GLOBAL PARTNERSHIP FOR SOCIAL ACCOUNTABILITY

SECOND GLOBAL CALL FOR PROPOSALS
November 18th, 2013 – January 6th, 2014

Part 2: Main Application Form

Instructions

- **GPSA requires that all grant applications be submitted using an online electronic platform. Part 1: Proposal Basic Information must be filled out in the online platform. Part 2: Main Application must be completed using this form, and uploaded in the "Attach Files" section of the platform. Part 3: Proposal Budget must be completed using the Excel template, also available at the online platform (www.gpsa/worldbank.org).**
- **Please make sure you read the guidance included in the endnotes section, which will help you in answering the questions. Refer also to the GPSA Application Guidelines before completing your application.**
- **The Proposal must provide clear and concise answers that directly address the application's questions. Use the "word count" to comply with the word limit set for each question. Do not change the formatting of this application form.**
- **You may contact the GPSA Helpdesk at gpsa@worldbank.org for questions about the grant application process.**

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1. Define the overall objective(s) of the proposal.[1] State clearly:

(a) What are the governance and development challenges the proposal will contribute to solving? Specify the public policy problem or issue being targeted, including available data evidencing the problem.
(b) What is/are your proposed solution(s)? What type of changes (in public policies and processes, programs, service delivery, institutions, skills and behaviors) you intend to achieve in the proposal's timeframe?
(c) Who are the sectors of the population that would benefit from these changes and in which ways (e.g. observable benefits in the form of infrastructure, service delivery, etc.)? Are poor/extreme poor and vulnerable groups (e.g. women, children, persons with HIV, etc.) included amongst those sectors?
(d) What is the proposal's geographic scope? Provide information that may help us understand the proportion of the targeted population and administrative/political organization (e.g. # municipalities, # districts, # provinces, etc) in relation to the country's total population and overall administrative/political organization.

Please apply SMART (Specific, Measurable, Attainable, Realistic, Time bound) criteria when defining the objectives. Make sure to answer all the above sub-questions.

(a) The project will contribute to solving the following development and governance issues: The Democratic Republic of the Congo has experienced violence and political instability for decades. Although profoundly disrupted, basic social services such as healthcare have remained active. Public facilities are the main source of health-care for 65 (Bas-Congo) to 95% (South Kivu) of the population (Cordaid surveys 2012 & 2013) but they are ill-equipped and rarely manage to address the needs of the population, which tends to be suspicious towards the medical staff. Often, chief-nurses and medical staff run their health facility paying little attention to the users (Cordaid 2013), who are voiceless vis-à-vis the medical staff and health authorities. Mismanagement is frequent. As a consequence, access to frontline health care, such as child and maternal care (vaccination, pre and post-natal care, delivery, nutrition), and the quality of health-care (waiting time, attention given to patients, operating hours, etc.) remain inadequate.

(b) Our proposed solution is to strengthen the Health Facility Committees through which citizens/service users can voice their concerns and preferences to the health centers and hold them accountable for quality services. Health Facilities Committees (*Comités de Développement Sanitaire* - CODESA), made of elected members of the catchment area of the health facilities have existed for over 15 years in DRC but little attention and support has been paid to them for a decade. However, they constitute a legal system through which ordinary citizens can voice their concerns and preference to the health center. The mechanism is based both on the decision powers the committee has at the health facility (human resources, budget, possibility to bring issues to the health zone level). It also rests on the local-level culture of village assemblies and governance. A recent Cordaid pilot project shows that health committees that are trained on their role and aware of their function can lead to improved access, management, and quality of health care. This proposal expands the geographical coverage of the pilot project, adds a new focus on vulnerable groups, and brings in a new tool, micro-grants, to reinforce the social contract between the population and its committee. Behavioral changes are expected at two levels: (1) *the service provider and its hierarchy*, civil servants will take the voice of the users into account not only because it is their duty but also because it makes services more efficient and profitable; (2) *the community*, empowered citizens and their committees will re-gain control of their services. The quality and use of services is expected to increase and the institutional culture of the health providers (and authorities) is expected to change.

(c) The main beneficiaries of the project are rural communities who use the health facilities. Most of those people are women and children. The medical staff who work in those facilities, as well as the health system -from district officers to province-level officials- should also benefit from this project that will allow them to better understand users' needs. Comparing to the previous pilot project, this proposal pays more attention to marginalized groups (ethnic minorities, vulnerable people ('*indigents*'), chronically ill people, etc.) that will be empowered through the committees. Increase in the use of services -especially by the most vulnerable fringes of the population, satisfaction with the services, as well as better, user-oriented, management (through openness about budget, prices, and activities) will be visible and measurable impacts of the project.

(d) The project will cover nine stable health zones of South Kivu. In an attempt to kick-start a new nationwide interest for health facility committees, the project will also cover three health zones (two among them are qualified as development zones) in the more stable province of Bas Congo. An estimated 190 health facilities will be concerned by the project, serving over 2.2 million people (a third of the population of South Kivu and a tenth of the population of Bas Congo).

2. Which public sector institution(s) and agency(ies) *[e.g. Sector Ministry, National Program, Local Governments, Parliamentary Office/Committees, Supreme Audit Institution, Regulatory Agency, Ombudsman, etc.]* **will use the project's feedback to solve the identified problem?** [2] Explain clearly:

(a) If you have already engaged with these actors to find out what kind of information and citizen feedback is needed and how it would be used to implement changes that would help to solve the problem.
(b) What are the incentives these actors have to do something with such information? Why should they use the information produced by the project and what concrete benefits would derive from using it?
(c) How do you propose to work with these institutions/agencies?

The following institutions will use the project's feedback to solve the identified problems: (1) The Health facility committees which are local-level public sector institutions, (2) the South Kivu and Bas Congo ministries of Health (*Inspection Provinciale Sanitaire*) and Planning and their decentralized units (health zones).
Because of the weakness of the state (and violence in South Kivu), there is indeed a disconnection between institutions and 'their' people (which has often been acknowledged by the public authority during the pilot project).

(a) From the project pilot, we know that reinforced health facility committees can convey important information about the difficulties users experience when using health services. Our pilot project shows that the quality of care -such as waiting times, clarity of bills or welcoming at the health facility- is an important concern for the population and that reinforced health committees can be in a position to instill positive change at the health facility and force changes. We also learned that when people's problems cannot be addressed at the health facility (for instance because of a conflict with the nurses), the health committee can successfully voice them at the health zone level and they can be addressed from there. Citizens' feedback on the management of the health facility also helps the medical staff to be more accepted by the population and better manage inputs (drugs, etc.). This is especially important in parts of South Kivu where health zone supervision is sometimes irregular (2012 Cordaid survey).

(b) The pilot project shows that actors understand the strategic interest of using feedback from the services users. The project will also use a carrot and stick approach to ensure that the public authority acts upon the information it receives. Financial incentives (see point c below) are the carrot while the re-establishment of the authority of the health committees over the medical staff and close collaboration with the provincial level authorities constitutes the stick. At the moment, the problem seems not to be the authorities' reluctance to take into account people's feedback but rather the absence of such pieces of information. In a country where the long road of accountability through MPs, local representatives, and the democratic system in general is hazardous, a more direct sort of feedback to sectorial policy-makers is absolutely central to coordinate interventions and programs.

(c) Civil servants from the provincial ministries of Health and Planning will be invited to participate in the training of the health committees. They will gradually take the lead in the supervision and support. On the other hand, we propose to incentivize the authorities (including health facilities) to develop good practices of accountability through adding basic governance indicators (public information, existence of community meetings, and meetings, etc.) to the list of indicators health facilities and health zones are already contracted for.

3. What is the social accountability approach[3] that will be used to generate the feedback needed to solve the identified problem? Explain clearly:

(a) The proposed social accountability process, including formal and informal mechanisms for gathering citizen's feedback, and other complementary strategies, such as communications and media work, research and data analysis, negotiation and consensus-building, among others. Specify, if applicable, if you're planning to use any ICTs (information and communication technologies) for gathering or organizing citizens' feedback to complement the latter. Please note that the use of ICTs is not a requirement.

(b) Why would the proposed approach work, and how is it different or better from previous or existing attempts at solving the problem by engaging citizens? How would it complement and/or add value to existing initiatives implemented by other stakeholders (including the government, CSOs and other donor-supported projects)?

(c) If this approach can work to help solve the problem, how would it become sustainable beyond the project's duration?

(d) If you're proposing to work in a subset of geographic areas, how would this approach be replicated at a larger scale?

(a) The project seeks to establish a new short route to accountability in health care services. Health facility committees are an interface for direct contact between the service provider and the population. Since they are made of volunteers, chosen by the population, they also guarantee a form of democratic control on health facilities. At the same time, the members of the health committee will use social accountability tools such as community-score cards or community audits of the health facilities. Health committee members, as representatives and as implementers of community score-cards and community audits, will gather information that will be shared and discussed with the health facilities staffs. The health committee also has the power to make decisions at the health-facility and, in case the situation with the health facility is stuck, can reach the health and administrative authorities. The committee also transmits health-facility information to the population. ICTs are not central here, although health committees 'help lines' will be maintained.

(b) The mechanism is not new but has not been supported for long. The pilot project has demonstrated that, in addition to basic training on the roles and functions of the health facility committees, two innovative tools have an important potential to energize the health facility committees: (1) terms of reference of the health facility committees that are jointly written with the medical staff and (2) community score-cards to identify and tackle problems.
In addition, we propose to introduce matching micro-grants that would allow committees to be better considered by the medical staff and the population as those micro-grants could be used to further tackle problems identified through community score-cards.
The project is complementary to performance-based initiatives that do not have very developed downwards mechanism of accountability (making it complicated to check whether performances are in line with people's needs).

(c) The following mechanisms and processes will insure that the project will become sustainable beyond the project duration: Provincial authorities and their decentralized units are supposed to support the health facility committees but often do not know how. The project will train them and make them reliable actors who are in a position to carry out supervision over and support to the health facility committees in a longer term. The project will also develop handover procedures to ensure continuity between old and newly-elected health facility committees. Building on the pilot project, we will continue developing easy-to-use training and operational guidelines and manuals on the health facility committees with the local health authorities. National level restitution of the experience and lobby through provincial health authorities are expected to trigger a new national strategy for the health committees, insuring their sustainability.

(d) The approach will be easily replicated in a larger scale through the developed tools well mastered by the civil servants. Presentations and field visits in the project sites by national and provincial-level officials should be organized to foster replications. Committees are a reality of the DRC health system and different actors, in other provinces, are interested in efficient ways to strengthen them in the Congolese context.

4. Partnerships.[4] Describe the nature and purpose of the proposed partnering arrangements, including what each partner will do and how the partnership will be governed. Be as specific as possible in clarifying the lines of responsibilities and accountability within the project.

Cordaid's mission and philosophy is to reinforce local actors and work through partnerships and multi-stakeholder coalitions rather than direct implementation. For this reason, partnerships are the cornerstone of this project:

- The first 'partners' are the health committees that will benefit from the intervention. They are not passive, they nurture the project through feedback sessions and constant interaction with the project's team. Joint recycling sessions, where committees from different area meet, as well as working session with actors and authorities from other sectors, will be organized in order to foster multi-stakeholders coalitions.

- The provincial ministries of health will be a partner in the definition and approval of the reinforcement strategy of the health committees. The objective is that the team at that level is fully capable to understand what the project is about and its importance; on the other hand, they give the project access to resources and authorization to operate. The Ministry of planning is also a partner in working together on the creation of a framework for the better inclusion of health committees in the tissue of local governance and planning. The responsibility of these two partners is to have the legal and regulatory framework right.

- The health zones and their agents are responsible, in a later stage of the project, for the supervision of the health facility committees. They are trained for that task, contracted, and incentivized and they are also invited to develop strategies to sustain the project in the medium run.

- Local CSOs supervise and train the committees. They are in a position to deliver context-sensitive support to the committees. Their training on issues of social accountability will generate positive externalities. Their responsibilities are established by contract and the quality of their work is verified by the project team.

5. If your proposal is part of an ongoing project in your organization explain how GPSA's support would add value to it: what are the specific activities that would be funded by GPSA and how are these different from what you're already doing? **If your proposal is a new project for your organization**: how does it relate to what you've been doing until now?[5]

The proposal is to upscale an existing pilot project funded by the World Bank Civil Society Fund on reinforcing health committees in four health zones. The pilot project will come to an on January 25th. It shows impressive results that are being confirmed by an independent research conducted by the Oxford University. The Dutch Ministry of Foreign Affairs has already decided to fund a Euro 140,000 project to continue the work in these four health zones for one more year. The GPSA's support would enable Cordaid to (1) scale-up the initiative to other zones and in terms of duration and (2) add new components to it.

(1) The project is currently limited to four health zones: Katana, Miti-Muresha, Walungu and Idjwi. The support is for one year starting from February 2014. With the GPSA fund, the project could be extended to another seven Health zones that are categorized as in a 'development' phase (versus 'emergency' phase), now covering Uvira, Lemera, Kalehe, Mubumbano in South Kivu and Mwanda, Kitona and Boma-Bungu in Bas Congo. The inclusion of Bas Congo's health zones is a deliberate attempt to start scaling-up good practices acquired in South Kivu to other provinces and initiate a national-level renewed attention and support to health facility committees. The 5-year funding would also help to ensure that profound institutional changes can take place. As mentioned earlier, behavioral and institutional changes take time.

(2) With the GPSA support, another arm could be added to the pilot project approach, in all areas. It is a pro-vulnerable inclusion strategy that contains measures to ensure representation and empowerment of vulnerable groups within the committee and the set-up of a commission for vulnerable people within the committee. The issue of vulnerable people was often raised during the pilot project but has not been specifically addressed.

6. Institutional strengthening.[6] Does the proposal include activities for strengthening your organization's internal management and planning capacities (e.g.: fundraising, strategic planning, financial management, Board strengthening, human resources training, etc.)? If not, indicate "No".

No.

7. Project areas/components: how do you propose to organize your project?[7]

Area/Component 1	Reinforcing the health facility committee system
Activities	1. Information session and training at the provincial level for provincial-level officials (topics: what is a health facility committee, how is it supposed to work, what is your role vis-à-vis the committee?). 2. Information session and training in each health zone (topics: what is a health facility committee, how is it supposed to work, what is your role vis-à-vis the committee?). 3. Training for committees that haven't been trained during the pilot project (on terms of reference, basic tools, community score card, etc.), using the guidelines that were developed during the pilot project. 4. 2 refresher session per committee the first year. 5. 1 refresher session per committee the next two years. 6. Set-up of supervision and support system through CSOs and the provincial health authorities. 7. "Contracting" within the health system to take into account the health committees in the objectives of the health facilities and health system.
Outputs[8]	1. Trainings are organized. 2. Refresher sessions are organized. 3. Supervision and support system is in place.
(Intermediate) Outcomes[9]	✓ Health committees know their roles and are equipped to assure it. ✓ Health committees have capable referees at the upper-level (health zone) ✓
Area/Component 2	Re-appropriation of the health facility through community actions and projects
Activities	1. Conditions for giving out micro-grants are defined. 2. Health committees that meet the requirement can apply for a micro-grant. A limited number of micro-grant is attributed each year and the selection process is transparent, with part of the jury external to Cordaid. 3. Monitoring of the micro-grant execution (partly by partner CSOs). 4. Support for after micro-grant management strategy (partly by partner CSOs). 5. Set-up of health committees hotlines for users (phone numbers that can be called by citizens who would like to discuss health related issues – this is only relevant in the most remote intervention area).
Outputs	1. Micro-projects are undertaken. 2. Micro-projects' management lead to a new "best practice" (inclusive, representative and context-sensitive) management behavior. 3. The population is in touch with the committee, with whom it has been involved in a transformative project.
(Intermediate) Outcomes	✓ A new social contract between the citizens, the committee and the medical staff is established. ✓ Trust is restored. ✓ Micro-projects lead to better quality and use of services.

Area/Component 3 Knowledge and Learning (K&L)[10]	K & L: health facility committees are fully integrated into the health system and beyond.
Activities	1. Integration of a social accountability approach in all health-related Cordaid (and its partners) intervention through a Cordaid country policy and internal workshops of health committees. 2. Quarterly newsletter for all the partners involved in the project, including CSOs and health committees. The newsletter will focus on examples of good practice of the health committees. Health authorities would be involved in this. 3. Training/workshop on social accountability for contracted CSOs as well as monthly discussion sessions. 4. Update and exposure of the project through active participation to online communities of practice such as GPSA, COPASAH (Community of practice on Accountability and Social Accountability in Health), CoP Financial Access to Health, and CoP Performance-based financing and media. 5. Visits to and exchange with similar projects supported by Cordaid in Burundi and other countries. 6. Publications on the project and its unfolding through Cordaid's network of partners in DRC and abroad. 7. National-level workshop with the Ministry of Health, lobby for a deeper attention of the central level on health facility committees. 8. Creation and dissemination of new guidelines and refreshed framework for health facility committees.
Outputs	1. Trained CSOs and health authorities. 2. Quarterly newsletter. 3. National-level workshop and participation to international gathering. 4. Frequent update and presence on digital communities of practice and media. 5. New guidelines and national policy is issued. 6. Impact and implementation reports circulated between partners.
(Intermediate) Outcomes	✓ Health facility committees are a well-known strategy for improving access to health-care. ✓ A system for permanent reflection and evolution of the committees exists. ✓ National attention is given to health facility committees and other social accountability measures in primary health care.
Area/Component 4	Integrating the poorest and most vulnerable fringes of the population in the health facility committee and decisions on health-care services.
Activities	1. Selection of 100 health facilities where the approach will be experimented during 2 years before it is scaled-up, baseline study. 2. Session with the health committee and medical staff on identifying the most vulnerable sections of the population and reflecting on their inclusion in the health committee. 3. Reservation (quotas) in the health committee, including the executive members (the *comité restreint*), for vulnerable people. Election of the representatives for vulnerable people. 4. Support and training of vulnerable people representatives within the health committee. 5. Special training session and follow-up on the creation of a social commission within the committee. The idea of a social commission is not new; it is an existing mechanism that is under-used. 6. Impact evaluation and scaling-up.
Outputs	1. Health committee meetings minutes show an active participation of the representative of the vulnerable people. 2. The commission for social affairs meets regularly and makes decisions. 3. Frequentation of the health facility by vulnerable people increases. 4. Vulnerable people's satisfaction with services increases.
(Intermediate) Outcomes	✓ The committee represents everybody, with a specific attention on the poorest groups. ✓ Socio-economic barriers to access to care by vulnerable people are lowered.

7. Action Plan.[11] Use the Gantt chart below to present your proposal's Action Plan. Please refer to the examples provided in the endnotes.

Key Activities[12]	**Main Outputs/Deliverables**[13]	**Estimated Schedule** *(use years applicable to proposal's duration)*									
		Year 1		**Year 2**		**Year 3**		**Year 4**		**Year 5**	
		Sem. 1	Sem. 2	Sem. 1	Sem. 2	Sem. 1	Sem. 2	Sem. 1	Sem. 2	Sem. 1	Sem. 2
Component 1: Reinforcing the health facility committee system											
1. Training of committees.	1. Sessions organized, reports.										
2. Refresher sessions for committees.	2. Sessions organized, reports.										
3. Training sessions for health authorities.	3. Sessions organized, reports.										
4. Supervision system.	4. CSOs and health authorities are trained, supervision reports are produced on a regular basis										
5. Contracting system.	5. Indicators defined, contracts signed and renewed.										
Milestones[14] *[List milestones in this column. Add rows as needed] Shade cells to indicate milestone achievement estimated timeframe.*											
➢ **All committees are trained**											
➢ **All officials are trained**											
➢ **All committees have new terms of reference**											
➢ **End of first contracting round**											
Component 2: Re-appropriation of the health facility through community actions and projects											
1. Definition of selection criteria and type of project eligible.	1. Guidelines and public instructions, call for applications circulated.										
2. Selection of committees.	2. Jury session organized, list of laureates available.										
3. Follow-up of projects.	3. Supervision reports, projects realized in the field.										
Milestones											
➢ **Call is out.**											
➢ **Projects selected.**											
➢ **Projects finalized.**											
Component 3: K & L: health facility committees are fully integrated into the health system and beyond.											
1. CSOs training, meetings and discussion groups.	1. Minutes meetings, strategy documents, micro-adjustment of the project.										
2. Health facility committees newsletter.	2. Newsletters.										
3. Online advocacy and exposure of the project.	3. Media article, online discussions.										
4. National lobby.	4. New law and guidelines for health facility committees.										
Milestones											
➢ **First online reporting to CoPs.**											

Key Activities[12]	**Main Outputs/Deliverables**[13]	**Estimated Schedule** *(use years applicable to proposal's duration)*									
		Year 1		**Year 2**		**Year 3**		**Year 4**		**Year 5**	
		Sem. 1	Sem. 2	Sem. 1	Sem. 2	Sem. 1	Sem. 2	Sem. 1	Sem. 2	Sem. 1	Sem. 2
➢ **Exchange with Burundi.**											
➢ **National Workshop.**											
Component 4: Integrating the poorest and most vulnerable fringes of the population in the health facility committee and decisions on health-care services.											
1. Impact evaluation	1. Baseline and end-line reports.										
2. Sensitization and action session.	2. Local-level inclusiveness strategy is defined.										
3. Set up of pilot commissions for social affairs.	3. Commissions for social affairs exist and are active.										
4. Scaling-up.	4. All committees have vulnerable people representatives and commission for social affairs.										
Milestones											
➢ **Final impact evaluation (pilot).**											
➢ **First commission set up.**											
➢ **Scaling up starts.**											

8. Monitoring and evaluation:

(a) How do you define the proposal's success indicators? Identify the most critical ones and link them to the outputs and outcomes presented in questions 1 and 3.
(b) How will you monitor the proposal's progress? Describe the methods and tools that will be used.
(c) What will you evaluate and what type of evaluation(s) will be used? Specify if you plan to carry out an independent evaluation.

(a) The main success indicators will be the following:
    a. Health facility committees are active and represent the population.
        i. *Output*: committee meetings and attendance, training and refresher sessions, understanding of the participants to the trainings (evaluated through tests), community meetings, training on and realization of community score-cards.
        ii. *Outcome*: health facility committees are a space for discussing local-level health problems and addressing them (visible through meeting reports and population reports).
    b. Health facility committees have a say in the management and organization of the health facilities.
        i. *Output*: committees are trained on their role together with the medical staff, terms of reference define rights and roles, joint meetings between health zone/administrative officials and committee members.
        ii. *Outcome*: health facility committee is a respected actor of the health system; it has direct and indirect ways to influence the health facility management (visible through committees' minutes and interviews/survey).
    c. People, especially the poor, trust and interact with their committees and health facilities.
        i. *Output*: organization of community-score card that lead to micro-project through matching micro-grant, quota for vulnerable people within the committee, support to vulnerable health committee members.
        ii. *Outcome*: people come to committee members to express their concerns.
    d. The health system has a full ownership of the health facility committee concept and promotes and sustains them in the long-run.
        i. *Output*: training sessions and field visits to health facility committees by health care officials, national and provincial guidelines, guidelines for cross-sectorial cooperation within the ministry of planning.
        ii. *Outcome*: health facility committees are a well-accepted and well-known strategy by the authorities (place of the committees in policy documents and in coordination meetings).

(b) Routine monitoring of the proposal progress will be done through: (1) the regular analysis of the meeting minutes of the health centers and their committees as well as (2) routine health information system data and (3) follow-up reports from partner CSOs. Health information system data allows us to better understand what some of the measurable outcomes (use of services, sessions and activities of the health facility committees, etc.) of the program are as they unfold. The analysis of the meeting minutes as well as follow-up reports aims indicates whether interventions are taking place as expected and which micro adjustments may be needed. The project team already has experience in using these tools. All information on the situation in each health facility will be indexed in a single file in order to better monitor the situation there.

(c) Mixed-methods impact evaluation will be used. On the one hand, routine complemented with baseline, mid-term and end-line survey serve to track changes in key measurable indicators (use of services,

transparency in management, activities of the committees, etc.). On the other hand, as this pre- and post-intervention quantitative data may not be enough to assess what the *behavioral* changes are, participatory rapid appraisals will also be conducted.
For the newer arm of the project, a pilot will first be randomly tested during the two first years and modified/scaled-up later on.

9. Project Team. Explain clearly:

(a) Describe how you will assemble the Project Team. Indicate if the Team members are part of your current staff, and explain which new positions, if any, will need to be hired. Include any relevant positions that will be hired as consultant positions as well. Refer to the Proposal Budget for guidance.
(b) If the Proposal includes a Partnership and/or Mentee CSOs, explain what positions and roles they will perform as part of your Project team.

(a) Project Team:

- The overall project will be coordinated by an experienced project manager based in Kinshasa who will dedicate one third of his time to the project.
- In South Kivu, the project will be supported by an experienced technical Advisor who has worked on the pilot project and its extension. He has worked on community participation in South Kivu for the last decade; he will support the project specifically on quality insurance and field work. He will be the technical manager of the project. He will be assisted by a Technical Assistant who will support local CSOs. He will be recruited during the project time. Both will be supervised on a daily basis by the health program manager in South Kivu.
- In Bas-Congo, the project will be supported by one Technical Assistant with long time experience in working in this province with the health sector actors. He will work under the direct supervision of the project manager who is actually his current supervisor.
- A finance officer will insure the financial performance under the supervision of the project manager and the CORDAID finance controller.
- For the impact evaluation and strategy of the new arm of the project (vulnerable groups), the team will be supported by an international consultant (who is an Oxford researcher) who already worked in the pilot project and delivered valuable evaluations as well as strategic advice. Other impact evaluations using health information system and survey data would be performed by a local consultant, with possible support of the finance officer and project team.

(b) This proposal is solely handed by Cordaid and partnerships, although already discussed and agreed on with some actors, will be formalized only after the proposal is accepted. We already have a good idea of which CSOs we would like to work with in this project (for instance *Agence d'Achat de Performances* and *Community-Based Initiative* for South Kivu) but we believe the selection should follow an open and transparent procedure so we do not want to confirm any name at the moment. The exact role of CSOs will be defined through contract; they mostly are in charge of supervision and evaluation and meet with the (technical) manager monthly. Those meetings are also the occasion to jointly discuss possible changes/evolutions in the project. The Provincial Ministry of Health has been associated to the present proposal and will be heading the steering committee and be in charge of communication with its decentralized units.

10.1 Please fill out the table below:

Team member name*1	Position	Time devoted to Project*2	Project Components	Project Main Responsibilities
Paul Khomba	Project Manager	Part-time Personnel Full project duration	Component 1	▪ Overall Project coordination ▪ Supervise Project team's performance ▪ Lead periodic strategic planning team meetings and approve adjustments to Project's flow
			Component 2	▪ Contact with upper-level state actors. ▪ Coordination with existing projects within Cordaid and its partners.
			Component 3	▪ Support for administrative and financial technical aspects.
Michel Zabiti	Technical Advisor South Kivu (Quality and Implementation)	Full-time Personnel Full project duration	Component 1	▪ Liaises with ministry and other partners. ▪ Establishes training curriculum. ▪ Trains colleagues and trainers. ▪ Collects Health Information System Data and primary analysis.
			Component 2	▪ Access health committees' proposal. ▪ Coordinate the team for establishing selection criteria and selecting projects. ▪ Liaise with health zones for quality control of CSOs and health committees.
			Component 3	▪ List potential partner CSOs. ▪ Participates in international conferences and workshop. ▪ Organizes the national-level conference. ▪ Supervises and coordinates monthly reports.
			Component 4	▪ Monitor activities of commissions for social affairs. ▪ Supervise the implementation of the reinforcement strategy. ▪ Supervises enumerators for surveys (also general survey in Component 1).
To be recruted	Project Assistant CSOs	Full-time Personnel Full project duration	Component 1	▪ List potential partner CSOs. ▪ Help with defining PBF indicators. ▪ Trains health committees. ▪ Supervises CSO for follow-up and supervision.
			Component 2	▪ Assess projects. ▪ Liaise with CSOs and quality control of CSOs.
			Component 3	▪ Online publication. ▪ Assemble the newsletter
			Component 4	▪ Monitor activities of commissions for social affairs. ▪ Supervise the implementation of the reinforcement strategy, does the first training session and train trainers for the rest.
Adolphe Malanga	Project Assistant – Bas Congo	Part time Personnel Full project duration	Component 1	▪ List potential partner CSOs. ▪ Help with defining PBF indicators. ▪ Trains health committees.

				▪ Supervises CSO for follow-up and supervision.
			Component 2	▪ Assess projects. ▪ Liaise with CSOs and quality control of CSOs.
			Component 3	▪ Online publication. ▪ Assemble the newsletter
			Component 4	▪ Monitor activities of commissions for social affairs. ▪ Supervise the implementation of the reinforcement strategy, does the first training session and train trainers for the rest.
			Component 2	▪ Quality control of partner CSOs. ▪ Quality check of mirco-projects and respect of disbursement of funds.
Christian Bahizi	Finance officer	Part-time Personnel Full project duration	Component 1	▪ Process ▪ Budget Monitoring ▪ Financial Reporting ▪ Validation of expenses

***1 |** You must list all the Project Team, including existing staff, staff to be hired, and individual consultants. If you're proposing to hire consulting firms to deliver specific tasks that are critical to the project (e.g. Project evaluation, ICT products/services, etc.) you MUST also include them in the table.
***2 |** Indicate (a) if full or part-time, (b) if CSO personnel or consultant, and (c) if team member will be employed for the full duration of the Project or for specific periods or tasks.

Guidance for Answering Part 2: Main Application Questions

[1] **Question 1: Proposal's overall objectives.** The proposal's theme must be aligned with one or more of the priority areas identified in the country call for proposals. Within the chosen theme or sector, the specific issue(s) or problem(s) that will be addressed through social accountability must be clearly spelled out. For example:

- If the proposal focuses on monitoring health service delivery, identify the specific services or issues that will be monitored, such as service inputs (e.g. availability of vaccines for children 0-5 years old, of micro-nutrients for pregnant women, antiretroviral treatments for HIV patients, etc.), or service access (e.g. hours of operation at local health clinics, availability of doctors and nurses, infrastructure conditions, etc.)
- If the monitoring process encompasses budget monitoring, the precise issues to be covered must also be indicated: following the latter example, the social accountability approach may include gathering information about sector transfers to health clinics, procurement of inputs and contract supervision, among others.

- For budget monitoring as a more general theme, the specific issues to be monitored must also be spelled out: for instance, enforcement of budget accountability laws and regulations at the sub-national level, citizen participation mechanisms for agreeing on local spending priorities, budget allocations for public investments in critical basic infrastructure, procurement and contract monitoring, etc.

In this question, the reference to the proposed solution(s) must briefly and concisely explain *(a) what social accountability approach will be used to (b) achieve what type of changes in the proposal's lifetime. Point (a) must clearly define the type of citizen feedback that will be generated to address the issue or problem.*

Citizen "feedback" is understood as the information provided by citizens and is based on their experiences in accessing or using a certain service or program delivered by the state or a third party contracted out by the state. Information about a public service or program is also generated indirectly by analyzing and systematizing information either from data that is proactively made available to the public, or from requests for access to such public information. Whether the feedback is produced directly or indirectly, it is intended to be used as a basis for the improvement of a specific public service or program.

The justification of the need for this feedback should be briefly mentioned here, and expanded on questions 2 and 3.

Suggested guidance for defining the proposal's strategic objectives: "The Super Duper Impact Planning Guide", by Albert Van Zyl, International Budget Partnership, available at http://internationalbudget.org/wp-content/uploads/Super-Duper-Impact-Planning-Guide.pdf

[2] **Question 2: role of government and public sector institutions.** The answer must provide a justification for the proposed solution(s) put forth in question 1 by answering all the sub-questions. By reading the answer it should be clear *(a) who in the public sector (including institutions within and outside the Executive branch) is/are interested in obtaining the type of citizen feedback that would be generated by the project, (b) why do they need this information and in which ways will this information benefit their positions and interests in order to motivate or incite them to take action.*

[3] **Question 3: social accountability** is approached as a process encompassing (a) the use of a combined set of mechanisms and "tools", including formal (i.e., mandated by laws and regulations) and informal (set up or organized by CSOs and citizen groups themselves), (b) whereby the choice of mechanisms and tools is grounded on several considerations, such as a cost-benefit analysis of alternatives, an analysis of the political-institutional context, an assessment of needs and problems regarding the service delivery chain or the management process, among others, as well as of "entry points" for introducing the process, and of existing capacities and incentives of the actors to be engaged, including service users, CSOs, service providers and public sector institutions.

The approach thus assumes that in order to be effective the social accountability process must engage citizens and public sector institutions, especially those with decision-making power to address the issues raised by citizens and CSOs. It is a double-way process, and as such, it cannot rely only on the assumption that the solution rests on building citizen capacities to generate feedback, or on the generation of such feedback by itself; these are necessary, albeit not

sufficient conditions for generating the changes needed to improve or solve the issue. Therefore, the proposed process must be as explicit regarding the actions on the part of public sector institutions (and of other relevant stakeholders such as the private sector, the media, etc.) that will be required for it to be considered a plausible and realistic approach.

Suggested guidance for defining capacity-building activities: "The Capacity Development Results Framework. A strategic and results-oriented approach to learning for capacity development", by Samuel Otoo, Natalia Agapitova and Jay Behrens, World Bank Institute, June 2009. Available at the GPSA website.

[4] **Question 4: Partnerships**. The GPSA encourages applicants to identify partners who may complement the applicant's expertise, outreach capacity and influence in working towards achieving the proposed objectives. It is assumed that governance and development challenges call for multi-stakeholder coalitions, encompassing stakeholders from diverse sectors, to work together in order to solve them. Partnership arrangements may include "mentoring" schemes, whereby the main applicant CSO has identified one or more "mentee" CSO(s), that are usually nascent, or with less social accountability experience, and puts forth a capacity-building process that uses the proposed operational work as a means for the mentee(s) to "learn by doing". Partnerships with other CSOs with specific, complementary expertise, outreach and influence may also be put forth. If partners will take on specific responsibilities within the proposal, that are directly related to its planned activities, outputs and outcomes, they must be included as part of the project team (see Question 10) and are expected to participate in a funds' sharing scheme (see the Proposal Budget guidance).

[5] **Question 5: Ongoing/new project.** For ongoing projects, the answer should clearly explain the value added of GPSA support, and what would GPSA funding support within such project. A summary of the ongoing project achievements and challenges should also be included here, as well as a clear explanation of its sources of funding. For new projects, the answer should relate the proposal to the organization's experience on social accountability and in related projects.

[6] **Question 6: Institutional strengthening.** GPSA support may include activities aimed at investing in the applicant CSO's institutional capacities that will ensure the organizations' sustainability of operations beyond the proposal's duration. CSOs working on social accountability usually operate in contexts of limited resources and one of GPSA's central objectives is to offer "strategic and sustained support" that may allow for mid to long-term strategic planning. The GPSA gives special consideration to the ability of the applicant CSO to relate the proposal to the organization's current state of development, including efforts to invest in strengthening staff's capacities on social accountability, but also other activities such as those mentioned in the question.

[7] **Question 7: Project areas/components.** The proposal should be structured around areas or components, which consist of sub-sections that are organized together because of their direct relation to one or more intermediate outcomes. A Project component must thus group those activities and outputs that can be directly linked to specific intermediate outcomes as defined in the proposal's results framework. By reading the Project component one must be able to understand the linkages between the activities included therein, as well as the relationship between the expected outputs and outcomes. See footnotes 7 and 8 below.

[8] Outputs are the direct products of project activities and may include types, levels and targets of services to be delivered by the project. The key distinction between an output and an outcome is that an output typically is a change in the supply of services (E.g. # of CSOs trained on social accountability, # of meetings with government officials, website set up and running, etc.), while an outcome reflects changes derived from one or more of those outputs (E.g. CSOs apply the skills learnt by implementing a social accountability process, XX Government actor introduces X change/s in the delivery of X service, Supply of X service is increased by X%, Quality of X service is improved as measured by XX, etc.)

[9] Outcomes are the specific changes in project participants' behavior, knowledge, skills, status and level of functioning; they should be defined in a SMART way: strategic, measurable, action-oriented, realistic, and timed. Intermediate outcomes are attributable to each component, and would contribute to the achievement of final outcomes at the Project level. An intermediate outcome specifies a result proximate to an intended final outcome, but likely more measurable and achievable in the lifetime of a project to an intended final outcome. To ensure the accuracy of assigned intermediate outcomes, the consideration of each proposed outcome should include reviewing who is best situated to achieve the outcome (that is, is this within or outside the scope of this intervention?) and how the outcome might be effectively measured. Example: Teachers use the new teaching methods (intermediate outcome) to improve learning among students (final outcome).

[10]

Guidance for designing the Knowledge & Learning (K&L) Component

A key GPSA objective is to contribute to the generation and sharing of knowledge on social accountability (SAcc), as well as to facilitate knowledge exchange and learning uptake across CSOs, CSOs networks, governments and other stakeholders. GPSA aims to support its grantees with the best knowledge available on social accountability tools and practices, and also to develop and disseminate them widely among practitioners and policy-makers in order to enhance the effectiveness of SAcc interventions.

GPSA will promote K&L activities such as nurturing practitioner networks and peer learning, especially South-South exchanges through events, on-line resources, and technical assistance. An online Knowledge Platform will provide access to knowledge, support sharing of experiences, facilitate learning, and networking.

GPSA requires that grant proposals include a K&L Component, whereby applicants develop a plan in which the proposed interventions include opportunities for advancing knowledge about strategies and pathways for promoting transparency, accountability and civic engagement. Special emphasis should be made on learning mechanisms (internships, peer-to-peer reviews, Communities of Practice, etc.) focused on grant recipients and partner CSOs, as well as on key external audiences.

Some key questions to answer in designing the K&L Component are:

- ✓ What particular contribution to K&L on SAcc will our proposal make, such as developing tools, replicable models, impact indicators etc., which may have broader usage?
- ✓ What are our K&L needs and knowledge gaps? While proposals are being assessed on their strengths, the proponent's ability to recognize needs and weaknesses is an important aspect as well.
- ✓ What K&L resources do we have? Are they effective in achieving the objectives for which they were developed or do we need to improve them? Are we prepared to share these resources?
- ✓ Who are the specific audiences that we would like to engage in our K&L plan? What are their specific needs and what are the objectives we seek to accomplish in terms of K&L devised for them?
- ✓ How will we realistically develop and disseminate K&L derived from our project? How will we build sustained capacity with our project participants/beneficiaries and key audiences beyond, for example, one-time training or capacity building events?

[11] **Question 8: Proposal Action Plan**. The action plan should provide a clear summary of your proposal's operational roadmap. By reading it, it should be possible to understand (a) the activities and outputs that are considered critical for project implementation; (b) the sequencing logic devised (whereby a set of critical activities would lead to X outputs, that must be completed in order to proceed to deliver Y activities and outputs) which should be reflected in the planned calendar; and (c) the milestones that will flag the component's progress towards your expected outcomes. See endnote 14 below for examples.

[12] List only the key activities that best reflect the Component's successful implementation throughout the project's lifetime.

[13] List only the key outputs that best reflect the successful delivery of planned activities.

[14] Milestones must be linked to the outputs and expected Component-level intermediate outcomes:

- ➔ They should summarize the Component's critical achievements by year geared to achieving key project-level outcomes by the end of the project.
- ➔ While a planned output will indicate the project's progress towards achieving a certain level of completion of an activity, for example, the target you have defined for training local CSOs and other stakeholders on the use of a social accountability tool or mechanism (E.g. 5 in Year 1, 10 in Year 2, and so on), a milestone would be achieved when these groups are able to actually use the tool or mechanism which would enable you to assess whether the participants have learned the skill and are able to implement it with increasing levels of independence, and whether these activities are leading up to certain outcomes that you expect to achieve incrementally throughout the project's lifetime.
- ➔ Similarly, you may need to define certain outputs for the process of engaging decision-makers, service providers and others power-holders; these outputs may range from sharing systematized data or information that you have produced independently (E.g. independent budget analyses) or that has been generated jointly by community stakeholders (users of a specific service) and service providers as a result of the implementation of a social accountability tool (E.g. Action Plans derived from community scorecards processes), to other type of outputs that are considered critical such as setting up a civil society-government (or multi-stakeholder) working group, or participating in X number of public hearings, among others.
- ➔ The milestones related to all these outputs, however, should help you identify the actions and events that would indicate that the project is progressing towards its expected outcomes. In relation to the examples provided, some questions that you may ask would be:
    - What do we expect will happen if we share independent budget analyses with XX decision-makers? What would progress mean to us? Could we use certain standards -for instance, we expect sector budget allocations or allocations to fund a specific service within a sector to change in any way- in order to define incremental measures or targets of progress?
    - How would we define progress as a result of the implementation of Action Plans agreed upon in the framework of a community scorecards process?
    - If a multi-stakeholder working group is set up, what are the measures of progress that would indicate that the working group is really functioning?
- ➔ There are also process-related milestones that may be critical for the project, such as, for instance, reaching an agreement with a certain government or public sector agency on the local-level service centers (E.g. schools, health centers, etc.) that will be targeted incrementally by the project; integrating the results of the project's end of Year 1 initial assessment (an output of the project's M&E system) into the project's operational plan, including by adjusting planned activities and outputs; etc. etc.