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- NOFO Number: Notice of Funding Opportunity: RFA-615-16-000008 Human Resources for Health (HRH) Program
- Project Title: Project to strengthen the access to health care in 12 health of South Kivu, DRC
- Name of the organization(s) submitting the application: **Action for the Promotion of the Social Environment, APSE.**
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b. Table of Contents (not included in page limit)
c. Acronym List (not included in page limit)

d. Executive Summary

The perpetuation of the project results depends on the reasonable use of the available resources for sanitary development, the real provision of quality basic health care, and the establishment of a maintenance culture. The qualitative raising of the health staffs management capacities, an efficient plan and management of the health resources and services will enhance the technical efficiency and the cost-efficiency relationship of the project, which will have as effect to contain the recurrent charges.
The interventions relative to the capacity building for this project were integrated in the conceptual framework. Consequently, the funds target the institutional capacity building at the central and ground levels at the same time. The institutional durability will be better guaranteed as a result of the training and the establishment a ratio of trained health personnel and allow them continue to administer qualitative and basic health care after the cessation of the external contributions. It guarantees a technical durability as well by actively promoting the transfer of expertise and knowledge at all levels that establish enough protection against dependency.
The expected increase from the services dispensed in modernized sanitary structures will lead to a massive participation of the beneficiaries in funding the health services on a basis of regulating rates currently paid by the users thus generating additional revenues meant for the upkeep. The added value that constitutes the mixing of sanitary education to the prevention will contribute to a significant awareness and assume more responsibilities in the household in the protection and promotion of the health domain.

The project will be implemented in the South Kivu province over the 12 targeted health zones following the needs for capacity building. The project life span is extended over 3 years starting from September 1st, 2016 to august 30th, 2019 and requires an approximate budget of USD 2.350.000 (US Dollars two millions three hundred fifty thousand).

e. Technical Understanding and Proposed Approaches

The technical application body shall be organized using the same headings as the technical selection factors. The sections are listed and further described below:

1. Selection factor #1- Technical understanding of HRH context and proposed approaches to achieve objectives (60 points)
2. Selection factor #2 - Key Personnel and Management Structure (20 points)
3. Selection factor #3 - Organizational Capacity and Experience (20 points)

1. Selection factor # 1 – Technical understanding of HRH context and proposed approaches to achieve objectives (60 points)

From when the DRC adhered to the international sovereignty, its health system is essentially based on hospitals and health centers supported by mobile teams to fight against endemic diseases. The numerous political crises that the country experienced after then, and that was followed by progressive economic decline, did not leave out the health sector. Thus many hospitals and health centers of the country went lacking in equipments, and the supply chain of drugs broke in between the central level and the ground.

Many meetings are to be mentioned as far as health is concerned: - the organization of the general health states in December 1999; - the holding of the SANRU symposium in February 2003 with the topic « rebuild the primary health care in the DRC » by the community foundation, partners as well as social sectors; - and least, the holding of the health round table in May 2004.

The South Kivu province had experienced and still is going through an unstable political environment back when the country hosted the Rwandese refugees since 1994. The Alliance of Democratic Forces for liberation war in 1998 and the Nkunda and Mutebusi attacks in 2004 are extensions of regional conflicts of (Rwanda, Burundi and Uganda).

Nevertheless, there is hope to rebuild strong democracy and promote liable authorities, supported by a population that wants to break out of ruined years of corruption of all kind, as a result of the electoral process that took the DRC out of transition.

The consequences of wars and tensions are obviously numerous, only to mention psychological and somatic trauma as a result of rape and other forms of torture caused by many armed troops, diseases outbreaks such as malnutrition, and HIV, rural depopulation as a result of insecurity and the desertion of the farming activities that results into overpopulation of the Bukavu town and the increase of the rural an urban poverty.

The lack of access to basic social services :health care, clean water, education should especially be addressed as priority as well as rebuilding basic socioeconomic (roads to transport agricultural produce, water discharge, wells, latrines, health center, bridges,…). Therefore, the drastic decrease at the population's life level and its access to basic needs that should be handled by the revivals of a DRC with a secure territory that is concerned with a

population of South Kivu estimated at 4.538 706 inhabitants with an average density of 69 inhabitants by Km^2.

Currently, a significant proportion of the population of that region is under extreme poverty (less than 1$/day). According to a study of a Netherland-Congolese mixed team (South Kivu provincial department of health, Bukavu Diocesan office of Medical Works and the Netherland NGO Cordaid) led in 2005 by the health economist Dr Robert Soeters, about 2.776 people shared out over 440 households in 4 health zones of the northern district of the South Kivu province; 76% of the population live under poverty with an annual income below USD 67 per person. The average income for the population target of the study is of USD 65, 99.

The South Kivu province in general, and the WALUNGU, KABARE, KALEHE, UVIRA territories in particular, is currently experiencing a difficult economic situation. This situation is featured by a fall of the formal economy, the production mode inherited from colonization that was laid over big agricultural and mining production units. The production capacities have significantly decreased. Many mining enterprises have closed and the yield of the soil has declined as a result of overexploitation.

The South Kivu economy is formally deregulated and dominated by a very dynamic informal system (trade, crafts, etc.) but unfortunately do not manage to initiate a significant job creation process. The absence of a legitimate State device, road, health, medical infrastructures and the insecurity over the last twenty years have been unfavorable to the economy of the Kalehe, Uvira, Walungu and Kabare territories. It has displayed a negative impact on the health care of the population.

The South Kivu province counts 34 health zones shared out into 5 health districts. As far as the health care infrastructures are concerned, the province counts: 1 provincial hospital, 16 general hospitals of reference, 21 secondary hospitals and hospital centers and 412 health centers.

Among these sanitary formations, most of them have stopped functioning or are functioning to idle as a result of insecurity sources due to wars, the dilapidation of the buildings, the systematic lootings; destructions by armed troops and the drug shortage as well as the lack of other medical facilities.

The Walungu, Kabare, Kalehe and Uvira territories like other territories of the DR Congo have been experiencing a deplorable socioeconomic situation over decades. In this way the access to health care is hindered. According to the same study, the health expenditures per person and per year are on an average of USD 5, 69 for the poorest and of USD 20, 75 for the wealthiest “fortunate”, the average expenditures per person are of USD 12, 6.

This represents 13% of the annual budget for the poorest and 7% for the middle class « fortunate » and a general average of 10% expenditures for the health/income per person per year. *Income and expenditures for the health per inhabitant (Soters, IPS, BDOM 2006).* The health care cost is significantly high considering the population’s income. The study estimates

USD 1, 89 as an average cost for an external consultation and USD 10 for a hospitalization per day. That study proves that 51% of people believe that the external consultation bills are extremely expensive. From that same sample, 28% of the respondents mentioned that they had to loan to pay and 33% sold something (goats, cows, clothes, lands, plots, etc.) to clear for their health care bills.

The health care costs are therefore worrisome considering the poor access to financial resources. In that study, over an average of 2, 8 diseases occurrence/person/year, 16% of the affected persons lacked the money to pay for the health care bills and remained at their homes. Many strategies were established by APSE to make the health care accessible by all in the Walungu, Kabare, Uvira and Kalehe territories among others: the reduction of costs through the intervention of improved qualitative performance, the improvement of people' income through the promotion of income generating activities projects in economic rehabilitation sphere of women victim of rape and other vulnerable, the development of mutual solidarity, advocate for the supply of drugs, etc.

These mechanisms turn out to be an interesting sustainable development strategy. On top of its contribution to the reduction of the health care costs; it is job creating and a sustainable local expertise.

The issues identified in the health sector in 2015 can be grouped under 6 categories:

1. **Factors due to emergency situations.**
   The emergency situations that prevailed over the past years with a further worry to do everything at the spot have been an excuse to take medical interventions in a disparate way, without a coherent procedure. One of the consequences of such a way to do is the increase in number of infrastructures that do not meet any logical rationalization of the health cover. Through the logic of bringing closer the health care to the beneficiaries, we assist the establishment of the Reference health centers (CSR) practicing surgical interventions and health posts (PS) in the health areas. Besides the fact that the establishment of CSR and PS have got a harmful influence to the health care quality, the outcomes have got as well, as consequence, through their inefficiency, effects of a long run over the system durability, in an economic point of view but also the technical point of view.

2. **Absence of a real reference framework to define the services of the health zone**

The hospital seems to have been « forgotten » as a structuring component of the health zone and as structure in charge to support the development of first grade services. The division of responsibilities between the management of the hospital and the health zone (head doctor of the hospital and head doctor of the health zone) constitutes as well, a dismantling component of the system. This lack of a common vision has been pointed out during several forums organized within the health sector. Some of these forums can be mentioned: the round table of the health sector held in May 2004, the 2004 annual review, etc. the strategy to strengthen the health system defined in this paper and that is essentially based on the development of the health zones is in fact meant to bridge the gap.

3. The financial system and its pernicious effects

The financial system of the health sector in DRC mainly lies on a tripod made of the State budget, the external contributions (bilateral and multilateral) and the collection of the health care costs and health services to the users (up to 70% of the running fees). The State budget allocated to health and its implementation rates remained poor. For example in 2001, less than 1% of the State budget was allocated to health with an implementation rate of 50%. This budget has certainly increased since 2015, but it remains very low considering the needs in the sector.

There were created a capital flow where the funds raised by the patients are allocated to fund the running of the senior administration as a result of a gradual withdrawal of the State in funding the health system. As years went by, the informal and unfair taxation system rooted and became one of the system's mainsprings for the financial survival of individuals and institutions.

The external aid devoted to the health has certainly increased since 2001, but it is mostly allocated for vertical programs (world funds to fight malaria, HIV/AIDS and tuberculosis, Multi Country Aids Program, etc.). the fact that these resources meant for vertical programs have been practically the ones available in the health sector the following day after the redefinition of the national health policy, has certainly contributed towards the marginalization of the strategy based on the primary health care and the health zone as operational unit.

In a poverty context, the humanitarian interventions were perceived by certain political leaders as the only way to grant resources (vehicles, motorcycles, generators, etc.) to its community. This is the reason as to why the number of health zones decreased from 306 to 515 in 2003 in DRC.

4. Community participation misunderstood

From the view point of poor service delivery, we see many flowing « community networks » rising which are not qualified and have poor technical levels to bring positive change to the health sector personnel. If a resort could be made to the "community networks" during the 70s, the situation has completely changed, whereby the context of the health system is currently featured by an overabundance of nurse personnel and a proliferation of medical teaching schools.

One of the central ideas of the community participation is to make the community own the health sector whereby they have a say over what to offer: we are far back away. Yet the population contributes about 70% to the funding of the recurrent charges to the running of certain health zones.

5. The issue of human resources

Though fragmentary, the current data demonstrate that the human resources for the health sector represent a problem in DRC. If we could confirm that back in 1998 the number of doctors was estimated at 2000 and that of nurses at 27,000, nowadays, it is hard to determine the actual number of doctors and nurses in DRC. In fact, as mentioned above, there are about 60 colleges training doctors and nurses. Every year the Kinshasa and Lubumbashi universities produce about 1500 doctors not to mention the other cities of the country. This makes us believe that their number has been significantly increasing since the beginning of 2000. The Medical Techniques Institutes (ITM), which are about 362 throughout the country complete a training of 7.000 nurses every year. The number is in rapid growth for this category either.

The effects of this perverted inflation of the health sector personnel are already felt on ground. We are witnessing an increase in the number of health structures in the HZ (Health Zones). The number of the health areas that have more than 10 health structures is becoming more and more significant. These structures are being mostly created by the health personnel trained as surplus and that failed to get employment with formal structures. For individual and institutional survival reasons as described above, these health structures that offer quality health care for the least questionable, are maintained from the fact that they contribute to the running of high hierarchical levels.

The lowness of the current salaries offered by the public sector is another factor seriously jeopardizing the implementation of our health policy based on primary health care and the carrying out of other national and international priorities (MDGs). In fact, besides the strengthening of the survival strategy mentioned above, the attitude of not granting the salary funds makes the staffs unstable and thus the continuous tendency to find out a better employer. The lack of incentives to the staffs has led, in specific interventions support logic, to an establishment of achievement allowance systems and other remuneration modes per per-diem, which are the pernicious effects over the staffs and the services, could not wait. This system lead inexorably to payment to an act which is absolutely conflicting with the global approach of health and opposite to the solidarity principle withheld in the national health policy. The sharing out for the least non equitable of human resources between the rural and the urban areas is another issue hindering a good human resources management for the health sector in the DRC.

6. Absence of a leadership in the sector's ministry

The almost constant fall of the State budget allocated to the health has got among others as consequences, the loss of independent decision making within the health Ministry, orient and implement the health national policy (PN) and sub sectoral policies, the inadequacy of coordination from the funders that intervene in the sector by inadequate competent national frameworks able to handle the coordination in line with clearly defined policies and strategies (a large number of national frameworks migrated to the partners and others went expatriate), a lack of control over the sector's finances from the Ministry to the extent that the ones in charge are not aware of the beginning of each budgetary year, of how much resources they

possess and their sources in order to implement the health national policy, making every long term plan uncertain even at the territory level, the conceptual model of the health system based on the health zone as operational unit gets so severely disrupted by other models through which the funders convey their funds.

In conclusion, under the urge of events which are mainly the bad governance, the armed conflicts and the weakness of the Ministry's leadership in the consecutive sector to a constant fall of national resources dedicated to the health, there came up the least doubtful quality health services for which the essential can be summarized as:

- A disarticulation or the splitting up of the services in the health zones due to the inadequacy of the national resources allocated to the sector, and henceforth the loss of the prescriptive power of the Ministry to coordinate the sponsors.
- None coordinated, less effective, less efficient vertical interventions on behalf of the integrated, continuous and global health services meeting the emergency or humanitarian needs.
- Emergency of none coordinated profit making private services and of doubtful quality and that makes the qualitative health care services delivery more complex.

Objectives of the Project

Overall objectives

Contribute to a better overall health level outcome and address the inequalities in health matters amongst the South Kivu inhabitants in the Democratic Republic of Congo

Specific objectives

- Improve the scope covered by basic and qualitative health care in the Walungu, Kalehe, Uvira and Kabare territories in the South Kivu
- Build the technical and operational capacities of 500 health care services providers in the Ruzizi, Lemera, Uvira, Mubumbano, Walungu, Kaniola, Kalehe, Minova, Bunyakiri, Katana, Miti-Murhesa, Kabare health zones in South Kivu.

Expected results

The outbreak of malaria and the extent of the HIV/Aids epidemic are alarming. When there are no struggle measures, the household income and the national savings will highly start on by the increased health expenditures brought about by major public health issues. A wider access to complete quality health care that underserved communities will benefit from will include economic advantages for the households, as a result of lessening the number of good health lost by diseases facts, which will give more chances to people to devote to productive economic activities.

The access to quality health care constitutes one of the barriers to health care for the women, especially in the rural communities. The sanitary infrastructures in the rural areas are often in a poor state, not equipped and lack personnel. Most of people in rural areas leave to distant urban centers seeking for better health care. The health facilities that will be built and/or rehabilitated, equipped, furnished and endowed of well trained personnel will therefore lessen the time to move and the fees related to that quest, and this will provide the rural people (often the poorest) with more time that they will devote to productive activities.
Once these activities are well carried out they will deliver basic health care of a good quality, with a wider scope, to the underserved population in the counties, by providing good productive health services, nearby services and the struggle against HIV/Aids and malaria. These activities will rescue as many people' lives as possible and will boost the productivity and the social well being. The significant disparities women/men at the morbidity charge level, as measured by the death and the life expectancy corrected by the incapacity (AVCI), will appreciably fall down. The messages concerning malaria and HIV/aids can reach as many times as possible millions of people through radio broadcasts, news papers, posts, in schools and clinics and wherever people gather.
If, for e.g. 2 millions of people have acquired adequate knowledge concerning the prevention of malaria and HIV/aids and that only 20 or 30 apply the behavioral change, the risks would have decreased and henceforth, so many human lives will get rescued over the projects' lifespan.

Proposed activities :

- **Bring assistance to the health service delivery in the targeted territories:** the USAID funds will be granted to improve the poor's access to quality primary health care at the health zone level. It is scheduled to inject more resources in this section for categories **Goods**, **Services** and **miscellaneous**. To be able to boost the access to health care of the concerned population from 40%, there will be need for funds to support the expansion of effective actions in terms of cost-effectiveness, that ensures the promotion of basic health care services such as toxic/clinic wastes management, the integrated support to infantile diseases (PECIMI), the safe maternity, and the struggle against transmittable diseases. The module applied for technical training by the health Ministry at the health zone level will be used to train 500 staffs of the targeted health zones. Essential equipments and materials will be granted to disseminate the use of effective strategies such as the PECIMI and the safe maternity.

- **Train 500 health staffs in hospitals and health centers:** the activities that should be funded in this matter will be assessed under proven strategies relevant to the international integrated support to the infantile diseases and the SMI/PF interventions. An assistant will be assured to deal with issues of highly excessive rates of maternal mortality at the health zone level by raising the access level to the SMI/PF, training the traditional obstetricians, by raising the capacity of the midwives and so avoiding complications resulting into abortions with risks, and the availability of blood bank in the transfusion departments. A supplementary training will be given out to the targeted zones, in the management of health services in the health zones for about 50 medical managers, as well as 10 trainers of ophthalmological intervention and about hundred

nurses in the emergency health care and accidents. Training will be organized on top of that for fifty generalist doctors in the treatment instruction matter and the training of the health care staffs for their caution.

- **Intensify the fight against HIV/Aids in the targeted health zones:** instruments cases for HIV test, medical analysis laboratories and edibles meant for the reduction of mother-baby transmission will be granted on top of the IEC equipments, ICT materials and software for the national program for the fight against HIV/aids. There will be support to the CDV and to the local structures for young people and adolescents over sexual reproductive health of the young people and the adolescents in the targeted health zones.

- The USAID funds will be used to build 04 modern pediatrics units to assist children with malformations and affections that require expertise and bring assistance to the children left on their own by their parents: each of the pediatrics will have the capacity to host fifty children and will be constructed around health centers and hospitals. The intervention in the hospital sector is also part of the USAID health policy, and acknowledges that public hospitals are a way to bridge the gap and promote access to the health care by the poor. On top of the establishment of effective clinic intervention services in the health zones, it will help overcome the high medical costs of serious diseases in terms of cost-efficiency. The technical plans match the typical plans of the Ministry of health. The list of equipments contains modern equipments but modest. The furniture includes beds and other furniture for administrative services.

- **The project will fund as well the support to developing a culture of maintenance at the health zone level :** it will be all about allocating resources for sensitization campaigns over the necessity of a preventive upkeep to the managers, as well as topics regarding the upkeep of health investments in the territories to the territory health staffs, to the local authorities and local communities; 30 agents of the health zones will benefit from short training courses such as the upkeep of equipments and the infrastructures. The project will take into account, all the health staffs in the sanitary structures (health centers, hospitals, community clinics, etc.) as well. 04 trainings will be held during two days over the upkeep of equipments as well as a meeting/dialogue with the territory authorities and the civil society over the upkeep of the health investments in the territories. This approach will make the society own the health investments in the health zones.

- **Constructing sanitary works where there is no any and renovate the existing ones (wells, bore holes, public latrines…):** 60 public latrines, 60 bore holes, 12wells will be constructed in each territory. The most targeted areas are schools, hospitals, markets, and towers.

- **Renovate hospitals and equip the new medical infrastructures and provide drug kits in the health zones:** this will be all about donating medical equipments to the

new medical infrastructures for their smooth running. The same thing will be done for the existing ones that have once been looted, stolen and perpetrate fire by armed troops. Below are the kits that will be donated:

- **Operating room:** (operating table, sialitic lamps, linen sterilization drums, dry heat sterilization autoclave, humid heat sterilization autoclave, tool boxes for caesarean, camisoles (operating apron).
- **Maternity :** delivery table, tool boxes for the delivery, gynecological table (bed)
- **Doctor's office :** consultation table, chaires, tables
- **Hospitalization room** : beds, mattresses, trolley, bed sheets, blankets
- **Laboratory :** microscopes, spectrometers, stirring rods, fridge, tensiometer, stethoscopes, thermometer, saccharometer, cauliculus for glycemia and pregnancy tests
- **Pharmacy :** all the essential drugs
- **Single use materials** : 10 ml syringes, 5ml syringes, IV instrument kits, catheters (G22, 20 and G24), plasters, surgical gloves, sterilized gloves, compress rolls, cotton roll

- **Monitoring and evaluation of the project**
  - ✓ **Monitoring from the beginning:** the project monitoring belongs to APSE to handle. The administrative and financial management of the project will have to match the norms contained in the APSE administrative and financial procedures manuals and the agreements issued between APSE and USAID. The project implementation will have to take into account from the beginning the plans produced by APSE following the reference terms of the funds agreement.
  - ✓ **Monitoring during the project (half-way):** the monitoring during the project consists of ensuring a smooth running of the project activities within its prescribed lifespan. Its main objective is to measure, once it happens, the gaps between the reality and the plans and explain the causes and consequences over the start and the completion of other activities. This monitoring is called the internal monitoring and its only handled by APSE and carried out by the project manager (working under the General Direction's authority). It is basic to make clear that the monitoring will have to obey some techniques such as quantitative data collection, working out of qualitative analysis and the proposal of corrective measures. These data will be backed up daily, weekly, monthly or quarterly depending on the case. It is essential however, to mention that the monitoring is not all about holding files, but mostly to stop by specific moments to analyze the collected data and determine whether the activities or the job are running smoothly as foreseen whether that be technically or the prescribed lifespan as well as the financial aspects. APSE will hold coordination meetings every month with the other partners involved in the project over the evolution of the activities.

Meanwhile, the participation in clusters and other regional forums on health is compulsory.

- ✓ **Monitoring at the project completion :** this monitoring will help APSE focus on :
    - **Significance and conceptual quality:** did the project objectives meet the problems, needs and real priorities of the target groups/beneficiaries? Was the conception through which the objectives were achieved adequate?
    - **Efficiency in the implementation**: how were the foreseen means applied, mobilized and helped achieve the foreseen activities?
    - **Effectiveness:** were the coordination and communication levels between APSE, USAID and the beneficiaries optimal?
    - **Coherence:** is the project coherent with the mandate and principles of the organization? Does the project fit its environment? Was there coherence of the health activities in line with the security context (do not harm)?
    - **Scope:** does the project meet all the people in need in the intervention area?
    - **Impact:** what is the likely contribution (positive/negative) of the project to its global objective?
    - **Viability:** what is the likelihood to perpetuate the benefits of the project once the USAID support is over? What are the contributing factors?

Integration of the principle « do not harm »

The right to receive and give out a humanitarian assistance is a fundamental humanitarian principle that every beneficiary should benefit from this project in Bukavu. The main reason for this intervention is to relieve the suffering of the least capable victims to handle the consequences. By carrying out the activities of socioeconomic rehabilitation, we fulfill an act which is neither favoring nor political, and that should not be considered as such in any case.

While implementing this project, APSE commit to abide by the **code of good practice** that is conform with the neutrality, impartiality, unselfish actions, non discrimination of people stressed by wars ; the principles that govern all the humanitarian intervening in the conflict areas. Our field staffs and social workers are trained, empathic and equipped with the governing principles of quality assistance. The above will not lack an effect over the basic human rights and take into account the humanity in the Bukavu town.

The assistance is given regardless the race, the belief or the nationality of the beneficiary, and without any form of discrimination. The priority in the assistance matter is determined by the unique needs. We commit, as far as possible, to found rehabilitation based on a need assessment of the survivors and the existing local capacity to provide for it. We shall take into

account the principle of proportionality, for each constituent of our programs. The human suffering should be relieved from wherever it is felt, for life is so precious everywhere. We shall therefore support according to the extent of vulnerability aimed to relieve in this project framework. We are absolutely conscious by applying this principle, of the crucial role fulfilled by women in the communities struck by disasters, and we shall ensure that this project of socioeconomic rehabilitation strengthens that role instead of weakening it. The implementation of such a universal, impartial and independent policy requires the possibility for both the beneficiaries and us, to have access to relevant resources to bring about equitable assistance without distinction.

Contributions of the project towards meeting the environmental issues

APSE would like to improve the hygiene and the sanitation conditions through the promotion of health activities, of the sites where different industrial activities are being carried out ; reduce the morbidity and mortality rates in the community ; reduce water related diseases ; promote changes within the beneficiaries' households ; raise awareness within the community on how to foster positive attitudes as far as hygiene and sanitation are concerned while carrying out the activities of socioeconomic rehabilitation.

Being an organization for the promotion of a fair management of the environment, APSE commits to ensure that the nature plays its traditional role of protection and conservation of the ecosystems and the conservation of the biodiversity and the fight against the global warming. APSE will monitor the sites where the different agricultural activities of the beneficiaries of the project are being carried out in order to spell out the actions perceptible to improve the environment. In case the site requires a reforestation, APSE will use its nurseries located in the other territories of the South Kivu province.

Integration of the equity and gender principles

The rape and the sexual violence are in general a matter of power, of force relationship between the rapist and the victim. Likewise, the gender based violence is also a matter of domination power of men over women. This issue questions the human right observance relative to the status and the women's empowerment. Many forms of sexual violence are linked to customs and traditions of our societies and convey the gender inequalities in the Congolese society which is mostly paternalistic.

That's the reason why in health matters, it will be certainly relevant to raise issues of equity and equality between men and women. But also the fight against sexual violence requires a long term vision by considering all the contingencies, among which, we mentioned it above, the human rights in general and those of women in particular. Considering the above, the activities to carry out will aim at the mentality change and men's attitudes towards women and vice-versa. That's the reason for a certain number of activities and strategies to contribute to the mentality change and the attitudes of the community members such as teaching how to read and write.

The equality and equity worries between men and women, girls and boys, at all levels while implementing the project will be for us as a dynamic resilience that will make all our activities bring about short term results although the mentality change draws from a long term.

Logical Framework or similar tool detailing the link between activities, deliverables, expected results, and how performance will be measured.

	Narrative summary	Indicators	Versification means
Global Objective:	Contribute to a better global health level outcome and address the inequalities in health matters amongst the South Kivu inhabitants in the Democratic Republic of Congo	% of people affected by diseases and which are well assisted by the project in the targeted health zones: 75%	South Kivu health cluster reports, AMS constituent report, reports of the DRC health Ministry, evaluation report of the impact
Specific objectives1	-improve the scope for basic and quality health services in the Walungu, Kalehe, Uvira and Kabare territories in South Kivu	% of areas covered and where the population has easy access, at lower costs for tailor made services : 100%	Project progress reports The database of the project and the Ministry of health, audio-visual aids,
outcomes	-100% of sanitary structures that will be constructed and/or renovated, equipped, furnished and provided with well trained staffs are to reduce therefore the time and resources wastage for health care, it will save time for the rural people (often the poorest), that they would have spent for more productive activities.	Number of supported structures : 12 Number of renovated structures:12 Number of built structures: 4 Number of pediatric centers supported : 4 Number of equipment kits donated to sanitary structures : 16	Various periodic reports, audit reports, financial check reports, service performance contracts, financial documents, construction agreement, purchase bills, logistic documents, audio-video aids
	-1200 abandoned first three months children are granted a chance to life, children born with malformations and other serious affections through the services offered by the 04 modern pediatric centers built.	Number pediatric centers built : 04 Number of equipment kits offered : 04 Number supported children : 1200	Various periodic reports, audit reports, financial check reports, service performance contracts, accounting books, construction agreement, purchase bills, logistic documents, specification sheets, audio-video aids
Specific objective2	-technical and operational capacity building of 500 heath service providers in the Ruzizi, Lemera, Uvira, Mubumbano, Walungu, Kaniola, Kalehe, Minova,	Number of trained personnel : 500 Number of trainings carried out : 8	Training reports, attendance lists, accounting books, modules, audio-visual aids, various contracts

	Bunyakiri, Katana, Miti-Murhesa, Kabare health zones in South Kivu.		
	-100% of successfully carried out activities will offer better quality basic health services, with a wider scope, to the most underserved in the health zones, by providing them with better nearby productive health services and the fight against HIV/aids and malaria. -the services will rescue thousands of human lives; will increase the productivity and the social well being. - The significant disparities women/men at the morbidity charge level, as measured by the death and the life expectancy corrected by the incapacity (AVCI), are appreciably on fall. - The messages concerning malaria and HIV/aids can reach as many times as possible millions of people through radio broadcasts, news papers, posts, in schools and clinics and wherever people gather. If, for e.g. 2 millions of people have acquired adequate knowledge concerning the prevention of malaria and HIV/aids and that only 20 or 30 apply the behavioral change, the risks would have decreased and henceforth, so many human lives will get rescued over the projects' lifespan.	% activities carried out with the required norms: 100% Number of HIV cases assisted : 1000 Number of malaria cases assisted: 50 000 Type et Number of actions carried out if favor of the population against HIV : 12 Type et No of actions to combat malaria : 12 % of mortality and morbidity reduction within the population in the targeted health zones : 30% Number of actions supported to combat HIV/AIDS in the targeted health zones: 12 Number of actions supported to combat malaria in the targeted health zones: 12 Number of sensitization sessions carried out : 1728 Number of radio broadcasts : 1728 Number of magazines produced : 36 Number of sensitization aids produced : 1000	Reports Ministry of health, progress reports, project monitoring and evaluation report, project database, sensitization reports, sub projects reports supported for HIV/Aids and reproductive sexual health of young people and adolescents Reports of the activities to combat malaria Sensitization and protection cluster reports Audio-visual aids Accounting books and various service contracts
Activities	- Bring assistance to the health service delivery in the targeted territories - Train 500 health staffs in hospitals and health centers		Reports Ministry of health, progress reports, project monitoring and evaluation report, project database,

	- Intensify the fight against HIV/Aids in the targeted health zones -construction of 04 modern pediatric units - The project will fund as well the support to developing a culture of maintenance at the health zone level - Construct health facilities where there is no any and renovate the existing ones (12 wells, 60 bore holes, 60 public latrines…) - Renovate 12 hospitals, 24 health centers, equip and provide them with medical kits in the health zones -Project monitoring and evaluation		sensitization reports, sub projects reports supported for HIV/Aids and reproductive sexual health of young people and adolescents Reports of the activities to combat malaria Sensitization and protection cluster reports Audio-visual aids Accounting books and various service contracts

-**Gantt Chart** or similar tool detailing the schedule of activities over life of project.

	ANNEE I				**ANNEE II**				**ANNEE III**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
support the health services in the targeted territories	XXX											
Train 500 staffs nursing in hospitals and health centers	XXX				XXX				XXX			
Strengthen the fight against HIV/Aids in the targeted health zones	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
Construction of 04 modern pediatric units		XXX	XXX	XXX								
Participate in the promotion of a maintenance culture at the health zone level				xxx	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
Construct health facilities and renovate the existing ones (12 wells, 60 bore			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		

holes, 60 public latrines…).												
Renovate 06 hospitals, 20 health centers, equip and donate them drug kits in the health zones		XXX	XXX	XXX	XXX	XXX	XXX	XXX				
Project Monitoring	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
Project Evaluation		XXX		XXX		XXX		XXX		XXX		XXX

-**Draft First Year Work Plan** including the timeline for mobilization and timing of proposed activities in the first year.

Activities	**YEAR I : From Sept 2016 to Sept 2017**											
	Sept	Oct	Nov	Jan	Feb	March	April	May	June	July	Aug	Sept
Support the health services in the targeted territories	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
Train 500 staffs nursing in hospitals and health centers		xxx	xxx	xxx	xxx							
Strengthen the fight against HIV/Aids in the targeted health zones	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
Construction of 04 modern pediatric units				xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
Participate in the promotion of a maintenance culture at the health zone level										xxx	xxx	xxx
Construct health facilities and renovate the existing ones (12 wells, 60 bore holes, 60 public latrines,…)							xxx	xxx	xxx	xxx	xxx	xxx
Renovate 12				xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx

hospitals, 24 health centers, equip and donate them drug kits in the health zones												
Project Monitoring	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
Project Evaluation						XXX						XXX

-**Draft Monitoring and Evaluation Plan** including standard and customized indicators, targets, and frequency of reporting.

We shall need to consider the following information during the monitoring and evaluation:

- **Norms and policies ;** the APSE intervention will have to comply with the politics and the accepted guide lines in the health sector
- **Relevance and adequacy;** So far as the intervention is adapted to the context and local needs and comes to supplement the other sectors interventions.
- **Efficiency**. The way the outcomes were reached at lower costs within its timeline.
- **Effictiveness.** The way an intervention has reached, or is likely to reach, the immediate expected outcomes.
- **scope.** The way the population groups are included or excluded from an intervention, and a specific impact over those groups.
- **Impact.** The positive or negative effects, scheduled or fortuitous, direct or indirect brought about by the intervention.
- **Coherence.** The way the intervention comply with relevant policies (F.eg. so far as humanitarian aid, health and development are concerned) and takes into account the sanitary considerations and issues related to the human rights promotion.
- **Durability and inter connectivity.** The likelihood to see the effects of the project persisting even when the USAID aid has ceased.

Plan 1: participation of different actors in this project, the table will be applied:

Stages	**Sponsor**	**NGO**	**Evaluator**	**Other actors**	**Beneficiaries**
Planning (to define the project policy)	USAID	APSE	To be selected	DRC Ministry of health	
Project identification (need and capacity assessment)	USAID	APSE	To be selected	DRC Ministry of health	

formulation (the project is formulated in a complete way)	USAID	APSE	To be selected	DRC Ministry of health	
Decision making assessment.	USAID	APSE	To be selected	DRC Ministry of health	
Establishment of management tools	USAID	APSE	To be selected	DRC Ministry of health	
Monitoring, report(s) drafting, audit/control, half-way evaluation	USAID	APSE	To be selected	DRC Ministry of health	
Production of a report at the completion of the project	USAID	APSE	To be selected	DRC Ministry of health	
ex-post evaluation	USAID	APSE	To be selected	DRC Ministry of health	

Plan 2: activity monitoring model: this table is applied almost daily

Scheduled activities	Schudul ed date	actors	Data collection	Decision making	facts	Explanation	Recommendation
support the health services in the targeted territories							
Train 500 staffs nursing in hospitals and health centers							
Strengthen the fight against HIV/Aids in the targeted health zones							
Construction of 04 modern pediatric units							
Participate in the promotion of a maintenance culture at the health zone level							
Construct health facilities and renovate the existing ones (12 wells, 60 bore holes, 60 public latrines…).							
Renovate 12 hospitals, 24 health centers, equip and donate them drug kits in the health zones							
Project Monitoring							
Project Evaluation							

Plan 3: monitoring of the outcomes

Outcomes	Indicators	facts	Explanation	Recommen

				dation
100% of sanitary structures that will be constructed and/or renovated, equipped, furnished and provided with well trained staffs are to reduce therefore the time and resources wastage for health care, it will save time for the rural people (often the poorest), that they would have spent for more productive activities.	Number of supported structures : 12 Number of renovated structures: 12 Number of built structures : 4 Number of pediatric centers supported : 4 Number of equipment kits donated to sanitary structures : 16			
1200 abandoned first three months children are granted a chance to life, children born with malformations and other serious affections through the services offered by the 04 modern pediatric centers built.	Number pediatric centers built : 04 Number of equipment kits offered : 04 Number supported children : 1200			
--100% of successfully carried out activities will offer better quality basic health services, with a wider scope, to the most underserved in the health zones, by providing them with better nearby productive health services and the fight against HIV/aids and malaria.	% activities carried out with the required norms: 100% Number of HIV cases assisted : 1000 Number of malaria cases assisted: 50 000			
The services will rescue thousands of human lives; will increase the productivity and the social well being.	Type et Number of actions carried out if favor of the population against HIV : 12 Type et Number of actions to combat malaria : 12			
The significant disparities women/men at the morbidity charge level, as measured by the death and the life expectancy corrected by the incapacity (AVCI), are appreciably on fall.	% of mortality and morbidity reduction within the population in the targeted health zones : 30%			
The messages concerning malaria and HIV/aids can reach as many times as possible millions of people through radio broadcasts, news papers, posts, in schools and clinics and wherever people gather. If, for e.g. 2 millions of people have acquired adequate	Number of actions supported to combat HIV/AIDS in the targeted health zones Number of actions supported to combat malaria in the targeted health zones: 12			

knowledge concerning the prevention of malaria and HIV/aids and that only 20 or 30 apply the behavioral change, the risks would have decreased and henceforth, so many human lives will get rescued over the projects' lifespan.	Number of sensitization sessions carried out : 1728 Number of radio broadcasts : 1728 Number of magazines produced : 36 Number of sensitization aids produced : 1000			