USAID | UGANDA
FROM THE AMERICAN PEOPLE

Issuance Date:	November 28, 2012
Deadline for submission of Questions:	December 10, 2012 4pm EST (Washington, DC)
Anticipated date of response to Questions:	On or about December 14, 2012
Closing Date for Application Submission:	January 15, 2013
Closing Time:	4pm EST (Washington, DC)

Subject: **Request for Application (RFA) Number RFA-617-13-000001: "USAID/Uganda Communication for Healthy Communities (CHC)"**

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 application(s) 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 **December 7, 2012.**

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.

TABLE OF CONTENTS

SECTION I – FUNDING OPPORTUNITY DESCRIPTION

PROGRAM DESCRIPTION

I.1 EXECUTIVE SUMMARY

USAID/Uganda anticipates awarding a new, $50 million, five-year cooperative agreement for an activity titled Communication for Healthy Communities (CHC) program. The goal of this program is to contribute to a reduction in HIV infections, total fertility, maternal and child mortality, malnutrition, malaria and tuberculosis (TB). The Strategic Objective of the program is to increase adoption of healthy behaviors (including uptake of critical health services) through strengthened health communication, in order to contribute to these improved health outcomes. To achieve this objective, Communication for Healthy Communities aims to achieve the following three Intermediate Results (IRs):

- IR1: High quality health communication interventions designed and implemented;
- IR2: Improved coordination of health communication interventions; and
- IR3: Increased research and knowledge management to enhance health communication.

The Communication for Healthy Communities program will design and execute well-coordinated, evidence- and theory-based health communication interventions to improve knowledge, attitudes, norms, behaviors, and demand for services relating to HIV, tuberculosis, malaria, nutrition, maternal and child health and family planning. Capacity strengthening of the Government of Uganda (GoU) and other stakeholders, particularly U.S. Government (USG) service delivery partners, is critical to the success of this program. The program will strengthen skills needed to design, manage and evaluate health communication interventions, and to adapt and scale up communication efforts in support of service delivery activities at the community level. This program will also enhance the GoU's capacity to lead and coordinate health communication interventions. Finally, Communication for Healthy Communities will support a robust learning agenda to strengthen program implementation, document impact, and contribute to the knowledge base relating to health communication.

I.2 CONTEXT

I.2.1 Health Status in Uganda

Available data suggest that the health status of Ugandans has seen limited improvement over the past decade. Uganda continues to bear a heavy burden of HIV, with an estimated 1.2 million persons living with HIV (PLHIV). Uganda experienced dramatic declines in HIV infection rates in the late 1980s and early 1990s, attributed primarily to population-level shifts in sexual behavior, including a notable reduction in the number of sexual partners. For the last two decades, HIV prevalence plateaued around 6-7 percent, but recently, the 2011 AIDS Indicator Survey (AIS) found an increase from 6.4 percent in 2004-05 to 7.3 percent in 2011. With population growth, the absolute number of new HIV infections has risen by about 50 percent.

Uganda's HIV epidemic is still primarily driven by heterosexual transmission, which accounts for 75-80 percent of infections. Vertical infections account for 20 percent of new infections, while blood-borne and other modes of transmission account for less than 1 percent. The main drivers of HIV infection have evolved in recent years. Currently, most new infections are among stable, married couples, driven by sero-discordance, multiple and concurrent extra-marital partnerships, as well as transactional, early and cross-generational sex. Formal sex-work also plays an important role in HIV transmission. The AIS 2011 found increases in some risk behaviors since 2004-05; notably, condom use at last higher risk sex declined sharply for both men and women.

According to the 2011 preliminary results of the Uganda Demographic and Health Survey (UDHS), contraceptive prevalence in Uganda is 26 percent and 30 percent for modern methods and all methods respectively. Oral contraceptive pills and injectables are the most commonly used methods, although there is increasing demand for long acting and permanent methods (LAPM), including implants (for which availability is still limited). Unmet need for family planning (FP) in Uganda, at 34.3 percent in the 2011 UDHS, is one of the highest in sub-Saharan Africa. The current population growth rate of 3.2 percent and total fertility rate of 6.2 are among the world's highest, undermining Uganda's economic and social development gains.

UDHS 2011 also indicates that the maternal mortality ratio persists at 438 per 100,000, and has fallen only slowly over the last decade. Hemorrhage and sepsis are the most common causes of death among pregnant women in Uganda, who are often unable to get to a skilled provider or health facility. While almost all pregnant women (94 percent) attend at least one antenatal care (ANC) visit with a skilled provider, ANC attendance drops off sharply at subsequent visits.

According to UDHS 2011, between 2006 and 2011, infant mortality declined from 76 to 54 per 1,000 live births, and mortality for children under five from 137 to 90 per 1,000 live births, respectively. Uganda also faces significant nutritional challenges: 14 percent of children are underweight and 33 percent are stunted. Under-nutrition is an underlying cause of mortality, accounting for 60 percent of deaths among children under five years of age. Exclusive breastfeeding of infants under six months is reportedly practiced by 60 percent of Ugandan women; however, initiation often does not occur in the first hour of life. Micronutrient malnutrition poses a huge burden, especially on women and children. Rates of vitamin A deficiency are 20 percent in children and 19 percent in women; 75 percent of children and 49 percent of women respectively suffer from anemia.

The leading causes of death among children under five are malaria (25 percent), neonatal diseases (23 percent), pneumonia (19 percent), and diarrhea (17 percent). Data from the 2009 Uganda Malaria Indicator Survey (UMIS) show that 47 percent of households nationwide owned one or more insecticide-treated nets (ITNs), and 44 percent of pregnant women and 33 percent of children under the age of five years old had slept under an ITN the night before the survey.

The high burden of tuberculosis (TB) against a background of high HIV sero-prevalence contributes to high TB-related mortality. Late presentation of patients to diagnostic and treatment units impedes early TB treatment initiation and exacerbates case fatality rates. An estimated 20 percent of patients who initiate TB therapy do not complete the

prescribed eight month course of treatment, heightening the risk of developing drug resistance.

For more information on these topics see studies and reports listed in Section J, Attachments.

I.2.2 GoU and USG Policy Frameworks and Key Partnerships

The USG strategic approach in the health sector is rooted in the frameworks and policy documents the GoU has developed, and supports the goals expressed in these documents. USAID/Uganda's health sector assistance is increasingly focused on ensuring GoU ownership of health programs, in order to increase the sustainability of health services and interventions.

The 2011/2015 *National Development Plan,* the GoU's pre-eminent planning document, expresses a vision for "a transformed Ugandan society from a peasant to a modern and prosperous country within 30 years." The *National Health Policy II 2011/2020* aims "to attain a good standard of health for all people in Uganda in order to promote a healthy and productive life," while the *National Health Sector Strategic Investment Plan (HSSIP) 2010/2011- 2014/2015* lays out ten guiding principles for the health sector. Other relevant documents include the *Roadmap for Accelerating the Reduction of Maternal & Neonatal Mortality and Morbidity*, the *National Child Survival Strategy*, the *National Malaria Policy*, the *National Policy Guidelines & Standards for Reproductive Health Services,* and the *Uganda Nutrition Action Plan*. The *Uganda Gender Policy* establishes a framework for implementation and coordination of efforts to promote gender equality and women's empowerment. The Ministry of Health (MOH) also has an Information Education Communication (IEC)/Behavior Change Communication (BCC) strategy. Although many GoU health policies and plans have been developed, their implementation faces multiple political, institutional and operational constraints and challenges.

In the area of HIV/AIDS, the *National HIV/AIDS Strategic Plan* 2007/08 – 2011/12 provides overall direction to the HIV/AIDS response in the country. The *National HIV Prevention Strategy 2011/2015* aims to strengthen planning, implementation, and monitoring of high-quality, evidence-informed, and universally accessible HIV prevention initiatives, within a multi-sectoral response. The prevention strategy seeks to improve the effectiveness of HIV prevention programs in Uganda through improved targeting of at-risk groups, prioritizing evidence-based prevention interventions, delivering combination HIV prevention packages at multiple levels, and strengthening coordination, monitoring and evaluation of HIV prevention efforts.

The Communication for Healthy Communities activity is expected to build strategic partnerships with key GoU entities. All communication initiatives shall be closely coordinated with relevant GoU stakeholders, including: the Uganda AIDS Commission (UAC) and the MOH including their IEC/BCC working group, Health Promotion Department, the Maternal-Newborn and Child Health (MNCH)/FP revitalization working group, the National TB and Leprosy Control Program, National Malaria Control Program, and AIDS Control Program. This program will also work closely with other relevant Ministries, such the Ministry of Education and Sports, and the Ministry of Internal Affairs

which oversees the police, non-military uniformed personnel, prisons and district administrations.

I.2.3 THE U.S. PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)

PEPFAR is the largest global initiative responding to the AIDS epidemic. The second phase of PEPFAR, authorized in 2008, aims to: 1) transition from an emergency response to sustainable country programs; 2) support host governments to take active leadership in the response and embed HIV/AIDS services into national health and development systems; 3) expand HIV/AIDS prevention, care and treatment; 4) integrate and coordinate HIV/AIDS activities with broader health and development programs to maximize impact on health systems; and 5) invest in innovation and operations research to evaluate impact, improve services and maximize outcomes. PEPFAR global 2013 targets include: providing antiretroviral treatment to 6 million people with HIV/AIDS; preventing 12 million new HIV infections; and providing care for 12 million people, including 5 million orphans and vulnerable children.

PEPFAR Uganda activities must contribute significantly to these global targets. In alignment with Uganda's National Development Plan, National Strategic Plan (NSP), Health Sector Strategic Investment Plan (HSSIP), and other key GoU strategies, PEPFAR Uganda will continue to expand and strengthen the coverage and scope of HIV/AIDS services in Uganda, as well as build institutional capacity and systems for long-term sustainability. The vision of the U.S. President's Emergency Plan in Uganda remains: "Within the framework of Uganda's multi-sectoral response, the Emergency Plan will contribute to strengthening national capacity to address the HIV/AIDS epidemic, achieving improved quality of life, equitable access to services, and sustainable systems."

Other relevant USG initiatives in Uganda include the *Global Health Initiative (GHI)*, which focuses USG efforts on key principles including sustainability, integration and gender equality; *Saving Mothers, Giving Life* which aims to significantly reduce maternal mortality in four western districts in one year; *Feed the Future,* which addresses the root causes of hunger and aligns USG resources with country-owned processes; and the *President's Malaria Initiative (PMI*), which supports proven and cost-effective malaria prevention and treatment interventions, including insecticide-treated mosquito nets.

I.3 USAID/UGANDA PROGRAM

I.3.1 USAID/Uganda Strategic Directions in HIV/AIDS and Health

The Communication for Healthy Communities program will support the achievement of USAID/Uganda's Health, HIV/AIDS and Education Office's Development Objective 3 (DO3): "Improved health and nutrition status in focus areas and population groups," under USAID/Uganda's new 2011-2015 Country Development and Cooperation Strategy (CDCS). The CDCS is accessible online at: https://www.fbo.gov/index?s=opportunity&mode=form&id=f573abb95a1080cb1ccc621fc4108ca1&tab=core&_cview=0. The new Communication for Healthy Communities

activity must proactively contribute to USAID's portfolio of integrated health, HIV/AIDS and cross-cutting programs, described below.

Within PEPFAR, USAID works together with the U.S. Centers for Disease Control and Prevention (CDC), Department of State, Peace Corps, and Department of Defense through a common five-year strategy and annual country operational plans to expand the scope and coverage and strengthen the quality of integrated HIV/AIDS services in Uganda. The annual country operational plans are developed in collaboration with GoU ministries, non-governmental organizations, and other development and implementing partners. Currently, the USG supports more than 80 percent of Uganda's national HIV/AIDS response. As of September 2011, PEPFAR directly supported 257,689 of 300,000 Ugandans accessing ART. PEPFAR also supports strengthening of health systems and HIV care and support.

HIV prevention remains an important priority for PEPFAR/Uganda and for the new Communication for Healthy Communities program. The PEPFAR *Guidance for the Prevention of Sexually Transmitted HIV Infections, (*available at http://www.pepfar.gov/guidance/171094.htm), calls for a "combination prevention" approach that includes biomedical, behavioral and structural interventions. In line with the priority given to high impact evidence-based interventions in the prevention guidance, the USG works with the GoU to scale-up voluntary medical male circumcision (VMMC) services and to increase demand for VMMC. USG is also working with the GoU and other stakeholders to support the national acceleration plan to virtually eliminate Mother-to-Child Transmission within the next two years. USG supports a wide range of HIV testing and counseling (HTC) efforts, including provider-initiated counseling and testing at health facilities, and client-initiated counseling and testing for high HIV prevalence communities and most at-risk populations (MARPs). USG promotes correct and consistent condom use, and supports social marketing to make condoms widely available through retail networks at affordable prices.

USG also supports evidence-based interventions to address risky behaviors, with the relative emphasis on adults, youth and at-risk groups tailored to the local epidemiology. USG partners work to heighten individual risk perception among key target groups, including sex workers, fishing communities, truckers, and sero-discordant couples. USG also invests in social mobilization to address social and gender norms such as tolerance of multiple concurrent sexual partnerships. Communication for Healthy Communities is expected to make significant contributions to social mobilization for VMMC, prevention of mother to child transmission (PMTCT), and HTC, including couples counseling and testing, and to also support behavioral prevention efforts and ART adherence.

USAID's integrated family planning (FP), reproductive health (RH), and MNCH programs focus on enhancing health system functionality, increasing health service uptake, and improving FP and maternal and child health (MCH) outcomes by mainstreaming high impact interventions in these technical areas. USAID supports procurement of contraceptive commodities, and has intensified its focus on improving the contraceptive method mix. USAID partners also work to make methods that are typically only offered at higher-level health facilities available at the community level through mobile outreach and other appropriate service delivery strategies. Family planning-related communication also promotes uptake of long-acting contraception,.

USAID works with the MOH to prevent malnutrition and micronutrient deficiencies in children and women of reproductive age through: promotion of vitamin A supplementation and deworming during child days; provision of iron and folic acid; introduction of zinc for diarrhea to health providers; and promotion of food fortification in the local food industry. The USG works to prevent and to control malaria via: scale-up of insecticide-treated bed-nets; indoor residual spraying with insecticides; intermittent preventative treatment during pregnancy; and diagnosis and treatment with artemisinin-based combination therapies. Communication for Healthy Communities will support these USAID health sector initiatives through enhanced communication, including demand creation.

I.3.2 USAID/Uganda HIV/AIDS and Health Programs and Donor Collaboration

The Communication for Healthy Communities program will build on past USAID/Uganda support for health communication, and collaborate with current USAID HIV/AIDS and health sector partners on a strategic basis to maximize programmatic impact. USAID implementing partners include the following:

- From 2007 to 2012, the *Health Communication Partnership* (HCP) implemented programs to change individual behavior, mobilize communities, and create an enabling environment for sound health practices. A final evaluation of HCP activities is forthcoming, and will inform the new activity. Communication for Healthy Communities will build on HCP's successes, with increased emphasis on strengthening national capacity to carry out and coordinate communication programs.

- The *AFFORD Project/Uganda Health Marketing Group (UHMG)* works with communities and private sector networks to increase the demand for and sale and use of critical health products and services, such as condoms and insecticide-treated bednets.

- The *Strengthening TB and HIV and AIDS Response (STAR)* programs in the East Central (*STAR -EC*), Southwest *(STAR-SW*), and Eastern (*STAR-E*) regions support comprehensive HIV and TB prevention, care and treatment services on a regionalized basis. Through their comprehensive approach, the STAR programs facilitate linkages across the range of HIV services and enhance the continuum of response.

- Several sector-specific USAID partners are also engaged in the battle against HIV/AIDS. *Supporting Public Sector Workplaces to Expand Action and Responses Against HIV/AIDS (SPEAR)* works with selected government ministries to develop HIV/AIDS workplace policies and to provide HIV services to employees and their families. *Health Initiatives for the Private Sector (HIPS)* works with the business community to facilitate access to health services for company employees, their dependents and surrounding communities. *The Inter-Religious Council of Uganda (IRCU)* implements HIV prevention efforts in the faith-based sector. The *Civil Society Fund* provides small grants and capacity building to civil society organizations engaged in HIV/AIDS activities.

- *STRIDES for Family Health* works with the MOH, districts, communities, providers and private organizations to increase contraceptive use, promote appropriate timing and spacing of pregnancy, and decrease maternal and child mortality. *Strengthen Decentralization for Sustainability (SDS)* works to improve the results and sustainability of decentralized HIV/AIDS and health services, with initial emphasis on the local government level. The *Long Term/Family Planning* program aims to expand access to affordable, quality family planning services and contraceptive choices, including making long-acting and permanent methods available in rural areas at the community level.

USAID Uganda also seeks to enhance cooperation with other development and health sector partners. The following are the most significant of these donors:

- *The Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria* supports the Ugandan health system in scaling up comprehensive services to address these diseases.

- *The UK Department for International Development (DfID)* supports the health sector through assistance in family planning and malaria.

- *The World Bank* supports health systems strengthening with particular emphasis on maternal and child health. Additionally, it procures family planning commodities.

- *UNICEF* supports critical child health services: PMTCT, pediatric AIDS treatment, bed net distribution, integrated management of childhood illnesses, the expanded program on immunization, and emergency obstetrics and newborn care training in seven regions.

USAID implementing partners and other programs working to strengthen the delivery of health services at the community level all have a need for supportive communication activities, including demand creation. Many already engage in outreach to promote increased uptake of services. However, for the most part, these partners have limited expertise in the development of health communication activities and materials. Additionally, coordination of communication activities across the many health sector implementing partners is weak. The new Communication for Healthy Communities activity will design and implement communication initiatives including mass media, develop and produce materials to support the work of other implementing partners, build capacity in health communication, and strengthen the quality and coordination of health communication efforts.

I.4 Results Framework

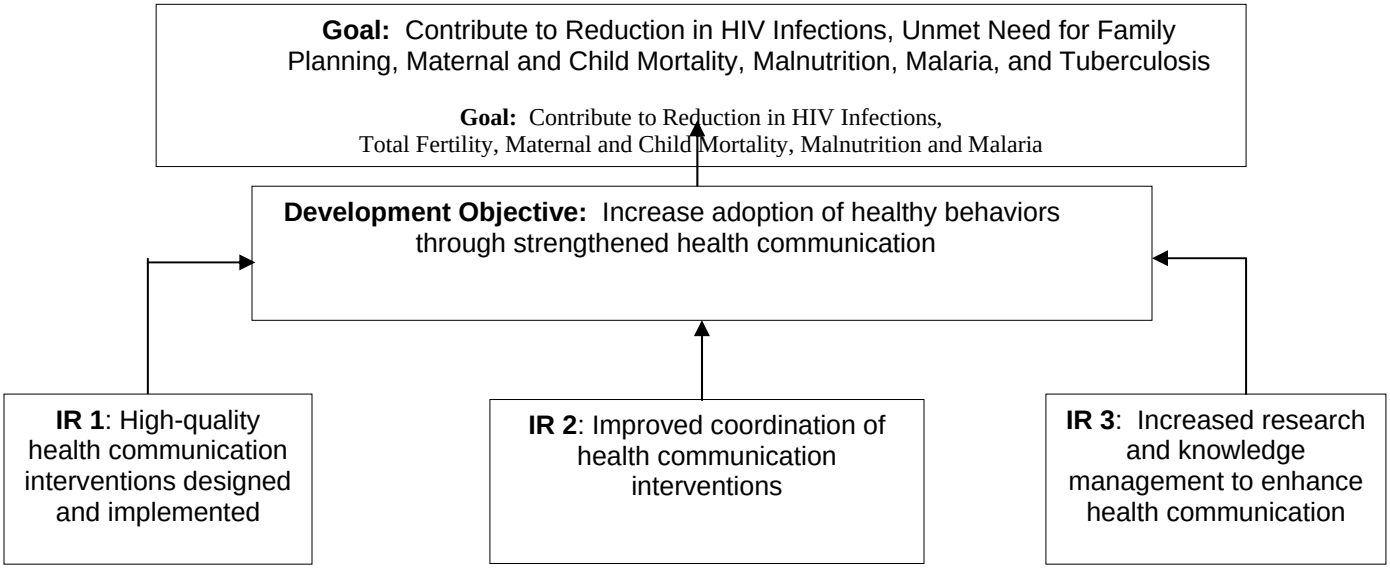
I.4.1 Development Hypothesis

The goal of the Communication for Healthy Communities activity is to contribute to improved health outcomes: specifically, to a reduction in new HIV infections, total fertility, maternal and child mortality, malnutrition, malaria, and Tuberculosis. Communication for Healthy Communities' strategic objective is: increase adoption of healthy behaviors through strengthened health communication.

The development hypothesis underlying the design of this activity is that the strategic objective above will be achieved if high-quality, well-coordinated health communication interventions are conducted based on research and evidence relevant for Uganda's context. Such interventions, it is hypothesized, will increase adoption of healthy behaviors, including utilization of critical, high-impact health services, resulting in improvements in health status as reflected in the Results Framework below.

The Communication for Healthy Communities program will carefully track, verify or adjust implementation of the activity's development hypothesis, informing USAID of appropriate opportunities for adjustment, in order to modify direction as needed to ensure achievement of results that will impact the HIV epidemic and other health problems.

Communication for Healthy Communities: Results Framework



I.4.2 Development Objective (DO), Activity Overview and Illustrative Indicators

SO: Increase adoption of healthy behaviors through strengthened health communication

The program will design, execute and evaluate well-coordinated, evidence-informed and theory-based health communication interventions relating to HIV/AIDS, TB, malaria, nutrition, maternal and child health and family planning. These interventions are expected to improve relevant knowledge, attitudes, beliefs and norms in geographic and programmatic areas where campaigns and other communication efforts are implemented. These changes are expected, in turn, to contribute to improved health behaviors, including increased utilization of proven, effective, high-impact HIV interventions and other health services. Additionally, it is anticipated that, by increasing

clients' knowledge and demand, communication interventions will put pressure on the health system to provide better quality services.

Communication for Healthy Communities will work closely with the MOH, UAC and other stakeholders to ensure country ownership of health communication initiatives and that interventions reflect health sector priorities and are embedded in the health system. Health communication activities will address key elements that drive or influence a particular health problem, and should be designed and implemented at a scale and intensity expected to achieve desired outcomes.

The program will not address these issues in the traditional manner of one organization being solely responsible for design and delivery of communication interventions. While Communication for Healthy Communities will execute national-level communication initiatives, it will work closely with the MoH and other USG-funded service delivery partners to ensure that these programs are linked to community-level activities that respond to needs at the local level, and to harmonize communication efforts. In addition, the successful applicant will build the capacity of other USG implementing partners and stakeholders to implement health communication interventions and to adapt them as needed for specific priority populations. Explicit collaboration and coordination with USG service delivery partners and other stakeholders will therefore be a cornerstone of this mechanism.

The program will carry out a robust operations research and evaluation agenda to assess the extent to which health communication campaigns, messages and materials resonate with target audiences, and are effective in changing behaviors and promoting service uptake.

SO: Illustrative Indicators
The following are illustrative indicators of the types of behaviors and service uptake that Communication for Healthy Communities aims to influence in order to contribute to better health outcomes:

- Number of men aged 15-49 seeking VMMC services
- Percent of adults having more than one sexual partner in the last 12 months who report using a condom at last sexual intercourse
- Percent of HIV-positive women initiated on PMTCT who are retained in the cascade through the end of the breastfeeding period
- Percent of births delivered in a health facility
- Prevalence of exclusive breastfeeding among children under 6 months in targeted areas
- Percent of identified TB patients who complete their treatment
- Prevalence of increased correct and consistent Long-Lasting Insectide Net (LLIN) use among pregnant women and children under five
- Percent of women using modern contraceptive methods

I.4.3 Intermediate Results and Illustrative Indicators

IR 1: High-quality health communication interventions designed and implemented **(60% emphasis)**

Social and behavioral factors play a key role in achieving good health. Numerous studies show that carefully designed and well implemented communication programs can influence and change complex behaviors, and that communication can also contribute substantially to the uptake and effectiveness of health services. Communication efforts most likely to succeed in changing behaviors incorporate well-established characteristics of effective programs.

Communication for Healthy Communities will design and implement state-of-the-art, evidence-driven health communication initiatives that increase comprehensive knowledge and deepen understanding of priority health issues, promote positive health behaviors, and strengthen demand for key health services. These efforts should include plans to monitor and evaluate results that are observable and/or verifiable through qualitative and quantitative data collection. Soon after the award, this program will work closely with the GoU, USAID and other stakeholders to develop an overall plan that identifies priority topics for health communication initiatives and their optimal timing and sequencing. Additional priorities may be identified during the life of the activity.

Communication efforts implemented by this program will reflect evidence-based best practice. They will: use a combination of approaches; be solidly grounded in behavioral theory and formative research; and incorporate clear behavioral objectives and outcomes. Communication for Healthy Communities will respond in a comprehensive yet tailored manner to the complex drivers of specific health concerns. Message content will address the multiple determinants and levels of human behavior, including individual knowledge, attitudes and motivations, social norms, interpersonal relationships, and structural factors that encourage or hinder healthy behaviors. Interventions will incorporate cross-cutting themes such as gender and pay particular attention to promoting links to health service utilization, including across different health areas. Interventions will utilize interactive methodologies, be delivered with sufficient intensity and duration, and address the needs of specific target populations.

Beyond reflecting best practice, communication activities undertaken by this program should be bold and innovative. Given the limited improvement in health indicators over the last several years, as well as increases in some sexual risk behaviors and in prevalence of HIV, the situation in Uganda demands bold new initiatives and not "business as usual."

Communication for Healthy Communities is designed to have national coverage, and will support multi-channel efforts (electronic and non-electronic), including mass media initiatives that are national in reach. However, in some instances, the activity may work with selected partners to target and tailor interventions to specific Ugandan contexts and cultures. Interventions, whether national or targeted, will ensure appropriate coverage and reach to achieve impact on priority health outcomes.

Communication for Healthy Communities will support implementation by other partners by developing and adapting evidence-based communication approaches and materials.

Communication for Healthy Communities should consider developing tailored strategies and tools for reaching specific audiences with effective interventions, including standardized communication "toolkits" to help harmonize messages across diverse implementing partners. Health providers may also need materials and job aids, for example, check lists to support HIV couples counseling and testing or discussion of contraceptive options.

Communication for Healthy Communities' efforts to strengthen capacity in health communication will prioritize GoU entities and USG service delivery partners, but may also address the needs of other stakeholders. Partners will be capacitated to design and implement high quality communication programming, including at the community level. This program will develop a range of capacity strengthening and technical support approaches and tools that cater to the needs of stakeholders with varying levels of expertise. Approaches might include undertaking initial capacity assessments, implementing training workshops in state-of-the-art health communication approaches, and follow-up mentoring and technical assistance. The successful applicant will utilize, where possible, available capacity building tools and resources that have been developed through other global and regional health communication efforts such as the C-Change activity (see http://www.c-changeprogram.org).

In summary, the successful applicant will:

- Enhance knowledge, attitudes, beliefs and norms relating to key health issues and interventions among priority target groups for HIV/AIDS, family planning, maternal and child health, nutrition, malaria and TB interventions;
- Work with and strengthen GoU technical capacity to design, execute and evaluate high quality health communication initiatives; and
- Work with and strengthen the capacity of multiple implementing and service delivery partners to design, execute and evaluate enhanced health communication initiatives.

IR1: Illustrative indicators

Illustrative indicators proposed in the following sections are not exhaustive; applicants may propose alternative measures that have potential to capture the desired results.

- Extent to which national communication initiatives on priority health topics have been developed and rolled out at scale
- Extent to which standardized, high quality, "packages" for specific target populations, job aids for providers, curricula, and other materials,have been developed and field tested, and are available to and widely utilized by implementing partners
- Skills of GoU and implementing partners to design, execute and evaluate health communication initiatives measurably improved
- Extent to which community mobilization and interpersonal communication activities implemented by district and community-level partners incorporate evidence-based best practice and complement national initiatives
- Improvements in comprehensive knowledge, attitudes, beliefs, norms, self-efficacy, motivation and intentions relating to HIV/AIDS, family planning, maternal and child health, nutrition, malaria and TB, among priority target groups.

***IR2: Improved coordination of health communication interventions* (20% emphasis)**

Strong leadership and coordination are essential to the effectiveness of national health communication efforts. Improved coordination can help to harmonize approaches with key national strategy documents, facilitate the scale up of evidence-based approaches, reduce duplication between partners, and ensure that all Ugandans receive harmonized health messages. Ideally, the GoU should closely coordinate the design, implementation, and oversight of all communication initiatives at the national level, and also ensure coordination between national initiatives and programs working at the community level.

A key element of the this program will be to strengthen capacity of relevant GoU structures, especially MoH and UAC working groups at the national level, to play a stronger leadership role in coordination of health communication and to ensure government ownership of these initiatives. These efforts will complement technical capacity building of the GoU and other partners to improve the design and implementation of communication efforts under IR 1.

The program will work closely with the MOH to establish and/or strengthen sustainable mechanisms to guide health communication efforts and to enhance their effectiveness. These should include coordination fora through which the GoU can actively engage the large number of partners working in the development and execution of health communication initiatives. These coordination fora can also assist with technical updates, and share research results and best practices from implementation. Communication for Healthy Communities will assist the GoU in ensuring that communication initiatives are aligned with national strategies and priorities and coordinated throughout the country. It will also work to ensure stronger linkages and feedback between mass media and community-level activities.

At the national-level, such leadership may be reflected in the establishment of quality assurance standards and guidelines for communication activities, and standardization of messages on specific health issues and/or for specific target audiences. Communication for Healthy Communities will help strengthen the GoU's oversight and monitoring of communication activities. The program may also support MoH engagement in policy development and advocacy as needed to foster effective communication approaches and ensure national ownership of communication initiatives.

In addition to strengthening capacity for coordination and leadership on the part of the GoU, the program will improve the capacity of the various USG implementing partners to better coordinate their various communication activities, and to ensure that these activities complement and reinforce each other. Communication for Healthy Communities will also support the GoU in efforts to reduce programmatic duplication and geographic overlap of communication activities. Additionally, the program will work to enhance linkages between communication activities and referrals to services.

In summary, the successful applicant shall:

- Work with GOU to strengthen mechanisms for coordination of health communication by MOH,UAC and other implementing partners;

- Strengthen the capacity of the MOH to take leadership in health communication coordination; and
- Strengthen the capacity of implementing partners to coordinate their health communication activities

IR2: Illustrative indicators

- Extent to which MOH and other relevant GoU HIV and health communication working groups are convening regularly, have standard operating procedures, and are functioning effectively
- Integrated national operational plan for health communication completed with buy-in from all key stakeholders
- Increased leadership by GoU/MOH in health communication coordination, as reflected in issuance of high quality, relevant guidelines, standard operating procedures, etc.
- Extent of GoU engagement in and contributions to CHC's development of communication initiatives and materials for priority target audiences
- Extent to which different health sector implementing partners disseminate nationally harmonized and standardized messages through their own communication activities
- Mapping to avoid duplication and overlap of community-level communication partners completed
- Mechanisms to facilitate sharing of materials and resources by health program partners working in Uganda established and well utilized

IR3: Increased research and knowledge management to enhance health communication (20% emphasis)

Policymakers in Uganda and elsewhere need to know to what extent investments in health communication contribute to improved health outcomes. The evidence indicates that it is possible to change human behavior to reduce health risks. However, it is difficult for behavioral interventions to demonstrate a direct impact on biological outcomes. In general, there is greater consensus on the contribution of communication programs to increasing service uptake.

Measuring the public health impact of health communication programs remains challenging. It is difficult to measure an event that did not occur, such as an HIV infection averted, and to attribute a "non-event" to an intervention. Complex communication programs combining multiple strategies and stakeholders appear more effective, but are harder to evaluate than a single intervention. There is a need for further rigorous evaluation of communication programs that are implemented at scale, and for new methodological approaches to evaluating such programs when randomization is not feasible. In sum, much work remains to build the evidence for communication programs with more methodological rigor and comparability across studies.

The program, in close consultation with USAID, will develop and implement a robust Learning Agenda, i.e., a set of strategic questions for which the program intends to produce evidence, findings, and answers, primarily through research and evaluation. Communication for Healthy Communities will develop a plan to generate and disseminate knowledge to strengthen implementation of its health communication initiatives, and to document their effect on adoption of key behaviors and service utilization. The Learning Agenda should also generate evidence to support the causal pathway between CHC's planned investments and its higher-level goal of improving

health status. Of further interest is to better understand which interventions have the greatest impact in a given context, which are most cost effective, and what combination and/or sequence of interventions impact behavior. Additionally, the project should contribute to the global evidence base on the role of health communication in influencing positive health outcomes.

The learning agenda should consider the following key questions:

1) To what extent have health communication interventions undertaken by the program increased comprehensive knowledge of health issues, improvements in self-reported behaviors,[1] and uptake of HIV and health services?

2) To what extent has the activity enhanced the technical capacity of national and local-level implementing partners to deliver high quality, state-of-the-art, evidence-based, health and behavior change communication interventions?

3). To what extent has the activity contributed to an enhanced coordination and leadership role by the MOH, and to a more coordinated HIV and health communication response?

Communication for Healthy Communities must incorporate a strong impact evaluation component. This will require systematic collection of baseline data against which progress can be measured, and the use of rigorous, experimental and/or quasi-experimental research designs. Where feasible, affordable and appropriate, the program should consider including biomarkers in impact evaluations. Given their high cost, impact evaluations may be carried out on a selective basis, based on the level of investment in the intervention and the potential to contribute to the global knowledge base. It will be important to verify that the interventions to be evaluated have been well implemented.

Research will cover priority groups of interest, e.g. sex workers, fishing communities, people living with HIV, married couples, women of reproductive age, youth. Communication for Healthy Communities should utilize a mix of quantitative and qualitative research methods. The latter can provide insights into the extent to which initiatives are working, why they worked or did not, and how they can be improved. This program should carry out formative research on target audiences, to feed into the design of interventions. As communication interventions roll out, qualitative research can also help to assess audience feedback on how messages are disseminated, received and internalized and to validate message content and choice of communication channels. Communication for Healthy Communities will also emphasize innovative research methods that provide improved insights, demonstration of impact, or alternatives to relying on self-report, which is widely recognized as a flawed measure of behavioral outcomes.

Communication for Healthy Communities will carry out research and evaluation in close collaboration with other health communication and service delivery partners, and should

[1] Examples of targeted behaviors include increased condom use at last risky sex, reduction in numbers of partners, increased women enrolled on PMTCT interventions and increased use of family planning.

also collaborate with and build capacity of local research institutions whenever feasible. Additionally, Communication for Healthy Communities should coordinate with other data collection, monitoring and evaluation activities such as Health Management Information System (HMIS), Lot Quality Assurance Sampling (LQAS), and proposed MCH surveillance.

Communication for Healthy Communities should develop a knowledge management strategy, and establish a structure and process for and dedicate staff to implementation of this strategy. This strategy will address how Communication for Healthy Communities will disseminate research and evaluation findings, utilize these findings to improve programs on a continuing basis, and ensure the exchange of best practices and lessons learned in health communication. Research and evaluation findings should be shared as part of capacity strengthening efforts, and research tools should be made available to other health and research organizations in Uganda. USAID/Uganda shall have joint participation with the recipient in the formulation and development of research (e.g. Surveys, studies) and communication campaigns.

In summary, the successful applicant shall:

- Conduct operations research and impact evaluation in order to understand the effectiveness of approaches used under this program;
- Utilize data to adapt approaches, in consultation with USAID, to improve program impact; and
- Document the contribution of health communication activities to adoption of improved health behaviors, including utilization of health services.

IR3: Illustrative Indicators

- Extent to which audience feedback from process evaluations utilized to strengthen design and implementation of CHC communication interventions
- Number of indigenous institutions with strengthened capacity in design and execution of research studies
- Number of rigorous evaluations of the impact of communication initiatives on health behaviors, including service uptake, completed and disseminated
- High impact communication approaches relevant to different populations and health issues identified, tested and proven
- Extent to which promising evidence-based communication practices have been disseminated through knowledge management activities
- How well lessons from development and implementation of communication initiatives have been used to inform communication programs of other partners
- Number of studies disseminated which contribute to the global knowledge base on health communication
- Progress made in implementation of the Learning Agenda
- Implementation status of the knowledge management strategy.

I.5 STRATEGIC PRINCIPLES

- *Country ownership* is key to sustainability. USAID/Uganda places great importance on engendering GoU leadership of all health sector activities. The GoU will be supported to lead coordination of health communication efforts. Priority should be placed on engaging in activities and capacity building efforts that contribute to Ugandan ownership of health communication initiatives. This requires alignment of this program with GoU strategic and policy frameworks, and development of technical, management and leadership competencies within the GoU and local organizations.

- *Use of local-level networks and resources* is another important strategy for achieving results and sustainability. Engagement with cultural gatekeepers and other sources of local knowledge can deepen understanding of social norms, contexts, and risk factors in different regions. These resources have the potential to contribute to the long-term sustainability of health communication initiatives at the community level. Many health sector partners are successfully engaging local communities in health communication activities. Communication for Healthy Communities C should take such engagement to scale, with local-level involvement in communications research, design, implementation, and monitoring.

- *Integration* across different areas of health is important. Integration can help ensure efficient and effective use of communication resources, given the interrelated nature of health problems at the community level, and the comprehensive approach of GoU health services and USG-supported health and HIV/AIDS programs. Specific priorities for health communication will be determined collaboratively by the GoU, USAID, and other stakeholders, and may also depend on available USAID funding streams. However, to the extent feasible, Communication for Healthy Communities should demonstrate ways in which multiple health issues can be addressed in an integrated manner.

- *Gender equity* is crucial to the achievement of positive health outcomes. Gender norms play a role in access to messages and services, resources, treatment and subsequent health outcomes. The *National HIV Prevention Strategy* highlights the importance of addressing gender and social norms in HIV/AIDS interventions as a key focus area. Communication for Healthy Communities must consider how every health communication activity will affect gender dynamics and how established gender norms and roles will affect activity results. In actual implementation, communication activities must integrate gender as a key element in order to be successful in changing community and social norms. Key areas of focus for this program will include gender norms, decision-making practices and the prevention of gender-based violence (GBV).

- *Innovation* and *state-of-the-art* can also strengthen health communication efforts. USAID-supported health communication programs have often relied too heavily on traditional approaches, to the neglect of emerging private sector innovations pertaining to human behavior and communication. Such innovations are growing, especially with the use of electronic and social media, and include new qualitative research practices, application of social network principles, expanded use of mobile and digital media, and increased focus on dialogue and audience engagement.

Communication for Healthy Communities will pilot, assess, adapt, apply and diffuse creative, new, proven and promising technical innovations in communication from diverse fields, including marketing, design, advertising, anthropology, psychology and economics.

- *Young people* are key to improving health and nutrition status in Uganda. Communication for Healthy Communities should demonstrate an appropriate youth-adult balance in planning interventions, especially in reproductive health and HIV programming, in alignment with epidemiology and other factors. CPC communication activities should address the needs of adolescent girls for information about how to prevent both HIV and unintended pregnancy and access FP services. Within the youth population, the applicant should consider prioritizing out-of-school, high-risk youth in efforts to encourage utilization of health services and adoption of healthier behaviors.

I.6 KEY PERSONNEL

Five key staff are considered essential for implementation of the program.These positions are the Chief of Party and Deputy Chief of Party; Senior Technical Advisor for Health Communication; Director, Financial Management and Operations; and Senior Advisor, Monitoring, Evaluation and Research. Key personnel must have demonstrated relevant knowledge, experience and skills for their planned areas of responsibility. Management personnel must have experience leading large health communication programs in developing countries. They must also have demonstrated ability to effectively interact with national, district and community authorities, the USG and other donors, as well as USG and other implementing partners. Technical specialists proposed as key personnel must have the necessary expertise in the subject areas for which they are proposed.

A minimum of four out of the five key personnel positions must be from either Uganda or the East African Region. Countries comprising the East African Region include Uganda, Burundi, Democratic Republic of Congo, Eritrea, Ethiopia, Kenya, Rwanda, Tanzania, Somalia, and Southern Sudan. The following factors are minimum requirements for specified key personnel.

1. Chief of Party (COP): 100% Time

The Chief of Party (COP) shall be either a Ugandan citizen or from the East African region. The COP will work 100% time on this project . The COP shall provide overall strategic leadership and oversight to the program. Requisite qualifications include an appropriate balance of technical, managerial and interpersonal skills and experience. S/he shall have a deep understanding of Communication for Healthy Communities program goals and objectives and be able to articulate the strategic vision for the program. Experience in interacting with host country agencies including central and local government, development partners, civil society and community based organizations is

essential. The skills and experience of the COP shall be complementary to those of the Deputy Chief of Party. Specifically the COP will have:

- A Master's Degree or higher in Public Health, Social Sciences or equivalent field
- Minimum 10 years of progressively increasing responsibility working in public health in the fields of health communication, promotion and/or education
- Demonstrated leadership skills in working collaboratively with other donors, host country institutions, and international organizations
- Documented experience in providing the level of technical assistance that is required to complete the work detailed in Section C
- Excellent past performance references (contacts shall be provided, including email)
- Working knowledge of and experience with USG funded activity management, policies and procedures
- Excellent organizational, analytical, and oral and written communication skills (in English)
- Relevant field experience in similar settings with significant management responsibility, including relevant supervisory experience of professional (technical) staff.

2. Deputy Chief of Party (DCOP): 100% Time

The Deputy Chief of Party (DCOP) directly assists the COP in activity implementation and management. The DCOP shall have complementary technical skills and experience to the COP. The DCOP shall report directly to the COP, and will take over leadership and oversight of the activity in the absence of the COP. Specific qualifications include:

- A Master's Degree or higher in Public Health, Social Sciences or equivalent field.
- Minimum eight years of progressively increasing responsibility working in public health in the area of health communication, promotion and/or education
- Experience in developing countries managing large-scale health communication activities
- Demonstrated management skills, including relevant experience in direct supervision of professional staff
- Depth and breadth of knowledge of and experience in health communication programming.

3. Senior Technical Advisor, Health Communication: 100% Time

This individual shall directly assist the Chief of Party in the design, roll-out and day-to-day management and implementation of health communication interventions. S/he shall have depth and breadth of technical expertise and experience in designing and implementing comprehensive health communication interventions, and related capacity strengthening. S/he shall have the requisite management expertise, interpersonal skills and professional relationships to fulfill the requirements detailed in Section C. S/he will have the following qualifications, skills and experience necessary to support this activity:

- Master's Degree in public health, or a related field, with specific emphasis on health communication, promotion and/or education.
- Minimum seven years experience with progressively increasing responsibility in:

- Designing, managing and implementing complex, large scale health communication programs in developing countries involving multiple stakeholders and implementing partners
- Building capacity in health communication with the public sector, civil society, and private sector.

4. Director, Financial Management and Operations: 100% Time

This individual shall be responsible for overall financial management and administration of the activity. Minimum requirements for this position should include:

- Master's Degree in Business Administration, Finance, Accounting or other relevant field, or a Bachelor's or certified accounting degree with 10 years experience
- Minimum eight years experience in administrative and financial management of large-scale, complex, international development assistance programs
- Demonstrated supervisory experience
- Familiarity with USG financial reporting and compliance requirements
- Demonstrated experience and skills in developing and managing large budgets
- Proficient in relevant computer applications and databases.

5. Senior Advisor, Monitoring , Evaluation and Research: 100% Time

The individual will be in charge of the monitoring, evaluation and research components of this cooperative agreement. S/he will be responsible for the design and implementation of the Communication for Healthy Communities Learning Agenda. S/he shall also develop monitoring, evaluation and reporting

(MER) systems that include appropriate indicators, baseline data, targets and a plan to evaluate performance and produce timely accurate and complete reporting. S/he will have the following qualifications, skills and experience:

- Master's Degree or higher in Public Health, Social Sciences, or other relevant discipline
- Eight years working in monitoring, evaluation and research in the public health field, with progressively increasing level of responsibility. Experience working with multiple stakeholders will be an added advantage
- Demonstrated expertise in rigorous quantitative and qualitative research and analytical methods
- Proven experience in research/study design and implementation, including design and data analysis of quantitative and qualitative studies, rapid appraisals, etc.
- Demonstrated hands-on practical experience setting up and managing MER systems for health programs in developing countries.
- Familiarity with PEPFAR indicators and reporting requirements
- Excellent report writing, analytical and communication skills, including oral presentation skills
- Experience in knowledge management and dissemination of research findings.

B. The personnel specified above are considered to be essential to the work performed under this cooperative agreement. Prior to replacing any of the specified individuals, the

successful applicant shall immediately notify both the Agreement Officer and USAID Agreement Officer's Representative reasonably in advance and shall submit written justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the activity. No replacement of personnel shall be made by the successful applicant without the written consent of the Agreement Officer.
.

1.7 PERFORMANCE MONITORING PLAN

The successful applicant shall develop a robust monitoring and evaluation (M&E) approach. The applicant will undertake operations research and impact evaluation under the Learning Agenda elaborated in Section C, Program Description, under C.4.3, Intermediate Result 3, "Increased research and knowledge management to enhance health communication." Such research and evaluation will assess the effectiveness of CHC approaches in achieving desired outcomes, be used to adapt approaches to improve program impact in consultation with USAID, and document the contribution of health communication activities to adoption of improved health behaviors, including utilization of health services.

Additionally, the successful applicant will develop and implement a performance monitoring plan (PMP) to measure and assess activity results, with appropriate indicators for each level of the results framework
Upon award, the successful applicant shall work with the USAID/Uganda Agreement Officer's Representative (AOR) and the Health Office Strategic Information staff to ensure that indicators are aligned with the Mission's strategic objectives and intermediate results framework, as well as with required PEPFAR and health strategic objectives. The successful applicant will also consult with relevant implementing partners and MOH M&E Technical Working Groups in developing the final PMP. PMP indicators will feed into DO3 PMP, USAID annual report, PEPFAR reporting, and data needs for other Presidential initiatives. Please refer to the following link for the PEPFAR Next Generation Indicator Guide: www.pepfar.gov/documents/organization/81097.pdf.
Within 90 days of award, the successful applicant shall submit in writing to USAID/ Uganda a final Performance Monitoring Plan for the time frame of the activity. USAID requires that all performance measures be part of a coherent system that will objectively assess the overall progress and impacts of activities with the ultimate goal of achieving the expected results outlined in the Program Description. Where relevant, the PMP should enable tracking and attribution of higher-level outcomes to project activities.

The PMP should include indicators, baselines and targets, pertinent to activity-level management and monitoring, which clearly support achievement of USAID/Uganda's Health, HIV/AIDS and Education goals and targets. To collect this data, the successful applicant shall develop a robust data collection system, which includes adequate data quality controls and complies with all USAID data quality requirements, ADS 203.3.5.1. Each indicator in the final PMP will have a performance indicator reference sheet that provides detailed description of the indicator, numerator and denominator where per cent measures are used and a data collection plan. Where appropriate, PMP baselines should draw on AIS and UDHS results as well as other studies and surveys.

The PMP shall specify approximate dates for data collection, the method, type, and source of information to be collected, and shall report on these indicators in line with

existing and future USG guidance. It is expected that Communication for Healthy Communities will collaborate with other data collection, monitoring and evaluation activities such as the health communication study implemented collaboratively with other USG partners, the National Health Management Information System (HMIS), Lot Quality Assurance Sampling (LQAS), Monitoring and Evaluation of the Emergency Plan Progress (MEEPP), USAID/Uganda Learning Activity and proposed MCH surveillance to avoid duplication in data collection and analysis.

The PMP should also present measures and approaches through which outcomes of capacity building and coordination efforts can be measured and verified. The PMP will describe how the project will measure: the progress and impact of capacity building activities at individual, organizational, and institutional levels, and the extent to which capacity strengthening tools and products are accessed and used, with or without adaptation.

USAID expects the successful applicant to be innovative and creative in their efforts, capturing, documenting, and reporting all the outcomes of USAID assistance.

USAID/Uganda anticipates an external evaluation of the activity at least once during the period of implementation. The agreement shall include provisions and funding to prepare for and participate in the evaluation on/around Spring 2016**.**

I.8 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. Contractor environmental compliance obligations under these regulations and procedures are specified in the following paragraphs of this contract.

1a) In addition, the contractor 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 contract 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 funding this contract. The IEE covers activities expected to be implemented under this contract. USAID has determined that a **CATEGORICAL EXCLUSION**

applies to the proposed activities. This indicates that if these activities are implemented subject to the specified conditions of the program design, they are excluded from 22 CFR 216 requirements and/or are expected to have no significant adverse effect on the environment.

3a) If the contractor 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.

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

I.9 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) – 73%; Population - 5%, TB/Infectious-5 Malaria (PMI) – 4%; MCH-6%, Nutrition – 7%

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 **five-year period from date of agreement officers signature.**

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 a minimum cost share of 5% 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), January 11, 2013.** 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 5% 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 Times New Roman 11pt., 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 maintaining **environmental compliance and management**, to including:

- 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 and email contacts.

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. Draft PMP: Applicants shall provide a draft PMP as an Annex to the application that includes program indicators and targets that will be used to assess progress towards the Strategic Objective and Intermediate Results

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 Applications will be assessed are as follows, in descending order of importance:

Technical Criteria

A. Technical Approach
B. Key Personnel
C. Management Approach
D. Past Performance

A. Technical Approach

The Technical Approach will be evaluated on the following sub-criteria considered to be equally important.

1. Understanding the Problem/Overall Approach: The extent to which the Applicant demonstrates clear understanding of the challenges to be addressed by the activity, and provides a clear, logical, and technically sound approach to fulfill the Development Objective, Intermediate Results and Strategic Principles detailed in section C, including meaningful approaches to addressing gender.

2. Feasibility and Scalability of Approach: How the proposed approaches can have a broad reach and scale to create significant public health impact, and the degree to which the proposed interventions work with the different stakeholders to design, implement and scale up the various HEALTH COMMUNICATION interventions.

3. Innovation: The extent to which the Applicant uses the available information to propose new and bold key interventions and approaches, as well as innovative and cost effective capacity building approaches for GoU health institutions and USG partners.

4. Monitoring and Evaluation: The extent to which the Applicant provides within their illustrative PMP clear outputs, indicators, benchmarks and targets which are results-oriented; and is able to identify key research gaps to be investigated as they relate to health communication programming, with the aim of increasing knowledge and understanding of the various activity areas and ultimately, to integrate the Learning Agenda to achieve intended impact and outcomes.

5. Approach to Collaboration with Other Partners: The extent to which the Applicant's proposed approach to engaging, collaborating and working with other USG and health sector partners, government institutions and private sector partners in the implementation of the activity addresses capacity strengthening needs at various levels and contributes to achievement of the Strategic Objective, Intermediate Results and Strategic Principles.

B. Key Personnel

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

Chief of Party and Deputy Chief of Party: The extent to which the Applicant proposes a Chief of Party and a Deputy Chief of Party who together possess the appropriate technical and management skills, as specified in section I.6 to complete the work detailed in Section I.

Other Key Personnel: The extent to which the Applicant proposes a Senior Technical Advisor, Health Communication, Director, Finance and Operations, and Senior Advisor, Monitoring, Evaluation and Research, who possess the appropriate technical and management skills specified in section I.6 to complete the work detailed in Section I.

.

C. Management Approach

The Management Approach will be evaluated based on the following sub-criteria, which will be considered equal in importance.

1. Organizational Capacity: The extent to which the Applicant' s institutional experience in designing, managing and implementing health communication programs of similar size, scale, duration, nature and complexity, to promote behavior change and service utilization, meets the requirements outlined in section C.

2. Staffing and Management Plan: The extent to which the Applicant's proposed Staffing and Management Plan demonstrate clearly how they shall support the proposed technical approach to achieve results, and the extent to which they intend to utilize local, well-qualified Ugandan professionals and administrative staff. Sub-partner Management Plan**:** The extent to which the Applicant explicitly describes the distinctive roles and responsibilities of the sub-partners, if

necessary, and how they contribute to achieving the activity impact and outcome.

D. Past Performance

Evaluation of past performance will focus on how well an applicant performed, relevancy of the work performed under the program, instances of good performance or poor performance, significant achievements and/or problems plus any indications of excellent or exceptional performance in the most critical areas.

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 weight but will be evaluated for cost reasonableness, allocability, allowability, cost effectiveness - including cost share - and realism, adequacy of budget detail. 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 **60 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.

- Additional PEPFAR Financial Reporting

  Applicants should note that it is anticipated that all PEPFAR implementing partners will be subject to an additional mandatory reporting requirement to improve program monitoring, which has already been piloted in a number of countries. Data will be collected on the DS-4213, PEPFAR Program Expenditures; OMB-1405-XXXX, which is currently undergoing approval by the Office of Management and Budget (OMB) pursuant to the Paperwork Reduction Act.

[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.

PEB 2012-05 "Hortatory Language for Introduction of Mobile Money - Better Than Cash (BTC) Initiative

[END SECTION VIII]

SECTION IX – REFERENCES AND ATTACHMENTS

Attachment A	**National HIV Prevention Strategy 2011 - 2015**
Attachment B	**Health Sector Strategic & Investment Plan**
Attachment C	**UGANDA NUTRITION ACTION PLAN**
Attachment D	**UGANDA NATIONAL MALARIA STRATEGIC PLAN**
Attachment E	**The Uganda Gender Policy on www. mglsd.go.ug**
Attachment F	**Final RH HIV Strategy**
Attachment G	**NATIONAL STRATEGIC PLAN FOR HIV&AIDS 2011/12 -2014/15**
Attachment H	**Malaria Operational Plan for FY 2012**
Attachment I	**National Development Plan (NSP) 2010/11- 2014/15**
Attachment J	**Budget Template**
Attachment K	**List of USAID & CDC Contractors and Implementing Partners**
Attachment L	**List of Acronyms**
Attachment M	**Representations, Certifications & Assurances**