Australian Government

AusAID

Australia - Myanmar Cooperation Agreement

31 October 2008

ANNUAL PROGRESS REPORT

AS AT *30 September 2008*

1.0 GENERAL INFORMATION

Program Name	Mobilising Access to Sexual and Reproductive Health in Burma
AusAID Reference Number	*37913/6*
NGO Name	Marie Stopes International Australia
Delivery Organisation's Name/s	Marie Stopes International Myanmar
Date Project Commenced (Contract Signed)	1 October 2007
Expected date of completion	30 September 2012
Report covers activities implemented in the period	1 October 2007 to 30 September 2008

1.1 Introduction

Briefly state the origin and preparation stages for the Project listing the main reference documents and the major implementing agencies. Outline how you prepared the Annual Plan and which parties were involved in the consultation.

The AusAID Periodic Funding for Humanitarian Assistance to Burma (PFHAB) provides a unique opportunity for MSI to further develop and expand SRH program in Myanmar. The Activity Design Document (ADD) was written in-line with AusAID policies, principally: *A White Paper on the Australian Government's Overseas Aid Program*, the *Framework for Humanitarian Assistance to Burma (Draft)*, *Humanitarian Action Policy 2005* and *Guiding Principles for Australian Assistance for Family Planning Activities.* The Australian Government recognises the importance of strong and effective SRH policies and programs, with a particular emphasis on "addressing the needs of women and children by focusing on maternal health, sexual and reproductive health, access to safe and effective contraception based on informed choice"[1]. This project focuses on one of three key areas outlined in the *Framework for Humanitarian Assistance to Burma (Draft)* - Health (reproductive health). The Design Team, an inter-disciplinary team comprised of both Burma and Australia based members, used the AusGuide specifications to guide the production of the ADD, and the PFHAB template was used as a broad guide. The Annual Plan was drafted following a series of planning sessions by the Design Team.

In addition, following documents were referred in preparation of the project:

- National Health Plan 2006 - 2011, the Five-Year Strategic Plan for Reproductive Health in Myanmar 2004-2008, the National Reproductive Health Policy 2002, and the Draft National Population Policy 1992
- National situation analyses reports including the Reproductive Health Needs Assessment (1999), Fertility and Reproductive Health Survey (2001), Profiles for Family Planning and Reproductive Health Programs (Futures Group, 2005) and Health in Myanmar (2006).
- Gender Equality in Australia's Aid Program, Reproductive Health in Crisis Issues Paper Draft (September 2006), and the Family Planning and the Aid Program: A Comprehensive Guide.

[1] Australian Aid: Promoting Growth and Stability, White Paper on the Australian Government's Overseas Program, Page 49.

- ICPD Program of Action (1994); the Millennium Development Goals and Sexual and Reproductive Health (Family Care International, 2004).
- PFHAB documents including the MSIA PFHAB Capacity Statement, Needs Analysis, Concept Paper and AusAID Comments on the Concept Paper.

This report covers the processes and progress of the first year of the project and most of the background information has also been reported in annual plan submitted in July 2008 as well.

1.2 Project Description:

1.2.1 *Program Goal :*

Contribute to the improvement of the sexual and reproductive health of the Burmese population.

Purpose:

To increase adoption of safer SRH practices through the use of quality and accessible SRH services for men and women of reproductive age (15-49 years) and youth (10-24 years) in 4 townships.

1.2.2 Major Development Objectives:

1. Service delivery teams effectively deliver quality, client friendly SRH services.

2. Men and women of reproductive age, youth and Sex Workers are making informed choices about seeking SRH information and service, including contraceptive choices.

3. Delivery of comprehensive SRH services (FP/birth spacing, STI, VCCT, ANC, PAC, ARH) through 4 integrated service delivery centres and community based service provision (monthly mobile clinics, community based distribution of contraceptives).

4. To build a more supportive operating environment through advocacy with the public sector and collaboration with PFHAB partners.

5. Public and private sector providers have improved their capacity for providing quality, more integrated, client friendly SRH services.

1.2.3 Brief description of key components

The project is being implemented in four townships in Myanmar; Kale in Sagaing division, Myingyan in Mandalay division, Thingungyun in Yangon division and Ye in Mon state and based on 4 main component (1) Building the capacity of MSIM team to expand its SRH information and services (2) Increasing SRH knowledge through IEC and behaviour change communication intervention (3) Delivering Quality Information and Services through SRH centres and outreach services (4) Advocacy and Co ordination.

2.0 ACHIEVEMENTS AND ANALYSIS

2.1 Overall Activity Rating/ Major Development Objectives

2.1.1 Table: *What is the NGO's self- evaluation of the overall success of the activity? To what extent have the Major Development Objectives, as described in the original project proposal, been achieved to date? [Use the NGO Rating Guide to rate the achievement of these major objectives]*

Please insert brief comments to clarify or further explain the rating (Optional).

Table: 1: Overall Activity Rating

Overall Activity Rating	Rating
	S

Major Development Objectives	Rating
1.Service delivery teams to effectively delivery quality ,client friendly SRH services	S
2. Men and women of reproductive age, youth and Sex Workers are making informed choices about seeking SRH information and service, including contraceptive choices.	GP
3. *Delivery of comprehensive SRH services* (FP/birth spacing, STI, VCCT, ANC, PAC, ARH) through 4 integrated service delivery centres and community based service provision (monthly mobile clinics, community based distribution of contraceptives).	GP
4 To build *a more supportive operating environment* through advocacy with the public sector and collaboration with PFHAB partners.	S
5. *Public and private sector providers have improved their capacity for providing* quality, more integrated, client friendly SRH services.	S

2.1.2 Narrative: *Provide a narrative outlining key achievements/progress toward objectives and purpose of the project*

Centre based service delivery is functioning well in both of the two existing centres (Myaingyan and Thingangyun) and the two new centres (Kale and Ye). Monthly mobile clinic operations are also operating effectively out of the three non-Yangon centres. Awareness raising on HIV/STI, Family Planning, Maternal Care are being carried out by trained SRH promoters and field teams. Geographical coverage is expanding to rural areas and service uptake is improving over time in two new project sites. Community based distribution of contraceptives are also implemented especially to reach rural areas where quality commodities are otherwise unavailable. Advocacy and coordination with the public sector is being done on different levels on an ongoing basis. Advocacy efforts with government officials are being undertaken on an individual basis, under a low profile. In existing sites, with the support of the project, sex workers self help groups regularly meet and discuss SRH issues with the project team. Mobilization of sex workers self help groups (SHG) has also been started in two new project sites. Field teams are regularly conducting community based IEC activities. In addition, project team has been working with local traditional theatre troupes to organize performance with education activities in coming festival season. Technical updates on SRH have been provided to public and private providers through continuing medical education forums in new project sites.

2.2 Significant Project Outputs.

2.2.1 *List the* Significant Project Outputs *as stated in the original project proposal. Were these Outputs produced according to plan, up to this point? Please also list Aggregatable Benefits [eg, no. of villagers trained, metres of cleared, etc. – see Attachment 13 of POI]*

Table 2: Significant Project Outputs

Significant Output	Performance Indicator	Achievements during reporting period and Lessons Learnt	Aggregatable Benefits
1. *Service delivery teams* effectively delivering quality, client friendly SRH services	80% of all clients reporting that they are satisfied with the quality of MSI services. 90% of service delivery team members perform clinical responsibilities according to competency training and protocol and 100% of counsellors providing counselling according to competency training protocol.	- Service providers trained on FP and STI services, and VCCT - Client satisfaction survey is conducted with systemic sampling and will be reported at the end of Year 2. Findings and comments from clients will be applied to improve quality of service. - On site competency assessment will be done on Year 2 after developing a set of SRH guidelines and training according to them - Service delivery teams are supervised via regular quality monitoring via checklists by project teams and the clinical services coordinator, 2-4 times per year.	- (22) Service providers are (Medical doctors, nurses, counsellors, lab technician) trained. (4 Centre In Charges/Managers, 7 nurses, 7 councellors,4 lab technicians)
2. *Men and women of reproductive age, youth and Sex Workers are making informed choices about seeking SRH information and service, including contraceptive choices.*	- Increase of 10% from baseline. Men and women aware of at least three modern methods of family planning (gender, age, location and ethnicity disaggregated). - Increase of 15% from baseline of women of reproductive age aware of at least three benefits of birth spacing. (gender, age, location and ethnicity disaggregated).	- Baseline study (both quantitative and qualitative assessment) has been conducted to understand level of SRH knowledge, attitude and practice in the beginning of the project. Achievement against the indicators (% improvement of knowledge) will be assessed again in endline evaluation to measure the change. - Gender analysis was also done to understand gender context and constructs influencing SRH of the community. - Baseline assessment and gender analysis not only provides baseline information	- Baseline assessment and gender analysis completed and report finalized

	- Increase of 15% from baseline men and women of reproductive age aware of at least three service delivery points to access modern SRH service providers. (gender, age, location and ethnicity disaggregated). - Increase in 10% from Baseline of sex workers aware of STI treatment service providers.	but also inform project implementation and IEC activities. Activities being delivered to achieve this output of making informed choices with improved knowledge are: 1. Printed IEC materials have been developed and distributed to promote knowledge on SRH issues. 2. CBD and SRH promoters providing SRH information to men and women. Peer educators from existing Reproductive Health for Young People Project also support the youth SRH activities.	Approximately 50,000 pamphlets on antenatal care and birth preparedness, STI, VCT, and family planning been developed and distributed. - 11CBD and 28 SRH promoters been trained and carrying out SRH promotion activities. - Number of people reached through awareness raising activities (individual and group discussion) are: HIV/STI 7,886 FP 8,985 Maternal care 3,135 Combined SRH 10,895 SRH counselling 6,155 SRH referral 1,531 - Of total 38,558 people participated in information sessions; 10,256 (27%) are male and 28,061 (73%) are female. Urban rural ratio of people receiving information is 6:4. - Among the participants of information sessions, 23,513 are men and women of reproductive age (29% of cumulative target for 5 years) - Number of male and female youth who have participated in the sessions is 9,033 (56% of cumulative target for 5 years) - Total 197 sex workers (39% of cumulative target for 5 years) received HE and BCC from trained SRHp.

<table>
<tr><td></td><td></td><td>3. Discussion with CBOs (Mon Women Organization) and local performance troupes have been ongoing for capacity building of them and for organizing awareness raising initiatives with their participation.

4. Ongoing advocacy is being done with gate keepers of sex workers and sex workers themselves. Sex Workers SHG have been supported in existing sites. Establishment of SHGs in new sites will be done in Year 2. It will take some time to train SHG members in peer education and BCC methods.</td><td>- 1 Local theatre group in Mon State, 1 Traditional performance troupe in Myingyan and a group of youth amateur performers in Kalay have been contacted and preparations are underway for performance in coming festival season.

- 3 SHGs supported in existing centre townships. 20 Sex workers participating in SHG activities.</td></tr>
<tr><td>3.. Delivery of comprehensive SRH services (FP/birth spacing, STI, VCCT, ANC, PAC) through 4 integrated service delivery centres and community based service provision (by monthly mobile clinics, community based distribution of contraceptives).</td><td>Increase in client numbers of men and women of reproductive age, youth and sex workers using MSIM centre and out reach services (Gender, service age, ethnic group, location disaggregated)</td><td>- Service uptake is improving in new centres.
- AN care package strengthened including screening and treatment of uncomplicated malaria following National Treatment Guideline of Malaria have been introduced in project sites.
- Service utilization by rural population is still low and field teams are increasing mobile clinic activities to increase the rural reach.

- Project team was able to gather service data disaggregated by ethnic groups starting from May 2008. Prior to that recording formats were still in development and it took some time to orientate the team about the format, and how to get the data from the community avoiding misunderstanding from</td><td>- 4 integrated service delivery centres delivering comprehensive SRH services.
- Services provided:
✓FP 22,883(57% of cumulative target for 5 years)
✓ANC 1,062 (53% of cumulative target)
✓RTI/STI 3,787 (38% of cumulative target)
✓VCT 1,026 (21% of cumulative target)
✓Post abortion care 208 (50% of cumulative target)
(Among those services provided, 1,800 were provided through mobile clinics).

- Commodities provided through CBDs and SRHPs
✓22,170 Oral contraceptive pills and ECP strips
✓34,000 condoms.

- Service utilization by ethnic groups (June to September 2008) are shown in the following table:
<table>
<tr><th>Ethnic group</th><th>SRH service utilization N= 5,093 (%)</th></tr>
<tr><td>Myanmar</td><td>3,859 (75.80)</td></tr>
<tr><td>Mon</td><td>253 (4.97)</td></tr>
<tr><td>Chin</td><td>187 (3.67)</td></tr>
<tr><td>Kayin</td><td>22 (0.43)</td></tr>
<tr><td>Kayah</td><td>2 (0.04)</td></tr>
<tr><td>Rakhine</td><td>15 (0.29)</td></tr>
</table></td></tr>
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		minority groups. - A fee for service affordability survey for 2 new centres has been conducted. Recommendations on pricing and quality marketing have been implemented.	Shan 10 (0.20) Kachin 1 (0.02) Others 744 (14.60)
4. To build a more supportive operating environment through advocacy with the public sector and collaboration with PFHAB partners.	- PFHAB partner coordination meetings both in country (quarterly) and in Australia (semi-annual) highlight lessons learned, share information on operational issues.	- PFHAB partners have liaised through participation in coordination and advocacy meetings with other stakeholders including public sector officials. However, no formal coordination meetings specifically for PFHAB partners in Myanmar have been convened. In Melbourne a PFHAB coordination meeting was convened in September 2008.	Coordination meeting with health personals (Township Medical Officers physicians) from government sectors, NGOs and UN agencies.
	- Regular forums at central level enabling dialogue between SRH service providers from public, private and NGO sector on SRH policy issues	- MSI also participates in technical fora and monitoring mechanisms coordinated by the government. (e.g., MSIM centres are participating in National External Quality Assurance Scheme for HIV testing coordinated by National Health Laboratory, the Ministry of Health.) - In addition, MSI is one of the key actors in HIV_SRH working group under Health Cluster for Cyclone response and has been engaging in discussions and advocacy around SRH with different stakeholders including National AIDS Control Programme, UNFPA, UNAIDS, Unicef, and international and local NGOs.	
	- Forums in at least 2 project townships for SRH service providers explore linkages between traditional RH and STI services (including HIV).	- This activity has not been carried out yet. Scheduled for Y2Q1.	

5. *Public and private sector providers have improved their capacity for providing* quality, more integrated, client friendly SRH services.	80% of partners reporting an increase in knowledge in modern SRH management.	- To be measured at end-of-project. - SRH updates (Minimum Initial Service Package for Reproductive Health) have been shared to public and private providers in Ye. - Project team is discussing with Myanmar Medical Association partners in project townships for enhancing SRH capacity building for partners. It still needs to stimulate their interest to spare their time and cooperation.	2 public providers and 5 private providers participated in technical updates session.

2.2.2 Emerging Issues & Narrative

This section will include analysis of progress and indications of impact on achievement of the Project goal and outputs, to elaborate on the above table. This section should identify key emerging issues; when occurred; action or proposed action to address issues; who was responsible or involved. (OPTIONAL – can also use the table contained in the 6 month reporting format)

Table 3: Emerging Issues

Key Issues	When Occurred	Action to Address Issues	Who was (will be) Responsible or involved?
1. Tightened restriction by Department of Health (DoH) and local government officials on family planning interventions (commodities import, service delivery disruptions - especially of IUD)	Since November 2007, reiterated again in January 2008 (Import license for oral contraceptive pills and emergency contraceptive pills submitted in November 2007 was approved in May 2008 and order arrived in June. License for injectables and IUD submitted in December 2007 and resubmitted again recently again as advised by DoH	*With DoH* - Providing justification on quantity of commodities order (geographical coverage, and for multi-year implementation) *With MSIA and supplier outside of Myanmar* - Explore other alternatives to bring quality commodities into Myanmar. - Some MSIM team members who travelled overseas procured	- Country Director, MSI Myanmar. Complete. - Programme Support Manager, MSI Australia. Ongoing. - Country Director, MSIM. Marketing Officer, MSI Myanmar.

Key Issues	When Occurred	Action to Address Issues	Who was (will be) Responsible or involved?
	to restart the process, still pending approval)	commodities there and brought them into the country with supporting document, donation letter from another MSI partner. - MSIM is also exploring potential for bringing in the commodities through border (provided quality is assured) *With local market* - Identify reliable supplier/s of commodities in country	Ongoing. - Marketing Officer, MSI Myanmar. Ongoing.
2. DoH restriction on data collection and research conducted by NGOs	January 2008	- Develop an understanding of what these internal gov't policies are, and what they mean operationally for MSIM. - The project has successfully conducted a survey over time in low profile manner under the guise of day to day activities.	- Programme support team, field teams. Complete.
3. Heightened scrutiny of international entities (administrative and health departments hindering community based activities in preparation for political referendum, INGOs asked to stop activities in suspicion of linkages	March 2008	- Communicate within the organization and with other agencies about political and operating environment, safety and security related	- Programme support team, centre teams. Ongoing

Key Issues	When Occurred	Action to Address Issues	Who was (will be) Responsible or involved?
with opposition, drop-in centres told not to continue operations.)		information and plan accordingly - Adjust the activities according to local situation - Update MSIA and donor about the situation	 - Programme support team, centre teams. Ongoing. - Country Director. Ongoing.
4. Tropical Cyclone Nargis struck Southwestern part of Myanmar The UN estimates 2.4 million people were affected, mostly in the Ayeyarwady Delta region and Yangon Division. The official death toll was 84,537, with 53,836 reported missing. Infrastructure collapsed and health system disrupted. Tremendous socio economic and health issues of survivors need to be addressed. One of the PFHAB centres (Thingangyun) and MSI team members' houses damaged due to cyclone. Field based activities were stopped and centre opening hours shortened for a few days for team members to attend their family needs. Project team members involved in emergency response activities while maintaining momentum of the project.	May 2008	- Update the situation to MSIA and the donors - Participate in coordination meeting on cyclone response, share the information with the team - Plan and implement emergency response activities as well as ongoing interventions	- Country Director, MSI Myanmar. Complete. - Country Director and programme support team. Complete. - Programme Support Manager, MSIA; Country Director, MSI Myanmar, Programme Support team. Ongoing.

Review of the progress

Notwithstanding the above mentioned emerging issues, the project is progressing on track for almost all service delivery outputs. However, MSI has not yet been able to complete some of the activities, particularly for capacity building of MSI Myanmar (Component 1) and Advocacy and Coordination (Component 4) planned for year 1.

Activities planned for Year 1 but behind the schedule:

Component 1: Capacity building of MSI Myanmar team

Output 1: Service delivery teams effectively delivering quality, client friendly SRH services

- Establishment of CTTT: MSI is still finding suitable persons for CTTT especially to work on gender, social mobilization and with vulnerable groups.
- Development of integrated SRH guidelines: It will be completed once CTTT is in full strength. Meanwhile, programme team has already started collecting and reviewing references materials for guidelines and will start the development process with the existing team.
- Service providers training on integrated SRH: Service providers will be trained using integrated guidelines developed. Even though training using newly developed integrated SRH guidelines have not been organised, different trainings for service providers and ongoing supervision from support team are attuned to integration.
- Client centred service quality and service marketing framework has not been done yet. However, Service quality training has been conducted to orientate the team with the concepts. The framework will be done in Year 2 with involvement of clients, field workers and clinical team members.

Output 4: To build a more supportive operating environment through advocacy with the public sector and collaboration with PFHAB partners.

- PFHAB Partner coordination meetings in country: Regular quarterly meetings in country have not been organized yet as all partners are highly involved in response to Cyclone Nagris. However, MSI and PFHAB partners participate together in other coordination forums. Australian-based partners have met.
- Forums in at least 2 project townships for SRH service providers: Discussion with SRH providers to explore linkages between traditional RH and STI services (including HIV) have not been organized yet as project team is building relationship with providers in townships. Integrated SRH guidelines (unfinished activity from output 1) will also be beneficial for carrying out this activity.

MSI is putting concerted effort to speed up implementation for all components and some of the uncompleted activities will be carried out in Year 2. Monitoring and evaluation systems and approaches will be strengthened in Year 2 onwards following the M&E consultancy input.

Report on sustainability

Local team members are facilitating capacity building of CBOs and coordinating with local groups to maximise relevance, effectiveness and sustainability. Mobilization and empowerment of self help groups have been started which yet need to be strengthened.

Gender analysis has been conducted and findings and recommendations will be applied to increase gender sensitivity of project activities and to contribute to promoting gender equality in the community.

MSIM raises Australian identity by putting AusAID logo in all IEC materials developed and displaying it in training or other forums in the community or activities with other stakeholders.

3.0 ANNUAL PLAN: 1 October 2008 – 30 September 2009

3.1.1 Components, *Planned outputs, indicative activities-*

Components	*Planned outputs*	*Indicative activities*
1.Building the capacity of MSIM to expend its SRH information and services	1. MSIM Service delivery teams to effectively deliver quality, client friendly SRH services	- Core Technical training team (CTTT) recruitment and training - Develop a set of integrated SRH guidelines (clinical and non clinical) based on existing good practice - Train service delivery team - Establish and implement client centred service quality and marketing framework - Train CIC in the 4 townships on cost control and budget management.
2. Increasing SRH knowledge through IEC materials and BCC interventions	2.. Men and women of reproductive age, youth and Sex Workers are making informed choices about seeking SRH information and service, including contraceptive choices.	- On going SRH promoters support, refresher training and monitoring - Advocacy with Sex work gatekeepers in new project sites - Mobilize and train sex workers *SHG members* - IEC development for gender sensitivity - Health promotion discussion on SRH with target groups - Consolidate referral network - Work with CBOs - Work with local performance troupes (traditional groups and pwe) to conduct community theatre events on SRH issues
3.Provision of quality and integrated RH,STI,HIV and maternal health services	3. Delivery of comprehensive SRH services through 4 integrated service delivery centres and community based service provision	- Deliver SRH services through the centres and mobile clinics - MIS data collected for all client presentations in all sites and updated monthly - MSI centres participate in NEQAS scheme - Yangon Support Office oversees procurement and supply management of all

Components	Planned outputs	Indicative activities
		centres ensuring no pipe line rupture
4. Strengthening advocacy and coordination to enable an environment conductive to SRH information and exchange	4. To build *a more supportive operating environment* through advocacy with the public sector and collaboration with PFHAB partners.	- Begin quarterly coordination meetings between PFHAB partners in Myanmar, - Semi- annual meeting between PFHAB partners in Australia to share implementation progress and lesson learned
	5. Public and private sector providers have improved their capacity for providing quality more integrated client friendly services	- Conduct sensitization to SRH rights to public and private sectors providers - Contribute to semi annual technical update through MMA's CME programme of SRH issues to public hospital, GPs and partners INGOs

3.1.2. Strategy for Implementation *including Project Management approach, coordination, resources*

As stated in project proposal, MSI Myanmar has identified the strategies informed by local problem analysis, lessons learned from past MSIM experience and from the MSI Global Partnership and MSI Australia, MSI Myanmar, MSI Global Partnership and international best practice for FP and RH service provision.

Implementation strategies/principles that have been formulated for this project are:

- Increasing SRH knowledge with a focus on Behaviour Change
- Maximising the Choice of Services: An Integrated Delivery Model
- Delivering Quality Information and Services

Guided by these, the project is delivering following components of activities:

- Capacity building for MSI Myanmar team
- Behaviour Change Communication and Contraceptive Social Marketing
- Integrated service delivery methods
- Advocacy and Coordination

3.1.3 Confirmation of delivery organisation inputs

Comprehensive services include FP, RTI/STI management, VCT for HIV, maternal care and youth specific RH services .SRH clinical services are delivered by trained team members from each centre.

3.1.4 Sustainability approach

MSI Myanmar promote sustainability of the SRH interventions through recruiting local people for MSI field teams as much as possible as their understanding of culture and language can help them provide client friendly services. To further contribute to sustainability of the activities and service delivery, local team has started networking and capacity building of partners including CBOs and local groups and it