC supports the improvement of quality of comprehensive HIV/AIDS care and treatment at central, district and facility level. HCI project also builds capacity of USAID development partners to develop quality improvement (QI) interventions in line with the national QI framework. Currently, HCI is in the process of transitioning supported health facilities and district QI teams to the District-based Technical Assistance programs.

**The Long Term Methods** Project, implemented by Marie Stopes Uganda (MSU) has received funding from USAID to implement Family planning outreach, capacity-building of the public sector to implement long-term and permanent methods (LTPM), and a voucher-based program, redeemable at PFP and PNFP facilities, to offer services for LTPM. The Program will operate in all target districts.

***USAID Non-Health Projects in northern Uganda***

**The Strengthening Governance, Accountability, Participation and Performance (GAPP)** project (currently in procurement) will seek to promote **"**more equitable, efficient and effective service delivery." To achieve this goal, the program will enhance accountability, improve local government governance and support non state actors to increase voice and demand for improved services. It will operate in all the target districts.

**The Community Connector** is USAID/Uganda's flagship program to provide a comprehensive and multi-sectoral approach to poverty, food insecurity, and under-nutrition in Uganda, targeting those communities that witness disproportionate levels of each. The CC will work in five (5) target districts. The CC will adopt and build on existing programs to sustainably enhance food security, nutrition and reduce poverty. This will be done using a mix of strategies depending on local needs and peculiarities that address issues regarding access to higher quality foods and adoption of healthy nutrition practices.

Coverage of the large and relevant USAID projects with district-level implementation is as follows, though this list is not exhaustive.

| **Target District** | **CC** | **GAPP** | **UCP** | **HCI** | **SURE** | **SUNRISE** | **SCORE** | **MSU** |
|---|---|---|---|---|---|---|---|---|
| Pader | X | x | x | x | x | | | X |
| Agago | X | x | | | | | | X |
| Dokolo | X | x | x | | | X | | X |
| Kole | X | x | | | | | | X |
| Oyam | X | x | x | | x | | | x |
| Lira | | x | x | | | X | x | X |
| Alebtong | | x | | | | | x | X |
| Nwoya | | x | | | | | x | X |
| Amuru | | x | X | | | X | X | X |
| Otuke | | x | | x | | | x | X |
| Lamwo | | x | | x | | | X | X |
| Gulu | | x | X | x | | X | x | X |
| Apac | | x | X | | x | X | | X |
| Amolatar | | x | X | | x | X | | X |
| Kitgum | | x | X | x | | X | X | X |

Attachment E – DISTRICT HRH PACKAGE AND EXPECTED ROLE OF DISTRICT IMPLEMENTING PARTNERS

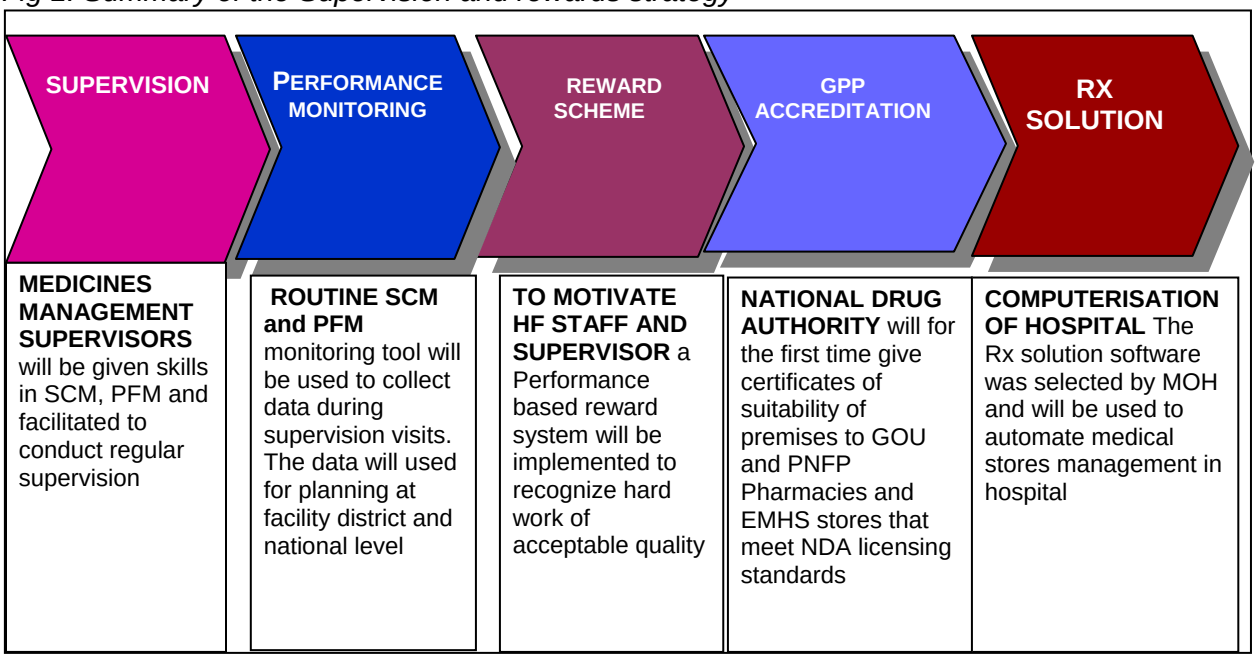
| **Intervention** | **Role of UCP** | **Expected Role of District based IP** |
|---|---|---|
| Established functional and sustainable HRIS (includes ensuring data use for decision making) | TA in system design, software and hardware satisfaction, installation and training of users and IP; technical support to IP | Logistical support for maintenance of the system, IT support, ensuring data analysis, use and regular reporting. |
| Orient districts on implementation of HRH policy guidelines and strategies | Support all districts to develop annual HRH action plans and budgets | Participate in HRH planning and integrate own HRH related activities , support advocacy to integrate HRH action plans and budgets into the district plans and budgets; support implementation of HRH plans and include HRH in routine monitoring activities and reporting |
| Develop and implement Performance Improvement (PI) plans and other supervision strategies at the district level. | Work with MOH and related IPs to develop the implementation frame work and tools. Train national and district teams, demonstrate in selected districts, provide TA to MOH, districts and IP as they implement. Provide all necessary documents and tools. | Participate in district training. Supporting training of facility teams, performance assessment and planning interventions.<br><br>Support implementation in facilities and further roll out of PI in own districts. Adopt PI for structured and systematic way of support supervision. |
| Improve communication between district Human Resource (HR) managers and Professional Councils | Establish district supervisory authorities with access to the Council databases and use.<br><br>Support the development of a data system to support sharing of information related to professional qualifications , competence | IPs to support districts to ensure that all the serving health workers have valid practicing licenses through the district supervisory authority.<br><br>IPs to strengthen capacity for HRH data analysis and sharing in districts |

| | | |
|---|---|---|
| | and ethics between Health Professional Councils and district HR managers through the district Supervisory Authority | |
| Provide support to districts to recruit new staff to increased percentage of approved posts filled by trained health workers. | District annual recruitment plans will be developed and will be consolidated into a national recruitment plan for local Governments. The support of the DSC and orientation of new health staff. | IPs will provide logistical and financial support to Districts Service Commissions (DSC)s to carry out the recruitment in a timely manner. |
| Provide support to District service Commissions | DSCs in selected districts will be supported with basic office furniture and equipment.<br><br>The members of the DSC will be trained on their roles.<br><br>The support to the DSCs will include provision of basic office furniture, equipment, a computer aided short listing tool as a best practice. | IPs will provide similar support to DSC in their districts |
| Improve work climate for Health workers | Training of Health and HRH managers in leadership and management, and advocating for improved infrastructure equipment and supplies at the health facility level to ensure supportive work climate. | IPs to work with districts to improved infrastructure equipment and supplies at the health facility. |
| Establish systems to enhance work place safety | Develop and produce implementation guidelines, tools and job aids. Implement work place safety in five districts | IPs to roll out work place safety implementation in their districts |
| Build capacity for use of Workload Indicators of staffing Needs (WISN) methodology in the management of health workers | Work with MOH to develop the tools for WISN methodology, train central resource teams and test in selected districts. Train district teams and IPs in the methodology. | IPs to roll out WISN methodology in their districts |

**Note: Please show costs for implementing the HRH Package separately in budget proposal**

Attachment F – The District Supply Chain Management Strengthening Package

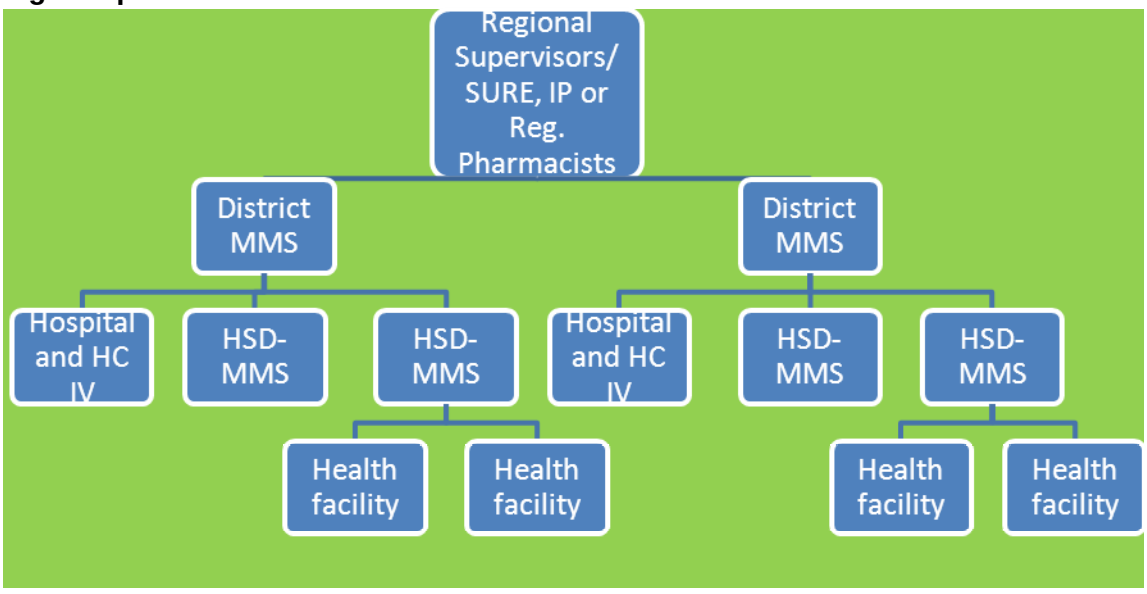
*Fig 1: Summary of the Supervision and rewards strategy*




*Supervision*

Regular supervision will be the main mode for capacity building at facility level. Trained supervisors will mentor and coach health facility staff and focus on improvement of management of EMHS. As shown in figure 2 below, the regional field office provides support, to district supervisors who in turn support the Health sub district supervisors. The supervisors are District/MOH employees who are trained and facilitated to carry out supervision in addition to their normal duties.

**Fig 2.Supervision Structure**



*Performance Monitoring*
All supervisory visits will also involve data collection on a number of indicators that measure the performance of health facilities on stock management, storage of commodities, ordering, reporting and rational use. The supervisors will be facilitated with netbooks and modems to collect and analyses the data in real time and share this information with the district managers. The data will also be sent to the national Pharmaceutical Information Portal at MOH where it will be accessible to all stakeholders

*Reward system*
The Supervision and performance monitoring system has a built- in reward system for facilities and supervisors. On achieving predetermined performance targets the supervisor will be given the following: Motorbike, phone Airtime, Netbook, internet access (Modem), online course.

*GPP Accreditation*
The National Drug Authority is mandated to carry out inspection of all medicines outlets on a regular basis to ensure that premises, personnel and practices are at a level that meet minimum standards as set out in the guidelines. Whereas inspection and licensing has been going on in the private sector since the inception of NDA, the public and PNFP facilities have been excluded. Beginning this year and in collaboration with SURE and pharmacy division, NDA will inspect and license health facilities. The pharmacists and store keepers will be trained and coached to make improvements before NDA inspections.

*Rx solution (optional component)*
SURE will support the computerization of medical stores in hospitals. It will procure the hardware and train stores staff in use of Rx solution, software for stock management selected by MOH. The health facility staff will be able to analyze and use data generated for better planning

**Implementation of the District SCMS Strategy (District Support Package)**
A set of steps that needs to be taken by the NU-HITES IP to implement the national District SCMS strategy as listed below. The steps are developed on the basis of the experiences gained from the SURE pilot districts, prior SDS organized meetings, meetings held with STAR programs and discussions with Pharmacy Division. The steps should form the basis for the work plan for this activity:

1. Identifying and assigning districts to Partners
2. Signing MOU with the districts
3. Training IP logistics advisors as regional supervisors (Medicines Management Supervisors (MMS) 2 weeks training course + practical training together with experienced SURE regional staff or experienced MMS)
4. Setting up the supervision structure and routines including procurement of motorbikes or availing other forms of transport, Net books, printers etc.)
5. Clarifying roles and responsibilities and protocols for operations - Set up administrative procedures for remuneration, reporting, fueling etc.
6. District to appoint District and HSD MMS-
7. Training of MMS in Supply Chain Management, mentoring, data collection, analysis etc.
8. Training of MMS ( if needed) in motorbike driving
9. Training in use of equipment IT, data collection tool/ analysis etc.

10. Application of the national data collection tool and if needed inclusion of additional specific indicators to the supervision tool
11. Supervision of Health facilities to cover:
    - All Public and PNFP facilities
    - All Logistics areas including Lab, ARV and EMHS
12. Regular and standard report from Facilities and automation of data collection and analysis (training and data utilization)
13. Regular meeting with MMS and feed back
14. Implement performance reward scheme
15. Regular district meeting put in place to discuss supply chain issues
16. Continued M and E training for all supervisor
17. Support districts to establish systems for coordination of logistics activities and improve district capacity to use information for planning

Resources: Outside of SURE districts, SURE will provide trainers for the Logistic training (ARV focal persons), and MMS training/ TOT. SURE to provide implementation guidelines with software

**Note: Please show costs for implementing District Support Package separately in budget proposal**

Attachment G – QUALITY MANAGEMENT DISTRICT-SUPPORT PACKAGE

Quality management (QM) is considered as a set of coordinated activities implemented so as to continuously improve a program's performance. Therefore, the following three main components of QM should be supported in order to effectively improve quality of service delivery:

1. Quality assessment against: 1) national standards and indicators; 2) customer's needs, expectations and perceptions. It is important for programs to attain baselines so as to measure a demonstrated change.
2. Quality improvement: Identification of problems; test changes; assess; and implement on wider scale.
3. Quality control and Quality Assurance: through routine monitoring, supervision and effective feedback mechanisms.

**DO3 Priorities**

1. Interventions should support national QI structures in line with the national QI framework;
2. District-based implementing partners should ensure smooth transition from HCI project that ends in September 2013;
3. Support expansion of QI interventions across other health areas such as MNCH, FP/RH, malaria as well as support services (data management, laboratory, supply chain). Entry points such as OPD, IPD, child clinics which are important for linkages should also be targeted;
4. District leadership should be actively engage so as to promote ownership and sustainability. Partners should support activities that aim to strengthen District capacity to coordinate, plan and monitor QI activities. Measurement of capacity building activities is pertinent.
5. Monitoring, measurement and reporting of improvement should be a planned for from the outset.
6. Projects are expected to plan for phased transition to national QI structures during the project life time.

| | **What to support** | **Expected Interventions** |
|---|---|---|
| **Structures** | Quality Assurance Department | Participate in central level coordination for a Support dissemination of policies, guidelines and standards. |
| | Regional QI Teams | In areas not covered by SUSTAIN, a district-based partner is expected to support Regional QI Teams. |
| | District QI Teams | Partners are expected to build the capacity of district QI teams to train, monitor, mentor and coach facility QI teams. |
| | Facility QI Teams | Partners are expected to support facilities implement QI models, engage service users and continuously improve service delivery processes. |
| | Community Health | Partners are expected to support integration of |

| | **What to support** | **Expected Interventions** |
|---|---|---|
| | Structures | QI in community health activities (VHTs, PHA networks, etc) |
| | | |
| | | |
| **Health Areas** | HIV pre-ART and ART, PMTCT, HCT, Safe Medical Circumcision, TB/HIV | Partners should support the ART QI framework: those eligible are enrolled in care and treatment services; retained and adhere to treatment; and have good health outcomes.<br>Partners are expected to integrate QI in PMTCT prongs:<br>1. Prevention of HIV in women<br>2. Prevention of unwanted pregnancy in HIV positive women<br>3. Prevention of Mother- to- Child Transmission of HIV<br>4. Care and support for HIV positive women, infants and their families<br>Other HIV/AIDS services (HCT, TB/HIV, SMC) should be in line with national guidance and standards. |
| | Maternal, neonatal and child health; Family Planning and Reproductive Health; Malaria; and Nutrition | At a minimum, partners are expected to support expansion of QI into these health areas. |

**Note: Please show costs for implementing District Support Package separately in budget proposal**

Attachment H – Reference Document List

| Reference | Title |
|---|---|
| 1 | *Uganda Health Sector Strategic and Investment Plan (2010-2015)* www.health.go.ug/docs/HSSP_III_2010.pdf |
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| 11 | PEPFAR Indicator Guidance http://www.pepfar.gov/guidance/index.htm |
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