USAID | GUINEA
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Issue Date:	June 21, 2017
Deadline for Questions:	July 31, 2017
Posting of Clarifications:	August 11, 2017
Closing Date:	August 25, 2017
Closing Time:	14:30 PM (GMT) Local Senegalese Time

Subject: Notice of Funding Opportunity No. RFA-675-17-000003

Program Title: Guinea Malaria Bilateral

Ladies/Gentlemen:

The United States Agency for International Development (USAID) is seeking applications for a cooperative agreement from qualified U.S. and Non-U.S. organizations to fund a program entitled Malaria Bilateral. Eligibility for this award is unrestricted; see Section C of this NOFO for eligibility requirements.

Subject to the availability of funds an award will be made to that responsible applicant(s) whose application(s) best meets the objectives of this funding opportunity and the selection criteria contained herein. While one award is anticipated as a result of this notice of funding opportunity (NOFO), USAID reserves the right to fund any or none of the applications submitted.

For the purposes of this NOFO the term "Grant" is synonymous with "Cooperative Agreement"; "Grantee" is synonymous with "Recipient"; and "Grant Officer" is synonymous with "Agreement Officer". Eligible organizations interested in submitting an application are encouraged to read this funding opportunity thoroughly to understand the type of program sought, application submission requirements and evaluation process.

To be eligible for award, the applicant must provide all information as required in this NOFO and meet eligibility standards in Section C of this NOFO. This funding opportunity is posted on www.grants.gov, and may be amended. Potential applicants should regularly check the website to ensure that they have the latest information pertaining to this notice of funding opportunity. Applicants will need to have available or download Adobe program to their computers in order to view and save the Adobe forms properly. It is the responsibility of the applicant to ensure that the entire NOFO has been received from the internet in its entirety and USAID bears no responsibility for data errors resulting from transmission or conversion process. If you have difficulty registering on www.grants.gov or accessing the NOFO, please contact the Grants.gov Helpdesk at 1-800-518-4726 or via email at support@grants.gov for technical assistance.

The successful Applicant will be responsible for ensuring the achievement of the program objectives. Please read each section of the NOFO.

Please send any questions to the point(s) of contact identified in section D. Questions must be clear and concise, and direct to the point. The deadline for questions is shown above. Responses to questions received prior to the deadline will be furnished to all potential applicants through an

amendment to this notice posted to www.grants.gov.

Issuance of this notice of funding opportunity does not constitute an award commitment on the part of the Government nor does it commit the Government to pay for any costs incurred in preparation or submission of comments/suggestions or an application. Applications are submitted at the risk of the applicant. All preparation and submission costs are at the applicant's expense.

Thank you for your interest in USAID programs.

Sincerely,

Yves Koré
Agreement Officer

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ABBREVIATIONS AND ACRONYMS USED IN THIS NOFO

ABBREVIATIONS:

ACT	ARTEMISININ-BASED COMBINATION THERAPY
ADS	AUTOMATED DIRECTIVE SYSTEM
ANC	ANTENATAL CARE
AO	AGREEMENT OFFICER
AOR	AGREEMENT OFFICER'S REPRESENTATIVE
ASM	AMERICAN SOCIETY FOR MICROBIOLOGY
CBO	COMMUNITY BASED ORGANIZATION
CDC	CENTER FOR DISEASE CONTROL
CDCS	COUNTRY DEVELOPMENT COORDINATION STRATEGY
CENAFOD	CENTRE AFRICAIN DE FORMATION POUR LE DEVELOPPEMENT
CFR	CODE OF FEDERAL REGULATIONS
CHW	COMMUNITY HEALTH WORKER
CLA	COLLABORATING, LEARNING AND ADAPTING
DCS	MUNICIPAL DIRECTORATE OF HEALTH (DIRECTION COMMUNALE DE LA SANTE)
DEC	DEVELOPMENT EXPERIENCE CLEARINGHOUSE
DHIS-2	DISTRICT HEALTH INFORMATION SYSTEM 2
DHS	DEMOGRAPHIC AND HEALTH SURVEY
DRS	REGIONAL DIRECTORATE OF HEALTH (DIRECTION REGIONALE DE LA SANTE)
DO	DEVELOPMENT OBJECTIVE
DPS	PREFECTURAL DIRECTORATE OF HEALTH (DIRECTION PREFECTORALE DE LA SANTE)
ECOWAS	ECONOMIC COMMUNITY OF WEST AFRICAN STATES
EEO	EQUAL EMPLOYMENT OPPORTUNITY
ER	ENVIRONMENTAL REVIEW
ERF	ENVIRONMENTAL REVIEW FORM
GAAS	GENERALLY ACCEPTED AUDITING STANDARDS
GDA	GLOBAL DEVELOPMENT ALLIANCE
GDP	GROSS DOMESTIC PRODUCT
GHSC-PSM	GLOBAL HEALTH SUPPLY CHAIN-PROCUREMENT AND SUPPLY MANAGEMENT
GOG	GOVERNMENT OF GUINEA
HFG	HEALTH FINANCE AND GOVERNANCE
HIS	HEALTH INFORMATION SYSTEM
HSD	HEALTH SERVICE DELIVERY
HIV/AIDS	HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNODEFICIENCY SYNDROME
HRH	HUMAN RESOURCES FOR HEALTH
IDB	ISLAMIC DEVELOPMENT BANK
IDSR	INTEGRATED DISEASE SURVEILLANCE AND RESPONSE
IEE	INITIAL ENVIRONMENTAL EXAMINATION
IP	IMPLEMENTING PARTNER
IPC	INFECTION PREVENTION AND CONTROL
IPTP	INTERMITTENT PREVENTIVE TREATMENT IN PREGNANCY
IR	INTERMEDIATE RESULT

IRS	INDOOR RESIDUAL SPRAYING
ITN	INSECTICIDE TREATED NET
JHPIEGO	JOHNS HOPKINS PROGRAM FOR INTERNATIONAL EDUCATION IN GYNECOLOGY AND OBSTETRICS
KAP	KNOWLEDGE ATTITUDE AND PRACTICE
LLIN	LONG-LASTING INSECTICIDE TREATED NET
LMIS	LOGISTICS MANAGEMENT INFORMATION SYSTEM
LMG	LEADERSHIP MANAGEMENT AND GOVERNANCE
MCSP	MATERNAL CHILD SURVIVAL PROJECT
M&E	MONITORING AND EVALUATION
MICS	MULTIPLE INDICATOR CLUSTER SURVEY
MICS-PALU	MULTIPLE INDICATOR CLUSTER SURVEY- WITH MALARIA BIOMARKERS
MIP	MALARIA IN PREGNANCY
MOH	MINISTRY OF HEALTH
MOP	MALARIA OPERATIONAL PLAN
NGO	NON GOVERNMENTAL ORGANIZATION
NICRA	NEGOTIATED INDIRECT COST RATE AGREEMENT
NOFO	NOTICE OF FUNDING OPPORTUNITY
NHIS	NATIONAL HEALTH INFORMATION SYSTEM
NIH	NATIONAL INSTITUTE OF HEALTH
NMCP	NATIONAL MALARIA CONTROL PROGRAM
OFDA	OFFICE OF FOREIGN DISASTER ASSISTANCE
OMVS	ORGANISATION POUR LA MISE EN VALEUR DU FLEUVE SENEGAL
PCG	PHARMACY CENTRALE DE GUINEE
PEV	PROGRAMME ELARGI DE VACINATION
PMI	PRESIDENT'S MALARIA INITIATIVE
PMP	PERFORMANCE MONITORING PLAN
PPP	PUBLIC-PRIVATE PARTNERSHIP
PRSP	POVERTY REDUCTION STRATEGY PAPER
PQM	PROMOTING QUALITY MEDICINES
PTF	PARTENAIRES TECHNIQUES ET FINANCIERES
RBM	ROLL BACK MALARIA
RDT	RAPID DIAGNOSTIC TEST
RFA	REQUEST FOR APPLICATION
RMNCH	REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH
SIAPS	SYSTEMS FOR IMPROVED ACCESS TO PHARMACEUTICALS AND SERVICES
SMC	SEASONAL MALARIA CHEMOPREVENTION
SP	SULFADOXINE-PYRIMETHAMINE
SP+AQ	SULPHADOXINE-PYRIMETHAMINE + AMODIAQUINE
UNICEF	UNITED NATIONS CHILDREN'S FUND
USAID	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
USG	UNITED STATES GOVERNMENT
WHO	WORLD HEALTH ORGANIZATION

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SECTION A: PROGRAM DESCRIPTION

INTRODUCTION

The United States Government (USG) seeks to enter into a Cooperative Agreement (the Agreement) for a five-year, $28 million Malaria Bilateral Program to address critical malaria prevention and control issues in Guinea. Specifically, the award recipient (the Awardee) will play the lead role in the President's Malaria Initiative (PMI) suite of programs to support the National Malaria Control Program (NMCP) through technical assistance and community based service support for the prevention, diagnosis and treatment of malaria in Guinea.

The Malaria Bilateral Program will contribute towards achieving USAID/Guinea's Development Objective of "Utilization of Quality Health Services Increased" as outlined in its 2015-2019 Country Development Cooperation Strategy (CDCS). To maximize impact, USAID/Guinea expects that the Malaria Bilateral Program will work in concert with USAID-supported health programs in support of the national strategies and health sector development plans.

A. BACKGROUND

Country Context

Guinea is a coastal country in West Africa composed of four areas with distinct ecologies: lower Guinea, which includes the coastal lowlands; middle Guinea, the mountainous region running north-south in the middle of the country; the Sahelian upper Guinea; and the forested jungle area in the south. Guinea borders Guinea-Bissau and Senegal to the north, Mali and Côte d'Ivoire to the east, and Liberia and Sierra Leone to the south. Guinea has 33 prefectures (districts) divided into eight administrative regions, one of which is the capital city of Conakry and its five communes. Guinea's entire estimated population of 12,093,349 (July 2016 est.) is at risk of malaria. According to the 2015 Human Development Index, Guinea has among the lowest health and development indicators, ranking 182 out of 188 countries.[1] Poverty has been steadily increasing over the past decade and as of 2012 over half (55%) of Guinea's population lived below the World Bank poverty headcount ratio.[2]

The overall literacy rate is 41% for adults over 15 years (52% males, 30% females). Infant and under-five mortality rates are 81 and 130 per 1,000 live births, respectively. Although antenatal care (ANC) coverage of at least one visit is high (88%), the percentage of women who make at least two to three visits is still low at 18%. The lifetime risk of maternal death is one of the worst in the world, at 1 in 26. Total GDP expenditure on health is 4.7% and life expectancy at birth is low at 55 years.

The Health System in Guinea

The health care system in Guinea is managed by the Ministry of Health (MOH) and based on the administrative division of the country into eight regions. Within the eight regions there are 38

[1] http://hdr.undp.org/sites/default/files/ranking.pdf
[2] http://data.worldbank.org/country/guinea
3 https://www.cia.gov/library/publications/the-world-factbook/geos/gv.html

health districts composed of 334 rural municipalities and 38 urban municipalities. The MOH has three levels in its administrative structure: central, intermediate, and peripheral. The health system is organized around a pyramidal structure on three levels:

1. The central level is responsible for the strategic development plan, policy, monitoring and evaluation, and resource allocation. The Minister of Health is instituting a reorganization of the MOH. The proposed reorganization includes many of the previous positions, but also includes restructured directorates. The reorganized MOH includes the cabinet of the Minister of Health (Secretary General, advisers, chief of staff, and support services), as well as National Directorates: the National Directorate of Pharmacy and Medicines, the National Directorate for Hospital Facilities and Hygiene, the National Directorate of Family Health and Nutrition, the National Directorate of Community Health and Traditional Medicine, and the National Directorate of Epidemiology and Disease Control (which includes the National Malaria Control Program, NMCP).
2.
3. The intermediate level includes the seven Regional Directorates of Health (DRS) plus the Conakry Directorate of Health. Within each region there are four sections: prevention and disease control, a regional inspection of pharmacies and laboratories, administrative and financial section, and a hygiene section. Each section or unit is filled by one individual. The prevention and disease control officer alone oversees all diseases within the region. The pharmacist inspector alone oversees all pharmaceutical activities within the region.
4.
5. The peripheral level includes the 38 Prefectural and Municipal Directorates of Health (DPS/DCS). Within each prefecture there is a section of Prevention and Disease Control, as well as lab-pharmacy, planning and training, administration and finance, and hygiene sections.

Health care is provided by the public and private sectors. Public health facilities consist of health posts, health centers, prefectural hospitals, regional hospitals, and national hospitals. There is a rapid growth of the private health sector in Guinea, providing basic to specialized health services, with very limited or no control by the Ministry of Health. When supported by a program, community health workers (CHWs) attached to health centers provide essential basic care at the community level, particularly in the management and prevention of malaria and other diseases.

Public health facilities are organized into three levels that provide primary, secondary, and tertiary health care. The first level is represented by the health district and consists of three levels:[3]

1. About 963 health posts provide basic primary care and serve several villages (about 3,000 people) each. Health posts are usually staffed by an *agent technique de santé*, a clinical officer with three years of training.
2. About 413 health centers provide preventive and curative care (about 10,500 people each) and supervise the health posts. Health centers are staffed by several clinicians,

[3]The number of health posts and hospitals are based on 2011 estimates; the number of health centers is based on a 2013 estimate.

including nurses, midwives, and doctors.

3. About 26 district hospitals serve as a reference for health centers and provide care to an average of 285,777 people in the district.

The second level is represented by the regional hospital and serves as a reference for the districts. There are 7 regional hospitals plus 9 municipal hospitals providing care to an estimated 1,401,400 people in the region.

The third level consists of the university hospitals at the national level. This is the highest level of reference for specialized care and includes two such hospitals in the country: Donka and Ignace Deen hospitals, both in Conakry. In addition, there is a highly-specialized Sino-Guinean hospital built by the Chinese Government, which is also in Conakry.

In addition to public structures, Guinea has a large number of private structures and traditional practitioners. At the community level, CHWs and hygiene committees have the responsibility of understanding health issues, monitoring health programs, and coordinating with local medical officers to improve access and quality of care in their communities.

Access to care is a major problem in Guinea. The MOH estimate that only 55% of the population has access to public health care services. The MOH and partners are investing in community case management through a trained nationwide cadre of CHWs to expand healthcare access to communities, especially in remote and inaccessible areas. A comprehensive policy on community health care has been developed and a mapping of CHWs was conducted in January 2016, which showed that Guinea has a total of 5,871 CHWs. More than 3,300 CHWs have been trained and provide health education and basic curative care to surrounding communities. However, this was impacted by the Ebola epidemic of 2014/15, resulting in fewer CHWs providing a standard set of services. The CHWs have been specifically trained on infection control and diagnosis of malaria using rapid diagnostic tests (RDTs), and provide artemisinin-based combination therapy (ACTs) to patients with uncomplicated malaria. Guinea's MOH strongly supports integration of priority national health programs, including malaria, HIV/AIDS neglected tropical diseases, nutrition, reproductive health and family planning, safe delivery, and epidemic surveillance.

Malaria Situation in Guinea

Guinea has year-round malaria transmission with peak transmission from July through October in most areas. The three main vectors are *Anopheles gambiae, An. coluzzii,* and *An. funestus*. According to the national strategy, malaria remains the number one public health problem in Guinea, with 92% of malaria infections caused by *Plasmodium falciparum* (2012 DHS). The annual incidence rate in 2011 was estimated to be 92 per 1,000. National statistics in Guinea also show that among children less than five years of age, malaria accounts for 31% of consultations, 25% of hospitalizations, and 14% of hospital deaths. This estimate does not include malaria cases seen in the community or in private facilities. Among the general population, malaria is also the primary cause of consultations (34%), hospitalizations (31%), and death (14%) according to the Ministry of Health (MOH).[4]

[4] National Malaria Control M&E Strategy 2014-17.

According to the results of the 2016 MICS-Palu survey, Guinea has made great strides in addressing malaria. The survey showed that national malaria prevalence among children under five decreased from 43.9% in 2012 (Demographic and Health Survey 2012)[5] to 15.3% in 2016 using microscopy and from 46.9% to 30.1% based on RDT results. There remains a wide variation in prevalence across the country, ranging from just under 2% in Conakry to around 30% in N'zérékoré. Parasitemia prevalence also shows strong variations by place of residence, with 21% in rural areas compared to 4% in urban areas (strongly influenced by Conakry). The 2016 survey results also showed that 16% of children 6-59 months had severe anemia (Hgb<8g/dl).[6]

Coverage estimates for key interventions, although improving, showed room for improvement in reaching targets. Almost 85% of households surveyed had at least one mosquito net, most of them being long lasting insecticide treated nets (LLIN; 83.5%). These proportions were higher in rural areas (88.6%) than in urban (74.2%). However, the percentage of households having at least one LLIN for every two persons who slept in the house the night before the survey was only 48% (33.2% urban/56% rural). The proportion of children who slept under an LLIN the night before the survey was 67.6%. This proportion was higher in rural areas (72.8%) than in urban (57.5%). In households with an LLIN, the proportion of children under five years of age who slept under an ITN the night before the survey was 79.3%, with a smaller difference between urban and rural households (75.1% and 81.2%, respectively). Almost 70 % of pregnant women reported sleeping under a LLIN (69.4%) the night before the survey. In households with a LLIN, the proportion of pregnant women who slept under a LLIN the night before the survey was 83.1%. Coverage with indoor residual spraying (IRS) was relatively low as this intervention is carried out mainly in communities reached by the mining sector funded malaria control activities.

Malaria treatment indicators while improving, continue to reflect low coverage: among children less than five years old with fever in the two weeks before the DHS survey, 42% had sought advice or treatment for the fever; 18% had received any antimalarial treatment; and only 2% received an ACT on the same or next day. Of those children under five with fever that took any antimalarial, only 14% of these took an ACT; of the rest, 21% took quinine, 20% took monotherapy Amodiaquine, 15% took chloroquine, and 30% took something else.

Since 2005, prevention of malaria among pregnant women using sulfadoxine-pyrimethamine (SP) was included in the national ANC health package with support to the NMCP from several partners. In 2013, the country updated its policy to reflect the new WHO guidance on IPTp. According to the 2016 MICS-Palu, 49% of women reported receiving at least 2 doses of SP during their last pregnancy while 30% reported receiving 3 or more doses.

[5] *Institut National de la Statistique (INS)* and ICF International. 2012. Guinea Demographic and Health Survey 2012. Conakry, Guinea

[6] Institut National de la Statistique (INS), Programme National de Lutte contre le Paludisme (PNLP) et ICF. 2017. *Enquête de prévalence parasitaire du paludisme et de l'anémie en Guinée 2016*. Rockville, Maryland, USA: INS, PNLP et ICF

Current Status of Malaria Indicators

Table 1. Evolution of Key Malaria Indicators in Guinea from 2005 to 2012

Indicator	MICS 2007	National Coverage Survey		DHS 2012	MICS -Palu 2016
		2009	2010		
% Households with at least one ITN	12.5	23.4	78.8	47.4	83.5
% Households with at least one ITN for every two people	-	-	-	9.7	48
% Children under five who slept under an ITN the previous night	6.7	12.0	60.4	26.1	67.6
% Pregnant women who slept under an ITN the previous night	5.1	24.7[1]	46.8[1]	28.3	69.4
% Households in targeted districts protected by IRS (national-level indicator; IRS is not a key intervention)	-	-	-	1.7	-
% Children under five years old with fever in the last two weeks for whom advice or treatment was sought	-	-	-	37.1	42.4
% Children under five with fever in the last two weeks who had a finger or heel stick	-	-	-	8.5	17
% Children receiving an ACT among children under five years old with fever in the last two weeks who received any antimalarial drugs[2]	-	-	-	4.8	14
% Women who received two or more doses of IPTp during their last pregnancy in the last two years	-	35.9[3]	41.0[3]	22	49.1
% Children age 6-59 months with severe anemia (Hgb <8g/dl)[7]	-	-	-	15.9	16.4
% Children age 6-59 months with parasitemia according to microscopy	-	-	-	43.9	15.3

[1] The 2009 survey report specifies use of long-lasting ITNs by pregnant women while the 2010 survey report does not (i.e., it includes any treated nets).
[2] ACTs were not the first-line treatment at the time of the DHS and MICS surveys; the 2010 coverage survey report did not provide adequate data to calculate this indicator in the standard format (i.e., the denominator could not be determined).
[3]The 2009 and 2010 coverage surveys include a five-year look-back period instead of a two-year period and do not specify that at least one dose was taken at an ANC visit.

[7] A measure of hemoglobin <8g/dl is the value typically used as an indirect indicator of anemia associated with malaria.

B. NATIONAL MALARIA CONTROL STRATEGIC PLAN

Following a mid-term review, document review and an external review of the performance of the National Malaria Control program under the previous strategic plan, the Government of Guinea adopted a new five year National Malaria Control Strategic Plan in February 2017 covering the period 2018-2022. The goal of this plan is to move the country towards pre-elimination by reducing malaria-related morbidity and mortality by 50% compared to 2016 levels.

The National Strategic Plan objectives are:

- Protect at least 90% of the population with effective preventive interventions for malaria;
- Ensure correct and prompt treatment of at least 90% of malaria cases; and
- Strengthen capacity in management, partnership, coordination, communication and ME of the National Malaria Control Program at all levels.

The main interventions to reach these objectives include:

- Vector control:
  - Distribution of LLINs through mass campaigns and continuous distribution channels (ANC, PEV, communities, schools) including the private sector;
  - Indoor Residual Spraying (IRS): feasibility studies and pilot projects; and
  - Larviciding focusing on hygiene and sanitation, and destruction of breeding sites.
- Targeted prevention interventions:
  - Intermittent preventive treatment during pregnancy and
  - Seasonal malaria chemoprevention.
- Ensure laboratory confirmation by RDT or microscopy for all suspected cases of malaria and proper management of all confirmed cases in health facilities and in the community.
- Strengthening pharmaceutical management, including improved quantification, storage and distribution, logistics information system, pharmacovigilance, and quality control, as well as strengthening the Central Pharmacy of Guinea (PCG).
- Behavior change communication including interpersonal communication, mass media, advocacy and social mobilization.
- Strengthen M&E at all levels for the collection and analysis of high quality data to inform decision-making.
- Improved program management at the national, regional and district levels and strengthened partnership.

More details about the NMCP, its previous Strategic Plan and achievements and the mid-term review can be found at the following link: http://pnlp-guinee.org/

Expected outcomes of the Strategic Plan by the end of 2022 are:

- At least 90% of the population at risk of malaria use LLINs;
- At least 90% of children between 3 and 59 months of the areas targeted for seasonal malaria chemoprophylaxis have been protected;
- At least 90% of pregnant women have received IPTp3 protection during pregnancy;
- At least 90% of the populations in the areas targeted by IRS have been protected;
- At least 90% of suspected malaria cases are tested in health facilities and at community

level;
- At least 90% of simple malaria cases are treated with an effective antimalarial in the community in accordance with national guidelines;
- At least 90% of malaria cases (simple and severe) are treated in health facilities in accordance with national guidelines;
- At least 90% of health and community facilities have antimalarials and other commodities for the prevention, diagnosis and treatment of malaria;
- At least 90% of the population applies recommended preventive measures against malaria;
- The M&E system can generate quality data to inform program monitoring and evaluation indicators at all levels;
- At least 90% of public and private health facilities provide reliable reports on malaria;
- At least 90% of the community structures involved in malaria activities provide reliable reports;
- At least 90% of malaria emergencies and epidemics are detected and adequately managed in accordance with national guidelines; and
- Program management and coordination capacities are strengthened at all levels.

These objectives are in line with the 2016-2030 United Nations Sustainable Development Goals, the WHO Global Technical Strategy Paper for the Fight against Malaria 2016-2030, the document "Action and Investment to Overcome Malaria 2016-2030" (RBM), the ECOWAS Malaria Control Goals, the Poverty Reduction Strategy Paper (PRSP), the National Health Policy Guidelines, the strategic thrusts of the 2015-2024 National Health Development Plan and the national malaria control policy.

The malaria control policy is based on universal principles and values, namely social justice, solidarity, equity, ethics, probity and quality in alignment with the national health policy. The guiding principles are based on good governance, gender approach, respect for scientific evidence and international recommendations in the choice of malaria interventions. These guiding principles and values are in line with the country's various commitments in the fight against malaria.

C. DEVELOPMENT PARTNERS' SUPPORT TO MALARIA CONTROL IN GUINEA

US Government's President's Malaria Initiative (PMI)

When it was launched in 2005, the goal of PMI was to reduce malaria-related mortality by 50% across 15 high-burden countries in sub-Saharan Africa through a rapid scale-up of four proven and highly effective malaria prevention and treatment measures: insecticide-treated mosquito nets (ITNs); indoor residual spraying (IRS); accurate diagnosis and prompt treatment with artemisinin-based combination therapies (ACTs); and intermittent preventive treatment of pregnant women (IPTp). With the passage of the Tom Lantos and Henry J. Hyde Global Leadership against HIV/AIDS, Tuberculosis, and Malaria Act in 2008, PMI developed a U.S. Government Malaria Strategy for 2009–2014. The contributions of PMI, together with those of other partners, have led to dramatic improvements in the coverage of malaria control interventions in PMI-supported countries, and all 15 original countries have documented

substantial declines in all-cause mortality rates among children less than five years of age. In 2015, PMI launched the next six-year strategy, setting forth a bold and ambitious goal and objectives. Under the PMI Strategy 2015-2020, the U.S. Government's goal is to work with PMI-supported countries and partners to further reduce malaria deaths and substantially decrease malaria morbidity, towards the long-term goal of elimination.

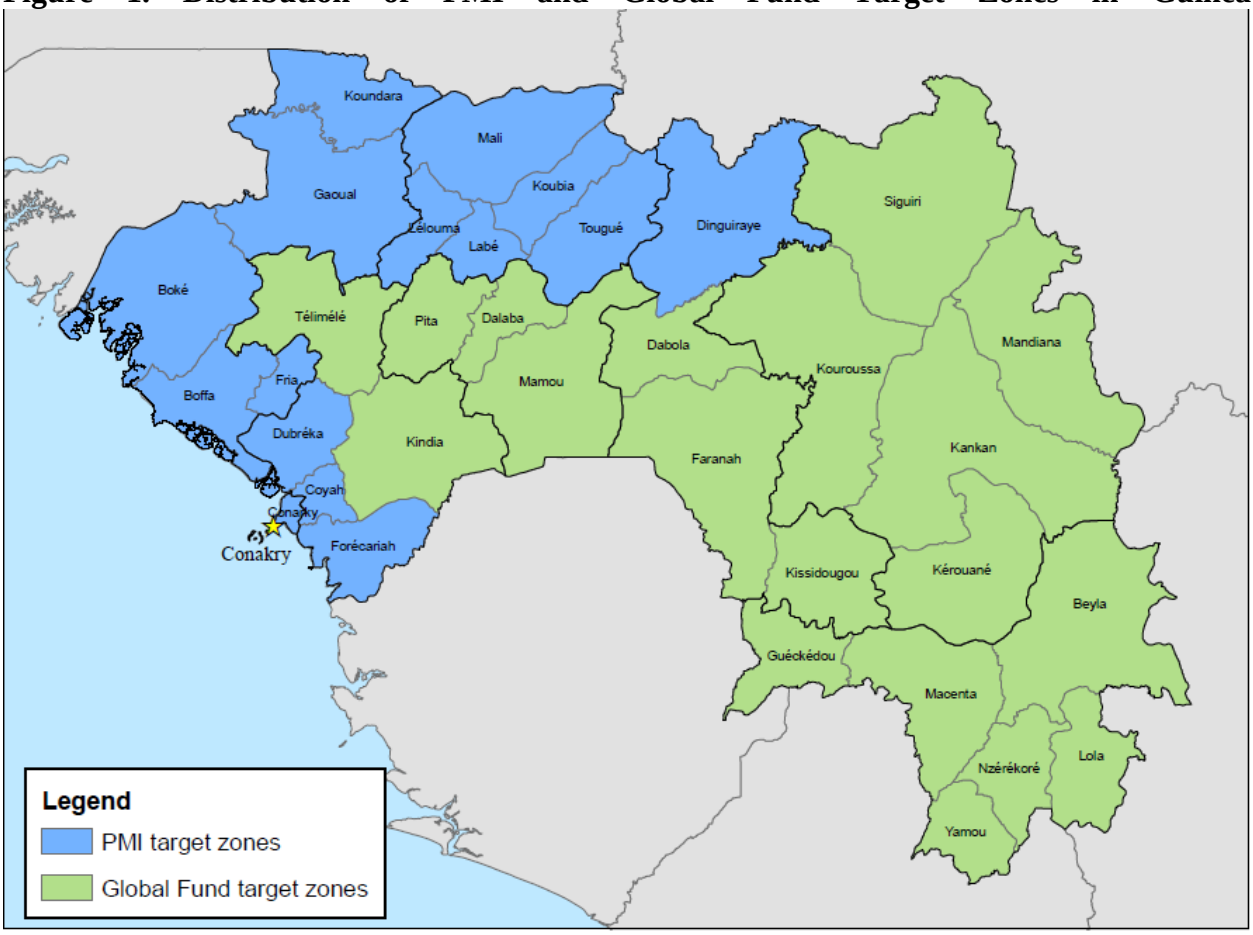
Guinea was selected as a PMI focus country in FY 2011. From an initial allocation of $10 million in FY2012, PMI's budget increased to $15 million for FY16. The FY 2017 Malaria Operational Plan (MOP)[8] presents a detailed implementation plan for Guinea, based on the strategies of PMI and the NMCP. The activities that PMI supports are well aligned with the National Malaria Control strategy and plan and build on investments made by PMI and other partners to improve and expand malaria-related services, including the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) malaria grants.

Other donor support: Integration, collaboration and coordination

In addition to PMI, the Global Fund is the other main donor supporting the malaria program in Guinea (see the map below for donor target zones). The two donors divide their support across the eight regions and 33 districts (prefectures) of the country. PMI supports 14 districts in upper and middle Guinea and the five communes of Conakry, while Global Fund supports the remaining 19 districts in middle Guinea, lower Guinea, and the forest areas. This divide also provides an equitable population-based split of responsibility. PMI and Global Fund work collaboratively to address the needs that were identified through the gap analysis by NMCP and all its stakeholders. Both donors use the same education and communications materials and policy tools, and collaborate on a number of activities, especially at the national level. In their respective target zones, the two donors finance a number of activities separately (training and supervision of health care workers and community agents, local behavior change communications; and distribution of malaria commodities). The Global Fund and PMI use the same materials and guidelines in both health facility-based and community-based interventions to ensure activities are coordinated. These materials are developed under the leadership of the NMCP with support from malaria partners.

[8] Available at https://www.pmi.gov/where-we-work/guinea

Figure 1. Distribution of PMI and Global Fund Target Zones in Guinea



The NMCP has also developed partnerships with other various organizations and institutions involved in the fight against malaria, including Roll Back Malaria (RBM), Research Triangle Institute, Plan Guinea, Population Services International, Catholic Relief Services, German Development Cooperation, Médecins sans Frontières, Helen Keller International, Rio Tinto, Islamic Development Bank (IDB), World Health Organization (WHO), United Nations Children's Fund (UNICEF), World Bank, Organisation pour la Mise en Valeur du Fleuve Senegal (OMVS), and Japan International Cooperation Agency. These partnerships reinforce the collaboration and coordination between malaria stakeholders for the benefit of the Guinean population and will be strengthened by the current Coordinating Committee of technical and financial partners (PTF).

D. PROGRAM DESCRIPTION: RATIONALE, EXPECTED RESULTS AND LINK TO THE MISSION'S RESULTS FRAMEWORK

Rationale for Malaria Bilateral Activity

With the increase of malaria funding and the ending of the current PMI-funded malaria flagship project, the USAID/Guinea Mission decided to develop a multi-year bilateral mechanism to assist the Government of Guinea's efforts to control malaria. Awarded in May 2013 as a 4-year Activity, StopPalu is USAID/Guinea's current flagship project supporting malaria prevention

and control activities. The Activity is funded by PMI with the goal of assisting the Government of Guinea (GOG) to achieve the PMI target of reducing malaria morbidity and mortality to 50% of pre-initiative levels through multiple interventions in prevention, diagnosis and treatment, and capacity building of the MoH and NMCP. StopPalu is implemented by RTI International, supported by sub-partners JHPIEGO, the American Society for Microbiology (ASM), and Centre Africain de Formation pour le Développement (CENAFOD). The Activity is implemented in 14 out of 38 prefectures and the 5 communes of Conakry, covering for half of the country. As with the rest of the health services in the country, the program was disrupted by the catastrophic Ebola epidemic, which slowed and stopped implementation from 2014 until the country was declared Ebola-Free in 2016. Because of this and other structural issues, StopPalu was extended by another year and now will end in September 2017.

In collaboration with other development partners, the current program has contributed to the scale up of malaria diagnosis, treatment and prevention interventions across the country through training and supervision of health workers, procurement and distribution of materials to support health workers both in the facilities and at the community level, and capacity building in entomological monitoring and surveillance. At the National level, the program has contributed to strengthening the leadership, management, and improved the coordination capacity of the NMCP. Over of the years StopPalu has supported the development and roll out of policies, guidelines, protocols and other strategic documents in line with malaria prevention and control.

Results from the 2016 Multi-Indicator Cluster Survey (MICS) indicate that malaria prevalence is 15.3% whereas the 2012 DHS reported a prevalence of 44%. The MICS results indicate that the overall mosquito bed net ownership is 83.5% but the utilization is still low (63.6%). Care seeking behavior is still very low as well as the quality of care. Data reporting from the districts to the national level has increased from 30% in 2013 to about 100% but there are still report completeness and data quality issues.

Building on the success of the current program, USAID/Guinea would like to continue its PMI support to the GOG through a new, five-year malaria control Activity. The Activity will be built around key behaviors that underlie the desired health outcome (reduction of malaria-related morbidity and mortality) that is use of insecticide treated nets, IPTp use during antenatal visits, prompt care seeking and treatment and the delivery of a full dose of SMC. This new mechanism will address the remaining gaps in malaria prevention and control by supporting essential health service delivery (including malaria diagnosis and treatment) at the health facility and community levels, behavior change communication, capacity building and supervision, and monitoring and evaluation. While communication is critical to addressing both social and behavioral challenges facing individuals and families, other actions such as policies, financing, availability of services and products, capacity building, and behavior enabling technologies are often required to fully resolve the challenges. The strategies supported by this Activity will enable caregivers, family members and others to meet the challenges they face in practicing those behaviors. Such an approach will be more likely to affect positive health outcomes and do so sustainably.

The underlying hypothesis for this Activity states that if community awareness and attitudes towards malaria prevention and treatment are improved, technical and interpersonal skills of health service providers including community health workers are enhanced alongside improved

availability of malaria prevention and treatment commodities, then communities especially women and children will adopt appropriate malaria prevention and care seeking behaviors resulting in a reduction in malaria related morbidity and mortality. Concurrently, a strengthened NMCP that has the capacity to manage, monitor and implement prevention and treatment activities will ensure a sustainable availability and access to quality malaria care and treatment services thereby contributing to the overall goal of reducing malaria related morbidity and mortality.

This hypothesis is based on the assumption that partnerships with the Global Fund and other donors will continue to invest in malaria control initiatives in alignment with the national malaria control strategy. Other USAID activities in supply chain management responsible for procuring and distributing malaria commodities, strengthening of RMNCH and health systems strengthening are complementing the New Malaria Bilateral Activity to address the overall health service delivery issues and health systems strengthening.

Links to the Mission's Strategy

The Malaria Bilateral Activity supports the overall vision and goal of USAID/Guinea's CDCS. Both the vision, *Citizens Drive Improvements to Guinean Quality of Life,* and the goal, *More Participatory Governance for a Healthier Guinea,* elevate the citizen to the center of development. The behavioral lens applied in the development of this project is especially appropriate as it also places the focus on the citizen and meeting his or her needs to accomplish key behaviors for a healthier life.

Within the CDCS, the Malaria Bilateral Program falls under Development Objective 1 (DO1): Utilization of Quality Health Services Increased. The new malaria bilateral award results of increased use of Insecticide Treated Nets (ITNs) by population; increased use of Intermittent Preventive Treatment for Pregnant women (IPTp) during antenatal visits; increased prompt care seeking and treatment and delivery of an increased full dose of seasonal malaria chemoprevention (SMC) in timely manner support the following elements of the Health Project Appraisal Document: Sub-purpose 1: Delivery of Quality Health Services Improved; Sub-purpose 2: Healthy Behaviors and Demand Quality Health Services Increased; and Sub-purpose 3: Health System Strengthened.

Other Related USAID Activities:
This activity will leverage other donor investments and collaborate closely with the following ongoing USAID funded programs:

Health Services Delivery (HSD) Project: The goal of the Guinea Health Services Delivery (HSD) Project is to ensure that a package of essential and integrated care for family planning (FP) and maternal, neonatal, and child health (MNCH) is constantly provided at a high level of quality in health facilities and surrounding communities in the regions of Boké, Conakry, Kindia, Mamou, Faranah, Kankan and Labé. The integrated package is designed to be offered across the household-hospital continuum, where key interventions of the project will ensure that high quality of care is available at each level as well as access to information and referral for serious illness, obstetric fistula, and family planning methods for long-lasting and permanent action. The

HSD project is a five-year project that is scheduled to end in 2020. It is implemented in the same geographic areas as the Malaria Bilateral Award.

Maternal Child Survival Program (MCSP): This activity is aimed at rebuilding and strengthening the health system by restoring maternal, neonatal and child health services at the health facility and community level following the Ebola outbreak. MCSP contributes to and supports the Ministry of Health and the health care system in Guinea by: a) providing assistance in updating national level policies and procedures for infection, prevention and control (IPC) and its integration in RMNCH; b) Supporting national, regional and prefectural engagement in the quality improvement process; c) Supporting improved coordination of the national immunization program; and d) ensuring engagement with national health management information system (HMIS) initiatives to strengthen data collection and analysis. This activity is implemented in Conakry, Boke, N'zérékoré, Kissidougou, and Kindia. It will end in December 2017.

Global Health Supply Chain-Procurement and Supply Management (GHSC-PSM). The purpose of GHSC-PSM is to procure a range of pharmaceuticals and medical supplies. In Guinea, GHSC-PSM will be procuring malaria commodities such as long lasting insecticide treated bed nets to achieve universal coverage; sulfadoxine-pyrimethamine (SP) for prevention of malaria in pregnancy; microscopes and Rapid Diagnostic Tests to support malaria diagnostics, and Artemisinin Combination Therapy (ACT) and other medicines for the treatment of simple and complicated malaria. In addition, GHSC-PSM will be continuing the work begun under **Systems for Improved Access to Pharmaceuticals and Services (SIAPS**) when it ends on September 30, 2017. In this area, GHSC-PSM will ensure the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. Toward this end, the GHSC-PSM project result will include: 1) improving governance; 2) building capacity for pharmaceutical management and services; 3) addressing information needed for decision-making in the pharmaceutical sector; 4) strengthening financing strategies and mechanisms to improve access to medicines; 5) increasing quality pharmaceutical services, and 6) biomedical waste management.

Promoting the Quality of Medicines (PQM): PQM supports the strengthening of Guinea's drug regulatory system and promotes the use of quality medicines. A particular focus of PQM is to strengthen leadership, management and governance in the sector and build the capacity of the national laboratory for quality control of medicines. PQM ends in September 2019.

MEASURE Evaluation: The overall objective of the assistance of MEASURE Evaluation is to work in concert with various USAID and non-USAID partners to strengthen the institutional capacity in health information systems within the Guinean Ministry of Health (MOH). This support includes embedding advisors in the MOH to initiate the following activities: support the development of a new Health Information System (HIS) strategy 2016-2020, as well as a costed operational plan for country-led HIS development; complete comprehensive mapping of existing HIS; continued advocacy for MoH's leadership role in the National Health Information System (NHIS) and the use of District Health Information System 2 (DHIS- 2) as the electronic platform for NHIS in Guinea; provide a list of needed equipment and software for central level HMIS staff; and identification and coaching of an institutional capacity building focal person;

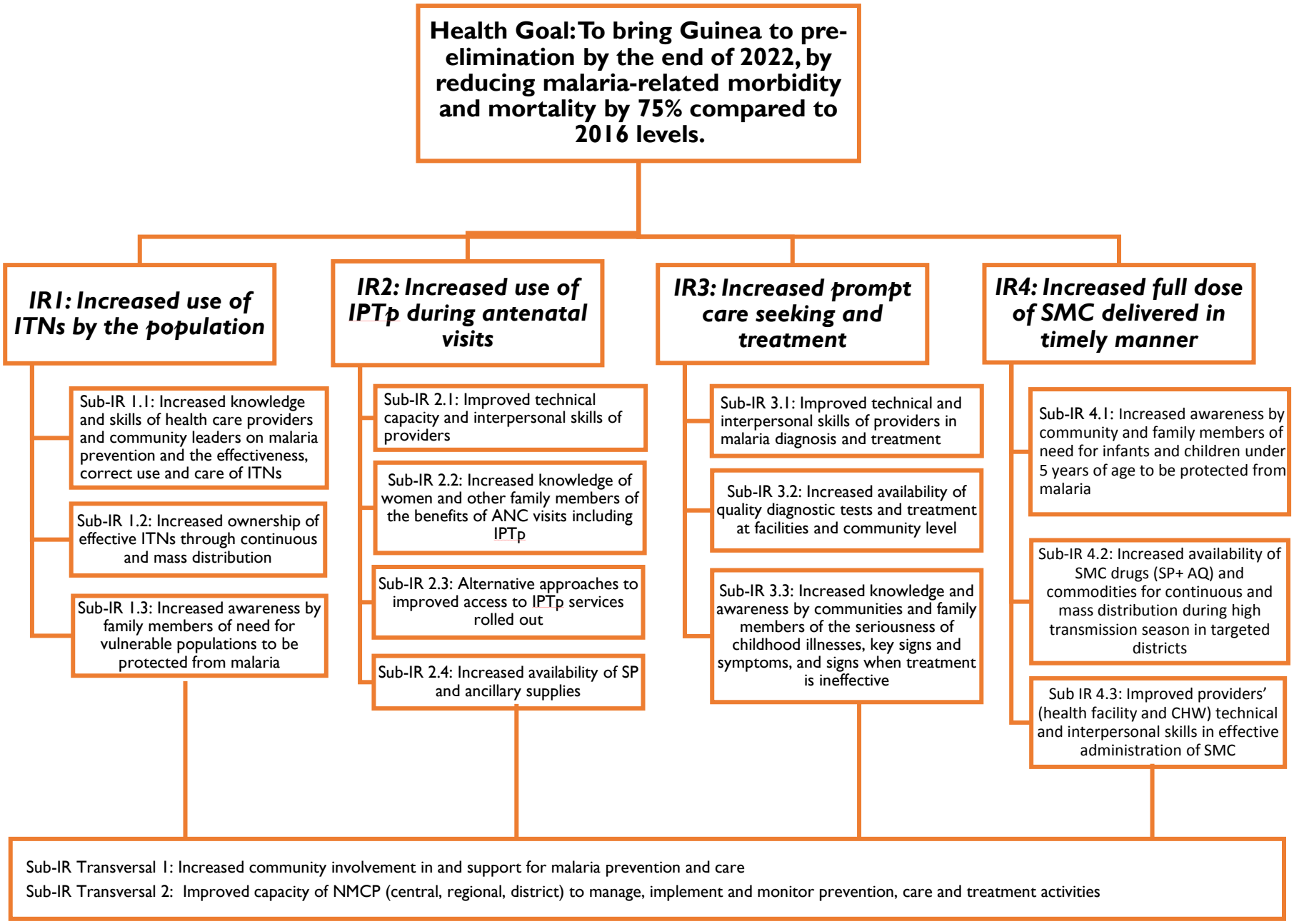
Health Financing and Governance (HFG): This activity is aimed at rebuilding the health system to better respond to crises such as the Ebola outbreak. The goal of the project is to strengthen Guinea's health system to enhance functionality of institutions and programs and improve their capacity to deliver better health services to the population of Guinea by: a) Improving institutional capacity and health governance across the health system; b) Enabling the health financing environment and improving the capacity of the Ministry of Health (MOH) to mobilize and manage efficiently resources to foster greater coverage of quality health services; and c) Improving the institutional capacity of the MOH to effectively manage human resources for health (HRH). This Activity has a national coverage.

The Leadership, Management and Governance Project (LMG) is a global, five-year Cooperative Agreement awarded by USAID/Washington, designed to strengthen and expand the people-centered capacity-building strategy pioneered under the previous Leadership, Management and Sustainability Program. The goal of the LMG/NMCP Project is to build the capacity of the NMCP through targeted technical and organizational support provided by a Senior Technical Advisor, embedded in the NMCP, so that the NMCP is able to effectively manage and implement national malaria strategies. In Guinea, LMG has assisted in the development of policy and strategy documents; partner coordination support, donor planning documents such as the MOP and the Global Fund applications; the reviewing and revising action plans, following up on past recommendations, coaching staff on how to develop workplans and monitor implementation. LMG is scheduled to end in September 2017.

In addition to the above programs, this activity will also collaborate and coordinate with CDC on the technical support they provide in the areas of entomological surveillance and routine data systems strengthening.

Activity Results Framework

The Malaria Bilateral Activity will contribute to the overall PMI and GOG NMCP goal of reducing malaria-related morbidity and mortality. The Activity will implement a subset of activities outlined in the PMI/Guinea MOPs to achieve the behavioral objectives and results based on the behavioral profiles (see also figure 1; the behavioral profiles are in Attachment 3 of this NOFO):


Health Goal: To bring Guinea to pre-elimination by the end of 2022, by reducing malaria-related morbidity and mortality by 75% compared to 2016 levels.
IR1: Increased use of ITNs by the population
Sub-IR 1.1: Increased knowledge and skills of health care providers and community leaders on malaria prevention and the effectiveness, correct use and care of ITNs
Sub-IR 1.2: Increased ownership of effective ITNs through continuous and mass distribution
Sub-IR 1.3: Increased awareness by family members of need for vulnerable populations to be protected from malaria
IR2: Increased use of IPTp during antenatal visits
Sub-IR 2.1: Improved technical capacity and interpersonal skills of providers
Sub-IR 2.2: Increased knowledge of women and other family members of the benefits of ANC visits including IPTp
Sub-IR 2.3: Alternative approaches to improved access to IPTp services rolled out
Sub-IR 2.4: Increased availability of SP and ancillary supplies
IR3: Increased prompt care seeking and treatment
Sub-IR 3.1: Improved technical and interpersonal skills of providers in malaria diagnosis and treatment
Sub-IR 3.2: Increased availability of quality diagnostic tests and treatment at facilities and community level
Sub-IR 3.3: Increased knowledge and awareness by communities and family members of the seriousness of childhood illnesses, key signs and symptoms, and signs when treatment is ineffective
IR4: Increased full dose of SMC delivered in timely manner
Sub-IR 4.1: Increased awareness by community and family members of need for infants and children under 5 years of age to be protected from malaria
Sub-IR 4.2: Increased availability of SMC drugs (SP+ AQ) and commodities for continuous and mass distribution during high transmission season in targeted districts
Sub IR 4.3: Improved providers' (health facility and CHW) technical and interpersonal skills in effective administration of SMC
Sub-IR Transversal 1: Increased community involvement in and support for malaria prevention and care
Sub-IR Transversal 2: Improved capacity of NMCP (central, regional, district) to manage, implement and monitor prevention, care and treatment activities

Goal: To bring Guinea to pre-elimination by the end of 2022, by reducing malaria-related morbidity and mortality by 75% compared to 2016 levels.

IR1: Increased use of ITNs by the population

Sleeping under an ITN prevents mosquitoes from biting individuals sleeping under it while the insecticide in the net provides greater protection by repelling mosquitoes and killing those that land on it. When a community has a high level of ITN use – which is associated with greatly reduced populations of mosquitoes that transmit malaria – the risk of malaria infections can be reduced even among those not using an ITN. In Guinea, pregnant women, infants and children under 5 years of age are at considerably higher risk of contracting malaria and developing severe disease than the general population. In sub-Saharan Africa, up to 90 percent of deaths due to malaria occur in infants and children under age 5. ITNs are essential interventions for these vulnerable populations.

In addition to routine net distribution of ITNs during ANC and immunization visits, Guinea has conducted two national bed net distribution campaigns starting in 2013 where more than 5 million long lasting ITNs (LLINs) were distributed and in 2016 where 7,891,383 LLINs were distributed with a 96% coverage of the targeted sleeping spaces. However, despite the high net coverage, utilization is still low due to a combination of factors such as limited awareness of the effectiveness of nets, myths associated with use of nets among pregnant women, and the lack of skills to maintain and repair damaged nets. More information on distribution and net use in Guinea can be found in the 2016 end of distribution campaign report and the 2014 Knowledge Attitude and Practice survey report attached as Attachment 1 to this NOFO.

The Malaria Bilateral Program intends to increase the utilization of ITNs through achievement of the following results.

- Sub-IR 1.1: Increased knowledge and skills of health care providers and community leaders on malaria prevention and the effectiveness, correct use and care of ITNs
    - Possible strategies:
        - Develop and implement communications strategy targeting all aspects of ITN use, including care and maintenance in line with the national strategy
        - Develop essential package of education and communication materials for ITN use, care and maintenance for all levels

- Sub-IR 1.2: Increased ownership of effective ITNs through continuous and mass distribution
    - Possible strategies:
        - Ensure procurement of ITNs matches household and population needs and local conditions. This would include monitoring net use, insecticide resistance, and effective ITN life (durability).
        - The partner will work closely with the supply chain mechanisms to set up effective supply chain, including Logistics Management Information

System (LMIS), and quality control systems to ensure quality ITNs are available for continuous and mass distribution. (Primary responsibility of another IP).

- Sub-IR 1.3: Increased awareness by family members of need for vulnerable populations to be protected from malaria

    - Possible strategies:
        - Conduct outreach education and BCC activities to households, women group and schools to emphasize impact of malaria on most vulnerable, efficacy and safety of use of bed nets and social accountability for practice of behavior
        - Develop and implement communications strategy targeting all aspects of ITN use, including care and maintenance.
        - Develop a package of essential education and communication materials for ITN use, care and maintenance for all levels

<u>IR2: Increased use of IPTp during antenatal visits</u>
In Africa, malaria infection in pregnancy is a major threat to the lives of mothers, fetuses, and infants. Pregnant women are particularly vulnerable to malaria infection and iron deficiency, which increase the risk of poor maternal and newborn outcomes, including maternal anemia, maternal death, spontaneous abortion, stillbirth, prematurity, low birth weight, and newborn and infant death. PMI supports routine IPTp using SP as recommended by WHO in high malaria transmission zones such as Guinea.

Preliminary findings of the 2016 MICS indicated a high (84.3%) overall ANC attendance and a relatively high percentage of women who took the first dose of SP but only 29.9% taking at least three doses of SP. Previous studies such as the 2014 KAP survey have attributed the low uptake of SP to limited client awareness of the importance of ANC visits and IPTp for safe motherhood. Many providers also lack skills to properly administer IPTp.
Achieving increased use of IPTp during antenatal visits will be attained through:

- Sub-IR 2.1: Improved technical capacity and interpersonal skills of providers.

    - Possible strategies:
        - Improve collaboration with the maternal child health program to integrate IPTp into all ANC services and other reproductive health activities.
        - Provide assistance to NMCP to update IPTp protocols in line with the latest international guidance and ensure distribution throughout the country
        - Train providers (health facility and CHW) in technical and interpersonal skills in effective administration of IPTp as per national guidelines.

- Sub-IR 2.2: Increased knowledge of women and other family members of the benefits of ANC visits including IPTp

- Possible strategies:
  - Develop and implement communications strategy promoting ANC and IPTp use
  - Develop essential package of education and communication materials for IPTp for all levels
  - Collaborate with HSD Activity and other USAID Partners to streamline messaging and coordination of efforts around promotion of antenatal visits.

- Sub-IR 2.3: Alternative approaches to improved access to IPTp services rolled out

  - Possible strategies:
    - Explore delivery of IPTp through CHWs (e.g. delivery of subsequent doses after the initial dose has been given by the health provider) to increase the use of IPTp
    - Work closely with supply chain IPs to set up effective supply chain, including LMIS, and quality control systems to ensure IPTp drugs and supplies consistently available (Primary responsibility of another IP)

- Sub-IR 2.4: Increased availability of ancillary supplies and SP

  - Possible strategies:
    - Procure and distribute ancillary supplies used in delivering SP
    - Work closely with supply chain IP to set up effective supply chain, including LMIS, and quality control systems to ensure IPTp drugs and supplies consistently available (Primary responsibility of another IP)

<u>IR3: Increased prompt care seeking and treatment</u>
Effective case management of malaria remains one of the cornerstones of malaria prevention and control as prompt and appropriate treatment of uncomplicated malaria is critical in preventing progression to severe disease and death. PMI guidance, in accordance with WHO guidelines, calls for universal diagnostic testing and rapid treatment with a recommended antimalarial drug (ACT) only when a test is positive. ACTs have been estimated to reduce malaria mortality in children aged 1–23 months by 99% (range: 94–100%), and in children aged 24–59 months by 97% (range: 86–99%).

In Guinea, ACTs continue to be effective as the first line treatment for malaria, however, health seeking behavior continues to be low and the respect for treatment protocols poor. Preliminary results of the 2016 MICS indicated that of all children aged between 0-59 months who had fever in the last two weeks preceding the survey, only 17% were tested and out of those tested, only 2.5% received ACTs (of which 2.1% received ACTs 24 hours after onset of the fever) while the rest received other antimalarial treatments, including monotherapies.

- Sub-IR 3.1: Improved technical and interpersonal skills of providers in malaria diagnosis and treatment

    - Possible strategies
        - Provide assistance to NMCP to update malaria diagnosis and treatment protocols to reflect latest international guidance and ensure distribution throughout the country
        - Train providers (health facility and CHW) in technical and interpersonal skills in effective diagnosis, treatment and education on malaria prevention as per national guidelines

- Sub-IR 3.2: Increased availability of quality diagnostic tests and treatment at facilities and community level

    - Possible strategies
        - Work with supply chain partners to support the setup of an effective supply chain, including LMIS, and quality control systems to ensure diagnostic and treatment supplies consistently available (LMIS and supply chain will be the primary responsibility of another IP although the quality aspect of the antimalarial [Therapeutic Efficacy Studies] including protocol development, sample collection and results reporting, would be the responsibility of this Activity.)

- Sub-IR 3.3: Increased knowledge and awareness by communities and family members of the seriousness of childhood illnesses, key signs and symptoms, and signs when treatment ineffective

    - Possible strategies:
        - Develop and implement communications strategy targeting all aspects of care-seeking behavior
        - Develop essential materials package for malaria diagnosis and treatment for all levels

<u>IR4: Increased full dose of SMC delivered in timely manner</u>
In Guinea, infants and children under 5 years of age are at considerably higher risk of contracting malaria and developing severe disease than the general population. Seasonal malaria chemoprevention (SMC) defined as the intermittent administration of full treatment courses of an antimalarial medicine during the malaria season in areas of highly seasonal transmission. This has been shown to be 75% protective against uncomplicated and severe malaria in children under 5 years of age.

In Guinea, SMC was introduced in 2015 targeting six districts (Dinguiraye, Gaoual, Koundara, Mali, Koubia and Tougué) with a plan to expand to an additional two districts by 2017 and to a

total of 13 by 2018. The first distribution was conducted during the month of July 2015 and distribution has continued since then to cover the targeted population during the months of highest transition (July - October). WHO recommends that a complete treatment course of amodiaquine plus sulfadoxine-pyrimethamine (AQ+SP) be given to children aged between 3 and 59 months at monthly intervals, beginning at the start of the transmission season, to a maximum of four doses during the malaria transmission season.

SMC is cost-effective and safe and can be administered door-to-door in the targeted areas by community-health workers (WHO SMC guideline 2013).

- Sub-IR 4.1: Increased awareness by community and family members of need for infants and children under 5 years of age to be protected from malaria.
    - Possible strategies:
        - Conduct community mobilization activities to emphasize SMC effectiveness, efficacy and safety during high transmission season.
        - Develop and implement communications strategy targeting the benefit of SMC administration
        - Develop a package of essential education and communication materials for SMC
- Sub-IR 4.2: Increased availability of SMC drugs (SP+AQ) and commodities for continuous and mass distribution during high transmission season in targeted districts
    - Possible strategies:
        - Work with the procurement partner(s) to ensure procurement of SMC drugs (SP+AQ) and commodities match population needs in targeted districts.
        - Collaborate with supply chain programs to set up an effective supply chain to ensure reliable stock of SMC drugs (SP+ AQ) and commodities are available for continuous and mass distribution in targeted districts.
- Sub-IR 4.3 Improved providers' (health facility and CHW) technical and interpersonal skills in effective administration of SMC
    - Possible strategies
        - Ensure SMC protocols reflect latest international guidance and are distributed throughout the targeted districts
        - Train providers (health facility and CHW) in technical and interpersonal skills in effective SMC administration as per national guidelines

Cross cutting sub-intermediate results

The following results support achievement and lay a foundation for sustaining behavioral change results anticipated by this activity.

- Transversal Sub-IR: Increased community involvement in support of malaria prevention and care

    - Possible strategies:
        - Use existing community structures to increase community ownership of interventions through their involvement in the planning and implementation of activities targeting households, women groups and schools.
        - Conduct community mobilization activities for caregiver and caregiver support systems around malaria care-seeking, diagnosis and treatment
        - Conduct community mobilization activities to promote value of preventive services to mother and unborn child
        - Conduct community mobilization activities for caregiver and caregiver support systems around SMC

- Transversal Sub-IR (Capacity building of the NMCP): Improved capacity of NMCP (national, regional, district) to manage, implement and monitor prevention, care and treatment activities:
    - Possible strategies:
        - Monitor accessibility to nets and support the NMCP to coordinate relevant IPs to ensure availability nets for continuous and mass distribution.
        - Improve capacity of NMCP and decentralized coordination structures – RBM focal points through training, coaching and mentoring to manage, implement and monitor continuous and mass distribution of ITNs
        - Facilitate improved utilization of data for malaria prevention, care and treatment activities executed through the public health care system

E. PROGRAMMATIC CONSIDERATIONS AND GUIDING PRINCIPLES

Geographic Coverage

The Malaria Bilateral Program will target 14 districts (Forécariah, Coyah, Dubréka, Fria, Boffa, Boké, Gaoual, Koundara, Mali, Lélouma, Labé, Koubia, Tougué, Dinguiraye) and the five communes of Conakry (Kaloum, Dixinn, Ratoma, Matam and Matoto). The Awardee will create linkages with other donors and stakeholders implementing interventions in these areas, as well as with donors and government institutions supporting the national malaria program and central level initiatives. The Awardee will also support national, strategic technical assistance to ensure that consistent quality care and prevention efforts are implemented throughout the country, even in geographic zones supported by other donors.

Collaborating, Learning and Adapting Approach

It is required that this activity is to embraces USAID's commitment to a multi-faceted Collaborating, Learning and Adapting (CLA) approach to development. This involves pursuing strategic collaborations intentionally with stakeholders to share knowledge and reduce duplication of effort, learning systematically by drawing on evidence from a variety of sources and taking time to reflect on implementation and adapting interventions and approaches based on applied learning. The Awardee is required to embed this approach in the implementation specifically during the work plan and the monitoring, evaluation and learning process.

Partnership with other USAID Programs and other Related Donor Programs

In line with the CLA approach defined above, strategic collaboration with other USAID activities and other USG agencies such as CDC, OFDA, NIH and others will be critical to avoid duplication and to leverage resources to extend the impact of the USG investment. The Malaria Bilateral Activity is thereby required to demonstrate how they will collaborate closely and create synergies with these USG implementing partners including: i) programs covering high impact reproductive, maternal, neonatal and child health services including nutrition; health systems strengthening, including commodity/pharmaceutical logistics; and health management information systems, including for national level health sector evaluations; ii) USAID supported interventions in other sectors, such as agriculture and economic growth (e.g., Feed the Future), and governance where it is appropriate; iii) CDC entomological surveillance.

Likewise, the Partner will create linkages with other donors, private sector actors and stakeholders implementing malaria interventions in the targeted prefectures and communes, as well as with donors and government institutions supporting the national malaria program and central level initiatives. The Partner will also support national, strategic technical assistance to ensure that consistent quality care and prevention efforts are implemented throughout the country, even in geographic zones supported by other donors.

Gender Considerations

Infants and pregnant women are the most at risk populations to malaria. Research has demonstrated that gender norms and values that influence the division of labor and sleeping arrangements may lead to different patterns of exposure to mosquitoes for men and women[9]. Gender influences the self-efficacy of women seeking diagnostic and treatment services and also influences access to preventive measures for themselves and their children. A thorough understanding of the gender related dynamics of treatment-seeking behavior, as well as of decision-making, resource allocation and financial authority within households is key to ensuring effective malaria control programs.

The Malaria Bilateral activity must incorporate gender considerations, ensuring that both men and women benefit from USAID support and that gender sensitivity is built-in to all technical approaches and activities. Furthermore, the program will support women's empowerment in seeking health services and control over health decision making being mindful the potential

[9] http://www.who.int/gender/documents/gender_health_malaria.pdf

conflicts any activities may create. The Partner will therefore conduct a gender analysis at the beginning of the Activity to understand the effect of gender in access and use of malaria prevention and treatment services in Guinea to effectively direct interventions.

To ensure that USAID assistance makes possible the optimal contribution to gender equality in developing all components, technical approaches must consider the following two questions:

1. How will the different roles and status of women and men within the community, political sphere, workplace, and household (for example, roles in decision-making and different access to and control over resources and services) affect the work to be undertaken?
2. How will the anticipated results of the work affect women and men differently?

The purpose of the first question is to ensure that 1) the differences in the roles and status of women and men are examined; and 2) any inequalities or differences that will impede achieving results are addressed in the planned work design. The second question calls for another level of analysis in which the anticipated programming results are: 1) fully examined regarding the possible different effects on women and men; and 2) the design is adjusted as necessary to ensure equitable and sustainable Malaria Bilateral Program impact.

USAID will consider the appropriateness of Applicant's' proposed activities, staff, and budget with regard to gender integration. Applications must specifically show how gender issues will be addressed, how results will be determined taking gender into account, and what resources will be provided to do this.

Youth Considerations

Guinea's population of more than 11 million is growing at a rate of 3.1 percent per year and is increasingly urban and overwhelmingly young. By 2014, 61.5% of the population was under 25 years old. With Guinea's rapidly growing population burdened with health challenges, including high infant and maternal mortality and poor nutrition, the youth are an essential group to target for health services. The Activity will identify key youth considerations and embrace a positive youth development approach in the implementation of the program. This will be based on an understanding the role and needs of the different categories of youth including those in and out of school, young mothers and fathers, among others. Results monitoring must disaggregate the impact of the program on youth.

In a consensus statement, Roll Back Malaria (RBM) and the World Health Organization (WHO) recommend continuous net distribution in order to maintain universal coverage. Mass campaigns remain the most efficient and effective method of quickly scaling up universal coverage, and in areas where universal coverage has not yet been achieved, using other channels to quickly scale up ITN access and ownership is more difficult. With PMI, the NMCP is exploring other potential mechanisms for net distribution that appear to be promising in the Guinea context. The NMCP is considering including a continuous net distribution strategy in its new national strategic plan that will involve other channels of net distribution, such as distribution through schools and religious communities. Though the NMCP has used the youth in net distribution during campaigns, the

new strategy will not only include net distribution but also communication and education on malaria prevention to school children and use them as agents of change. Other opportunities for youth development in the battle against malaria must be explored.

Local Capacity Development

A key element of the Malaria Bilateral Program is to build the institutional capacity of local organizations within Guinea to ensure sustainable results. These include both the government actors as well as the civil society, including the regional/district level representatives within the PMI supported prefectures.

The Activity must plan to deliberately work with and build the institutional capacity of the National Malaria Control Program and of their regional/district level representatives within the PMI supported prefectures to manage and monitor the implementation of the malaria strategy. While the Malaria Activity will not be providing direct funds to the NMCP, provision for their appropriate engagement in training events, pertinent national and international conferences, development of critical guidelines and protocols, and their capacity to ensure the strategic planning and operational oversight of the clinical and community based malaria prevention and control activities must be considered in the proposed interventions with an eye toward strengthening leadership and thereby sustainability.

Local NGOs and Community Based Organizations (CBOs) will be important facilitators of the citizen engagement process by assisting in such areas as direct service provision, advocacy for accountability, and transparency, and will act as intermediaries between their stakeholders at different levels of government (national vs. sub-national), and at various links in the delivery supply chain. Applicants are required to identify, partner with, and strengthen civil society organizations that can help meet Malaria Bilateral Program objectives and achieve results. While civil society organizations remain quite weak in Guinea, engagement of local government authorities to provide essential services to clients must be considered as a means of strengthening local capacity and ensuring sustainability of efforts after the life of the Malaria Bilateral Program.

Applicants must be able to clearly define the mission objective of potential partner local NGOs, and then assess the capacity gap, and propose resources to mitigate risks inherent in administering a USAID grant.

Public-Private Partnerships (PPPs)

USAID views partnerships as an arrangement involving two or more parties acting together to achieve a common goal and/or objective by bringing to bear a set of complementary assets. Ideally, each partner offers assets that draw on its core institutional capabilities. Moreover, the process of partnering produces concrete value-added attributes that benefit all partners, helping each to achieve something that no single partner could have achieved on its own. Similarly, each partner is better able to achieve its own objectives than it could have operating alone. As USAID/Guinea favors partnerships because of their potential for long-term benefits to targeted communities and beneficiaries, Applicants are required to demonstrate in their technical

approach how interventions will create opportunities for private sector collaboration and sustained programmatic impact.

The MOH has prioritized the application of advanced Information and Communications Technology (ICT), and USAID/Guinea is an active proponent of using ICT to improve quality service delivery in the health sector. Applicants are encouraged to explore private sector partnership opportunities that integrate science and technological innovations that increase preventive behaviors and care-seeking for the prevention and control of malaria and improve performance delivery for a transformed Guinean health system including a reliable, effective and transparent pharmaceutical system. Applications must describe how Applicants will seek, develop, and maintain private and public sector partnerships that augment Malaria Bilateral Program interventions and sustain them beyond the life of the program without additional USG funds.

Historically, USAID Missions undertaking PPPs or Global Development Alliances (GDAs) that leverage private sector cash and in-kind resources, jointly design, plan, and manage activities with implementation partners. Over the years, USAID has identified a broader array of benefits other than leverage that come with working in partnership such as private sector acumen brought to bear in achieving public national development results. The Awardee could be asked to track the leverage ratio, or the proportion of private sector funds relative to USG funds invested in the development program. As an additional requirement, PPPs/GDAs must achieve at least a 1:1 ratio of USG to private sector funds.

F. MONITORING, EVALUATION AND LEARNING

Performance management is essential for ensuring effective management and results achievement of the Malaria Bilateral Program. The Partner will be required to develop and maintain a performance management system to track progress and generate learning that can inform ongoing adjustments and strategies towards achievement of the results under this program description.

Specifically, this Malaria Bilateral Program will develop an Activity Monitoring Evaluation and Learning Plan which must include clearly defined indicators, baselines, and targets for output, outcome, and impact level monitoring, as well as benchmarks for performance over the five-year implementation period. Additionally, the Program will empirically demonstrate how the capacity of key local NGOs and CBOs, the MOH, and local government authorities has been improved using both indicators and other appropriate organizational assessment measures. All performance indicators and targets must be gender disaggregated wherever possible.

Below is a list of USAID indicators that the Applicant is required to track over the course of Activity.

- Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds

- Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTs) or microscopy) with USG funds
- Number of health workers trained in intermittent preventive treatment in pregnancy (IPTp) with USG funds
- Proportion of pregnant women who received least three doses of SP during their last pregnancy
- Number of CSOs receiving USG assistance engaged in health advocacy
- Percentage health centers with the ability to perform diagnostic testing for malaria (microscopy and/or rapid diagnostic testing)
- Percentage of community health workers capable of using rapid diagnostic tests (RDTs) at household level
- Percentage of diagnostic tests (microscopy and/or RDTs) interpreted correctly (positive–negative)
- Percentage of patients (all ages) who tested positive (via microscopy or RDT) and who received an effective anti-malarial as reported by health facilities
- Percentage of patients with suspected malaria referred for a diagnostic test (microscopy or RDT)
- Percentage of patients with a negative diagnostic test who received treatment for malaria
- Percentage of health workers nationwide with malaria-related responsibilities that received at least one supervision every three months
- Percentage of children under 5 with fever in the last 2 weeks who received treatment with ACTs within 24 hours of onset of fever
- Percentage of children U5 who slept under an LLIN the previous night
- Percentage pregnant women who slept under an LLIN the previous night
- Comprehensive malaria M&E plan developed and implemented as an integral part of the new National Malaria Strategic Plan (Proportion of performance measures on the Malaria M&E Plan for which updated data exists)
- Extent of progress made against recommendations of assessment/organizational audit of NMCP
- Number of quarterly coordination meetings under NMCP's leadership held with meeting minutes distributed

The Partner may propose additional indicators and monitoring approaches including surveys, organizational capacity assessments and other qualitative methods that will best support the measurement of results and promote learning and adaptation during the course of implementation. USAID Guinea may also require the Partner to track and report on additional performance indicators subject to changing of Agency guidance and/or the requirements of specific funding sources and the Mission's own Performance Management Plan (PMP).

The Applicant is also required to propose a strategy for intentional collaborating and learning internally, with NMCP and other critical stakeholders. As part of the monitoring, evaluation and learning plan, the Partner will propose a learning agenda and methods for reflection on progress and other changes in the implementation context to inform ongoing adjustments to the program and dialogue for policy reform.

USAID will conduct an independent third-party evaluation to assess the performance of the Malaria Bilateral Program and identify any necessary course corrections. The Partner will be involved in the design of the evaluation to ensure that their individual learning needs are being met and appropriate action is taken on the findings. As with all USAID evaluations, the evaluations may include other questions that are pertinent to program design, management, and operational decision making.

Notwithstanding the need for specific reporting as noted above, the Awardee must immediately notify USAID/Guinea of any developments that have a significant impact on award-supported activities. Further, notification must be given in the case of problems, delays, or adverse conditions which materially impair the ability to meet the objectives of the Malaria Bilateral Program. These notifications must include a statement of the action taken or contemplated, and any assistance needed to resolve the situation.

At a minimum, the Awardee will be required to meet regularly with the AOR/PMI team in country and submit written quarterly performance progress reports on implementation and strategic direction of the Malaria Bilateral Program and to engage in PMI related reviews, assessments and plans.

G. PERSONNEL REQUIREMENTS

Applicants must propose technical personnel and other personnel, as deemed appropriate, to implement the major tasks above. USAID anticipates that a large proportion of the work will be done by Guineans. The positions suggested as Key Personnel include the following, but Applicants must propose and justify the appropriate staffing structure needed to execute their technical approach:

- Chief of Party
- Senior Technical Advisor
- Director of Finance/Administration
- SBCC Advisor
- Monitoring and Evaluation Specialist.

Key Personnel (and any changes to those individuals specified) will require concurrence of the AOR and approval of the Agreement Officer (AO) throughout the life of the Agreement. It is useful that other essential positions be identified and potential candidates described in the proposed applications to provide a clear view of the approach to technical components of the work. An organizational chart would be one way to clearly represent this linkage. In addition, specific expertise may be needed given the technical scope of the work to be conducted. CVs or brief bio-sketches of key proposed personnel, whose expertise would strengthen the merit of the application, are also to be included in the Application.

Other Personnel

The Awardee has the discretion to determine the proper number and mix of additional personnel, personnel from local organizations, short-term technical staff, and others to meet Malaria Bilateral Program requirements, to be described in the Application. If the Applicant proposes technical leads for particular areas, USAID strongly encourages that Guineans (i.e., locally hired) technical leads be considered and proposed for all positions. Familiarity with the political, social, economic, and cultural context of working in Guinea is also necessary.

[END OF SECTION A]

SECTION B: FEDERAL AWARD INFORMATION

1. Estimate of Funds Available and Number of Awards Contemplated

Subject to funding availability, USAID intends to provide up to $28,000,000 in total USAID funding over a five-year period. The ceiling for this program is $28,000,000. Actual funding amounts are subject to availability of funds.

USAID intends to award one Cooperative Agreement pursuant to this notice of funding opportunity.

USAID reserves the right to fund any one or none of the applications submitted.

2. Start Date and Period of Performance for Federal Awards

The period of performance anticipated herein is five years. The estimated start date will be upon the signature of the award, on or about December 11, 2017.

3. Substantial Involvement

ELEMENTS OF SUBSTANTIAL INVOLVEMENT

USAID/Guinea intends to have the following elements of Substantial Involvement in the proposed Cooperative Agreement:

a. Approval of the Recipient's Implementation Plans

b. Approval of Specified Key Personnel

Key personnel are only those positions that are essential to the successful implementation of the recipient's program, generally no more than five positions or five percent of recipient employees working under the award, whichever is greater.

c. Agency and Recipient Collaboration or Joint Participation:

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

(2) Concurrence on the substantive provisions of sub-awards. 2 CFR 200.308 already requires the recipient to obtain the AO's prior approval for the subaward, transfer, or contracting out of any work under an award. This is generally limited to

approving work by a third party under the agreement. If USAID wishes to reserve any further approval rights for sub-awards or contracts, it must clearly spell out such Agency involvement in the substantial involvement provision of the agreement.

(3) Approval of the recipient's monitoring and evaluation plans.

(4) Monitor to authorize specified kinds of direction or redirection because of interrelationships with other projects. All such activities must be included in the program description, negotiated in the budget, and made part of the award.

d. Agency Authority to Immediately Halt a Construction Activity

4. Title to Property

Property title under the resultant agreement will be vested with the Cooperating Country (Host Government).

5. Authorized Geographic Code

The Authorized Geographic Code for procurement of goods and services under the resulting award is 935. This includes any area or country in the Free World, including the cooperating country (Guinea). The Free World does not include the foreign policy excluded countries.

6. Purpose of the Award

The principal purpose of the relationship with the Recipient and under the subject program is to transfer funds to accomplish a public purpose of support or stimulation of the prevention and control of malaria in Guinea, which is authorized by Federal statute.

The successful Recipient will be responsible for ensuring the achievement of the program objectives and the efficient and effective administration of the award through the application of sound management practices. The Recipient will assume responsibility for administering Federal funds in a manner consistent with underlying agreements, program objectives, and the terms and conditions of the Federal award. The Recipient using its own unique combination of staff, facilities, and experience, has the primary responsibility for employing whatever form of sound organization and management techniques may be necessary in order to assure proper and efficient administration of the resulting award.

[END OF SECTION B]

SECTION C: ELIGIBILITY INFORMATION

1. Eligible Applicants

U.S. and non-US organizations may participate under this NOFO.

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

Applications for renewal or supplementation of existing projects are eligible to compete with applications for new Federal awards.

Applicants must have established financial management, monitoring and evaluation processes, internal control systems, and policies and procedures that comply with established U.S. Government standards, laws, and regulations. The successful Applicant(s) will be subject to a responsibility determination assessment (pre-award survey) by the Agreement Officer (AO).

The Recipient must be a responsible entity. The AO may determine a pre-award survey is required to conduct an examination that will determine whether the prospective recipient has the necessary organization, experience, accounting and operational controls, and technical skills – or ability to obtain them – in order to achieve the objectives of the program and comply with the terms and conditions of the award.

2. Cost Sharing or Matching

Cost sharing is required at 5% of the budget value as provided by USAID. Such funds may be mobilized from the recipient; other multilateral, bilateral, and foundation donors; host governments; and local organizations, communities and private businesses that contribute financially and in-kind to implementation of activities at the country level. For guidance on cost sharing in cooperative agreements, see 2 CFR 200 (https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title02/2cfr200_main_02.tpl) and 2 CFR 700 (https://www.ecfr.gov/cgi-bin/text-idx?SID=531ffcc47b660d86ca8bbc5a64eed128&mc=true&node=pt2.1.700&rgn=div5), and ADS 303.3.10 (https://www.usaid.gov/sites/default/files/documents/1868/303.pdf).

3. Other

Organizations may submit only one application under this NOFO.

[END OF SECTION C]

SECTION D: APPLICATION AND SUBMISSION INFORMATION

1. Agency Point of Contact

Primary:
Name: Abdullahi Sadiq
Title: Agreement Specialist
Street Address: USAID/Senegal, c/o U.S. Embassy, B.P. 49, Route des Almadies, Dakar, Senegal
Email: asadiq@usaid.gov
Phone number: +221.33 879. 4000

Alternate:
Name: Yves Kore
Title: Regional Agreement Officer
Street Address: USAID/Senegal, c/o U.S. Embassy, B.P. 49, Route des Almadies, Dakar, Senegal
Email: ykore@usaid.gov
Phone number: +221.33 879. 4000

2. Questions and Answers:

All questions regarding this NOFO must be submitted in writing to the email address of the primary and alternate agency contacts above with a copy to Hamed Cisse at hcisse@usaid.gov.

Questions regarding this NOFO must be submitted by email no later than the date and time mentioned on the cover page of this NOFO to provide sufficient time to address the questions and incorporate the questions and answers as an amendment to this solicitation. Questions must be clear and concise, and direct to the point. Any information given to a prospective Applicant concerning this NOFO will be furnished promptly to all other prospective Applicants as an amendment to this NFO, if that information is necessary in submitting applications or if the lack of it would be prejudicial to any other prospective Applicant.

3. Content and Form of Application Submission

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

Preparation of Applications:

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

Any erasures or other changes to the application must be initiated by the person signing the application. Applications signed by an agent on behalf of the Applicant must be accompanied by

evidence of that agent's authority, unless that evidence has been previously furnished to the issuing office.

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

"This application includes data that must not be disclosed outside the U.S. Government and must not be duplicated, used, or disclosed – in whole or in part – for any purpose other than to evaluate this application. If, however, a grant is awarded to this Applicant as a result of – or in connection with – the submission of this data, the U.S. Government will have the right to duplicate, use, or disclose the data to the extent provided in the resulting grant. This restriction does not limit the U.S. Government's right to use information contained in this data if it is obtained from another source without restriction. The data subject to this restriction are contained in sheets {insert sheet numbers} and, mark each sheet of data it wished to restrict with the following legend:

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

Applicants must retain for their records one (1) copy of the application and all enclosures which accompany it.

4. Application Submission Procedures

It is the Applicant's responsibility to ensure that all necessary documentation is complete and received on time.

USAID bears no responsibility for data errors resulting from transmission or conversion processes associated with electronic submissions.

All applications must be submitted by email to the address mentioned above.

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

Our preference is that the technical application and the cost application be submitted as single email attachments, e.g. that you consolidate the various parts of a technical application into a single document before sending them. If this is not possible, please provide instructions on how to collate the attachments. USAID will not be responsible for errors in compiling electronic applications if no instructions are provided or are unclear. All applications received by the

submission deadline will be reviewed for responsiveness to the NOFO and the application format. No addition or modifications will be accepted after the submission date.

After you have sent your applications electronically, immediately check your own email to confirm that the attachments you intended to send were indeed sent. If you discover an error in your transmission, please send the material again and note in the subject line of the email that it is a "corrected" submission. Do not send the same email more than once unless there has been a change, and if so, please note that it is a "corrected" email.

5. Technical Application Format

The technical application will be the most important factor for consideration in selection for award of the proposed Cooperative Agreement. The technical application must be specific, complete and presented concisely. The application must demonstrate the Applicant's capabilities and expertise with respect to achieving the goals of this program. The application must take into account the requirements of the program and evaluation criteria found in this NOFO.

The technical application must include six sections:

- Cover Page;
- Acronyms;
- Table of Contents;
- Executive Summary;
- Technical Application Body; and
- Annexes.

Applications must be submitted in searchable Word or PDF format, written in English, single spaced, using Times New Roman font size 12. Each page must be numbered consecutively and have at least one inch margins on the top, bottom, and sides. The technical application must not exceed 41 A4 sized pages, excluding annexes. An application that exceeds this page limit will only be evaluated through page 41.

While tables, graphs, and charts may use a smaller font, USAID/Guinea reserves the right to take appropriate action, including elimination of the application from further consideration, if the use of smaller font in tables, graphs, and charts in the application is not respected.

Specific information on each of the sections of the technical application is provided below.

The Cover Page (1 page) must include the following:

- Program title;
- Request for Applications reference number;
- Name of organization (s) applying for the agreement;
- Any partnerships; and
- Contact person, telephone number, fax number, email addresses, address, and types name(s) and title(s) of person(s) who prepared the application, and corresponding

signatures.

The Acronym Page (1 page) must include list of acronyms of the technical application.

The Table of Contents (1 page) must list all sections and attachments of the technical application with page numbers.

The Executive Summary (maximum of 2 pages) must provide a brief description of the proposed approach, anticipated results, technical and managerial resources of the applicant's organization, any public-private partnerships, and how the overall activity will be managed.

The Technical Application Body (maximum 36 pages) must contain the four subsections:

- Technical Approach (25 pages), inclusive of transversal elements, such as gender and M&E;
- Management Approach (5 pages);
- Personnel (3 pages); and
- Organizational Capability and Experience (3 pages).

The purpose of the Technical Application Body is to provide the information necessary to allow USAID/Guinea to fairly and completely evaluate the applicant under each of the technical evaluation review criteria specified in Section E of this NOFO.

6. Cost Application Format

The Applicant must sign and submit the cost application standard form number SF-424 and SF-424A. Standard Forms can be accessed electronically at www.grants.gov.

The Cost or Business application is to be submitted as a separate file from the Technical application (but must be submitted as part of the same email submission). The Cost/Business application is to be submitted in Microsoft Excel 2010. The Applicant is requested to submit a budget broken down by program years with an accompanying detailed budget narrative (in Word 2010 or PDF searchable format) which provides in detail the total costs for implementation of the program as further detailed below.

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.

There is no page limit on the Cost Application. However, unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective application in response to this NOFO is not desired. Elaborate art work, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor wanted.

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

The following sections describe the documentation that the Applicants 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 details to address the following:

1. The budget must have an accompanying detailed budget narrative and justification that provides in detail the total program amount for implementation of the program your organization is proposing. The budget narrative must provide information regarding the basis of estimate for each line item, including reference to sources used to substantiate the cost estimate (e.g. organization's policy, payroll document, and vendor quotes, etc.).

2. A budget for each program year with an accompanying detailed budget narrative which provides in detail the total costs for implementation of the program. The budget must be submitted using Standard Form 424 which can be downloaded from the following web site at http://apply07.grants.gov/apply/FormLinks?family=15

3. A breakdown of all costs associated with the program according to the costs of, if applicable, headquarters, regional and/or country offices.

4. Applicants who intend to utilize contractors or sub-awardees should indicate the extent intended and a complete cost breakdown. Extensive contracts/agreement financial plans should follow the same cost format as submitted by the primary Applicant. A breakdown of all costs according to each partner organization, contract or sub-awardee involved in the program must be provided.

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

The cost/business application must contain the budget categories as shown on the SF-424A.

The Applicant must submit a Negotiated Indirect Cost Rate Agreement NICRA if the organization has such an agreement with an agency or department of the U.S. Government. If no NICRA the Applicant must submit the following:

Reviewed Financial Statements Report: a report issued by a Certified Public Account (CPA) documenting the review of the financial statements was performed in accordance with Statements on Standards for Accounting and Review Services; that management is responsible for the preparation and fair presentation of the financial statements in accordance with the applicable financial reporting framework and for designing, implementing and maintaining internal control relevant to the preparation. The account must also state the he or she is not aware of any material modifications that must be made to the financial statements; or

Audited Financial Statements Report: An auditor issues a report documenting the audit was conducted in accordance with Generally Accepted Auditing Standards (GAAS), the financial statements are the responsibility of management, provides an opinion that the financial statements present fairly in all material respects the financial position of the company and the results of operations are in conformity with the applicable financial reporting framework (or issues a qualified opinion if the financial statements are not in conformity with the applicable financial reporting framework.

The proposal must not include:

Compiled financial statements will not be accepted because the Accountant does not obtain or provide any assurance that there are no material modifications that should be made to the financial statements.

7. COST SHARE

Cost share refers to the resources a recipient contributes to the total cost of an agreement. Cost share becomes a condition of an award when it is part of the approved award budget. The cost share must be verifiable from the recipient's records; for U.S. organizations it is subject to the requirements of 2 CFR 200.306, and for non-U.S. organizations it is subject to the Standard Provision, "Cost Share"; and can be audited. Cost sharing may also be demonstrated either through direct funding, beneficiary contributions, in-kind assistance, or a combination thereof. USAID will make the final determination and assess whether or not the Applicant's cost share contributions (e.g. categories or items) meet the standards set in 2 CFR 200.306 or the Standard Provision "Cost Share" for non-U.S. organizations. Cost Shares must be calculated as dollar value rather than a percentage of overall budget for tracking purposes.

If a recipient does not meet its cost share requirement, the AO may apply the difference in actual cost share amount from the agreed upon amount to reduce the amount of USAID funding for the following funding period, require the recipient to refund the difference to USAID when this award expires or is terminated, or reduce the amount of cost share required under the award. The recipient must provide **cost share of $1,400,000.00 representing at least 5% of USAID**

funding.

The Applicants must estimate the amount of cost-sharing resources to be mobilized over the life of the agreement and specify the sources of such resources, and the basis of calculation in the budget narrative. Applicants should also provide a breakdown of the cost share (financial and in-kind contributions) of all organizations involved in implementing the resulting Cooperative Agreement.

The business section of the cost/business application must include:

1. Required assurances, certifications and representations. Obtain form at https://www.usaid.gov/sites/default/files/documents/1868/303mav.pdf

2. Evidence of responsibility the Agreement Officer can use to determine the Applicant

a. Has adequate financial resources or the ability to obtain such resources as required during the performance of the award;
b. Has the ability to comply with the award conditions, taking into account all existing and currently prospective commitments of the Applicant;
c. 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;
d. Has a satisfactory record of integrity and business ethics; and
e. Is otherwise qualified and eligible to receive a Cooperative Agreement under applicable laws and regulations (e.g., EEO).

3. Certificate of Compliance: Please submit a copy of your Certificate of Compliance if your organization's systems have been certified by USAID/Washington's Office of Acquisition and Assistance (M/OAA).

4. Statutory and Regulatory Certifications:
The Applicant must complete the certifications in Section IV, B. Required Certifications and sign and date in the signature space provided. The signed and dated printout must then be submitted with the application as an annex to the cost application. Original signed hardcopy of the certifications will be requested from the successful applicant prior to the agreement award.
USAID's "Certifications, Assurances, Other Statements of the Recipient" available at https://www.usaid.gov/ads/policy/300/303mav. The Recipient must complete Parts I-IV as applicable.

8. Potential Request for Additional Documentation

Upon consideration of award or during the negotiations leading to an award, Applicants may be required to submit additional documentation deemed necessary for the Agreement Officer to make an affirmative determination of responsibility. Applicants must not submit the information

below with their applications. The information in this section is provided so that Applicants may become familiar with additional documentation that may be requested by the Agreement Officer:

The information that may be requested should substantiate:

1. Bylaws, constitution, and articles of incorporation, if applicable; and

2. Whether the organizational travel, procurement, financial management, accounting manual and personnel policies and procedures, especially regarding salary, promotion, leave, differentials, etc., submitted under this section have been reviewed and approved by any agency of the Federal Government, and if so, provide the name, address, and phone number of the cognizant reviewing official.

9. Required Certifications

1. Applicant must submit the application using the SF-424 series, which includes the:
   • SF-424, Application for Federal Assistance,
   • SF-424A, Budget Information – Non-construction Programs, and
   • SF-424B, Assurances – Non-construction Programs.

2. All Certifications and statements found in ADS 303mav, Certifications, Assurances, and Other Statements of the Recipient and Solicitation Standard Provisions.
   All certifications are contained at
   https://www.usaid.gov/sites/default/files/documents/1868/303mav.pdf

10. Unique Entity Identifier and System for Award Management

Dun and Bradstreet and SAM.gov Requirements

USAID may not award to an applicant until the applicant has complied with all applicable unique entity identifier and SAM requirements. Each applicant is required to:

(i) Be registered in SAM before submitting its application. SAM is streamlining processes, eliminating the need to enter the same data multiple times, and consolidating hosting to make the process of doing business with the government more efficient.;

(ii) Provide a valid unique entity identifier in its application; and

(iii) Continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency.

It is the Applicant's responsibility to ensure that all necessary documentation is complete and

received on time.

11. Funding Restrictions

a. Profit

USAID policy is not to award profit under assistance instruments. However, all reasonable, allocable and allowable expenses, both direct and indirect, which are related to the agreement program and are in accordance with applicable cost principle under 2 CFR 200 Subpart E. of the Uniform Administrative Requirements may be paid under the anticipated award.

b. Construction

Construction is not an allowable activity under this program.

c. Pre-Award Costs

No costs chargeable to any award resulting from this RFA may be incurred before receipt of either a fully executed Agreement or a specific, written authorization from the Agreement Officer.

[END OF SECTION D]

SECTION E: APPLICATION REVIEW INFORMATION

1. Criteria, Review and Selection Process

USAID intends to award a single Cooperative Agreement from this NOFO. However, USAID reserves the right to make more than one award or no award if determined to be in the best interest of the Government. Each application submitted compliant with the terms of this NOFO will be reviewed according to the process set forth below.

A Selection Committee (SC) will conduct a merit review of all applications received that comply with the instructions in this NOFO. The evaluation will be conducted using the adjectival rating system. The SEC will evaluate Technical applications according to the criteria described below. Committee members will examine the logic, feasibility and appropriateness of the technical approach, including responsiveness to cross-cutting themes, indicators and anticipated development results or impacts; quality and availability of personnel in response to stated qualifications or requirements; and several institutional factors.

After evaluations have been completed, the SC will then recommend the apparently successful applicant. The Agreement Officer (AO), considering the SC recommendation and the cost evaluation, will then make the final selection. USAID may engage in discussions or negotiations with the Apparently Successful Applicant regarding any matter to be covered in the final technical and cost application. USAID may also award without discussions with the selected Applicant.

Applicants must note that these technical criteria serve to: (a) identify the significant matters that Applicant should address in their applications and (b) set the standard against which application will be evaluated.

APPLICATION REVIEW INFORMATION

A. Technical Evaluation

USAID will conduct a merit review of all applications received that complies with the instructions in this NOFO. The Selection Committee (SC) will evaluate the various components of the application set forth below in descending order of importance:

1. Project Design/Technical Approach: The extent to which the proposed technical approach (including the monitoring and evaluation aspects) demonstrates a clear understanding of the expected results and guiding principles of the program and a convincing approach to achieve them. Feasibility, effectiveness, scalability, sustainability, and gender integration of the technical approach will all be taken into consideration. The application must clearly describe how the operational approach will achieve the proposed objectives. The proposed approach will also be evaluated in terms of feasibility and effectiveness in fostering transformative change through sustainable local systems development.

The review will look for:

- An innovative implementation planning and approach that addresses the key objectives in line with the national malaria control strategy; evidence of contextual knowledge and implementation flexibility; plans for impact and sustainable interventions;

- Demonstrated understanding of the national and local political landscape, understanding of the malaria services delivery system and its limitations, and broad and deep insight into the Guinean context, as well as knowledge of current national/regional strategies, programs, structures, and opportunities; and any recommended changes to the existing strategies, financing, other systems, or regulatory framework; and

- Technical quality of the application including:
    - a strategic vision for the interventions;
    - a clear set of results leading to an overall goal with heavy emphasis placed on the application of dynamic and innovative examples of promising practices;
    - feasibility of implementing strategy;
    - flexibility within strategy to adjust interventions with experience;
    - potential for measurable impact; and
    - plans for direct and continued involvement with local entities to facilitate change that will catalyze improved equity, access, and quality of malaria health services in Guinea, including planned linkages to existing resources and structures, resulting in an improved enabling environment for accelerated behavior change and malaria health indicators

2. <u>Project Management, Technical Experience and Institutional Capacity</u>: The extent to which the proposed management approach demonstrates the ability to effectively and efficiently implement this program, including engagement with the NMCP and other stakeholders in Guinea's malaria response. Feasibility, efficiency, effectiveness, scalability, and sustainability of the management approach will all be taken into consideration, as will the extent to which the applicant and its teaming partners, if any, demonstrate successful past performance in achieving results on similar programs.

The review will look for:

- Corporate experience in effective design and implementation of malaria control programs in developing contexts; successful management of health development programming and institutional capacity building initiatives with host country counterparts;

- Demonstrated broad experience, technical expertise, and a successful track record of the Applicant's organization in the proposed area of work, including experience with the Government of Guinea (at federal, provincial, and district levels);
- Demonstrated effectiveness in working as a trusted partner with the private sector, as well

as local and provincial government entities for collaborative success;

- Technical and administrative capacity to oversee the proposed project;

- Capacity for immediate start-up; and

- If the proposal includes partners, demonstrated experience of the Applicant in leading an effective consortium and the complementary technical expertise of each partner.

3. Key Personnel and Staffing: The extent to which the proposed key personnel and staffing plan convincingly demonstrate the ability to successfully and effectively implement the proposed program, achieve the expected results, and integrate the guiding principles, including gender.

The review will look for:

- The expertise, experience and qualifications of the proposed candidates for each of the Key Personnel positions in relation to minimum requirements and preferences for each position;

- Evidence that the proposed organizational structure for the project has an appropriate size, breadth, and reporting effectiveness; and

- Staffing plan depicting appropriate skills and capacities when assessed individually for specific responsibilities/scopes and collectively as a management team to successfully execute the proposed suite of activities in a cost-effective manner.

4. Monitoring and Evaluation Plan: The extent to which the proposed monitoring and evaluation plan is appropriate and feasible, allowing for assessment of program performance and program monitoring against the selected indicators and objectives.

The review will look for:

- Monitoring systems (including PMP) that will provide for necessary monitoring and reporting on the proposed activities; and

- Indicators which are measurable and will reflect programmatic impact including monitoring and reporting.

5. Gender: The extent to which the program design reflects an understanding of the role of gender and its influence upon susceptibility to malaria and on care seeking behaviors in a Guinean context, and of the aspects of programmatic intervention designed to address or mitigate any related obstacles to the program objective.

The review will look for:

- evidence that the proposed project will: (1) address disparities in opportunities for women and girl children to access to health services, (2) strengthen women's decision-making and access to resources, (3) promote communications that can change behaviors affecting women's access to malaria prevention and care in clinics as well as in the community, and (4) promote roles of women in providing services and managing health services; and

- Extent to which the technical application demonstrates appreciation of the role played by gender in impacting (negatively or positively) malaria related risks and behaviors and how such elements will be mitigated or enhanced (respectively) through strategic program design

B. Cost Evaluation

The cost application of the apparently successful technical application will be evaluated for cost reasonableness, allowability and allocability. The cost application must be complete with adequate budget detail and must be consistent with elements of the technical application. USAID will assess whether the overall costs are realistic for the work to be performed, whether the costs reflect the Applicant's understanding of the requirements, and whether the costs are consistent with the technical application.

While cost is less important than technical and is not weighted, however, the cost applications of the apparently successful technical application will be evaluated for cost effectiveness including the level of proposed cost share. Other considerations are the completeness of the application, adequacy of budget detail and consistency with elements of the technical application. In addition, the organization must demonstrate adequate financial management capability to be measured for a responsibility determination.

The application with the lowest estimated cost may not be selected if award to a higher priced technical application offers a greater overall benefit for the program (value for money). All evaluation factors other than cost or price, when combined, are significantly more important than cost. However, estimated cost is an important factor and the estimated cost to the Government increases in importance as competing applications approach equivalence and may become the deciding factor when technical applications are approximately equivalent in merit.

Cost estimates will be analyzed as part of the application evaluation process. Proposed costs may be adjusted, for purposes of evaluation, based on results of the cost analysis and its assessment of reasonableness, completeness, and credibility.

Cost Sharing

A 5% cost share is required from this Award from leveraged non-USAID resources from private firms and institutions (such as equipment, training, level of effort and any in-kind contributions)

as these may extend the reach, impact and potential sustainability of the program. Cost sharing may be also demonstrated either through direct funding, in-kind assistance, or a combination thereof. USAID will make the final determination and assess whether or not the Applicant's cost share contributions (e.g. categories or items) meet the standards set in 2CFR 200.

[END OF SECTION E]

SECTION F: FEDERAL AWARD ADMINISTRATION INFORMATION

1. Federal Award Notices

Award of the agreement contemplated by this NOFO cannot be made until funds have been appropriated, allocated and committed through internal USAID procedures. While USAID anticipates that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for the award. The Agreement Officer is the only individual who may legally commit the Government to the expenditure of public funds. No costs chargeable to the proposed Agreement may be incurred before receipt of either a fully executed Agreement or a specific, written authorization from the Agreement Officer.

2. Administrative & National Policy Requirements

The resulting award from this NOFO, will be administered by USAID in accordance with the following:

> **For U.S. organizations**: 2 CFR 200, 2 CFR 700, and ADS 303maa, Standard Provisions for U.S. Non-governmental Organizations are applicable.
>
> **For non-U.S. organizations:** ADS 303mab, Standard Provisions for Non-U.S. Non-governmental Organizations will apply.

3. Reporting Requirements.

Financial Reporting:

The recipient shall account for expenditures for activities carried out to ensure funds are used for their intended purposes. Financial reports shall be in accordance with 2 CFR 200.327.

(a) Quarterly Report: The recipient will submit an SF 425, the Federal Financial Report, via electronic format to the U.S. Department of Health and Human Services (http://www.dpm.psc.gov) within 30 calendar days following the end of each quarter of the United States Government fiscal year. A copy of this form shall be simultaneously submitted to the Agreement Officer's Representative (AOR) and the USAID/Guinea Office of Financial Management.

(b) Final Report: The recipient will submit within 90 calendar days following the estimated completion date of this award the original and three (3) copies of the final Federal Financial Reports (SF-425) to: (a) USAID/Washington, M/CFO/CMP-LOC Unit; (b) the Agreement Officer, (c) Agreement Officer's Representative (AOR). The electronic version of the final SF 425 will be submitted to the U.S. Department of Health and Human Services (http://www.dpm.psc.gov) in accordance with paragraph (a) above.

Electronic copies of the SF-425 can be found at:
http://www.whitehouse.gov/omb/grants/standard_forms/ff_report.pdf and
http://www.forms.gov/bgfPortal/docDetails.do?dId=15149

Line item instructions for completing the SF-425 can be found at:
http://www.whitehouse.gov/omb/grants/standard_forms/ffr_instructions.pdf.

Performance Reporting

The successful Applicant will provide the following reports to the USAID Agreement Officer's Representative (AOR) and the Agreement Officer, as specified below, in accordance with 2 CFR 220.327 and 220.328. The Recipient will use the standard form Performance Progress Report (SF-PPR) to report performance progress for the program under the award.

a) Annual Work Plan

A draft Year One work plan must be submitted to USAID/Guinea within 60 days of the award of the Cooperative Agreement. It will cover the first year of performance. USAID will provide written comments to the Recipient within one month of submission. The plan will be finalized by the Recipient no later than two (2) weeks after the Recipient's receipt of USAID's written comments. For each subsequent program year, the Recipient is required to prepare and submit an annual implementation plan by September 1st, 30 days before the beginning of the fiscal year that the plan covers.

The workplan will serves as a guide for program implementation. As such, it must demonstrate the links between activities and intended results; present a sound basis for budget estimates; and serve as the foundation for the monitoring and evaluation plan. The work plan will outline key activities and the expected results to be accomplished for that year, including a timeline with relevant milestones, tied to the recipient's Performance Management Plan. A budget with sufficient detail to allow the AOR to judge the efficiency of the annual implementation plan must be included. The work plan budget must delineate an overall budget by line item, and a budget per objective and activity.

b) Performance Management Plan

Within 60 days of signing the Cooperative Agreement, The recipient must submit to USAID/Guinea a final Performance Management Plan for the life of the project. USAID expects that performance measures will objectively assess the progress of project activities and their impact. The plan must describe how instruments and schedules will be harmonized to support Government of Guinea GOG and

USAID/Guinea data reporting needs. The recipient must include milestones that set forth the activities/tasks and results that the recipient will work toward achieving. The milestones must be clearly defined, readily measurable and linked with the program objectives. For each milestone

proposed, the recipient will consider how the milestone accurately predicts progress towards the achievement of the expected results.

The recipient must use effective and efficient mechanisms to monitor the progress, impact, and success of their activities. USAID expects the recipient to be innovative in its efforts to capture, document, and report all the outcomes of USAID assistance, while strengthening and using relevant facility-bases and district level reporting systems.

i. Quarterly and Annual Status Reports

The recipient must submit one copy of the quarterly report to The Agreement Officer's Representative (AOR). Due dates for the quarterly program reports are not later than 30 days after the end of each reporting period. These reports will include sub-awardee(s) reports and the following information:

- Include a brief summary of activities during the concluding quarter;
- Discuss benchmarks and achievements relating progress to indicators and/or impacts achieved to-date as identified in the Recipient's annual monitoring and evaluation plan. The report will identify which impacts achieved were directly attributable to recipient's activities, and those where the recipient played a supporting role. This discussion will be supported by quantitative and qualitative evidence, which will remain auditable under the terms of the agreement and USAID program implementation procedures.
- Identify key problems or issues encountered, how they were or will be resolved, and, as required, recommended USAID intervention to facilitate their timely resolution;
- Present success stories that USAID/Guinea might use in reports to the GOG or USAID/Washington.

The Annual Status Report will include the fourth quarterly status report for the concluding year. Draft status reports may be submitted to USAID in French for review; however final reports must be submitted in English.

ii. Close-out Plan

Three months prior to the completion date of the Cooperative Agreement, the Recipient shall submit a Close-out Plan to the Agreement Officer and AOR. The close-out plan shall include, at a minimum, an illustrative Property Disposition plan; a plan for phase out of in-country operations; a delivery schedule for all reports or other deliverables required under the Agreement; and a timeline for completing all required actions in the Plan.

iii. Final Performance Report

In accordance with 2 CFR 328, the recipient must submit a final performance report within

ninety (90) days following the estimated completion date of the Agreement. The end-of-Activity report will summarize the major achievements and results, outcomes and outputs under the Activity, as well as obstacles overcame and remaining challenges, all disaggregated by gender if possible and appropriate.

This report shall be in sufficient detail to describe comprehensively the results achieved. This report shall consist of the work performed and results obtained for the entire agreement period of performance as stated in this RFA. An Annual, Quarterly or Monthly Progress Report will not be required for the period when the Final Report is due.

Development Experience Clearinghouse (DEC) Requirements

USAID recipients are required to comply with the submission requirements for the Development Experience Clearance (http://dec.usaid.gov) pursuant to the Standard Provision entitled "Submissions to the Development Experience Clearinghouse and Publications (June 2012)."

In addition, the recipient must submit one electronic copy of development experience documentation to the AOR.

Program Income:

No program income is anticipated under this award.

Branding & Marking:

Pursuant to ADS 303.3.6.3.f and ADS 320.3.1.2, the apparently successful applicant 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 will be prepared in accordance with the guidance in ADS 320.3.1.2, 2 CFR 700.16 and the references therein.

Please note that the Branding Strategy and Marking Plan will not be included with the original application but must be provided only after a written request of the Agreement Officer. Cost of Branding and Marking must be included in cost application.

USAID does not intend to make an award without an approved Branding Strategy and Marking Plan.

ADS Chapter 320 sections concerning "assistance" apply to this RFA. ADS Chapter 320 sections concerning "acquisition" do not apply to this RFA. ADS Chapter 320 can be found on the USAID website: http://www.usaid.gov/policy/ads/300/320.

Additional resources can be found below:
ADS 320 Branding and Marking: www.usaid.gov/ads/policy/300/320
Grants and Cooperative Agreements with Public International Organizations: ADS 320.3.6

Interagency Agreements: ADS 306
Logo files: www.usaid.gov/branding/resources
Templates: www.usaid.gov/branding/resources
2 CFR Regulations 700.16 (Marking): www.ecfr.gov
USAID Graphic Standards Manual and Partner Co-Branding Guide: www.usaid.gov/branding
USAID Mission & Message Manual: www.usaid.gov/branding/resources
USAID's Photography and Video Style Guide: www.usaid.gov/branding/resources

Environmental Compliance

An Initial Environmental Examination (IEE) for the Project is completed and is attached as Attachment 4 to this NOFO.

(a) Section 117 of the Foreign Assistance Act of 1961, as amended, 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, as codified in 22 CFR 216 and in USAID's Automated Directives System (ADS) 204, 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. The environmental compliance obligations of the Recipient of the award(s) resulting from this NOFO under these regulations and procedures are specified in the following paragraphs.

(b) In addition, the Recipient must comply with host country environmental regulations unless otherwise directed in writing by USAID. In case of conflict between host country and USAID regulations, the latter will govern.

(c) No activity funded under the award(s) resulting from this NOFO may be implemented unless an environmental threshold determination, as defined by 22 CFR 216, has been reached for that activity, as documented in a Request for Categorical Exclusion (RCE), Initial Environmental Examination (IEE), or Environmental Assessment (EA) duly signed by the Bureau Environmental Officer (BEO). (Such documents are hereinafter described as "approved Regulation 216 environmental documentation.")

(d) As part of its annual work-plans, the Recipient, in collaboration with the AOR and BEO, will review all ongoing and planned activities under the award to determine if they are within the scope of the approved Regulation 216 environmental documentation. If the Recipient plans any new activities outside the scope of the approved Regulation 216 environmental documentation, it will prepare an amendment to the documentation for USAID review and approval. No such new activities will be undertaken prior to receiving written USAID approval of environmental documentation amendments. Any activities found to be outside the scope of the approved Regulation 216 environmental documentation will be halted until an amendment to the documentation is submitted and written approval is received.

(e) The Recipient will be required to use an Environmental Review Form (ERF) or Environmental Review (ER) checklist using impact assessment tools to screen sub-award and contract proposals to ensure the funded proposals will result in no adverse environmental impact, to develop mitigation measures, as necessary, and to specify monitoring and reporting. Use of the ERF or ER checklist is required when the nature of the proposals to be funded is not well enough known to make an informed decision about their potential environmental impacts; yet, due to the type and extent of activities to be funded, any adverse impacts are expected to be easily mitigated. Implementation of these activities cannot proceed until the ERF or ER checklist is completed and approved by USAID. The Recipient is responsible for ensuring that mitigation measures specified by the ERF or ER checklist process are implemented. The Recipient will also be responsible for periodic reporting to the AOR, as specified in the award.

(f) The costs of environmental compliance will be reimbursable under the award(s) resulting from this NOFO provided that they are otherwise in accordance with the terms and conditions of the award.

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

[END OF SECTION F]

SECTION G: FEDERAL AWARDING AGENCY CONTACT(S)

The point of contacts for this NOFO and for any questions during the NOFO process is:

See Section D.1

[END OF SECTION G]

SECTION H: OTHER INFORMATION

H.1. Pre-Award Survey

The Applicant must have established financial management, monitoring and evaluation processes, internal control systems, and policies and procedures that comply with established U.S. Government standards, laws, and regulations. Prior to making an award under this RFA, the Agreement Officer may determine that a pre-award survey is required to determine whether the prospective recipient has the necessary organization, experience, accounting and operational controls, and technical skills – or ability to obtain them – in order to achieve the objectives of the program and comply with the terms and conditions of the award, or whether specific conditions will be needed. If notified by USAID that a pre-award survey is necessary, the Applicant must prepare in advance the required information and documents. A pre-award survey does not commit USAID to make an award to any organization.

H. 2. Standard Provisions

The following Solicitation Standard Provisions are hereby incorporated by reference:

1. Branding Strategy – Assistance (June 2012)
2. Marking Plan – Assistance (June 2012)
3. Prohibition on Providing Federal Assistance to Entities that Require Certain Internal Confidentiality Agreements – Representation (May 2017)

The Applicant may view the full text of these provisions in the ADS 303mav document entitled "Certifications, Assurances, Other Statements of the Recipient and Solicitation Standard Provisions" which may be accessed at https://www.usaid.gov/ads/policy/300/303mav (see Part V).

The Applicant is also advised to review the Standard Provisions for U.S. Nongovernmental Organizations and Non-U.S Nongovernmental Organizations that will be incorporated into an agreement resulting from this RFA, as applicable.

The Standard Provisions are available in ADS Chapter 303 at https://www.usaid.gov/ads/policy/300/303maa. and https://www.usaid.gov/sites/default/files/documents/1868/303mab.pdf.

H.3. USAID reserves the right to fund any or none of the applications submitted.

H.4 List of Attachments:

1. Knowledge Attitude and Practice Survey report; and

2. Plan Stratégique National de Lutte Contre le Paludisme 2013 – 2017 (for new plan 2018-

2022, refer to: http://pnlp-guinee.org/.

3. Guinea Behavior Profile: Care seeking; and

4. Initial Environmental Examination

[END OF SECTION H]

RESULTS FRAMEWORK