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| **Federal Agency Name:** | United States Agency for International Development |
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| **Questions Deadline for this APS Document:** | March 3, 2021 at 12:00 pm ET |

**For questions on this APS document, please submit all questions to Mrs. Jacquelin Bell via email at jacbell@usaid.gov by the deadline specified above.**

**Please see individual Round documents for each Round's deadlines and submission instructions for concept papers.**

**For a USAID Mission or USAID/Washington Office wishing to issue a Round under this APS, the program description must fit within Section I of this document. Please contact Kuyosh Kadirov (kkadirov@usaid.gov) for review of the Round document - it must be reviewed before being posted publicly under this APS. All new Rounds must be posted as a Frontier Health Market (FHM) APS Round on the USAID Business Forecast.**

To Interested Applicants:

This Annual Program Statement (APS) publicizes the intention of the United States Government (USG), as represented by the United States Agency for International Development (USAID), Bureau for Global Health (GH), to fund one or multiple awards to address the overarching APS program purpose. The purpose is to increase private health sector contributions to advancing voluntary family planning (FP), reproductive health (RH), and/or other health (maternal, newborn and child health (MNCH), malaria, tuberculosis (TB), other infectious diseases, and HIV/AIDS) outcomes.

This APS document outlines the goal, purpose, expected results, and priorities of the Frontier Health Markets (FHM) project, and may result in multiple awards issued under subsequent APS Rounds. Note: when referencing FHM in this document, it is referring to the full portfolio of possible awards under this overall purpose. This document is an umbrella APS and will not solicit concept papers or applications. Prospective applicants will be provided a fair opportunity to develop and submit competitive concept papers to USAID for potential funding via Rounds under this APS.

For the purposes of the FHM APS, a "Round" is defined as a specific program description that falls under the larger FHM APS goal, purpose, and results but is tailored to a certain focus. Under each Round, applicants will first submit a short concept paper that will be reviewed for responsiveness to the overall FHM purpose, selected results, and Round's focus and then scored according to the evaluation criteria provided in the Round document. USAID may utilize co-creation with prospective applicants during various stages of Round procurements and applicants may be invited to participate in virtual or in-person events. Following the concept paper stage (and co-creation event when called for), selected applicants (individual organizations and/or consortia developed at concept paper stage or during co- creation) will be requested to submit a Full Application, the content and format of which will be provided in greater detail by the Agreement Officer. Publishing this APS does not commit USAID to make any awards. USAID also reserves the right not to conduct a co-creation workshop and request Full Applications from successful applicants at the concept paper stage.

As Rounds occur, notifications will be posted on Grants.gov.

Sincerely,

Alisa J. Dunn

Alisa J. Dunn
Supervisory Agreement Officer
Office of Acquisition & Assistance

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**ACRONYM LIST**

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|---|---|
| ADS | Automated Directives System |
| AO | Agreement Officer |
| AOR | Agreement Officer's Representative |
| APS | Annual Program Statement |
| BEO | Bureau Environmental Officer |
| CA | Cooperative Agreement |
| CII | Center for Innovation and Impact |
| CFR | Code of Federal Regulations |
| DDI | Bureau for Development, Democracy, and Innovation |
| DUNS | Data Universal Numbering System |
| EA | Environmental Assessment |
| FAM | Fertility Awareness Methods |
| FP | Family Planning |
| GH | Bureau for Global Health |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome |
| HTSP | Healthy Timing and Spacing of Pregnancy |
| IEE | Initial Environmental Evaluation |
| IR | Intermediate Result |
| LMICs | Low- and Middle- Income Countries |
| MCH | Maternal and Child Health |
| MCHN | Office of Maternal Child Health and Nutrition |
| MEL | Monitoring, Evaluation, and Learning |
| NGOs | Non-Governmental Organizations |
| NPI | New Partnerships Initiative |
| NUP | New and Underutilized Partners |
| OHA | Office of HIV/AIDS |
| OHS | Office of Health Systems |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PRH | Office of Population and Reproductive Health |
| RH | Reproductive Health |
| SAM | System for Award Management, Registration, Renewal, & Migration |
| USAID | United States Agency for International Development |
| USG | United States Government |
| WASH | Water, Sanitation, and Hygiene |
| WHO | World Health Organization |

# SECTION I: FUNDING OPPORTUNITY DESCRIPTION

The U.S. Agency for International Development's (USAID) Office of Population and Reproductive Health (PRH) is pleased to announce the Frontier Health Markets (FHM) Annual Program Statement (APS) which aims to help achieve global U.S. Government (USG) health priorities and commitments, specifically related to preventing child and maternal deaths, controlling the HIV/AIDS epidemic, and combating infectious diseases. FHM will improve the functioning of local health markets and will support the effective engagement and systemic inclusion of the private sector to advance voluntary family planning, maternal, newborn and child health, malaria, TB, and HIV/AIDS outcomes. FHM will leverage existing evidence and best practices, as well as catalyze new ideas, forge partnerships, and innovative approaches to foster the introduction, scale up, and sustainability of quality healthcare delivery in the private sector to achieve our ambitious global health targets and help enhance countries' ability to fortify and diversify healthcare delivery.

The public sector health system faces many constraints and cannot meet the growing needs and market demand for voluntary family planning (FP) and other health products and services in low- and middle-income countries (LMICs) alone[1]. Users in LMICs are increasingly accessing health services through the private sector, but challenges remain in ensuring voluntary FP and other health markets are resilient, robust, and capacitated to deliver appropriate, affordable, quality health products, services, and information in a self-reliant manner. A robust private sector is an inextricable stakeholder in driving and sustaining outcomes capable of moving countries beyond the need for assistance, and offers much needed infrastructure, staff, networks, and other technical and financial resources to contribute to overall health systems performance. The private sector continues to play an unprecedented role in creating and shaping opportunities and reaching a scale that improves the lives of the people and communities USAID supports. An additional area of importance and key requirement for a quality health market is strengthening the stewardship capacity of the public sector to improve delivery of private sector health services for better health outcomes.

The design of FHM reflects the evolution in USAID's private sector programming with a greater emphasis on strengthening health market systems. It is designed to enhance countries' ability to fortify and diversify healthcare delivery and to ensure that USAID's investments are tailored to country contexts and needs. Fundamental to FHM's design is the premise that market-based approaches can lead to greater scale and sustainability of development outcomes. This is based on the assumption that as long as a business case or market system exists for a good or service, it has a greater likelihood of sustaining itself without external support. FHM also recognizes that countries which received USAID support have different local contexts, from a business and health policy point of view, as well as a regulatory lens, that require unique support.

FHM will also include a greater focus on building the technical capacity, sustainability, and resilience of local partner institutions, while maintaining an emphasis on advancing the scale-up of evidence-based approaches and interventions. FHM will aim to forge new partnerships with a significant number of development actors and diversify USAID's partner base through concentrated efforts to engage the local private sector at the country level for state-of-the-art

[1] Universal Health Care Coverage Fact Sheet https://www.who.int/en/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

technical expertise, local market intelligence, and service delivery.

FHM aims to leverage the expertise of established partners while also reaching, engaging, and increasing the capacity of a wide variety of new and local partners with relevant technical expertise. These could be local small-medium businesses, private sector organizations, non-governmental organizations [NGOs], private voluntary organizations, faith-based and community-based organizations [FBOs and CBOs]. FHM will use co-creation strategies to bring traditional, new, and local partners together and anticipates bids from a broad range of sectors. The solicitation will encourage the leadership and substantive engagement of new and local partners by reducing barriers to entry. For example, FHM awards will seek to issue performance-based, capacity-building, and/or innovation sub-awards and sub-grants to local organizations which may become transition awards. All sub-awards to local organizations will specify clear, achievable, and measurable outcomes mapped to priority health indicators, and connect to specific, national priorities. Country programs in particular may be well positioned to target a variety of new, local or locally established partners.

FHM builds on a long history of USAID's involvement in public-private partnerships at the country- and local-level and incorporates lessons, data, and results from past and current private sector health projects including: Family Planning Enterprise (ENTERPRISE) and Technical Information on Population for the Private Sector (TIPPS) (1985-1991); Promoting Financial Investments and Transfers (PROFIT) (1991-1997); Commercial Market Strategies (1998-2004); Private Sector Partnerships for Better Health (PSP) One (2003-2009); Banking on Health (2004-2009); Sustaining Health Outcomes through the Private Sector (SHOPS) (2009-2016); Achieving Sustainability through Local Health Systems (2019-2024); SHOPS Plus (2015-2021); Scale for Impact (2016-2021); Support for International Family Planning Organizations (2010-2015); Support for International FP and Health Organizations 2: Sustainable Networks (SIFPO2) (2015-2020); Momentum Private Healthcare Delivery (MPHD) (2020-2025); and The New Partnerships Initiative (NPI) Expanding Health Partnerships: NPI EXPAND (2020-2025). FHM will continue the work of predecessor projects in advancing knowledge and best practices for private sector expansion in voluntary family planning, maternal, newborn and child health, malaria, TB, HIV/AIDS and other infectious diseases. It will continue providing global technical leadership, evidence generation and dissemination, and ensure the linkages between knowledge generation, global dialogue, and country action to achieve global health goals.

FHM supports USAID's four strategic pillars of development: 1) *respecting American taxpayers' investments*, 2) *advancing national security, 3) strengthening our core competencies; and 4) empowering our people to lead*, by:

- Increasing coordination across the public and private sector for sustained health outcomes;
- Building capacity of local private and public health organizations, thereby strengthening the long-term effectiveness and durability of investments;
- Using a variety of assistance models to help countries effectively plan for, manage and finance a mixed health delivery system;
- Aligning USAID investments with country-owned and -led national and subnational health, social, and economic investment plans to maximize cost-efficiency and increase sustainability;

- Optimizing strategic partnerships and engagement to increase financial investments and establish long-term, enduring, and sustainable engagement by non-donor stakeholders towards mutual goals.

## A. Background

As the world's largest bilateral donor for voluntary FP/RH and TB, a global leader in MNCH, and one of the key agencies implementing the President's Emergency Plan for AIDS Relief (PEPFAR) program, USAID partners with governments, for-profit and nonprofit organizations, faith-based organizations (FBOs) and civil society organizations (CSOs) to meet the health needs of women, men, and children. For more than 50 years, USAID programs have saved lives and improved health outcomes across the globe. Today, due in part to USAID investments, there has been: an average 30 percent increase in modern contraceptive prevalence with family size dropping to 4.4 children per woman in USAID priority countries[2]; 44 percent reduction in global maternal mortality[3]; 52 percent reduction in newborn mortality since 1990; and the global under-five mortality rate has fallen to 38 deaths per 1,000 live births[4]. USAID's investments through the PEPFAR program have also helped countries advance toward the global 90-90-90 targets for HIV/AIDS, with 81% of all people living with HIV knowing their status, 82% of those knowing their status are accessing treatment and 88% of those on treatment are virally suppressed as of 2019[5]. Since 2000, on average, in the 23 countries where the United States provides TB bilateral funding, the incidence of TB decreased by 27 percent, mortality from the disease decreased by 44 percent, and notifications of individuals with active TB disease increased by 114 percent.[6] As a part of pursuing these broader TB goals, USAID has been a leader in increasing private provider engagement in quality TB services.[7]

USAID has led the introduction of a wide range of innovative interventions that contribute to improved health outcomes, including but not limited to oral rehydration therapy and zinc supplementation, doorstep delivery of contraceptives, mobile outreach, social franchising, and new contraceptive technologies. Since 2008, USAID investments helped save the lives of close to five million children and 200,000 women in 25 priority countries[8]. In fiscal year 2019, USAID's PEPFAR investment yielded over 1.2 million people newly identified as being HIV-positive and 1.1 million people newly initiated on treatment for a total of 5.9 million men women and children supported on life-saving HIV treatment[9].

While FHM aims to build on the last twenty five years of work to help strengthen the capabilities

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[2] USAID Family Planning and Reproductive Health Programming Overview https://www.usaid.gov/sites/default/files/documents/1864/FP-program-overview-508.pdf

[3] "Trends in Maternal Mortality: 2000-2017," WHO, UNICEF, WB, and UNFPA, there was a 38% reduction in MMR during 2000 and 2017. https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/

[4] Children: Improving Child Survival and Well Being Factsheet. https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality

[5] UNAID Global HIV/AIDS Statistics- 2020 Fact Sheet https://www.unaids.org/en/resources/fact-sheet

[6] Accelerating Action to End TB: Tuberculosis Report to Congress https://www.usaid.gov/sites/default/files/documents/1864/2020_Report_to_Congress_01-WEB-READY-FINAL.pdf

[7] Engaging Private Health Care Providers in TB Care and Prevention: A Landscape Analysis. https://www.who.int/tb/publications/2018/PPMLandscapeAnalysis.pdf?ua=1

[8] https://www.usaid.gov/results-and-data/progress

[9] Levels and Trends in Child Mortality https://www.unicef.org/media/79371/file/UN-IGME-child-mortality-report-2020.pdf.pdf

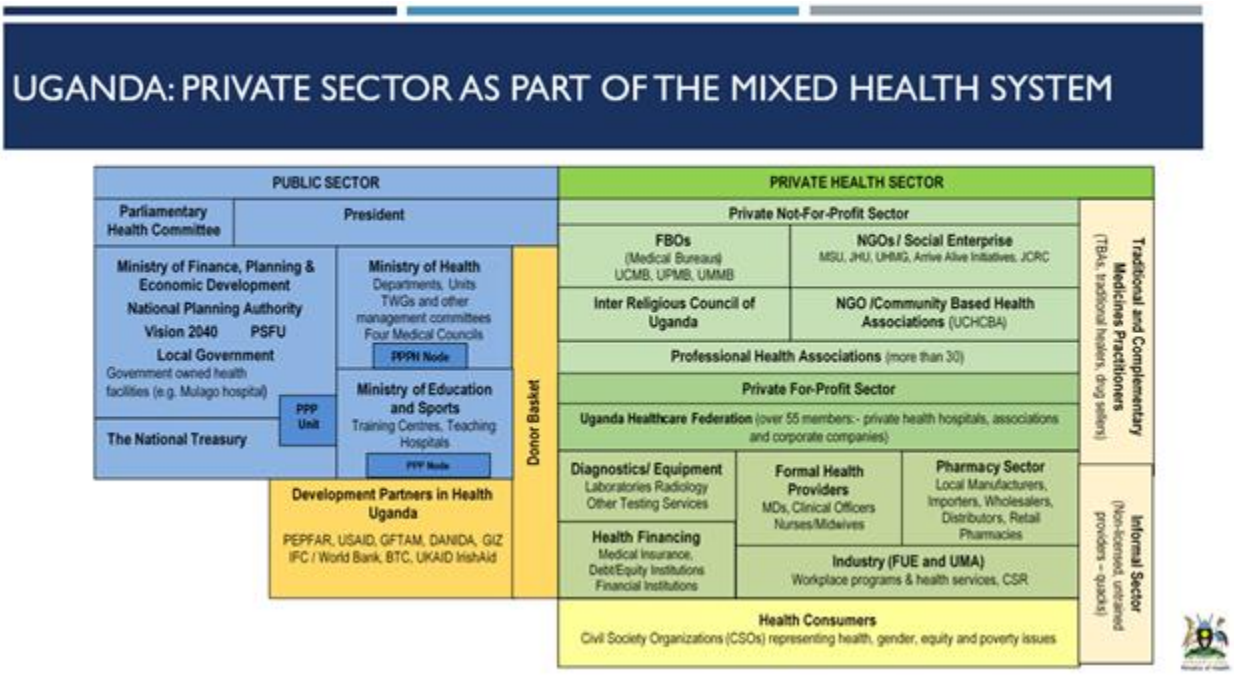
of the private sector to deliver health products, services, and information, FHM is also an evolution in USAID thinking to embrace a systemic, market development approach that addresses the root causes of market inefficiencies that limit the ability of the private sector to deliver quality, affordable, appropriate health information, products, and services for a range of health seekers across different market segments. Health market development approaches may include interventions aimed at increased access to financing, strategic use of subsidies, tax and other incentives, balanced application and enforcement of health policy, rules and regulations, increased availability and use of health market data, improved donor coordination and government's stewardship of health markets, and platforms for systematic engagement between governments and private sector organizations.

FHM will build upon these premises and apply lessons from previous and current USAID and other donor health market development experiences. To maximize its impact and to ensure that future investments maintain past gains, FHM will catalyze the development of new ideas, mobilize local resources and expertise, help build additional capabilities, and accelerate progress by uniting partners around the common goal of ensuring equitable access to quality healthcare. FHM will also provide global technical leadership, evidence generation and dissemination and ensure linkages between knowledge generation, global dialogue, and country action to achieve global health goals.

**Private Health Sector**

The private sector landscape is large and diverse, and the ecosystem of actors include a wide range of commercial and non-profit healthcare providers and facilities, such as hospitals, labs, pharmacies, clinics and health centers, drug shops, traditional medicines practitioners/healers, community health workers, and the organizations that represent them, such as professional councils, and industry associations. The landscape also includes key enablers and supporting players that can advance and innovate in supply chain and distribution networks, those providing technology and digital solutions, health data and information for providers and clients, training and support to health care workforce, financing and insurance industries, the research sector, marketing industries, as well as manufacturers of healthcare commodities and supplies. Given this context, the private sector presents significant opportunities to improve access to and coverage of health products and services that are critical for meeting public health goals. The range of private health sector actors are broad, as illustrated in Figure 1 below, and varies from country to country.

**Figure 1: Range of Private Sector Actors in Uganda's Mixed Health System**




Source: Exploring Partnership Opportunities To Achieve Universal Health Access: 2016 Uganda Private Sector Assessment In Health

*Family Planning, Reproductive Health, Maternal Newborn and Child Health*
The private sector is essential for the effective provision of health information, products, and services. Data demonstrate that a large proportion of people in USAID priority countries rely on the private sector for provision of healthcare. According to Demographic and Health Survey (DHS) data, the private health sector is an important source of modern contraceptive methods and information. On average, across 36 LMICs in Southeast Asia and Africa, the majority of short-term family planning (FP) resupply methods, such as condoms and pills, are obtained from private sector sources (61 percent and 52 percent, respectively); roughly one out of three modern method users rely on private sector sources (34 percent); and approximately one-quarter of IUD users, injectable users, and sterilized women went to private sector sources for their method (29 percent, 26 percent, and 24 percent, respectively)[10].

Often, more women access antenatal care (ANC) services in the private sector than delivery services. A systematic review of 57 LMICs data, found that overall, one in five women delivered in the private sector, with wide variation among countries, ranging from 9 percent to 46 percent[11].

[10] Sources for Family Planning in 36 Countries: Where Women Go and Why It Matters https://www.shopsplusproject.org/sites/default/files/resources/Sources%20for%20Family%20Planning%20in%2036%20Countries-Where%20Women%20Go%20and%20Why%20it%20Matters.pdf

[11] Benova, L. et al. (2015). Role of the Private Sector in Childbirth Care: Cross-Sectional Survey Evidence from 57 Low- and Middle-Income Countries Using Demographic and Health Surveys https://onlinelibrary.wiley.com/doi/full/10.1111/tmi.12598

Secondary analysis of DHS data from 24 USAID priority countries found that 43 percent of children who receive treatment for acute respiratory infections, fever, and diarrhea do so in the private sector, but this varies greatly by region and country[12]. A similar secondary analysis of DHS data from 45 LMICs revealed that when newborns are sick, among caregivers who seek care outside of the home, 52 percent use public facilities, 46 percent use private sources (24 percent private facilities, 22 percent private retail outlets), and 6 percent go to other sources such as family or friends.[13]

*Tuberculosis*

In some countries with a high burden of Tuberculosis (TB), the private health sector plays an important role in TB care. Based in part on extrapolations from DHS data, it is estimated that in seven of the highest burden countries for TB, private providers are the destination for 75 percent (67-84 percent) of initial care-seeking, private expenditure represents 61–74 percent of total expenditure on health, and private markets deliver 15–54 percent of all anti-TB drugs. At the same time, private for-profit TB notifications represent only 19 percent (5–28 percent) of total notifications and 12 percent (1–18 percent) of estimated incidence.[14] These seven high burden countries account for 57 percent of the global TB incidence and 63 percent of missing TB patients.

*HIV/AIDS*

The private sector plays a smaller, but still significant, role in provision of HIV/AIDS services. Analysis of AIDS Indicator Surveys from 18 countries revealed that on average 16 percent of those who received an HIV test did so in the private sector. This ranged greatly, from 1 percent of women in Mozambique to 43 percent in Haiti. In nearly all countries, men were more likely than women to test in the private sector.[15]

The private health sector serves both the poor and wealthy, urban and rural, and all socio-economic segments in between. Global data demonstrate that even the very poor access services from the private sector and often pay for products and services out of pocket. For example, about two in five caregivers from the poorest households rely on the private sector for care of a sick child. Secondary analysis of DHS data has shown that urban and wealthier women disproportionately use the private sector compared to rural, poorer women. According to DHS surveys conducted between 2000 and 2018, on average 24 percent of women in the highest wealth quintile delivered in the private sector, compared to 11 percent of women overall. Wealthier populations also use the private sector at greater rates for family planning, antenatal care, and treatment of childhood diarrhea and fever

[12] Bradley, Sarah E. K., Lauren Rosapep, and Tess Shiras. 2017. Sources for Sick Child Care in 24 USAID Priority Countries. Brief. Bethesda, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates. https://www.shopsplusproject.org/resource-center/sources-sick-child-care-24-usaid-priority-countries

[13] Bradley, Sarah E.K., Rosapep, Lauren. "Where Do Caregivers Take Their Sick Children for Care? An Analysis of Care Seeking and Equity in 24 USAID Priority Countries." Global Health: Science and Practice, October 2020 8(3): 518-533https://www.ghspjournal.org/content/8/3/518

[14] Public–private mix for TB prevention and care: a roadmap. WHO/CDS/TB/2018.32 https://www.who.int/tb/publications/2018/PPMRoadmap.pdf?ua=1

[15] Johnson, D., & Cheng, X. (2014). The Role of Private Health Providers in HIV Testing: Analysis of Data from 18 Countries. International Journal for Equity in Health, 13, 36. doi:10.1186/1475-9276-13-36 https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-13-36

(Figure 2). Urban women are also 1.2–2.8 times more likely to use the private sector than rural women for child, maternal and family planning.[16]

**Figure 2: Analysis of data for the period 2009–13 (round 6) from forty-three Demographic and Health Surveys**




Source: Grepin, Kate. 2016. "Private Sector an Important but not Dominant Provider of Key Health Services in Low- and Middle-Income Countries"

Significant variation in size and use of the private sector also exists between countries[17] [18] [19]. LMICs such as India or Nigeria have dominant private sectors providing the bulk of health care to

[16] Grepin, Karen. Private Sector an Important but not Dominant Provider Of Key Health Services In Low- And Middle-Income Countries https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.0862

[17] Montagu D, Visconti A. Importance of the private sector for outpatient healthcare in LMICs. Toronto, Canada; 2011.

[18] Campbell OMR, Benova L, Macleod D, Goodman C, Footman K, Pereira AL, et al. Who, What, Where: an analysis of private sector family planning provision in 57 low- and middle-income countries. Trop Med Int Health. 2015 Dec;20(12):1639–56.

[19] Chakraborty, N; Sprockett, A. 2016. The relationship between wealth and use of health services in the private sector: A literature review and secondary data analysis focusing on family planning and common childhood illness. Washington, DC.

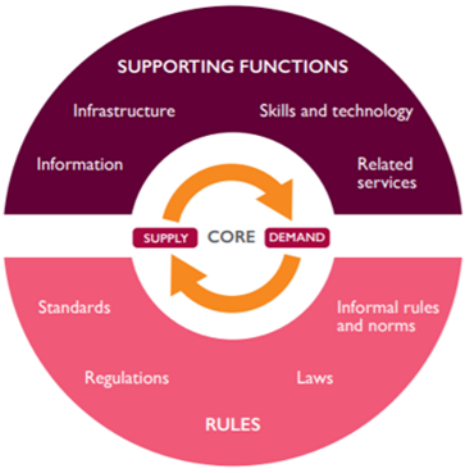
a diverse population and a high proportion of out-of-pocket payments fueling both private and public service provision. Other countries, such as Tanzania or Nepal, have large public sectors offering free care and stratified private sectors composed of both formal and informal providers catering to wealthy and poor populations, respectively. In contrast, countries like South Africa or Namibia, have a relatively small private sector that caters to the formal-sector, insured population, while the informally employed population predominantly rely on the public sector. [20]

## Challenges and Opportunities in Private Health Markets

The public health sector faces many constraints and cannot meet the growing market demand for FP and other healthcare in LMICs alone. The private sector offers much needed infrastructure, staff, networks, and other technical and financial resources and many Ministries of Health (MOHs) are looking for ways to increase private sector contribution in the delivery of health products, services, and information. The Frontier Health Markets project will support market development and private sector engagement approaches that improve the functioning of the local health market, which includes all sectors: public, private, not-for-profit and informal. Most importantly, within a market development approach, the private health sector's contribution is systematic, complementary, and enhances countries' ability to fortify and diversify their healthcare delivery. Hence, FHM will invest in market-based approaches, provide country-level strategic implementation and capacity building support, and facilitate engagement platforms that bring together healthcare market suppliers, consumers, financiers, and regulators from across the public and private sectors. FHM will engage these diverse players to develop a common vision for healthy local markets that improves access, affordability, and increases use of health products, information, and services in an equitable, efficient, and sustainable manner.

A health market can be defined as a system (as depicted in Figure 3) with core supply and demand functions, as well as the rules and supporting functions that are shaped by a variety of market players. These include: individuals and entities "who demand/buy services" (e.g. consumers, governments); a wide range of private organizations "who supply/sell services" (e.g., clinics, pharmacies, NGOs); and various government and regulatory bodies, financing institutions, and development and technical assistance organizations who "enable" the systemic exchanges. Across supply, demand, rules, and supporting functions, the interplay of preferences and motivations between key actors will lead to improvements in quality, equity, and sustainability of healthcare in the private sector. Understanding these functions as well as the root causes that influence and/or limit effective interactions among these players is critical.

**Figure 3: The Market System**




Source: The Operational Guide for the Making Markets Work for the Poor (M4P) Approach

[20] Mackintosh, Maureen, et al. (2016). What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. Lancet 2016; 388: 596–605. https://www.sciencedirect.com/science/article/pii/S0140673616003421

Health markets need structures to coordinate the various efforts to identify barriers and causes of market inefficiencies and facilitate a strategic response, often defined as "stewardship". The government has a mandate for overall stewardship of the entire health system, but to be effective in stewarding the health market, structures need to be in place that amplify private sector voices and support their participation along with other key stakeholders. As a key supporting function for health markets, stewardship facilitates strategic engagements such as demand planning and commodity forecasting for the entire market, private sector access to government initiatives (e.g. training, free commodities), and supporting sustainable data platforms that increase the visibility of the private sector landscape.

Markets also need clear rules and regulations and efficient allocation of resources to function effectively and equitably. While policy and regulatory oversight is a core government rule-making function, involvement of the private sector in developing the policies and regulations that impact them often improves adherence. Financing strategies that include the private sector are vital to the development of robust and effective local health markets and are often a mix of government budget support (e.g. government contracting), donor financing, social insurance (e.g., other government agency), out of pocket client costs and other private sources (e.g., credit, insurance, capital).

Governments, as stewards of their own healthcare systems, face many challenges in overseeing health markets, such as insufficient understanding of constraints and barriers that inhibit the functioning of local markets. In many cases, they would benefit from improved knowledge of where private providers are located, the nature and level of the services they provide, and specifically what family planning and other health products, services, and information are offered. Government stewards may also benefit from improved human resources and market data needed to build and implement effective monitoring and supervision systems. In turn, these systems will strengthen governments' ability to devise policies that include the private sector, to better regulate private healthcare delivery, and develop health procurement and financing strategies that support the entire healthcare market and enable strategic engagement with the broader private sector for improved health outcomes[21].

Market actors, particularly private sector entities and healthcare consumers, often face numerous constraints which inhibit their full participation in the health market and limit the effectiveness of local health markets. Some of the common causes of health market inefficiencies are discussed below. FHM will address these through a combination of market development and private sector engagement approaches rather than relying on any single modality.[22]

***Asymmetries in information*** negatively affect both consumers and private healthcare providers. For consumers, this lack of information results in limited knowledge of health issues in general, low demand for quality health products and services, and lack of transparency on fair pricing of products and services. For providers, limited clear information about policies and regulations constrains their ability to offer services aligned with national policies, since they are

[21] Lagomarsino, Gina & Ferranti, David & Pablos-Mendez, Ariel & Nachuk, Stefan & Nishtar, Sania & Wibulpolprasert, Suwit. (2009). Public stewardship of mixed health systems. Lancet. 374. 1577-8. 10.1016/S0140-6736(09)61241-1.

[22] Montagu, D., and Goodman, C. 2016. Prohibit, constrain, encourage, or purchase: how should we engage with the private health-care sector? https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30242-2/fulltext

unaware of expectations and risks. As a result, consumers cannot make meaningful comparisons in terms of service quality and affordability.

The lack of readily accessible ***market intelligence*** on the depth, breadth and location of the private sector offerings make it difficult to understand the full scope of the health market. Difficulties arise for those who want to "buy services" to find those "who sell services", particularly limiting consumer decisions. It also makes it difficult for the private sector to demonstrate their contributions to the overall health market, advocate for resources and for the government to effectively engage with the private sector.

For-profit providers often struggle to provide ***quality*** services due to several factors. These factors include: inaccessibility of policy updates to the private sector; lack of coordination between the public and private sector; lack of information on technical updates and inability to gain new technical and clinical skills; difficulty attracting and retaining quality staff; lack of financial support for the provision of public health (vs curative) services; and lack of funds for medicines, equipment, supplies and maintenance. Lastly, these providers rarely receive any supportive supervision visits that could provide them with updated information.

***Medicines*** are a key driver of high out-of-pocket costs for consumers. In many countries, supply chains are highly fragmented and inefficient. The cost of quality assurance is high for local wholesalers and distributors who often sell medicines to providers and pharmacies on credit with long repayment periods. Many private health businesses are small, which means they pay high prices for small volumes of medicines and other supplies. The lack of price controls and market transparency, such as a recommended retail price, mean that additional costs are added to the products as they are distributed to the last mile, resulting in clients paying high prices for their medicines and other supplies. In addition, weak regulatory enforcement leads to leakage of products between sectors, poor quality, substandard and/or counterfeit products.

Financing of health services often falls on the consumer. ***Out-of-pocket*** (OOP) spending, particularly among the poor, is a significant barrier to healthcare and may contribute to financial hardship and impoverishment[23]. In South Asia and West Africa, OOP spending constituted about 64 percent of total health spending in 2017[24]. High OOP spending is correlated with large private health markets and tend to be few financial protections or social safety net programs. Research also suggests a lack of equity exists in such contexts; poorer patients are more likely to go without healthcare than wealthier patients, and to spend proportionately more of their incomes on healthcare[25] [26]. In many countries, risk pooling and/or insurance or other financing mechanisms are nascent and often exclude for-profit providers. Strategies such as contracting out services to the private sector or use of vouchers can improve equity and access but may be limited in scope.

[23] Universal Health Care Coverage Fact Sheet, https://www.who.int/en/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

[24] Flows of Global Health Financing, https://vizhub.healthdata.org/fgh/

[25] Where Do Poor Women in Developing Countries Give Birth? A Multi-Country Analysis of Demographic and Health Survey Data Montagu D, Yamey G, Visconti A, Harding A, Yoong J (2011) Where Do Poor Women in Developing Countries Give Birth? A Multi-Country Analysis of Demographic and Health Survey Data. PLOS ONE 6(2): e17155. https://doi.org/10.1371/journal.pone.0017155

[26] Gwatkin DR, Bhuiya A, Victora CG. Making health systems more equitable. Lancet. 2004 Oct 2-8;364(9441):1273-80. doi: 10.1016/S0140-6736(04)17145-6. PMID: 15464189.

While OOP spending from users or participation in health financing programs can help cover the costs of some health products and services, private sector health businesses cannot grow without ***capital*** investments. Private sector businesses (e.g., wholesalers, clinics, pharmacies) are often small and fragmented with limited business acumen, and not seen as creditworthy investments by financial institutions. In many LMICs, limited access to affordable financing options, for both nonprofit and for-profit health businesses, is a key constraint to providing quality services and growing their business.

FHM aims to address the challenges identified above to facilitate the removal of key market barriers in order to improve equitable access to high quality FP and/or other health sector information, products, and services. Some key market opportunities include, but are not limited to the following:

- Build upon growing acknowledgement by governments that the private sector is a key contributor to health in order to engage governments in market stewardship;
- Strengthen appropriate structures to enable key stakeholders to participate in the market system, particularly the MOH to fulfil their stewardship role to improve health services;
- Introduce and share models of joint regulation and oversight to ensure quality of care within the private sector without being unduly restrictive;
- Incentivize the private sector to provide quality and equitable health products, services, and information;
- Support sustainable data platforms that improve visibility of the private sector landscape and increase availability of market analytics to benefit all sectors;
- Improve service offering and price transparency information to consumers;
- Develop/scale up tools and approaches to enhance affordability of private sector services;
- Enhance access to affordable risk pooling and working capital financing.

**Cross-Cutting Considerations for the Private Health Sector**

*Urbanization*
More than half of the global population now lives in urban areas. In sub-Saharan Africa, urban areas currently contain 472 million people, and this will double over the next 25 years. Studies have found that the private health sector is largely urban based, with a lesser footprint in rural areas, except for the informal sector. Urban populations are more likely to use the private sector than rural populations. In addition, in many countries urban primary health care is governed by a city or municipal body, rather than the Ministry of Health, which can create challenges for financing and adequate supervision. Rapid urbanization could be an opportunity for the private health sector to deliver quality services, including family planning, if their capacity is built and relevant government officials are able to engage and effectively provide oversight.

*Building resilience in response to COVID-19*
The COVID-19 pandemic has illustrated the need to engage the private sector to build more resilient health systems to respond to existing challenges as well as future pandemics. The private health sector, especially pharmacies and drug shops, are often the first source of treatment for respiratory infections, making them front-line responders in screening, treatment, and referrals for COVID-19. Other private providers can be leveraged to surge capacity in a crisis if there is an ability of the public sector to contract these private providers. Strengthened engagement of private providers is integral for ensuring continued delivery of essential services, including family

planning, during a pandemic response. The global recession caused by COVID-19 has increased the need to leverage private capital to supplement donor and domestic government financing for health. Lastly, private sector expertise and technology can help find innovative solutions to get contraceptives, medicines, services, and information to patients more effectively and efficiently. Engaging the private sector at all levels of the health system can serve to increase client-centered care and create more sustainable, resilient systems.

*Youth*

There are more than 1.8 billion young people (ages 10-24) worldwide[27], with the majority living in LMICs, primarily across South Asia and sub-Saharan Africa. Youth often face barriers in accessing products, services, and information at health facilities, such as provider bias and age restrictions. Thus, they turn to private pharmacies and drug shops where they can more easily access condoms, emergency contraception (ECs), oral contraceptive pills (OCPs), or HIV self-test kits, and to social media for information. Youth and adolescent-friendly services, products, and information are needed to empower youth to make healthy decisions starting at a young age and to help youth avoid risky behaviors.

*Gender*

While gender gaps have narrowed over the past two decades, substantial inequities remain across every development priority worldwide. USAID's Gender Equality and Female Empowerment Policy (Appendix B), USAID's Essential Considerations for Engaging Men and Boys for Improved Family Planning Outcomes (Appendix K), and the United States Strategy to Prevent and Respond to Gender-Based Violence (Appendix L) highlight key USAID priorities. The private health sector can play a key role in closing gender gaps by catering to unique demographic groups. For example, although men are significantly less likely to know their HIV status or be retained in HIV care, they are more likely to access HIV testing in the private sector. Sexual minorities and other key populations (e.g. men who have sex with men, female sex workers, transgender men and women) are also more likely to access care in the private sector, particularly at non-profit/civil society organizations.

Under each Round, applicants are requested to incorporate fundamental cross-cutting principles underlying each of the outcomes of FHM's Results Framework. These principles are:

- Implementing evidence-based approaches and interventions;
- Fostering iterative, continuous learning and adaptive management;
- Improving the quality of care provided across the continuum from household to facility;
- Promoting client-centered care by listening to and engaging individuals, families, and communities;
- Addressing the role of social norms, both as barriers and contributors to achieving health and development outcomes;
- Coordinating research, monitoring, and evaluation agenda across FHM investments for strategic alignment, learning and information exchange;
- Partnering with a range of private sector health and non-health actors;
- Promoting dignity, respect, and equity in healthcare services;

[27] The Power of 1.8 Billion Adolescents, Youth and the Transformation of the Future https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP14-Report_FINAL-web.pdf

- Fostering gender equality by increasing use of approaches designed to empower vulnerable populations including women and couples, and engage men more fully in FP and/or other health areas; and
- Building and bolstering the resilience[28] of populations and communities, thereby encouraging sustainability, and leveraging the work of other US government agencies and donors.

**Coordination of Awards**

FHM will complement and build upon other private sector engagement mechanisms within USAID. While there are a range of awards within the agency that focus on private sector engagement, none of them engages in the development of health markets in the way that FHM will. FHM will be expected to collaborate with related awards to ensure complementarity and that there is no duplication of efforts. USAID private sector engagement awards with which FHM may want to coordinate include, but are not limited to:

- **CATALYZE (DDI/PSE Hub):** CATALYZE engages with domestic and international finance providers to mobilize financing across sectors, geographies and transaction type and size. This market development approach enables enterprises to obtain the necessary investment and working capital to sustain and grow their businesses, and advance development priorities. While FHM may incorporate aspects of financing in its work, the main focus will be market development approaches for improved healthcare delivery in the private sector and improved market functioning.

- **Integrated Health Systems IDIQ and TO 1 "Local Health System Sustainability" (GH/OHS):** This mechanism supports partner countries and USAID operating units to plan and implement health system strengthening (HSS) solutions with the overall goal of improving health and transitioning capacity to local partners. The mechanism focuses on overall country health systems strengthening including a mix of public and private interventions. Complementary to this focus, FHM will focus on supporting the private sector through market development approaches in voluntary family planning and/or other specific health/disease areas.

- **Scale for Impact (GH/CII):** Scale for Impact aims to accelerate and magnify the impact of priority global health innovations by leveraging the most successful private sector principles and practices. The objective is the rapid development and diffusion of innovations by ensuring timely and appropriate planning for and introduction of priority global health products and technologies. FHM and Scale for Impact may choose to collaborate when FHM's market development work touches upon the rollout and scale-up of global health innovations.

- **MOMENTUM Private Healthcare Delivery (MPHD) (GH/PRH):** MPHD is a service delivery award seeking to expand access to - and use of - evidence-based, quality MNCH/FP/RH information, products, and services through private providers by: (1)

[28] USAID defines resilience as "the ability of people, households, communities, countries and systems to mitigate, adapt to, and recover from shocks and stresses in a manner that reduces chronic vulnerability and facilitates inclusive growth" (USAID, 2012)

ensuring increased availability of and demand for evidence-based, quality, voluntary family planning and MNCH information, services, and supplies through private providers; and (2) expanding public and private partnerships to ensure a total market approach for improved health care access and coverage. While MPHD's focus is on service delivery, FHM's scope is broader, including systemic improvement for market development, private sector engagement, creating an enabling environment for the private sector, and local business support.

Specific rounds of FHM may specify other USAID agreements or contracts that FHM should coordinate with during implementation of those rounds.

## B. Results Framework

**Goal:** Contribute to the Agency's priorities of preventing maternal and child deaths, controlling the HIV/AIDS epidemic, combating infectious disease, and strengthening countries' healthcare markets.

**Purpose:** Increase private health sector contributions to advance voluntary family planning (FP), maternal, newborn and child health (MNCH), malaria, tuberculosis (TB), other infectious diseases, and/or HIV/AIDS) outcomes[29].

### Expected Results

### Result 1: Improved market environment for greater private sector participation in the delivery of health products and services.

FHM will focus on improving the market environment for private sector delivery of FP and/or other health outcomes. It will strengthen the capacity of the public sector to be a more effective steward of the private sector through coordination and collaboration to break down key barriers for private sector engagement including financing, policy, regulatory frameworks, data and information management and commodities. It will also work with the private sector to assess the impact of policies, identify and advocate for key issues, and help organize and engage in dialogue with the government to ensure the provision of quality FP and/or other health products, services, and information. Rounds under this APS will create relationships and networks, mobilize resources, and generate market intelligence for investment. It will also support access to timely and accurate health market data for use by the public and private sector to improve performance and effectiveness as well as to inform planning and management decisions.

This will be achieved through the following intermediate results:

- IR 1.1: Strengthened and supported effective public sector stewardship of and engagement with, the private sector
- IR 1.2: Mobilized and leveraged financial and non-financial resources and incentives to improve private sector capacity, responsiveness, and financial sustainability

[29] Each FHM round may specify health areas of focus.

- IR 1.3: Improved institutional norms, rules and regulations, and organization of the private sector to support market growth
- IR 1.4: Increased effective collection, integration and utilization of private sector data and market intelligence for informed public and private-sector decision-making

**Result 2: Improved equal access to, and uptake of, high-quality consumer-driven health products, services, and information.**

FHM will generate demand and increase the supply of quality private sector-led FP and/or other health interventions, while ensuring equity in access. There will be an increase in demand and utilization of private sector FP and/or health interventions, by improving the quality and client-centered nature of these interventions, which will further accelerate the development of health markets in low- and middle-income countries. FHM will enhance the supply and availability of quality FP and/or other health products and services through approaches that improve the market environment (Result 1) and increase resources to and capacity of private providers.

This will be achieved through three intermediate results:

- IR 2.1: Improved quality of care and client-centered focus of healthcare services in the private sector
- IR 2.2: Enhanced, sustainable supply of quality, affordable health products and services in the private sector
- IR 2.3: Increased client-driven demand for priority health products and services in the private sector

**Illustrative set of indicators of market performance (not comprehensive):**

- Changes in total volume and total value distributed across public and private sectors of quality FP and/or other health products and services;
- Trends in reported use, affordability, and accessibility of priority health care/products across private and public sectors and in relation to the addressable health market;
- Progress against standards in market-diversification and equity of access in terms of brands, price, and coverage/availability;
- Measures of market development in terms of optimum subsidy and funding diversity (donor, domestic, commercial) at the micro/macro levels;
- Number of private sector health and non-health actors and new and local partners engaged and actively contributing to the growth of a local health markets;
- Value of private capital or grants distributed to the private health sector, and number of private providers participating in health insurance/risk pooling schemes.

Subsequent Round documents may propose additional illustrative indicators.

## C. Legislation

This APS is issued under the Foreign Assistance Act of 1961, as amended. In each Round, award(s) will be made under relevant federal regulations and Agency policy. For U.S. non- governmental organizations, awards must be administered according to 2 Code of Federal Regulations (CFR) 200 and 2 CFR 700, and USAID Standard Provisions will

apply (http://www/usaid.gov/policy/ads/300/303maa.pdf). For non U.S. non-governmental organizations, USAID provisions for non U.S. non-government organizations will apply (http://www.usaid.gov/policy/ads/300/303mab.pdf).

**End of Section I**

# SECTION II: AWARD INFORMATION

Issuance of this APS and/or related Round under this APS do not constitute an award commitment on the part of the U.S. Government, nor do those commit the U.S. Government to pay for any costs incurred in the preparation or submission of questions, comments, suggestions, Concept Notes, and/or Full Applications. Applicants submit Concept Notes/Applications at their own risk, and all preparation and submission costs are at their expense.

Note: This APS is not a request for Concept Notes. Applicants must provide Concept Notes in response to, and in accordance with the instructions provided in a specific Round to this APS. Specific information and instructions for Concept Notes submission under this APS will appear in individual Rounds. Each Round will be the exclusive source of funding through this APS and will be posted on www.grants.gov.

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

The funding for the Rounds under this APS may be provided through GH offices, as well as USAID Mission field support for USAID/W issued Rounds, and direct USAID Mission funds for USAID/Mission Rounds. USAID's GH Bureau anticipates awarding multiple grants and/or cooperative agreements as a result of this APS to meet the Purpose and Results mentioned above. The actual number of assistance awards, if any, under this APS is subject to the availability of funds and the interests and requirements of Operating Units (OUs), as well as the viability of eventual Applications received. There is no predefined minimum or maximum number of awards USAID OUs will support through this APS. The financial range for award(s) will be specified in each Round.

## B. Start Date and Period of Performance for Federal Award

The proposed period of performance for each agreement awarded as a result of each Round under this APS will not exceed five years in duration beginning from the negotiated start date, and subject to availability of funds. Full applications should propose activities for a five-year period of performance. If the expected period of performance will be less than five years for a specific Round, that Round's procurement document will include that information. Additionally, the anticipated start date for a possible award(s) will be specified in each Round.

## Type of Instrument

Awards that result from this APS may take the form of a grant or cooperative agreement. Each Round will define the type of award that will be issued.

## C. USAID's Substantial Involvement

USAID's substantial involvement during the implementation of cooperative agreements will be limited to approval by the Agreement Officer's Representative (AOR)—delegated to the AOR by the Agreement Officer (AO)—of the elements listed below, and as stated in ADS 303.3.11. Any, changes to the program description, key personnel, or the approved budgets will require AO approval.

*Approval of the Recipient's Implementation Plans:* Implementation plans include, but are not limited to, annual work plans, including planned activities for the following year and any

subsequent revisions, international travel plans, planned expenditures, international meeting preparation, research studies or protocols, and any changes to any activities, locations, and beneficiary population under the cooperative agreement.

USAID requires the approval of implementation plans annually to ensure alignment with stated goals, milestones, and outcomes. The implementation plan communicates how and when the Recipient will complete award activities and is drafted annually to describe new and ongoing activities. This plan will be developed in partnership between the Recipient and the AOR team. The AOR will ensure that the implementation plans fit within the program description and the terms and conditions of the agreement.

*Approval of Specified Key Personnel will be specified in each Round's procurement document.* Key personnel positions will require concurrence from the AOR and approval from the AO.

**Agency and Recipient Collaboration or Joint Participation:**

- *Approval of the recipient's Monitoring and Evaluation plans.* This describes USAID involvement in monitoring progress toward the achievement of program objectives during the performance of the award, including written guidelines for the content of annual reports and final evaluations in accordance with 2 CFR 200.328 and guidance conforming with PEPFAR reporting requirements at country level, if necessary. While an illustrative Activity Monitoring, Evaluation, and Learning (MEL) Plan may be requested in the full application submission, the final Activity MEL Plan will be developed in consultation with USAID post- award. During the initial award planning period, the awardee shall work closely with USAID to establish major milestones, program monitoring indicators, baseline data collection plans, and performance targets that will demonstrate successful achievement of the results addressed in the cooperative agreement. The Activity MEL plan shall be finalized within 90 calendar days of the award. The awardee and USAID will jointly review progress on a periodic basis.

- *Monitor to authorize specified kinds of direction or redirection because of interrelationships with other projects.* Activities will be included in the program description, negotiated in the budget, and made a part of the award. Note: the AOR will provide review of the proposed change, and the AO is the only individual who can provide approval for this element of substantial involvement.

- *Concurrence on the substantive provisions of sub-awards.* 2 CFR 200.308 (or Mandatory Provision 3. Amendment of Award and Revision of Budget (August 2013) for non US NGOs) requires the recipient to obtain the AO's prior approval for the sub-award, transfer, or contracting out of any work under an award. The term 'sub-award' includes both sub-agreements and contracts under assistance. Some of the sub-award approval responsibilities may be delegated to the AOR. Please note that any sub-awards (sub-agreements or contracts) to foreign governmental organizations or parastatals of any amount must be approved by the AO, and may warrant additional clearances.

- *Agency Authority to Halt a Construction Activity.* The AO may immediately halt a construction activity if identified specifications are not met. However, major construction

activities are not anticipated under any award(s) resulting from each Round under this APS pursuant to Automated Directive System (ADS) 303. On a case-by-case basis, the awards under each Round(s) of this APS may have the ability to engage in minor renovation and small-to medium-scale rehabilitation of health facilities to improve the quality and/or availability of MNCH/FP services. Examples may include, but are not limited to, installation of water and sanitation facilities such as handwashing stations, refurbishment of maternity wards, repair of roofing, and enhancements for client privacy. Any minor renovation or rehabilitation of health facilities will be funded by field support with the exception of any possible unforeseen emergency appropriation directives (i.e. Ebola). Therefore, USAID Missions must complete relevant risk assessments before the partner can incur costs for any minor construction work as per ADS 201.3.4.3, ADS 201maw Construction Risk Management, and ADS 303maw USAID Implementation of Construction Activities.

**D. Intellectual Property**

Intellectual Property is discussed in 2 CFR 200.448 (for US NGOs) and in Mandatory Provision 7. Title to and Use of Property (December 2014) (for non-US NGOs). In general, awardee(s) may elect to pursue ownership of intellectual property that is developed as a result of an award from a Round of this APS. In such cases, USAID would typically retain a nonexclusive, non-transferable, royalty-free license to use any such intellectual property.

**E. Environmental Impact**

The Foreign Assistance Act of 1961, as amended, Section 117 requires that the impact of USAID's activities on the environment be considered and that USAID include environmental sustainability as a central consideration in designing and carrying out its development programs. This mandate is codified in 22 CFR 216 and in USAID's ADS Parts 201 and 204, which, in part, requires that the potential environmental impacts of USAID-financed activities are identified prior to a final decision to proceed and that appropriate environmental safeguards are adopted for all activities. All recipient's environmental compliance obligations under these regulations and procedures are specified in the following paragraphs of this APS.

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

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

It has been determined that the activities conducted under this APS will not negatively impact the environment. In accordance with the 22 CFR 216, an IEE recommended a negative determination with conditions as any award(s) resulting from a Round under this APS will not have a significant effect on the human, physical, and biological environment. The AOR management teams will provide the awardee(s) with a copy of the IEE and will continue to collaborate with the GH

Environmental Officer to ensure the award(s) and associated activities incorporate environmentally sound principles in implementation and adhere to this determination of a "Negative Determination with Conditions." All awardees will comply with country, USAID, and World Health Organization (WHO) guidance for disposal of sharps and biohazards, as necessary, in preparing an integrated Waste Management Plan (WMP) or equivalent standard operating procedures (SOPs). All awardee(s) will also prepare and implement an Environmental Mitigation and Monitoring Plan (EMMP), as well as annually prepare and submit an Environmental Mitigation and Monitoring Report (EMMR) to the AOR, the latter of which will include a screening in the annual work plan for all on-going and planned activities to ensure they are within the scope of the IEE. Any activities found to be outside the scope of the IEE shall be modified to comply or halted until an amendment to the IEE is submitted and approved. Any sub-awards (sub-agreements, contracts, and grants) must reference and require compliance with the IEE, and completion of all requirements for ethics review and adequate medical monitoring of human subjects who participate in research trials must be documented and in place prior to initiating any trials.

## F. Authorized Geographic Code

The authorized geographic code for the procurement of services and commodities is 937.

## G. Benefiting Geographic Areas

Frontier Health Market award(s) will provide global leadership and will implement activities in countries where USAID currently supports health and other complementary private sector engagement activities, primarily in Asia and sub-Saharan Africa, with a limited number of countries in the Latin American and Caribbean region. Current MCHN, PRH and OHA priority countries are Afghanistan, Bangladesh, Benin, Botswana (OHA only) Burkina Faso, Burma (MCHN only), Cameroon (OHA only), Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Haiti, India, Indonesia (MCH only), Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia (OHA only), Nepal, Niger, Nigeria, Pakistan, Philippines (FP only), Rwanda, Senegal, South Africa (OHA only), South Sudan, Tanzania, Togo, Uganda, Yemen, Zambia and Zimbabwe. OHA (through the PEPFAR program) has additional regional programming in Asia and Latin America. The links to a full list of PEPFAR and TB priority countries can be found in the footnotes[30] [31]. This does not, however, preclude activities in other countries which received USAID support. If a Round of this APS has a specific geographic focus, it will be clearly stated.

**End of Section II**

[30] https://www.state.gov/where-we-work-pepfar/

[31] https://www.usaid.gov/global-health/health-areas/tuberculosis/countries

# SECTION III. ELIGIBILITY INFORMATION

## A. Eligibility Criteria

U.S. and non-U.S. public, private, for-profit, and nonprofit organizations, as well as institutions of higher education, public international organizations, and non-governmental organizations, are eligible to submit a concept paper under each Round(s) of the APS. Further, the organization must be a legally recognized, organizational entity under applicable law, legally registered in a country within the geographic code 937 ("the United States, the recipient country, and developing countries other than advanced developing countries, but excluding any country that is a prohibited source," per ADS 310.3.1.1).

Each recipient must be a responsible entity. The AO 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 prospective recipient has the necessary organization, experience, accounting and operational controls, and technical skills – or ability to obtain them – in order to achieve the objectives of the program.

Organizations in developing countries are strongly encouraged to apply, inasmuch as they will support not only the objectives of this APS and the Round(s) they are applying to, but also USAID's objectives to build the capacities in local organizations that are needed for sustainable development. USAID strongly encourages applications from potential new partners who meet the eligibility requirements and are willing to be subjected to a Pre-Award Survey.

Concept papers from organizations that do not meet the above eligibility criteria will not be reviewed and evaluated. Individuals are not eligible to apply for any Rounds of this APS.

While for-profit firms may participate, pursuant to 2 CFR 200.400(g) it is USAID's policy not to award profit to prime recipients and subrecipients under assistance instruments. However, while profit is not allowed for sub-awards, the prohibition does not apply when the recipient acquires goods and services in accordance with 2 CFR 200.317 -326, "Procurement Standards." This is discussed more specifically in ADS 303sai "Profit Under USAID Assistance Instruments".[32]

Program income may be generated under awards resulting from this APS. Program income for all award(s) resulting from Rounds under this APS may be used for cost-sharing or matching in accordance with 2 CFR 200.307(e) for US NGOs and the Required as Applicable Provision "Program Income" (December 2014) in ADS 303 for non-US NGOs. If the program income is to be utilized in a different way, the Round document will include this information. It must be used in a manner allowable under the CFR and ADS references above.

If an organization does not submit a successful concept paper and is not invited to attend a co-creation workshop or submit a full application in a specific Round, that organization may still submit another concept paper in a future Round(s), if one occurs. Evaluation criteria will be revised to the specifics of the Round; another submission in another Round does not guarantee a successful concept paper and invitation to attend a co-creation workshop/submit a full application.

[32] https://www.usaid.gov/sites/default/files/documents/1868/303sai.pdf.

## B. Cost Share

Cost share will be required in each Round (unless the Round document specifies otherwise). A required range for cost share will be provided in the request for full applications for each Round; the range will allow for the proposed amount to be commensurate with an eligible organization's financial capabilities and access to resources, especially those that have not previously partnered with USAID. Such funds may be mobilized from the recipient; other multilateral, bilateral, and foundation donors; host governments; and local organizations, communities and private businesses that contribute financially and in-kind to the implementation of activities at the country level. Mobilization of funds from outside sources through cost share of award activities is highly encouraged.

For guidance on cost sharing in grants and cooperative agreements, please see the ADS 303.3.10 and 2 CFR for US NGOs. For non-US NGOs, all cost sharing would be subject to the Required as Applicable Provision "Cost Sharing" in ADS 303mab.

**End of Section III**

# SECTION IV. CONCEPT PAPER SUBMISSION INFORMATION

Concept papers will be accepted under issued Rounds of the Frontier Health Markets (FHM) APS. Please refer to the specific Rounds for detailed information on the concept paper submission guidance including concept paper requirements and evaluation criteria. General guidance for all Rounds under this APS is provided below.

## A. Concept Paper Process

Concept papers received under FHM APS Rounds will be reviewed based on full and open competition and under the procedures and criteria identified in Section V and any additional criteria identified in each specific Round documentation. After a concept paper is received, USAID reserves the right to pose clarifying questions to applicants, but may not opt to do so if it believes it has sufficient information in the concept paper itself.

For applicants seeking to receive USAID funding to implement proposed activities under a Round of this APS, USAID's discussions with those applicants will take place within the parameters of publicly available information. These parameters provide ample room for extensive, robust discussions regarding the development problem/goal in question (Section I of this APS, and specified in each Round), best practices, lessons learned in the relevant technical sectors, and pertinent research and evaluations and various other matters. After concept papers have been submitted, USAID personnel can have highly specific, detailed activity design discussions with the applicants throughout the remainder of the process, e.g., up to and through any award that might be issued under a Round of this APS. USAID also reserves the right to make an award without discussions if determined to be in the Government's best interest. Additionally, USAID may make an award on the basis of initial concept papers received, without scheduling a co-creation workshop.

Concept papers should be free of any intellectual property that the applicant wishes to protect, as the concept papers may be shared with other organizations as part of the co-creation process. However, once potential partners have been invited to engage in further discussions, they will work with USAID to identify proprietary information that requires protection. Therefore, organizations submitting concept papers provide USAID a royalty free, non-exclusive, and irrevocable right to use, disclose, reproduce, and prepare derivative works, and to have, or permit others to have, use of any information contained in the concept paper submitted under each Round(s) of this APS. If USAID engages with the organization regarding its concept paper, the parties can negotiate further intellectual property protection for the organization's intellectual property. Organizations must ensure that any submission under all Round(s) of this APS is free of any third-party proprietary data rights that would impact the license granted to USAID herein.

Concept papers are not evaluated against other concept papers, but rather against the criteria stated in the individual Rounds. The evaluation of the content in the concept papers against the Round-specific criteria will allow USAID to determine if an organization could make valuable technical contributions to the co-creation process; the ideas in the concept papers may or may not be the same approaches developed further during co-creation, though the solutions and strategies generated may draw from these ideas.

No additions or modifications to concept papers will be accepted after the submission date for each Round of this APS. Concept papers that are submitted late or are incomplete may not be considered for the co-creation workshop or request for full applications (if co-creation workshop is not held). Additional information in the concept paper not requested by each Round of the APS may be removed and may adversely affect an applicant's evaluation/review.

Not every organization that submits a concept paper through a Round of this APS will automatically be selected to participate in co-creation. Due to the number of concept papers received, USAID is not able to provide details on why concept papers were not selected. USAID may limit the number of initial submissions selected to move forward based on efficiencies.

If requested to submit a full application, the applicant(s) (unless the applicant is an individual or Federal awarding agency that is excepted from those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the Federal awarding agency under 2 CFR 25.110(d)), are required to:

i. Be registered in SAM (System for Award Management) before submitting its application;
ii. Provide a valid DUNS (Data Universal Numbering System) number in its application; and
iii. Continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency.

USAID will not make a Federal award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements. Applicants must comply with the requirements listed above, at the time of application submission. USAID may determine that the applicant is not qualified to receive a Federal award and use that determination as a basis for making a Federal award to another applicant.

Per 2 CFR Appendix I to Part 200, Full Text of the Notice of Funding Opportunity, Section E, 3, USAID informs all potential applicants:

i. That the Federal awarding agency (USAID) prior to making a Federal award with a total amount of Federal share greater than the simplified acquisition threshold, is required to review and consider any information about the applicant that is in the designated integrity and performance system accessible through SAM, currently Federal Awardee Performance and Integrity Information System (FAPIIS) (see 41 U.S.C. 2313);

ii. That an applicant, at its option, may review information in the designated integrity and performance systems accessible through SAM and comment on any information about itself that a Federal awarding agency (USAID) previously entered and is currently in the designated integrity and performance system accessible through SAM;

iii. That the Federal awarding agency (USAID) will consider any comments by the applicant, in addition to the other information in the designated integrity and

performance system, in making a judgment about the applicant's integrity, business ethics, and record of performance under Federal awards when completing the review of risk posed by applicants as described in CFR 200.205 Federal awarding agency review of risk posed by applicants.

**End of Section IV**

# SECTION V. APPLICATION REVIEW INFORMATION

**Review of Concept Papers and Full Applications**
Once a concept paper has been submitted in response to a Round under the Frontier Health Markets APS, USAID will conduct an initial review of the concept paper using the criteria outlined in the individual Round of the APS. The awarding Mission or Operating Unit of the FHM APS Round will review submissions.

The purpose of the initial review is to determine whether USAID wishes to engage in further discussions regarding the proposed approach and activities. The initial review and communication will result in one of three outcomes:

- A decision to forego further consideration of the approach proposed in the concept paper;
- A decision to provide the Applicant an opportunity to submit a revised concept paper (this is very rare); OR
- An invitation to engage in more in-depth and specific co-creation discussions aimed at further developing the proposed approach and determining whether to request a Full Application.

**Co-Creation Opportunity**
USAID may use co-creation with prospective applicants during various stages of Round procurements using either virtual or in-person approaches and different formats (e.g. technical workshops, document review and feedback, etc.). The goals of co-creation efforts are envisioned as follows:

- To explore and validate key challenges and problems, and then jointly develop promising solutions or adapt and expand upon existing solutions;
- To bring together a diverse group of potential applicants, to identify potential consortia and partnerships to support these new or existing solutions and activities;
- To facilitate learning, sharing, and networking across USAID, a range of partners and relevant technical experts.

**Note: Any costs associated with attending a co-creation workshop will not be reimbursed by USAID.**

**Note on additional partners/resources**: Until full applications are submitted, both the applicant and USAID may identify and include potential additional technical partners and/or potential resource partners that may or may not have submitted concept papers. Additional partners may be included as sub-partners on a full application if there is an agreement to do so between the potential sub-partner, the original concept paper applicant, and USAID, but this is not guaranteed. Discussions with potential technical and/or resource partners may continue throughout each Round's process and during implementation.

USAID reserves the right to remove any co-creation participant from award consideration should the parties fail to reach agreement on activity concept, design, award terms, conditions, or cost/price within a reasonable time, the participant fails to provide requested additional information in a timely manner, or the U.S. Government believes it is in its best interest.

**Note: None of USAID's communication during the co-creation process in all Rounds of this APS should be interpreted as a commitment to making an award of USAID funding.**

Applicants are advised that participation in the co-creation process under Rounds of this APS is entirely at their own risk; the Government is not responsible for any costs incurred by the applicant, if the applicant decides to accept the invitation to co-create with USAID. A commitment to an award of USAID funding is only made when a cooperative agreement is signed by the Agreement Officer.

**Full Application Process**

Following concept paper review and evaluation, highly rated applicants will be asked to submit a full technical and cost application, though a Request for Application (RFA). The RFA will provide submission instructions and the evaluation criteria. The RFA should not be interpreted as a commitment to funding or guaranteed issuance of the award. Full applications received in response to the RFA, will be evaluated by the Merit Review Committee.

Each Round will provide evaluation criteria for both the concept paper and full application stages. The Merit Review Committee may suggest revisions and additions to the proposed project as well as potential partners and resources. USAID will continue to have robust communication with applicants, potential partners, and other key stakeholders regarding the technical substance of the evolving approach, as well as the identity and roles of proposed or additional partners. USAID may request that key personnel of applicants deemed responsive and eligible deliver an oral presentation describing their proposed technical approach to inform the technical merit review.

**End of Section V**