ANNEX 2: LOGICAL FRAMEWORK MATRIX

Narrative Description	Objectively Verifiable Indicators	Means of Verification	Assumptions
Goal: Contribute to the improvement of the sexual and reproductive health of the Burmese population.	Reduced incidence of STIs including HIV Reduction in maternal mortality rate Reduction in number of unwanted pregnancies	Official statistics from MoH, UNAIDS, UNFPA, the Millennium Development Goal Indicators, local statistics	
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 Kale, Myingyan, Thingangyun and Ye townships.	Increase of 5 % of women and men of reproductive age reporting current use of modern contraceptive methods. Increase of 20% the number of SW reporting condom use with the last client and consistent condom use with all clients in the past month. Increase of 20% of youth reporting consistent use of condoms. 10% annual increase of Couple Years Protection within people of reproductive age.	MSIM Baseline and Endline survey MSIM Baseline and End line survey MSIM Baseline and End line survey MSIM Core Monitoring Information System.	Continued support for the project by the Government No worsening of the security situation Health and social conditions do not deteriorate further. Behaviour change communication leads to positive changes in sexual and reproductive health practices.
Output 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 (i.e. range of services, opening times, wait times, provider care, confidentiality, privacy, price). 90% of service delivery team members perform clinical responsibilities according to competency training and protocol.	Customer satisfaction exit questionnaires using MSI client service quality framework. Mystery client assessment On-site competency assessments.	Good quality staff can be hired and retained throughout the project period.

	100% of counsellors providing counselling according to competency training and protocol. All centres effectively manage their expenditure to within +/- 10% of budgets.	On-site competency assessments. MSIM SUN Financial information system.	
Output 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). 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.	MSIM Baseline and Endline survey MSIM Baseline and Endline survey MSIM Baseline and Endline survey MSIM Baseline and Endline survey	Permission for Baseline and Endline Surveys granted. Official approval given by local authorities to research, develop and distribute IEC materials in Bamar and ethnic languages. Peer education, outreach activities and theatre events are given permission to be delivered. Periodic police crackdowns on SW do not prevent access to (and further marginalise) these populations.
Output 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).	Increase in client numbers of men and women of reproductive age using MSIM centre and outreach services. (Gender, service age, ethnic group, location disaggregated) Increase in client numbers of youth using MSIM centre and outreach services. (Gender,	MSIM Core Monitoring Information System. MSIM Core Monitoring Information System.	The Government and social environment supportive of community members accessing SRH services. Existing agreement with Government continues for SRH service provision in the project areas throughout the project period.

	service age, ethnic group, location disaggregated) Increase in the number of Sex Workers using MSIM services (Service disaggregated)	 MSIM Core Monitoring Information System.	Support of stakeholders such as the local population, department of health and local leaders.
Output 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. Regular forums at central level enabling dialogue between SRH service providers from public, private and NGO sector on SRH policy issues Forums in at least 2 project townships for SRH service providers explore linkages between traditional RH and STI services (including HIV).	Meeting minutes into Quarterly Project Reports Meeting minutes into Quarterly Project Reports Meeting minutes into Quarterly Project Reports	Government participate in SRH working group.
Output 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.	Year 1 and Year 5 Partner Questionnaire based on MSI Partner Defined Quality (PDQ) framework.	Providers at township levels participate in capacity building activities.
Indicative Activities:			
Output 1: 1.1 Core Technical Training Team (CTTT) established 1.2 Develop a set of integrated SRH guidelines covering clinical skills (FP, STI Management, HIV VCT, maternal care, post abortion care) and non clinical skills (Advanced SRH counselling, BCC methods) based on existing best practices (WHO, national, MSI guidelines). 1.3 Train 20 clinical service providers (5/centre) and 96 outreach workers (48 CBDs and 48 SRH Promoters) on integrated SRH guidelines 1.4 CTTT create annual training plan and conduct annual competency assessments of clinical and outreach programme team. 1.5 Ongoing coaching and mentoring and capacity building by CTTT through field based monitoring 1.6 CTTT manage program of mystery client assessments and client feedback exit forms. 1.7 Establish and implement client centred service quality and service marketing framework to be adapted for “local service standards” 1.8 Train 4 Centre In Charge team members in cost control and budget management.			
Output 2:			

2.1 Conduct Baseline survey 2.2 Conduct Gender analysis 2.3 Community and MSIM identify and select SRH promoters 2.4 MSIM train SRH promoters 2.5 Develop and modify existing IEC materials 2.6 Training for youth peer educators in accessing youth populations and BCC methods. 2.7 Advocate with SW gatekeepers (brothel owners, pimps) to support and enable access to SW for SRH services 2.8 SRH Promoters conduct small group sessions with all target populations to promote safer SRH practices 2.9 Establish Self Help Groups with Sex Workers and train SHG members in peer education and behaviour change communication methods so they become “peer educators”. 2.10 Identify, develop and consolidate referral networks 2.11 Work with local CBOs (such as the Culture and Literature Association) to conduct small group awareness raising sessions on SRH issues 2.12 Work with local performance troupes (traditional groups and *pwe*) to conduct community theatre events on SRH issues 2.13 Community and MSIM identify and select CBDs 2.14 MSIM train CBDs 2.15 Ongoing CBD support and monitoring provided by CTTT
Output 3: 3.1 Establish and equip 2 new fixed clinic facilities (Kale and Ye) 3.2 Upgrade equipment in the 2 existing clinic (Myingyan and Thingangyun) 3.3 Establish 2 new mobile clinic facilities for the new centres 3.4 Fee service affordability survey for 2 new centres 3.5 MIS data collected for all client presentations in all sites and updated monthly 3.6 MSIM centres participate MoH/DoH National External Quality Assurance Scheme Laboratory 3.7 Yangon support office oversees procurement and supply management of all centres ensuring no pipeline rupture
Output 4: 4.1 Quarterly coordination meetings between PFHAB partners in Myanmar to share implementation progress and lessons learned. 4.2 Semi-annual coordination meetings between PFHAB partners in Australia to share implementation progress and lessons learned. 4.3 MSIM Country Program Director advocates to establish a central level SRH discussion forum between government, international organisations, NGO, and private sector service providers to bring together more “traditional” RH and STI (including HIV) 4.4 Participate in township level coordination mechanisms to share information and advocate for more collaboration on SRH issues
Output 5: 5.1 CTTT contact public and private sector providers to assess knowledge gaps and conduct sensitisation to SRH rights 5.2 Contribute to semi-annual technical updates through the Myanmar Medical Association’s Continuing Medical Education Programme of SRH issues to public hospitals, GPs and partner INGOs.