May 20, 2015

Key Information and Dates

Funding Opportunity Title	Integrating Community Health APS	
Funding Opportunity Number	APS-OAA-15-000004	
APS Issuance Date	May 20, 2015	
Pre-Submission Meeting	The anticipated date of meeting is the week of June 15, 2015 in Washington, DC. More information will be provided regarding the pre-submission meeting via an amendment on grants.gov Virtual meetings will also be held for potential Applicants outside of the Washington, DC area.	
Review Windows for Concept Papers Submitted between the Following Dates	**Concept papers due by 3pm EST on October 9, 2015**	Review Window 1 – Concept Papers submitted from APS Issuance Date to October 9, 2015
	Concept papers due by 3pm EST on February 5, 2016	Review Window 2 – Concept Papers submitted from October 10, 2015 to February 5, 2016
	Concept papers due by 3pm EST on April 29, 2016	Review Window 3 – Concept Papers submitted from February 6, 2016 to April 29, 2016
Question Due Dates	30 calendar days prior to the close of each Review Window. For Review Window 1, please also submit any questions by 3pm EST on May 31, 2015 so that answers can be presented at the Pre-Submission Meeting. Additional questions may still be submitted 30 days prior to the close of Review Window 1.	

Dear Potential Applicants,

Pursuant to the authority granted in the Foreign Assistance Act of 1961, as amended, the United States Government (USG), represented by the U.S. Agency for International Development (USAID), Global Health Bureau (GH) is issuing this Annual Program Statement (APS) for USAID and its Missions to use as a platform for obtaining concept papers, full applications and issuing awards for Integrating Community Health (ICH) projects.

USAID, in collaboration with UNICEF, is requesting concept papers from qualified local and international organizations with the goal of supporting governments and their key partners in accelerating progress by achieving and sustaining effective coverage of high impact health and nutrition technical interventions at scale. The selected organization(s) will strengthen the role of community health approaches to reduce barriers in achievement of this goal. The selected organization(s) are expected to work across diverse systems to support and strengthen national and local policies and implementation plans. The selected organization(s) will work to:

- Sustain and scale up community health approaches within national plans for health systems strengthening;
- Strengthen collaboration between governments and non-governmental actors with a focus on community health; and,
- Advance the field of community health and primary health care globally.

This APS serves two purposes: 1) as a platform by which concept papers can be submitted for efforts in USAID/Washington or USAID Missions, and 2) as a mechanism for USAID/Washington or USAID Missions to issue Addenda to the APS with specific Program Descriptions relevant to the area of Integrating Community Health. Funding will primarily be available through Addenda.

At the issuance of this APS, USAID/Washington funding is only available under Addendum #1 (APS-OAA-15-000005). Addendum #1 is being issued simultaneously with the issuance of this APS. Each Addendum may include specific concept paper/application submission instructions and merit review criteria or follow the APS instructions and merit review criteria for concept papers and applications. Although USAID/Washington funding is only available through Addendum #1, concept papers not tied to a specific Addendum may be submitted during the Review Windows noted above.

Pursuant to 2 CFR 200.400(g), USAID Standard Provisions for U.S NGOs and USAID Standard Provisions for Non-U.S. NGOs, it is USAID policy not to award profit under assistance instruments. However, all reasonable, allocable, and allowable expenses, both direct and indirect, related to the project and in accordance with applicable cost standards may be paid under the eventual award(s).

This APS consists of this cover letter and the following:

1. Section I – Program Description
2. Section II – Federal Award Information
3. Section III – Eligibility Information
4. Section IV – Application and Submission Information
5. Section V – Application Review Information
6. Section VI – Federal Award and Administration Overview
7. Section VII – Federal Awarding Agency Contacts
8. Section VIII – Other Information

This APS and any future amendments and Addenda can be downloaded from www.grants.gov. Prospective Applicants who are not able to retrieve the APS from the Internet can request a copy by contacting ICH-APS@usaid.gov.

The issuance of this APS does not constitute an award commitment on the part of the Government, nor does it commit the Government to pay for costs incurred in the preparation and submission of a concept paper or application. In addition, awards cannot be made until funds have been appropriated, allocated, and committed through internal USAID procedures. Potential Applicants are hereby notified that all awards are subject to the availability of funds and

agreement of the parties, and USAID reserves the right to make no awards. All preparation and submission costs incurred are at the Applicant's expense. USAID may amend this APS as necessary. Amendments will be posted to www.grants.gov.

As indicated on the first page (above) under Key Information and Dates, any questions on this APS should be submitted to ICH-APS@usaid.gov at least 30 calendar days prior to the close of each Review Window. For Review Window 1, questions should also be submitted by May 31, 2015 so that answers can be provided at the Pre-Submission Meeting.

Sincerely,

Christopher Egaas
Agreement Officer
USAID Office of Acquisition and Assistance
M/OAA/GH/GHI

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Section I – Program Description

Overview

In order to accelerate progress towards achieving universal health coverage, countries are developing and refining existing policies and implementation plans to improve effective coverage of high impact health and nutrition interventions at scale. Strategies are needed to address current gaps to increase impact, such as equity, accountability, demand side interventions, and broader determinants of health to support ambitious goals in health (e.g., ending preventable child and maternal deaths; creating an AIDS free generation; and other health goals, such as protecting communities from infectious diseases and reducing chronic malnutrition). In this shifting policy and program context, community health approaches[1] are gaining importance in national and global acceleration strategies and plans. Partnerships between governments, communities, and non-state actors (e.g., civil society, private sector) that can leverage resources, coordinate action in local systems, and promote the use of evidence and learning, are critical for advancing community health in national policies and plans.

USAID, in collaboration with UNICEF, is requesting concept papers from qualified local and international organizations with the goal of supporting governments and their key partners to achieve and sustain effective coverage of high impact health and nutrition technical interventions at scale. The selected organization(s) will strengthen the role of community health approaches to reduce barriers in achievement of this goal. The selected organization(s) are expected to work across diverse systems to support and strengthen national and local policies and implementation plans. The selected organization(s) will work to:

- Sustain and scale up community health approaches within national plans for health systems strengthening;
- Strengthen collaboration between governments and non-governmental actors with a focus on community health; and,
- Advance the field of community health and primary health care globally.

The Integrating Community Health APS will support countries in achieving and sustaining effective coverage[2] of high impact health and nutrition interventions at scale in order to accelerate progress towards ambitious health goals. It will do this by strengthening the role of community health approaches in diverse systems [e.g., public, private, non-governmental organization (NGO)] to support national policies and implementation plans through three interrelated objectives that address current gaps: institutionalization; measurement; and, inclusive and effective partnerships.

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[1] A range of proven or promising community health approaches that can reduce barriers to effective coverage by strengthening community engagement and capacity to collaborate with health and other local systems in the following areas will be supported: service delivery (e.g., equitable access, quality, demand); delivery oversight, governance, and accountability; and, community empowerment and voice for health and development.

[2] Effective coverage is defined as the proportion of the population in need of an intervention that receives an effective intervention, a definition that is posed in equity terms since its denominator is need. (Tanahashi, T. Health service coverage and its evaluation. Bulletin of the World Health Organization. 1978; 56(2): 295–303. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2395571/).

Background

1. Global Trends in Progress in Health And A Changing Global Health Landscape

Developing countries have made significant progress during the past two decades in reducing preventable child and maternal deaths and decreasing the incidence of HIV infections and AIDS related mortality. The total number of child deaths fell by 50% (from 12.7 million in 1990 to 6.3 million in 2013) and the total number of maternal deaths decreased by 45% (from 523,000 in 1990 to 289,000 in 2013). Contraceptive prevalence has increased up to 55% by 2011, reducing total fertility rates to 2.6 in less developed countries and to 4.1 in the least developed countries. The number of people newly infected with HIV/AIDS decreased by 21% over a ten-year period (between 2001-2011). Between 1990 and 2011, stunting (i.e., low height-for-age), a measure of chronic under-nutrition, declined by 35 percent, while wasting, a measure of acute under-nutrition, declined by 11%.

As countries transition from the Millennium Development Goals (MDGs) to the post-2015 sustainable development goals, this progress has inspired global and national health and development actors to envision an end to preventable child and maternal deaths in a generation and to create an AIDS free generation. This vision to accelerate progress is supported by political commitments and resources from developing and donor countries, multi-laterals, foundations, civil society organizations, private sector entities, and partnerships, and has significantly expanded collaboration for health programming (see: A Promise Renewed and the Partnership for Maternal, Newborn, and Child Health). USAID has also focused its resources in priority countries to support country-led strategies to achieve ambitious goals in health (see: Acting on the Call: Ending Preventable Child and Maternal Deaths, PEPFAR 3.0). Goals in health include but are not restricted to:

- *Child Mortality:* Reducing child mortality rate to below 20 child deaths per 1,000 live births by 2035;
- *Neonatal Mortality*: Reducing neonatal mortality rate to 10 or less newborn deaths per 1,000 live births by 2035;
- *Maternal Mortality*: Reducing maternal mortality ratio to below 70 maternal deaths per 100,000 live births by 2035;
- *HIV Infections*: Elimination of new infections among children by 2015 and keeping their mothers alive;
- *Family Planning*: 120 million more women and girls use contraceptives by 2020; and,
- *Nutrition*: 40 percent reduction of the global number of children under five who are stunted by 2025.

Investment beyond health programs in multi-sectoral strategies to address both direct and indirect causes and broader determinants of health, including strategies to empower women and support and enabling environment, will be required to accelerate progress towards these high level goals and targets and promote sustainable development.

National health policies and systems are increasingly linked to global initiatives and strategies aimed at accelerating progress for women, newborns, and children towards the MDGs and beyond.[i] These global initiatives, strategies, and plans prioritize partnerships between

governments and non-state actors and promote an evidence-based approach to health systems strengthening that includes community engagement. Partnerships between government and non-state actors support the implementation of these strategies and play a role in holding governments accountable for their commitments. Important global initiatives and strategies include but are not restricted to: UN Every Woman Every Child (2010-2015) and Global Strategy 2.0 (2016-2030); UN Commission on Information and Accountability for Women and Children's Health; UN Commission on Life-Saving Commodities for Women and Children; Countdown to 2015; Every Newborn Action Plan (2015-2035); Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea; A Promise Renewed/Child Survival Call to Action; Scaling Up Nutrition (SUN); Family Planning 2020; Global Vaccine Action Plan (2011-2020); WHO Global Strategy on People Centered and Integrated Services (being developed; 2014-15).

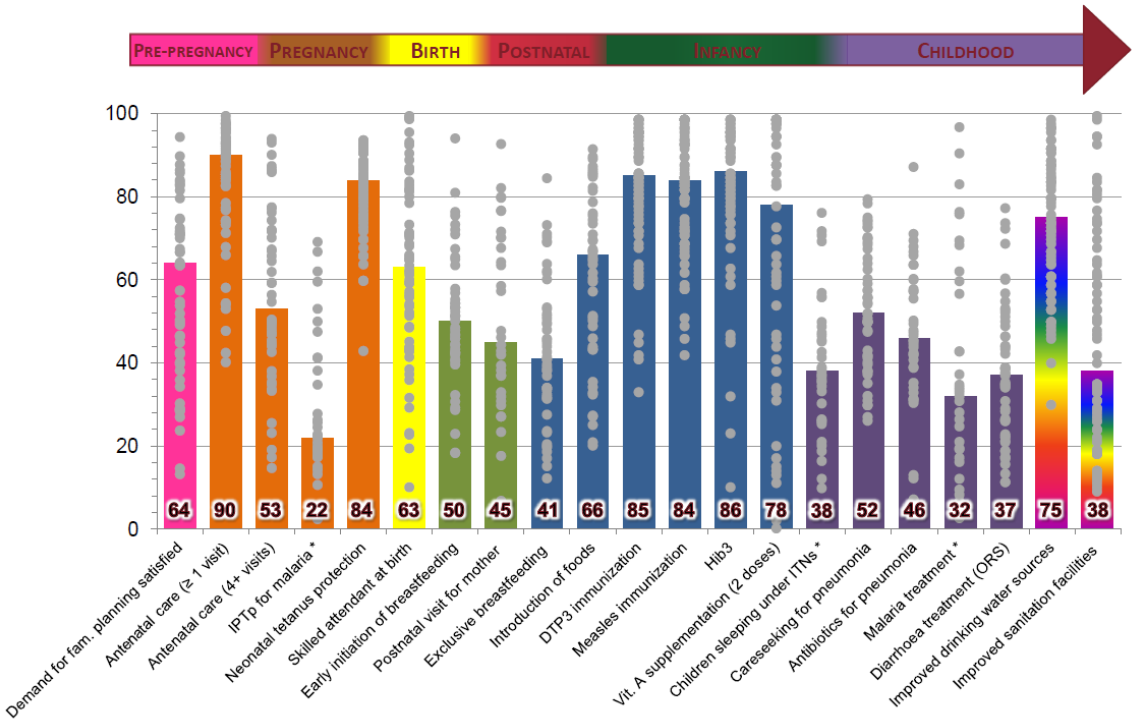
The U.S. Government focuses its investment in health on delivering meaningful results in three key areas: ending preventable child and maternal deaths, creating an AIDS-free generation, and protecting communities from infectious diseases. Improving partnerships between governments and a range of non-state actors is critical to doing business differently and for promoting sustainability towards our collective mission to end extreme poverty and build resilient, democratic societies through the implementation of sharpened national plans. USAID has aligned its resources in priority countries and toward the life-saving interventions that have the greatest impact. As a global leader in health, the U.S. Government has developed the following initiatives, strategies, and visions to support countries in accelerating progress towards the MDGs and in the post-2015 sustainable development context: Global Health Initiative; Feed the Future (FtF); President's Emergency Plan for AIDS Relief (PEPFAR), including PEPFAR 3.0, the Accelerating Children's HIV/AIDS Treatment Initiative , and the Human Resources for Health Strategy; Presidential Malaria Initiative (PMI); Multi-Sectoral Nutrition Strategy; USAID Water and Development Strategy, USAID Maternal Health Vision for Action; Strengthening Health Systems for Lasting Impact: Draft USAID Vision for Action for Health Systems Strengthening (2015-2019); USAID's Local Systems Framework, President Obama's high level memo focusing on deepening U.S. Government efforts to collaborate with and strengthen civil society (September 2014).

2. USAID's Strategic Focus on Integrating Community Health in National and Local Policies and Systems through Inclusive and Effective Partnerships between Governments and Non-State Actors

Despite considerable progress made by developing countries during the past two decades, several countries are not on track to achieve the MDGs. Gaps in effective coverage of high-impact interventions persist along the continuum of care across countries, with widening disparities in some cases.[ii] For example, coverage remains low for behavioral interventions such as breastfeeding for which inequities tend to be smaller as well as skilled birth attendance for which inequities are greater due to the need for a strong health system.

Figure 1: Coverage of interventions varies across the continuum of care
Source: Countdown to 2015 Report (2014)

Median national coverage (%) of reproductive, maternal, newborn and child health (RMNCH) interventions in Countdown countries, most recent survey, 2008 and later



Several technical interventions highlighted in Figure 1 can be delivered at the community level through effective, low-cost community-based approaches by strengthening the capacity of health and local systems to engage with communities to build strong systems outside of health facilities.[iii] To increase effective coverage of high impact health and nutrition interventions, communities must be actively engaged with health systems in ensuring equitable access to high-quality, essential services; promoting healthy norms and behaviors; and, providing appropriate and timely oversight and support. Successful community engagement in these efforts can also be a stimulus for broader community empowerment for development and for harnessing community resources to strengthen the system.

A growing body of evidence and successful country experience demonstrate that increasing investment in partnerships with communities can accelerate progress by improving health outcomes with equity and at low cost; strengthening the performance and reach of systems; and, building the capacity of communities to contribute to improved governance and accountability.[iv, v, vi vii,viii,ix,x xi,xii,xiii,xiv, xv] There is an increasing recognition that advancing community health approaches will require stronger political commitment, adequate resources, and coordination for action and learning between government and non-state actors to scale up and sustain community health approaches as a part of national and local policies, plans, and systems.[xvi,xvii] It is imperative to support countries in generating local evidence and lessons to

scale up and sustain a range of community-based approaches and shift the paradigm to leverage and coordinate community and local resources for health and local systems strengthening. [xviii,xix,xx xxi,xxii,xxiii]

A range of proven or promising community health approaches can be integrated with health and local systems to improve equitable health, nutrition, and development outcomes by driving improvements that include, but are not restricted to the following:

- Expand the reach of health systems at low cost and with improved efficiency;
- Improve equitable access to improve and increase the demand for, quality services; make services more responsive to communities (e.g., more inclusive, less discriminatory; culturally oriented);
- Facilitate positive change in household and community norms and behaviors;
- Strengthen inclusion, participation, and empowerment of vulnerable communities to enhance their voice and leverage their assets; strengthen the voice and perspectives of civil society in local, national, and global policy;
- Empower women and communities to catalyze collective action that addresses the broader social and cultural determinants of health;
- Promote effective collaboration and linkages in local systems to leverage intersectoral collaboration to improve health;
- Build the capacity of communities and local actors to collaborate, monitor progress, and use data for decision-making towards improved accountability and governance; and,
- Increase sustainability and local/community ownership through a bottom-up approach.

The strategic benefits of community engagement and inclusive partnerships in health and local systems across the continuum of care are integral to the success of USG/USAID-supported initiatives, strategies, and visions for health and local systems. The Integrating Community Health APS is aligned to support and strengthen community engagement and inclusive partnerships in USG/USAID investments in health and other sectors relevant to improving health (e.g., democracy and governance, education, economy, environment).

Community Health Approaches: Summary Points

- Growing evidence and country experiences demonstrate that ***community-based approaches are essential*** to improving population-based health outcomes with equity and there is a critical need to integrate and scale them up in diverse systems to accelerate country progress;
- Health and local systems strengthening approaches need to systematically ***incorporate and sustain partnerships with communities*** as a key component;
- A ***stronger investment in action and learning*** focusing on community engagement and empowerment in health and local systems is needed to address existing gaps in both evidence and practice; and
- A ***range of partners*** can facilitate the integration and scale-up of community health approaches, and more effective government-civil society-private sector partnerships are critical for implementing and influencing community health in national and local policies and plans.

3. Goal, Purpose, and Objectives for the Integrating Community Health APS

Through the Integrating Community Health APS, expected to be issued three times over the next few years, USAID, in collaboration with UNICEF, will expand partnerships and leverage new resources for community health. USAID's catalytic investment focusing on community health through this APS is designed to be integrated and synergized with broader investments in health and local systems and decision-making processes in countries to achieve a wider influence and impact within the national context. Partners will contribute to strengthening implementation; monitoring, evaluation, and learning; and knowledge translation and policy engagement to support planning, decision-making, action, and learning for community health in priority countries.

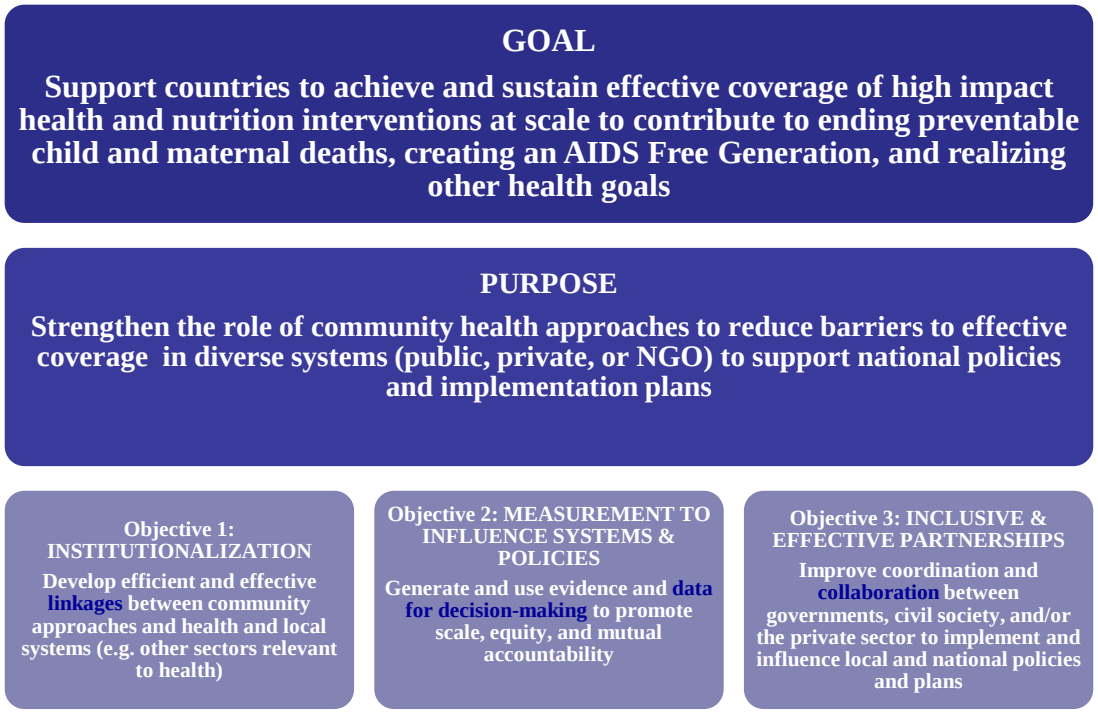
The ***goal*** of the Integrating Community Health APS is to support countries in achieving and sustaining effective coverage[3] of high-impact health and nutrition interventions at scale in order to accelerate progress towards ambitious health goals. Its ***purpose*** is to strengthen the role of community health approaches to reduce barriers[4] to effective coverage in diverse systems [e.g., public, private, NGO] to support national policies and sharpened implementation plans. In doing so, partners will complement and support broader government efforts to strengthen the reach and responsiveness of health systems and promote household and community behavior change through effective partnerships with non-governmental actors and communities. See Annex 1 for additional information on health and community systems contexts across priority counties.

Applicants may tailor project design to support national and local implementation and planning needs by focusing on one or more of three inter-linked objectives that reflect current gaps and areas of opportunity for strengthening the role of community health approaches in diverse systems (Figure 2). Applicants are strongly encouraged to use USAID Integrating Community Health APS funds to maximize a focus on community health approaches and foster linkages with higher levels of the system. Applicants must integrate a strategic focus on community health approaches within the broader context of local and health systems strengthening (e.g., program platforms and/or decision-making processes and/or partnerships in-country), as relevant, while facilitating country decision making about integration and expansion within existing country capabilities (e.g., policies, implementation plans, systems and partnerships).

Figure 2: Goal, Purpose, and Objectives for the Integrating Community Health APS

[3] Effective coverage is defined as the proportion of the population in need of an intervention that receives an effective intervention, a definition that is posed in equity terms since its denominator is need. (Tanahashi, T. Health service coverage and its evaluation. Bulletin of the World Health Organization. 1978; 56(2): 295–303. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2395571/).

[4] Coverage barriers (bottlenecks) can be found in Table 4 (page 70) in USAID's Acting on the Call Report 2014.



Applicants may focus on a range of proven or promising community health approaches that can reduce barriers to effective coverage by strengthening community engagement and capacity to collaborate with health and other local systems in the following areas: service delivery (e.g., equitable access, quality, demand); delivery oversight, governance, and accountability; and, community empowerment and voice for health and development. USAID encourages Applicants to engage with communities to support diverse roles in health and local systems, including but not restricted to: community based health providers (e.g., promoters of health; providers of preventive and curative services; facilitators of referrals; agents of change, etc.); community members as service users, educated consumers, and producers of health in households; community representatives and their role as participatory decision-makers and actors (e.g., roles in identifying local priorities, guiding service delivery approaches, co-managing service delivery, etc.)[xxiv]. Applicants will integrate community health approaches, for which evidence and experience exist[5], into country systems while addressing the needs of key decision-makers for local knowledge to institutionalize and scale up community health approaches.

USAID seeks organizations with promising or proven approaches and visions for key inputs needed to institutionalize and promote scale-up, and facilitate buy-in from the national government and other relevant decision makers for health policies and programs. Projects will facilitate action-oriented learning and support translational activities (e.g., advocacy, planning, development of tools or training materials) to advise governments and their partners on how a successful approach can be better integrated with existing systems and brought to a broader scale. While the focus is on integrating and expanding community health approaches in diverse

[5] Evidence and experience for community health approaches may include peer review publications, grey literature, and other systematic and credible documentation of program experience (e.g., process documentation, participatory assessments, etc.).

systems for which evidence and/or experience already exists[6], Applicants may combine these with more creative approaches, as feasible and relevant, to address particular barriers (e.g., issues related to public trust and/or credibility). It is not USAID's intent to support one-off, small-scale pilot projects that focus solely on demonstrating the effectiveness of innovative approaches.

USAID will not provide separate technical assistance to partners. Any anticipated technical assistance needs (i.e. for monitoring & evaluation, knowledge management, etc.) must be built into project design.

USAID anticipates that the vast majority of funding will be used in the field (or in-country at the local and national level) with efficient levels of support from any headquarters functions or partner organizations based outside of the country of operation.

A. Objectives, Illustrative Activities, and Results Aimed at Strengthening the Role of Community Health Approaches in National Policies, Systems, and Implementation Plans

The Integrating Community Health APS will reduce key coverage barriers that can be addressed by integrating and expanding a range of proven or promising community health approaches in health and local systems. It will also improve the capacity of governments, civil society, and/or private sector actors to develop effective partnerships with communities and harness community and local resources to overcome key coverage barriers, and through this action increase coverage of high impact health and nutrition interventions with the potential for effective coverage at national scale. We expect Applicants to contribute to overarching results relevant to the country context through a vision to influence and improve existing systems and policies with context-specific, systems strengthening projects. Applicants will contribute to improving health and implementation outcomes by:

- Improving equitable access to quality services and driving healthy norms and behaviors;
- Improving health system responsiveness and accountability through linkages with strengthened communities;
- Influencing the sustainability and scalability of a range of proven or promising community health approaches; and,
- Building the global and national evidence, experience and learning to advance the integration and expansion of a range of community health approaches in systems and policies.

Applicants may reduce coverage barriers by integrating and expanding a range of proven or promising community health approaches to support national frameworks. The following are overarching illustrative examples:

[6] Evidence is not restricted to peer review publications and may also include experience of the applicant(s), grey literature, and other systematic and credible documentation of program experience (e.g. process documentation, participatory assessments).

- Identifying vulnerable groups or groups not receiving needed information and services, and developing and implementing plans to help these groups access services (need measures of access and equity);
- Assessing quality of services provided at health facilities and by community health workers (CHWs) and working together to identify root causes and implement quality improvement activities (need measures of quality and accountability);
- Identifying health information needs/gaps among and between health workers and community members and improve systems to collect, disseminate, and use information (need measures of knowledge, availability and use of information and data quality);
- Identifying social norms that are barriers to adequate care practices in the home and developing and implementing plans to address these barriers (need measures of adequate care practices, qualitative data, and social norms);
- Identifying gaps in continuity of care between the health facility and the community and improving processes and information systems to improve continuity (need measures of continuity of care, and whether or not processes are being complied with); and,
- Identifying barriers to scaling-up and sustaining high impact interventions such as perceptions (among community members, civil society organizations, vulnerable groups) about the appropriateness/fit, acceptability, feasibility, and cost of interventions being implemented by the health system, and subsequently informing decision makers on identified barriers and contributing to testing new ways of implementation.

Applicants may also refer to Annex 2 for illustrative examples of awards that support one or more of the objectives.

Current gaps in countries for strengthening the role of community health approaches in national policies and implementation plans to reduce barriers to effective coverage can be addressed through three objectives (Figure 2). These three objectives support the general purpose of the Integrating Community Health APS as well as its focal theme for 2015 focusing on CHW programs (See Addendum #1; APS-OAA-15-000005). Applicants may select one or more objectives and tailor them to country context, as necessary, given the wide variation in country context (Annex 1) and effective inputs capable of catalyzing improvements in policies, systems, and partnerships for community health.

Objective 1 (INSTITUTIONALIZATION): Develop Effective and Efficient Linkages of Community Health Approaches in Systems, Policies, and Plans (Health, Other Relevant Sectors; Local and National)

Applicants are encouraged to promote sustainable, locally led action, and learning with a broad range of traditional and non-traditional community, local, and national systems actors to foster efficient and effective linkages of proven or promising community health approaches with the formal health system and enhance recognition in national policy and implementation frameworks. Applicants may foster diverse linkages that promote health and well-being using multi-sectoral approaches, develop a team approach between community and facility-based providers to support the continuum of care, and strengthen dialogue and advocacy at different levels of the system. Applicants may also develop new knowledge (e.g., cost analysis) and indicators for institutionalization; and, document changes in government and other relevant

institutions, such as improved policies, norms, and financing for integrating and expanding community health approaches.

Illustrative Results:

- Community health approaches are effectively integrated into routine service delivery (e.g., supervision/oversight, financing, policies, and norms);
- Performance of CHW programs improved with support from functional community structures recognized by the health system;
- Increased community engagement and voice of underserved communities in the local systems;
- Policies and plans are strengthened to support and scale up community health approaches in local and national systems; and
- Strengthened systems (within and across sectors) capable of leveraging community resources for health and responding to community needs.

Objective 2 (MEASUREMENT TO INFLUENCE SYSTEMS & POLICIES): Generation and Use of New Data and Knowledge for Decision Making to Influence Local and National Systems and Policies (e.g., scale, equity, accountability)

An important strategy to promote sustainability, scale, equity, and accountability involves a strong focus on data to promote inclusive and participatory action at the local level in decentralized systems with effective links to national policies and implementation plans from the beginning. Applicants are encouraged to strengthen the generation and use of data at the community level as well as at higher levels of the system to promote a data-driven approach for identifying barriers and solutions to support in-country decision-making processes. Applicants are also encouraged to use new technology and a range of methods (e.g., indicator- and non-indicator based methods) to document processes and results while improving information flows and local capacity to collaborate and use data to drive decisions and actions. Applicants must build on existing country systems and processes and meaningfully expand the evidence base and learning. Please see Section IV (below) for additional guiding principles focusing on monitoring, evaluation, and learning.

Illustrative Results:

- Improved capacity to generate new data and use it for decision making at community and higher levels of the health system to prioritize community needs and track progress;
- Community information systems integrated with health information systems and/or district scorecards;
- Approaches and methodologies identified to better monitor and target information and services to high-burden populations; and,
- Improved performance of CHWs and household level behaviors through integration of mobile health (mhealth) technology in community health programs to facilitate health education, monitoring and use of data for supervision, and linkages with higher levels of the health system for advice and referrals/counterreferrals.

Objective 3 (INCLUSIVE & EFFECTIVE PARTNERSHIPS): Improved Coordination and Collaboration between Government and Non-State Actors (Civil Society[7], Private Sector[8])

Applicants are encouraged to broaden multi-stakeholder collaboration in a country's health system and improve the participation of diverse systems actors (e.g., public, private, NGO/civil society, including faith institutions, traditional, formal, etc.) based on their distinct roles, assets and resources in support of the national health and development agenda. Developing an inclusive approach that engages citizens and communities with the government and strengthens and expands relevant local entities or institutions towards enhanced ownership, transparency, trust, and social capital in the system will be important. Applicants are encouraged to strategically leverage the assets and resources of existing global, national, and/or local coalitions and partnerships and/or extend their reach and effectiveness by integrating a community focus, as relevant and feasible (Section I.7, Strategic Partnerships).

Illustrative Results:

- Increased participation between government, civil society and/or the private sector for the implementation of national and local health plans;
- Improved coordination and collaboration to leverage assets, resources, and commitments of non-state actors to support community health approaches in national plans;
- Increased financial commitments of non-state actors to support and sustain community health approaches coordinated with national plans; and
- Stronger advocacy for community voice and action in national and local systems, policies, and plans.

4. Guiding Principles for Monitoring, Evaluation, and Learning

The information needs of key decision-makers (i.e., governments and its partners) for advancing the role of community health approaches in national and local policies and implementation plans are central to the Integrating Community Health APS. Through investment in the development and use of new knowledge to guide inclusive actions, partners are expected to influence a range of decisions at multiple levels of the system to strengthen community engagement in health systems in countries at varying stages of policy development and implementation. These decisions may include and are not restricted to: improved implementation; increased resource allocation; coordination and leveraging of existing or new partnerships to support national plans; and, integration and uptake of approaches in policies and programs. In collaboration with local and national decision-makers, the awards will facilitate learning for action about how to improve systems and advance SOTA measurement for community health. The learning needs of policymakers and program managers to improve systems at scale will be met through improved generation and use of data for community health decision making with routine monitoring and evaluation (M&E) systems, population-based surveys, and other appropriate quantitative and/or qualitative methods (e.g., implementation research; methods that promote adaptive learning;

[7] Civil society may include community groups, non-governmental organizations, labor unions, indigenous groups, charitable organizations, faith-based organizations, professional associations, and foundations.
[8] Private sector may include the following: multi-national, domestic privately/publically held company; private sector providers; and investors.

complexity aware monitoring; participatory methods; equity sensitive methods; case studies; scale up maps, etc.) for advancing evidence and learning in real-world settings. Efforts are needed to ensure information for decisions is accurate, flowing in the right directions to reach the right people at the right time, and in a usable format. Capacity building will be integral to these efforts so that systems are strengthened to improve accountability and quality. These efforts may be in health systems as well as integrated with other sectors relevant for improving health. Partners will advance global learning for the Integrating Community Health APS theme and objectives through documentation of processes, outputs, and outcomes as well as context, including the conditions or attributes of the system and capturing systems change.

Partners are expected to develop a robust focus on M&E and knowledge translation and must demonstrate expertise in a broad range of measurement and knowledge translation skills or build necessary support into the award to ensure high quality data. Partners will be expected to produce peer review quality journal articles using data from projects to document achievements and engage in evidence-based advocacy and must plan appropriately within their budgets.

5. Cross-cutting Priority: Women's Empowerment and Gender Issues

Gender sensitivity and women's empowerment, as cross-cutting themes, are crucial for positive outcomes for all awards made under this APS. Gender-related inequalities and disparities disproportionately compromise the health of women and girls and, in turn, affect families and communities. Gender-sensitive and transformative strategies, including the engagement of men and boys as supporters, advocates, and champions, should be pursued (and incorporated in activity design, workplans, M&E, and learning agendas) to ensure equitable access of women to information and decision-making in households and community social, economic, and political structures. Applicants should incorporate indicators, as appropriate, to monitor and evaluate the degree of gender equity in processes and outcomes.

6. Context & Collaboration

The Integrating Community Health APS is aligned with identified priorities focusing on community engagement across USG/USAID-supported initiatives, strategies, and visions for health and local systems. The Integrating Community Health APS also builds on the lessons of the Child Survival and Health Grants Program (CSHGP) and is informed by consultations within USAID (HQ and Missions) and externally with a range of development partners.

USAID is building on and expanding its collaboration with UNICEF to accelerate progress to end preventable child and maternal deaths. The Integrating Community Health APS strengthens the synergies in community health priorities and investments at the country level in the health sector (as well integration with other sectors relevant to health such as, democracy and governance, education, agriculture, and economic development) to improve health outcomes and address the broader context of health and development. UNICEF will coordinate with USAID and engage its country offices, alongside USAID Missions, to participate in the in-country dialogue and uptake of evidence and lessons focusing on community health approaches. UNICEF's role may vary depending on the specific Addendum, the approach of the concept

paper, and/or UNICEF's interests and resources. Addenda will specify UNICEF's envisioned role.

USAID's Maternal and Child Survival Program (MCSP) will convene a community of practice at the regional level focusing on the Integrating Community Health APS awardees, USAID and UNICEF headquarters and country representatives, and other key stakeholders to enable cross-fertilization of plans and progress; and, share state-of-the-art (SOTA) technical resources to advance action and learning in community health. MCSP will work closely with USAID and UNICEF stakeholders to amplify awardee knowledge translation strategies and facilitate the strengthening of linkages with broader portfolios, partnerships, and policy engagement processes in priority countries, as feasible and necessary.

7. Strategic Partnerships

Strategic partnerships are critical to APS investments, which are not designed as stand-alone investments but require effective integration and alignment of bottom-up approaches with national and global investments, policies, and implementation plans. The APS includes an inherent focus on strengthening in-country partnerships, and reinforces an inclusive approach to partnerships put forward by USAID's Local Systems Framework. This framework highlights the important contribution of multiple and interconnected actors in achieving development outcomes that are locally owned, led, and sustained.

Partners may include but are not restricted to the following types of health and development actors: civil society actors, including but not restricted to NGOs; community groups and community-based organizations; indigenous groups; charitable organizations; faith-based organizations; recognized networks of local NGOs; universities (including but not restricted to historically black colleges and universities); professional associations, foundations and policy entrepreneurs; private sector; national/sub-national Ministries of Health (MOH), including district level planners and program managers, etc. The appropriate partners may vary across country settings, and engagement with global groups may be considered as well. Applicants must collaborate with appropriate stakeholders in the health system (community to national level) in-country. Partnerships (including consortia or networks of organizations) are also eligible and encouraged to apply.

A partnership engaging a variety of health and development partners allows for leverage of respective assets of partners in terms of skills, experience, and in-country relationships to contribute to increased country and community ownership and achievement of the stated goal and objectives of this Addendum. Applicants must address any anticipated technical assistance needs through partnerships with international or national organizations with relevant expertise.

Applicants may develop collaboration with USAID's existing Global Development Alliances (GDAs) to expand or strengthen a community orientation or integrate health, as relevant. Examples of USAID-supported Health focused GDAs and Public Private Partnerships include but are not restricted to the following: Survive and Thrive; Helping Babies Breathe (HBB); the International H_2O Collaboration; and Saving Mothers, Giving Life.

8. High Impact Health Interventions and Funding Streams

Integrating Community Health APS funds may be used to strengthen community health approaches that contribute to improving coverage of high impact health interventions for maternal and child health, population and reproductive health, malaria, nutrition, and HIV/AIDS. Please see Annex 3 for information on high impact health and nutrition interventions. Applicants must align the technical intervention package with the priority country information and guidance for use of specific funds provided in Annex 4 when developing concepts.

Focusing beyond the health sector (e.g., democracy and governance, education, economy, environment) to improve health outcomes is encouraged but must be included as either cost share or program leverage, depending on the requirement of the category of interest to the applicant.

Future funding may include special funds for countries recovering from health-related threats/epidemics, such as Ebola Virus Disease, and USAID's focus on rebuilding health systems.

9. Geographic Focus

Concept papers may be submitted for any USAID Mission under this APS. However, see Annex 4 for specific requirements for MCH's 24 priority countries.

10. Authority

USAID is authorized to initiate this project pursuant to the authority granted in the Foreign Assistance Act of 1961, as amended.

Section II – Federal Award Information

A. Estimated Total Amount

USAID/Washington funding is not currently available under this APS. However, Applicants may submit concept papers against this APS for USAID/Washington or USAID Mission efforts, which may be funded if determined to be meritorious and if funding is available.

Please refer to individual Addenda for pre-identified funding opportunities.

As discussed later in Section III, cost share (25%) is required of all Applicants. Leverage (1:1 match) is encouraged, and cost share can count towards leverage in concept papers submitted under this APS. USAID anticipates the Applicant leveraging its own financial and in-kind resources, as well as those from public and private sector stakeholders, the media, etc.

B. Period of Performance

The Applicant shall specify the period of performance in the concept paper. The Applicant may propose no more than a five-year period of performance.

Each Addendum will specify a period of performance.

C. Type of Award

USAID will issue cooperative agreement(s) as the successful result of a two-step process review: 1) concept paper and 2) full application submission. The number of awards is dependent upon the number of meritorious applications and available funding. Accordingly, USAID reserves the right to award none, one, or multiple cooperative agreements as a result of its review of concept papers and subsequent full applications.

Each Addendum will also specify the number of awards available.

D. Substantial Involvement

USAID's substantial involvement during the implementation of the project will be limited to approval of the elements listed below:

1. Annual Implementation/Workplans, including planned activities for the following year and any subsequent revisions, international travel plans, planned expenditures, knowledge management plans, event planning/management, research studies/protocols, international meeting preparation and changes to any activities, locations, or beneficiary population under the cooperative agreement.
2. Key Personnel - Approval of proposed Key Personnel.
3. Monitoring and Reporting - USAID involvement in monitoring progress toward the achievement of project objectives during the performance of the project, including

written guidelines for the content of annual reports and final evaluations in accordance with 2 CFR 200.328.

4. Subawards - All subawards not included and approved in the original cooperative agreement require Agreement Officer approval, per 2 CFR 200.308 for US NGOs or RAA7, Subawards (December 2014), in USAID's Standard Provisions for Non-U.S. NGOs.

Section III – Eligibility Information

A. Eligible Entities

Through this APS, USAID seeks to make awards to organizations and/or partnerships that have concrete assets for advancing community health within national and local policies and implementation plans, including a strong track record in implementation, monitoring & evaluation (M&E), local capacity building with a focus on learning and use of data for decision-making, and credibility in policy engagement processes. Concept papers may be submitted that build on previous agreements with USG or other resource partners, or are new concepts.

To be eligible for a cooperative agreement under this APS, an organization must be any of the following types of organizations:

1. **Non-Federal Entities (referred to as U.S. NGOs)** – U.S. NGOs that meet the definitions in 2 CFR 200.69.

2. **Non-profit Organizations (also referred to as U.S. NGOs)** – U.S. non-profit organizations that meet the definition in 2 CFR 200.70.

3. **Foreign Entities (referred to as non-U.S. NGOs)** – either non-profit or for profit organizations not affiliated with a foreign government that meet the definition in 2 CFR 200.47.

Each Applicant must be found to be a responsible entity before receiving an award. The Agreement Officer may determine a pre-award survey is required and if so, would establish a formal survey team to conduct an examination that will determine whether the Applicant 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 project. Applications from individuals will not be considered for award. Applicants who do not currently meet all USAID requirements for systems and controls may still be eligible under special award considerations and should not be discouraged from applying. USAID welcomes applications from organizations that have not previously worked with the Agency.

B. Cost Share

To be eligible, Applicants must propose a minimum cost share of 25% of the projected USAID funded amount. Such funds may be mobilized from the Applicant; other multilateral, bilateral, and foundation donors; host governments; and local organizations, communities and private businesses that contribute financially and in-kind to the implementation of activities. For guidance on cost sharing in grants and cooperative agreements, please see 2 CFR 200.306 and the USAID Cost Share Standard Provisions for U.S. and Non-U.S. NGOs.

Applicants must comply with required cost share application instructions detailed in Section IV, Application and Submission Information. Per Section V, Application Review Information, cost share will be reviewed as part of cost effectiveness.

C. Resource Leveraging Requirements

In an effort to facilitate partnering and significantly increase the scope, quality of outcomes, and results achieved under this APS, as well as foster greater impact, the Integrating Community Health APS encourages Applicants to leverage additional resources (e.g., private sector, other donors and foundations, private citizen resources, etc.) for their projects; however this is not an eligibility requirement. The concept of leveraging and developing effective interactions between USAID and other in-country investments to strengthen a community health focus also positions partners to influence government policies, strategies, and associated partnerships. The intent of leverage is to further the development impact of this project. Resource leveraging may include program platforms (health and other sectors), M&E systems and resources, local capacity building, and/or policy engagement processes.

Leveraging represents all of the non-USAID resources that are expected to be applied to a project. Leveraging includes resources that third parties bring to the project without necessarily providing them to the recipient of the USAID assistance award. These parties may include the host government, private foundations, businesses, or individuals. The recipient is not responsible for meeting the leveraging amounts/resources and leveraging is not subject to audit.

Illustrative resource leveraging examples include program platforms (e.g., ongoing health systems strengthening activities; integrated or vertical health programs; multi-sectoral programs relevant to health outcomes), partnerships, and local and national policy engagement activities and/or decision-making processes supported with non-USAID funds that are leveraged to support activities under this APS.

Leverage must be from non-USG partners and sources. Resource leverage is not limited solely to contributions from the Applicant, but may include the total from all the Applicant's partners. Applicants are encouraged to develop strategic and complementary partnerships to maximize opportunities for leverage that enhance results and increase impact.

Though resource leveraging is not subject to the requirements of 2 CFR 200.306, entities must be able to demonstrate whether leveraged contributions have been obtained as proposed, in order to determine whether the desired impacts are being achieved. USAID retains the right to determine whether proposed resource leveraging contributes to and significantly advances the desired outcomes, and may request that applicants revise proposed resource leveraging. Although the partners are not subject to the guidelines in 2 CFR 200.306 when "resource leveraging" is used, USAID has the ability to revise or withdraw from the agreement when contributions are not forthcoming as originally proposed in the agreement. USAID also has the ability to determine that the resource leveraging is not contributing to the desired outcomes as proposed, and to require that the Recipient make changes to its resource leveraging.

D. Limitations on Submissions

Each Applicant is limited to one concept paper submission per Review Window. Submitting an application for the APS does not prevent the Applicant from submitting against an Addendum. However, concept papers submitted under the APS must not be the same concept paper submitted for an Addendum. An Applicant under this APS may also be a proposed sub-recipient proposed as part of the submission of other Applicants.

E. Multi-Tiered Review

This APS utilizes a two-step process:

(1) Applicants submit concept papers in accordance with the due dates for each Review Window. USAID will then conduct a merit review of the concept papers based on the merit review criteria provided in Section V, Application Review Information. USAID Mission-specific concept papers under the APS will be provided to that particular Mission for review.
(2) After review of the concept papers, full applications will be requested from those Applicants with the most highly rated concept papers. Concept papers not advancing to full application will be provided brief explanation letters detailing USAID's rationale. For the convenience of all Applicants, Section IV, Application and Submission Information, and Section V, Application Review Information, include full application instructions and merit review criteria. All Applicants are encouraged to review these sections to ensure they are able to meet USAID's requirements if their concept papers are selected.

Section IV – Application and Submission Information

A. APS Package Distribution

The preferred method of distribution of USAID assistance information is www.grants.gov. This APS contains all necessary information, web links, and materials to submit a complete concept paper and, if invited, a full application. Any additional information regarding this APS will be furnished through amendments and will be communicated through Grants.gov. This APS and any future amendments can be downloaded from www.grants.gov. For instructions on how to register for Grants.gov, see Appendix A.

All inquiries and communication, including questions on this APS, must be submitted to ICH-APS@usaid.gov.

B. Submission Dates and Times

Please refer to the Key Information and Dates on the Cover Page. Three Review Windows have been established during the course of the APS. Applicants are encouraged to submit concept papers near due dates and no later than the Review Window due date and time. Concept papers shall be submitted electronically via ICH-APS@usaid.gov before the due dates and times on the Cover Page. Late submissions will NOT be accepted. Hard copies, whether hand delivered or by postal mail, will NOT be accepted.

C. Application Process

Applications received under this APS will be reviewed in accordance with the merit review criteria set forth in the APS. Competition under this APS will consist of a two-step process whereby Applicants first submit a concept paper for an initial competitive review, and those successful in the first stage (i.e., selected concept papers) will then be invited by USAID to submit a full application. To be considered for funding under this APS, applications must meet all of the requirements for the concept paper and for the full application respectively.

D. Content and Format of Application Submission

Content and format instructions must be followed, or Applicants risk being found non-compliant and eliminated from the review. Regardless of concept paper or full application, the following requirements apply for documents submitted for this APS, with the exception of Government-issued forms:

- 8.5”x11” with 1” margins.
- Written in English.
- 12-point Times New Roman font for all narrative and tables.
- Graphics/charts may use 10-point Times New Roman font.
- Submitted via Microsoft Word or PDF formats, except budget files which must be submitted in Microsoft Excel.

- Budgets should show US Dollars (USD), and if a non-U.S. NGO Applicant, also the local currency and the currency exchange rate used.

D.1 Concept Paper Required Content and Instructions

Concept papers are limited to six (6) pages total, excluding the cover page, visual summary, and estimated cost summary. Concept papers must follow the required content and format below.

Cover Page (not included in the 6-page limit)

- Concise title of project;
- Country(ies) of focus;
- APS Solicitation Number;
- Name and address of the Applicant organization;
- Type of organization (e.g., for-profit, non-profit, university, network, etc.);
- DUNS Number;
- Contact point (name, telephone, and e-mail); and
- Names of major sub-recipients and types of organizations (local non-profit, etc).

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

"This application includes data that shall not be disclosed outside the U.S. Government and shall not be duplicated, used, or disclosed – in whole or in part – for any purpose other than to review 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 shall have the right to duplicate, use, or disclose the data to the extent provided in the resulting grant. This restriction does not limit the U.S. Government's right to use 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."

1. Technical Approach
   i. Present a clear and ***concise situation analysis*** of the national and local context for strengthening the role of community health approaches.
      a. Discuss the Applicant's knowledge and understanding of policies, programs, partnerships, and systems relevant to improving community health programming in the selected country(ies). The Applicant must reference existing landscape analyses, needs assessments, or recent evaluations of the country's community health program context (e.g., programming, formal and informal systems, partnerships, policy, financing, decision making bodies and processes) in addressing its understanding and stating a need for the proposed approach. Identify key, high impact health and nutrition intervention(s) (either at a national

level or within sub-groups that have low coverage) and barriers that can be reduced (partially or fully) through community health approaches. The Applicant may use different types of data sources to support this analysis and prioritization (e.g., DHS, UNICEF analysis of barriers in the Acting on the Call Report 2014, MICS, SPA, qualitative work, etc.)

ii. Describe the proposed approach, its technical and geographic scope and scale[9], and how it aligns with the Program Description goal, purpose and prioritized objective(s) and any necessary adaptations to the country context for community health. Include how the proposed approach is aligned with USG/USAID and UNICEF priorities.
    a. Clearly delineate the technical package of high impact health and nutrition interventions and health outcomes that would be improved and feasible endpoints associated with scale and sustainability.
    b. Clearly identify which barriers to effective coverage would be reduced through community engagement and action in systems.
    c. Describe how the selected approach(es) builds on evidence and experience to reduce barriers by engaging communities with health and local systems. Please describe the nature of community engagement (e.g., roles of communities) and types of linkages with the existing systems that will be strengthened clearly and concisely. *[Important Note: Evidence and experience for community health approaches may include peer review publications, grey literature and other systematic and credible documentation of program experience (e.g., process documentation, participatory assessments, etc.)]*

iii. Visual Depiction of the Health System in the Context of the Technical Approach (not included in the 6-page limit, but limited to one page) - The Applicant must include a visual depiction demonstrating the system into which the technical approach is being integrated and the roles of all relevant systems actors (e.g., public, private; health system, community; formal, traditional) and the extent to which communities are engaged with the health and local system. The roles of key partners and stakeholders (at all levels of the system from the community to the national levels) must be highlighted in a clear and concise manner.

2. Potential to Contribute to National Influence and Impact

i. Describe the potential for the proposed approach to achieve a catalytic effect beyond the bounds of USAID/USG funding, as well as the potential for national influence and impact, and the nature of strategic integration and/or alignment of improvements with country-level investments and/or key decision-making processes (e.g. host country program implementation, and/or systems strengthening, and/or partnerships, and/or policy and program decision-making context). Include collaboration with any existing fora at the national level, such as country coordination and facilitation entities and

[9] The concept of strengthening systems at scale in this context is defined as deliberate efforts to increase the impact of successfully tested community health approaches so as to equitably benefit more people and to foster policy and program development on a lasting basis [Adapted from http://www.expandnet.net/PDFs/WHO_ExpandNet_Practical_Guide_published.pdf]. This may include strengthening an approach currently implemented at scale or moving to scale. This may include the public sector, private sector (including NGOs), or a combination of the two. It is important for the Applicant to clearly demonstrate which actors the approach seeks to influence to meet health goals as specified in country priorities.

decision-making bodies. The Applicant must demonstrate how the approach aligns with USAID/USG and UNICEF priorities, as relevant to the country context.

ii. Clearly present a logical pathway and feasible endpoints for influencing scale-up and sustainability of high impact health and nutrition interventions through community health approaches. Clearly describe the critical end users of new knowledge in relation to current gaps and information needed to guide specific decisions and actions. The Applicant should demonstrate support for and commitment to the proposed approach from key decision makers, influencers, and champions at the country level.

iii. Describe how the concept strengthens leadership and ownership at the local and national levels and facilitates collaboration between governments, communities, and other relevant systems actors.

3. Organizational Capacity

i. Describe the capacity, roles and responsibilities and collaboration of the Applicant and any proposed sub-recipients/partners. Detail the organizational experience of the Applicant and any proposed sub-recipients/partners with regard to the approach and how it builds on the experience and assets of the organizations and in-country relationships.

4. Estimated Cost Summary (not included in the 6-page limit)

i. Applicants must submit an estimated cost summary in the format below, containing all of the anticipated elements in the full cost/business application (see D.2.b below), but only showing a summary of the costs rather than cost details. (Note: While USAID understands that the budget summary in the concept phase may differ somewhat from the full cost/business application, it expects Applicants to present a realistic and reasonable budget summary that will align closely with the full cost/business application, if requested. By doing so, the Applicant will have demonstrated a thoughtful, achievable approach for the concept paper within the proposed funding.)

Cost Element	**Y1**	**Y2**	**Y3**	**Y4**	**Y5**	**Total**
Direct Labor						
Salaries – U.S Personnel						
Salaries – Non-U.S. Personnel						
Fringe Benefits – U.S. Personnel						
Fringe Benefits – Non-U.S. Personnel						
Allowances						
Consultants						
Travel						
International Travel						
Domestic/Local Travel						
Equipment						
Supplies						
Sub-Awards						
Sub-Award #1						

Cost Element	Y1	Y2	Y3	Y4	Y5	Total
Sub-Award #2, etc.						
Other Direct Costs						
Indirect Costs						
Total Cost Contribution Requested from USAID						
Cost Share						
Total Cost						

- Include a narrative that describes the sources for the estimated cost share proposed by the Applicant and sub-recipients.
- If resource leveraging is also proposed, the Applicant must include a narrative on the proposed leverage.

D.2 Full Application

If an Applicant is successful at the concept paper stage, USAID will request the Applicant to submit a full application in the format described below and any additional instructions from the Agreement Officer. Additional instructions may include feedback from the Selection Committee on the concept paper. Applicants may not submit a full application unless requested to do so by the Agreement Officer. Instructions from the Agreement Officer will include a deadline for the submission of the full application.

D.2.a Full Technical Application Instructions

The full Technical Application, excluding the cover page, executive summary, table of contents, past performance references, and annexes, must not exceed 20 pages. The Applicant must paginate pages (except for the cover page) at the bottom and should present the pages in the following order:

1. Cover Page (not included in the page limit)
   - Include the same elements as those required in the concept paper stage
2. Table of Contents (not included in the page limit)
3. Executive Summary (not included in the page limit, but limited to two (2) pages)
4. Body of Application (See Below)

1. Technical Approach

i. Provide relevant contextual country information and analysis to develop a solid rationale for the approach to strengthen the role of community health approaches to reduce barriers to effective coverage by integrating and expanding them within a health and local systems context, specifically including:
   - Clear description of the country's policies, systems, programming, and partnerships as well as gaps, barriers and opportunities for strengthening

community health policies and/or programming and any fragmentation in-country in relation to the prioritized APS goal and objectives.

ii. Describe the proposed approach, its technical and geographic scope and scale, and how it aligns with the Program Description goal, purpose, prioritized objective(s), and any necessary adaptations to the country context to engage communities in health and local systems to reduce barriers to effective coverage; describe how the proposed approach is aligned with USG/USAID and UNICEF priorities, specifically including:
    - Clearly link contextual analysis to the approach for strengthening stakeholder engagement to improve and synergize programming in-country. Clearly identify who these stakeholders are and their institutional affiliations.
    - Describe the evidence and/or experience of the proven or promising approach(es) to engage communities in systems to reduce barriers to effective coverage and the buy-in from key stakeholders.
    - Describe how gender affects health outcomes, and how the proposed project approach addresses this.

iii. Demonstrate the contribution of the proposed approach to national influence and impact through strategic integration and/or alignment (e.g., broader country investments, program platforms, partnerships, decision-making processes, including but not restricted to USG/USAID and UNICEF investments and priorities; evidence of agreements reached and/or Memoranda of Understanding can be included as annexes). Include details of collaboration with and strengthening of existing fora at the national level, such as country coordination and facilitation entities and decision-making bodies.

iv. Provide a comprehensive description of the proposed approach and include a logic model (the logic model may be included as an Annex) that provides a clear understanding of the identified barriers and proposed approach(es)/solution(s) to strengthening the role of communities in systems, the strategic fit within the existing policies, program implementation, and systems context, as well as the feasibility (e.g., economic, political, cultural) for integration and expansion in the system at a relevant scale to contribute to national health priorities. *The Applicant should clearly distinguish inputs and processes that are being funded through this APS from the broader strategic investments or platform or processes with which the inputs are being aligned and/or integrated while demonstrating synergies that will produce expected outcomes.* The logic model should be accompanied by a clear description of the system (formal, traditional; health, community) and key actors who are a part of it and how those actors will be strengthened to promote greater accountability and effectiveness of community health programming that will contribute to building national, local, and community leadership and ownership.

v. Describe how the approach will be implemented, including timelines and clearly delineated roles of all actors and collaborators in the system and the key phases of the project (e.g., operationalization, knowledge generation, knowledge translation and advocacy, capacity building of national and local actors, etc.), as relevant.

2. Monitoring, Evaluation, and Learning (MEL)

Note: Please also refer to Section I.4 for guiding principles

i. Building on the logic model, the Applicant should provide a clear monitoring, evaluation, and learning (MEL) plan that includes appropriate methods, documentation of processes,

and indicators (including gender) for tracking the implementation of the proposed approach and changes in health outcomes and clear knowledge management processes for sharing and using project generated learning by stakeholders at multiple levels. Applicants should also describe how the wider influence and impact of their efforts will be documented.

ii. The MEL plan should build on and strengthen existing systems, and strengthen local and national capacity to use data for decision making and promote accountability. Describe the approach for building the capacity of local and national actors and strengthening existing systems based on clearly identified needs.

iii. The MEL plan must describe how the Applicant will support and promote the creation, analysis, and sharing of relevant data and knowledge for scaling up and sustaining effective coverage through community health approaches. Include an explanation of the Applicant's strategy for facilitating use of data for decision making and for collaborating with and meeting the information needs of key decision makers. Define knowledge management processes for sharing, disseminating, and using knowledge with clear roles for stakeholder engagement. Knowledge management processes are not only internal to the project, but should also include external audiences including key in-country stakeholders (e.g., government, donors, other projects and partners supporting a national strategy or plan) as well as global audiences.

3. Key Personnel

i. Provide a CV (in Annex B) for the key personnel position of Project Coordinator. The Project Coordinator's primary responsibilities will be credible technical leadership, coordination and collaboration with all implementing partners, and strategic and management oversight of all partnerships and activities to achieve project objectives. The required skills, expertise and experience of the Project Coordinator are: in depth experience in strengthening community and health systems; expertise in engaging stakeholders spanning local/community, national and global levels; expertise in managing complex partnerships; skills in implementation of MEL plans; strong skills in knowledge management and translation (implementation to policy); and, strong management, interpersonal, communication, and facilitation skills. The Applicant may propose other Key Personnel, as applicable to the proposed approach.

4. Institutional Capacity

i. Describe the experience and skills of the Applicant's (and any relevant partner organizations) proposed staff, as well as the Project Coordinator, to adequately manage and implement the project with high quality and credibility, including dialogue with government leaders and other systems actors.

ii. Provide visual depictions (e.g., organogram) of the proposed organizational/partnership and staffing structures to support the approach. The roles, responsibilities, forms of collaboration and lines of authority on the project team and between any sub-recipients must be clearly articulated. Indicate any anticipated needs for technical assistance (e.g., M&E to generate high quality data, produce peer review publications and other

knowledge management and translation) and how those needs have been planned for in the application.

iii. Provide a summary of the staffing plan that describes the position name, number of positions, location of the positions, U.S.-based or local staff, and the level of effort of those positions on an annual basis in relation to the Applicant's approach.

5. Annexes (not included in page count but limited to no more than 20 pages total across annexes)

Annex A – The Logic Model diagram and associated details may be included as an Annex.

Annex B – CVs and Letters of Commitment of Key Personnel – While only a Projector Coordinator is required to be Key Personnel, the Applicant may elect to propose additional Key Personnel based on their approach and the Applicant must provide CVs of all proposed Key Personnel. Though USAID is not imposing a page limit, the Applicant is encouraged to limit each CV to two pages maximum. The Applicant must submit signed letters of commitment from the proposed Key Personnel.

Annex C – Sub-Recipient Letters of Intent and Partner MOUs – The Applicant must provide a signed letter of intent from each sub-recipient proposed (if any). The letter must commit the organization to participation in the project, and briefly state that the sub-recipient understands its role on the project. Though USAID is not imposing a page limit, the Applicant is encouraged to limit each letter to one page maximum. MOUs with partner organizations (non sub-recipients) must also be provided in Annex C.

Annex D - Past Performance References (Must be Submitted in Microsoft Word) – Using the template in Appendix B, the Applicant must provide three recent and relevant past performance references for itself. Recent is defined as the last three years. Relevant is defined as projects of similar size, scope and complexity. Past performance references shall be for contracts, grants, and cooperative agreements for recent and relevant projects carried out by the Applicant.

If sub-recipients are anticipated, one past performance reference is required for each proposed sub-recipient. Sub-recipient past performance references do not count as part of the three required past performances for the Applicant.

D.2.b Full Cost Application Instructions

The Cost Application is to be submitted under a separate cover from the Technical Application. There is no page limit on the Cost Application. Applicants are encouraged to be as concise as possible, but still provide the necessary details. However, unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective application in response to this APS is not desired. Elaborate artwork, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor wanted. The Cost Application must illustrate the full period of performance using the budget format shown in the SF-424A.

The Cost Application must contain the following sections:

1) Cover Page
2) SF 424 Forms
3) Budget
4) Budget Narrative
5) Dun and Bradstreet and SAM.gov Registration
6) Certifications, Assurances and Other Statements of the Recipient

1. Cover Page

The Cost Application Cover Page must contain the same information as the Technical Application Cover Page.

2. SF 424 Form(s)

The Applicant must submit the application using the SF-424 series:

Instructions for SF-424	http://www.grants.gov/web/grants/form-instructions/sf-424-instructions.html
SF-4249	http://apply07.grants.gov/apply/forms/sample/SF424_2_1-V2.1.pdf
Instructions for SF-424A	http://www.grants.gov/assets/InstructionsSF424A.pdf
SF-424A	http://apply07.grants.gov/apply/forms/sample/SF424A-V1.0.pdf
Instructions for SF-424B	http://www.grants.gov/assets/InstructionsSF424B.pdf
SF-424B	http://apply07.grants.gov/apply/forms/sample/SF424B-V1.1.pdf

Failure to accurately complete these forms could result in a non-funded application.

3. Budget

The Budget must be submitted as one unprotected Excel file (MS Office 2000 or later versions) with visible formulas and references and shall be broken out by project year, including itemization of the federal and non-federal (cost share) amount. Files must not contain any hidden or otherwise inaccessible cells. Budgets with hidden cells lengthen the time required to make award and may result in a rejection of the cost application. Please note that construction is not permitted under this APS.

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

a. Summary Budget, inclusive of all project costs (federal and non-federal), broken out by major budget category and by year for activities implemented by the Applicant and any potential sub-recipients for the entire period of the project.
b. Detailed Budget, including a breakdown by year, by budget category, by budget line items, and by headquarters, regional and/or country offices (if applicable) for all federal funding (core and field support) and cost share and/or resource leverage for the entire implementation period of the project.

c. Detailed Budgets for each sub-recipient, for all federal funding and cost share and/or resource leverage, broken out by year, by budget category, by budget line items, and by headquarters, regional, and/or country offices (if applicable) for the entire implementation period of the project.

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

Salaries must be identified by U.S. and non-U.S. personnel and proposed in accordance with the Applicant's personnel policies, if applicable. The Budget Narrative must include as much as possible information about the personnel's name, position, status, salary rate, level of effort, and salary escalation factors. Explain assumptions in the Budget Narrative. If the organization has standing policies across all projects for annual salary escalations that exceed current inflation rates, those policies, their application in the organization (e.g., entire organization, select projects, etc.) and the effective date of those policies must be provided with the application, as well as the personnel policies.

Fringe Benefits, if applicable, must be applied to the salaries and wages in a manner that allows USAID to ensure proper application of the fringe benefits. Adequate justification for the proposed rate must also be provided. If the Applicant has a fringe benefit rate approved by an agency of the USG, the Applicant must use such rate and provide evidence of its approval. If an Applicant does not have a fringe benefit rate approved, the Applicant must propose a rate and explain how the Applicant determined the rate. In this case, the Budget Narrative must include a detailed breakdown comprised of all items of fringe benefits (e.g., superannuation, gratuity, etc.) and the costs of each, expressed in U.S. dollars and as a percentage of salaries.

Allowances, if provided must be detailed in terms of the type of allowance and its application.

Consultants, if used by the Applicant, must contain a line item for each consultant that will be used, including daily or hourly rates as appropriate. The Budget Narrative must detail why the consultant is being used, proposed hours, proposed rate and totals.

Travel must be separated into international and domestic travel. Each category should include the number of trips, the departure and arrival cities, the number of travelers, and the duration of the trips. Per Diem must be based on the Applicant's travel policies, if applicable. When appropriate, provide supporting documentation as an attachment, such as the Applicant's travel policy, and explain assumptions in the Budget Narrative, including details explaining the purpose of the proposed trips.

Equipment must include information on estimated types of equipment, models the cost per unit and quantity. The Budget Narrative must include the purpose of the equipment and the basis for the estimates.

Supplies must include information on estimated types of supplies and the cost per unit and quantity. The Budget Narrative must include the purpose of the supplies and the basis for the estimates.

Contractual must specify the services or goods provided by the sub-recipients. The sub-recipients must prepare similar Detailed Budgets and Budget Narratives that align with the same requirements as the Applicant. If using a sub-recipient, the sub-recipient must provide its USAID Negotiated Indirect Cost Rate Agreement (NICRA) or an approved letter from a cognizant U.S. Federal audit agency to substantiate fringe or indirect rates. If none exists, the organization must provide two years of audited financial data and a narrative that supports how the fringe and indirect rates were calculated. U.S. organizations must also include a cost element for Allowances, if any are expected.

Other Direct Costs must include programmatic costs not included under any other cost element. This may include meeting costs, training sessions, advertisements, etc. The Budget Narrative must detail the number of meetings/trainings, meeting/training costs such as facility rental, audio visual rental, meals, local travel for participants, etc, as well as the basis for such cost estimates. Meals and local travel must not be duplicated for the Applicant's staff in travel and transportation, but must only cover non-Applicant or non-sub-applicant employees attending the meetings/trainings. It must also include items such as: office rent, utilities, communication equipment service costs, report preparation costs, insurance (other than insurance included in the Applicant's indirect rates), etc. The Budget Narrative must support the unit number, price, and reason for all other direct costs.

As part of ODCs, it is important that the MEL plan receive adequate funding throughout the life of the project and that this is clear in the project budget. It is recommended that adequate resources be dedicated to the MEL plan and associated capacity building and advocacy to use data for decision-making and action.

Indirect Costs must be supported with information to substantiate the calculation of the indirect cost. 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 the Applicant does not have a NICRA the Applicant should 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 should be made to the financial statements; OR
- Audited Financial Statements Report: An auditor issued report documenting the audit was conducted in accordance with Generally Accepted Auditing Standards (GAAS), the financial statements are the responsibility of management, providing 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 issued a qualified opinion if the financial statements are not in conformity with the applicable financial reporting framework).

As an alternative, if the Applicant has never received a NICRA, the Applicant may elect to charge indirect rates at a de minimis rate of 10% of modified total direct costs as per ADS 303.3.12.a. If the prospective Applicant chooses the de minimis rate, the AO will incorporate the 10% indirect cost rate in the award budget and the recipient must follow the requirements in 2 CFR 200.414(f). Local organizations may also include indirect costs as fixed costs.

A Cost Share of 25% is required for the Applicant to be eligible. The Applicant 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. The Applicant must also provide a breakdown of the cost share (financial and in-kind contributions) of all organizations involved in implementing the resulting Cooperative Agreement.

4. Budget Narrative

The cost elements provided in the Detailed Budget should also be provided in the Budget Narrative, but with text that explains the rationale for the choices and costs. As noted throughout the cost elements above, the Budget Narrative should contain sufficient detail so that USAID can read the Budget Narrative while reviewing the Detailed Budget and understand the proposed costs. The Budget Narrative should be thorough and include sources for costs to more quickly enable USAID to determine the cost as fair and reasonable. 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.). If resource leveraging is also proposed, the Applicant must include a narrative on the proposed leverage.

If the Applicant has established a consortium or another legal relationship among its partners, the Cost Application must include a copy of the legal relationship between the parties. The Application will 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 the effort (work) 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.

Applicants must also include evidence of responsibility the Agreement Officer can use to determine that the Applicant:

a. Has adequate financial resources or the ability to obtain such resources as require 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 integrity and business ethics; and

d. Is otherwise qualified and eligible to receive a Cooperative Agreement under applicable laws and regulations (e.g., EEO).

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).

5. Dun and Bradstreet and SAM.gov Requirements

All Applicants are required to:

i. Be registered in the System for Award Management (SAM) (www.sam.gov);
ii. Provide a valid DUNS number; 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.

USAID may not make a Federal award to an Applicant until the Applicant has complied with all applicable DUNS and SAM requirements. Registration must occur before submission of the full application.

6. Required Certifications, Assurances, and Solicitation Provisions

Applicants must complete the Certifications, Assurances, and Representations and include a PDF with the full application submission, see:
http://www.usaid.gov/sites/default/files/documents/1868/303mav.pdf

Note: Past performance is not required to be completed with this information since it is being provided via the Past Performance Form in Appendix B.

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 should 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 submitted should substantiate:

1. Bylaws, constitution, and articles of incorporation, if applicable.
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. The Applicant should provide copies of the same.

Section V – Application Review Information

USAID Selection Committees (SCs) will conduct a merit review of all Applications (both concept papers and full applications) received in response to this APS in accordance with the merit review criteria detailed below. SCs may be from Washington, Missions, or a mix of USAID offices/missions.

After a careful and thorough review of all concept papers received by the due date, Applicants whose concept papers are most advantageous to the Government, considering both technical and cost review criteria, will be invited to submit full applications.

After a careful and thorough merit review of all full applications by the USAID SCs, the Agreement Officer will make the final determination and an award will be made to the Applicant(s) whose full application offers the best solution, considering both technical and cost review criteria. Award may be made without additional discussions.

The merit review criteria can help Applicants identify the significant matters that they should address in concept papers/applications, as the same criteria will be the standard against which all applications will be reviewed.

Relative Importance of Merit Review Criteria and Review Plan
The merit review criteria (1, 2, 3, etc.) are listed below in descending order of importance. The sub-criteria (i, ii, iii, etc.) have equal importance, unless indicated otherwise. Ratings will only be provided at the criteria level.

A. Merit Review Criteria for Concept Papers

1. Technical Approach
   i. The Applicant demonstrates in-depth knowledge and understanding of the country context (e.g., policies, systems, programs, partnerships) relevant to strengthening the role of community health approaches to reduce barriers to achieving and sustaining effective coverage of high impact health and nutrition interventions at scale in the selected country(ies).
   ii. The approach is feasible and clearly addresses the Program Description goal purpose and objective(s); and, builds on evidence and experience to engage communities in health and local systems to reduce barriers to effective coverage.
   iii. The visual depiction of the health system in the context of the technical approach demonstrates a clear understanding of the policy and systems context and the roles and linkages of community and systems actors in the proposed approach.

2. Potential to Contribute to National Influence and Impact
   i. Strong potential exists to catalyze wider change beyond the USAID/USG investment through this APS. Applicant demonstrates capacity to facilitate change in the country's community health programs and/or systems and/or policies through strategic integration and/or alignment of improvements with country-level investments and/or key decision-making processes (e.g., host country program implementation, and/or systems

strengthening, and/or partnerships, and/or policy and program decision-making context) and buy-in from key national and local stakeholders. The Applicant's approach demonstrates synergies and alignment with USG/USAID and UNICEF priorities, as relevant.

ii. Clear presentation of a logical pathway and feasible endpoints for influencing scale-up and sustainability of high impact health and nutrition interventions through community health programming that reduces identified barriers, including identification of knowledge gaps and how end users will use new knowledge to guide decisions and actions.

iii. The approach is feasible for strengthening national and local leadership, ownership, and collaboration towards greater accountability and effectiveness of community health programs.

3. Organizational Capacity
   i. The Applicant and sub-recipients/partners have demonstrated organizational experience, and bring resources and expertise to successfully conduct and manage the project.

4. Estimated Cost Summary
   i. Costs are feasible for the proposed approach, including cost share and/or resource leverage, and explain how the Applicant will achieve the proposed cost share and resource leverage (as applicable).

B. Merit Review Criteria for the Full Application

If selected and invited to submit a full application, Applicants must organize the application in accordance with the detailed guidelines found in Section IV, Application Submission and Information, which align with the merit review criteria discussed below.

1. Technical Approach

The Technical Approach section will be reviewed against the following:

i. The Applicant demonstrates exceptional knowledge and understanding through its contextual analysis of community health programming as well as the gaps and barriers that need to be addressed to harmonize, integrate, and expand community health approaches within a national framework and with relevant in-country stakeholders.

ii. The proposed approach, and its technical and geographic scope and scale, as well as timelines, are feasible and likely to result in improved outcomes that are well defined. The approach clearly aligns with the Program Description goal, purpose and prioritized objective(s) and is adapted to the country context to address barriers to scaling up and sustaining high impact health and nutrition interventions through community health approaches within the national framework.
   a. The Applicant's approach effectively addresses barriers to strengthening the role of community health approaches and builds on evidence and experience to

engage communities in health and local systems to reduce bottlenecks to effective coverage.

b. Gender effects on health outcomes are thoroughly identified and addressed in the approach.
c. The logic model is realistic and poised to improve performance by clearly delineating inputs and processes at community and higher levels of the system, as necessary, and outcomes that are feasible to achieve within the proposed time frame and resource envelope.

iii. The Applicant's approach identifies and strategically engages relevant stakeholders to influence, synergize, and improve community health programming in-country. Stakeholders and their institutional affiliations are clearly identified and relevant to the proposed approach. The approach demonstrates how it contributes to national influence and impact through strategic integration and/or alignment of improvements with country-level investments and/or key decision-making processes (e.g., host country program implementation, and/or systems strengthening, and/or partnerships, and/or policy and program decision-making context) and is likely to be successful. The Applicant's approach demonstrates synergies and alignment with USG/USAID and UNICEF priorities, as relevant.

iv. The approach includes a clear plan and logic model for how the roles and responsibilities of all relevant actors (from the community to national level) will be strengthened to promote greater accountability and effectiveness of community health programming and will contribute to building national, local, and community leadership and ownership.

v. A feasible implementation approach is proposed, including realistic timelines the key phases of the project (e.g., operationalization, knowledge generation, knowledge translation and advocacy, capacity building of national and local actors, etc.), as relevant.

2. Monitoring, Evaluation, and Learning (MEL)

i. Demonstrates a clear MEL plan, with specified indicators (incorporating gender); appropriate methods for generating new knowledge and monitoring progress; and, knowledge management processes, that responds to the identified needs of specific decision-makers or end-users and facilitates the use of data for decision-making to support the country's overall community health programming.

ii. Compelling plan for strengthening existing mechanisms for monitoring, reporting, building local capacity and collaboration in systems to generate and use data for decision-making and increasing ownership and accountability from the community to national policy and planning levels.

iii. Well-defined knowledge management approach that collaboratively creates, disseminates and promotes use of knowledge with local, national, and global audiences (including decision makers and other key stakeholders) and contributes to meaningfully expanding the evidence base for community health approaches through publications and other formats for dissemination

3. Key Personnel

i. The proposed Key Personnel has the experience, expertise and skill sets to effectively execute the roles and responsibilities, which are relevant and appropriate for the proposed approach.

4. Institutional Capacity

i. Applicant and any relevant partner organizations, proposed staffing, and Project Coordinator demonstrate adequate experience and skills to manage and implement the project with high quality and credibility, including the ability to dialogue with government leaders and other systems actors.
ii. Visual depictions (e.g., organogram) present clear, lean and responsive organizational/partnership and staffing structures to support the approach. The roles, responsibilities, forms of collaboration and lines of authority on the project team and between any sub-partners are clearly articulated. Technical assistance needs, if any, are identified and planned for in the application to ensure high quality data generation, translation, and use.
iii. The staffing plan demonstrates an appropriately sized and structured staff with the relevant level of effort and skill sets to successfully execute the approach.

5. Cost Effectiveness and Cost Realism

Once the technical review of the full applications is completed, USAID will review the cost application(s) of the apparently successful Applicant(s) for effectiveness and realism.

Cost sharing is an important element of the USAID-Recipient relationship and the Applicant's compliance with Section III, Eligibility Information, will be a consideration for award. The cost application should clearly demonstrate the Applicant's plan for providing the required cost share. The proposed contributions should meet the standards in the "Cost Share" Standard Provision for either U.S. NGOs or Non-U.S. NGOs. Resource leverage, if proposed, will also be a consideration for award.

Section VI – Federal Award and Administration Overview

A. Federal Award Notices

1. Applicants will be notified in writing, via email, of their application status for both concept papers and full applications, if relevant (successful or unsuccessful) upon completion of the review process.

2. Applicants notified of a successful application status will be requested to provide a Branding and Marking Plan that complies with ADS 320. Notification of successful application status is ***not*** an authorization to begin performing proposed activities or performance in general.

3. Applicants notified of an unsuccessful application, either at the concept paper stage or the full application stage, will not be considered for award under that APS Review Window. Applicants who are notified that their full application was unsuccessful are advised that they are able to request additional information within 10 working days following receipt of the notice. The unsuccessful Applicant may send a written request for additional information to ICH-APS@usaid.gov.

B. Authority to Obligate the Government

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.

C. Mandatory Standard Provisions

For U.S. organizations, 2 CFR 700, 2 CFR 200, and ADS 303maa, Standard Provisions for U.S. Non-governmental Organizations are applicable.

For non-U.S. organizations, ADS 303mab, Standard Provisions for Non-U.S. Non-governmental Organizations will apply.

D. Required As Applicable Standard Provisions

In addition to the Mandatory Standard Provisions mentioned above, Required As Applicable (RAA) standard provisions shall also apply depending on the scope of the concept paper submitted. USAID will provide the specific RAA standard provisions in the request for full application.

E. Reporting Requirements

1. Workplan: To be submitted within 30 calendar days after the award. The recipient must provide a workplan describing the activities to be undertaken. A corresponding revised line item budget should also be provided.

2. Annual Reports: To be submitted 90 calendar days after the award year which is in accordance with 2 CFR 200.328(b).

3. Final Report: To be submitted 60 calendar days after the expiration or termination of the award which is in accordance with 2 CFR 200.328(b).

4. Financial Reporting: In accordance with 2 CFR 200.327, the SF 425 and SF 272 will be required on a quarterly basis.

F. Program Income

Any program income generated under the award will be treated in accordance with 2 CFR 200.307 for U.S. NGOs and RAA15, Program Income (December 2014) from USAID's Standard Provisions for Non-U.S. NGOs.

G. Environmental Compliance

An Initial Environmental Examination (IEE) has been approved for this activity (see Appendix C). The IEE covers activities expected to be implemented under a cooperative agreement awarded under this APS. USAID has determined that a **Negative Determination with conditions** applies to one or more of the proposed activities. This indicates that if these activities are implemented subject to the specified conditions, they are expected to have no significant adverse effect on the environment. The recipient shall be responsible for implementing all IEE conditions pertaining to activities to be funded under this APS.

1. As part of its initial Work Plan, and all Annual Work Plans thereafter, the recipient, in collaboration with the USAID Cognizant Technical Officer and Mission Environmental Officer or Bureau Environmental Officer, as appropriate, shall review all ongoing and planned activities under the cooperative agreement to determine if they are within the scope of the approved Regulation 216 environmental documentation. The IEE (see Appendix C) contains an Environmental Screening Form to assist in identification of applicable conditions.

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

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

4. When the approved Regulation 216 documentation is (1) an IEE that contains one or more Negative Determinations with conditions and/or (2) an Environmental Assessment (EA), the recipient shall:

a) Prepare an EMMP or M&M Plan describing how the recipient will, in specific terms, implement all IEE and/or EA conditions that apply to proposed project activities within the scope of the award. The EMMP or M&M Plan shall include monitoring the implementation of the conditions and their effectiveness. Note this is not required if the approved Regulation 216 documentation contains a complete environmental mitigation and monitoring plan (EMMP) or a project mitigation and monitoring (M&M) plan.

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

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

Section VII – Federal Awarding Agency Contacts

The Applicant may contact the following USAID personnel in writing via email regarding this APS. Applicants must use the ICH-APS@usaid.gov email address in contacting either point of contact.

Primary Point of Contact:
Christopher Egaas
Agreement Officer
M/OAA/GH/GHI

Alternate Point of Contact:
Courtney J. Magill
Agreement Specialist
M/OAA/GH/GHI

Section VIII – Other Information

A. USAID Rights and Funding

USAID may (a) reject any or all concept papers/applications; (b) accept other than the lowest cost application; and (c) waive informalities and minor irregularities in the concept papers/applications received.

Issuance of this APS does not constitute an award or commitment on the part of the Government, nor does it commit the Government to pay for costs incurred in the preparation and/or submission of a concept paper/application. Applicants who come under consideration for an award that have never received USAID funding may be subject to a Pre-Award audit to determine fiscal responsibility, ensure adequacy of financial controls, and establish an indirect cost rate (if applicable).

B. Regulations and References

2 CFR 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards

USAID Policies and Procedures

Mandatory Standard Provisions for U.S., Nongovernmental Recipients

Mandatory Standard Provisions for Non-U.S. Nongovernmental Recipients

Technical Annexes:

- Annex 1 – Varying Context For Developing Plans To Influence Scale And Sustainability Of Community Health Approaches
- Annex 2 – Examples Of Integrating Community Health Projects
- Annex 3 – High Impact Health and Nutrition Technical Interventions
- Annex 4 – Country-Specific Requirements

See the following Appendices:

- Appendix A – Grants.gov Instructions
- Appendix B – Past Performance Form
- Appendix C – Initial Environmental Examination

Annex 1 – Varying Context for Developing Plans to Influence Scale and Sustainability of Community Health Approaches

Plans to promote sustainability and scale will require a context-specific approach that leverages and strengthens existing health and community systems policies and partnerships in the 24 priority countries. Effective partnerships for strengthening the role of community health approaches in diverse systems will need to be tailored to the national and local policy and program contexts. While the opportunities and barriers to strengthening linkages between health and community systems will be context-specific, there are some broad characteristics that can be used to understand the nature of community engagement with systems and how sustainability and scalability considerations may vary. Some of these characteristics include the organizations and structures involved in implementing community health; the scale of community health activities and beneficiaries; the actors involved in driving community health policy and implementation; and contextual factors such as governance and status of devolution. *Partners are encouraged to develop appropriate strategies to influence the scale and sustainability of community health approaches based on the characteristics of and strategic fit within diverse national and local systems.*

- In some countries, national governments are key players in driving community linkages with health systems, with NGOs in a technical assistance role. These countries may have primary health care programs (including formal community health worker strategies) operating at scale and driven by the public sector. Partners will need to operate within the national political and governance structure and engage both national and local stakeholders to develop expanded models of local collaboration and community engagement.
- In post-conflict countries, weak governance and the role of mixed government and NGO/faith-based organization service delivery models will have to be factored into partner strategies for sustainability and scalability of community engagement approaches within the system.
- In countries marked with strong governance and a long history of civil society engagement in health and development, partners will be able to mobilize well-coordinated government, civil society actors, and community structures in improving the reach and quality of existing community health platforms as well as governance and accountability strategies in a robust manner.

Applicants will also need to analyze patterns within a country context to influence scale and sustainability. For example, the specific characteristics of operating in a complex country environment, such as fragile, post-conflict, or marginalized and poor performing areas, will need to be understood and factored into the development and adaptation of plans or pathways for scale and sustainability.

Annex 2 – Examples of Integrating Community Health Projects

The following examples demonstrate how an Applicant may develop projects that respond to one or more of the Integrating Community Health APS objectives and design systems strengthening projects to achieve wider influence and change to support the purpose. These are general illustrations for advancing a range of community health approaches.

- Community mobilization through women's groups (e.g., participatory learning and action groups, Care Groups[10], etc.) is effective for improving behaviors, expanding the coverage of key interventions, and promoting empowerment of women. However, community mobilization approaches have not been successfully integrated within the capacities of existing health systems or scaled up as a part of costed national plans in many of the 24 priority countries. New guidance from World Health Organization (WHO) and USAID partners consolidates global evidence of effectiveness and recommends that countries integrate and expand these approaches to accelerate progress. To implement this recommendation, countries must address persisting information gaps focusing on sustainability and develop effective processes and partnerships for scaling up in existing health systems. Grantees ***support national and local decision-making needs to inform the sustainability and scalability of women's groups in a particular system***. To address in-country decision maker needs at the national and local levels, grantees works with the government and its key partners to strengthen supervision of women's groups and their linkages with community health workers and local community-based organizations. These improvements are costed and integrated into district policies and plans. The grantee influences and supports national stakeholders to use the knowledge to plan the expansion of the improved approach (targeting to specific areas or at scale) through local partners and develop an approach to technical assistance, including adaptation of technical tools and identification of partners who can be supported to provide necessary technical support.

- By the end of the project, a grantee ***focusing on promoting institutionalization*** would have collaborated with and influenced decision makers in a ***national technical working group focusing on CHWs to adopt a systematic approach to working with community volunteers into existing CHW strategies and implementation plans*** to extend the equitable reach of CHW information and services. The grantee develops partnerships with multiple local NGOs and CBOs to integrate and adapt the common approach and conduct monitoring and evaluation using standard methods across local partners. The evidence generated by multiple local partners of the grantee demonstrates that CHWs,

[10] A Care Group is a group of 10-15 volunteer, community-based health educators who regularly meet together with project staff for training and supervision. It is different from a typical mother's group in that each volunteer is responsible for regularly visiting 10-15 of her neighbors, sharing what she has learned, and facilitating behavior change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication addressing relevant child survival, health and nutrition issues of mothers, infants and young children.

supported by existing health and community systems (e.g., primary health care facilities, village health committees), can effectively supervise and support volunteers at low cost. The grantee also documents improvement in equitable coverage of health interventions at the request of the national technical working group. The grantee develops tools and materials and provides initial technical assistance to key partners identified by the government to harmonize plans for integrating the approach, including estimations of the costs and support needed to ensure quality in implementation and expansion of the approach as part of refined local and national plans.

- By the end of the project, a grantee focusing on improving ***measurement to influence policies and systems*** would have ***supported district health decision makers and planners to institutionalize a cost-effective and inclusive methodology to enhance an equity focus in the existing district monitoring system and supported national stakeholders to learn from experience and expand the methodology***. Based on past success with a participatory methodology (e.g., community monitoring system using a citizen report card to improve joint monitoring of primary health care facilities by health care providers and community representatives), the grantee integrates community monitoring into multiple USAID- and United Nations Children's Fund- (UNICEF) supported districts in which broader health systems strengthening and equity-focused work is underway. The grantee generates evidence and lessons to support decision-making needs and effectively uses selected implementation sites as "centers of excellence" to inform and train national stakeholders to enable further adaptation and expansion of the methodology.

- By the end of the project a grantee ***focusing on improving inclusive and effective partnerships*** would have demonstrated an effective ***model of collaboration between government, local private sector and civil society actors*** (e.g., NGOs, professional associations, faith institutions) at the sub-national level to support specific objectives of the national Every Newborn Action Plan (ENAP) and supported national stakeholders to replicate it. The grantee leverages resources of the private sector against USAID investment (1:1 leverage from the private sector) and facilitates effective integration between the work of the private sector (focusing on improving the quality of services and ensuring commodities through a global alliance) and civil society organizations (focusing on harnessing parent power and promoting household-level behavior change through community platforms). The grantee also collaborates with the government and USAID and UNICEF country leadership to host a national workshop to share evidence of success (e.g., improved norms and behaviors and quality of services) and lessons focusing on partnership; and, to harmonize technical resources and behavior change messages with key private sector and civil society actors in country to promote dialogue and coordination among partners supporting the ENAP scale-up plan.

Annex 3 – Guidance for High Impact Health and Nutrition Technical Interventions to Contribute to Ending Preventable Child and Maternal Deaths

The following provides guidance for acceptable programming to drive progress on high impact health and nutrition technical interventions to contribute to Ending Preventable Child and Maternal Deaths (EPCMD). Applicants are encouraged to use this guidance in combination with Annex 4, County-Specific Requirements, and country-level information that is adapted to community health programming. The following are elements and sub-elements that support the Investing in People objective in the Foreign Assistance Framework.

Element: Maternal and Child Health (MCH)

Within the MCH element, Applicants are encouraged to program toward the highest impact interventions identified for their country and project area with a focus on supporting a community health platform within a broader context of health and local systems strengthening. The technical considerations for these sub-elements apply when this particular sub-element has been deemed a priority area within the Applicant's project.

Sub-elements: Birth Preparedness and Maternity Services and Treatment of Obstetric Complications and Disabilities

In alignment with USAID's Maternal Health Vision for Action, Applicants are encouraged to work with stakeholders to:

1. Enable and mobilize individuals and communities to promote healthy behaviors that improve maternal health, activate communities to hold health systems accountable for maternal health outcomes, and improve equity of access to maternal health services for the most vulnerable.
2. Advance quality, respectful care– including scaling up high impact interventions for complications especially postpartum hemorrhage and pre-eclampsia/eclampsia, maternal nutrition, and integrated infection prevention and treatment- including for HIV and AIDS, malaria and tuberculosis.
3. Strengthen health systems for maternal health through promoting public and private resource mobilization, strengthening supply chains for commodities, foster quality of care, expand and strengthen human resources, improve referral systems, and improve monitoring and promote data for decision making.

Sub-element: Newborn Care and Treatment

A strong evidence-based program that will end preventable newborn deaths requires the following three program activities:

1. Support the scale-up of five evidence-based, high-impact interventions: resuscitation, antenatal corticosteroid, kangaroo mother care, injectable antibiotics, and chlorhexidine as part of an integrated package of newborn interventions to address the three major causes of newborn mortality, i.e., preterm birth and low birth weight complications,

asphyxia, and sepsis. Applicants are highly encouraged to integrate newborn and maternal health programs for maximum impact.

2. Strengthen health systems to support the scale-up of these interventions including: referral networks, financial incentives, perinatal death audits, quality improvement approaches (including compliance with standards and team-work in health facilities), community health workers and facility health providers, and logistics management of essential commodities (bag/mask/suction device), injectable antibiotics, and chlorhexidine per national policy.
3. Support national policy change/updates to align with the global Every Newborn Action Plan including development or sharpening of a costed national newborn strategy/plan and intervention-specific policies/operational guidelines for: resuscitation, antenatal corticosteroid, kangaroo mother care, injectable antibiotics, and chlorhexidine

Across these three program activities, Applicants are encouraged to invest in catalyzing activities which leverage others investments and/or support implementation of newborn programs nationally or in focus regions.

Sub-element: Other Immunizations

Applicants are encouraged to work to optimize USAID's global vaccine investment in Gavi (*approximately $200 million annually*) by engaging with country level vaccination programs. GAVI largely supports vaccine purchase and some health systems strengthening. Applicants should work to complement Gavi's investments by strengthening various components of the national immunization program including improving quality of immunization services and coverage at the subnational level, policy (e.g. sustainable vaccine and immunization financing), and health systems strengthening (e.g. cold chain and logistics) to effectively provide all routinely recommended vaccines to all children. Strengthening such systems will enable effective new vaccine introduction.

USAID considers routine immunization activities to include any general vaccine delivery effort through the country led, country owned Expanded Program on Immunization (EPI) that are planned, cost-based and budgeted for, including operational and recurrent costs, regardless of the required method of delivery, as long as it builds a stronger, reliable, sustainable immunization system that can deliver vaccinations in a timely to all children under five who need them. This can include fixed site, regular outreach, and periodic intensification of routine (surge) approach.

Sub-element: Treatment of Child Illness

Strong programs for scaling up treatment of child illness include approaches that ensure correct assessment followed by treatment (minimally for diarrhea, ORS, zinc; for pneumonia, amoxicillin). Use of these treatments may be part of an integrated community case management (iCCM) approach or for primary care (especially) facilities, this may be part of integrated management of childhood illnesses (IMCI). At facility, this may also include more intensive high impact interventions (e.g., IV fluids, injectable antibiotics/anti-malarials, oxygen, etc.). It is anticipated that the platform for malaria treatment in facilities and communities will be the foundation for also including treatment of pneumonia and diarrhea. The Global Action Plan for

Pneumonia and Diarrhea (GAPPD) is a good technical resource when considering these interventions.

Sub-element: Household Level Water, Sanitation, Hygiene (WASH) and Environment

Strong WASH programs are based on the understanding of the contribution of diarrhea to child mortality, particularly in the post-neonatal period from 1-59 months, and support correct, consistent and sustained adoption of evidence-based hygiene behaviors. Achieving sustained impact through WASH programming relies on three pillars: 1) *hardware and technologies*, such as safe and reliable water systems, hygienic sanitation facilities, and water disinfection products, 2) *behavior change* to build demand for services and products and to promote and sustain desired behaviors, and 3) *an enabling environment* to support the sustainability of the other two pillars, including strong institutional capacity, financial access for services and products, supportive policies, effective intersectoral collaboration and a strong private sector role.

Since key hygiene behaviors (handwashing with soap, safe disposal of feces, treatment and safe storage of water and food hygiene) are "product-supported" and "infrastructure-supported", the Applicant may need to identify other stakeholders making investments in water supply and sanitation marketing. Strong programs also broadly leverage activities of other donors and stakeholders to achieve intervention coverage at a scale. This is particularly important for WASH, since the infrastructure investments like water supply required to enable the improved hygiene behaviors typically happen outside the health sector. Any programming related to indoor air-quality should describe the risk analysis used to include (or not) indoor air quality interventions like improved cook stoves associated with pneumonia and low birth weight. The integrated Global Action Plan for Pneumonia and Diarrhoea (GAPPD) notes that many of these WASH and household behaviors can be promoted jointly.

Sub-element: Service Delivery

Service delivery interventions are encouraged to emphasize high-quality, highly-effective provider and client approaches that provide a broad range of contraceptive information, products, and services in ways that help clients choose and correctly use the contraceptives that meet their lifestyle and reproductive needs for delaying, spacing, or limiting childbearing. Social and behavior change communications messages should be coordinated with and reinforce service delivery interventions. In countries *where modern contraceptive use is below 30% nationally*, service delivery interventions should focus on expanding access to services broadly. In countries *where modern contraceptive use is at or above 30% nationally* service delivery interventions should focus on reaching underserved groups and reducing inequities to contraceptive access among key underserved populations (e.g., lowest wealth quintile, youth, young married (below age 18) women, post-partum women, post-abortion clients, rural populations). Finding synergies and common service platforms with Maternal, Newborn, and Child Health (MNCH)

interventions is also an essential component. Particular attention should be given to implementing and scaling-up proven and promising FP High Impact Practices[11]:

1. Diversify service delivery channels and expand method choice: Static clinics, mobile outreach*, social marketing*, drug shops and pharmacies*, community health workers*, and non-traditional outlets (beauty parlors, shops, etc.).
2. Identify smart FP/MNCH integration opportunities: FP/immunization contacts*, post abortion FP*, FP/HIV, and FP/Essential Newborn Care.

Element: Family Planning

Family planning interventions are encouraged to emphasize high-quality, highly-effective provider and client approaches that provide a broad range of contraceptive information, methods, and services in ways that help clients choose and correctly use the contraceptives that meet their lifestyle and reproductive needs for delaying, spacing, or limiting childbearing. Social and behavior change communications messages should be coordinated with and reinforce service delivery efforts. Interventions should focus on reaching underserved groups and reducing inequities to contraceptive access. Special target populations could include youth, young married (below age 18) women, post-partum women, post-abortion clients, and rural, urban and peri-urban poor populations). Particular attention should be given to implementing and scaling-up proven and promising service delivery FP High Impact Practices[1]. Programs will:

1 Promote interventions that increase access to high-quality family planning counseling and services. This may include but is not limited to: improved FP in static clinics, mobile outreach*, social marketing*, drug shops and pharmacies*, social franchising, and community based family planning*.

2 Where relevant, integrate FP into existing service delivery platforms. This could include maternal, child and newborn health services such as FP/immunization*, postabortion FP*, and postpartum family planning.

3 Strengthen the enabling environment for service delivery through select interventions including advocacy and policy,* supply chain management*, social and behavior change communication*, and financing*.

* Throughout this FP section, Family Planning High Impact Practices are noted with an asterisk. More information on the Family Planning High Impact Practices can be found on the High Impact Practices Website: http://www.fphighimpactpractices.org/.

Element: Nutrition

Nutrition activities are primarily directed towards pregnant women and children under the age of five with emphasis on the "1,000-day" window from pregnancy to a child's second birthday. Nutrition-specific activities should target populations or geographic areas of the country in Global Health Initiative priority areas and Feed the Future 'zones of influence'.

[11] Throughout this FP section, Family Planning High Impact Practices are noted with an asterisk. More information on the Family Planning High Impact Practices can be found on the High Impact Practices Website: http://www.fphighimpactpractices.org/

Sub-Elements: Individual Prevention Programs and Population-based Nutrition Service Delivery (including micronutrient supplementation)

In reaching the goals of the USAID Multi-sectoral Nutrition Strategy, Applicants are encouraged to include: 1) Appropriate infant and young child feeding including immediate breastfeeding within first hour after birth and exclusive breastfeeding through six months, appropriate and timely complementary feeding (as measured by 'minimum acceptable diet') with continued breastfeeding through age two, with promotion of early childhood care and development; and 2) Maternal and child micronutrient supplementation including iron and folic acid supplementation for pregnant women, and vitamin A supplementation for children 6-59 months, and other micronutrients, as appropriate. Population-based service delivery programs should support delivery of nutrition services through existing primary health care systems and community based management of acute malnutrition. In particular, emphasis should be placed on integration of nutrition activities to enhance systems within MNCH, family planning and other platforms supported by USAID.

Sub-Element: Nutrition Enabling Environment and Capacity

Applicants are encouraged to focus on institution and policy strengthening, including advocacy for greater government commitment to nutrition as well as capacity strengthening of government and private institutions in order to effectively assess, plan, design, manage, monitor and evaluate nutrition programs. In many cases, greater political will and multi-sectoral stakeholder engagement (including public and private sector) is essential to increase commitment to nutrition goals.

Annex 4 – Country-Specific Requirements

If submitting a concept paper with efforts in one of the following 24 MCH priority countries, Applicants must be aware of and comply with the information following the table below.

Country	MCH	Family Planning	Malaria/PMI	HIV/AIDS PEPFAR	Nutrition	FFP	FtF	WASH
Afghanistan	X	X				X*		X
Bangladesh	X	X		X	X	X	X	X
DR Congo	X	X	X	X	X	X		X
Ethiopia	X	X	X	X	X	X	X	X
Ghana	X	X	X	X	X		X	X
Haiti	X	X		X	X	X	X	X
India	X	X		X				X
Indonesia	X			X				X
Kenya	X	X	X	X	X	X*	X	X
Liberia	X	X	X	X		X	X	X
Madagascar	X	X	X	X		X		
Malawi	X	X	X	X	X	X	X	X
Mali	X	X	X		X	X	X	X
Mozambique	X	X	X	X	X		X	X
Nepal	X	X		X	X		X	X
Nigeria	X	X	X	X				X
Pakistan	X	X				X*		X
Rwanda	X	X	X	X	X		X	X
Senegal	X	X	X	X	X		X	X
South Sudan	X	X	X	X		X*		X
Tanzania	X	X	X	X	X		X	X
Uganda	X	X	X	X	X	X	X	X
Yemen	X	X				X*		X
Zambia	X	X	X	X	X		X	X

*These are Food for Peace countries with only emergency programs with World Food Programme and/or UNICEF.

Nutrition and Food for Peace Funding Parameters

Malnutrition is an underlying cause of 45% of under five deaths. In Nutrition and FFP focus countries, concept papers/applications with nutrition components must complement existing nutrition, health or food security and water supply, sanitation and hygiene efforts, as appropriate. Inadequate access to clean water and unsafe sanitation and hygiene practices increase the risk of pathogen exposure and severe infectious diseases, major contributors to child malnutrition. In FFP countries, concept papers/applications for integrating community health approaches and systems strengthening in countries where there are FFP development or emergency programs must be developed and implemented in coordination with FFP's focus on vulnerable populations and in coordination with USAID mission and Washington FFP efforts. In Feed the Future focus (FTF) countries, concept papers/applications should emphasize synergies or complementarity

with Feed the Future strategies and existing efforts supported by USAID FTF missions. Additional information and technical guidance on which technical interventions and programs to emphasize at the community, policy and private sector level can be found in the USAID Multi-Sectoral Nutrition Strategy and accompanying technical reference materials available at: http://www.usaid.gov/nutrition-strategy.

Malaria Funding Parameters

In PMI countries, concept papers/applications with malaria components must be developed and implemented in collaboration with PMI efforts and priorities in country, which are based on close planning with National Malaria Control Programs (NMCPs). See the PMI website at www.pmi.gov for more information, including annual PMI country malaria operational plans for each PMI country. Technical resources on behavior change are available at www.pmi.gov/technical/bcc/index.html. In all countries, projects should be consistent with NMCP strategies and approaches. In addition, in PMI-countries, partners should seek to reinforce local and community-led initiatives that target malaria prevention and control, including promotion of the use of bed nets and case management in health facilities and at the community level.

Family Planning Funding Parameters

Voluntary family planning enables a woman to delay, time, space, and limit her pregnancies allowing women to bear children at the healthiest times of their lives and ensuring healthier maternal, newborn, and child outcomes. By reducing the number of unintended pregnancies and births, fewer women, infants, and children are exposed to pregnancy-related health risks, including pregnancies that occur during high risk periods, (e.g. too early or late in age, too closely spaced together, or are too high in parity). All women, including adolescent girls, should have the information and access to services that allow them to choose whether and when to become pregnant. In Family Planning focus countries, concept papers/applications with family planning components must abide by all USG Family Planning policy and compliance requirements, complement local government policies & guidelines, and work in collaboration with other donor-funding national family planning efforts. A concept paper/application that integrates family planning must increase access to high-quality voluntary family planning services and information, making referrals where appropriate, and should aim to expand method choice, such as increasing access to long-acting and reversible methods. Technical resources on family planning can be found in the Facts for Family Planning booklet at: http://www.fphandbook.org/factsforfamilyplanning.

HIV/AIDS Funding Parameters

In PEPFAR countries, concept papers/applications with HIV components must be aligned with national HIV plans and are complimentary to PEPFAR in-country strategic approaches and programs. Concept papers/applications with HIV components must support capacity building and sustainability of community led programs for prevention messages and services that ensure all reached are tested and that all positive persons identified are linked to care and treatment with pro-active follow-up for retention in care and adherence to treatment. Additionally, concept papers/applications must be aligned with the PEPFAR HRH strategy objectives, which, focus on both clinical and community-based workers such as CHWs that are integral for clients HIV continuum of care.

WASH Funding Parameters

In focus countries for the Water Strategy, concept papers/applications with WASH components must complement existing water supply, sanitation and hygiene efforts. The first Strategic Objective (SO1) of the Strategy seeks to improve health outcomes through the provision of sustainable water supply, sanitation, and hygiene (WASH). For countries receiving funds under the water directive, activities must support the achievement of the three intermediate results (IRs) included under SO1:

- IR1.1 – Increase first time and improved access to sustainable water supply
- IR1.2 – Increase first time and improved access to sustainable sanitation
- IR1.3 – Increase adoption of key hygiene behaviors

Additional information and technical guidance on which technical interventions and programs meet the requirements of the water directive can be found in the USAID Water And Development Strategy Implementation Field Guide available at: (http://www.usaid.gov/sites/default/files/documents/1865/Strategy_Implementation_Guide_web.pdf)

Appendix A – Grants.gov Registration Process

Before submitting an application under this APS, it is highly recommended that applicants read the entire Section IV, Application and Submission Information in this APS. Reviewing these sections thoroughly will assist an Applicant in submitting a complete, full application.

Register Online at Grants.gov

New Applicants Applying to Grants.gov:

It is **strongly encouraged** that new organizations immediately begin the 5-step Grants.gov registration process (listed below), while simultaneously completing the application package. The registration process may take up to two weeks to complete. USAID understands that delays in the registration process may be beyond your control. If an organization has begun the registration process but experiences delays that make it difficult for to meet the application deadline, contact the APS POC(s) who will work with you to find a solution. If an organization is having difficulties, contact the Agency POC(s) listed in the APS as soon as possible.

Register as an organization on Grants.gov if you are not already registered. All organizations must register. See below for a brief overview of the registration steps. Grants.gov is also available to lead you through the process.

STEP 1: Obtain a Data Universal Number (DUNS)

The Data Universal Number System **(DUNS)** number is a unique nine-character number that identifies your organization. It is a tool of the federal government to track how federal money is distributed. Most large organizations, libraries, colleges and research universities already have DUNS numbers. Ask your grant administrator or chief financial officer to provide your organization's DUNS number or search online by using the DUNS search.

If your organization does *not* have an existing DUNS number, you will need to request one. You can request a DUNS Number here.

STEP 2: Register Your Organization with the System for Awards Management (SAM)

You must also register with SAM. SAM is the primary registrant database for the U.S. Federal Government. SAM collects, validates, stores and disseminates data about the federal government's trading partners in support of the contract award, grants and the electronic payment processes.

STEP 3: Username and Password

If your organization's E-Business Point of Contact (E-Biz POC) has assigned you Authorized Organization Representative (AOR) rights,

you are authorized to submit grant applications on behalf of your organization. AORs must create a username and password to serve as their "electronic signature" when submitting an application on behalf of their organization. To register as an AOR and create a username and password, go to: https://apply07.grants.gov/apply/OrcRegister

STEP 4: AOR Authorization
Your E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the "MPIN" password obtained in Step 2) and approve the AOR, thereby giving permission to submit applications. When an E-Biz POC approves an AOR, Grants.gov will send the AOR a confirmation email that includes the requesting AOR's name, e-mail address and phone number. In some cases the E-Biz POC can also be the AOR for an organization. If the E- Biz POC wishes to submit applications on behalf of their organization, he or she must also complete a separate AOR profile with username and password (Step 3 of the registration process) using a different email than the one used for their E-Biz POC registration.

STEP 5: Track AOR Status
To verify that your organization's E-Biz POC has approved you as an AOR, please track your status. You cannot apply for grants without E-Biz POC approval.

For questions, please consult:
- Organization Registration User Guide
- Organization Registration Checklist
- Grants.gov Contact Center: 1-800-518-4726 or support@grants.gov. Hours of Operation: 24 hours a day, 7 days a week.

If you are concerned that you will not finish your SAM registration in time to meet the overall application deadline, contact the USAID POC(s) listed in Section VII who will work with you to find a solution. If an organization is having difficulties, contact the Agency POC(s) listed in Section VII above as soon as possible.

Appendix B – Past Performance Form

PAST PERFORMANCE SUMMARY
1. Information Provided in Response to APS No:
2.Applicant:
PART I: Award Information
3. Awarding Organization:
4. Awardee Organization Reference Name, Title, Email Address and Phone Number: (individual completing this questionnaire who is the equivalent of a USAID AOR or AO) Name: Title: Email Address: Phone Number:
5. Award Number:
6. Award Has a Completed CPARS Report in PPIRS (Yes or No – only for contracts):
7. Award Type:
8. Award Value:
9. Description of Work/Services:
10. Problems: (if problems encountered on this award, explain corrective action taken)

Appendix C – Initial Environmental Examination

PROGRAMMATIC INITIAL ENVIRONMENTAL EXAMINATION (PIEE)
Accelerating Community Health Impact through Empowerment and Voice for Equity (ACHIEVE)

TABLE OF CONTENTS

ACRONYM LIST

ACHIEVE	Accelerating Community Health Impact through Empowerment and Voice for Equity
AIDS	Acquired Immune Deficiency Syndrome
APS	Annual Program Statement
AO	Agreement Officer
AOR	Agreement Officer's Representative
BCC	Behavior Change and Communication
BEO	Bureau Environmental Officer
CBO	Community-based organization
CFR	Code of Federal Regulations
CO	Contracts Officer
DPT	Diphtheria, Pertussis, Tetanus
EMMP	Environmental Mitigation and Monitoring Plan
EMMR	Environmental Mitigation and Monitoring Report
FP	Family Planning
FY	Fiscal Year
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
GH	Bureau for Global Health
HCW	Healthcare waste
HIDN	Health, Infectious Diseases and Nutrition
HIV	Human Immunodeficiency Virus
HTC	HIV/AIDS Testing and Counseling
IEC	Information, Education, and Communication
IEE	Initial Environmental Examination
MNCH	Maternal, Newborn, and Child Health
M&E	Monitoring and Evaluation
MEO	Mission Environmental Officer
MSDS	Materials Safety Data Sheet
NGO	Non-governmental Organization
ORS	Oral rehydration salt
PEPFAR	President's Emergency Fund for AIDS Relief
PIEE	Programmatic Initial Environmental Examination
PMTCT	Preventing Mother-to-Child Transmission
REO	Regional Environmental Officer
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SIEE	Supplemental Initial Environmental Examination
TA	Technical Assistance
TB	Tuberculosis
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

PROGRAMMATIC INITIAL ENVIRONMENTAL EXAMINATION (PIEE)
Accelerating Community Health Impact through Empowerment and Voice for Equity (ACHIEVE)

PROGRAM/ACTIVITY DATA

PIEE Number:	GH-14-XX
Program/Activity Title:	Accelerating Community Health Impact through Empowerment and Voice for Equity (ACHIEVE)
Country/Region:	Global
Functional Objective:	Investing in People
Program Area:	Health
Program Elements:	Maternal and Child Health, Malaria, Nutrition, Family Planning/ Reproductive Health, HIV/AIDS

1.0 BACKGROUND AND ACTIVITY AND PROGRAM DESCRIPTION

1.1 Purpose and Scope of PIEE

The purpose of this Programmatic Initial Environmental Examination (PIEE) is to review the activities foreseen under the Accelerating Community Health Impact through Empowerment and Voice for Equity (ACHIEVE) portfolio and their potential environmental impact, and provide threshold determinations of environmental impact and conditions for prevention or mitigation of negative environmental impacts. ACHIEVE encompasses a series of grants and cooperative agreements under an Annual Program Statement (APS) with the aim to strengthen community engagement and empowerment in local health policies and systems to improve responsiveness and achieve equitable coverage of high impact health interventions in high burden populations.

In addition, this PIEE sets out procedures intended to assure that the conditions detailed in this PIEE are translated into activity-specific mitigation measures, and to assure systematic compliance with this PIEE during activity and project implementation and reporting. These procedures are themselves a general condition of approval for the PIEE, and their implementation is therefore mandatory.

This PIEE is a critical element of a mandatory environmental review and compliance process meant to achieve environmentally sound activity design and implementation.

1.2 Program Background (Context and Justification)

Challenge and Opportunity

Developing countries have made significant progress during the past two decades in reducing preventable child and maternal deaths and decreasing the incidence of HIV infections and AIDS related mortality. The total number of child deaths fell by 48% (from 12.6 million in 1990 to 6.6 million in 2012) and total number of maternal deaths decreased by 45% (from 523,000 in 1990 to 289,000 in 2013). The number of people newly infected with HIV/AIDS decreased by 21% (between 2001-2011). This success has resulted in the development of more ambitious goals,

supported by both USAID and developing countries: ending preventable child and maternal deaths (< 20 child deaths per 1,000 live births; <70 maternal deaths per 100,000 live births by 2035) and creating an AIDS Free Generation (elimination of new HIV infections among children by 2015 and keeping their mothers alive).

In despite this progress, several countries are not on track to achieve the Millennium Development Goals. Gaps in effective coverage of high impact interventions persist along the continuum of care across the 24 priority countries, with widening disparities in some cases[3].

Governments and non-state actors have pledged their commitment to support a new, more effective approach to accelerate progress in health by investing in and supporting strategic shifts in national plans which include: reaching the most underserved populations; scaling up high impact innovations; investing beyond health programs to include empowering women and supporting an enabling environment for health; and creating transparency and mutual accountability at all levels.

While a growing evidence base demonstrates that community health approaches are effective, improve equity, and are scalable, political commitment, adequate resources, and coordinated country action between government and non-state actors to scale up community health approaches as a part of national plans remains weak[4]. Particularly in the context of decentralization of governance to districts and sub-districts, it is critical to support countries in increasing both the political will and future investment of resources in a range of community health approaches through inclusive partnerships for learning and action between governments, non-state actors and empowered communities. These approaches can contribute to accelerating progress by improving equitable access to quality services; facilitating household and community behavior change; and enabling communities and local civil society to generate and use new data to track progress and strengthen mutual accountability.

Project Goal, Purpose, and Results

The goal of this project is to support countries in achieving and sustaining effective coverage[5] of high impact interventions at scale in order to accelerate progress towards ambitious health goals. Its purpose is to strengthen the role of community health approaches in diverse systems (public, private, NGO) to support national policies and sharpened plans. This purpose will complement and support broader government efforts to strengthen the reach and responsiveness of health systems and promote household and community behavior change. USAID will invest in generating evidence and learning to promote the uptake of community health approaches that strengthen community engagement in the following areas: 1.) delivery (equitable access, quality, demand); 2.) community empowerment and voice for health and development; and 3.) delivery

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[3] Countdown 2015: http://www.countdown2015mnch.org/countdown-highlights

[4] Perry H et al. Prospects for Effective and Scalable Community-Based Approaches to Improve Reproductive, Maternal, Newborn, and Child Health (RMNCH): A Summary of Experiences from the Maternal and Child Health Integrated Program (MCHIP) and the Child Survival and Health Grants Program (CSHGP) and a Review of the Evidence. Jhpiego. Baltimore, MD, 2014.

[5] The Tanahashi definition of effective coverage is defined as the proportion of the population in need of an intervention that receives an effective intervention, a definition that is posed in equity terms since its denominator is need.

oversight, governance, and accountability. USAID and governments across the 24 priority countries are currently not sufficiently investing in improving and expanding community approaches to accelerate progress in health. Across the priority countries, community health approaches are a weak component of scale up plans or not considered responsibility of government. This strategic focus also supports identified priorities focusing on community engagement across USG/USAID supported initiatives, strategies and visions for health and local systems[6].

USAID recognizes that this purpose cannot be achieved without harnessing the expertise, capacity and resources (in-kind or cash) of a range of partners capable of supporting and influencing governments and non-state actors across the 24 priority countries. Partners with expertise and program resources in community health will test the integration of approaches within health and local systems; build local capacity to generate and transfer new knowledge from the community to higher levels of the system to support decision-making needs; and, develop effective models of collaboration and coordination between governments, civil society, and the private sector. The project is poised to create new opportunities to learn about community engagement across USG/USAID strategic initiatives and health elements alongside USAID's flagship maternal and child survival project.

By investing in this project, USAID will improve the capacity of governments, civil society, and private sector actors to develop effective partnerships with communities and harness community resources to support achievement of results across the 24 priority countries. USAID will achieve the following results:

- *Institutionalization of Community Health Approaches in National and Local Systems, Policies, and Plans*
- *Generation and Use of New Data for Decision-Making*
- *Improved Coordination and Collaboration Between Government and Non-State Actors*
- *Improved norms and behaviors, particularly at the family and community level*
- *Equitable coverage of high impact interventions at scale improved*

Four annual program statements, drafted to ensure that eligible applicants support the overall purpose and objectives, are anticipated, with each resulting in about 8 awards (cooperative agreements). Four rounds of awards (approximately 8 awards with a total estimated cost of $10 million; consisting of two types of award ceiling levels: up to $1 million and up to $3 million) with core funds are planned.

1.3 Technical Elements

In order to increase to accelerate progress towards ending preventable child and maternal deaths, efforts must include communities as resources to influence and strengthen high-impact interventions within the health system, and sustain reductions in mortality as we address the broader context of health.

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[6] President's Emergency Plan for AIDS Relief (PEPFAR); President's Malaria Initiative (PMI); Every Newborn Action Plan (WHO); USAID Multi-Sectoral Nutrition Strategy (2014-2025); USAID Maternal Health Vision for Action (2014-2020); Global Plan to Stop TB (2011-2015); USG Evidence Summit on Community Health Worker Performance; USG Population-Level Behavior Change Evidence Summit for Global Health; Food for Peace; USAID Local Systems: A Framework for Supporting Sustained Development

The ACHIEVE portfolio of project activities encompass numerous technical areas in the Reproductive, Maternal, Newborn, and Child Health (RMNCH) arena. These technical areas are consistent with the priority strategic areas include the following: maternal, newborn and child health; immunization; healthy timing and spacing of pregnancy and postpartum family planning; maternal anemia, breastfeeding, complementary feeding; health systems strengthening (quality improvement, health workforce, community health workers, health information systems, behavior change communication). Activities under this PIEE will also link to family planning and reproductive health programs, health systems strengthening, nutrition, water sanitation and hygiene, HIV/AIDS, and malaria.

Within the abovementioned technical areas, ACHIEVE project activities consist largely of participatory processes which may include: education, training, technical assistance/capacity building, communication, and information transfer that have no physical interventions and therefore, no direct adverse effects on the environment. With required leverage, ACHIEVE implementers may leverage program platforms that conduct complementary activities to strengthen the implementation of the aforementioned activities, enable healthy behaviors, and further improve health outcomes, such as procurement and distribution of relevant public health commodities, including vaccinations, nutritional supplements, select pharmaceuticals, and insecticide treated nets; training of professional and paraprofessional health care workers in methods that may result in generation and disposal of hazardous waste; small-scale water/sanitation activities (such as the digging of wells and latrines); small-scale gardening/farming activities; and on rare occasions, small-scale rehabilitation of health facilities.

2.0 COUNTRY AND ENVIRONMENTAL INFORMATION

This PIEE covers the global ACHIEVE project activities. Specific country-level information, including environmental regulations and conditions, project activities and monitoring of prevention and mitigation efforts, and reporting, will be detailed in annual Environmental Mitigation and Monitoring Plans (EMMP) (Annex B), and annual Environmental Mitigation and Monitoring Reports (EMMR) (Annex C) that reference this PIEE.

3.0 EVALUATION OF POTENTIAL ENVIRONMENTAL ISSUES

Many of the ACHIEVE activities do not have direct adverse environmental impacts, as they entail technical assistance/capacity building, information, education, communication, training, research, community mobilization, planning, management, and outreach activities. These activities are detailed in Table 1.

Certain activities indirectly supported under ACHIEVE, through implementers' required leverage, however, may directly or indirectly affect the environment, or have the potential to do so. Based on the analysis conducted by the AOR these activities could affect the environment in five ways:

1) Procurement, storage, management and disposal of public health commodities, including pharmaceutical drugs, immunizations and nutritional supplements, laboratory supplies and reagents.
2) Training professional and paraprofessional health care workers in methods that result in the generation and disposal of hazardous or highly hazardous medical waste (e.g., basic

and emergency obstetric care techniques, administration of injectables, HIV or TB testing, malaria diagnosis, etc.)
3) Small-scale water and sanitation activities (such as covered wells and latrines)
4) Small scale gardening/farming activities
5) Small-scale rehabilitation of health facilities

Each of these potential impacts is discussed in detail below, and summarized in Table 2 at the end of this section.

3.1 Procurement, Storage, Management and Disposal of Public Health Commodities
This activity includes procurement of pharmaceutical drugs and vaccines, family planning products and condoms, personal protective gear, laboratory and medical supplies, and basic medical equipment.

Pharmaceutical drugs are chemicals used for diagnosis, treatment (cure/mitigation), alteration, or prevention of disease, health condition, or structure/function of the human body. Pharmaceuticals including vaccines have specific storage time and temperature requirements, and may expire or lose efficacy before they are able to be used, particularly in remote areas where demand is low and/or infrequent. Pharmaceutical waste may also accumulate due to inadequacies in stock management and distribution, and lack of a routine system of disposal.

The effects of pharmaceuticals in the environment are different from conventional pollutants. Drugs are designed to interact within the body at low concentrations to elicit specific biological effects in humans, and which may also cause biological responses in other organisms. There are many drug classes of concern, including antibiotics, antimicrobials, antidepressants, and estrogenic steroids. Their main pathway into the environment is through household use and excretion, and through the disposal of unused or expired pharmaceuticals.

Effects on aquatic life are a major concern in disposal of pharmaceuticals. A wide range of pharmaceuticals have been discovered in fresh and marine waters globally, and even in small quantities some of these compounds have the potential to cause harm to aquatic life. Exposure risks for aquatic organisms are much larger than those for humans, because aquatic organisms have continual (and multi-generational) exposures, explores to higher concentrations, and possible low-dose effects.

Traditional environmental toxicology focuses on acute effects of concentrated exposures rather than chronic effects of low level exposures. Measured toxicities of some tested pharmaceuticals have shown that acute effect of single substances in the aquatic environment is very unlikely. However, effects of pharmaceuticals may be subtle because they occur in the environment in low concentrations. Some tests with combinations of various pharmaceuticals have revealed stronger effects than expected from the effects measured singly. More research is need on combination effects and chronic studies are needed to assess the environmental risk of drug residues. Certainly pollution prevention (e.g., source elimination or minimization) is preferable to remediation or restoration to minimize both public cost and human/ecological exposure.

Antibiotics and undiluted disinfectants should not be disposed of into the sewage system as they may kill bacteria necessary for the treatment of sewage. Additional health risks related to disposal include burning pharmaceuticals and plastic medical supplies at low temperatures or in open containers results in release of toxic pollutants into the air, and inefficient and insecure sorting and disposal may allow drugs beyond their expiry date to be diverted for resale to the general public. In some countries scavenging in unprotected insecure landfills is a hazard.

The other commodities covered under this activity are not associated with major health risks, including packaging material, and should be disposed of as solid waste.

References for this section include:
http://www.who.int/water_sanitation_health/medicalwaste/pharmaceuticals/en/
Pharmaceuticals In The Environment: Sources, Fate, Effects And Risks (2nd ed). 2004. Klaus Kümmerer, ed (online version).

3.2 Training professional and paraprofessional health care workers in methods that result in the generation and disposal of hazardous or highly hazardous medical waste
Small-Scale healthcare initiatives, such as rural health posts or clinics, mobile clinics, urban clinics and small hospitals, and community health workers provide important and often critical healthcare services to individuals and communities that would otherwise have little or no access to such services. These health workers working in these underserved contexts are the front line of defense against epidemics such as HIV, TB and a key component of any comprehensive health development program. The medical and health services they provide improve newborn, child and maternal health, prevent disease, cure debilitating illnesses, and alleviate the suffering of the dying.

However, improper handling, storage and disposal of the waste generated in these facilities or activities can spread disease through several mechanisms. Transmission of disease through infectious waste is the greatest and most immediate threat from healthcare waste. If waste is not treated in a way that destroys the pathogenic organisms, dangerous quantities of microscopic disease-causing agents—viruses, bacteria, parasites or fungi—will be present in the waste. These agents can enter the body through punctures and other breaks in the skin, mucous membranes in the mouth, by being inhaled into the lungs, being swallowed, or being transmitted by a vector organism. Those who come in direct contact with the waste are at greatest risk. Examples include healthcare workers, cleaning staff, patients, visitors, waste collectors, disposal site staff, waste pickers, substance abusers and those who knowingly or unknowingly use "recycled" contaminated syringes and needles. Although sharps pose an inherent physical hazard of cuts and punctures, the much greater threat comes from sharps that are also infectious waste. Healthcare workers, waste handlers, waste-pickers, substance abusers and others who handle sharps have become infected with HIV and/or hepatitis B and C viruses through pricks or reuse of syringes/needles.

Contamination of water supply from untreated healthcare waste can also have devastating effects. If infectious stools or bodily fluids are not treated before being disposed of, they can create and extend epidemics. The absence of proper sterilization procedures is believed to have increased the severity and size of cholera epidemics in Africa during the last decade.

Healthcare wastes generally fall into three categories in terms of public health risk and recommended methods of disposal:

- ***General*** healthcare waste, similar or identical to domestic waste, including materials such as packaging or unwanted paper. This waste is generally harmless and needs no special handling; 75–90% of waste generated by healthcare facilities falls into this category, and it can be burned or taken to the landfill without any additional treatment.
- ***Hazardous*** healthcare wastes including infectious waste (except sharps and waste from patients with highly infectious diseases), small quantities of chemicals and pharmaceuticals, and non-recyclable pressurized containers. All blood and body fluids are potentially infectious.
- ***Highly hazardous*** healthcare wastes, which should be given special attention, includes sharps (especially hypodermic needles), highly infectious non-sharp waste such as laboratory supplies, highly infectious physiological fluids, pathological and anatomical waste, stools from cholera patients, and sputum and blood of patients with highly infectious diseases such as TB and HIV. They also include large quantities of expired or unwanted pharmaceuticals and hazardous chemicals, as well as all radioactive or genotoxic wastes.

If a project's training activities for professional health workers or community health workers involve techniques that would generate and require disposal of hazardous or highly hazardous waste, the Implementing Partners shall be required to include training in or ensure that the training curriculum covers best management practices concerning the proper handling, use, and disposal of medical waste, including blood, sputum, and sharps.

As appropriate, the implementing partners will work with facility, local, regional and/or national officials, to implement and apply appropriate best management practices which incorporate appropriate health and safety measures and environmental safeguards, including proper disposal of medical waste in accordance with international norms as spelled out by the WHO in "WHO's Safe Management of Wastes from Healthcare Activities." National policies and laws should also be considered, though most countries follow WHO Guidelines.

References for this section include:
http://www.who.int/water_sanitation_health/medicalwaste/167to180.pdf
http://www.bchealthguide.org/healthfiles/hfile29.stm
Safe management of wastes from health-care activities, edited by A. Prüss, E. Giroult and P. Rushbrook. Geneva, WHO, 1999,
http://www.who.int/water_sanitation_health/Environmental_sanit/MHCWHanbook.htm. English
EGSSAA Chapter 8, "Healthcare Waste: Generation, Handling, Treatment and Disposal" (http://www.encapafrica.org/EGSSAA/Word_English/medwaste.doc) for additional guidance on proper handling and disposal of medical waste.

3.3 Small-Scale Water and Sanitation Activities

All small-scale water and sanitation activities such as the digging of wells or creation of latrines should be conducted with good design and implementation practices and with consideration of protecting human health and the surrounding environment.

Some potential environmental impacts are possible with these interventions, and will depend on the local circumstances, including:

Water Supply

- Improper siting of facilities that damages or destroys natural ecosystems (within wetlands, protected areas, or other sensitive habitats, etc.)
- Depletion or degradation of local or downstream freshwater resources (surface and groundwater)
- Creation of stagnant (standing) water near water points that could create breeding opportunities for water-borne disease vectors
- Natural or human-caused biological or chemical contamination of water sources (surface and groundwater), causing increased human health risks, including:
- High arsenic or other mineral/chemical levels
- Poor management of water points and/or poor design of pipes leading to leakage and contamination of water with fecal matter, solid waste, etc.

Sanitation

- Increased human health risks from contamination of surface water, groundwater, soil, and food by human waste and disease pathogens
- Degradation of surface and groundwater quality and land habitats due to inappropriate siting or construction of latrines or wastewater collection systems, or release of human waste from sanitation facilities
- Defecation around locked or unusable latrines or other sanitation facilities, potentially contaminating surface water and/or shallow groundwater sources, adversely affecting both human and ecosystem health
- Damage to the aesthetics of the sanitation facility site (visual, smell, etc.)

Reference for this section is
USAID Sector Environmental Guidelines: Water Supply and Sanitation
(http://www.usaidgems.org/Sectors/watsan.htm).

3.4 Small-Scale Gardening and Farming Activities

Small scale gardening/farming activities should be conducted considering minimum impact to local habitat, avoiding introduction of non-native species and genetically modified organisms, and protecting human exposure to animal waste and viruses.

Some potential environmental impacts are possible with these interventions, and will depend on the local circumstances, including:

- Ecological and Human Health-Surface water nitrification/eutrophication due to excrement flowing into streams, ponds, and other water sources which can affect the health of aquatic species and drinking water quality.

- Ecological and Human Health-introduction of non-native species may cause unwanted competition, predation etc. on native species. Non-native or non-regional species may compete with species that are naturalized (more likely to thrive) and critical to existing community food sources.
- Ecological-destruction of habitat critical to the survival of threatened and endangered species, or habitats that support those species survival.
- Human health exposure to parasites in animal excrement.
- Human health exposure to viruses such as H5N1 and others.

3.5 Small-scale Rehabilitation of Health Facilities

Small-scale rehabilitation of health facilities should be conducted considering minimum impact to the physical and social environment surrounding the health facilities, use of appropriate and non-hazardous materials, and appropriate disposal of old or unused materials in the rehabilitation process. Construction of health facilities is beyond the scope of this IEE.

Some potential environmental impacts are possible with these interventions, and will depend on the local circumstances, including:

- Contamination of groundwater and surface water supplies through improper disposal of human and other biological wastes during the rehabilitation period
- Contamination of ground and surface water supplies through improper disposal or handling of toxic materials used in rehabilitation (e.g., solvents, paints, vehicle maintenance fluids (oil, coolant), and diesel fuel)
- Adverse social impacts due to displacement of local inhabitants, influx of outside workers, inequitable distribution of economic benefits of rehabilitation, etc.
- Damage to aesthetics of site/area
- Improper extraction of rehabilitation materials such as wood, stone, gravel, or clay that damages terrestrial ecosystems (e.g., wood may come from relatively intact or natural forests)
- Use of toxic materials during rehabilitation, such as lead paint.

Reference for this section is:
USAID Sector Environmental Guidelines on Construction, as the guidelines are appropriate for rehabilitation activities (http://www.usaidgems.org/Sectors/construction.htm).

Table 1: ACHIEVE Activities Not Likely To Have An Adverse Effect On The Environment

(activities covered by the following citations in Reg. 216, by subparagraph of 22 CFR 216.2(c) (2): (i); (iii); (v); (viii); (xi); (xiv) except to the extent the activities directly affect the environment)

Education, Technical Assistance, or Training

Develop or strengthen capacity of the community to identify problems, develop solutions, and monitor progress
Provide information, education and communication (IEC), including household and community mobilization
Provide IEC aimed to support appropriate health seeking behavior and increasing early and effective treatment
Provide technical assistance and training to ministries of health to integrate community centered approaches into policy and practice

Analysis, Program Evaluation, Workshops and Meetings

Conduct participatory needs assessments (may include surveys, focus groups, community mapping, and other methods)
Carry out analyses and document process information (implementation science) on topics relevant to health service delivery, engaging and strengthening local research capacity and health information systems when possible
Gather, process, manage, and evaluate program data
Monitor and evaluate project progress and impacts and uptake

Document and Information Transfers

Conduct media campaigns
Develop and/or distribute educational materials on relevant health sector topics
Develop and disseminate lessons learned and best practices

Programs involving health care or services, except where directly affecting the environment

Establish and/or build capacity of health committees, community-based organizations, community health volunteers, and/or local government officials
Provide sound and credible information in a usable form and strengthen local health information systems for decision making, planning, and management, including documents and maps
Facilitate the active and positive engagement of the private sector

Studies, projects or programs intended to develop the capability of recipient countries and organizations to engage in planning

Facilitate participatory sustainable health services planning efforts with the involvement of all stakeholders
Facilitate and provide technical assistance for supply chain management and strategic planning with regard to systems
Develop or strengthen the capacity of governments, NGOs, academic institutions, etc. to collect, process and manage health or other relevant information for decision-making
Carry out advocacy campaigns for policy reform

Table 2: ACHIEVE Activities with Potential Negative Environmental Impacts					
Investing in People: Health Program Areas	**Procurement, Storage, Management and Disposal of Public Health Commodities**	**Training in methods that could result in generation, and need for disposal of hazardous and highly hazardous medical waste (as defined in Section 3 of this IEE)**	**Small-Scale Water and Sanitation**	**Small-Scale Gardening/farming**	**Small-Scale Rehabilitation of health facilities**
Maternal and Child Health, Family Planning	• Laboratory reagents and supplies • Micronutrient supplements • Antibiotics • Vaccines • Other pharmaceuticals • Contraceptives/condoms	• Generation of sharps • Generation of hazardous and highly hazardous medical waste, including blood.	• Construct or rehabilitate latrines at individual households, schools, communities, or health facilities. • Create covered wells for safe drinking water in communities or individual households. • Construct or rehabilitate hand washing stations, laundry facilities, public showers, latrines, and wastewater and drainage at health facilities, training centers or laboratories.	• Increase accessibility and availability year round of micronutrient-rich foods for consumption • Create new or support existing home gardens • Improve agricultural practices to increase yield and protect environment	• Rehabilitate hospitals, clinics, labs or training centers
HIV/AIDS	• HIV test kits • ARVs • Nutritional supplements				

Table 2: ACHIEVE Activities with Potential Negative Environmental Impacts					
Investing in People: Health Program Areas	**Procurement, Storage, Management and Disposal of Public Health Commodities**	**Training in methods that could result in generation, and need for disposal of hazardous and highly hazardous medical waste (as defined in Section 3 of this IEE)**	**Small-Scale Water and Sanitation**	**Small-Scale Gardening/farming**	**Small-Scale Rehabilitation of health facilities**
	• Condoms				
Malaria	• Antimalarial drugs • Packing materials for products				

4.0 RECOMMENDED DETERMINATION AND CONDITIONS FOR IMPLEMENTATION

Based on the analysis presented above in Section 3, this IEE recommends threshold decisions for activities implemented under ACHIEVE. The conditions for implementation are presented below. USAID/GH acknowledges that the environmental screening and review procedures described here do not substitute for the recipient country's own environmental laws and policies.

The overall threshold determination for activities implemented under ACHIEVE is a **Negative Determination, with conditions**.

I. Activities presented in Section 3. Table 1 of this document

A **Categorical Exclusion** is recommended for the activities presented in Table 1 in Section 3 of this document, because no environmental impacts are expected as a result of these activities. These fall under the following citations from Title 22 of the Code of Federal Regulations, Regulation 216 (22 CFR 216), subparagraph 2(c)(2) as classes of activities that do not require an initial environmental examination:

(i) Activities involving education, training, technical assistance or training programs except to the extent such programs include activities directly affecting the environment (such as construction of facilities, etc.);

(iii) Activities involving analyses, studies, academic or research workshops and meetings;

(v) Activities involving document and information transfers;

(viii) Programs involving nutrition, health care, or family planning services except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.); and

(xiv) Studies, projects or programs intended to develop the capability of recipient countries and organizations to engage in development planning.

Conditions:

No environmental impacts are expected from these activities.

If the topic of these training activities is one that trains health care workers in methods that will generate hazardous or highly hazardous medical waste, HIV and/or TB testing, then the training should include information on safe disposal of the sharps and biological samples generated from this testing. See below for more information on this area.

While the above activities are considered to have no impact on the environment, environmental health and quality considerations should be incorporated into all relevant steps along the health care continuum, as part of quality assurance and infection prevention approaches. Implementing partners have an opportunity to include health care waste management messages, and to provide for appropriate disposal facilities in home-based care and community-based situations. Positive messages about personal and household hygiene, sanitation, and proper disposal of potentially harmful materials should also be delivered, as appropriate, along with the standard health care messages.

II. Activities presented in Section 3. Table 2 of this document

Pursuant to 22 CFR216.3(a)(2)(iii), a **Negative Determination with Conditions** is recommended for any ACHIEVE activities that have potential for negative impact on the environment in the following categories, as presented in Table 2 in Section 3 of this document:

1. Procurement, storage, management and disposal of public health commodities, including pharmaceutical drugs, immunizations and nutritional supplements, laboratory supplies and reagents.
2. Training professional and paraprofessional health care workers in methods that result in the generation and disposal of hazardous or highly hazardous medical waste (e.g., basic and emergency obstetric care techniques, administration of injectables, HIV or TB testing, malaria diagnosis, etc.)
3. Small-scale water and sanitation activities (such as covered wells and latrines)
4. Small scale gardening/farming activities
5. Small-scale rehabilitation of health facilities

Table 3 below indicates the Conditions for each category of activity.

TABLE 3: CONDITIONS FOR IMPLEMENTATION OF CATEGORIES OF ACHIEVE ACTIVITIES	
Activities	**Conditions**
Procurement, Storage, Management and Disposal of Public Health Commodities	Consignees for all pharmaceutical drugs and other public health commodities procured under this funding will be advised to store the product according to the information provided on the manufacturer's Materials Safety Data Sheet (MSDS). These are supplied by the manufacturer, and can also be found on the internet by using the active ingredient and MSDS as search terms. If disposal of any of these pharmaceutical drugs is required, due to expiration date or any other reason, the consignee will be advised that the preferred method of disposal is to return to the manufacturer. If this is not possible (for example if the expired or spoiled pharmaceuticals are considered hazardous and as such, if transferred across frontiers, become regulated and subject to the Basel Convention and the transfrontier shipment of hazardous wastes) then follow the guidelines in the WHO document *Guidelines for Safe Disposal of Unwanted Pharmaceuticals During and After Emergencies*, found at www.who.int/water_sanitation_health/medicalwaste/unwantpharm.pdf. At the request of the Mission, subject to available funding, the implementing partner will make all reasonable attempts to facilitate the disposal of expired drugs under this activity to mitigate the impact of medical waste. Implementing partners will work with the host country as appropriate on aspects of essential medicine supply chain management, including estimating demand, distribution, and storage issues of time and temperature. Commodities that, during use, become hazardous or highly hazardous waste are managed under the conditions in the following section "Activities that involve the collection, safe handling and disposal of hazardous and highly hazardous medical waste" Packaging and disposal of all other public health commodities will be treated using the guidelines provided in Environmental Guidelines for Small-Scale Activities in Africa (EGSSAA) 2nd Edition, Chapter 15: Solid Waste (http://www.encapafrica.org/EGSSAA/Word_English/solidwaste.doc)
Training professional and paraprofessional health care	If a project's training activities for professional health workers or community health workers involve techniques that would generate and require disposal of hazardous or highly hazardous

workers in methods that result in the generation and disposal of hazardous or highly hazardous medical waste (as defined in Section 3 of this IEE)	waste, the Implementing Partners shall be required to include training in or ensure that the training curriculum covers best management practices concerning the proper handling, use, and disposal of medical waste, including blood, sputum, and sharps. As appropriate, the implementing partners will work with facility, local, regional and/or national officials, to implement and apply appropriate best management practices which incorporate appropriate health and safety measures and environmental safeguards, including proper disposal of medical waste in accordance with international norms as spelled out by the WHO in "WHO's Safe Management of Wastes from Healthcare Activities." National policies and laws should also be considered, though most countries follow WHO Guidelines. Healthcare waste is most appropriately identified by color-coding bags and containers. In addition, the following are well-established practices in the safe handling, storage, and transportation of health-care waste: • Sharps should be collected together (regardless of whether or not they are contaminated), and stored in puncture-proof, impermeable, and tamper-proof containers with fitted covers. If plastic or metal containers are unavailable, then containers made of dense cardboard are recommended. • Highly infectious waste should be immediately sterilized by autoclaving. • On-site collection of waste should be handled at frequent intervals to avoid accumulation, and an adequate supply of fresh collection bags/containers should be available for replacement. • Waste should be stored in an accessible room with adequate space and protection from sunlight. • In any area that produces hazardous waste - hospital wards, treatment rooms, operating theatres, laboratories, etc., three bins plus a separate sharps container will be needed to separate these types of waste. (If hazardous and highly hazardous waste will be disposed of in the same manner, they should not be collected separately.) • For hazardous waste and highly hazardous waste the use of double packaging, e.g. a plastic bag inside a holder or container is recommended for ease of cleaning. • To make separate collection possible, hospital personnel at all levels, especially nurses, support staff, and cleaners, should be trained to sort the waste they produce.

	See EGSSAA Chapter 8, "Healthcare Waste: Generation, Handling, Treatment and Disposal" (http://www.encapafrica.org/EGSSAA/Word_English/medwaste.doc) and USAID Sector Environmental Guidelines "Healthcare Waste" (http://www.usaidgems.org/Sectors/healthcareWaste.htm) for additional guidance on proper handling and disposal of medical waste. Other important references to consult are "WHO's Safe Management of Wastes from Healthcare Activities" http://www.who.int/water_sanitation_health/medicalwaste/wastemanag/en/
Small-Scale Water and Sanitation	All water supply and water quality assurance activities should be conducted in a manner consistent with the good design and implementation practices described in USAID Sector Environmental Guidelines: Water Supply and Sanitation (http://www.usaidgems.org/Sectors/watsan.htm). For example, microbiological contamination of improved wells can often be prevented by aquifer protection measures and proper well design and maintenance. Separate wells should be used for human consumption and animal watering, or an overflow trough should be constructed well away from the protected water source. Water quality assurance and water testing is essential for determining that the water from a constructed water source is safe to drink and to determine a baseline so that any future degradation can be detected. Among the water quality tests which must be performed are tests for the presence of arsenic, nitrates, nitrites, and coliform bacteria, plus tests for any additional parameters required by the host government. USAID requires testing for arsenic for all USAID-funded water supply projects, as there is currently no way to determine which locations may contain natural arsenic deposits. Simple and cost-effective sample kits for *E. coli* and fecal coliforms are available through a variety of manufacturers (e.g., 3M Petrifilm, Idexx Colilert or Coliscan Easygel). Initial water quality testing is the responsibility of the program to assure, but when feasible the program should also set in place capacities and responsibilities to provide reasonable assurance that ongoing water quality monitoring occur. The standards for initial and ongoing testing -- types of contaminants for which testing should be conducted, testing methods, testing frequency, and issues such as public access to results -- should follow any applicable USAID guidance, as well as host country laws, regulations and policies. Furthermore, a response protocol should be established in

	the event that water quality testing detects contamination. An illustrative list of environmentally sound principles for water and sanitation activities includes: • Community mobilization to ensure sustainability of the physical infrastructure • Water sources should be located upgrade from potential sources of pollution, including latrines or toilets. • Water sources are protection from both human and animal contamination. • Ensure latrines are sited far away from shallow wells, cisterns, spring sources and boreholes. Latrine pits will be dug in the unsaturated zone above the water table, and latrine pits are protected against flooding and overflow due to intense rainfall. Establish and train community water and sanitation committees to manage, repair and maintain all water points and the watersheds immediately surrounding the water points, including watering of livestock, and to provide hygiene education to participating communities. • Training in sanitation and hygiene for health workers, community health and water committees, community area based development groups, and/or municipal water board members. • Ensure community mobilization and public awareness of human health risks associated with water-borne disease vectors. • Relevant local community rules and best practices and procedures of promotion of better environmental health are developed and adhered to. Verification through site visits and photos should be done to assure practices are in accordance with local community rules and "best practices" through community monitoring tools and municipal water board's evaluation system. • Take measures to minimize standing water. • Where water supplies for drinking or washing patients or laundry are upgraded or provided, measures will be taken to ensure that drainage from laundry and bathing facilities does not affect the water supply nor pose threats for transmittal of infectious diseases. • Provision of potable water supplies and/or latrines will follow host country or WHO standards concerning the appropriate separation of wells and latrines and measures to avoid contamination of water sources.

Small-Scale Gardening / Farming activities	Conditions: • Implementing partner will check to determine the extent of any threatened or endangered species in the area. • Existing fields will have a buffer zone between the field and any wetland, stream, pond. • Implementing partner will not remove trees nor create new agricultural land. • Vaccines for animals will not use Genetically Modified Organism (GMO) live cultures • GMO species (plant or animal) will not be introduced • Pesticides (registered by the U.S. as pesticides), will not be used. Only organic, non-chemical pest management techniques will be promoted and practiced. • When animals or plants/seeds are brought into the country from other countries or regions, appropriate quarantine controls will be enforced prior to bring the animal or plant/seeds into the region • No raw excrement will be used as fertilizer directly on plants; only composted waste will be used. • Animal waste will composted, decomposed in approximately 12-15 weeks and used as fertilizer. Animal waste will be stored in marked Farm yard manure (FYM) pits approximately 3 ft in depth. Length and width will be determined based on the size of the small farm or home garden. Compost pits will be marked with appropriate signage to minimize human exposure. Farms/gardens will have covered composting pits but home gardens will not (according to local customs). FYM pits will be located a minimum of 30 ft from water sources and 50 feet from households. • Structures such as coops, fenced areas, and barns and fields will not be built in ecologically sensitive areas such as ponds, wetlands, or heavily forested areas. • Cages, coops, and any animal housing will be set away from homes, drinking water sources, low lying or wet areas, and surface water (ponds, streams). • Compost pits will be secured using locks, fences, and other appropriate hardware so that human exposure is minimized. • Tools (shovels, hoes and rakes) and protective gear, as appropriate, will be used to collect and compile animal waste.
Small-scale rehabilitation of health posts, clinics,	For the rehabilitation of existing facilities, these activities shall be conducted following principles for environmentally sound rehabilitation, as provided in the USAID Sector Environmental

laboratories, hospitals or training centers	Guidelines on Construction, as the guidelines are appropriate for rehabilitation activities (http://www.usaidgems.org/Sectors/construction.htm). An illustrative list of environmentally sound construction principles includes: • As part of the selection/screening for potential sites, the implementer will perform Environmental Due Diligence for proposed sites to ensure that the site is free of environmental concerns including those from off-site sources. • The majority of materials used will be of local origin and will not contain any hazardous materials (e.g., asbestos or lead). • Investigate and use less toxic alternative products. • Excess materials will be recycled wherever possible and disposal of unusable material will be done in an environmentally sound manner. • Rehabilitation activities will not require the use of any heavy equipment, or in the unlikely event it does, proper safeguards will be taken to prevent destruction of vegetation and soil erosion (e.g., runoff from the site which may be high in suspended solids or which may cause disruption to local drainage patterns). • No lead-based paint will be used. When (lead-free) paint is used, it will be stored properly so as to avoid accidental spills or consumption by children; empty cans will be disposed of in a environmentally safe manner away from areas where contamination of water sources might occur; and the empty cans will be broken or punctured so that they cannot be reused as drinking or food containers. • For any TB laboratories renovated under this program, provide room(s) with negative pressure to mitigate any cross contamination potential, and provide owner/operators of the renovated facility with written guidelines for proper maintenance of the facility.

For project activities described above in Sections 1 and 3, the conditions presented above in Table 3 must be implemented as a part of program design and implementation. In addition to the specific conditions enumerated in Table 3, the negative determinations recommended in this PIEE are contingent on full implementation of the following general monitoring and implementation requirements:

1. **Consideration of capacity to perform environmental compliance.** USAID procurement should include consideration of the implementing partner's ability to perform the mandatory environmental compliance requirements as envisioned under ACHIEVE. The Agreements Officer (AO)/Contract Officer (CO) shall include required environmental compliance and reporting language (www.usaid.gov/policy/**ads**/200/**204**.pdf) into each implementation instrument, and ensure that appropriate resources (budget), qualified staff, equipment, and reporting procedures are dedicated to this portion of the project.

2. **Provision of PIEE and Briefing of Implementing Partners on Environmental Compliance Responsibilities.** The ACHIEVE USAID Management Team shall provide each Implementing Partner, with a copy of this PIEE; each implementing partner shall be briefed on their environmental compliance responsibilities by the AOR. During this briefing, the PIEE conditions applicable to the implementing partner's activities will be identified. Implementing Partners will complete the Environmental Screening Form to assist in identification of applicable conditions (Annex A).

   The AOR and/or on-site manager or their representative of the Program/Project will undertake field visits, as possible, and consultations with implementing partners to jointly assess the environmental impacts of ongoing activities, and associated mitigation and monitoring conditions

   b. The AOR, in consultation with the mission activity managers and implementing partners, Mission Environmental Officers (MEO), Regional Environmental Officers (REO), and/or Bureau Environmental Officers (BEO) as appropriate, will actively monitor and evaluate whether environmental consequences unforeseen under activities covered by this PIEE arise during implementation, and modify or end activities as appropriate. If additional activities are added at the primary award level that are not described in this document, an amended PIEE must be prepared.

3. **Include language in partner documentation that WHO guidelines for the disposal of medical waste will be followed.** In partner awards, annual workplans, and/or reports, stipulate that the partner will follow all WHO guidelines for the disposal of medical waste

4. **USAID AOR monitoring responsibility.** As required by ADS 204.5.4, the USAID AOR will actively monitor and evaluate whether the conditions of this PIEE are being implemented effectively and whether there are new or unforeseen consequences arising during implementation that were not identified and reviewed in this PIEE. If new or unforeseen consequences arise during implementation, the team will suspend the activity and initiate appropriate, further review in accordance with 22 CFR 216. All site visits should incorporate monitoring of environmental compliance, using the EMMP.

5. **New or modified activities.** As part of its Work Plan, and any Annual Work Plans thereafter, implementing partners, in collaboration with their AOR, shall review all on-going and planned activities to determine if they are within the scope of this PIEE.

   Any ongoing activities found to be outside the scope of the approved Regulation 216 environmental documentation shall be modified to comply or halted until an amendment to the documentation is submitted approved. If activities outside the scope of this PIEE are planned, the team shall assure that an amendment to this PIEE addressing these activities is prepared and approved prior to implementation of any such activities.

6. **Supplemental Initial Environmental Examinations (SIEE), when appropriate.** In the event that any new proposed activity differs substantially from the type or nature of activities described here, or requires different or additional mitigation measures beyond those described, an amendment to this PIEE will be prepared and the SIEE will reference the amended PIEE. The SIEE will document compliance with agreed environmental mitigation for specific country level sub-awards.

   SIEEs, referencing this PIEE, will be prepared by the activity manager or his/her designee and submitted to the mission/office director, the MEO, and the Regional and Global Health Bureau Environmental Officers for approval.

7. **Development and integration of EMMP.** Each implementing partner whose activities are subject to one or more conditions set out in section 3 of this PIEE or associated SIEE shall develop and provide for AOR review and approval an Environmental Mitigation and Monitoring Plan (EMMP) documenting how their project will implement and verify all PIEE/SIEE conditions that apply to their activities (see Annexes B and C).

   These EMMPs shall identify how the implementing partner shall assure that PIEE/SIEE conditions that apply to activities supported under subcontracts are implemented. (In the case of large subcontracts, the implementing partner may elect to require the subcontractor to develop their own EMMP.)

   Each implementing partner shall integrate the EMMP into their project work plan and budgets, implement the EMMP, and report on its implementation as an element of regular project performance reporting (see below).

   Annex B is an illustrative EMMP report, and Annex C is the EMMP for inclusion in the annual report. Annexes D and E are checklists which may be used in training materials and programs, as a part of the project EMMP and as appropriate. Annex F is the required annual certification of environmental compliance.

   The USAID Global Environmental Management Support website provides EMMP guidance and sample EMMP formats: http://www.usaidgems.org/mitMonRep.htm

8. **Compliance documentation and reporting.** ACHIEVE implementing partners shall annually complete and submit to the AOR the attached Environmental Mitigation Monitoring Report (EMMR) to document compliance with the conditions of this PIEE (Annex C and F). The report is due to the AOR with the annual report (submitted 30 days after the end of each fiscal year of the agreement). The implementing may develop and propose for AOR and GH BEO approval an alternate form serving this purpose. The EMMR or alternate form will be reviewed and

approved by the designated AOR and the GH BEO. If the implementing partner only conducts activities during the reporting year that are covered by the categorical exclusion, they will submit a memo to the AOR/COR describing the activities that were conducted and confirming that no EMMR (monitoring report) is needed.

9. **Integration of compliance responsibilities in prime and sub-contracts.** The Management Team shall assure that any future agreements for implementation of ACHIEVE activities, and/or significant modification to current agreements shall reference and require compliance with the conditions set out in this PIEE or any associated SIEEs, as required by ADS 204.3.4.a.6 and ADS 303.3.6.3.e. Implementing partners shall assure that subcontractors or subgrantees have the capability to implement the relevant requirements of this PIEE and any associated SIEEs. The implementing partner shall, as and if appropriate, provide training to subcontractors in their environmental compliance responsibilities and in environmentally sound design and management of their activities.

10. **Sub-Agreements or Funds Transfers**: Implementing partners must ensure that any sub-agreements or fund transfers from the implementing partners to other organizations incorporate provisions stipulating:
    a. Any sub agreement or funds transfer must include provisions that stipulate the implementation of an EMMP
    b. the completion of an annual environmental monitoring plan and report, and
    c. Any activity to be undertaken will be within the scope of the environmental determinations and recommendations of this PIEE. This includes assurance that any mitigating measures required for those activities be followed.

11. **Compliance with Host Country Requirements.** Nothing in this PIEE substitutes for or supersedes implementing partner or sub-grantee responsibility for compliance with all applicable host country laws and regulations. The implementing partners and their sub-grantees must comply with host country environmental regulations unless otherwise directed in writing by USAID. However, in case of conflict between host country and USAID regulations, the latter shall govern.

Annex A. ACHIEVE Project Environmental Screening Form

Name of Implementing Organization:_____ Funding Period for this award: FY____- FY____

Geographic location of project (country, province, district):_____ Report prepared by: Name: _____ Date: _____

Indicate which activities your organization plans to implement under ACHIEVE (including leverage).

Table 1: Key Elements of Project/Activities Implemented with no direct impact on the environment Activities such as:		Yes	No
1	• Education, technical assistance, or training • Analysis, program evaluation, workshops, or meetings • Document and information transfers • Programs involving health care, nutrition, or family planning except where directly affecting the environment • Studies, projects, or programs intended to develop the capability of recipient countries and organizations to engage in development planning		

Table 2: Key Elements of Project/Activities Implemented with direct or indirect impacts on the environment **Activities such as:**		Yes	No	% Total Budget
2	Procurement, Storage, Management, and Disposal of Public Health Commodities			
3	Training professional and paraprofessional health care workers in methods that result in the generation and disposal of hazardous or highly hazardous medical waste			
4	Small-Scale Water and Sanitation Activities			
5	Small-Scale Gardening or Farming Activities			
6	Small-Scale Rehabilitation of Health Facilities			
7	Other activities that include physical interventions that have direct or indirect impacts on the environment that are not covered by the above categories			

Provide a brief description of potential environmental threats of any key project activities in the "Yes" column in Table 2.

Category of Activity	Potential environmental threats
2.) Procurement, Storage, Management, and Disposal of Public Health Commodities	
3.) Training professional and paraprofessional health care workers in methods that result in the generation and disposal of hazardous or highly hazardous medical waste	
4.) Small-Scale Water and Sanitation Activities	
5.) Small-Scale Gardening or Farming Activities	
6.) Small-Scale Rehabilitation of Health Facilities	
7.) Other activities that include physical interventions that have direct or indirect impacts on the environment that are not covered by the above categories	

Certification

I certify the completeness and the accuracy of the Environmental Screening Form described above. I agree to implement the mitigative measures put forth in the ACHIEVE Programmatic IEE for those activities noted in the Environmental Screening Form that have potential environmental threats. I agree to include a mitigation plan in the workplan for any activities with a potential environmental threat (Annex B) and to submit annual reports on the status of mitigation measures (Annex C).

_____ _____

Signature Date

_____

Print Name

_____

Organization

_____

BELOW THIS LINE FOR USAID USE ONLY

USAID Clearance of Environmental Screening Form:

Agreement Officer's Representative:_____ Date:_____

Bureau Environmental Officer:_____ Date: _____

Note: If clearance is denied, comments must be provided to applicant.

Annex B: Illustrative EMMP

ACHIEVE
ENVIRONMENTAL MITIGATION AND MONITORING PLAN

Table A: Environmental Mitigation and Monitoring Plan (EMMP)

Please consult the PIEE for information on categories of activities, specific environmental threats, and description of specific mitigation measures.

Category of Activity	Describe specific environmental threats of your organization's activities	Description of Specific Mitigation Measures for these activities	Who is responsible for monitoring	Monitoring Indicator	Monitoring Method	Frequency of Monitoring
For instance: 1. Education, technical assistance, training, public health commodities, etc.	List any environmental impacts anticipated as a result of these activities	For example, education, technical assistance and training about activities that inherently affect the environment include discussion prevention and mitigation of potential negative environmental effects.	List the staff and organization responsible for monitoring	For example, discussion of environmental impact included in education, technical assistance, training and other materials	For example, review of materials, interviews, site visit to health center waste location	For example: Weekly, Monthly, Bi-Annually

Annex C. Illustrative EMMR

ACHIEVE
ENVIRONMENTAL MITIGATION AND MONITORING REPORT
ANNUAL REPORT

Implementing Organization:
Geographic location of USAID-funded activities:
Period covered by this Reporting Form and Certification:

List each Mitigation Prevention/Mitigation Activity in the EMMP (See Annex A)	Status of Mitigation Activity	List any Outstanding Issues related to Mitigation	Remarks
(fill this in from the conditions specified in Section 3)			

Annex D. Healthcare Waste Management Minimal Program Checklist and Action Plan to be Included in Training Materials/Programs

Elements/Actions	*In Place?*	*Next Steps to be done*		
		What	*By Whom*	*By When*
Written plans and procedures				
1. *A written waste management plan* Describing all the practices for handling, storing, treating, and disposing of hazardous and non-hazardous waste, as well as types of worker training required.				
2. *Internal rules for generation, handling, storage, treatment, and disposal of healthcare waste.*				
3. *Clearly assigned staff responsibilities that cover all steps in the waste management process.*				
4. *Staff waste handling training curricula or a list of topics covered.*				
5. *Waste minimization, reuse, and recycling procedures.*				
Staff Training, Practices, and Protection*				
6. *Staff trained in safe handling, storage, treatment, and disposal.* Does staff exhibit good hygiene, safe sharps handling, proper use of protective clothing, proper packaging and labeling of waste, and safe storage of waste? Does staff know the correct responses for spills, injury, and exposure?				
7. *Protective clothing available for workers who move and treat collected infections waste* such as surgical masks and gloves, aprons, and boots.				
8. *Good hygiene practices*. Are soap and, ideally, warm water readily available workers to use and can workers be observed regularly washing.				

9. *Workers vaccinated* for against viral hepatitis B, tetanus infections, and other endemic infections for which vaccines are available.				
Handling and Storage Practices				
10. *Temporary storage containers and designated storage locations.* *11.* Are there labeled, covered, leak-proof, puncture-resistant temporary storage containers for hazardous healthcare wastes?				
12. *Minimization, reuse, and recycling procedures.* • Does the facility have good inventory practices for chemicals and pharmaceuticals, i.e.: o use the oldest batch first; o open new containers only after the last one is empty; procedures to prevent products from being thrown out during routine cleaning; and				
13. *A waste segregation system.* • Is general waste separated from infectious/hazardous waste? • Is sharp waste (needles, broken glass, etc.) collected in separate puncture-proof containers? • Are other levels of segregation being applied e.g. hazardous liquids, chemicals and pharmaceuticals, PVC plastic, and materials containing heavy metals ((these are valuable, but less essential)?				
14. *Temporary storage containers and designated storage locations.* • Are there labeled, covered, leak-proof, puncture-resistant temporary storage containers for hazardous healthcare wastes? • Is the location distant from patients or food?				
Treatment Practices				
15. Frequent removal and treatment of waste • Are wastes collected daily?				

• Are wastes treated with a frequency appropriate to the climate and season? o Warm season in warm climates within **24 hrs** o In the cool season in warm climates within **48 hrs** o In the warm season in temperate climates within **48 hrs**				
16. *Treatment mechanisms for hazardous and highly hazardous waste*. (The most important function of treatment is disinfection). • Are wastes being burned in the open air, in a drum or brick incinerator, or a single-chamber incinerator? • If not are they being buried safely (in a pit with an impermeable plastic or clay lining)? • Is the final disposal site (usually a pit) surrounded by fencing or other materials and in view of the facility to prevent accidental injury or scavenging of syringes and other medical supplies?				
17. If the waste is transported off-site, are precautions taken to ensure that it is transported and disposed of safely?				

*** Training should be conducted before starting activity implementation**

For more detailed checklists and guidance consult: *Safe management of wastes from health-care activities*, edited by A. Prüss, E. Giroult and P. Rushbrook. Geneva, WHO, 1999, http://www.who.int/water_sanitation_health/Environmental_sanit/MHCWHanbook.htm. English

Annex E. Disposal and Treatment Methods Suitable for Different Categories of Healthcare Waste to be Included in Training Materials/Programs (EXAMPLE)

Method	Infectious Waste (laboratory cultures, excreta)	Sharps (needles, blades, broken glass)	Pharmaceutical Waste (expired pharmaceuticals, boxes contaminated by pharmaceuticals)	Chemical Waste (laboratory reagents, solvents)	Radioactive Waste (unused liquids from laboratory research)
Rotary kiln	✓	✓	✓	✓	✓[2]
Pyrolytic incinerator	✓	✓	✓[1]	✓[1]	✓[2]
Single-chamber incinerator	✓	✓			✓[2]
Drum or brick incinerator	✓	✓			
Chemical disinfection	✓	✓			
Wet thermal treatment	✓	✓			
Microwave irradiation	✓	✓			
Encapsulation		✓	✓	✓[1]	
Safe burial on hospital premises	✓	✓	✓[1]	✓[1]	
Sanitary landfill	✓		✓[1]		
Discharge to sewer			✓[1]		Low-level liquid waste
Inertization			✓		
Other			Return to supplier	Return to supplier	Decay by storage

1: Small quantities only
2: Low-level infectious waste

Annex F: Required Annual Certification of Environmental Compliance

ACHIEVE
ENVIRONMENTAL MITIGATION AND MONITORING PLAN
ANNUAL CERTIFICATION

Certification

I certify the completeness and the accuracy of the Environmental Mitigation and Monitoring Plan Reporting for activities funded by USAID ACHIEVE in Fiscal Year 20____ covered by the ACHIEVE PIEE or associated SIEE for which I am responsible:

_____ _____
Signature Date

_____
Print Name

_____
Organization

_____
BELOW THIS LINE FOR USAID USE ONLY

Bureau Environmental Officer:

_____ Date: _____

Agreement Officer's Representative:

_____ Date:_____

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