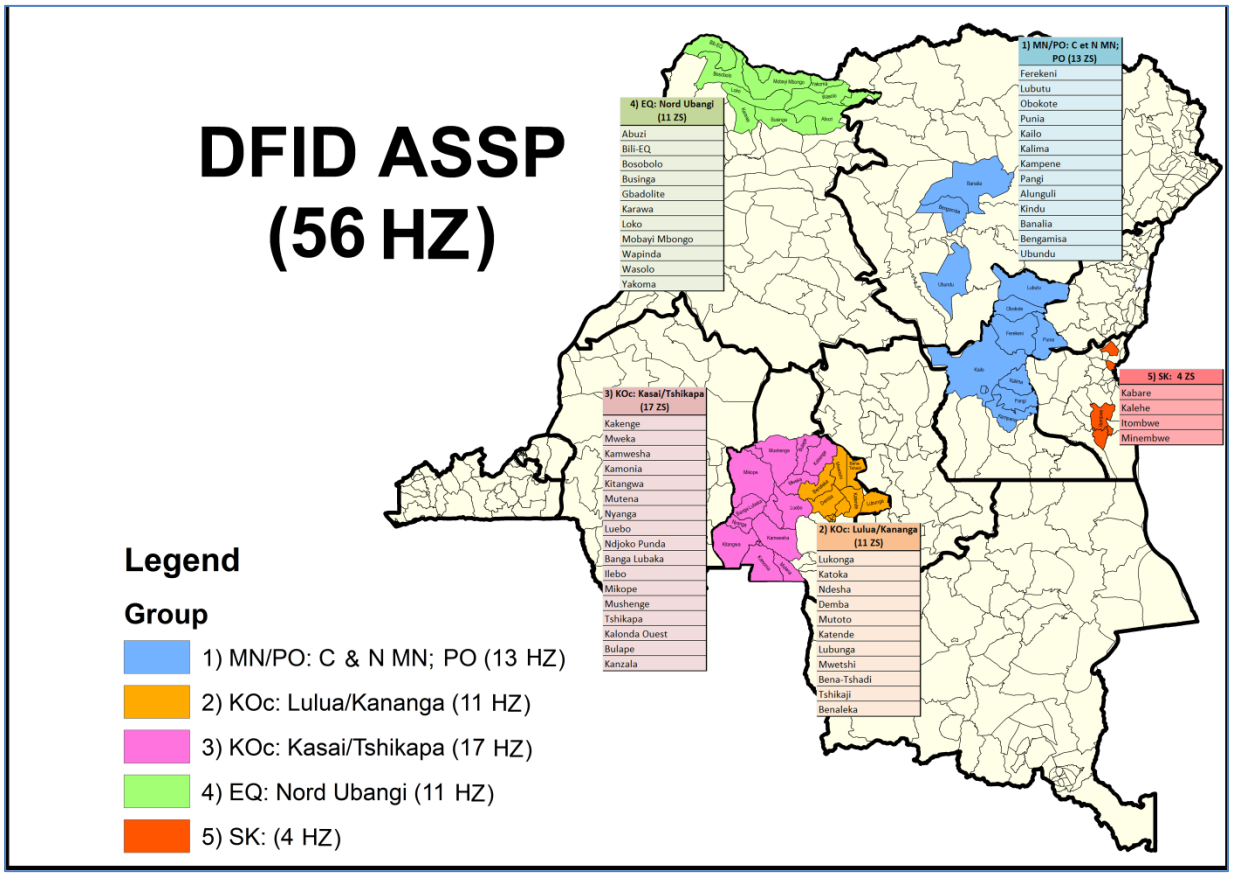
Solicitation of Implementing Partners for the DFID *Accès aux Soins de Santé Primaires* Project
(Version 1 – December 20, 2012)

The Democratic Republic of Congo will be receiving major health development assistance from the Department for International Development (DfID) of the United Kingdom through a project called *Accès aux Soins de Santé Primaires* (ASSP). The ASSP project will provide health systems strengthening and *Appui Global* assistance to health zones in order to increase population access to the Ministry of Health's Minimum Package of Activities (MPA) for primary health care. Project assistance will include all of the elements of the MOH recommended *Appui Global* assistance, including infrastructure rehabilitation, in-service training, equipment, support for supervision, water/sanitation, solar energy equipment, essential medicines, Behavior Change Communications, community empowerment and operations research. The anticipated level of investment over for this five-year project will be approximately £4.50 per person per year.

Through a competitive bidding process DfID has selected IMA World Health to serve as the Consortium Lead to design and implement the ASSP project to provide health development assistance to five groups of health zones (HZs) in the provinces of Equateur, Oriental, Maniema, Kasai Occidental and South Kivu[1]. The location and names of the 56 health zones that are proposed for this assistance are shown in the map below. Factors used in the HZ selection process included low levels of vaccination coverage, high levels of malnutrition, high levels of poverty and the absence of a health zone development partner. All of the 20 health zones supported by DFID's previous Access to Healthcare Program are also included the ASSP project.

[1] IMA has been awarded a design and build contract with two breakpoints. The first breakpoint occurs in January 2013, and the second in January 2015. These breakpoints will also apply to the contractual agreements with implementing partners.



The IMA-led consortium includes technical partners (Tulane School of Public Health, PathFinder International, Pact, HISP and IntraHealth) to provide additional expertise for Operations Research, Monitoring & Evaluation, Family Planning and Reproductive Health, Community Empowerment & Accountability and Information Systems.

It is estimated that the ASSP project will provide assistance to 56 health zones at an average of £486,000 per HZ per year. Of this amount, IMA will expend roughly 35% per year for centralized functions such as the funding of performance primes[2] and purchasing of essential medicines, supplies & equipment. The remainder (~£315,000 per year) will be allocated to the implementing partners. An illustrative list of health zone activities and the division of labor between the implementing partners and IMA is provided in Annex A.

Implementing Partners (IPs) will be the ASSP project's main interface with the Provincial, District and Health Zone Management Teams. Implementing partners will be responsible for supporting these management teams to plan, implement and supervise the full package of the MoH's *appui global* approach. A detailed description of the anticipated terms of reference for implementing partners has been developed by DFID and provided as Annex B to this solicitation.

This solicitation provides an opportunity to apply to become an Implementing Partner for this project for one or more groups of health zones, with the exception of the South Kivu cluster which is not open for bidding at this time. Given the objectives and scope of the project only organizations that fulfill **all** of the following criteria will be considered:

1) The organization is already be established in DRC (registered nationally) with documented experience in providing health development assistance to health zones that

[2] The specific approach to primes and user fees in the ASSP project will be determined at the end of the ongoing design phase.

adheres to the National Program for Health Development (PNDS). Preference will be given to organizations that are currently working or have worked in one or more of the five geographic areas targeted by the ASSP project;

2) The organization has a history of effectively and efficiently managing or actively participating in at least one *Appui Global* project that provided assistance to multiple health zones in collaboration with the MOH and a major donor;
3) The organization has strong links and documented experience in working with and capacity building of both community-based and civil society partnerships, including faith-based organizations/networks.
4) The organization is fully prepared to provide assistance (technical, material and financial) for all components of primary health care, including family planning and the use of modern contraceptive methods such as injectables and pills;
5) The organization is willing to use a "value-for-money" approach that maximizes investments within health zones and minimizes project management costs. Of the funding allocated to implementing partners, no more than 15% can be used for management costs. Management costs include: salaries for all personnel, fringe benefits and indirect costs.

Organizations that sufficiently comply with the above criteria are invited to send a one-page letter expressing interest along with a summary document in MS Word format of **not more than five pages in total** (A4 format, 1" margins, 12pt font) that briefly explains why your organization qualifies to be selected as an Implementing Partner for the ASSP project. Please use the outline below to develop that summary document. Submission letters and the summary document must be received by IMA via email no later than 18:00 hours on Sunday, January 13th, 2013 and should be sent to the Luke King, Deputy Chief of Party at IMA World Health, at lukeking@imaworldhealth.org.

Name of Submitting Organization: _____

For which group(s) of health zones would you like to apply to serve as Implementing Partner? You must agree to assist all HZs within a group. No sub-division of groups or addition of supplemental HZs will be permitted. Please circle one or more group(s) below:

1. Maniema & Oriental **13 Health Zones**
2. Kasai Occidental Lulua & Kananga **11 Health Zones**
3. Kasai Occidental Kasai & Tshikapa **17 Health Zones**
4. Equateur **11 Health Zones**

1. <u>Organizational Information and Capacity</u>: Please describe the type of organization, your legal basis for working in DRC, number of years working in DRC, number of permanent staff in DRC, annual budget for activities in DRC, geographic areas where you have worked in DRC, experience in supporting the MOH PNDS and in working in one or more of the five geographic groups targeted by ASSP.

2. <u>Management or Participation of an *Appui Global* Project</u>: Please provide the name of the project and explain why it qualifies as an *Appui Global* project. Also include the name of the donor agency, names of HZs assisted, and any other information relevant to serving as Implementing Partner for the ASSP project.

3. <u>Experience in developing partnerships</u>: Please explain your experience in working in with health zone management teams to develop both community-based and civil society partnerships, including faith-based organizations/networks. References to specific health zones where you have encouraged and developed these partnerships is required.

4. <u>Inclusiveness of PHC assistance</u>: Please affirm that your organization is open to providing assistance (technical, material and financial) for all components of primary health care, including family planning and the use of modern contraceptive methods such as injectables and pills. Please provide references to projects in which you have provided/developed family planning services, including use of modern contraceptives.

5. <u>Value for Money</u>: Please explain, with project-specific examples, how your organization has worked in a cost efficient manner. Please confirm that you would be willing and able to manage assistance to Health Zones within the management fee structure as explained above. Also, explain how, if selected as an IP for ASSP, you would implement "value-for-money" approaches that maximizes investments within HZs and minimize project management costs.

ANNEX A:

Illustrative List of Activities by Health Zone		
Objective 1: Enhanced health service delivery and quality in DFID-supported health zones	**Responsibility of Implementing Partners**	**Responsibility of IMA**
Training in PHC and PMA	x	
Train select MCZ or B5 coordinators at KSPH		x
Support RECO monitoring meetings at HZ office	x	
Distribute BCC Promotional Materials	x	
Provide RECO Training and Support Materials	x	
Support Reco monitoring meetings at AS	x	
Conduct training of HZMT	x	
Conduct training of ITs & RECOs in C- IMCI	x	
Drug Quality Assurance and End-User Verification in collaboration with MOH		x
Support to CDRs (repairs and equipment)		x
Support to CDRs (subsidy for operations)		x
Drugs and materiels transportation from CDR to Health Facility	x	
Drugs & Med. Materials for Hospitals		x
Drugs & Med. Materials for Health Centers		x
Providing Training in Drug Management	x	
Provide each antenne PEVwith kerosene for cold chain or refrigerators parts	x	
Contribute to the transportation of vaccines and syringes from Kinshasa/Provinces to DFID Support's Antennes PEV / HZ (where needed)	x	
Participate in EPI campaign & Accelerated activities	x	
Provide Bicycles to improve RED approach		x
Replace solar batteries as needed		x
Training of HZMT in MLM of EPI	x	
Training of nurses in ACZ	x	
Provide HZ with solar refrigerators		x
Provide each BCZ with kerosene for cold chain	X	
Management of epidemics and emergency situations	x	
Conduct training in IMCI-clinique (include Malaria training)	x	
Provide HZ with LLINs to be distributed in the routine and acelerated activities		x
Provide ACTs and other malaria drugs, TDRs at each HC		x
Provide Hospital and HFR with microscopes and supplies		x
Conduct training of Microscopists on Malaria detection		x
Organize distribution of LLINs with Hang up strategy in health areas with low coverage	x	
Equip HFs for growth monitoring		x
Training in CMAM (ITs and Relays)	x	
Training & Equipping for PD Hearth & home gardens	x	
Support Vitamin A campaigns in HZs	x	
Facilitate the provision of ANC as outreach activity.	x	
Provide AMTSL materials, posters and commodities		x

Facilitate Mother & Child week (routine acceleration in HZ with low performance)	x	
Equip maternities with newborn resuscitation kits		x
Repair Fistulas from partner managed mobile teams or referral based facilities combined with the training of doctors and nurses	x	
Facilitate the provision of ANC and CPoON in HFs (Fer folate, RPR, Mebendazole, SP see Malaria, Vit A…)	x	
Support Fistula repairs in tertiary hospitals	x	
Training HZMT providers in RH, Newborn resuscitation (include AMTSL)	x	
Training Nurses providers in RH, Newborn resuscitation (include AMTSL)	x	
Training of nurses at ITM and ISTM (scholarships)		x
Training of doctors from HZ or Districs at SOPH (scholarships)		x
Provide HC and relays with FP BCC materials for disseminating keys messages in community	x	
Provide the package of FP commodities to HFs	x	
Training of Trainers HZ level for FP		x
Training of Nurses on FP	x	
Train community Relays in FP/Healthy Timing & Spacing Preg. w/ male involvement (and encourage skilled deliveries)	x	
Comm-based distrib of injectables	x	
Train medical doctors from tertiairy hospitals in Fistula repair	x	
Support services of Medical assistance to survivors(with forms and subsidies for follow-up)	x	
Provide PEP Kits for Medical assistance		x
Train relays in SGBV conseling and referal	x	
Train HF staff in Basic SGBV Medical management and Kit PEP administration	x	
Promote TB program and ComBased-DOTS through community relays with BCC materials and via radio	x	
Establish at least 3 TB testing sites in each HZ (Training)	x	
Procure ARV other commodities for PMTCT		x
Train laboratory Assistants and nurses in safe blood activities	x	
Promote safe transfusion at each transfusing outlet service with adequate HBV,RPR and blood group tests, and transfusion supplies		x
Train HZMT and nurses in IST management	X	
Reinforce the community awareness on PMTCT services: key messages through BCC material reproduced & trained relays	x	
Establish PMTCT sites where needed	x	
Provide each HF with IST management drugs and commodities	x	
NTD mapping in schools	x	
Mass NTD treatment in schools	x	
Objective 2: Increased empowerment and accountability in health service planning and delivery in DFID-supported health zones		
Provide DPS with motorbikes to supervise HZs		x
Provide DPS with subsidies for theirs operations		x
Provide DS with motorbikes to supervise HZs		x
Provide DS with subsidies for theirs operations		x
Support district technical meetings (BTD, CCIA)	x	
Support provincial/district technical meetings (CPP,BTP)	x	

Assure the functionality of HZMT,COGE, CA and CODESA	x	
Identification & Assess of CBOs and FBOs.	x	
Org Cap Assessment of HZ , CBOs, FBOs, CODESA	x	
Support HZs to elaborate action plans & microplans	x	
Finance workshops in national level		x
Comm. mobilization to develop scorecards for AS (3days)	x	
Mentoring in Empowerment & Accountability	x	
Training CODESA for performance improvement	x	
Scorecard data interpretation workshops	x	
Support Provincial teams to supervise quarterly	x	
Support district teams to supervise quarterly	x	
Leadership and management training of HZMT	x	
Support the HZMT with subsidies to supervise Health providers		x
Negociate with communities episodic tarification system /w reduced care for vulnerable populations	x	
Comm. Health Endowment (CHE)		x
Objective 3: Improved access to health services in DFID-supported health zones		
Provide Laptop with network sim card, solar system, and printer for Electronic SNIS reporting to Health District and Provincial Office		x
Provide Laptop with network sim card, solar system, and printer for Electronic SNIS reporting at HZ level		x
Operational Research		x
Conduct integrated formative supervison with MOH(PNLS, PNLP and SNIS divison)	x	
Conduct a General Initial/Annual Need assessment to allocate effectively project resources (in PMA,Equipments/ Materials, Infrastructures…)	x	
Training/Refresh training of HZMT and nurses in SNIS	x	
Provide District and HZs with SNIS canevas included PMA registers and forms	x	
KPC Final study	x	
Maintain HR database		x
Training HZMT in completing & maintaining HRIS database	x	
Provide all HGR with IT kits 2 computers)		x
Establish Depots/CRDs for HZs that do not have a source for drugs		x
Provide HGRs and CSRs with equipment for improving quality(include Microscopes)		x
Support cars maintenance	x	
Provide HZ with solar lighting		x
Equip each BCZ with motorbikes for supervision		x
Repair of selected HF prioritizing maternities		x
Provide cars for supervision where needed(HZ including DPS and/or DS)		x
Repair or expand hospitals		x
Maintain and repair equipment	x	
Building of HF for unserved populations		x
Replacement of non-durable faclities		x
Replace motorbikes that are broken		x
Provide cars for HGR where needed		x

Repair of selected nursing school		x
Equip ISTMs or ITMS with materials and books		x
Shipping to DRC		x
Transport of Equipment from Warehouse to HZ.		x
Training for maintenance of solar equipment		x
GIK Transport Fees		x
Finance system linked to HMIS		x
Participation in Conferences and workshop		x
Conduct regular Data Quality Audit	x	
Assist GDRC-MOH adopt, Customize and Integrate iHRIS Database to collect GDRC-MOH HR data at all levels		x
Forms for disease surveillance system		x
Objective 4: Increased and sustainable access to safe drinking water, improved sanitation, hygiene education		
Support community mobilization and initial assessments for watsan activities	x	
Provide Promotion Materials for Clean Village (Flags, T-shirt, Bilboard,etc.)	x	
Training/Refresh training for Watsan supervisors in Clean Village Approach	x	
Promote proper composting technics for effective use of composts in home gardening and tree planting	x	
Home latrines using san plate	x	
Water testing (test kit in start up)	x	
Supply LSF at CPN starting in cholera areas	x	
Construction of compost latrines at HFs	x	
Construction of composting latrines at schools	x	
Spring capping (& maintenance/repair)	x	
Build cisterns at Schools and public buildings	x	
Provide materials (polybags, waste containers, safe boxes) to the HFs to improve waste collection	x	
Build efficient incenterators at HFs		x
Placenta pit		x

Annex B: Proposed Terms of Reference for Implementing Partners

Specifications for Implementing Partners at health zone level

The programme should be developed to follow the Ministry of Health's strategy for health sector development[3] based on their approach of "appui global" i.e. comprehensive support for the delivery of the Ministry's minimum package of services (Paquet Minimum d'Appui). A complementary package of services (Paquet Complémentaire d'Activités, PCA) at referral hospitals, according to Ministry of Health policies should also be included to ensure that there is a continuum of care.

Core Principles for implementing partners at health zone level

Consortium implementing partners are expected to:

- ☑ Be **aligned behind MSP** strategies and expenditure priorities.
- ☑ Contribute to progress against the relevant **MDGs** (including clearly identified gender targets endorsed by MSP for all projects).
- ☑ Work in accordance with **MSP policies and plans** as they develop
- ☑ Demonstrably factor in **capacity transfer** to state and national actors over the implementation period, adopting a phased approach, including training MSP officials and agencies.
- ☑ Where possible, seek to maintain services in **existing sites** of operation before supporting/constructing new facilities.
- ☑ Work to enhance **sustainability,** including environmental sustainability, of project impact and service delivery either through local government or local organisations.
- ☑ Employ a **conflict-sensitive** approach. At a minimum, 'do no harm' by not exacerbating existing tensions. Ideally basic service provision will build on conflict analysis to reinforce security and stability.
- ☑ Link service provision to **community-level demand** for services through processes of community participation and empowerment.
- ☑ Seek to build **accountability** at all levels: between implementing partners, service-users, faith based networks, local authorities and the MSP.
- ☑ Address issues of **social inclusion** by designing projects and programmes that address inequalities and are inclusive of women and men, survivors of SGBV, people living with HIV/AIDS, different ethnicities, returnees and refugees, and girls and boys.
- ☑ Promote **partnership** with and **build capacity** of local NGOs /FBOs and FBNs. Look for opportunities for collaboration and lesson learning;
- ☑ Aim to transition out of intensive operational support by the end of the project. A **transition strategy** will therefore need to be incorporated into all NGO proposals.

1. General approach required

1.1 Community participation and empowerment should be central to the approach of working with communities. This will be done through support for community development committees which have a key role in managing services/holding service providers accountable, outreach activities to empower citizens to make healthier choices and support through a range of strategies to strengthen community voice and have a greater say in how services are managed and delivered.

[3] Plan National de Développement Sanitaire (PNDS)

1.2 Integrated cross-sectoral components (such as Integrated Community Case Management ICCM care sites for areas out of reach of health centres), de-worming/school health and Villages Assaini should be included in project design to play a key role in improving health outcomes resulting from non clinic based interventions.

1.3 Implementing partners' approach should maximise sustainability. For example rehabilitation of facilities should be done by the communities themselves with materials and technical supervision being provided by the implementing partner. At health zone level implementing partners should shadow align or use government processes where possible.

1.4 Implementing partners should ensure that they do not undermine capacity in any way through either substitution (for example by embedding technical staff long term into ECZS) or through setting up parallel systems (for example by the implementing partner setting up a parallel drug management/distribution system separate from the ECZS).

1.5 Implementing partners should work closely with specific technical sub-projects to deliver key results in terms of family planning, operational research and empowerment and accountability.

1.6 Implementing partners should follow guidance on conflict and gender (as outlined in sections 14 and 15 of the Terms of Reference of the Consortium Lead).

1.7 DFID is committed to ensuring that user fees do not act as a barrier to care. To date, DFID has funded fully subsidised health care for targeted vulnerable groups (for example pregnant women, under fives and sexual and gender based violence survivors) under the existing Access to Healthcare Programme. In the new programme, implementing partners should continue to ensure that fees are not a barrier to care for vulnerable groups by *either fully or very heavily subsidising care for targeted groups*. When setting fees with Provincial/Health Zone authorities the Consortium Lead should assess elasticity of demand of vulnerable groups and also take into consideration the proportion of staff receiving incentives/salaries and whether there are any other sources of income for clinic staff. This process will be done by the CL during the design phase.

1.8 Implementing partners should where possible build the capacity of communities to do community income generating activities which may be used by health committees to continue some degree of subsidisation after the project has been completed. Implementing partners should also negotiate before the outset of the project which staff are registered on the MSP payroll and which staff will be added. This is an important negotiation which should be prioritised prior to any MOU being signed and prior to any support starting in health facilities. The Consortium Lead may assist with these negotiations at Provincial level.

1.9 Implementing partners are expected to actively participate and contribute to the operational research planned as part of this programme and to adapt their practice as lessons are learnt and new evidence becomes available (in particular on user fee policies).

1.10 Climate: In a move to ensure that this programme is "climate-smart", £2m has been allocated to the Consortium Lead to provide solar energy grants to implementing partners – this could be used to provide solar equipment for lighting and cold-chain. The Consortium Lead will provide guidance on how implementing partners can apply for funding for this. The CL may choose to use this as performance incentives for implementing partners i.e. link allocations to achievement of health outcomes.

2. Support to Health Facilities

Implementing partner responsibilities include but are not limited to;

2.1. Ensure that an adequate number of primary health care centres and a hospital (where feasible) are supported for the population in each health zone. The CL will provide guidance on standards, taking into consideration MSP norms.

2.2. IPs are responsible for ensuring that adequate supervision and training, pharmaceuticals, equipment, resources and infrastructure support are made available to supported health facilities to ensure an adequate quality of care.

2.3. IPs are required to meet targets on health outputs and outcomes – these will be set by the Consortium Lead in order to meet the targets agreed in the overall project log-frame with DFID. The Consortium Lead may choose to use some element of performance based incentives to assure attainment of results.

2.4. IPs should follow MSP standards as outlined in the PMA/PCA. They should ensure that the following project minimum standards are met on key services in every health zone;

- **Immunisation** - All should have an active EPI programme (either static or outreach) with health facility specific targets displayed in clinics and monitored.
- **Nutrition** – at least one functioning IMAM site or CMAM programme per health zone.
- **Health promotion** -All health centres to have an active health promotion programme coordinated from the facility (to include WASH/hygiene/ORS at home)
- **Maternal health** – all health centres to have Basic EMoNC facilities with one CEMoNC facility per health zone.
- **Modern Family planning** – available in all supported facilities with at least one outreach programme in each health zone. If a facility cannot have an FP service then an alternative site for FP should be set up to cover that Aire de Santé.
- **HIV/AIDS** – PMTCT services should be available in the health zone (integrated into antenatal care) with at least one VCT treatment site per zone by the end of the programme (in zones where a hospital is supported).
- **SGBV** – all health facilities should be able to treat survivors of SGBV (with at least one site for referral for PEP (post-exposure prophylaxis of HIV) in the health zone).
- **WASH** – Health facilities receiving support should have adequate access to clean water and sanitation. Additional funding for Village Assaini activities may be available to some health zones – targets will agreed in the sub-contract with the Consortium Lead where applicable.
- **School Health** – each health zone should have a school health programme in which the ECZS is supported to offer de-worming and other relevant school health activities in schools.

3. Support to ECZS (Equipes Cadres de la Zones de Santé)

- IPs should support the Health Zone management team to develop an annual health zone operational plan each year (this should including annexes outlining at least a joint supervision schedule and an EPI micro-plan).

- The IP should define an annual capacity building plan for the ECZS. This should include institutional/organisational strengthening e.g. on procurement/management of drugs, financial systems, attendance monitoring of clinic staff etc as well as technical assistance e.g. EPI micro planning/planning health interventions and monitoring health outcomes. The CL should summarise the plans in a table in the second quarterly report each year.

- IPs are responsible for ensuring that the ECZS have adequate infrastructure and resources to manage health services in the zone. ECZS should have access to the following as a minimum;

  - **Office space** (could be a room in a hospital)
  - **Transport** (a means of ECZS being able to visit clinics for supervision and deliver drugs)

- **Laptop/internet access for the ECZS to submit SNIS reports** – practical arrangements in each zone will depend on location/feasibility and budget.
- **Space for the ECZS to store drugs** – this could be in the hospital – separate implementing partner storage must be avoided at health zone level

4. Support to communities

IPs should provide the following support including but not limited to;

- Facilitate/ support a community committee that can provide support to each health facility included in the programme. (Some committees will exist already, some may only be for health, others for general development).

- Develop an annual plan of activities to improve social accountability and empowerment (with support and guidance from the agency delivering the Social Accountability and Empowerment technical assistance sub-contract).

- Ensure outreach from the facilities for health promotion, hygiene promotion, EPI and ANC. Each clinic should have an outreach plan and monitor progress (this could be a poster/flip chart displayed in the clinic).

- Implementing partners should give consideration to how to motivate community volunteers used for outreach based on lessons learnt from the previous project. The system by which community volunteers are selected may need to be reviewed to ensure that they have suitable skills.

- School health. Within each health zone the implementing partner should make an annual plan of school health activities and monitor progress e.g. de-worming, health education. Implementing partners should actively coordinate with any DFID funded education activities operating in the same health zone to maximise synergies.

Annex C : Acronyms	
ASSP	*Accès au Soins de Santé Primaires*
DFID	Department for International Development
MOH	Ministry of Health
HZ	Health Zone(s)
MPA	Minimum Package of Activities
IP	Implementing Partner
DRC	Democratic Republic of Congo
PNDS	National Program for Health Development
PHC	Primary Health Care
PMA	*Paquet Minimum d'Activites*
MCZ	Medecin Chef de Zone
KSPH	Kinshasa School of Public Health
RECO	*Relais Communautaire*
BCC	Behavior Change Communication
HZMT	Health Zone Management Team
IT	*Infirmier(e) Titulaire*
C-IMCI	Community –Integrated Management of Childhood Illness
CDR	*Centrale de Distribution Régionale des Médicaments Essentiels*
PEV	*Programme Elargi de Vaccination*
EPI	Expanded Program for Immunization
RED	Reach Every District
MLM	Middle Level Management
ACZ	*Atteindre Chaque Zone*
BCZ	*Bureau Centrale de Zone*
IMCI	Integrated Management of Childhood Illness
ACT	Artemisinin-based Combination Therapy
LLIN	Long Lasting Insecticide Net
HF	Health Facility
CMAM	Community-Based Management of Acute Malnutrition
PD	Positive Deviance
ANC	Antenatal Care
AMTSL	Active Management Third Stage of Labor
CPoON	*Consultation Post-Natale*
RPR	Rapid
SP	Sulfadoxine-Pyriméthamine
RH	Reproductive Health
ITM	*Institut Technique Médical*
ISTM	*Institut Supérieur des Techniques Médicales*
SOPH	School of Public Health
HC	Health Center
FP	Family Planning
PEP	Post-Exposure Prophylaxis
SGBV	Sexual and Gender Based Violence
TB	Tuberculosis
ARV	Anti Retroviral
PMTCT	Prevention of Mother to Child Transmission of HIV
HBV	Hepatitis B Virus
RPR	Rapid Plasma Reagent
IST	*Infection Sexuellement Transmissible*
NTD	Neglected Tropical Disease
DPS	*Division Provinciale de la Santé*
DS	*District sanitaire*
BTD	*Bureau Technique de District*
CCIA	*Comité de Coordination Inter Agence*
CPP	*Comité Technique de Pilotage*
BTP	*Bureau Technique Provincial*
COGE	*Comité de Gestion*
CA	*Conseil d'Administration*

CODESA	*Comité de Développement de l'Aire de Santé*
CBO	Community-based Organization
FBO	Faith-based Organization
AS	*Aires de Sante*
CHE	Community Health Endowment
SNIS	*Systeme Nationale d'Information Sanitaire*
PNLS	*Programme Nationale de Lutte Contre le Sida*
PNLP	*Programme Nationale de Lutte Contre le Paludisme*
KPC	Knowledge, Practice, Coverage
HR	Human Resources
HRIS	Human Resources Information System
HGR	*Hopital Generale de Reference*
GIK	Gifts in Kind
LSF	Lifestraw Filter
MSP	*Ministere de Sante Publique*
FBN	Faith-based Network
ECZS	*Equipe Cadre de Zones de Sante*
CL	Consortium Lead