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CHRISTIAN RELIE AND DEVELOPMENT ASSOCIATION

PAC/STDs/HIV/AIDS ACTION PLAN PROPOSED FOR IFH FUNDING

CONSOLIDATION AND INTENSIFICATION PHASE
2000 - 2001

CCRDA

Addis Ababa
December 1999

Concept Paper on Expansion and Intensification of PAC/STDs/HIV/AIDS Project by IFH/CRDA

I. Preamble

This concept paper is prepared in line with the previous decisions and proposals forwarded by the IFH head office and the CRDA. The main objective of this exercise has been to secure a fund for the purpose of the intensification of the ongoing programme and possibly expanding the project to the other regions that have not yet been considered.

The development of this paper takes into account the objectives of CRDA i.e. " Representing collective/individual interest of members with Governmental and International fora " and " Building and improving capacity of its members to achieve their objectives " in conjunction with the contemporary issues of Reproductive Health. Moreover, it also takes into consideration the fact that there are several members and church affiliated institutions that are engaged in providing reproductive health services and need to be constantly updated and oriented with newer scientific milestones.

The evolution of this concept paper also refers to the interests of FHD/MOH, keeping in harmony with the Health Sector Development programme (HSDP) which maintains and advocates Reproductive Health as an important health component of the national programme.

As per the recommendations of Ato Kebede Asrat, the Executive Director of CRDA, this document has now incorporated the major elements of the discussion paper presented by IFH in collaboration with Ato Leulseged Asfaw, Head of the Training Department. This favourable composite draft which takes into consideration the CRDA concept paper and the discussion paper presented by IFH is thus submitted for approval and dispatch to IFH head office for fund solicitation.

II. BACKGROUND

Ethiopia is one of the least developing and poorest countries in the world. The general health service delivery capacities do not go hand in hand with the development and population size. The health and health related indicators for Ethiopia are in conformity with the existing socio-economic level of the country and are equally appalling. Hence, high maternal mortality rate (560-850/100,000 Live births) secondary to unsafe abortion (53%), low contraceptive prevalence rate (7%), highly total fertility rate (7.7%) and

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infant/child mortality rate of (110-150/1000) remain to be sensitive public health issues within the Ethiopian context. It is also to be remarked that most of the Ethiopian population lives in remote rural areas and over 10% of the population served by churches and agencies that manage various health institutions.

The International Family Health, CRDA and FHD/MOH in collaboration with IPAS and the prime funding agencies have managed to introduce the integrated management approach of PAC/STD/HIV/AIDS in the SNNPRS and Oromia regions. The project has so far successfully trained 62 health personnel (physicians and nurses) involving 29 health facilities owned by the Regional Governments and NGO affiliated institutions.

As per the baseline survey and recommendations forwarded by the participants of the Familiarization and Tools Adaptation workshop and the trainees, there is an absolute need and room to improve upon the RH service in the country. The project in place, which in fact has attained an international acclamation in its scope and quality, was graded as essential and considered worth implementing at a national level. The decentralized management approach of incomplete abortion (miscarriage) and STDs/HIV/AIDS was also highly advocated.

In order to standardize the RH services in line with the current project, it has to be disseminated to other regions so as to improve the quality of all Ethiopian women's health . It should not merely be confined to the two regions where further intensification programmes are under consideration to ensure the sustainability of the already established programme.

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III. OBJECTIVES

The prime objective of the titled project is to upgrade the standard of management of the complications of abortion (miscarriage), delivery of post-abortion family planning and integrating these services within the conventional health delivery systems with other important RH issues like STDs/HIV/AIDS. The second objective is to ensure the dissemination of this integrated management approach to areas that were not previously covered/included.

IV. CONCEPTS FOR FUTURE PROGRAMME

The concepts conceived and are to be initiated in the next phase of the project embody the process of intensification and extending it eventually to accommodate other regions. These concepts are considered under the following headings:-

4.1 INTENSIFICATION

The process of intensifying the ongoing training programme in the two regions is assumed to enhance the institutional capacity building of the major health facilities of the

regions. Furthermore, this will enable them to establish their own training centres and make them capable to programme, coordinate and conduct training and ensure sustainability of the programme by reaching all the health facilities in their vicinity.

The needs for intensification of the ongoing programme are multifold and these are primarily based on the high attrition and turnover rate of the trained health personnel. This is a dynamic state which is an accepted phenomenon observed across the whole nation; and the two regions benefiting from the current project are by no means exceptions.

Intensification is assumed to give us ample chance to facilitate the provision of on-the-job training by the supervisors or monitors at regional and central levels. It also allows the dissemination of knowledge and skills down to the grass-roots levels.

It is also strongly believed that in the course of time, the referral system shall be strengthened and the management of postabortion complications and STD/HIV/AIDS treatment and counselling shall be uniformly standardized and eventually quality care can be provided at all levels to those who seek the services. It is quite unfair to simply wrap up the project at the end of its projected timeline/schedule and abandon it to the respective regions. They may not entertain such activities as their foremost priority areas and they may neither have the budget nor a well organized manpower to engage in intensifying the already established and specialized activities. Therefore, it is recommendable to seek for a funding agency and further support the project and allow it to have a strong footing and become more viable.

4.2 EXPANSION

It is obviously understandable to have an acceptable and a comprehensive national reproductive health programme and the introduction of the basic technology of MVA throughout the country is of paramount significance. Hence, expanding the project is an optimum means of ensuring widespread involvement of all health facilities and standardization of services. Moreover, the project has to ultimately indulge in supporting the teaching institutions as an affirmative action so that the technology could be incorporated in their respective curricula and taught to the health personnel.

There is an urgent need to extend the programme not to only strengthen the ongoing one, but to involve the other regions so that gradually all Government and NGO health facilities could be involved in providing a better, standardized and an up-to-date comprehensive care. This requires the identification of regional training centres and recruitment of regional programme staff.

However, it is to be noted that this matter of expansion requires a newer commitment from the regions, CRDA, IFH, MoH and the DPPC. Our past experience dictates us that the process of achieving a sound brokered agreement among the different partners is

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tedious, nerve costing and demanding a lot of negotiations at Zonal, Regional and Federal levels.

Hence, the expansion phase should assume a gradual process in parallel with the intensification phase.

In expanding the project to involve those that were not considered in the initial planning, it is more logical to include war affected (**Tigray, Amhara**) underprivileged and/or underserved regions (**Gambella, Benshangul**) as well as Islamic Organizations and population (**Afar, Harari, Somali**): and more importantly the regional NGOs. This definitely requires a thorough baseline data in order to reach at a plausible justification to base the selections since this is an extensive and ambitious undertaking.

The CRDA's role so far has remained to be that of a facilitator, coordinator and implementor. It should, therefore, revise its previous commitment and the existing terms of agreement between IFH and CRDA, if the programme is going to be expanded and accommodate more regions. The programme as a whole can be rated feasible and acceptable to all stakeholders.

Ideally, from CRDA's point of view of upholding the interest of its members, it seems that there is a need to have an acceptable number of NGO affiliated health institutions and health personnel in a given area. Moreover they should have a capacity to provide CRDA with the teaching facilities if and when they are to participate in the expanded programme.

This, however, automatically alienates government institutions and invites obstacles to the implementation of any such programme. CRDA believes that there should not be any compromise and distinction between NGOs and government institutions and remains staunch supporter of the programme strategy. It advocates the same credibility that it has enjoyed so far.

4.3 COMPOSITE STRATEGY

It is important to stress that the programme needs to be managed as a whole and that the two phases complement one another in the overall design though it is artificially staged. The complementarity and integration of the two phases is crucial in terms of ensuring standardization of practices and curricula as well as quality of care. In this respect, it will be important to include activities that facilitate sharing of experiences among current and new regions, as well as among NGOs with different levels of capacity, skills and, if appropriate, ethnic, cultural and religious specificity. This approach dispels the standstill that we were confronted with in the finalization of this document.

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V. GENERAL STRATEGIES

- Training MVA technique in the treatment of incomplete (safe, unsafe) abortions;
- Training in post-abortion family planning:- Integrating the above with other RH issues like STD/HIV/AIDS;
- Ensuring sustainability of the programme by advocating networking with RHDs, FHD/MOH, CRDA, IPAS, Training medical or nursing schools and other interested agencies;
- Involving specialized NGOs in taking over the training programme provided they have the capacity to do so

VI. EXPECTED OUTCOME

Both Governmental and NGO affiliated health facilities are to be involved with a total of about 100 health personnel to be ultimately trained and/or given refresher courses. The management of abortion complications and STDs/HIV/AIDS as well as the training shall be decentralized by involving host trainers supplying them with the instruments and educational materials and also availing the necessary funds to run the programme .

VII. PARTNERS

CRDA, FHD/MOH, IFH, IPAS, Regional and Zonal Health Bureaux and the training institutions.

VIII. RESOURCES

IFH/Packard Foundation/CRDA

IX. Duration of the Project - Three Years

X. OWNERSHIP

CRDA, IFH, FHD, RHBs are to remain as the prime owners of the programme.

XI. IMPLEMENTORS

The above organizations and also as an option NGOs engaged in RH service provision and conduct of training and have the institutional capacity to implement the project and conduct training may be encouraged to get involved in the execution of the programme. Special emphasis is ought to be given to institutions operating within the provisions of the existing legal system and are capable to render unbiased and non-profit oriented services. Nevertheless, CRDA would retain its role as the main facilitating, co-ordinating, and implementing partner throughout both the intensification and the expansion phases.

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XII. STAKEHOLDERS MEETING

Biannual stakeholders meeting will be planned.

XIII. ACTIVITIES

Detailed activities shall be worked out in due course as per the feasibility of the whole concept paper, commitment of the partners and the preliminary agreement. However, here below are tentatively considered in an outline fashion some essential and specific activities:

8.1 Training

- Number of trainees, and trainers trained
- Number of personnel given refresher course
- Duration of each training
- Training plan
- Areas of priority

8.2 Equipment

The presence and continuos supply of MVA instruments as deemed necessary is essential.

8.3 Learning Materials/References

These materials should be easily, timely and adequately available for a proper implementation of the programme.

8.4 Physical Status

Locations where PAC/STD/HIV/AIDS treatment and counselling services are given do require visual and auditory privacy and renovation money should also be made available.

8.5 Cost Sharing/Recovery

(I) STD drugs

- Piloting STD drug revolving fund in selected sites
- Functional system be in place
- Consider clients buying/purchasing capacity
- Define the amount to be paid and what is paid for

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(II) Family Planning

- Availability of seed money
- Quantity by type for distribution
- KAP on family planning
- Ordering system imposed by MoH and its impact
- Define contraceptives in high or low demand

8.6 Research

- Hospital and community based studies on unwanted pregnancy, abortion, family planning and STD/HIV/AIDS
- Community needs assessment
- MVA equipment status (use, misuse, supply, procurement)
- Number of providers trained
- Number of patients receiving treatment and counselling on PAFP/STD/HIV/AIDS
- Implementation of standard infection prevention protocols
- Community awareness programmes (private sector, women's group, youth group etc.)

8.7 Monitoring and Evaluation

For the purpose of planning and management as well as impact assessment, a regular supportive supervision, monitoring and evaluation should be conducted.

8.8 Referral System

To strengthen the referral system, a mechanism should be in place to upgrade the recording and reporting systems.

8.9 Budget

The budget breakdown can be worked out when the allocated sum is officiated.

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1. INTRODUCTION

This plan of action on the PAC/STDs/HIV/AIDS consolidation and intensification phase covers the period 2000 - 2001. It is based on the outcome of the stakeholders meeting held in Fura Development Studies Centre, Yirgalem on November 18 and 19, 1999. The objective of this meeting was to reflect on past performance and design an action plan for the consolidation phase with a view to making the programme need responsive and sustainable. The meeting was attended by Oromia and SNNPRS Regional Governments Bureau Heads, representatives from CRDA, health institutes and health facilities.

This document presents the major activities, strategies/approaches to be followed and the resources required for the next 24 months.

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CONSOLIDATION AND INTENSIFICATION PHASE

2. BACKGROUND AND RATIONALE

The International Family Health (IFH) Team visited Ethiopia in the last quarter of 1997 in order to make a **rapid need assessment and to identify an appropriate partner** for implementing the project on "**Reproductive Health Activities**". Accordingly the assessment was conducted and operational areas were selected by the Team in identifying appropriate counter-part for implementing the intended project.

Eventually, the IFH Team approached the Christian Relief and Development Association (CRDA) in the same period in order to establish partnership and conducted a brief informal meeting to discuss the possibilities of creating a stakeholder network to implement the project.

Following the informal discussion between the two parties a planning meeting was held in London, in mid-April 1998 consisting of MoH, CRDA and IFH experts. Therefore, the Christian Relief and Development Association and Family Health Department of the Ministry of Health (FHD/MoH) in collaboration with the International Family Health have managed to introduce the integrated management approach of PAC/STDs/HIV/AIDS in the SNNPRS and Oromia regions.

The above mentioned two regions were selected on the basis of their large population size and concentration of Government and NGO Health facilities.

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According to IFH, the integrated training program was originally introduced in Nigeria, particularly targeting the rural health institutions, where the majority of women in the country seek care. Furthermore, the program was initiated through the Christian Health Association of Nigeria (CHAN) network, involving religious health institutions in integrated reproductive health training including PAC, for the first time. The success of the program in Nigeria, therefore, encouraged IFH to seek support from Packard Foundation for extending the program to other African countries.

In line with the above-indicated situation, eight countries were identified by IFH depending on unmet need for integrated PAC/STD services, high rates of maternal mortality and a high or fast growing incidence of HIV infection and AIDS related illness. All the countries identified namely Ethiopia, Gambia, Ghana, Namibia, Sierra Leone, Uganda, Zambia and Zimbabwe, had a history of strong religious involvement in health care provision in rural areas, where government services are limited.

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The Christian Relief and Development Association has implemented the intended 18-month PAC/STDs/HIV/AIDS project in collaboration with FHD/MoH and Regional Health Bureaus, with financial and technical assistance from IFH, Packard Foundation being the back-donor, since mid-1998.

The project has so far successfully accomplished the following major activities:

- A total of 147 health professionals were trained (26 from NGOs) and a total of 23 trained on TOT in two rounds.

- A total of 55 health institutions were involved in the training out of which 17 were NGOs (5 Hospitals and 12 Health Centers)

- A total of 28 MVA Rooms have been established. The rest perform their procedure either in the operation theater or other rooms designated for gynecological activities.

- All the 55 health institutions involved in the said training were supplied with essential educational materials and MVA instruments.

- A comprehensive survey was done using a structured questionnaire. In addition, monitoring field visits was conducted and based on the results of the survey and monitoring visits, it was learnt that 75% of the institutions covered by the program provide PAFP/PAC. Six of the hospitals (35%) have regular training in place and 27% have received regular supervision.

- STDs drugs are reported to be available only in 14 health institutions (25%).

- Articles on the activities of the project were produced on CRDA monthly News.

The majority of activities were planned, managed and coordinated by CRDA. The training and financial management, monitoring and reporting were centrally organized while some technical support was provided by Central and Regional MoH. The Project Coordinating Unit consisting of Project Coordinator and an assistant was established within CRDA.

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Furthermore, an Advisory Board was organized consisting of the representatives of FHD/MoH, CRDA and the PCU.

The FHD/MoH and the Regional Health Bureaus have played a remarkable role for the successful implementation of the project through provision of training and creation of enabling environment. The project also enjoyed the full cooperation and continued support of IFH.

As the on-going project on PAC/STDs/HIV/AIDS will phase-out around December this year, there is a need to ensure its sustainability in the two regions and possible expansion of the best practices in other parts of the country.

However, the programme has not reached a stage of self-sustenance in the two regions. Above all, the institutional mechanism has not been created yet for ownership of the programme due to a variety of reasons. They require some support that would enable them to institutionalize the programme. Furthermore there are still a number of health institutions that are not reached yet. Therefore, the need to map-out strategies that increase capacity of NGOs, regional health offices and health institutions to sustain the programme and its outcomes in the long term. Hence there is a need to prepare a programme that would consolidate/intensify the first phase of PAC/STDs/HIV/AIDS project.

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3. OBJECTIVES

The overall objective of the second phase of the IFH/CRDA/MoH Project is to consolidate the gains made in the first phase and further intensify the

programme in Oromia and SNNPRS with a view to creating a viable programme to be managed and operated by the respective regions. The second phase aims at:

- Enhancing the institutional capacity of the major health facilities of MoH and NGOs through training of 400 health personnel and equipping same with basic relevant equipment and materials.
- Disseminating information and sensitization at the grassroots levels through awareness creation in reproductive health including family planning and safe motherhood.
- Strengthening the STD/HIV/AIDS component of the programme including the supply of STD drugs.
- Creating the necessary institutional arrangements for training management and monitoring at regional level in preparation for complete phase out at the end of the plan period.
- Exploring the possibility for expansion of programme activities in other areas.

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4. ACTIVITIES

The major activities to be undertaken in the plan period are:

4.1. Detailed Action Plan Preparation

Regional action plan detailing training programmes, monitoring and logistics support and cost breakdown will be worked in January. The plan will be prepared by local expertise with a technical backstopping consultancy service from CRDA and MoH. Monitoring format will be developed for the purpose.

4.2. Training

Training will continue to be the major activity and will be intensified during the consolidation phase. It is seen as one of the major strategic approaches to build local capacity and to ensure sustainability of the programme. 300 health workers will be trained in two years time. In addition 100-150 final year health officer, nurse and medical inters will be trained at the Jimma Institute of Health Science as this will be cost effective to reach a captured target group before leaving for the real world.

Three types of training programmes are envisaged:

4.2.1. Refresher course for past trainees inorder to enhance their practical skills. This will be given at hospitals and health centers in the region.

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4.2.2. Cascade training that aim at certifying medical doctor and health officers to perform MVA procedures and nurses with a function as supporting staff. All cascade training programmes will be given at five selected centers in the region.

4.2.3. Training for medical health officer and nursing students at their final year at the Jimma Institution of Health Science that has a well-developed and organized training facility. 80% of the trainees are from the project and adjacent areas.

All PAC training programmes will be given in linkage with STDs/HIV/AIDS and family planning. The Regional Health Bureau will assume full responsibility for training programmes in their respective regions. CRDA will provide technical backstopping service, approve and transfer funds to same. Jimma Institute will have a special status in that it will relate directly with CRDA for all programme approval material and financial support.

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4.3. Workshops and Consultative Meetings

Two sensitization and advocacy workshops are planned to be conducted in the two regions. The purpose of these workshops is to mobilize the support of local authorities in the fight against illegal abortion and the associated problems of STDs and HIV/AIDS. The workshops will be attended by local officials, traditional leaders; religious leaders, public figures and health personnel.

Two Consultative meetings will also be held in the regions to assess progress of project implementation including the new operational modalities.

4.4. Procurement and Distribution of Supplies

Timely procurement and delivery of supplies is an essential component of the project. Unlike in the first phase, equipment drug and medical supplies for service delivery as well as for training will be channeled through the Regional Health Bureau except Jimma Institute that will be supplied directly from CRDA. CRDA will take the lead responsibility for procurement while MoH will assist in the clearance of imported items.

Provisions have been made for new supplies, equipment and vehicles required for the smooth running of the project. It takes into account the priority needs of the regions, the activities to be undertaken especially the planning process regional workshops monitoring and delivery of supplies that entail frequent travel to the regions.

4.5. Development and Production of Local IEC Training Materials

In order to attain a wider and effective awareness, it is essential to produce IEC materials that are easily understood by the local people and compatible to the local culture. Teaching materials for lower level health professionals involved in instrument handling and health education will be prepared in local languages.

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4.6. Monitoring and Supervision

The monitoring and supervision component will be more systematic, coherent and strengthened. A mechanism and a format will be developed for the purpose with the technical support from MoH and CRDA. It will be delegated to the Regional Health Bureau. The frequency and other details will be worked out at a later stage.

5. STRATEGIES

The common strategies adopted in line with the envisaged activities consider the following concepts:

- *Integration*

The PAC/STD/HIV/AIDS related activities should be integrated into the comprehensive reproductive health services. It should no more be treated or understood as a vertical programme. This is believed to dissociate it from the stigmas that are associated with some of the sensitive socio-cultural, religious, political and academic issues that could undermine its scope of importance and acceptability.

- *Institutionalization*

An encouraging step is being taken by the Jimma Institute of Health Sciences to institutionalize the programme activities by incorporating it into the undergraduate medical, public health officers and post-basic

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nursing schools curricula. The already identified training venues are also to be encouraged to follow suit.

The budgetary dispositions for trainers, trainees, stationery, refreshment, transport, overhead cost and other unforeseen expenditures should be made available and easily facilitated through CRDA.

- *Decentralization*

The training programmes, management and monitoring are to be decentralized and delegated to the Regional Health Bureau and chosen training centers. These centers are the Jimma Institute of Health Sciences, Nekemte and Adama Hospitals for the Oromia Region and Arbaminch and Yirgalem Hospitals for the SNNPRS.

In commensurate with these responsibilities, strengthening of their potential to serve as training centers, budgetary allocation and the availing of other resources is considered. The Regional Health Bureau will be provided with administration costs for monitoring and managing the programme. The mandate to readjust the financial requirements ought to be given to CRDA in order to curtail the undue bureaucratic delays in correspondence and approvals.

- *Sustainability*

With the phasing out of the programme, the two regions in conjunction with MoH should be capable to sustain the project. Their corresponding Family Health and Training Departments are expected

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to play key roles in the realization of the sustainability of the programme. Enhancing their institutional capacity to effect this principle is given due consideration in the course of its implementation. Cost recovery and sharing mechanism should be in place in almost all health institutions. In addition, incorporating MVA procedures in medical and paramedical schools should be considered as a long-term investment.

- *Supplies and Distribution*

The supplies should be timely dispatched from the IFH Head Office, acquired here in Ethiopia and distributed in an orchestrated manner to the recipient centers. They should be adequate in quality and quantity. The timing of distribution should be carried out immediately following the trainings. A certain sum of money is made available to buy needed items, by some of the health facilities, from the local markets. These include basins, buckets, coaches, cupboard, bleaches and intravenous fluids.

- *Agreement*

An agreement will be signed between CRDA, MoH/Regional Health Bureau and DPPC stipulating the role of each party. The role of each party will be defined at a later stage, but will be within the framework of this plan of action.

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6. RESOURCE REQUIRED

With the intestification of the project, an additional 150 health institutions will be covered by the project. The number of trainees will more than double that of the first phase. Monitoring frequency is expected to increase. In addition on-going programmes will be consolidated.

Taking the above into account, the total budget required for the second phase amounts to Birr 3,081,000. This includes the purchase of two four-wheel land cruisers.

The breakdown is depicted in Table I.

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TABLE 1. ESTIMATED BUDGET EXPENDITURE FOR 2000-2001 (BIRR)

Category	*Number*	*Rate/Day*	*Duration in Days*	*Session*	*Total*	*Remark*
Trainers	3					
Per diem		100	8	20	48,000	
Honorarium		300	8	20	144,000	
Trainees	300					
Per diem		100	8	20	600,000	
Transport		200			60,000	
Coordinator						
Per diem	1	100	8	20	16,000	
Driver	1	100	8	20	16,000	
Per diem						
Backstopping Consultancy	400m/days	300			120,000	
Salary		Rate/month	Two Years			
Assistant Coordinator		2500	24 months		60,000	
Sensitization Workshop/ Consultative Meetings			Duration (days)			
Per diem	40	100		1	4,000	
Transport	40	200		1	4,000	
Honorarium	5	500			5,000	
Logistics						
MVA kits	1000 (DVK)					
Educational Materials	300 trainee packets					
STD Drugs	40 centers 4000/facility					
Speculum	240					
Tenaculum	160					
Dilators	80 sets				300,000	
Vehicles	2 Land Cruisers				760,000	
Computers	1 Lap Top and 1 Desk Top				38,000	
Stationary					60,000	
Newsletter	8				6,000	
International Travels	4				100,000	
Regional Supervision/Monitoring/ Admin.					40,000	
Stakeholders Meeting	2			2	60,000	
Administrative Cost					30,000	
Refreshment					40,000	
Hall Rent					25,000	
Medical, health officer and nurse students training			8 days	20	100,000	
Miscellaneous					40,000	
TOTAL					2,671,000	
Contingency 10%					267,000	
GRAND TOTAL					3,081,100	

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Figure I

Hierarchy of Aims	OVI	MOV	RISK AND ASSUMPTION
GOAL To have contributed to better reproductive health in the selected two regions.	□ Maternal mortality due to abortion reduced from 53% by 7%. □ Material morbidity due to abortion reduced from 50% by 7%	□ Regional census data □ Hospital/health center records	□ Regional governments increase present level of financial support to health services by 40%. □ Federal and Regional Government integrates commitment regarding HIV/AIDS integrates RH services on a continuos basis.
PURPOSE To have contributed to increased utilization of : a. Integrated and quality reproductive health services by women and adolescents. b. RH information and knowledge to bring about behavioral changes regarding responsible sexual and reproductive health practices.	□ CPR increased from 14% by 21%. □ Unmet need for RH reduced by 21%. □ Contraceptive mix improved all methods available. □ Women with complications of unsafe abortions treated in all hospitals and health centers. □ Use of STI services including services for HIV/AIDS increased. □ Abortion reduced significantly. □ RH services delivery visits by women and adolescents markedly increased. □ RH user satisfaction increased to an acceptable level.	□ RH services statistics □ RH reports	No change in regional government RH policy
OUTPUTS I. Improved access to quality RH services through. □ Improved access to cost-effective quality post-abortion Family Planning services, including: □ Provision of PAFP as part of integrated RH services in all hospitals and health centers □ Expansion of CBD services to all SDPs.	□ All service delivery points staffed and managed in accordance with set standards. □ All within proximity of SDPs served.	□ Management reviews □ Situational analysis □ Community surveys □ Supervision reports □ Service statistics	CBDs continue to be accepted in all communities. NGO accept conventional FP methods.
II. Improved access to cost-effective quality STI services through provision of STI prevention and treatment as part of Integrated RH services in all SDPs	□ All centers providing treatment for STIs in accordance with set standards	□ Reviews and records of SDPs □ Management reviews	Stigmas associated with STIs do not inhibit use of STI prevention services
III. Improved access to quality RH care services including :	□ All centers providing treatment for abortion complications.	□ Reviews and records □ Management reviews	Stigmas associated with abortion do not inhibit use of available PAC services.
□ Provision of PAC services as part of integrated RH services in all SDPs. Establishment of effective referral system for RH emergencies	□ All SDPs either provide emergency treatment or refer to the next centre	□ Supervision reports	

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Figure II

Activities	OVI	MOV	RISK AND ASSUMPTION
1. Detailed Plan	□ Prepare detailed training plan monitoring schedule, renovation plan and preparation of materials	□ Cooperation from MoH & regions will be required.	
2. Recruiting and training staff for PAC/STD/HIV/AIDS	□ Number of new staff completing basic technical training programme. % of existing staff completing technical retraining	□ Training report □ NGO records	
3. Equipping the SDPs	□ Review of equipment needs commissioned and conducted. □ Renovation arrangements operationalized	□ SDP survey reports □ Procurement report □ Situation analysis	
4. Recruiting, training and Supervision of CBD workers	□ Community meetings organized □ Quarterly supervision reports submitted by supervisors	□ CBD records	
5. Development of procurement and Logistics systems and procurement of contraceptives, STD prevention/ treatment drugs and MVA kits.	□ Procurement projections reviewed □ Logistics system reviewed □ Contraceptives, STD drugs and MVA kits procured □ Community IEC design prepared □ Video/IEC materials procured or developed	□ Cooperation from MoH and regions will be required. □ Training report □ NGO records	
6. Community based IEC campaigns	□ Number of community sessions completed		
7. Monitoring and Supervision	□ Monitoring format and schedule reports prepared □ All health facilities visited at least once.		

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