ACCESS
Access to SRH Information, Education and Services to Marginalized / Underserved Groups

IPPF Goal & Objective

All poor marginalized and underserved people in South Asia are able to exercise their rights and have access to SRH information, sexuality education and quality services including family planning.

FPAN Strategic Direction

Increase access to information, education and services on population, environment and SRH focusing to the poor, marginalized and socially excluded people, including Dalits, ethnic minority, indigenous groups, differently able people, internally displaced people, adolescent/young people, women and men through expanding gender sensitive and environment friendly education and services in underserved urban and rural settings.

FPAN Goal

Enable people in general, particularly the poor, marginalized, the socially-excluded and ensure that the underserved are able to exercise their rights to make free and informed choices about sexual and reproductive health, access to population, environment and SRH information, and high quality SRH services, including family planning

FPAN Objective

- To increase access to gender sensitive SRH information and services, including family planning services to the poor and marginalized people in underserved urban and rural area in FPAN's program districts
- To empower women to exercise their choices and rights in regard to their sexual and reproductive lives
- To increase access to information and education on environmental health

Project Title	**:**	**Access to SRH Information, Education and Services to Marginalized / Underserved Groups**
Project Duration	**:**	**1st January 2004 – on going**
Project No.	**:**	**2052004002**
Project Location	:	**31 Districts of 30 branches/projects** Baglung, Banke, Bardia, Baitadi, Chitwan, Dailekh, Dhankuta, Dhanusha, Dang, Doti, Illam, Jhapa, Kailali, Kanchanpur, Kaski, Kavre, Kapilbastu, Makwanpur, Morang, Mahottari,Nawalparasi, Palpa, Rupandehi, Sunsari, Sarlahi, Saptari, Surkhet, Tanahu, Valley (Bhaktapur, Lalitpur, Kathmandu).
Beneficiaries	**:**	**Women, men and youth of marginalized and underserved groups**

Summary

The project aims at increasing availability of gender sensitive SRH information & services including family planning in rural and underserved areas of Nepal especially for poor, marginalized, the socially excluded and other underserved people. The project will be implemented in 31 districts of 28 branches/projects with the support of IPPF core fund and other donor agencies (Aus-aid, World Bank and USAID) in 2014. SRH information and services including family planning will be provided to the clients through static clinics (FHC and community clinics) established at fixed strategic location, mobile outreach clinics and mobile VSC camps in rural area for increasing access of SRH information and services to marginalized and underserved people. Awareness program will be implemented using different mass media. Reproductive Health Female Volunteers (RHFVs) and Peer Educators(PE) will be key communicators of SRH information to community people at grass-roots level. The RHFVs and PEs will visits at the doorsteps of community people regularly for SRH counselling, contraceptive distribution, screening eclampsia and follow-up services. Side by side they will also refer the potential clients seeking long acting FP methods, safe abortion and other SRH services at appropriate service sites.

This program will provide family planning services, Gynaecological & Obstetric services, GBV counselling & services, SRH services including infertility, counselling and testing on cervical cancer, sexuality counselling, other medical services and re-canalization. FP/SRH training and orientation will also be provided to service providers and other support staff of FPAN and Government health staff.

The access focal point of FPAN, under the direct supervision of the Program Director will be responsible to implement the program activities with other supporting staff at central office and district branch manager and project coordinators.

Justification

Social inclusion of ethnic minorities in mainstream development in general and increasing access to and utilization of existing FP/SRH services by these minority groups in particular is one of the major concerns in health sector development in Nepal. 2001 population census has listed 103 ethnic groups in Nepal. Out of them National Ethnic Minority Development Committee of Nepal has listed 65 ethnic groups as deprived and socially excluded. Basic literacy and overall health status of some indigenous ethnic minority groups, including Magar, Tharu, Tamang, Damai, Sarki, Teli, Harijan, Koiri, Kurmi, Mushar, Sherpa, Kumal, Rajbansi, Lohar, Majhi, Dhobi, Chepang, Raute, Dhimal, Gaine, Meche, Lepcha, Hayau, Kusunda etc is relatively low compared with other so called higher caste groups. These socially excluded minority ethnic groups are difficult to reach because they stay in scattered location across the country. Targeted intervention among these minority groups has been a national need for increasing access of FP/SRH information and services among these socially excluded groups. Besides, economic marginalization of people is widespread across all ethnic groups particularly in rural area of Nepal. The poor people particularly live in mountain hill slopes and rely on subsistence farm economy in the hills and mountain ecological region. Whereas these groups live either in small patch of their own land or public land in Terai ecological region and rely on share cropping and farm wage labour for their subsistence. The migrant urban poor live in slum area and they have no access of safe drinking water, drainage, sanitation and health services. Their living condition is pity and increases their vulnerability to disease. Reaching with such socially excluded and economically marginalized people for increasing access of SRH information and services is a challenge to Nepalese GO,I/NGO and external development partners[1].

[1]Ministry of Health and Population 2007, Population Report 2007

Demographic and Health Survey 2006 reveals the maternal mortality ratio has declined significantly from 539 (deaths per 100,000 live births) in 1996 to 281 in 2006[2]. However, such significant decline reported in the survey is questioned by many independent experts during the decade long conflict and insurgency in the country. Though there is a declining trend, the existing level of MMR is still high compared to developed countries[3]. Significant proportion (18.9%) of maternal deaths occurs in adolescent age group and there is also high prevalence of chronic energy deficiency among adolescent girls. Most of the teenage mothers die due to complication during childbirth[4]. In Nepal, the most common causes of maternal deaths are haemorrhage, sepsis, toxaemia, obstructed labour and septic abortion[5]. Besides, majority (78%) of women deliver baby at home and the trained birth attendants (nurse or doctor) assist only 19 percent deliveries[6]. Ongoing practice of unsafe abortion in rural area of Nepal due to inadequate access of safe abortion service centre is another factor contributing to high MMR despite liberalization of abortion law in 2002.

Long labour pain during delivery at home and non-availability of assistance from skilled birth attendance has lead to high uterine prolapsed in Nepal. The SRH Morbidity Study indicates 10 percent women have uterine prolapsed problems where as the DHS Survey 2006 indicates 7 percent women have such problem. There is little discrepancy in data though this is a serious problem in improving the SRH status of women in Nepal. Uterine prolapsed is considered as major cause of maternal morbidity among women in Nepal. The UNFPA Nepal estimates that there are around 600,000 women with uterine prolapsed in Nepal[7].

According to the report of Demographic and Health Survey 2011, the total fertility rate per Nepalese woman aged 15-49 declined from 3.1 in 2006 to 2.6 in 2011[8]. However, this is still high compared with other countries in South Asia Region. Besides, the chance of bearing the pregnancy related complications is very high in Nepal as the women undergo multiple pregnancies within short time period.

The knowledge of at least one modern method of family planning among the women at reproductive age is almost universal in Nepal. 43% women are using modern method of contraception and the unmet need of family planning is 27% [9]. Similarly, high son preference has extra pressure for the women giving birth to daughters only increasing the chance of her husband to marry another woman.

The estimated number of people living below the absolute poverty line (earning less than US$ 1 per day) was 38% in 2000[10] which declined to 31 percent in 2005[11]. However, marginalisation and deprivation of people based on access to and utilisation of sexual & reproductive health information, services and rights is not estimated at large scale. A mini survey on SRH entitlement conducted by FPAN in one VDC and municipal ward reveals three fifth of women are deprived from basic SRH information and services[12]. This has given large scope for NGO and civil society organization to work in SRH field in order to increase access of SRH information and services to marginalized people.

[2]Ministry of Health and Population, DHS Nepal
[3]DHS Ibid
[4]Ministry of Health 1998, Morbidity study in Nepal
[5]WHO/FHI/MBP 1991
[6]DHS Ibid
[7]UNFPA, 2006 cited in DHS 2006
[8] DHS 2011, Preliminary Report
[9]DHS 2011
[10]National Planning Commission 2002
[11]Government of Nepal 2005, MDG+5Review Report of Nepal
[12]FPAN 2007, Entitlement Index Survey Draft Report

The government of Nepal established one Health Post/Sub-health Post in each Village Development Committee (VDC) and Health Post in selected strategic locations, one Primary Health Care Centre in each electoral constituency of the parliament and at least one hospital in each district. However, these health facilities could not provide expected health services to the clients due to HRH problems in MoHP. Besides, these general health facilities, the government does not have any specifically focussed health programmes for underserved and marginalized groups and ethnic minorities. The service centres are not in accessible locations in remote rural areas and people have to walk a long distance to reach there. The health facilities are located in fixed places and the community people requiring SRH services need to spend quiet long time to visit service sites. Particularly for women who hardly get time from the never ending household chores, it's a luxury to get out of the home for availing health services unless they are severely sick. Community is also not educated and sensitized enough about the benefits of these SRH services. That is why health services available in limited scale are also highly underutilized. More sensitive groups like adolescents and youth, particularly unmarried ones and girls are hardly found to visit such facilities due to lack of youth friendly services, stigma and shame. Service providers are also not well trained on how they should be dealing with these highly vulnerable groups. Inadequate outreach programs for information dissemination and education have lowered service seeking behaviour specifically among the poor and marginalized people. In this context, there is a tremendous need for a focused program for marginalized, under served and ethnic minority groups in rural areas of Nepal in order to increase their access to SRH information and services and to protect their SRH rights.

Purpose of the Project

To increase availability of gender sensitive SRH information & services including family planning services in urban and rural setting of FPAN operational areas

Expected Results/Output

1. **Increased access to sexual and reproductive health services by 57% from 1,936938 in 2012 to 3,395135 in 2014 and FP services by 61% from 1139377 in 2012 to 1865444 in 2014 through various service delivery points**

    1. Increased access to quality SRH services by strengthening quality assurance system through self-assessment, upgrading knowledge& skills of service providers through internal assessment, monthly QoC meetings, QAS action plan & budget within the organization

    2. Increased male client visiting FPAN service delivery points for sexual & reproductive health services to 15000 in 2014

    3. Increased male commitment to sexual and reproductive health

    4. Increased understanding on the concept of comprehensive sexuality and IPPF Declaration of Sexual Rights among service providers as well as community people

    5. Increased access to counselling services on sexual and gender based violence to women by 277% from 38,918 in 2012 to 1,08,056 in 2014 through various service delivery points established at district level and mobilization of community groups including reproductive health female volunteers.

Implementation/Activities

Result 1 Increased access to sexual and reproductive health services by 57% from 1,936938 in 2012 to 3,395135 in 2014 and FP services by 61% from 1139377 in 2012 to 1865444 in 2014 through various service delivery points

SRH services through Clinical Service Delivery Points (SDPs)

Family Planning Association of Nepal has been providing SRHR services from the following various service delivery point to achieve the objective one.

1. Family Health Center
2. Community Health Clinics
3. Mobile Out- reach Clinics
4. Associated clinics
5. Community Based Distributors (RHFVs & PEs)

1.) **Family Health Clinic (FHC)** doctor based static clinic: Currently, FPAN has 22 family health clinics. FHC comprises of medical doctor, staff nurse, ANM, counsellor, lab technician, male HA/AHW, health aid, clinic helper who have been trained on their role on Integrated Package of Essential Services (IPES) including all FP methods. Each of the FHC provides eight by eight (8/8) essential SRH services. Some family health clinics provide more than IPES. IPES services includes following services

a. Sexuality counselling, Relationship counselling, Life skill counselling
b. Contraceptives (counselling, male and female condoms, OCPs, ECs, Injectable, IUDs, Implants, VSCs) and recanalization
c. Safe abortion care (Pre and post abortion counseling, MA/MVA, Post abortion Contraceptives, Post Abortion Care)
d. Reproductive tract infections/sexually transmitted infections (RTIs/STIs) management (Syndromic and etiological)
e. HIV (prevention counseling, Voluntary Counseling and Testing, PMTCT, psycho-social support, BCC)
f. Gynaecology (Breast and cervical cancer screening, Pelvic examination, Uterine prolapse)
g. Prenatal and postnatal care, Safe delivery services
h. Sexual and gender-based violence (Screening, Counseling and Psycho-social support)

Other services

i. Pediatric services
j. Non SRH services (General check-up)
k. Delivery services

Family health clinics are located in both urban and rural areas. The service users in the family health clinics have diverse socio-demographic and socio-economic background, i.e. different groups of people come to the family health clinics to get services. The FHC has provision (MOU) of referral with government and private hospitals/medical colleges for additional services.

2.) **Community Clinics** (CCs) paramedics/nurses based static clinic: FPAN has 112 community clinics. CC comprises of staff nurse, ANM, and community counsellor who have been trained on their role on IPES including all FP methods. The community clinic offers 6/8 integrated package of essential services as follows:

a. Sexuality counselling, Relationship counselling, Life skill counselling
b. Contraceptives (counselling, male and female condoms, OCPs, ECs, injectables, IUDs, Implants)

c. Safe abortion care (Pre and post abortion counseling, MA, Post abortion Contraceptives) or HIV (prevention counseling, Voluntary Counseling and Testing, PMTCT, psycho-social support, BCC)
d. Reproductive tract infections/sexually transmitted infections (RTIs/STIs) (Syndromic)
e. Prenatal and postnatal care
f. Sexual and gender-based violence (Screening, Counseling and Psycho-social support)

Other services

g. Pediatric services
h. Non SRH services (General check-up)
i. Safe Delivery services

The community clinic is located in a semi urban or rural area at a distance of 5 kilometres to more than 100 kilometers with an average of approximately 40-50 kilometres from main cities. These clinics focus on poor, marginalized, under served and socially excluded people. Generally, community clinics refer service users to nearest FHC or district hospitals or medical colleges for comprehensive SRH services.

3.A) Mobile outreach clinic (doctor based): A team of service providers including medical doctors is responsible to provide modern methods of family planning services including permanent methods, long acting reversible contraception and short time contraception. Besides, FPAN also provides counselling, STI, gynaecological and other health services through the mobile clinics. The mobile clinics focus to PMSEU population. For further services the service users are referred to nearest FHC or district hospital or medical college.

3.B) **Mobile outreach clinic (paramedics/nurses based mobile clinic)**: The nurse or paramedical staff provides IPES 6 by 8 SRH services focusing on LARC to PMSEU people. For additional services, the service providers refer the clients to nearest FHC or district hospital.

4) Associated Clinic (paramedics/nurses based static clinic): FPAN supports 75 community based organizations (CBO) to provide FP/RH services to community people in project areas. The CBO has full time or part time health service providers who provide services. Mostly, the CBO provides condom, oral contraceptive pills, injectables and some provides LARC and SRH counselling and health education. FPAN provides technical services to the CBOs for strengthening their institutional capacity. It is a good example of social franchising. Generally, the associated clinics refer service users to nearest FHC or district hospitals for further services.

5.) CBD (RHFVs/ PEs, YIC, SIC): A total of 527 Reproductive Health Female Volunteers (RHFV), 252 Peer Educators trained on FP/SRH, 88 Youth Information Centres, 51 School Information Centres are providing Family planning and Counselling services.

All service centres will provide following amount of SRHR services to the men, women and youth of the operational areas of FPAN.

Services			
Oral Contraceptives COC&POC	**2012**	**2014**	Change %
Contraceptives - Oral Contraceptives - COC & POC - OTHER	310069	428075	138
Contraceptives - Progestogen Only Injectables (3 months) - OTHER	192850	261032	135
Contraceptives - Subdermal Implants - Removal	933	990	106
Contraceptives - Subdermal implants 2 rods - OTHER	4121	3460	84
Contraceptives - Condoms - Male Condom - OTHER	345229	469236	136
Contraceptives - Condoms - Female Condom - OTHER	199	2465	1239
Contraceptives - IUD - Removal	570	828	145
Contraceptives - IUD (10 years) - Initial Consultation/Insertion	2895	5437	188
Contraception Surgical - Female VSC - OTHER	1786	394	22
Contraception Surgical - Male VSC - OTHER	889	1008	113
Contraception - FP General Counselling	197323	545306	276
EC - Counselling	80455	145081	180
EC - Combined Oral Contraceptives - Yuzpe - Contraceptive Supply (Treatment)		637	
EC Progestogen Only Pills - Contraceptive Supply (Treatment)	2045	1493	73
EC Copper releasing IUD - DIU Insertion (Treatment)	13	2	15
SRH - Contraception Total :	**1139377**	**1865444**	164
Gynaecological Diagnostic Imaging - OTHER	29607	42569	144
Gynaecological Exam - Manual Breast Exam	4909	15754	321
Gynaecological Exam - Cervical cancer screening (Pap smear)	72	49	68
Gynaecological Exam - OTHER	195330	280089	143
Gynaecological Lab Test - OTHER	18376	36326	198
Gynaecological Counselling - OTHER		17010	
Obstetrics - Pre natal Care - OTHER	84426	153680	182
Obstetrics - Pre natal Counselling - Pre Natal Care Info	62149	146651	236
Obstetrics - Pre natal Counselling - Unplanned Pregnancy	36146	71390	198
Obstetrics - Pregnancy Tests - OTHER	12047	20381	169
Obstetrics - Child Birth, Vaginal Delivery	1996	2956	148
Obstetrics - Post natal Care - Consultation	16750	34523	206
Obstetrics - Post natal Care - OTHER	1531	2463	161
Obstetrics - Post-Natal Counselling - Breastfeeding Advice	53776	119429	222
Obstetrics - Post-Natal Counselling - OTHER	79473	223336	281
Infertility Lab Test - OTHER	391	643	164
Infertility Treatment - OTHER	1676	2912	174
Infertility/Subfertility Counselling	19659	61226	311
Counselling - GBV - Screening Only	13101	32769	250
Counselling - GBV - OTHER	13418	61857	461
Counselling - Domestic Violence - OTHER	12399	13430	108
Counselling - Other - Sexuality Issues (25 years and over)	10701	19230	180
Counselling - OTHER	81117	108627	134
Other SRH medical services - OTHER	48551	62391	129
SRH Non Contraception Total :	**1546778**	**1529691**	99
Paediatrics - Consultation	22000	21735	99
Paediatrics - Therapy / Treatment - Immunization	66619	79160	119

- Half-yearly meeting with DHO will be organized to share findings of the program and seek support from DHO on Family planning methods, health personnel to run the mobile and out- reach program including SGBV.
- Monthly meeting will be organised at all branch to review the achievement of each service delivery points including QOC matter and branch manager will discuss about future direction to achieve the expected results.
- Immunization services will be provided to mother & child through all Family health Centre in collaboration with District Health Office.

Partnership

- Strengthen referral linkage and partnerships with SRH service providers e.g. health centres, private chemists and druggists, private practitioners and NGOs working in the field of RH for community mobilisation.
- Sign MoUs with identified partner agencies at national, district and local level for referral services from FPAN to other partners and from other partners to FPAN and establish proper follow-up mechanism to make sure that the clients are responded properly by the referring and receiving agency.

Following activities will be implemented through Core + Initiative project Aus-aid Additional):

VSC Services:

VSC Mobile camps will be organized in collaboration with district health office with special emphisis in nine (Bardia, chitwan, Kailali, Kanchanpur, Kapilvastu, Mahottari, Nawalparasi, Sarlahi, Saptari) project districts and it can be organized as per the demand of other districts as well.

Long Acting LARM mobile service:

Long Acting Spacing FP Methods through Weekly Mobile clinics in 15 (Bardia, chitwan, Kailali, Kanchanpur, Kapilvastu, Mahottari, Nawalparasi, Sarlahi, Saptari, Jhapa, Sunsari, Morang, Dhanusha, Makwanpur, Rupandehi,) project districts will be conducted in collaboration with DHO and other civil society organization. And it will also be organized as per the demand of other districts as well.

Result 2: Increased access to quality SRH services by strengthening quality assurance system through self-assessment, upgrading knowledge & skills of service providers through internal assessment, monthly QoC meetings, QAS action plan & budget within the organization

Quality of Care of Reproductive Health Care Program

- QOC self-assessment will be conducted in 115 static clinics (21 clinics run by doctors and 94 clinics run by paramedics) of 33 branches and central clinic to identify the gaps and thereby improve for quality of reproductive services. The internal facilitator of the SDP will facilitate the self assessment exercise in support of SDP QOC team and one external facilitator from another SDP. The whole team will participate in self assessment process. At the end of the self assessment exercise the SDP has a completed QOC action plan to be implemented for the year. FPAN branches will start implementation of the QOC activities identified in the SDP action plan which do not need external support. The SDP will share the self assessment to the FPAN central office for additional support. The QOC coordinator will consolidate the SDP action plan.
- Management assessment will be conducted at central office. For this, the management self assessment checklist will be used to identify QOC gaps that needs support from the management level. The management self assessment will help to get commitment and support from the management level staff to overcome QOC gaps that will be identified through the management self assessment. Management action plan will be developed upon the completion of the management self assessment.
- FPAN's overall action plan will be developed at head office based on the consolidated action plan and management action plan. FPAN will incorporate the activities identified in QOC action plan in its annual program and budget to be supported by core as well as

other restricted projects. The overall action plan will also be shared with IPPF SARO for technical support and additional funding support. FPAN head office will also provide necessary feedbacks to the SDPs.

- QOC internal assessment will be conducted in 50Community Clinics comprehensive SRH clinics. The internal assessment will be based on the internal assessment checklist developed by IPPF. An internal assessment teams comprising service providers and manager will be formed to conduct internal assessment. The team will observe the clinics based on the observation checklists as well as the QOC guidelines and clinical protocols; monitor the QOC action plan (developed through self assessment) to assess the implementation status of the QOC activities; and get relevant information through the client exit interview. The team also review other QOC related documents including meeting minute, decisions, service statistics, progress reports etc. The team will prepare and send brief analytical reports with filled checklists and forms the FPAN head office. The head office will analyze and verify the internal assessment reports and documents.
- Conduct client exit interview to understand attitude and behaviour of the service providers and also to assess client satisfaction with available services.

Clinical Training:

Following activities will be implemented through IPPF Core Fund

- Meeting with trainers including managers of Six training sites(Central office, Kanchanpur, Rupandehi,Chitwan, Itahari/Sunsari, & Dhanusha) will be organized for the effective implementation of Family Planning & SAS training for both internal & external participants. Micro planning of each trainiing site will be done to sustain the sites with the help of NHTC.
- 60 days SBA training will be provided to three service providers of new and existing birthing centres
- Twelve days No-Scalpel Vasectomy training to 2 Medical Doctors of existing FHC will be organized in Kathmandu training site.
- Twelve days minilap training to 2 Medical Doctors & 2 staff nurses of existing FHC will be organized in Kathmandu training site.
- 16 days No-Scalpel Vasectomy training to 10 Health Assistant of FPAN & FHD will be organized in collaboration and co-ordination with Family Health division and National Health Training Centre, Teku for task shifting program. The task shifting program will be conducted under direct supervision & monitoring of Family Health Division.

(One session each on SRH right and gender, HIV & CSE will be added in all clinical and non clinical training to service providers).

Non-clinical Training

- One day orientation on annual program & budget 2014 will be conducted to 28 branch managers for finalizing the strategy to achieve the stated goal of 2014.

Output/Result 3 Increased male client visiting FPAN service delivery points for sexual & reproductive health services to 15000 in 2014

Following activities will be implemented through Core + Initiative project Aus-aid Additional):

- Three days training on male friendly behaviour will be organized to 30 service providers of FHC and Community clinics.

- Integrated SRH services will be provided to men through all FPAN clinics according to type of clinics and service package.
- FPAN will provide No-scalpel vasectomy service to the male clients through its all Family Health Centre In this context, these clinics will be upgraded with necessary equipments and infrastructure in 2014.
- Male condoms will be supplied in all FPAN SDPs as required to easy access of condoms to the clients during the program year.
- Male client friendly environment will be developed in all clinics.

Result 4: Increased male commitment to sexual and reproductive health

Following activities will be implemented through Core fund:

- Orientation on FPAN's branch level management & governance on FPAN's policy including Men and SRH based on IPPF policy during branch committee meeting.
- Interaction with Health facility management committee members at community level will be organized during self assessment.
- Broadcasting Cost on FPAN service and service site through local radion and TV program .

Result/Output 5: Increased access to counselling services on sexual and gender based violence to women by 277% from 38,918 in 2012 to 1,08,056 in 2014 through various service delivery points established at district level and mobilization of community groups including reproductive health female volunteers

Following activities will be implemented through IPPF core fund:

- Reprint of 80000 pieces of GBV screening formats
- GBV screening and counselling services will be provided to the survivors through 21 Family Health Centre and112 static clinics with other supporting staff including counsellors. Immediate Psycho-social counselling, and support services will be provided to 10000 survivors during the year 2014.
- GBV survivors will be referred at appropriate place for financial, medical and judicial and administrative support.
- All branch and project office will develop and activate GBV survivor support team.
- Financial and other Support to GBVs survivors

Monitoring and supervision:

The project activities will be monitored by Program, OLE and other concerned Division team from head office. All the branches and project staff will be given necessary inputs for the effective implementation of project activities.

Resource requirement (NRs.)

	IPPF	Internal	IPPF Core + Additional	Total in NRs.
Programme Cost	6,513,745	4,083,900	21,443,025	**32,040,670**
Personnel Cost	7,028,000	968,830	19,409,225	**27,406,055**
Direct Cost	**13,541,745**	**5,052,730**	**40,852,250**	**59,446,725**
Total Project Cost	**13,541,745**	**5,052,730**	**40,852,250**	**59,446,725**

Access to SRH Information and Service Program

Log Frame Analysis

Project element	Objectively Verifiable Indicators and (OVI)				Assumptions
	Quantitative indicators	MOV	Qualitative indicators	MOV	
Goal Enable people in general, particularly the poor, marginalized, socially excluded and ensure that the underserved are able to exercise their rights to make free and informed choices about their sexual & reproductive health, and access SRH information, sexuality education and high quality services, including family planning.	% of unmet need of FP in Nepal Increased level of CPR among indigenous ethnic groups (Janajatis) and ethnic minority (Dalit) groups	National statistics	Change in FP method mix	National statistics	Continue public sector financing in SRH sector
Purpose To increase availability of gender sensitive SRH information & services including family planning in rural setting of FPAN operational areas	Increased number of client visit for SRH services in FPAN outreach and community clinics	Record and reports	% of rural people knowledgeable on SRH issues in FPAN operational area % of clients expressing satisfaction with behaviour of the service providers/available services	Baseline and end line survey Client exit interviews	Better capacity of FPAN service providers to respond to SRH needs of the clients with regard to information and services in rural settings
Results/Outputs **Result 1:** Increased access to sexual and reproductive health services by 57% from 1,936938 in 2012 to 3,395135 in 2014 and FP services by 61% from 1139377 in 2012 to 1865444 in 2014 through various service delivery points	Number of marginalized and underserved people received quality SRH services	Service statistics	Type of services provided through FPAN clinics	Record and reports	Better capacity of the FPAN service providers to respond to the needs of the clients particularly marginalized and vulnerable ones.
Result 2: Increased access to quality SRH services by strengthening quality assurance system through self-assessment, upgrading knowledge& skills of service providers through internal assessment, monthly QoC meetings, QAS action plan & budget within the organization	# of service providers trained on SRH services # of clinics equipped with essential equipment based on IPES service package	Training report Reports	Number of clients visiting clinics displayed positive response on attitude of service providers Number of clients visiting clinics displayed positive response on integrated SRH service provided through clinics	Client exit interview Client exit interview	

Result 3: Increased male client visiting FPAN service delivery points for sexual & reproductive health services to 15000 in 2014	% of male clients in FPAN clinics	Clinic records	Number of male clients visiting clinics have positive response on male SRH service provided through clinics	Client exit interview	
Result 4: Increased male commitment to sexual and reproductive health	Number services offering SRH services to males	Records	Clients satisfaction	Client exit interview	
	Number of service providers trained on male SRH services	training reports			
	Number of women screened, identified GBV survivors and counsel	Training reports	Client satisfaction	Client exit interview	
		Records and reports	Type of support services (counselling, micro credit, care and support, legal assistance) provided to GBV survivors		Service providers will have positive attitude to screen GBV survivors and provide necessary support to the survivors
Result5: Increased understanding on the concept of comprehensive sexuality and IPPF Declaration of Sexual Rights among service providers as well as community people	Number of visit in SRH services outlets	Records and reports			
Result 6: Increased access to counselling services on sexual and gender based violence to women by 277% from 38,918 in 2012 to 1,08,056 in 2014 through various service delivery points established at district level and mobilization of community groups including reproductive health female volunteers	Number of women counselled	Records and reports	Client satisfaction		