

PD-ABM-817

2. COUNTRY/ENTITY: Uganda
 3. PROJECT NUMBER: 617-0133
 4. BUREAU/OFFICE: USAID/Uganda
 5. PROJECT TITLE: Delivery of Improved Services for Health
 6. PROJECT ASSISTANCE COMPLETION DATE (FACD): MM DD YY 09 3 09 9
 7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4): A. Initial FY 93 B. Quarter 4 C. Final FY 98

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(8,150)	()	(8,150)	(40,000)	()	(40,000)
(Loan)	()	()	()	()	()	()
Other U.S.						
Host Country						
Other Donor(s)						
TOTALS	8,150		8,150	40,000		40,000

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA				15,655				40,000	
(2)									
(3)									
(4)									
TOTALS									

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)
 11. SECONDARY PURPOSE CODE
 12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)
 A. Code
 B. Amount

13. PROJECT PURPOSE (maximum 480 characters)
 To increase the use of Maternal-Health and Family-Planning services, the accurate diagnosis and effective treatment of common STIs and prevalence of behaviors which constrain the transmission of HIV and other STIs.

14. SCHEDULED EVALUATIONS
 Interim MM YY 0 3 9 7 Final MM YY 0 3 9 9
 15. SOURCE/ORIGIN OF GOODS AND SERVICES
 000 941 Local Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)
 This amendment increases the life of project funding by \$15,000,000 to \$40,000,000, modifies activities under existing project components, and adds one new component related to HIV/STI behavior change.

17. APPROVED BY: Signature Leticia Diaz, Title Acting Mission Director, Date Signed MM DD YY 09 25 95
 18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

AID 13304 (8-79)

I have reviewed and hereby approve the methods of implementation and financing in this Project Paper.
 _____ /CONTROLLER

ACTION MEMORANDUM FOR THE ACTING DIRECTOR, USAID/UGANDA

FROM: Jay Anderson, GDO *J.A.*

SUBJECT: Delivery of Improved Services for Health (DISH) Project, 617-0133,
Project Paper Amendment No. 1

Problem: You are requested to approve an amendment to the DISH Project which adds a new component for community-level behavior-change activities related primarily to AIDS and other sexually transmitted infections, modifies previously existing project components and increases LOP funding, for the new component and previously existing components, by \$15 million.

Discussion:

The DISH Project was authorized in August 1993 with life-of-project funding of \$25 million and a PACD of September 30, 1999. The host-country contribution was waived. Implementation began in September 1994. The project provides technical assistance, training and other forms of support intended to reduce fertility and the transmission of HIV in up to 10 of Uganda's 39 districts. The project is implemented through a contract with Pathfinder International and sub-contracts with the University of North Carolina, Johns Hopkins University and E. Petrich and Associates; a cooperative agreement with Pathfinder International; a buy-in to USAID/W's Contraceptive Social Marketing Project; a grant to the African Medical and Research Foundation (AMREF); and grants to FINCA International and the Ugandan Women's Effort to Save Orphans (UWESO).

This amendment is the result of (a) the work of three design consultants who evaluated the Mission's AIDS Prevention and Control Project (APCP, 617-0127) in February 1995 and who, in May, drafted recommendations primarily related to the addition of AIDS, sexually transmitted infections (STIs) and evaluation activities to the project; (b) a review by all current DISH implementing agencies of estimated budgetary requirements through the PACD; and (c) the review, modification and synthesis of this material by the HIV/AIDS Advisor and the Health and Population Officer. If approved, this amendment will (a) modify the project components contained in the original PP and revise the budget for these activities based on the initial 10 months of project implementation and experience under APCP; (b) add a new behavior-change component primarily related to AIDS; and (c) increase the LOP budget to \$40 million, with the additional \$15 million intended primarily for HIV prevention. (In addition to these funds, \$4,000,000 are expected from G/PHN's field support budget from FY 96 through the PACD.) While the goal and purpose are re-phrased to make the goal more specific and include a behavioral element in the purpose, the basic intent of the project to reduce fertility and the transmission of HIV remains entirely unchanged.

Purpose and Rationale for the Amendment. Although designed to decrease fertility and the transmission of HIV, the project has, in practice, focused primarily on family planning (FP) , maternal health and STIs rather than on AIDS. It has also been more focused on women than on men and adolescents. This resulted largely from: (1) a realization during the original design that available funding might be insufficient, encouraging a narrower focus; and (2) the existence of the separate, \$15 million APCP project noted above. When DISH was designed in mid-1993, APCP was at its mid-point, fully funded, and largely un-evaluated. Since it was clear that the \$25 million then available for DISH were insufficient to cover FP, maternal health, STIs and AIDS interventions on the scale of APCP, USAID decided to wait for the conclusion of APCP and either add funds to DISH or design a separate APCP follow-on in 1995. Given a desire to integrate reproductive-health interventions and manage one project rather than two, the Mission has chosen the former approach.

Although USAID anticipated that \$25 million might be insufficient to fully implement all the activities in the original PP, the Mission decided to retain these activities, wait for actual cost proposals from implementing agencies, and either curtail activities, implement the project in fewer districts, or add additional funds later, as might be required. Costs eventually did prove to be under-estimated, a problem partly due to a depreciation in the value of the dollar since the project was authorized. As a result, initially planned AIDS activities were not initiated, and some project components were not funded to the PACD.

Modifications to the original PP. The principal purpose of this amendment is to add funds to the project to (a) support AIDS activities after the end of APCP in January 1996 and (b) fully fund the implementation of other initially planned activities. Only one entirely new component has been added to the project: community-level programs for behavior change related to HIV and other STIs (component 2.4). This component will be implemented under a cooperative agreement with an international NGO selected in response to a Request for Applications. In addition, support for the AIDS Information Center (AIC) and The AIDS Support Organization (TASO), anticipated in the original PP but not initiated due to insufficient funds, is provided under the amendment, and the social marketing of antibiotics for STI control is added to component 2.2.

In addition to these changes, which will result in the initiation of activities not currently being implemented under DISH, this amendment modifies project components which are being implemented, as indicated by experience during the first 10 months of project implementation and the previous two years of experience under APCP. All of the original project components are retained in the amendment, and all are modified to some extent. However, these modifications represent changes in degree and tactics rather than changes in the nature of the project or in basic strategy. They are summarized below for each project component, in the order that these components are described in the amended project description.

Component 1.1: Training Nurses and Midwives. The approximate number of nurses and midwives to be trained is reduced from 1,500 to the number currently estimated, through district-level assessments, to require training (850). Higher priority is accorded to curriculum development, including teaching and reference materials, and to the quality of training. The number of Ugandan trainers and clinical-training sites is increased from 12 to 16 and 4 to 8 respectively. A new, rather than revised, STI-training module is to be included in the curriculum. Training and supervision will encompass the organization of clinic activities for integrated service delivery. A pilot activity to train nurses and midwives to provide services to men and adolescents is added. Approximately 17% of the funding required for this component is expected from G/PHN's field support budget.

Component 1.2: STI and Lab Training. Training for physicians and medical assistants will be based on the same syndromic algorithms used for nurses and midwives, and, with the exception of RPR testing for syphilis and wet mounts for vaginitis, will not include laboratory diagnosis. Lab training will focus primarily on tests related to maternal health: malaria smears, hemoglobin and urinalysis. Lab equipment will be purchased by the MOH's World-Bank-funded STI Project, not by Pathfinder. The number of trainees is reduced based on an enumeration conducted by AMREF subsequent to the original PP, and most training will be conducted in the DISH districts rather than in Kampala. USAID, not Pathfinder, will provide short-term technical assistance to evaluate this project component.

Component 1.3: STI Reference Lab. AMREF's grant (1.2. above) was amended prior to the subject PP amendment to establish a small STI reference lab at Mulago hospital in Kampala to monitor the accuracy of syndromic STD diagnoses (1.1 and 1.2 above) and monitor antibiotic resistance.

Component 1.4: AIDS Information Center. Although anticipated in the original PP, support has not been provided to the AIC due to insufficient funds. Under the amendment, DISH will support existing AIC operations in DISH districts, but will not add additional branches as originally planned. Support will also focus on diversifying AIC's sources of funding and on the gradual evolution of the AIC into an organization which supports the provision of HIV testing and counselling services by other organizations, including public-sector facilities. DISH funds may be used to construct an AIC headquarters/counselling center in Kampala, in conjunction with contributions from other donors and the AIC itself (from accumulated fees).

Component 1.5: TASO. Support for The AIDS Support Organization (TASO) was also anticipated in the original PP but not initiated due to insufficient funds. Although DISH will support the operation of existing TASO branches in DISH districts, new branches will not be opened. DISH will not support income-generating projects or the provision of food or drugs for HIV + people. DISH will fund TASO's provision of supportive and preventive counselling, FP services and STI services for people with AIDS; will help will enable TASO to provide technical assistance to other organizations providing these services, and will assist ATSO to improve its management information systems.

Component 1.6: Surgical Contraception. Although USAID support for surgical contraception will continue in DISH districts, this is deleted as a DISH funded activity. In the interests of managerial simplicity, these activities, previously co-funded by USAID/Uganda and G/PHN, will be supported entirely through G/PHN's field support budget.

Component 2.1. TBA training. The number of traditional birth attendants to be trained is reduced in accord with what AMREF can reasonably expect to accomplish by the PACD. TBAs will be trained and supervised by nurses and/or midwives who have been trained under component 1.1 and to whom the TBAs will refer clients as necessary.

Component 2.2: SOMARC. SOMARC will hire more local staff than initially anticipated for social marketing activities, and USAID will procure additional vehicles. A new component for the trial marketing of pre-packaged antibiotics for STIs, permitted under the terms of SOMARC's contract with USAID/W, is added, and adolescents are included as a target group. To facilitate supervision and increase efficiency, a DISH District Sales Force will be based in Kampala, rather than in individual districts, as initially planned.

Component 2.3: Community Reproductive Health Services. Greater emphasis is accorded to STIs and HIV, rather than simply the community-based distribution of contraceptives, and to men and adolescents. Initially planned stipends for community-based workers and the gradual phasing in of districts are deleted. Approximately 62% of the funds required for this component are expected from G/PHN's field support budget.

Component 2.4: Community Behavior-Change Activities. This is a new component, not anticipated in the original PP, for behavior change related to the transmission of HIV and other STIs. It will be implemented by an international NGO to be selected through an RFA.

Component 2.5. FINCA/UWESO. In the interest of sustainability, the original emphasis on orphans-support activities on school fees is substantially diminished, and the emphasis on income generation is correspondingly increased. The budget is unchanged. Anticipated support for the Ministry of Labor and Social Affairs will be provided under the Mission's Policy Analysis and Capacity Building Project, not DISH.

Component 3.1: IE&C. Mass-media communications campaigns will focus, at least initially, on (a) removing obstacles ('myths and misconceptions') to the use of family planning among those who do not currently want more children and (b) where to go for services, rather than on general FP promotion. Target groups for communication activities are reduced from four to two, with greater emphasis in each group on men and adolescents. Greater emphasis is placed on the provision of teaching and counselling aids for use by service providers, on teaching materials for use by trainers, and on reference materials for trainees (see component 1.1). A training

video on how to integrate reproductive health services at the facility level will be produced, but no other video or audio materials will be funded for clinic use. The Family Planning Association of Uganda, the AIC and the Health Education Network will not implement communications activities. Vehicles will not be provided specifically for communications activities, and motorcycles will not be provided. FP training for AIDS counsellors is deleted as a communication activity; these staff will be trained as appropriate under component 1.1. DISH staff, not district health-education staff, will be responsible for communications research. About 23% of the funds required for this component are expected from G/PHN's field support budget.

Component 3.2: Information and Logistics Systems. The data to be captured by the project's Management Information System (MIS) have been modified. Two HIV sentinel surveillance sites in DISH districts have been added, subject to the availability of rapid HIV testing under component 1.4. STTA to refine the national contraceptive logistics system and estimate national contraceptive requirements has been deleted. The role of Pathfinder's Logistics and Information Systems Advisor has been expanded to include greater internal project monitoring responsibilities, and a locally hired MIS Assistant has been added.

Component 3.3: Financial Management and Cost Recovery. Two full-time staff will be hired locally in lieu of recurrent STTA from a local firm for cost-recovery and financial management activities. Given the highly decentralized nature of current cost-recovery activities in Uganda, computer systems and related training will not be provided for district financial management. TA in financial management/cost recovery will be provided to NGOs implementing USAID-funded reproductive health programs in DISH districts.

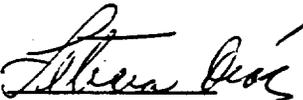
Other modifications. Greater emphasis is placed on project evaluation: an evaluation officer is to be hired locally by Pathfinder, funding is provided for special evaluation studies to be implemented by local organizations, and funding for mid-project and final evaluations has been increased. The budget has been re-formatted to allow expenditure reporting by specific functional categories (e.g., training nurses and mid-wives) rather than generic categories (e.g., salaries); "Sub-grants" has been deleted as a MACS cost elements and replaced with "Implementation Costs" and criteria for allocating specific expenditures among cost elements have been made explicit. Pathfinder will have an office in Kampala, rather than Entebbe; will not arrange for audits of other implementing agencies; will not develop or make sub-grants to NGOs (e.g. TASO, AIC, AMREF) for USAID, but will manage such grants; will provide a full-time Project Manager (Chief of Party), rather than combining this function with that of the MIS advisor; and will hire a local Assistant Executive Officer in addition to a local Executive Officer. The Ministry of Local Government has proved superfluous as a counterpart agency and is deleted as such. Funding for USAID's Family Planning and Child Survival Officer (David Puckett) ceased with Mr. Puckett's departure from post on August 11; USAID's HIV/AIDS and STI Advisors (Elizabeth Marum and John Cutler) will become completely DISH funded as their current funding under PACB is exhausted.

Mission Review. Mission staff discussed new project components with the design consultants and with a number of Ugandan professionals active in AIDS prevention at a meeting at USAID in April. A first draft of this amendment was circulated within USAID on July 20 and was reviewed by PPD, CONT and the Director. You, Patrick and Susan Fine and Elizabeth Marum were out of the country at that time, and a subsequent draft was circulated on August 25. Comments and suggestions were almost entirely editorial and have been incorporated in the current draft. Only one substantive issue was raised during this review process: the project was widely perceived as complex and ambitious. This issue was discussed by e-mail with those concerned, and Patrick Fine, Susan Fine, Elizabeth Marum, John Cutler and I met to discuss this on September 8. After considering alternatives for simplifying the project and realizing that such opportunities were limited, given that most of the activities in the amendment are already ongoing, we agreed that the benefits of curtailing new activities did not outweigh the advantages of continuing as planned. Therefore, we agreed that the project should remain as it is. Considering the review that has already occurred, an additional, formal review meeting is considered unnecessary.

The amendment was been reviewed in second draft by the following Ministry of Health staff: the Acting Commissioner for Maternal and Child Health and Family Planning, The Manager of the AIDS and STD control Program, the manager of the MOH's World Bank funded Sexually Transmitted Infections Project, and the Chief of the Health Planning Unit. Although their comments have been largely incorporated into the final draft, n significant policy or implementation issues were identified.

Authority. Under Delegation of Authority 551, as amended, you have the authority to amend project authorizations provided that the LOP funding does not exceed \$100,000,000, there are no significant policy issues or required waivers that exceed your authority, the project's purpose is not changed, and the LOP does not exceed 10 years. This amendment increases LOP funding to \$40 million and leaves the six-year LOP unchanged. The project purpose is substantively unchanged, there are no significant policy issues, and no additional waivers are required.

Recommendation. That you approve this amendment to the DISH Project by signing this memorandum, the amended project authorization (Attachment I) and the Project Data Sheet (Attachment II).

Approved: 

Disapproved: _____

Date: 9/25/95

Attachments: I. Project Authorization Amendment No.1
II. Project Data Sheet and Project Paper Amendment

Clearances: GDO: PFine PF
PPD: SFine PF
PPD: LDouris LD
PPD: NOlsen NO
D/CONT: KLizwelicha KL
A/DD: KLeBlanc KL
RLA: SPage (draft)

PROJECT AUTHORIZATION AMENDMENT NO. ONE

Country: Uganda
Project Name: Delivery of Improved Services for Health
Project Number: 617-0133

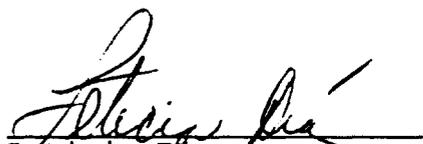
1. Pursuant to Section 496 of the Foreign Assistance Act of 1961, as amended, the Delivery of Improved Services for Health (DISH) Project was authorized on August 31, 1993. That authorization is hereby amended as follows:

Paragraph 1 of the authorization is hereby deleted in its entirety and replaced by the following:

"Pursuant to Section 496 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Delivery of Improved Services for Health ("DISH") Project for Uganda (the "Cooperating Country") involving planned obligations of not to exceed forty million United States Dollars (\$40,000,000) in grant funds (the "Grant") over a period of six years and one month from the date of initial obligation, subject to the availability of funds in accordance with USAID OYB/Allotment process, to finance foreign exchange and local currency costs of the project."

2. Except as amended above, the original project authorization dated August 31, 1993, remains in full force and effect.

Date: 9/25/95


Leticia Diaz
Acting Mission Director

Drafted: PO: LDouris  Date: 9-19-95
Clearance: HPO: JAnderson 9/20 Date: 9/19/95
C/GDO: PFine 9/19 Date: 9/19/95
PDO: SFine 87 Date: 9/19/95
D/CONT: KLizwelicha 9/22 Date: 9/22/95
A/D/DIR: KLeBlanc 9/22 Date: 9/22/95
RLA: SPage e-mail Date: 9/18/95

LIST OF ACRONYMS

AIC	AIDS Information Center
AMREF	African Medical and Research Foundation
APCP	AIDS Prevention and Control Project
AVSC	AVSC International
BRH	Basic Reproductive Health
CCP	Center for Communication Programs (Johns Hopkins University)
CRHW	Community Reproductive Health Worker
CSM	Contraceptive Social Marketing
DHS	Demographic and Health Survey
DHT	District Health Team
DMO	District Medical Officer (Office)
EOPS	End of Project Status
FINCA	Foundation for International Community Assistance
FLEP	Family Life Education Project
FP	Family Planning
FSN	Foreign Service National
G/PHN	Global Bureau, Center for Population, Health and Nutrition
GOU	Government of Uganda
HIV	Human Immune Deficiency Virus
IE&C	Information Education and Communication
INTRAH	Program for International Training in health (Univ. of North Carolina)
LISA	Logistics and Information Systems Advisor
MCH	Maternal and Child Health
MH	Maternal Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
OE	Operating Expenses
PACD	Project Assistance Completion Date
PASA	Participating Agency Service Agreement
PIO	Project Implementation Order
POV	Privately Owned Vehicle
PROAG	Project Agreement
PSC	Personal Services Contractor
SOMARC	Social Marketing for Change
STI	Sexually Transmitted Infections
STTA	Short-Term Technical Assistance
TASO	The AIDS Support Organization
TBA	Traditional Birth Attendant
USDH	U.S. Direct Hire
UWESO	Ugandan Women's Effort to Save Orphans

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I. Introduction

A. Background

1. General. The Delivery of Improved Services for Health (DISH) Project was authorized in August 1993 with life-of-project funding of \$25 million. Implementation began in September 1994, and the PACD is September 30, 1999. DISH is the Mission's principal means of achieving its Strategic Objective No. 4: to "stabilize the health status of Ugandans." The project seeks to expand the provision and use of basic reproductive-health (BRH) services (i.e., family planning; ante-natal, intra-partum and post-natal care; diagnosis and treatment of sexually transmitted infections -STIs; and AIDS prevention) in 10 of Uganda's 39 districts¹, containing about 29% of the country's population.

This amendment (a) modifies the project components contained in the original PP and revises the budget for these activities based on the initial 10 months of project implementation; (b) adds a new behavior-change component (II,C, 2.4 below) primarily related to AIDS; and (c) increases the LOP budget to \$40 million, with the additional \$15 million intended primarily for HIV prevention. (In addition to these funds, \$4,000,000 are expected over the LOP from G/PHN's field support budget. See VI, Financial Plan, below.) While the goal and purpose are re-phrased to make the goal more specific and include a behavioral element in the purpose, the basic intent of the project to reduce fertility and the transmission of HIV remains entirely unchanged.

2. Original Project Components. The components of the original project - all of which except 'd'² below remain in the amended project - are summarized as follows, in the order in which they are discussed in the original PP.

- a. Training, equipping, supervising nurses and midwives to provide basic reproductive health (BRH) services;
- b. Training traditional birth attendants (TBAs) to provide BRH services;
- c. Training physicians, medical assistants and lab staff to diagnose/treat STIs;
- d. Expanded access to surgical contraception;
- e. Social marketing of condoms, and oral and injectable contraceptives;

¹Luwero, Masindi, Jinja, Kamuli, Kampala, Masaka, Rakai, Mbarara, Ntungamo, Kasese

²Support for surgical contraception will continue, but will be funded entirely by G/PHN. See II, C, 1.6.

- f. Community programs in which local residents sell condoms and oral contraceptives in conjunction with the social-marketing component;
- g. Greater availability of HIV testing, counselling and support for HIV + persons;
- h. Information, Education and Communications (IE&C) campaigns; provision of teaching and counselling materials; IE&C training;
- i. Improved information and logistics systems for contraceptives and antibiotics;
- j. District-level cost-recovery schemes and improved financial management;
- k. School fees and income generation for families supporting orphans³.

3. Original Implementation Arrangements. By May 1995, the following implementation arrangements had been concluded for all components except (g), which was not initiated due to insufficient funds.

Instrument, Organization	Project Component
Contract: Pathfinder International	i) Management, Logistics Systems
- Sub-contract: INTRAH ⁴	a) Training nurses and midwives
- Sub-contract: CCP ⁵	h) IE&C
- Sub-Contract: E. Petrich & Assoc.	j) Cost recovery, financial management
Grant: Pathfinder International	f) Community Based Distribution

³Earmarked funds, to lessen the socio-economic impact of AIDS

⁴Program for International Training in Health (University of North Carolina)

⁵Center for Communication Programs (Johns Hopkins University)

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Grant: African Medical Research Foundation (AMREF)	c) STI training (clinicians and lab) b) TBA training
Buy-In: CSM III Project (SOMARC)	e) Social Marketing
Buy-In: AVSC Project	d) Surgical Contraception
Grants: FINCA, UWESO ⁶	k) Women's micro-enterprises, school fees

B. Rationale for Amendment

The original project was substantially more focused on family planning (FP), maternal health, STIs and women than on HIV, youth and men. This resulted largely from: (1) a realization during the original design that available funding might be insufficient, encouraging a narrower focus; and (2) the existence of a separate, \$15 million⁷ "AIDS Prevention and Control" project (APCP, 617-0127). In mid-1993, APCP was at its mid-point, fully funded, and largely un-evaluated. Since it was clear that the \$25 million then available for DISH were insufficient to cover FP, maternal health, STIs and AIDS interventions on the scale of APCP, USAID decided to hold AIDS somewhat⁸ in abeyance pending the evaluation and conclusion of APCP and to either add funds to DISH or design a separate APCP follow-on in 1995. Given a desire to integrate reproductive-health interventions and manage one project rather than two, the Mission chose the former approach.

Although USAID anticipated that \$25 million might be insufficient to fully implement all the activities in the original PP, the Mission decided to retain these activities, wait for actual cost proposals from implementing agencies, and either curtail activities, implement the project in fewer districts, or add additional funds later, as might be required. Costs eventually did prove to be under-estimated, especially local costs relating to (a), (e), (g) and (h) above, a problem partly due to a

⁶Foundation for International Community Assistance, Uganda Women's Effort to Save Orphans

⁷APCP included \$1 million for orphans activities; thus funding for AIDS per se was \$14 million. In May 1995, \$1.4 million was added, increasing AIDS funding to \$15.4 million and total LOP funding to \$16.4 million.

⁸The original DISH design included condom social marketing, STI training and AIDS IE&C activities and was thus not entirely lacking in AIDS-related components.

depreciation in the value of the dollar since the project was authorized⁹. Also, the scope of components (b), (c) and (e) was curtailed due to insufficient funds¹⁰.

II. Revised Project Description/Plan of Action

A. Project Goal and Purpose

Goal: to reduce unwanted fertility and the transmission of HIV infection in 6 to 10 districts.

Purpose: To increase use of maternal health and family planning services, the accurate diagnosis and effective treatment of common STIs, and the prevalence of behaviors which constrain the transmission of HIV and other STIs.

B. Project Outputs and Components

The project purpose will be achieved through the production of the following three outputs:

1. improved facility-based reproductive health services,
2. expanded community-based reproductive-health programs, and
3. an institutional and community environment supportive of improved reproductive health.

The production of these outputs will be characterized by the integrated implementation of 14 project components¹¹. "Integrated" in this context refers to:

- a client-centered approach under which service providers offer a full range of services consistent with their training and client needs during any client encounter;

⁹ Since the project was authorized, the exchange rate declined from \$1:Sh 1,100 to a low of 905 and is currently at 977.

¹⁰In addition, USAID/W's contract for the SOMARC program (component e) expires at the end of FY97, and DISH funds were not budgeted for this buy-in beyond that date.

¹¹Section I.A.2 lists the project's 11 original components. All of these 11 are included in the 14 noted here; all 11 have been modified to some extent based on implementation experience. One new component, a small STI reference lab (1.3 below), was added to the project prior to this amendment as a complement to the AMREF STI training component. An additional new component for community behavior-change (2.4) is added under this amendment. The third addition to the original 11 components derives from splitting the previous, un-implemented HIV component (I.A.3.g above) into two components based on the different organizations (AIC and TASO) involved.

- formal linkages and referral procedures among various service providers and implementing organizations to maximize synergy and impact; and
- standardized curricula, clinical and supervisory practice, education and counselling messages, and monitoring and evaluation procedures.

Project components, as revised, are described below under the output they are intended to produce, and the following completely replaces the project description in the original PP.

Output 1: Improved facility-based reproductive health services

This output will be produced by implementing the following seven components:

1.1 Training, Equipping and Supervising Nurses and Midwives

Approximately 850¹² nurses and midwives from DISH districts, including NGO staff and private midwives, will be trained in the clinical and counselling skills needed to provide basic reproductive-health (BRH) services, viz.: family-planning services; ante-natal, intra-partum and post-natal care, including the management of obstetric emergencies ("Life Saving Skills"); the syndromic diagnosis and treatment of common sexually transmitted infections (STIs); RPR testing for syphilis among antenatal women; and AIDS prevention, including HIV testing in selected facilities. Aseptic technique and universal precautions for infection prevention will be included in all clinical elements of this training. Except for Life Saving Skills, which will be taught to midwives only, training for nurses and midwives will be identical.

During the first year of project implementation, emphasis will be on developing a high-quality curriculum and well qualified, confident trainers, district supervisors and service providers at teaching facilities. Although training will be conducted during this first year as the curriculum is tested and refined and as trainers' skills are observed and sharpened in actual practice, the bulk of training and supervisory activity under this component will begin in year two.

Curriculum. Pathfinder, working through INTRAH and CCP, will design, implement and routinely evaluate a modular, in-service, basic-reproductive-health-services curriculum for nurses and midwives, including lesson plans, related teaching materials, and counselling aids and reference materials for trainees to use in subsequent clinical practice. This curriculum will focus on the mastery of specific skills rather than knowledge alone.

¹²The total of 1,500 nurses and midwives noted in the original PP (based on figures from the central MOH) seems to have been a substantial over-estimate. Actual counts of nurses and midwives conducted by Pathfinder in each district revealed only 1,168, of whom about 850 are currently estimated to occupy positions relevant to DISH.

While the curriculum will provide trainees with a solid technical grounding in the individual reproductive-health services noted above, it will also devote substantial attention to the integration of these services through a primary focus on clients, whose needs are often multiple and inter-related, rather than on individual interventions. This will be done through client-centered service-delivery algorithms which establish linkages between MH, FP, STI and HIV services. These algorithms will help ensure that a client who seeks services from a nurse or midwife for any one BRH service is offered other needed services during any provider/client encounter. The organization of facilities for the integrated provision of BRH services will also be included in the curriculum, as will supply-management procedures required to ensure the availability of contraceptives and antibiotics for STI treatment.

The maternal health and FP modules of the BRH curriculum will be based largely on the Ministry of Health's (MOH's) existing "Basic Family Planning and Maternal Health Curriculum" and "Life Saving Skills Course" (LSS - for midwives only); and the breastfeeding module developed with assistance from Wellstart for training in diarrheal-disease control.

A new STI module will be designed based on updated syndromic diagnostic and treatment algorithms developed in close coordination with AMREF (1.2 below). The counselling component of this module will emphasize (i) the importance of male and female STI clients informing their partners and encouraging them to seek treatment¹³, (ii) ways for clients to discuss this subject with their partners, and (iii) HIV counselling, including the possibility of HIV testing and counselling where available.

Training Teams. Training will be provided by four training teams established in Luwero, Jinja, Masaka and Mbarara and staffed by 16 Ugandan midwives selected and hired by Pathfinder/INTRAH. These staff will work full time for the project to design, provide and evaluate the training noted above. Any MOH staff serving on these teams will be seconded to the project on an unpaid leave of absence during the time of their employment under the project.

Pathfinder/INTRAH will provide two long-term nurse-midwives with substantial training experience to serve as Clinical Services Advisors (CSAs: one for five years, one for three) to train and supervise the four training teams and oversee the overall implementation of this component. One will be posted in Jinja, the other in Mbarara. These two advisors, with short-term technical assistance (STTA) provided by Pathfinder/INTRAH, will develop the BRH curriculum, train the 16 team members as trainers, and ensure that trainers' technical knowledge related to BRH services is sufficient for them to train and help supervise personnel who routinely provide these services.

¹³ When a client is syndromically diagnosed, his/her partner will be routinely treated for the same syndrome.

STIs. Acquiring and maintaining technical skills related to STIs will be difficult due to a lack of clinical experience with these infections among most Ugandan health workers and the changes to current practice being introduced by the new algorithms noted above. Pathfinder/INTRAH will ensure that trainers are thoroughly familiar with these new procedures by providing all 16 trainers with special STI training at AMREF's STD/HIV Intervention Project in Mwanza, Tanzania. Pathfinder/INTRAH will design, implement and evaluate STI training in close coordination with AMREF and with USAID/Uganda's STI advisor.

Training Sites. The 16 trainers will train nurses and midwives from the 10 DISH districts at sites in Luwero, Jinja, Mbarara and Masaka. Hands-on clinical practice will be provided in approximately eight working health facilities in these districts. Pathfinder will furnish these facilities with equipment required for the provision of BRH services, including client counselling aids developed or purchased by CCP, and will effect minor facility renovations as necessary (e.g., partitioning or screening to ensure client privacy; repairing roofs, windows and doors). Preparation of these practicum sites will also include on-the-job training for existing staff to upgrade clinical and counselling skills, provide basic mentoring skills, and reorganize the facilities for integrated service provision.

Minimum Standards, Training-and-Supervision Data Base. Compliance with minimum standards of performance for specific clinical and counselling skills will be required for satisfactory completion of the training. Pathfinder/INTRAH, with MOH concurrence, will specify these skills/standards and will document the mastery of each skill for each trainee in a computerized data base to be established with assistance from the project's Logistics and Information Systems Advisor (3.2 below).

Equipment and Facility Renovation. When a trainee successfully completes the training, Pathfinder will furnish equipment¹⁴ needed for the provision of BRH services to the trainee's facility. Pathfinder will ensure that facilities maintain proper inventories of this equipment, and supervisors will conduct routine end-use checks to assure that these inventories are accurate and up to date. In accord with previously conducted district assessments and available resources, minor renovations (as above) will be carried out at 76 facilities.

Supervision. The training teams will work with specially chosen district staff, including NGO staff, to supervise trainees after the completion of training. After each training 'cycle' trainers and supervisors will spend four to six weeks observing trainees in actual clinical practice to re-enforce the concepts and skills acquired in the training, help transfer some of these skills and concepts to other clinic staff, and re-organize facility operations for integrated service delivery. Thereafter, trainers

¹⁴ E.g., delivery kits, specula, angle electric lamps, cheattle forceps and jars, instrument trays and kidney dishes, sphygmomanometers, stethoscopes, fetoscopes, adult weighing scales, height tape measures (wall), IUD insertion kits, paraffin sterilizers and pots for boiling instruments, plastic basins, slotted soap dishes and pedal buckets. Basic equipment for handling obstetric emergencies will also be provided to facilities with midwives trained in Life Saving Skills, including district hospitals.

and supervisors will continue to periodically observe the actual delivery of clinical and counselling services by trained providers in their respective health facilities. Supervision guidelines, to be compiled by the trainers and supervisors and incorporating appropriate provisions of existing FP and LSS assessment instruments, will be used to compare actual performance with the standards established in the training.

All trainees will be observed in all skill areas at least twice a year, with an emphasis on supportive, interactive problem solving and on-the-job training. Observations, follow-up actions and recommendations from each supervisory visit to each trainee will be entered in the training-and-supervision data base to document supervision provided, monitor trainee progress over time, and maintain a continuing record of problems encountered, the latter to be used to periodically revise the curriculum. In addition, exit interviews with clients will be used to determine client satisfaction with services rendered and whether appropriate services were offered, per the service-delivery algorithms noted above. The results of these interviews will also be documented in the data base. Supervisors will also conduct regular inventories of contraceptives, antibiotics and project-funded equipment during supervisory visits.

Pathfinder will provide DISH District Medical Offices with vehicles and funds for supervisory expenses such as fuel, maintenance and travel allowances. An additional vehicle will be provided to the MCH/FP Division of the central MOH to facilitate supervision of project activities by relevant central-level staff and their possible replication in other areas. All these vehicles will be registered to the DISH project. Pathfinder will enter into memoranda of understanding with each DISH district regarding the use of vehicles and funds and will be responsible for accounting for all funds provided to districts.

Adolescents and Men. Given the preponderance of women and children as clients for preventive services at most facilities, most clients seen by project-trained staff are likely to be mothers or expectant mothers. However, the male partners of these women exercise significant influence over the decision to use family planning. And although providing STI services to women addresses only half the problem, it is often difficult for female nurses to provide STI services to men. Likewise, teenagers, generally a healthy population, are rarely encountered as clients for preventive services. Yet teenage pregnancy is common, and teenage girls are at high risk of HIV and other STIs. DISH will approach this problem on a pilot basis in a few selected facilities in Jinja and Mbarara, supported by special IE&C campaigns and counselling and reference materials (see 3.1 below).

Starting in the second year of project implementation, nurses and midwives in the selected facilities will be trained by Pathfinder/INTRAH to tailor FP, STI and HIV related services for men and adolescents. Training will be characterized by ample role play and clinical practice with men and teenagers to develop the confidence and composure required to discuss basic issues regarding reproductive health with these clients. For teenagers, training will emphasize low-risk behavior, including delaying sexual debut and condom use for adolescents already sexually active. In

addition to trying to attract adolescents and men to existing health facilities, perhaps on special days and at special times, Pathfinder and District Health teams will experiment with the provision, by existing, trained health staff, of services at sites such as youth clubs, frequented by men and young people.

As in DISH generally, treatment for STIs in males will be syndromic and will not routinely require a physical examination. When a male or female is diagnosed and treated, the same treatment will be given to sexual partners, whether symptomatic or not.

In addition, under component 1.2 below, AMREF will test in DISH districts an STI risk-assessment technique which would eliminate physical examinations and simplify diagnosis and treatment for both males and females. If feasible, risk assessment will be tested in some of the facilities participating in the pilot described above.

1.2 STI Training for Physicians and Medical Assistants; Lab Training

AMREF will train approximately 450 medical assistants and physicians (in both public and private practice) in the syndromic diagnosis and treatment of STIs and approximately 200 laboratory technicians and assistants to perform diagnostic tests related primarily to maternal health in the DISH districts. Antibiotics for STI treatment and laboratory equipment will be provided for trained staff through the MOH's World Bank-funded STI Project.

Training. Clinical STI training will consist of an approximately four-day course on the syndromic diagnosis of STIs followed by at least two days of clinical practice at seven health facilities in DISH districts. In collaboration with the MOH's Health Manpower Development Center, AMREF will train staff of the MOH's AIDS/STD Control Program and selected district clinicians as trainers. These individuals will train DISH-district personnel in syndromic diagnosis and treatment at health units in DISH districts, which AMREF will select and equip as needed. In consultation with the MOH's AIDS and STD Control Program, AMREF will develop a curriculum based on syndromic algorithms used by AMREF's STD/HIV Intervention Project in Mwanza, Tanzania. These algorithms will be modified by AMREF for use in Uganda, with the concurrence of the MOH.

In addition, AMREF will send the medical assistants and physicians posted to the eight practical training sites noted in 1.1 above to Mwanza for intensive training in syndromic STI diagnosis and treatment.

Lab training will consist of a two-week residential course conducted at the same seven sites (above) where clinical training will be held. AMREF will train Ugandan lab technicians as trainers and will design a curriculum based on AMREF's lab program in Kenya and on refresher lab training previously supported by AMREF in Uganda. Since it is unlikely that any site in Uganda can currently provide sufficient clinical specimens for the anticipated number of trainees, some trainees will require

on-the-job training to supplement the course. AMREF will arrange for these staff to work in functioning laboratories, staffed by competent technicians and as close as possible to the trainees' place of work, for one to two weeks.

AMREF will provide one Project Manager and one lab technician, both recruited in Uganda or regionally, to implement this project component.

Minimum Standards, Training-and-Supervision Data Base. In consultation with the MOH's AIDS and STD Control Program, AMREF will determine performance-based criteria for the satisfactory completion of the clinical and lab training and will document the mastery of each skill for each trainee in a computerized data base similar to that noted in 1.1 above. Pathfinder's Logistics and Information Systems Advisor will assist AMREF to establish this system and train staff in its use.

Supervision. AMREF will establish supervision guidelines to compare actual trainee performance with the standards established in the training and will, in coordination with District Medical Officers, identify a competent clinician and lab technician in each DISH district to supervise trainees routinely. AMREF will train these supervisors to conduct supportive supervision in coordination with the Health Manpower Development Center. During the first year of implementation, district supervisors will visit each trainee at his/her post every six weeks, once a quarter thereafter. Supervision will involve spending a full day observing trainee performance, providing refresher training, and identifying and solving specific problems encountered. Observations, follow-up actions and recommendations from each supervisory visit to each trainee will be entered in the data base noted above.

Asymptomatic STIs. Studies in Uganda and nearby countries have shown that asymptomatic or un-acknowledged STIs are very common among women and men. This is a major problem since individuals so infected will not seek treatment and will unknowingly continue to infect others. Researchers in Zaire, Kenya and Tanzania have developed sensitive, cost-effective risk-assessment techniques to identify and treat these people. Clients are screened by asking a few questions which are formulated based on common characteristics of a sample of people with known STIs. Clients with a history consistent with a particular syndrome (or syndromes) are treated using the recommended drug regimen for the syndrome(s) in question. AMREF will utilize technical assistance from its STD/HIV project in Mwanza and the reference lab noted in 1.3 below to adapt these techniques to Uganda and test them among male and female out-patients at selected sites in DISH districts. If so indicated by the test, risk assessment and treatment will be expanded to other sites in DISH districts.

1.3 STI Reference Laboratory

STIs are managed in Uganda based on syndromes and treatment plans that have not been revised since their inception in early 1993. Given the continuous, largely drug-induced evolution of etiologic agents, it is highly desirable to validate diagnostic and treatment procedures, including the new syndromic algorithms to be

implemented in DISH districts (1.2 above), routinely to assure that they result in accurate diagnoses and effective treatments.

To perform such validations, and to monitor the prevalence of various STIs in Uganda, the MOH's STD/AIDS Control Program requires a small laboratory which can identify the etiologic agents associated with the various syndromes and monitor the resistance of these agents to specific antibiotics. Such a lab should be near the site where patients are seen to minimize delays associated with transporting specimens, a major problem in successfully culturing organisms. DISH will support the establishment of such a lab at the STD clinic at Ward 12 at Mulago Hospital in Kampala. (Ward 12 has the largest concentrations of STD patients and skilled clinicians in the country.) Minor renovations will be made to one room at Ward 12 to house the lab initially. A non-DISH, USAID-funded local-currency project to enlarge the STD Unit at Old Mulago is anticipated in 1995/96, and the lab will be re-located in this new space at the conclusion of that project.

Confirmatory and antibiotic-sensitivity tests for gonorrhea, syphilis, chlamydia and chancroid will be phased in over a three-year period. In addition to renovation and required equipment, the project will support a consultant microbiologist and a full-time, locally hired lab technologist to work with one MOH counterpart at Ward 12 who will assume responsibility for the lab in 3 years. (A position for this counterpart already exists at Mulago, but is not currently filled.)

The performance of the lab will be evaluated by its accurate identification of "known" specimens of N. gonorrhoea, T. palidum, C. trachomatis and H. ducreyi.

1.4 HIV Testing and Counselling

The AIDS Information Center (AIC) has provided anonymous counselling and testing (C/T) services to over 230,000 people at its four branches and over 20 "satellite" sites since its founding in 1989. However, these services are not yet easily accessible to most Ugandans and, though apparently effective in changing behavior, their high cost raises significant sustainability issues. Nonetheless, demand for these services is high, resulting in compromises in service quality including group pre-test counselling, long waiting times, and pressure to expand to more satellite sites, despite the logistical difficulties and high costs inherent in these operations.

Cooperative Agreement. USAID/Uganda will enter into a cooperative agreement with the AIC to continue to fund the AIC at approximately the same level as currently provided under APCP. These funds will be used for operations in DISH districts only, i.e., to continue to operate three branches at Kampala, Jinja, and Mbarara¹⁵ and associated satellite sites. The Kampala branch will continue to serve the capital's urban and peri-urban areas, including satellite sites in selected high-risk areas, and will continue to operate satellites in southern Luwero. DISH funds may

¹⁵The branch in Mbale, a non-DISH district, will not be funded under DISH.

be used, along with contributions from other donors and the AIC, to construct a headquarters/counselling-and-training center for the AIC in Kampala. The Jinja branch will continue to operate outreach services in Kamuli district and will work more closely with Pathfinder's FLEP project in Busoga Diocese to extend HIV counselling and testing in Jinja and Kamuli. The Mbarara branch will continue outreach services in Mbarara and Ntungamo.

Rapid Testing. Easy-to-use HIV tests, which do not require the complex, centralized laboratory procedures characteristic of the current ELISA test, should make HIV testing considerably more accessible and, eventually, less expensive. Prior to the cooperative agreement noted above, the AIC, under the APCP Project, is expected to have confirmed the feasibility of using rapid tests to provide same-day results to clients and will have developed protocols for rapid testing and counselling, including confirmatory testing of positive results using an alternate rapid test.

If feasible, rapid testing will be adopted as the norm at the AIC, which will use rapid testing to expand the availability of C/T services in at least three public or private-sector facilities in each DISH district. These facilities will be selected in consultation among the AIC, Pathfinder, District Medical Offices and key NGO facilities such as Kitovu Hospital in Masaka and Kiwoko Hospital in Luwero. With DISH support, AIC will train local staff in pre and post test counselling and will work with the trainers and supervisors noted in 1.1 above to ensure quality control and adherence to established protocols. Two of these sites will be selected as HIV sentinel-surveillance sites to help monitor HIV prevalence in DISH districts.

AIC will procure rapid test kits for its own use and will, by 1997, hire phlebotomists and laboratory staff for its Kampala, Jinja and Mbarara branches. AIC will also procure rapid test kits for public and private-sector facilities with staff trained to provide C/T services. AIC will work with District Medical Offices to phase in district procurement of test kits through National Medical Stores by the end of the project.

Business Plan. By the end of the first year of the cooperative agreement, AIC will formulate a business plan describing (i) how USAID funds should be used to provide high-quality C/T services to the maximum number of people in DISH districts by September 1999 and (ii) how to enhance the organization's sustainability.

The former will involve consideration of the extent to which the AIC should provide C/T services itself or assist other organizations to provide them. This in turn will involve considerations of the market for C/T services in the DISH districts; the capacities of organizations, public and private, able to provide these services; the cost to these organizations of providing services (including the cost of the test itself) and how those costs can be covered, the costs to the AIC of assisting these organizations and how all or part of these costs can be recovered.

The latter will involve establishing that portion of specified AIC recurrent costs which should be covered by user fees and targets for diversifying the AIC's funding

sources. (Means of serving persons unable to pay, such as "free days", will also be described.) The plan will also describe ways to improve AIC's overall cost-effectiveness through the collection and analysis of unit cost data.

Technical Assistance. USAID's HIV/AIDS advisor, provided under a PASA with the U.S. Centers for Disease Control and Prevention (CDC), will be re-located to the AIC where she will spend approximately 50% of her time on the activities noted above. STTA will also be provided by CDC for these activities.

1.5 STI, Family-Planning and Counselling Services for People with AIDS

USAID will enter into a cooperative agreement with TASO to implement activities in DISH districts where TASO is already established (Kampala, Jinja, Masaka, and Mbarara). This agreement will fund the provision of general supportive counselling and basic medical care for people with AIDS. TASO will continue its efforts to help clients adopt behaviors which will protect others from HIV infection and themselves from infection with other STIs. TASO will ensure that all clients understand the risks of mother-to-child HIV transmission, that appropriate education and counselling is provided to all clients contemplating pregnancy, and that long-term FP methods are readily available from TASO staff (including sessional doctors) to all TASO clients. TASO will also ensure that screening and treatment for STIs is a basic element of the clinical care it provides for all its clients. (TASO staff are eligible for the family planning and STI training noted in 1.1 and 1.2 above.) TASO will ensure that the treatment it provides for other STIs is based on the syndromic algorithms developed by AMREF (1.2 above), using drugs provided by the World Bank's STI Project.

STTA will be provided from CDC to help TASO improve its management information system (MIS), with emphasis on the collection and use of data to track contraceptive distribution and prevalence, pregnancies and complications, and the prevalence and treatment of other STIs among TASO clients. Pathfinder's Logistics and Information Systems advisor will work with CDC consultants to install this and help TASO maintain this system.

In DISH districts with no existing TASO branch (Kamuli, Luwero, Masindi, Rakai, Ntungamo, Kasese), TASO will work with the District Health Team and NGOs supporting AIDS programs to improve the provision of supportive services to people with AIDS. TASO will develop a plan to provide technical assistance to such groups by the end of 1996. This TA will emphasize supportive counselling and intensive efforts to prevent further HIV transmission, including mother-to-child transmission, by making family-planning and STI services widely available. After TASO's MIS has been improved and evaluated, as above, TASO will assist other organizations to adapt the MIS to their own circumstances and use it to monitor their programs.

1.6 Voluntary Surgical Contraception

The original PP anticipated Mission/Global Bureau co-funding of surgical contraception through USAID/W's AVSC Project. With the subsequent advent of

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Joint Country Programming and in the interest of simplicity, all future AVSC funding, including funding for activities in DISH districts, will be from G/PHN's Field Support Budget; aside from an FY95 buy-in to AVSC, DISH funds will no longer be used for surgical contraception. Although surgical contraception services will continue to be provided, improved and expanded to at least three new sites in DISH districts and Pathfinder will continue to coordinate DISH activities with AVSC in those districts, surgical contraception is essentially deleted as a DISH-funded activity.

Output 2: Expanded Community Based Reproductive Health Programs

This output will be produced by implementing the following six components.

2.1 Training TBAs

AMREF will train approximately 650 TBAs in the DISH districts to:

- a. recognize common danger signs related to pregnancy (vomiting, severe headache or abdominal pain, bleeding or leaking of vaginal fluid, edema of the hands) and the syndromes (1.2, above) related to common STIs;
- b. refer problem pregnancies and suspected STIs to trained nurses or midwives;
- c. perform aseptic, normal deliveries, including first-aid for hemorrhage (uterine massage, nipple stimulation);
- d. provide post-natal care including family planning counselling and breastfeeding promotion; and
- e. distribute condoms and oral contraceptives.

AMREF will identify local organizations (e.g., NGOs, missions, government health units) and communities in each DISH district which (a) are interested in training and subsequently supervising TBAs and (b) support the objectives of the DISH Project. AMREF will provide technical and financial assistance to train TBA trainers (midwives at health facilities) for these organizations as may be needed, using the Uganda Community Based Health Care Association methodology. This typically requires three to four one-week training sessions and emphasizes training and communications skills rather than technical content. To maximize synergy among project components, AMREF will ensure that only nurses and midwives trained (or to be trained) under the DISH Project will be trained as TBA trainers.

AMREF will then provide trainers with training funds and technical assistance to develop a TBA training program. The curriculum will be flexible so that each organization can provide its own emphasis; however, the minimum content for all TBA training will include those topics noted above. About three weeks will be required to cover these topics. The curriculum developed by the American College

of Nurse Midwives will be a basic guide for TBA training, with additions as needed to include the proper distribution of oral contraceptives. TBA training will be scheduled in consultation with Pathfinder.

Supervision.

TBA trainers will supervise TBAs in their villages or in health facilities approximately once a week, per supervisory guidelines similar to those noted in 1.1 and 1.2 above and using means of transport which they currently use to supervise existing TBAs. The results of this supervision will be entered in a computerized TBA data base established by AMREF with assistance from Pathfinder's Logistics and Information Systems Advisor. Depending on requirements at individual facilities, AMREF may provide bicycles to facilitate this supervision. In addition, AMREF will periodically assess the performance of both TBA trainers and trained TBAs through site visits.

SOMARC (2.2 below) will supply trained TBAs with Protector condoms, Pilplan orals¹⁶ and promotional materials and will train TBAs to maintain proper inventory and sales records and ensure that Protector and Pilplan brand promotion is consistent with other SOMARC activities.

2.2 Social Marketing of Contraceptives and Antibiotics

DISH will support expanded contraceptive-social-marketing activities through a buy-in to G/PHN's CSM III (SOMARC) Project, which was initiated in Uganda in 1991 and is currently marketing Protector condoms and Pilplan orals nationwide. G-Bureau funding will be used to continue support for the national program and to cover some costs of the expanded program in DISH districts. DISH will fund a full-time, in-country marketing advisor¹⁷ plus support staff and the remaining costs of the expanded program in DISH districts¹⁸.

SOMARC will make Protector condoms and Pilplan orals widely available at low prices through retail outlets such as pharmacies, drug shops, clinics, hawkers, general merchandise shops, night clubs, private midwives, health facilities, and NGO programs. Consumers will be informed about these products through brand advertising on radio and in other media, product sponsorship of health-related radio programs, public relations activities, point-of-purchase brochures and promotional

¹⁶Pilplan will not be sold to lactating women. TBAs will be trained to prescribe progestin-only pills for as long as lactation is maintained.

¹⁷ SOMARC's contract with AID/W preclude the use of core funding for resident advisors.

¹⁸G/PHN funding for SOMARC is expected to amount to approximately \$500,000 /year. However, it is difficult, and probably not very useful, to determine a precise allocation of these funds between DISH and non-DISH districts (e.g. G funded radio ads are heard everywhere and the same promotional materials are used in DISH and non-DISH districts). For simplicity, the Mission considers G/PHN funding to cover national-level expenditures, not DISH-district expenditures, and these funds are thus not included in the project budget.

materials. Starting in year two of project implementation, SOMARC will market the injectable contraceptive, Depo-Provera, through private physicians and private midwives. SOMARC will train pharmacists and other retailers, physicians, midwives and CRHWs in the use of these products.

DISH District Sales Force. In addition to increasing sales of Protector and Pilplan in urban and peri-urban areas by expanding commercial distribution channels, SOMARC will significantly expand sales in rural areas of DISH districts. SOMARC will hire a 10-person "DISH District Sales Force" to make SOMARC products routinely available in areas of DISH districts not routinely served by the project's commercial distributor. These personnel will be based in Kampala, will report to the SOMARC marketing advisor, and will be provided with vehicles required for extensive travel in rural areas (and congested urban areas of Kampala). In addition to serving small retail outlets in trading centers and public-sector health facilities, these staff will be responsible for supplying and expanding a network of NGOs which utilize Protector and Pilplan in their health and family-planning programs¹⁹. This network will include AIC branches (component 1.4), TBAs²⁰ trained by AMREF (2.1), Pathfinder's community based reproductive health program (2.2), community organizations (2.4), village-banking groups established by FINCA (2.5), and others and others not necessarily supported under DISH.

Adolescents. SOMARC will make a special effort to increase Protector sales among sexually active teenagers. Youth initiatives may include recruiting young people as SOMARC sales agents, promotional campaigns targeted on sexually active youth, sponsoring youth-group activities, and the inclusion of teenagers' concerns in SOMARC-sponsored radio programs. Local promotional activities focused on youth will be implemented in coordination with the pilot program for adolescents and men noted under component 1.1.

Contraceptives. As noted under 3.2, DISH will not fund contraceptives.

Antibiotics. Self-treatment of STIs by men with drugs purchased at pharmacies and drug shops is common in Uganda. However, the correct drugs are not always purchased, and when they are, they are often bought in amounts insufficient for a full course of treatment. This may relieve some symptoms, but leaves the infection partially treated, which can lead to complications, antibiotic resistance, and continued transmission of the infection.

To improve the efficacy of treatment already being provided at drug shops and pharmacies, SOMARC will, subject to MOH approval, initiate a pilot project in

¹⁹ As noted under component 3.2, USAID will not provide free distribution contraceptives to any NGO. While NGOs in DISH districts may receive USAID funded contraceptive, these will be provided from the Central Medical Stores and through District Medical Offices, in response to orders from or approved by those offices.

²⁰ Only TBAs selected by SOMARC will sell Pilplan.

selected DISH districts to market antibiotics for the most common STIs. To encourage purchase of a full course of therapy, these drugs will be sold in sealed packets, color coded to indicate specific STI syndromes. Each packet will contain the standard dose recommended by the MOH for the respective syndrome, instructions for use, including use by low-literate people, and a number of Protector condoms sufficient to last through the course of treatment. Pre-packaged drugs will be purchased under the World Bank-funded STI Project, with condoms and instructions added locally by SOMARC.

SOMARC will work with AMREF (component 1.2 above) to train shopkeepers and a limited number of CRHWs or their supervisors (2.3 below) in syndromic STI diagnosis and treatment and will provide diagnostic guides and educational and promotional materials for these individuals. The same prepackaged drugs, condoms and instructions may also be supplied for sale by health units.

This pilot program will be conducted in collaboration with The Uganda Medical Association, the National Drug Authority, AMREF and USAID's STI Advisor. If the pilot phase is successful, it will be expanded to all DISH districts.

Monitoring. SOMARC will keep computerized records of the number and type of commercial outlets and NGO distributors in each DISH district and the stock and sales²¹ of each product (including antibiotics) by outlet. SOMARC will make periodic spot checks of a sample of outlets to ensure that the sale of contraceptives and antibiotics is accompanied by appropriate instructions for use. Monitoring data will be collected through observation, interviews, and mystery shoppers and will be recorded, by outlet, in a data base which will be used to plan periodic refresher training for retail and NGO staff. Pathfinder's Logistics and Information Systems Advisor will assist SOMARC to establish this data base.

2.3 Community Reproductive Health Services

Pathfinder will make sub-grants to indigenous NGOs to extend the availability of condoms, oral contraceptives, antibiotics and education about FP, STIs and HIV, and maternal health to the community level and to establish referral linkages between facilities with DISH-trained providers and communities for the provision BRH services. These programs will be based on the Church of Uganda's Family Life Education Project (FLEP) in Busoga Diocese, which Pathfinder has supported for several years and will be developed in consultation with the Ministry of Health. About 50 community residents per district²² will be deployed as "Community Reproductive Health Workers" (CRHWs) to:

²¹Sales to outlets and NGOs, not to the public.

²²This includes workers already trained by Pathfinder in its centrally funded Busoga and East Ankole Diocese projects in Jinja/Kamuli and in Mbarara/Ntungamo districts respectively.

- a. provide basic information and counselling about FP, STIs and HIV, including (i) the various FP methods available, contra-indications, correct use and management of side effects; (ii) the symptoms of common STIs; (iii) myths and misconceptions related to FP, STIs and HIV; and (iv) the links between the STIs and HIV and how to prevent both;
- b. screen for contraindications to the use of oral contraceptive and sell Protector condoms and Pilplan orals²³;
- c. starting on a limited, trail basis and expanding as indicated, syndromically diagnose common STIs and sell antibiotics to diagnosed clients (see 2.2 above);
- d. refer clients to facilities with trained providers for clinical FP methods (injectables, IUDs, surgical contraception, Norplant); STI diagnosis and treatment; professional HIV counselling and testing (where available); and ante-natal and post-natal care.

The population served by these personnel will be documented in catchment-area surveys conducted prior to selecting CRHWs. Implementing NGOs will train men, women and young people as CRHWs to ensure that these target groups are served. Where NGOs do not have sufficient training capability, training will be conducted by FLEP trainers. To facilitate supervision and sustainability, CRHWs will, where possible and reasonable, be drawn from the ranks of the NGO (or another, existing community-based organization) rather than from the community at large. CRHWs will be supervised by NGO staff, hired as needed to supervise 10 - 15 CRHWs each and with assistance from Pathfinder, using FLEP staff as appropriate.

CRHWs will be supplied, through the implementing NGOs, with Protector condoms, Pilplan orals, antibiotics and related promotional and educational materials by SOMARC's DISH District Sales Force (2.2 above), which will also train CRHWs to maintain proper inventory and sales records. Pathfinder will supply implementing NGOs with IE&C materials (component 3.1) for CRHWs to use in conducting group education and individual counselling sessions. CRHWs will not receive salaries or stipends, but will retain a portion of contraceptive sales revenue, in accord with SOMARC's established pricing policy. Other incentives such as bicycles, bags, uniforms, etc., may also be provided.

Pathfinder will hire a local Community-Based Projects Coordinator, a Program Analyst and support staff to assist local NGOs to implement this component and will provide a vehicle, a computer, and office supplies and equipment for this staff, which will be based at the Pathfinder office in Kampala. The Project Coordinator will

²³Contraceptives will not be distributed for free. In Jinja, Kamuli, Mbarara and Ntungamo, where free distribution has until recently been the norm, Pathfinder will formulate a plan for phasing out free distribution and phasing in the sale of SOMARC commodities.

report to Pathfinder's Chief of Party. Pathfinder will also provide STTA to implementing NGOs in information, management and financial systems; self-assessment techniques for improving service quality; IE&C and counselling skills; and performance assessment and feedback.

2.4 Community Behavior Change Activities

USAID will enter into a cooperative agreement with an international NGO (the recipient), selected through a Request for Applications (RFA), to (i) establish a mechanism for mobilizing and coordinating district-level support for NGO activities to change behaviors and social norms conducive to HIV/STI transmission and unwanted pregnancy²⁴ in DISH districts; and (ii) utilize that mechanism to plan and implement such activities and to leverage district-government funding for community reproductive-health programs. The recipient will utilize short-term technical assistance from the U.S. Centers for Disease Control and Prevention (CDC) to adapt CDC's model for community planning for HIV prevention to these ends.

District HIV/STI-Prevention Committees , Lead NGOs. The recipient, in coordination with District Medical Offices, will establish a District HIV/STI-Prevention Committee in each DISH district, which will include representatives of the District Health Team and locally active NGOs and community organizations interested in reproductive health. In each district, these committees will formulate and monitor the implementation of HIV/STI-prevention plans to be implemented through the organizations represented on the committee.

The committees will also choose one NGO in each district as "lead NGO"²⁵ for the implementation of the district plans. The recipient will make sub-grants and provide technical assistance to these lead NGOs for the implementation, in coordination with other committee members, of the activities specified in the district plans.

District Plans. The recipient and CDC will determine an approximate allocation of available funds among districts based on, but not necessarily limited to, population, estimated prevalence of HIV infection, and the extent of existing services and programs; and will provide the committees with information on the likely cost-effectiveness of various HIV-prevention alternatives.

The committees will, in consultation with the recipient, use this information to determine HIV/STI prevention activities for inclusion in the district plans. Activities

²⁴ Although this component is intended to focus, at least initially, on HIV and STI prevention, activities which prevent STIs and HIV are likely to prevent pregnancy as well. Programs which build upon this commonality by integrate FP concerns into HIV/STI prevention will also be considered.

²⁵ An NGO may be selected as lead NGO in more than one district.. E.g., TASO could be the lead NGO in the several districts where it has an established presence.

consistent with the objectives of DISH²⁶ may be funded through the lead NGO. The sustainability of these activities, as indicated by the officially expressed willingness of district governments to co-fund them, will be a major consideration in the recipient's provision of DISH funding. District plans may provide for the more extensive implementation of activities supported under other components of DISH (e.g., more C/T services than would otherwise be available, more community reproductive-health services, more district IE&C), and the recipient will encourage appropriate linkages between local organizations and organizations implementing other components of DISH.

The recipient will then work with the district committees and lead NGOs to formulate district plans which will include specific behavior-change objectives, process and outcome measures which indicate that these objectives are being attained, budgets, and responsible organizations. The recipient will have final approval authority for all DISH-funded activity and will be responsible for accounting to USAID for all funds disbursed under this component.

This component will not fund activities to increase general knowledge, which is already high, about HIV/AIDS and its transmission or to 'sensitize' individuals or communities about the need for behavior change. Rather, the emphasis will be on the use of specific information in ways which achieve observable changes in key behaviors such as condom use, partner reduction, avoidance of excessive alcohol consumption, delayed sexual debut among adolescents and the utilization of reproductive health services.

Organizational Development. Consistent with the recipient's assessment of the capacities of each lead NGO, as specified in pre-award organizational assessments, the recipient will provide technical assistance to strengthen its institutional capacity for strategic planning; project management, including financial management budgeting and supervision; and resource mobilization.

Project Monitoring. The recipient will assist lead NGOs to monitor program activities so as to routinely collect data on the process and outcome indicators specified in the district plans. This data will be entered in a computerized data base set up and operated by the recipient in consultation with Pathfinder's Logistics and Information Systems Advisor (3.2 below). The recipient will also routinely assess and record the evolving organizational development of lead NGOs, using the organizational assessments noted above as baselines.

Activities will also be monitored periodically by short-term consultants from CDC and routinely by USAID's HIV/AIDS advisor.

Phased Implementation. This project component will be initiated in a maximum of five DISH districts, and activities specified in district plans will be funded for no more

²⁶This component will not fund provision of drugs, food or income generation activities for HIV + people.

than two years. After this initial trial phase, this project component will be evaluated by USAID, and the Mission will decide whether to continue and expand it or not. This decision will be based on the quality of the district plans and the effective coordination among implementing organizations, the effectiveness of the committees in securing co-funding from district governments, and monitoring data which indicate that process and outcome objectives are being attained.

2.5 Improved Economic Status of Women

Under a grant from USAID/Uganda, FINCA International will expand an ongoing "village banking" program to enable poor women²⁷ in DISH districts to establish micro-enterprises. FINCA will assist small, established women's groups in DISH districts to establish banks, of which individual women will be members. FINCA will capitalize these banks, which will lend small sums (about \$50 initially) to members, require weekly interest payments in addition to full loan re-payment, and a minimum level of savings in the village bank. With increasing experience, members will become eligible for larger loans (up to \$300). FINCA will train members in basic literacy and numeracy as required, and will train bank "officers," elected by the members, in banking operations, loan administration, bookkeeping, accounting, and small-business administration.

FINCA will also provide technical assistance in various aspects of organizational development, including technical training, to establish its Uganda affiliate as a self-sufficient, micro-enterprise lending institution, gradually reducing a directive and supervisory role as FINCA/Uganda becomes more experienced.

DISH will also provide a small amount of funds to the Ugandan Women's Effort to Save Orphans (UWESO) to continue through December 1996 previous USAID support for school fees and related expenses for orphans. Since there are fewer girls than boys in primary school, especially in the upper grades, since half of Ugandan women become pregnant by age 19 and since young women are particularly vulnerable to HIV infection, an emphasis on education for girls is warranted. Therefore, UWESO will ensure that all primary-age-school-age girls in families supported by UWESO who should be in school are enrolled. In addition to school-fees support, USAID will assist UWESO, in collaboration with the Peace Corps, to increase its emphasis on income-generating activities for families supporting orphans. Support to UWESO will not be limited to DISH districts.

Output 3: An Institutional and Community Environment Supportive of Improved Reproductive Health

This output will be produced by implementing the following three components.

²⁷FINCA has found that up to 75% of the first 1,000 borrowers in 40 previously established village banks are caring for orphans. It is expected that at least 55% of borrowers supported under DISH will be women caring for orphans.

3.1 Information, Education and Communication (IE&C)

DISH will support (i) mass-media and district-level IE&C campaigns related to reproductive health and (ii) the provision of teaching/learning materials for use by trainers and service providers (1.1 above), AIDS counsellors (1.4), and CRHWs (2.3). CCP will provide a full-time Communication Advisor and up to four locally hired IE&C Coordinators²⁸ with IE&C experience related to FP and AIDS, plus STTA, to assist in the design, implementation and monitoring of these activities. Activities will be designed and implemented in coordination with MOH's Health Education Division, the AIDS Information Center (AIC) and other relevant NGOs, and District Health Educators (DHEs) from the DISH Districts. Pathfinder/CCP will procure all audio-visual equipment needed for these activities and will fund all costs associated with campaign design, implementation and evaluation and with materials production and distribution.

Campaigns. Mass-media and district-level campaigns will utilize a variety of media, including radio spots, serialized radio dramas and call-in or magazine shows; print; clinic signboards; posters; billboards; and traditional music and drama. The strategic direction and specific content of these campaigns will be based on extensive qualitative research (e.g., focus-group discussions and in-depth interviews) conducted by market research organizations and district health-education staff, with assistance and training from the Communication Advisor and/or the IE&C Coordinators.

Mass media campaigns will be designed and implemented by a local or regional commercial marketing/advertising firm, under contract to CCP. Pathfinder/CCP will ensure that all mass-media campaigns and materials are thoroughly pre-tested among target groups in the DISH districts. All mass-media strategies, campaigns and materials will be approved by USAID prior to implementation.

District-level activities will be specified, scheduled, costed, and assigned to responsible parties in a District IE&C Plan for each DISH district. These plans will be developed and implemented by the respective DHEs, in coordination with the Communication Advisor, the IE&C Coordinators and local organizations. This coordination will be effected through District Campaign Action Committees composed of representatives from public and private-sector organizations providing reproductive health services and education in each DISH district. Activities in approved district plans will be funded by the project under the terms of memoranda of understanding between Pathfinder /CCP and each district. Such activities may include film shows, community discussion groups, roving drama troupes, door-to-door visiting and the promotion of trained service providers. Whenever possible, district activities will use local entertainment and communication channels such as drama, music, storytelling, parades and sporting events.

²⁸ Two of these personnel may be provided at no cost to DISH under USAIDW's International Population Fellows Program.

Mass-media and district-level campaigns will:

- a. dispel specific rumors and misconceptions related to FP, STIs, HIV and maternal health;
- b. provide basic information on FP methods, how to use them, side effects and their management, and the benefits and contra-indications of each;
- c. provide information on (i) the symptoms and consequences of STIs, including the link between STIs and HIV; (ii) STI/HIV prevention; and (iii) STI treatment;
- d. encourage personal risk assessment related to sexual behavior, fewer sexual partners, condom use and prudent consumption of alcohol;
- e. encourage later sexual debut and changes in social norms promotive of early sexual activity among young people;
- f. promote HIV counselling and testing, as these services become more widely available;
- g. inform people where to go for FP and other BRH services as they become more widely available, stressing the quality of services available from project-trained providers;
- h. promote spousal communication and community discussion regarding FP, STIs and HIV; and
- i. encourage women to use ante-natal services early in pregnancy, seek assistance from trained personnel for deliveries, and utilize available post-natal services.

These campaigns will target the following audiences:

- a. boys and girls aged 15-19 (when risks associated with first pregnancy and HIV infection are high);
- b. men and women aged 20-35 (when the likelihood of poorly spaced births and more than four births and the cumulative risk of exposure to HIV and other STIs increases);

Campaigns will be developed in phases for FP, HIV and other STIs, and maternal health. By the end of the second year of project implementation, mass-media campaigns on FP, STIs and AIDS will have been launched. After six months of intensive media saturation, each campaign will enter a maintenance phase which will run for the duration of the project. Similar district-level campaigns will be running in all DISH districts by the end of the third year of implementation.

Campaigns will be integrated around a consistent theme or themes (e.g., "The choice is yours", "Put your mind at ease"), possibly re-enforced by a reproductive-health logo or other shared design characteristic, and will unify and continually reinforce messages on FP, STI/HIV and maternal health.

Adolescents and Men. As noted under 1.1 above, DISH will support a pilot effort to increase the utilization of FP and STI/HIV services by adolescents and men. The project will fund the design and implementation of local campaigns in the catchment areas served by the facilities involved to inform teenagers and men of the availability of providers specially trained to serve them; promote personal risk assessment related to pregnancy, STIs and HIV; and encourage service utilization.

Materials. The availability of durable, high-quality teaching materials for use by trainers will be important for the success of component 1.1 above. Subsequently, effective service provision by trainees will be enhanced by the availability of counselling and technical reference materials. Similar materials will be required for use by AIDS counsellors (1.4) and by community based staff (2.2).

Teaching materials to complement the curriculum described in 1.1 will be either purchased by CCP or designed and produced by CCP and a local/regional firm, according to needs specified by the Clinical Services Advisors. These materials will include a training video demonstrating how basic reproductive health services can be integrated at the facility level and materials on the syndromic diagnosis and treatment of STIs. The latter will be based on new syndromic algorithms developed by AMREF (1.2). Counselling aids²⁹, also based on the curriculum and including materials for low-literacy clients, will be provided, in local languages, for nurses and midwives to use during clinical practice and subsequent service provision, as will outlines for group health talks and individual counselling sessions using these materials. Posters for display in facility waiting areas (and for use in counselling), will be provided, as will brochures on FP, STIs and HIV for clients to take away.

Materials for use in AIDS counselling and testing will be developed and produced in collaboration with the AIC for use in component 1.4. Materials for use by CRHWs (2.3) will be adapted as appropriate from materials currently used in Busoga diocese and from those produced for nurses and midwives (above).

Project Monitoring. A local media-monitoring service in Kampala will report weekly during mass-media campaigns on the frequency of DISH-funded radio programming to ensure that the right spots, programs, etc., are broadcast at the right time and with the proper frequency. The distribution of print materials related to mass-media campaigns, and the need for additional materials, will be monitored by DHEs and their assistants and by an IE&C coordinator, in a sample of distribution sites in all DISH districts, using a form designed for this purpose. District level campaigns will also be monitored by DHEs, using a monthly event-monitoring form. Data on the

²⁹E.g., flip charts, anatomical models, cue cards, STI algorithms, wall charts.

above will be recorded in an IE&C data base, installed with the assistance of Pathfinder's Logistics and Information Systems Advisor.

District supervisors (1.1 above) will routinely monitor the distribution, use and availability of materials produced for use in facilities, and exit interviews (see 1.1) will include questions on client exposure to IE&C materials and the influence of those materials on clients' decisions to visit the clinic.

Training. Approximately nine senior district IE&C staff (including NGO staff) will attend the "Advances in Family Health Communication" course offered by Johns Hopkins University in Baltimore, and about 20 other district personnel will attend the Center for African Family Studies (CAFS) "Communication Training" course. Other appropriate training may be substituted in lieu of the above.

3.2 Information and Logistics Systems

In coordination with MOH efforts to improve the national Health Information System (HIS) and the ordering and distribution of drugs, the project will assist DISH districts and other organizations participating in DISH to install and use standardized systems which routinely (a) report service statistics related to FP, maternal health and STIs, including HIV, (b) monitor the implementation and effectiveness of various project components, and (c) assure a reliable supply of contraceptives and antibiotics for STI treatment. Pathfinder will provide a long-term Logistics-and-Information-Systems Advisor (LISA), a locally hired MIS Assistant, and a locally hired Contraceptive Logistics Assistant to implement this project component.

Service Statistics. Service statistics will be used to measure the quantity of BRH services delivered monthly by each facility in DISH districts and by each implementing agency, viz.:

- a. New family planning users by method;
- b. Couple-years of protection (CYP) distributed by method;
- c. Tubal ligations, vasectomies performed (where applicable);
- d. Number of STD treatments, by sex;
- e. Number of first antenatal visits, by trimester;
- f. Number of deliveries;
- g. Number of postnatal visits; and
- h. Number of HIV tests performed, by age and sex (where available).

The LISA will train two members of each DHT as District HIS Officers and assist them to train staff at individual facilities to operate systems, based on the MOH's revised national HIS, which capture and report this data to District Medical Offices. Pathfinder will provide 10 desk-top computer systems - one per DHT, including required software, un-interruptible power supplies, and surge-suppression and voltage-stabilization equipment and training - for the storage, quality control, analysis and reporting of the data noted above.

The LISA and MIS assistant will assist SOMARC (2.2 above) to establish a computerized system to collect and report periodic data on the number and type of retail outlets, health facilities (public and private) and NGOs selling its contraceptives and antibiotics in each district, along with stock levels and sales. They will also collaborate with STTA provided by Pathfinder to assist the Program Analyst noted in 2.3 above to establish NGO systems to report the number of new and continuing FP users and the number of referral appointments made and kept for FP, STI and HIV services, by CRHW and facility. Interventions under the community behavior-change component (2.4) are yet to be specified, but the LISA and MIS assistant will advise the implementing NGO on the establishment of systems compatible with those used elsewhere in DISH to report statistics relating to the indicators specified in individual sub-grant agreements.

The AIC (1.4) already has a well developed MIS and will ensure that counselling and testing data are routinely reported to DMOs and to USAID from facilities in DISH districts which offer these services. STTA will be provided from CDC to assist TASO (1.5) to improve its information system, and CDC will coordinate with the LISA to ensure that TASO's system for reporting data on FP and STI diagnosis and treatment is compatible with the HIS.

FINCA will report on the number of village banks established, the number of beneficiaries, the size of each bank's loan portfolio and deposits independently.

Project Monitoring. The LISA and the MIS Assistant will assist other long-term technical advisors and, as required, other DISH implementing organizations to establish and maintain³⁰ compatible computer data bases to store and report process data related to the implementation of other project components. This assistance will include establishment of the training-and-supervision data bases described in 1.1, and 1.2 above; the number of trained CRHWs per NGO and district by age and sex and their activities (2.3); monitoring data related to the behavior-change component (2.4); and the IE&C data base (3.1).

Contraceptives and Antibiotics. The LISA will assist DISH districts to develop routine procedures for collecting and reporting the following data to forecast contraceptive and STD-drug requirements and to order these commodities from the National Medical Stores on time and in sufficient quantity.

- a. Opening contraceptive and antibiotic balances;
- b. Contraceptives and antibiotics distributed to clients, by type;
- c. Contraceptives and antibiotics received, by type;
- d. Ending contraceptive and antibiotic balances, by type;

Procedures relating to contraceptives will be based on a Contraceptive Logistics Management manual, compiled in draft with assistance from G/PHN's FPLM Project,

³⁰The day-to-day operation and use of these data bases (e.g., routine data entry analysis and reporting) will rest with individual project implementors.

which will be finalized by Pathfinder in consultation with the National Medical Stores. Procedures for antibiotics will be those prescribed by the National Medical Stores for ordering drugs generally.

DISH will not fund contraceptives. USAID will utilize funds available from other sources to fund contraceptives for use in DISH districts and SOMARC contraceptives for sale nationwide. USAID funds will be used only to purchase contraceptives and ship them to Uganda; clearing all USAID-funded contraceptives through customs, including the cost of such clearance³¹, will be the responsibility of the GOU, which will also transport them to the National Medical Stores. SOMARC commodities will be handed over to SOMARC's distribution agent after customs clearance. All USAID funded contraceptives will be consigned to the Ministry of Health and, except for social marketing commodities, will be distributed through the National Medical Stores in response to orders from or approved by District Medical Offices. Given the availability of funds for condoms under the World Bank-financed STI project, USAID plans to cease providing condoms to Uganda in 1996.

USAID will not fund the purchase of antibiotics. DISH districts will be supplied with these drugs under the STI Project.

Contraceptive Logistics Assistant. To help institutionalize the new contraceptive logistics system at the National Medical Stores, to ensure that USAID-funded commodities are properly distributed and accounted for, and to help train DISH-district staff (and other district staff as time permits) in contraceptive logistics management, Pathfinder will hire locally one Contraceptive Logistics Assistant. This person will be posted at the National Medical Stores in Entebbe.

Contraceptive Procurement Tables (CPTs). During the first year of project implementation, Pathfinder will provide STTA to compile CPTs which will update future contraceptive requirements for individual DISH districts and for the country as a whole, including SOMARC requirements. Thereafter, CPTs for the DISH districts will be prepared by the District MIS Officers, assisted by the LISA and the Contraceptive Logistics Assistant. These CPTs will include the estimated requirements of all NGOs in the district which require USAID-funded, free-distribution contraceptives. Contraceptive requirements for non-DISH districts will be estimated by those districts, per the Contraceptive Logistics Management manual and in consultation with the National Medical Stores. CPTs for SOMARC will be prepared by SOMARC staff.

3.3 Financial Management and Cost Recovery

Some form of cost recovery is practiced at essentially all public health facilities in DISH districts. Individual Health Unit Management Committees set fees and determine the use of funds collected, a large portion of which is typically used for salary supplements with most of the remainder spent on drugs. These ad hoc

³¹The GOU will fund the clearance of SOMARC contraceptives starting in GOU FY 1996/97.

financing arrangements need to be systematized, and procedures for local accounting and control of revenues need to be installed.

Pathfinder/E.Petrich will provide one, long-term Financial Management Advisor and two locally hired Financial Management Assistants to help District Health Teams in the 10 DISH districts design and implement simple, standardized facility-level systems to account for receipts and expenditures; calculate basic, unit costs of providing services; estimate cost effectiveness and establish funding priorities; formulate annual budgets based on those priorities for inclusion in district health plans; and set and allocate fees based on those budgets. (These efforts will not extend to hospitals.)

The Financial Management Advisor and assistants will provide similar assistance to NGOs and CBOs implementing components 1.4, 1.5, 2.4 and 2.5 above and, as feasible, other USAID-funded reproductive health activities implemented in DISH districts.

III. Definition of Success

A. Intended Results and EOPS Indicators

The amended project seeks to reduce fertility and the transmission of HIV in up to ten districts by increasing the availability and use of reproductive health services and the adoption of protective behaviors among men, women and adolescents. EOPS indicators are noted in the logframe (Annex A).

B. Monitoring and Evaluation Plan

Four mechanisms will be used to evaluate the project: service statistics, internal project monitoring systems, special studies, and a mid-term and final evaluation by external consultants. The first two of these mechanisms have been described in 3.2 above; the latter two are described below.

Special Studies

1. Record Reviews. In collaboration with District HIS Officers, service statistics from each district will be analyzed periodically to establish trends related to reproductive-health service delivery and compare the performance of individual facilities. Semi-annual client-card reviews will be conducted in a sample of facilities in each district to estimate:

- a. Method-specific FP continuation rates;
- b. CYP distributed by client age and parity;
- c. Catchment-area contraceptive prevalence, STI treatment and HIV testing/counselling rates;
- d. Compliance with syndromic STI diagnostic and treatment procedures;

- e. Prevalence of syphilis among ante-natal clients (RPR);
- e. Antenatal visits and deliveries in facilities as a percent of expected pregnancies; and
- f. The accuracy of routinely reported service statistics.

DHS, census or catchment-area-survey data (component 2.3) will be used to provide required denominators for these studies.

2. IE&C Studies. Increases in service utilization will be documented through service statistics (above). The effectiveness of mass-media and local IE&C campaigns in producing these changes will be assessed through interviews of new clients by staff in 21 facilities in seven districts. New clients will be questioned before, during and after campaigns on their exposure to IE&C messages and the influence of those messages on their decision to come to the facility.

In addition, pre-post campaign surveys will be conducted among specific target groups (e.g., youth) to assess the effects of campaigns in communicating messages and effecting behavior change.

3. Community surveys. Rapid, 30-cluster surveys will be conducted mid-project and EOP in four DISH³² districts and two neighboring non-DISH districts to estimate:

- a. Self-reported HIV risk-reduction and the proportion of the population perceiving that their three closest age and gender peers are practicing at least one HIV risk-reduction behavior;
- b. The proportion of respondents who used condoms during the last sexual contact of risk; the source of the condoms used; and the proportion of users who can demonstrate correct use, using a model;
- c. Prevalence of specific myths and misconceptions related to FP, STIs and HIV;
- d. Location of nearest source of FP, STI, HIV services;
- e. Reach, comprehension and effect of specific IE&C messages;
- f. Perceptions of staff attitudes and practices at local health units re reproductive health services, including condom promotion and providing STI services; and
- g. Depending on cost, changes in STI prevalence based on blood and urine examinations.

³²These four districts will be selected from among the seven where IE&C studies will be conducted.

Clusters will be located around health facilities with DISH trained providers and in communities participating in the community-services and behavior change components (2.3, 2.4). Portions of the interviews will be open-ended and focus-group discussions will be conducted before the survey for clarification of topics and questions and/or after data collection to validate results.

4. AIC Sero-conversion study. A longitudinal study will be conducted among AIC clients to validate earlier observations of behavior change subsequent to HIV testing, to see if the magnitude of such change has increased or decreased, and, especially, to assess the efficacy of counselling and testing in preventing the actual acquisition of HIV infection. The latter will involve the periodic re-testing of a sample of AIC clients over one to two years.

5. Demographic and Health Surveys (DHS). The principal source of population-based information, at baseline and EOP, will be the DHS, conducted in from May through July 1995 and , tentatively, July through September 1999. The DHS will sample 6,500 women and 2,500 men nationally, with sufficient enumeration areas in DISH districts to permit the disaggregation of data for groups of those districts. The DHS will collect, inter alia, data on fertility, contraceptive prevalence, pregnancy and breastfeeding, maternal health, marriage and sexual behavior, AIDS and STIs (including many of WHO/GPAs priority prevention indicators), and health-service availability. The DHS will be funded by G/PHN, not DISH.

Evaluation Officer. The studies described in , 2 and 3 above will be the responsibility of a full-time Project Evaluation Officer who will be hired locally by Pathfinder and report to Pathfinder's Chief of Party. This individual will routinely monitor the implementation of all project components and will possess the technical and managerial expertise needed to design and manage the implementation of the studies noted above, including analysis, write-up and dissemination and discussion of results. The Evaluation Officer will coordinate closely with the MOH's Commissioner for MCH/FP, USAID's STI advisor and USAID/s AIDS Advisor in the design and implementation of these studies.

These studies will be implemented by competitively selected local institutions contracted by Pathfinder and supervised by the Evaluation Officer. The Evaluation Officer will ensure that all original data (e.g., diskettes with raw data, focus group transcripts, etc.) are maintained in good order and that reports of all baseline and follow-up studies are compiled, bound and available at the DISH Office in Kampala.

STTA from CDC will be provided to design the AIC study, monitor implementation and assist the AIC to analyze the results. However, the Evaluation Officer will work closely with CDC advisors throughout this process and will be responsible for routine monitoring and technical assistance to AIC between CDC visits.

The Evaluation Officer will not be responsible for the DHS.

Mid-term and Final Evaluations. USAID will recruit external consultants through G/PHN's Poptech Project to conduct these evaluations in approximately March 1997 and March 1999 respectively. Scopes of work will be prepared based on needs which are apparent around those times. However, given the monitoring and evaluation activity noted above, it is expected that emphasis will be on:

- a. the effectiveness of overall project management in implementing and monitoring a wide range of activities and in achieving synergies among them;
- b. the review of project data, the methods of their collection, and their independent validation based primarily on field visits;
- c. at mid-term, the use of project data and field visits to estimate the likely impact of individual project components and recommend whether specific components should be cut back or expanded; and
- d. at EOP, a final assessment of project impact and recommendations for a possible project extension through FY 2002.

Background information and project-specific data will be sent to evaluation-team members for review prior to arrival in Uganda. Logistics pertaining to both evaluations will be handled by Pathfinder.

IV. Project Management and Procurement

DISH will be managed by the Mission's USDH PHN Officer. He will be assisted by an HIV/AIDS Advisor (PhD, seconded under a PASA with CDC) who will be posted at the AIC and will have specific responsibility for components 1.4, 1.5 and 2.4. A PSC STI Advisor (MD, MPH) will assist with all components related to STIs (1.2, 1.3, parts of 1.1), and an FSN public health advisor (MD, MPH) will be responsible for 1.6, 2.2 and 2.3. The FINCA grant (2.5) will be managed by an FSN Private Sector Project Specialist. An experienced FSN Project Management Specialist will assist with general administration, including financial monitoring and accruals, procurement (including contraceptives), and commodity management. Except for the USAID PHN Officer and the private-sector specialist, all the above staff will be funded under the project. They will be assisted part-time by one OE-funded Administrative Assistant and one Secretary.

In addition, Pathfinder will:

- a. Assist DISH-District Health Teams to develop annual plans, to be incorporated in district health plans, for implementing DISH activities, including activities to be implemented by NGOs;

- b. Prepare annual workplans and budgets for components 1.1, 2.3, 3.1, 3.2, and 3.3 and for all internal evaluation activity and submit these plans to USAID for approval by September 1 each year;
- c. Procure, per applicable USAID regulations, all USAID-funded commodities (e.g., computers, clinic equipment, lab supplies) required for the implementation of the project components noted in (b) above;
- d. Arrange for all training to be financed under the components noted in (b) above, including identifying candidates, preparing PIO/Ps, enrolling trainees, paying fees, assisting with securing passports and visas, providing air tickets and travel advances, and collecting any refunds due;
- e. Report in writing twice a year to USAID on the implementation of all project activities except component 2.5, per a schedule and in a format compatible with USAID's semi-annual portfolio reviews;
- f. Submit quarterly expenditure reports, by budget line-item, to USAID for the components noted in (b) above; and
- g. Coordinate with G/PHN Cooperating Agencies (e.g., AVSC, SEATS, JHPIEGO, CARE) to avoid conflicting or duplicative activities and to maximize synergy with DISH where possible.

A Chief of Party will manage Pathfinder's contract, including sub-contracts with CCP, INTRAH and E. Petrich. The COP will be assisted by two local Executive Officers plus secretarial and clerical staff. Administration and logistics related to the operation of the training sites in Luwero, Jinja, Masaka and Mbarara will be managed by a local firm hired by INTRAH. The Project Office will be in Kampala.

USAID will coordinate project implementation with the following MOH officers: the Assistant Commissioner for MCH/FP, the AIDS/STD Program Manager and the STI Project Manager. In addition to these officers, the Principal Secretary of the MOH and a representative of the Ministry of Finance and Economic Planning will have signatory authority for Project Implementation Letters and Project Implementation Orders. At the district level, USAID and implementing agencies will coordinate project planning, implementation and evaluation with District Medical Officers.

To enable USAID to meet unforeseen project expenditures, approximately \$20,000 will be reserved for USAID/Uganda's use. To enable Pathfinder to exploit unanticipated opportunities and to meet unforeseen expenses, about \$80,000 will be provided under Pathfinder's contract for additional training, special studies, conferences or other project related purposes. None of these funds will be expended without prior approval of USAID/Uganda.

Procurement. The authorized geographic code in the original PP was 935, and this is unchanged by this amendment. Except for household furnishings, official vehicles

and office equipment already purchased by USAID to initiate project activities, most DISH-funded procurement will be done by the implementing agencies themselves.

Because there are no spare parts and service capabilities in Uganda for U.S. manufactured vehicles, DISH will finance non-U.S. vehicles for which spare parts and service are available locally, as authorized in the original PP. If, during the course of the project, spare parts and service capabilities become available for U.S.-manufactured vehicles required by the project, such U.S. vehicles will be purchased. In addition to vehicles purchased by USAID for Pathfinder's use in project startup and the 10 district vehicles noted in 1.1 above, Pathfinder will procure 4 vehicles for use by training teams in Luwero and Masaka (2), for office use in Kampala (1 sedan) and for use by Kampala based technical staff (1).

V. Analysis of Feasibility, Key Assumptions, and Related Risks

The original PP contains extensive material relating to feasibility. This section analyses the feasibility only of substantially revised or new interventions.

A. Improved facility-based reproductive health services

The principal substantive revision in this component is the expanded emphasis on men and youth. Ministry of Health morbidity and mortality statistics (Uganda Medical Bulletin, Jan-Apr 1994) show that persons 5-15 years old constitute approximately 1/6 of all clients treated for syphilis and 1/5 of all clients treated for gonorrhoea as outpatients. Similarly, the 5-15 age group were about 1/5 of total outpatients. This information is not dis-aggregated further by age (e.g., 11-15) or sex, and all persons over 16 are aggregated.

Another new emphasis is FP and STD services for people with AIDS. Current Uganda data (Miro and Marum) suggest that pregnancy accelerates the progression of HIV disease in asymptomatic seropositive women by about 50% - a drastic risk for the women and for their children who are at greater risk of becoming orphans when still young. Thus, greater attention is warranted for family planning where one or more of the partners is seropositive. A 1995 evaluation of TASO found that safer sexual practices were discussed in 80% of observed counselling sessions. This indicates that TASO and similar organizations can expand its role in preventing secondary HIV infection, other STIs, and unwanted pregnancy.

B. Community Reproductive Health Services

The principal new activity is the community behavior-change component (2.4). This strategy has been widely implemented by CDC in the United States, and has been found highly effective in stimulating community planning and implementation of HIV-prevention activities. USAID/Uganda has funded community HIV prevention activities since 1989 with measurable changes in knowledge, risk perception,

reported behavior change, and condom use.

Several NGOs have substantial Uganda experience which could enable them to implement this component, e.g., AMREF, CARE, Pathfinder, and World Learning, Inc. GOU policy is to collaborate with NGOs in the provision of social services (see White Paper on Health, 1993; Three Year Health Plan, 1993). A review of health projects, including AIDS projects, reveals a number of potential partner NGOs and other agencies already operating in one or more of the DISH districts; at least 20 groups probably meet the general criteria for implementing NGO grantee.

VI. Financial Plan

The original and amended project budgets are noted below, by the budget elements in the PROAG. These amounts represent USAID's contribution only; the normal 25% GOU contribution to the project was waived in the original PP.

BUDGET ELEMENT	ORIGINAL TOTAL	NEW TOTAL
Technical Assistance	15,262,542	12,560,973
Sub-Grants	7,626,368	0
Implementation Costs	0	12,351,978
Commodities	888,502	3,230,221
Project Management	1,017,587	10,480,662
Evaluation	80,000	1,257,300
Audit	125,000	118,866
TOTAL ³³	\$25,000,000	40,000,000

The budget element for "Sub-Grants" has been replaced by "Implementation Costs" in the interest of a more accurate categorization. Sub-grants to NGO's included costs applicable to all other budget elements, and aggregating all these elements for three sub-grants (AMREF, AIC, TASO) artificially lowers the amounts in the other

³³New total does not sum precisely due to rounding.

budget elements. Similarly, technical assistance formerly included most costs associated with the Pathfinder TA contract and with other implementation agreements. Many of these costs are more properly classified as costs of implementing the project rather than providing TA, making TA artificially high. In addition, a more rigorous classification of costs has been applied in this amendment across all budget elements³⁴. (These changes in how costs have been allocated among budget elements severely limits the validity of element-by-element comparison of the old and new budgets to ascertain where estimated costs have actually increased or decreased.)

The total of \$40,000,000 above represents Mission funding only. An additional \$4,364,775³⁵ will be needed from G/PHN's field-support budget over the LOP to augment Mission funding for components 1.1, 1.6, 2.3 and 3.1. G/PHN will provide these funds to INTRAH, CCP, Pathfinder and AVSC through existing G/PHN projects with these agencies. Full implementation of the activities noted under these components is contingent upon receipt of these funds by these agencies.

The amended multi-year budget, including G/PHN funds, and an obligation schedule follow below. Budgets for individual project components and implementing agencies are attached as Annex B.

³⁴Technical assistance costs include all expenses associated with resident expatriate and local technical staff and short-term consultants including salaries, differentials, COLAs and benefits; medical exams; housing and related costs; local and international travel; R&R and home leave; education allowance; shipment of household effects, consumables and POVs; storage of household effects; relocation costs for local staff; residential furniture for expatriate staff; official vehicles; central and branch-office rent and maintenance; and computers used by technical advisors. This includes DISH-funded salaries and allowances for USAID's HIV/AIDS and STI Advisors.

Implementation costs include all training costs exclusive of commodities; meetings, seminars, etc.; designing and distributing educational materials and designing and implementing mass-media activities; SOMARC distribution and marketing costs, including costs of the DISH-district sales staff; clinic renovations; and all costs incurred by districts or the MOH which are paid with project funds (e.g., supervision, fuel).

Commodity costs include the costs of all commodities purchased for use by health staff, e.g., clinic equipment, vehicles for district-health-team supervision, computers for districts, IE&C equipment, costs of purchasing or producing IE&C materials.

Project Management Costs include contractor/grantee home/regional office costs; indirect costs and fees; general-administration costs, including vehicle operation; CDC overhead and administrative costs; all costs associated with non-technical staff; all office furniture, equipment and supplies, except computers used by technical staff; and costs incurred by USAID for the two FSN staff noted in V above.

Evaluation costs include all costs associated with routine project evaluations, special evaluation studies, and Pathfinder's Evaluation Officer.

Audit costs include the cost of external audits of AMREF, FINCA, TASO and AIC. (Pathfinder and SOMARC are audited in the U.S, and these coats are included in their indirect costs.)

³⁵\$364,775 of this amount has already been received by Pathfinder and CCP (FY95 funds).

ESTIMATED MULTI-YEAR BUDGET

	FY 95 ³⁶	FY 96	FY 97	FY 98	FY 99	TOTAL
Technical Assistance	2,625,199	2,501,752	2,718,597	2,495,931	2,219,494	12,560,973
Implementation Costs	852,155	2,964,292	3,082,824	3,125,049	2,327,658	12,351,978
Commodities	796,436	808,003	635,736	472,189	517,857	3,230,221
Project Management	1,920,054	2,280,004	2,225,368	2,167,124	1,888,112	10,480,662
Evaluation	1,000	152,400	445,000	158,900	500,000	1,257,300
Audit	13,280	13,325	27,372	27,420	37,469	118,866
Mission Total	6,208,124	8,719,776	9,134,897	8,446,613	7,490,590	40,000,000
Ex-G	364,775	1,000,000	1,000,000	1,000,000	1,000,000	4,364,775
PROJECT TOTAL	6,572,899	9,719,776	10,134,897	9,446,613	8,490,590	44,364,775

OBLIGATION SCHEDULE

	FY 95	FY 96	FY 97	FY 98	TOTAL
Mission	14,927,900	9,134,897	8,446,613	7,490,590	40,000,000
Ex-G	364,775	2,000,000	1,000,000	1,000,000	4,364,775

³⁶Includes a small amount of FY 94 start-up costs.

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ANNEX A: Logical Framework

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p>OBJECT GOAL:</p> <p>reduce unwanted fertility and the transmission of HIV in 10 districts</p>	<p>MEASURES OF GOAL ACHIEVEMENTS:</p> <p>G.1 Total Fertility Rate decreases³⁷. G.2 HIV prevalence among 15-19 year old females at sentinel surveillance sites declines by 5%. G.3 Syphilis prevalence decreases by 5% at selected facilities.</p>	<p>G.1. DHS:1995, 1999 G.2. MOH Sentinel surveillance data G.3. Record reviews (RPR)</p>	
<p>OBJECT PURPOSE:</p> <p>increase the use of FP and maternal-health services, the accurate diagnosis and effective treatment of common STIs, and the prevalence of behaviors which constrain transmission of HIV and other STIs</p>	<p>EOPS³⁸:</p> <p>P.1. Prevalence of modern contraception among women 15-49 P.2. 30% increase in antenatal visits, facility deliveries, STI treatments per algorithms in facilities with trained staff P.3. % increase in condom use in most recent sexual contact of risk P.4. % perceiving that their three closest peers are practicing at least one risk reduction behavior</p>	<p>P.1, 2. DHS: 1995, 1999 P.2. Service statistics, record reviews, supervision P.3, 4. Baseline, mid-term, EOP surveys in selected districts</p>	<p>P.1. 1999 DHS has needed AIDS data, occurs within 6 months of EOP</p>

³⁷ Magnitude of decrease in TFR to be determined based on final results of 1995 DHS.

³⁸ Levels to be determined after '95 DHS and baseline surveys

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p>INPUTS:</p> <p>Improved facility-based reproductive-health services</p> <p>Activities:</p> <p>1. Train, supervise 850 nurses and midwives; renovated, equip 80 facilities.</p> <p>2. Train, supervise 450 physicians, medical assistants STI diagnosis and treatment</p> <p>3. Train 200 lab personnel to perform tests re maternal health</p> <p>4. Establish STD reference laboratory.</p> <p>5. Expand provision of HIV counseling and testing services.</p> <p>6. Increase STI-prevention, family-planning and counselling services for HIV + people</p>	<p>1.1. 80% of trainees (all categories) performing clinical and counselling functions satisfactorily</p> <p>1.2. 95% of upgraded units have functional RH equipment in place after 3 years and at EOP.</p> <p>1.3. 90% of facilities with trained staff delivering integrated RH services (N/MWs) or STD services (MDs/MAs) daily.</p> <p>1.4. HIV counseling and testing routinely available in at least three locations in each DISH district</p> <p>1.5 75% of clients of AIDS-support organizations receive FP and STD services, including counselling</p>	<p>1.1. Training-Supervision data base</p> <p>1.2. End-use checks</p> <p>1.3. Supervision data base</p> <p>1.4. Supervision</p> <p>1.5. Client records</p>	<p>1.2 MOH MIS format approved</p> <p>1.3 STI provides adequate supplies of STD antibiotics in DISH districts.</p>

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Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p>2. Improved community-based reproductive health services</p> <p>Activities:</p> <p>2.a. Train 650 TBAs.</p> <p>2.b. Expand community based reproductive health services.</p> <p>2.c. Expand social marketing of contraceptives; initiate social marketing of antibiotics.</p> <p>2.d. Initiate community programs to change behaviors, norms related to STI/HIV.</p> <p>2.e. Initiate poverty alleviation program for women/children in 5 districts.</p>	<p>2.1. 80% of TBAs perform satisfactorily</p> <p>2.2. 180,000 referrals to clinics by CRHWs for injectibles, IUD, Norplant and VSC; 225,000 new FP acceptors</p> <p>2.3. 2,000 fixed outlets in DISH districts selling SOMARC condoms and/or orals.</p> <p>2.4. 90% of CRHWs and other appropriate NGO/CBO staff demonstrate correct condom use with a model</p> <p>2.5. 50% of STD clients at participating drug shops receive appropriate advice on drug use.</p> <p>2.6. Indicator(s) for 2.d to be determined based on specific activities in community HIV program</p> <p>2.7. FINCA recovering all operating costs by EOP</p> <p>2.8. 311 village banks established with 8,397 members, a loan portfolio of \$2,400,000 and deposits of \$827,000</p> <p>2.9. Contraceptive prevalence, HIV risk-reduction among bank members</p>	<p>2.1. Supervision records</p> <p>2.2. NGO and facility records</p> <p>2.3 . SOMARC records</p> <p>2.4. Supervision records</p> <p>2.5. Phantom clients</p> <p>2.6. To be determined</p> <p>2.5. Project records</p> <p>2.8. Project records</p> <p>2.9. Surveys by FINCA</p>	<p>2.5. GOU approves social marketing of STD drugs.</p>

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Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
<p>3. An institutional and community environment supportive of improved reproductive health</p> <p>Activities:</p> <p>3.a. Design, implement local, mass-media IE&C campaigns; produce IE&C materials</p> <p>3.b. Establish MIS and contraceptive logistics system</p> <p>3.c. Improve financial management and increase cost recovery among local implementing agencies</p>	<p>3.1. IE&C campaigns implemented; materials produced, distributed to, used in 90% of facilities with trained staff.</p> <p>3.2. 90% of facilities (incl NGOs) with trained staff routinely file accurate reports of service statistics</p> <p>3.3. Training, supervision and IE&C data bases established</p> <p>3.4. 80% of service sites operate without stockouts of FP commodities and STD antibiotics, previous six months,</p> <p>3.5. 75% of local implementing agencies collect and use performance monitoring data for project management by end FY97.</p> <p>3.6. 75% of health centers, dispensary/maternalities and dispensaries use standardized systems to account for receipts and expenditures; calculate costs and formulate budgets; set and allocate fees.</p>	<p>3.1 IE&C data base</p> <p>3.2 District records</p> <p>3.3 Data review</p> <p>3.4 District records</p> <p>3.5 Supervision; pre/post award assessments</p> <p>3.6 Supervision, district records</p>	

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ANNEX B: Detailed Budget by Project Component

	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
TRAINING NURSES, MIDWIVES						
Technical Assistance	308,904	264,154	211,469	229,795	180,732	1,195,054
Implementation Costs	32,922	555,999	276,362	277,772	201,619	1,344,674
Commodities	608,499	45,829	1,323	695	729	657,075
Project Management	227,748	382,858	315,253	328,004	305,645	1,559,508
Evaluation	0	0	0	0	0	0
Audit	0	0	0	0	0	0
Mission Total	1,178,072	1,248,840	804,407	836,266	688,726	4,756,311
EX-G (PRIME)	0	250,000	250,000	250,000	250,000	1,000,000
Sub-Total	1,178,072	1,498,840	1,054,407	1,086,266	938,726	5,756,311
STD TRAINING: DOCs, M.A.s; LAB						
Technical Assistance	123,776	110,177	103,108	108,288	83,967	529,316
Implementation Costs	117,617	242,181	227,683	221,125	164,370	972,976
Commodities	15,375	20,676	788	0	0	36,839
Project Management	170,517	195,881	197,528	197,277	88,860	850,063
Evaluation	0	8,550	0	8,550	0	17,100
Audit	1,710	1,744	1,779	1,815	1,852	8,900
Sub-Total	428,995	579,209	530,886	537,055	339,049	2,415,194
HIV TESTING AND COUNSELLING						
Technical Assistance	0	5,000	5,000	5,000	5,000	20,000
Implementation Costs	0	240,000	265,000	270,000	185,000	960,000
Commodities	0	460,000	475,000	450,000	500,000	1,885,000
Project Management	0	130,000	140,000	135,000	130,000	535,000
Evaluation	0	30,000	30,000	30,000	50,000	140,000
Audit	0	5,000	5,000	5,000	10,000	25,000
Sub-Total	0	870,000	920,000	895,000	880,000	3,565,000

HIV+ SUPPORT SERVICES						
Technical Assistance	0	10,000	15,000	20,000	20,000	65,000
Implementation Costs	0	237,000	475,000	490,000	445,000	1,647,000
Commodities	0	120,000	30,000	10,000	10,000	170,000
Project Management	0	70,000	90,000	90,000	90,000	340,000
Evaluation	0	30,000	10,000	10,000	50,000	100,000
Audit	0	5,000	5,000	5,000	10,000	25,000
Sub-Total	0	472,000	625,000	625,000	625,000	2,347,000
SURGICAL CONTRACEPTION						
Technical Assistance	80,000	0	0	0	0	298,284
Implementation Costs	130,000	0	0	0	0	438,400
Commodities	60,000	0	0	0	0	228,000
Project Management	50,000	0	0	0	0	323,316
Evaluation	0	0	0	0	0	0
Audit	10,000	0	0	0	0	42,000
Mission Total	330,000	0	0	0	0	330,000
EX-G (AVSC)	0	250,000	250,000	250,000	250,000	1,000,000
Sub-Total	330,000	250,000	250,000	250,000	250,000	1,330,000
TBA TRAINING						
Technical Assistance	35,750	18,520	20,188	22,020	24,031	120,509
Implementation Costs	45,257	81,668	68,358	70,886	55,697	321,866
Commodities	3,125	0	0	0	0	3,125
Project Management	56,541	53,169	51,701	51,501	53,509	266,421
Evaluation	0	2,850	0	2,850	0	5,700
Audit	570	581	593	605	617	2,966
Sub-Total	141,243	156,788	140,840	147,862	133,854	720,587
COMMUNITY R. H. PROGRAMS						
Technical Assistance	0	47,704	36,124	28,108	17,562	129,498
Implementation Costs	0	77,272	56,324	21,392	14,902	169,890
Commodities	0	95,582	24,625	8,994	4,628	133,829

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Project Management	0	209,936	41,794	44,051	7,652	303,433
Evaluation	0	0	0	0	0	0
Audit	0	0	0	0	0	0
Mission Total	0	430,494	158,867	102,545	44,744	736,650
EX-G	198,000	250,000	250,000	250,000	250,000	1,198,000
Sub-Total	198,000	680,494	408,867	352,545	294,744	1,934,650
SOCIAL MARKETING						
Technical Assistance	216,033	162,296	174,019	145,346	151,687	849,381
Implementation Costs	111,716	459,652	512,185	405,360	311,277	1,800,190
Commodities	0	0	0	0	0	0
Project Management	303,847	309,538	319,799	282,062	296,165	1,511,411
Evaluation	0	0	0	0	0	0
Audit	0	0	0	0	0	0
Sub-Total	631,596	931,486	1,006,003	832,768	759,129	4,160,982
COMMUNITY HIV PREVENT.						
Technical Assistance	0	150,000	165,000	181,500	199,650	696,150
Implementation Costs	0	308,385	408,500	808,500	708,500	2,233,885
Commodities	0	0	0	0	0	0
Project Management	0	122,096	153,375	262,500	243,288	781,259
Evaluation	0	30,000	30,000	50,000	50,000	160,000
Audit	0	0	10,000	10,000	15,000	35,000
Sub-Total	0	610,481	766,875	1,312,500	1,216,438	3,906,294
ECONOMIC STATUSOF WOMEN						
Technical Assistance	99,566	168,147	143,110	77,730	0	488,553
Implementation Costs	107,725	203,779	270,729	77,135	0	659,368
Commodities	27,500	11,500	4,000	0	0	43,000
Project Management	132,501	241,724	244,188	144,166	0	762,579
Evaluation	1,000	1,000	25,000	7,500	0	34,500
Audit	1,000	1,000	5,000	5,000	0	12,000
Sub-Total	369,292	627,150	692,027	311,531	0	2,000,000

IE&C						
Technical Assistance	254,951	169,579	286,305	278,654	76,497	1,065,986
Implementation Costs	205,891	327,856	423,898	423,249	181,431	1,562,325
Commodities	19,250	50,000	100,000	2,500	2,500	174,250
Project Management	256,437	151,912	261,095	214,842	230,373	1,114,659
Evaluation	0	0	0	0	0	0
Audit	0	0	0	0	0	0
Mission Total	736,529	699,347	1,071,298	919,245	490,801	3,917,220
EX-G (PCS)	166,775	250,000	250,000	250,000	250,000	1,166,775
Sub-Total	903,304	949,347	1,321,298	1,169,245	740,801	5,083,995
MIS and LOGISTICS						
Technical Assistance	144,725	276,253	251,539	254,937	261,678	1,189,132
Implementation Costs	1,000	165,900	41,580	2,315	2,431	213,226
Commodities	62,687	4,416	0	0	0	67,103
Project Management	123,506	127,578	121,100	125,614	130,357	628,155
Evaluation	0	50,000	150,000	50,000	150,000	400,000
Audit	0	0	0	0	0	0
Sub-Total	331,918	624,147	564,219	432,866	544,466	2,497,616
COST RECOVERY						
Technical Assistance	226,747	237,554	240,980	247,835	284,501	1,237,617
Implementation Costs	1,000	39,600	32,205	32,315	32,431	137,551
Commodities	0	0	0	0	0	0
Project Management	214,377	229,138	226,135	237,107	254,463	1,161,220
Evaluation	0	0	0	0	0	0
Audit	0	0	0	0	0	0
Sub-Total	442,124	506,292	499,320	517,258	571,395	2,536,389
MISC. PATH. EXP.						
Implementation	0	20,000	20,000	20,000	20,000	80,000
USAID COSTS						
Technical Assistance	1,134,748	882,368	1,066,755	896,718	914,189	4,894,777
Implementation Costs	99,027	5,000	5,000	5,000	5,000	119,027

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Commodities	0	0	0	0	0	0
Project Management	384,580	56,174	63,400	55,000	57,800	616,954
Evaluation	0	0	200,000	0	200,000	400,000
Audit	0	0	0	0	0	0
Sub-Total	1,618,355	943,542	1,335,155	956,718	1,176,989	6,030,758
TOTALS						
Technical Assistance	2,625,199	2,501,752	2,718,597	2,495,931	2,219,494	12,560,973
Implementation Costs	852,155	2,964,292	3,082,824	3,125,049	2,327,658	12,351,978
Commodities	796,436	808,003	635,736	472,189	517,857	3,230,221
Project Management	1,920,054	2,280,004	2,225,368	2,167,124	1,888,112	10,480,662
Evaluation	1,000	152,400	445,000	158,900	500,000	1,257,300
Audit	13,280	13,325	27,372	27,420	37,469	118,866
Mission Total	6,208,124	8,719,776	9,134,897	8,446,613	7,490,590	40,000,000
Ex-G	364,775	1,000,000	1,000,000	1,000,000	1,000,000	4,364,775
PROJECT TOTAL	6,572,899	9,719,776	10,134,897	9,446,613	8,490,590	44,364,775

ANNEX C: Mission Budget by Implementing Agency

Pathfinder Contract	2,688,643	3,098,626	2,959,244	2,725,634	2,315,388	13,787,535
Pathfinder CA	0	430,494	158,867	102,545	44,744	736,650
SOMARC	631,596	931,486	1,006,003	832,768	759,129	4,160,982
AMREF	570,238	735,997	671,726	684,917	472,903	3,135,781
AIC	0	870,000	920,000	895,000	880,000	3,565,000
TASO	0	472,000	625,000	625,000	625,000	2,347,000
Grantee X	0	610,481	766,875	1,312,500	1,216,438	3,906,294
FINCA/UWESO	369,292	627,150	692,027	311,531	0	2,000,000
AVSC	330,000	0	0	0	0	330,000
USAID	\$1,618,355	\$943,542	\$1,335,155	\$956,718	\$1,176,989	\$6,030,758
TOTAL	\$6,208,124	\$8,719,776	\$9,134,897	\$8,446,613	\$7,490,590	\$40,000,000