MARIE STOPES INTERNATIONAL AUSTRALIA
In association with
MARIE STOPES INTERNATIONAL MYANMAR

Periodic Funding for Humanitarian Assistance in Burma: Activity design Document

MOBILISING ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH IN BURMA

13 August 2007

ACRONYMS

ADD	Activity Design Document
ARH	Adolescent Reproductive Health
BCC	Behavioural Change Communication
CBD	Community Based Distributors
CBO	Community Based Organisation
CPR	Contraceptive Prevalence Rate
CSM	Contraceptive Social Marketing
CTTT	Core Technical Training Team
DoH	Department of Health
FGD	Focus Group Discussions
FP	Family Planning
GP	General Practitioner
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
INGO	International Non-Government Organisation
KAP	Knowledge, Attitudes and Practices
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MIS	Management Information System
MoH	Ministry of Health
MSI	Marie Stopes International (Global Partnership)
MSIA	Marie Stopes International Australia
MSIM	Marie Stopes International Myanmar
NAP	National AIDS Program
NGO	Non-Government Organisation
PFHAB	Periodic Fund for Humanitarian Assistance in Burma
RH	Reproductive Health
RHC	Rural Health Centres
SHG	Self Help Groups
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
VCT	Voluntary Counselling and Testing

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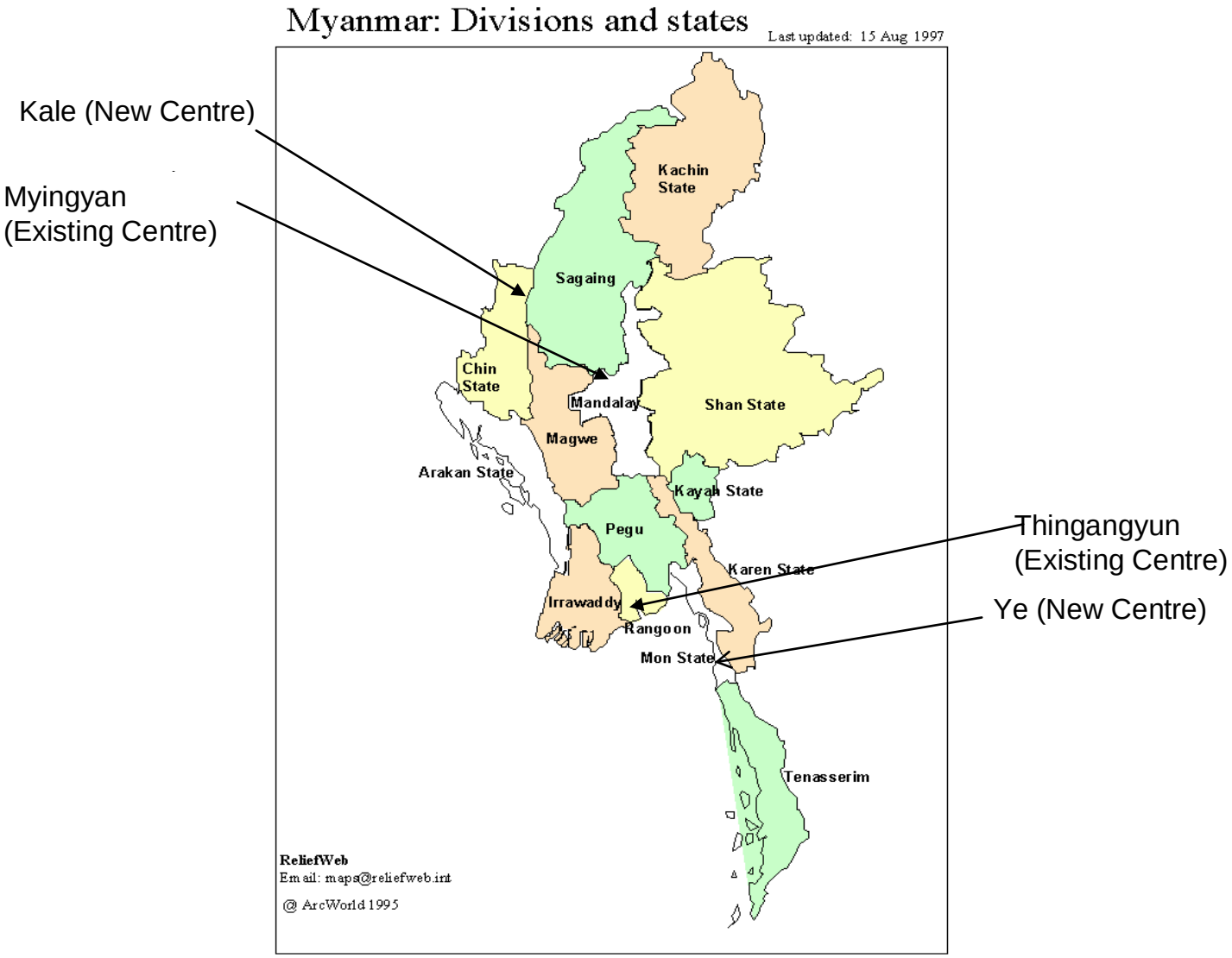
MSIM PFHAB PROJECT SITES



EXECUTIVE SUMMARY

Marie Stopes International Australia (MSIA) is a leading specialist agency in Sexual and Reproductive Health (SRH) supporting local partner programs in the Asia-Pacific region. ***Marie Stopes International Myanmar***[1] ***(MSIM)*** is MSIA's local counter-part in Burma. MSIA and MSIM are part of the Marie Stopes International (MSI) Global Partnership, one of the world's leading SRH agencies currently operating in forty countries.

MSIM is the ***only*** International NGO (INGO) currently providing direct RH service delivery in Burma. MSIM's strength as an organization lies in its focus on providing a comprehensive range of RH information, education and services including Family Planning (FP), Sexually and Transmitted Infections (STI) prevention and management, voluntary counselling and testing (VCT) of HIV, ante and post natal care and post-abortion care. These services are delivered through innovative operating models: Centre-based services; Community-based services and outreach work, including mobile services; Information, Education, Communication (IEC) and advocacy initiatives; Behavioural Change Communication (BCC) interventions and Contraceptive Social Marketing (CSM) programs. The AusAID Periodic Funding for Humanitarian Assistance to Burma (PFHAB) provides a unique opportunity to further develop and expand, over the next five years MSIM's SRH program.

This 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"[2]. This ADD 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 this ADD, and the PFHAB template was used as a broad guide.

The activity design process involved an analysis of the development context; reviews of relevant donor and government policies and protocols; local, national and international lessons learned; focus group discussions (FGD) with men, women, adolescents and SWs living in target townships and; consultations with other key stakeholders (e.g. representatives from Ministry of Health [MoH], National AIDS Program [NAP], public health facilities, members of Civil Society, UN agencies, INGOs etc). Data was collected, collated and analysed over a three month period (May-July). This participatory approach to the ADD ensures that the major components, activities and desired outcomes were developed in direct response to the SRH problems, barriers and unmet needs identified by target populations and key stakeholders.

The situational and needs analysis identified numerous problems in relation to SRH in Burma: lack of access to quality SRH information; limited FP and RH commodities and services; cultural and social factors influencing women's SRH practices. The culmination of these problems has led to an unacceptably low contraceptive prevalence rate (CPR) for modern methods among women of reproductive age. There is direct correlation between low CPR and high maternal mortality rates.

[1] To be consistent with Australian Government policy, throughout the document the term "Burma" has been used, except where the official name of an organisation or document uses the term "Myanmar".

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

In response, the Design Team propose an approach based on community and stakeholder participation, international best practice, national and international lessons learned to address these problems. The project goal is to ***contribute to the improvement of the sexual and reproductive health of the Burmese population***. The purpose is to *increase the adoption of safer SRH practices through the use of quality, accessible SRH services for men and women of reproductive age (15-49 years), youth (10-24 years of age) and SWs in Kale, Myingyan, Thingangyun and Ye townships.* The four core components of the activity design are:

1) Building the capacity of MSIM to expand its SRH information and services;
2) Increasing SRH knowledge through IEC materials and BCC interventions;
3) Provision of quality and integrated SRH, STI, HIV and maternal health services and;
4) Strengthening advocacy and coordination to enable an environment conducive to SRH information and exchange.

It is expected that the project will contribute to a reduced incidence of STIs, including HIV; a reduced maternal mortality and reduced number of unwanted pregnancies.

MSIM has established positive working relations with the government departments relevant to SRH operations in Burma. In addition, MSIM participates at both the central level and local level through various mechanisms to affect change on important SRH issues.

MSIA will be responsible for the contractual management of the PFHAB program. The MSIM Yangon Support Office will provide direct project management through the PFHAB Project Manager with general program support/oversight provided by the Program Director, Senior Program Advisor, Finance and Human Resource Managers as well as logistical and administrative staff. Progress on project activities will be overseen by MSIA and formally tracked through donor reports and MSIA's Global Partnership Reporting system which will provide monthly narrative, financial and statistical reports.

The feasibility, benefits and sustainability of the proposed project are clearly outlined in the ADD, providing ample justification for proceeding with the PFHAB project. MSI is a social enterprise providing SRH information and services and is compelled to use business-like cost-recovery techniques to deliver affordable contraceptive services sustainably to underserved fertile couples. The program is rooted in a principle of local involvement in service delivery. Public and private stakeholders, as well as target groups (men, women, youth and SWs) will actively participate by having the opportunity to influence the direction and detail of the design and implementation. Local ownership and community participation will be maintained throughout the project. MSIM have taken into account technology that is appropriate in terms of technical and financial criteria, as well as social, gender and cultural acceptability. As part of the PFHAB program, maximising the benefits will be an ongoing process which will be frequently reviewed and updated as circumstances and lessons are learnt from experience.

The likely impact that this activity will have on the development situation and the people and organisations involved will be substantial. The first of the MDGs is the eradication of extreme poverty and hunger. Reliable evidence shows that poor women have bad RH outcomes and that early and unintended childbearing—even in developed countries—leads to poverty[3]. RH, of which a major component is the promotion of FP, is unique among health interventions in the breadth of its potential benefits: reduction of poverty, and maternal and child mortality; empowerment of women by lightening the burden of excessive childbearing; and enhancement of environmental sustainability.

[3] Greene ME, Merrick T. Poverty reduction: does reproductive health matter? HNP Discussion paper. Washington DC: The World Bank, 2005

1.0 ACTIVITY PREPARATION STEPS

1.1 Activity Origin

a) The Request

One of the four key themes in a White Paper *"Australian Aid: Promoting Growth and Stability (2006)*[4]" is "Investing in People". This prioritises delivering better health programs that focus on the needs of women and children. The White Paper highlights the importance of strong and effective SRH policies and programs, proposing significant increases in support that improves the health and well being of people in the Asia-Pacific region. There is 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"[5].

The *Framework for Humanitarian Assistance to Burma* (draft) was developed by AusAID in mid 2006 and aims to "alleviate suffering by responding to the humanitarian needs of vulnerable Burmese people" focusing on three key areas: Health, Sustainable Livelihoods and Protection. The funding vehicle for operationalising this framework is the Periodic Funding for Humanitarian Assistance in Burma (PFHAB) which seeks to support Australian NGOs with strengths and long-term experience in Burma.

Appropriately experienced NGOs were requested to submit a Capacity Statement to AusAID in September 2006 for activities in the areas of Health (Basic Health, HIV & AIDS and RH) and Livelihoods. Following a review of the submissions and a technical interview process, three NGOs were selected to develop projects in line with the Framework for Humanitarian Assistance to Burma: Care (Basic Health and Livelihoods), Burnet Institute (HIV & AIDS) and Marie Stopes International Australia (RH).

b) Assessment and Preliminary Preparation

A Needs Analysis was developed in April 2007, based on the combined assessments of the three implementing NGOs and AusAID. This document outlines the humanitarian and sectoral (Health and Livelihood) needs, priorities for interventions, and justification for AusAID assistance in Burma. The needs analysis has been used to help inform the analysis section (Chapter 2) of this document.

In May 2007 MSIA/M presented a brief concept note to AusAID for RH improvement activities in Burma. The concept paper outlined the key components of the project, target beneficiaries and an indication of how the project would be managed. The concept was approved by AusAID with some recommendations to ensure a good ADD.

This detailed ADD addresses these comments and builds on the proposed project concept note.

1.2 Study Team and Method

a) Team and Mission

The proposed activity has been developed by an inter-disciplinary team comprised of both Burma and Australia based members. The Burma core design team was comprised of Dr. Sid Naing, the MSIM Country Program Director, Dr. Moe Moe Aung, a senior MSIM Program Coordinator, and Dr. Phone Saing, a local consultant. The Australia design team included Meg Quartermaine, the MSIA Burma Program Support Manager (Burma and Australia inputs), Don Smith the MSIA Regional Finance Manager (Australia), Ary Laufer, MSIA

[4] Referred to as the 'White Paper' from here on after.

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

Regional Manager (Australia), Lisa Edward, the MSIA Business Development Manager (Australia) and Kari Sann, a Consultant who provided support in both Burma and Australia.

The detailed activity design was undertaken between May and July 2007 in two stages. The first, conducted in May and June by the MSIM design team, was a set of field based focus group discussions reviewing existing SRH knowledge and needs of the target populations. This was supplemented by consultations eliciting the views of key local stakeholders including government, community based organisations (CBOs), other INGOs, private sector service providers, and members of civil society. MSIM field level team members were also consulted. Information on the Burma policy and legal context was collated by the MSIM design team in Burma.

The second stage of the design process was an analysis where the logical framework and risk matrix were constructed, initially by the Burma design team, but also shared and further developed by the Australia team. The drafting of this ADD was an iterative process discussed and agreed between the Australia and Burma based design team members.

b) Key Aspects of the Method

Focus group discussions were held by the MSIM design team in two proposed townships with the three target population groups: married men and women (aged 15-49 years); unmarried youth (aged 10-24 years); and female SWs. The sites selected for FGD include one existing MSIM Project township, Thingangyun in Yangon Division, and a proposed new township, Ye in Mon State. Participants from Ye included 13 married men, 16 married women, 5 unmarried female youth and 8 unmarried male youth. From Thingangyun (Yangon) participants included 4 married men, 5 married women, 6 female and 6 male youth, 10 SWs and the staff at the Thingangyun MSIM Centre (including doctors to community based distribution staff).

The FGD with men and women and youth aimed to elicit information on existing:

- Awareness and knowledge of SRH issues
- Access and utilisation of SRH services
- Perceptions of service quality and affordability

The discussions with Sex Workers aimed to elicit information on:

- Access and utilisation of STI services
- Qualities sought in a SRH service provider

Discussions with existing township level MSIM team members reviewed:

- Current levels of knowledge and skill
- Ability to access MSIM target clients
- Client health seeking behaviours
- Lessons learned from previous activities

Annex 7 summarises the key messages from the FGD.

Consultations with key stakeholders were an integral aspect of the design process. Key stakeholders were consulted on the relevance of the proposed program to the existing environment within Burma. One to one interviews were conducted by the MSIM design team. Those consulted include:

- Senior members of the MoH at the central level (NAP, Public Health and Reproductive Health Divisions)
- Township level government hospitals
- Peace and Development Council (administrative authority) at sub-township and village levels.

- Myanmar Medical Association
- Local GPs in some project sites,
- Local organisations including the Mon Women's Organization under the New Mon State Party, the Mon Development Network, the Myanmar Council of Churches, the Young Women Christian Association and the Myanmar Maternal and Child Welfare Association.
- UN organisations including WHO and UNFPA.
- International NGOs including International HIV/AIDS Alliance, International Organization for Migration, Médecins Sans Frontières (MSF-Holland), Population Services International, Save the Children, the Burnet Institute and Care Myanmar.
- Influential individuals consulted include an influential writer and women's rights activist, an environmental activist and the head monk of a Buddhist monastery active in social development work.

Annex 1 provides the details of people met in the design process.

A document review assessed:

- Relevant National (Ministry of Health) Guidelines and Policy such as the 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).
- AusAID policy framework and guidelines on Humanitarian Aid, the White Paper, 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.
- Technical papers on reproductive health including: Profiles for Family Planning and Reproductive Health Programs (Futures Group, 2005); Accelerating Progress towards Achieving the MDGs to Improve Maternal Health (Health, Nutrition and Population Section, The World Bank, 2006); 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.

Design team meetings were conducted in both Burma and Australia at critical junctures in the design process such as the development of the logical framework, the implementation schedule and the project risk matrix. The logical framework was initially constructed by the design team in Burma through a facilitated workshop. Drafts of all key documents were shared amongst and commented on by both Australia and Burma based design team members.

Due to the limited time and funds available for the design process it was not possible to conduct a full gender analysis or establish a detailed risk management plan. However, these activities will be completed during the first three months of the program. The design team fully supports the principle of ensuring women and men equally benefit from project activities, and that no dis-benefits accrue to women or men as a result of this project. Where possible the design team has identified gender issues and has designed the programme to

proactively tackle disparities that affect SRH decision making. A risk assessment has been conducted on the proposed design (See Annex 5).

2.0 ANALYSIS

2.1 Development Context

a. Location and Geography

Located between Bangladesh and Thailand, with India and China to the north, Burma covers an area of about 675,000km^2, approximately twice the size of Germany. The population is 56.1 million[6] people.

The country is divided into two classifications, Lower Burma incorporating the coastal areas, and Upper Burma, the interior and north of the country. There are fourteen administrative subdivisions comprised of seven Divisions and seven States. Sub-Divisions are divided into districts, which in turn are divided into townships. Townships consist of both ward (urban) and village (rural) areas.

The sub-divisions are considered to be ethnically-divided with Divisions being predominantly Bamar, and the States predominantly ethnic minority groups. Whilst this is broadly the case, there is significant people movement within Burma and all States and Divisions have people from multiple ethnic backgrounds.

b. Socio-Economic and Cultural Context

Burma is one of the least developed countries in the world and was ranked 132 in 2004 and 129 in 2005 according to the Human Development Index[7]. There is no credible national development plan and estimates suggest half the population is living below the poverty line. Over 70 per cent of the population reside in rural areas, primarily engaged in agriculture. These areas face serious ecological problems resulting in declining yields, increasing landlessness and migration. Estimates suggest up to 1 million people are internally displaced as a result of ongoing conflict, forced land confiscation, abuse and violence.[8]

Households are made vulnerable as a result of interconnected factors including existing levels of knowledge, social and political influences, and natural resource constraints. Economic hardship has worsened in recent years as a result of spiking inflation, restrictions on foreign currency and trade. Increases in the cost of living and the recent removal of subsidies on fuel and food have increased household vulnerability.

Burma has one of the world's lowest levels of public sector expenditure, with authorities spending less than $1 per person per year on basic health and education combined.[9] Malaria and tuberculosis are a major concern, although preventable or curable. One in three children aged five are moderately to severely malnourished, only 40 per cent of children complete 5 years of primary education, 50 per cent of all child deaths are attributable to preventable causes such as acute respiratory infection, malaria and diarrhoea. Maternal mortality is amongst the highest in the region. HIV is considered a generalized epidemic, with UNAIDS estimating that 350,000 adults (15 to 49 years) are infected with HIV, representing 1.3 per cent of the population in 2006. However, the prevalence rate is higher in youth (those under 24) at 2 per cent and in Sex Work populations (27.5 per cent).[10]

Against this backdrop of pervasive poverty across Burmese society, evidence suggests that small amounts of carefully targeted aid dollars have had a discernible impact over the last

[6] UNDP Human Development report, EIU Country report, 2004. Estimates place the population between 53 million and 56.1 million.
[7] Human Development Reports. http://hdr.undp.org/statistics/
[8] Estimates from Thai- Burma Border Consortium - TBBC
[9] DFID Country Plan for Burma, October 2004.
[10] Joint Program for HIV/AIDS in Myanmar, Progress Report 2003/4 and FHAM Annual Progress Report April 2004-March 2005, Pg 9.

decade. Priority needs are improvements in the health, education and livelihood conditions. Working effectively within this complex context requires a solid understanding of the micro as well as the macro context. Models developed at the national level require adaptation to very specific and dynamic localized conditions.

c. Key Stakeholders and their Interests in SRH Programs

Target Beneficiaries of MSIM services

MSIM is the ***only*** INGO providing direct RH services in Burma and has been operating in country since 1997. MSIM targets women and men of reproductive age (15 to 49 years) with specific targeting of male and female youth (10-24 years of age). Specialised programs for working with youth and SWs have been developed by MSIM. FGD sought the views of target populations on the SRH services required and how they should be delivered. The section below summarises participants' recommendations for a new program. Further detail can be found in section 3.2, the Situational Analysis.

Women and Men of Reproductive Age (15-49 years)

MSIM's RH and FP services have traditionally been targeted at sexually active women. In Burma, there is sexual conservatism and strongly held views that women, in particular, but also to a lesser extent males, are not sexually active prior to marriage. Therefore the most visible target population for a FP focused project is married women, who at present are the major users of MSIM services. The FGD revealed that women wanted more information on SRH but also felt it was important to educate men. Men are most likely to visit the centres like MSIM for STI treatment only with their wives. However, their health seeking preference is to self medicate and to only seek medical treatment if their symptoms persist. Males also expressed a desire for more information on SRH issues. The importance of recruiting local SRH service providers with existing networks into the community was reinforced by women.

Female and Male Youth (10 – 24 years of age)

The target population for youth aged between 10 and 24 was selected to be consistent with the definition in the 5 Year Strategic Plan for Reproductive Health in Myanmar. It should be recognised that males and females in this group may or may not be sexually active. Both male and female participants in the focus group discussions expressed a desire for more accurate information on SRH issues. Female youth expressed the view that community based awareness raising of SRH issues needed to be supplemented by smaller group discussions to explore relevant issues and concerns in more detail. They felt these discussions were best conducted / facilitated by youth peers. Male youth mainly consider SRH services to be for women. Yet, interestingly, more males than females attend the youth centres that form part of the existing MSIM centres, demonstrating such facilities form a valuable means of accessing and educating young men on safe sexual practices. However, it also highlights barriers to female youth using this service. Most youth are unemployed so affordability of services is critical. Good quality of care is judged by the participants as taking the time to listen, helping to resolve the issue, not judging or blaming, having a sense of humour and making the participants feel comfortable to discuss their problems openly.

Female Sex Workers

MSIM's experience is that many women, who test positive for HIV in their centres, are married and have contracted the virus from their husbands. It is generally accepted that these men have had unprotected sex with SWs. Protecting the health of women and children in the general population requires 100 per cent condom use in the community, particularly amongst SWs and their clients, and the best way of achieving this is through targeted programs. A relatively small number of brothel based SWs visit the existing MSIM centres, generally after outreach activities made them aware of the services. Accessing a large proportion of the SW population can be difficult as many move in and out of sex work as economic conditions

change. Many "freelance" (non-brothel based) SWs work a few days a week to supplement household income as required and consequently are more difficult to access. The FGD with SWs highlighted that they generally prefer female service providers. To make them feel comfortable attending a centre they value a client friendly environment (being warmly greeted and caring, warm, compassionate, patient, non-judgemental service providers), receiving relevant messages and affordability. SWs also value the opportunity to have small facilitated group discussions to discuss their experiences and concerns more in depth.

Public Sector

Stakeholders from the public sector acknowledge that RH needs in Burma can only be addressed through partnership with the private sector and NGOs, given their own limited resources. NGOs offer the potential to reach out to underserved population with relevant services. The NAP, the Reproductive Health Section of the Department of Health (DoH), UNAIDS and UNFPA have prioritised the Burmese townships with the highest HIV prevalence and unmet RH needs in the country. MSIM participated in this township prioritization exercise and have ensured township selection for this activity is in line with prioritised sites.

The public health sector staff at central level appreciate MSIM's efforts to deliver a wide range of services in line with the Five Year Strategic Plan for Reproductive Health (2004-2008). State and Divisional level DoH staff are supportive of MSIM's program and encourage coordination, partnership and information sharing. Staff from local level hospitals acknowledge that the RH need in the community is huge and they have limited resources, increasing the likelihood of people seeking assistance from unqualified and unsafe practitioners.

Private Sector (GPs)

The project design team consulted with general practitioners (GPs) running private clinics in urban as well as in rural areas. A considerably low proportion of their clientele are FP clients and they attribute this to low awareness about FP and people opting to use the services of cheaper and nearer providers, like "quacks"[11]. GPs believe that making quality affordable FP services available to communities in need would be beneficial for both women and their families. GPs acknowledge the huge need for community education on RH and feel this is an area that NGOs can really make a difference. In Ye township, in addition to RH, malaria is also a big health problem.

MSIM's unique capacity in service delivery and outreach approach is appreciated by private sector partners and linkages between GPs and NGOs have already been established around MSIM existing SRH centres.

There is a lot of potential for referral and sharing of expertise and knowledge amongst private sector, public sector and NGO service providers, including PFHAB partners. The establishment of referral networks and regular information exchange can create stronger linkages between service providers and thus improve the breadth and quality of services available to the general population.

Civil Society

Civil society organizations and local networks implement their interventions in a complex operating environment influenced by many factors. MSIM consulted civil society networks in Yangon and in project sites (e.g. the Mon Literary and Culture Association and the New Mon State Party). Different organizations and networks focus on different issues including HIV, development, building organisational capacity, and social welfare for local people.

[11] "Quacks" or "Quack Doctors" is a term used in Burma for people practicing traditional medicine but who are not trained by the formal medical education system.

SRH is seen by civil society representatives as one area that is integrally linked to the wider development agenda. Capacity building of civil society networks working on SRH issues is seen as highly beneficial for civil society and hence the community. As each civil society organization has their own network, knowledge, experiences, and mandate, any capacity building should actively seek participation of these organisations and be sensitive to their own priorities.

d. Policy and Program Context

Burma has somewhat complex policy environment around RH. The Government does not want to reduce the size of the population, but has initiated a set of policies that encourage maternal and child health, mainly through the promotion of the birth spacing and improving adolescent reproductive health (ARH) services. However, a number of legislative and administrative hurdles exist, particularly around sterilisation, abortion and provision of injections, which, when combined with frighteningly low public expenditure on the health system, act to undermine the policy intent and ultimately the range of safe SRH choices available.

Burma formulated a draft National Population Policy in 1992 which saw a shift from a pro-natalist to a health-oriented approach. This included the promotion of birth spacing to improve the health status of women and children, community level RH IEC materials, promotion of responsible reproductive behaviour, male involvement in RH and efforts to address adolescent and youth needs. Reproductive Health as an inclusive and coherent approach has been in place in Burma since 1996[12].

The *Myanmar Reproductive Health Policy* was introduced in 2002 stating that its role is to promote the rules, regulations and laws on reproductive health and to operate in conformance with the National Population Policy. The key features of the reproductive health policy include: integration of RH services into existing health services; partnerships and appropriate referral systems between government, NGOs and the private sector; research and monitoring of services to identify and prioritise needs; ensuring services are accessible and affordable to all including adolescents and elderly people; incorporating a gender based approach; and implementing appropriate socio-cultural approaches and ensuring sustainability of services. This policy forms the basis for the DoH *Five Year Strategic Plan for Reproductive Health in Myanmar 2004- 2008*. The intent of the Reproductive Health Strategic Plan is to reduce the high maternal mortality rates from childbirth and to reduce the deaths of women who access unsafe abortion.

The *Five Year Strategic Plan for Child Health Development 2005-2009* and the *Reproductive Health Strategic Plan* provide the roadmap for Burma to help achieve the Millennium Development Goals related to maternal and infant mortality. They include components of:

- Improving the skills of health care providers
- Strengthening the health system to deliver child health services
- Improving family and community practices.
- Improving the enabling environment
- Improving the evidence base for decision making.

A set of Policy Implementation Guidelines have been issued for reproductive health programs which highlight priorities in the areas of general reproductive health, ARH and obstetric care. In addition to the Burmese policy context, any Australian funded aid program must comply with the *Family Planning and the Aid Program: A Comprehensive Guide*[13]. This guide

[12] WHO Burma Birth Spacing Facts Sheet, 2004.

[13] *Family Planning and the Aid Program: A Comprehensive Guide, AusAID, 2002.*

establishes a set of principles for any Australian assistance to FP activity. A detailed analysis of how the proposed project responds to the Guiding Principles is available in Annex 8.

e. Institutional Context

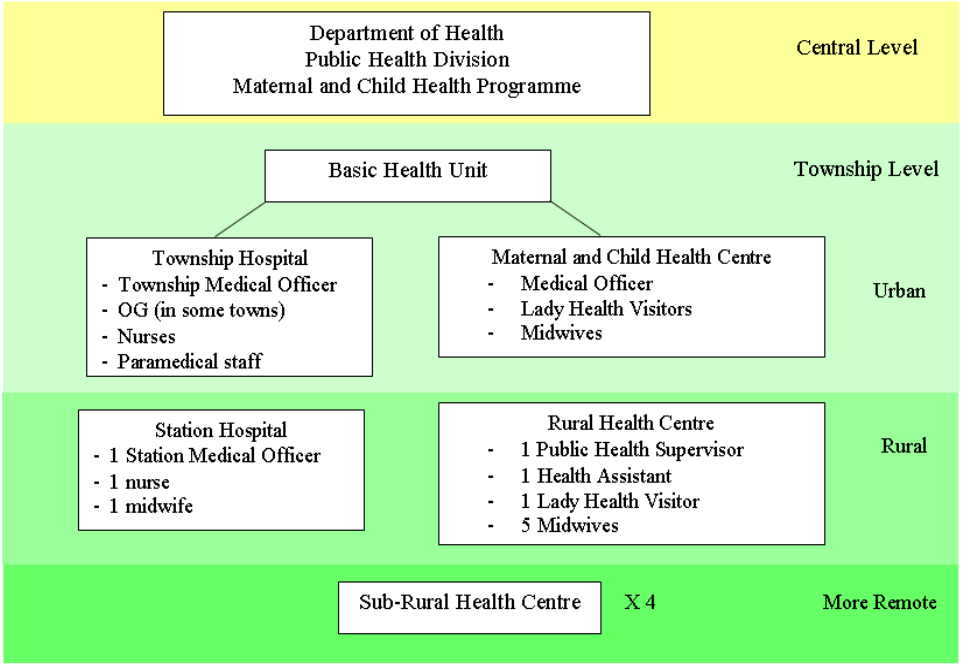
Refer to Table 1 for the structural outline of government service provided at each of the health service levels. The majority of women in urban and rural areas rely on the shoestring services provided by government medical staff (midwives, station and township hospitals) for their ante and post natal care. The DoH is the main stakeholder in Health with the majority of people reliant on the under-resourced public system. The Maternal and Child Health (MCH) Program under the Public Health Division coordinates RH interventions. All the townships have local structures for provision of basic health services and MCH, however, their capacity varies across the country. Quantity and quality of service providers and service delivery points are considered suboptimal particularly in rural and low opportunity areas.

At the township level there is a basic health unit, comprised of one township hospital and one MCH centre in the urban area. In the rural areas there is a station hospital and Rural Health Centres (RHCs). Each RHC has four sub-rural health centres. The number of station hospitals and RHCs varies depending on the number of villages and population of the area.

Township and station hospitals provide general medical services including emergency obstetric services. General reproductive health services are delivered by MCH centres and RHCs. Normal deliveries are conducted by lady health visitors and midwives of MCH centre and RHCs. Assisted deliveries, cases with complications during pregnancy, and abortions are all referred to the hospitals.

To supplement the unmet RH need in Burma, MSIM is delivering a comprehensive range of RH information, FP, STI prevention, VCT for HIV, ante and post-natal care and post abortion care services in 13 centres across the country. PFHAB funding will increase this number to 16, which is part of a nation-wide expansion program resulting in 49 centres being operational across the country by 2010 (with the necessary funding already secured).

Diagram 1: Public Sector Levels Health Structure



2.2 Situation Analysis

a. Identified Problem

The situation in Burma reflects a fundamental problem of a low contraceptive prevalence.

The CPR for modern methods among married women of reproductive age is only 33 percent[14], with significant disparity between urban (47 per cent) and rural (23 per cent). In 2001[15], approximately 37 percent of married women were using contraception and a staggering 44 percent of married women of reproductive age were not using any form of contraception but did not want any more children. Method failure appears to be a common problem, as 37 percent of women seeking treatment for complications of abortion report contraceptive use at the time the pregnancy occurred.

Burma has high rates of unplanned and unwanted pregnancies, resulting in high maternal mortality and morbidity associated with unsafe abortion procedures. Whilst abortion is illegal, estimates suggest approximately 567,000[16] are carried out each year, contributing to 50 percent of maternal deaths and 20 percent of all hospital admissions.

The Causes:

a. Lack of access to quality SRH information

The FGD in Thingangyun, Yangon (existing site) and Ye, Mon State (new site) revealed that knowledge about SRH is highly variable. The married men and women in both sites were aware of short term FP methods such as contraceptive pills and injectables, and of permanent methods of contraception such as vasectomy and tubal ligation. There are some misconceptions and rumours around the contraceptive pill and injectables. Males and Females in Ye, Mon State, believe using the pill will result in "dry uterus", uterine cancer, and infertility. As a result couples are unwilling to use these methods.

In Ye married women appreciated the dual role of condoms, but in Thingangyun condoms were not considered appropriate for married couples except if the women could not use other methods for medical reasons. There is stigma around purchasing condoms and women will not buy them from the shop as they fear they would be taken for SWs. Women also felt uncomfortable raising the issue of condom use with their husbands as it may seem the women do not trust their husband's fidelity. In both FGD sites contraception use before the first child is uncommon.

Knowledge of STIs (modes of transmission, symptoms and complications) was relatively low in all sites amongst married women but slightly better amongst the female youth in Thingangyun. Male youth were well informed about STI symptoms and how to seek treatment. There are some existing misconceptions, including that STIs can progress to HIV infection and that STIs can be prevented when having sex with SWs by taking penicillin. Both males and females reported that STI treatment would first be sought from drug stores with many too embarrassed to consult a medical practitioner, unless symptoms persisted.

Whilst the official and traditional view in Burma is that unmarried people, particularly females, do not engage in sex, FGD revealed otherwise. Female youth felt premarital sex is not uncommon amongst "sweethearts". In Thingangyun female youth estimated 9 out of 10 unmarried couples have sex and there is acknowledgement that young boys will visit SWs. Within the youth groups they discuss sex more as a form of "gossip", with less emphasis on the potential health consequences. Knowledge of the dual role of condoms varied across sites, with male and female youth in Ye noting that condoms were only for the prevention of

[14] Population Reference Bureau. 2006 World Population Data Sheet. Website:http://www.prb.org/DataFind/datafinder7.htm.

[15] Fertility and RH Survey, 2001. Ministry of Immigration and Population and UNFPA.

[16] Futures Group. 2005.

STIs. In Ye participants said they didn't know of any agency or person providing information on RH and that they have never received any SRH education.

The FGD revealed clear knowledge gaps that, if filled, have the potential to greatly contribute to lower rates of STI transmission and unplanned pregnancies in the community. Whilst there are strong cultural values against premarital sex, there is a high demand for RH information and services from adolescents. The focus group discussions highlight that small peer group discussions will be an important avenue for raising knowledge within this target group. Similarly, in the general community SRH matters are still the subject of much embarrassment. To effectively build knowledge, it is important to work sensitively and flexibly within the community.

b. Limited family planning and reproductive health commodities and services

Government, local NGOs, private sector centres, GPs, pharmacies and "quacks" all provide SRH services. Contraceptive pills are usually purchased from drug shops, injectables from township midwives, GP doctors, "quacks", or from MSIM. Tubal ligation is available at township hospitals following the necessary approvals. Women who opt for voluntary surgical contraception are faced with long waiting lists, and bureaucratic and administrative barriers that are personally intrusive. Application requires a citizenship card which women in some communities have no access to. Vasectomy, whilst technically illegal, is available through a few GPs with unreliable quality.

Women generally start seeking ante-natal care at around 5 months of gestation and commonly go to a midwife, station medical hospital or a MCH centre at the township level (all government services). Those with more money will visit an obstetrician / gynaecologist for care.

Abortion practices differ depending on the township. In Ye, married women report they will always have the baby if they are pregnant and only unmarried women whose partner won't or can't marry her will seek abortion. In Thingangyun both married and unmarried women sought abortions, predominantly from *Lethe* (untrained traditional birth attendant). Post abortion care is also provided by *Lethe* with complications being managed by township hospitals.

Within this limited resource setting, most women and men know where to go to access SRH services, safe or unsafe, but actual use is highly dependent on financial resources. There is a preference for using private clinics. These carry the perception of shorter waiting times, better care and better medicines.

However, knowing where to access services doesn't automatically result in more reliable and responsible SRH practices. ***Irregular supply of medicines and restrictive medical protocols*** often hinder women from continuous and appropriate contraceptive use and limit available contraceptive options. Limited supply also has ***cost implications*** with the cost of goods varying depending on stock availability. In a resource limited setting this greatly impacts ***affordability*** of vital contraceptive supplies. Burma's average GNP per capita is approximately USD 220[17]. Married men in one focus group discussion estimated that the average annual cost for family health care was around Kyat 200,000 per family (USD 160). The cost of hospital birth delivery is between Kyat 100,000-300,000 (USD 80-240) depending on the hospital and the level of complication with the delivery. This helps to explain why so few women attend hospitals for delivery. Difficulties accessing hospitals by people living in remote areas is also an important consideration.

Women in the focus group discussions felt Kyat 300-500 (USD 40 cents) was a reasonable cost for oral contraceptives for the majority of women but they typically pay between Kyat

[17] UNICEF, Myanmar Statistics at a Glance, 2005

250 and 2,000 depending on the brand. Similarly for 3 month injectables the cost is between Kyat 1,500 and 3,000 but the majority reported being able to afford between Kyat 700 and 1000. Importing of supplies into Burma is complicated and costly. It is clear from the above discussion that small price increases can render commodities unattainable for women subsisting on or below the poverty line.

c. Cultural and social factors influencing women's practices

The focus group discussions highlighted some differences between the genders in perception of RH decision making. Married women reported that husband and wife jointly agreed on decisions around birth spacing and contraception. However, women reported generally choosing the method of contraception (except condoms) with the advice of friends, an elder or a health service provider. Most women interviewed felt that their husbands were not very interested in or keen to support them using contraception.

Interestingly a number of the males interviewed were not aware whether their wives were using contraceptives. Some participants revealed that they had found out their wives were taking contraception. Those with children were supportive of their wives' decision but those without children were not happy due to fears of not being able to have children later as a result of the contraception.

Despite the apparent lack of interest and awareness of their wives contraceptive use, and limited knowledge of the cost of contraception, men interviewed felt that FP was also a man's responsibility. Behaviours seem to reinforce this view with women reporting that their husbands take extra care of them when they are pregnant, especially when they are near term. Additionally, some couples have birthing plans covering where they will deliver, who will be present at the birth and have saved funds for the delivery.

Those interviewed reported little or no conversation about STIs, HIV or condoms. If there is something on television about these issues couples may discuss the issue in general, but not as an issue that is relevant to their relationship.

There are gender differences around attitudes to sexual decision making. It appears more acceptable for males to engage in pre-marital sexual activity than females. Therefore in adolescence, females often lack confidence and power in making RH choices. These social and gender difference reinforce the value of accurately educating both men and women about reproductive health information and choices.

b. Lessons Learned

MSIM has over ten years experience operating in Burma, in addition to drawing on the 30 years experience of the MSI Global Partnership when identifying relevant lessons learnt.

Beneficiary Participation in Project Development

Building on good practice in international development programming and in concurrence with the *AusAID Family Planning and the Aid Program Guidance*, the design of this program has entailed consultation with key stakeholders and beneficiaries at existing and proposed project sites. Given the relatively short (6 week) design phase, field consultation was only possible in two sites, with further consultation planned during the inception phase of the proposed project. Further engagement with men, women and youth from target townships will continue throughout the life of the program through program monitoring (base line and end line surveys, client satisfaction exit questionnaires and annual program reviews) seeking their views and in a more informal way through ongoing community group discussions and regular meetings.

Integrated Service Provision
Since the commencement of its operations in Burma, MSIM has been committed to improving the RH of Burmese women and the community through addressing the dire unmet need for contraception. Meanwhile, the extent and impact of HIV transmission in Burma has been hampering the health and development of the country. As almost 70 per cent of HIV infection in Burma is sexually transmitted among men and women, MSIM sees benefit in integrating HIV prevention and STI treatment services into FP and RH services. Clients accessing FP services may well need HIV prevention and diagnosis services. Many clients with STI and those who are at risk of STI and HIV also need FP services. However HIV is one of many potential health risks. Experience from MSI globally highlights that providing a broad range of SRH services enables service providers to reach, and therefore protect, more people.

Complimentary Service Delivery Models
Community based education, distribution and mobile services complement the centre-based services. Provision of a broad range of services, promoting choices in commodities and services, and facilitating clients to make informed decisions are the pillars for program success. Outreach and mobile service delivery modes complement government SRH services by referring more complicated cases to government hospitals and reducing the burden on over-stretched local health resources. Outreach and mobile services provide those in more remote communities with better access to health resources, than fixed centres allow.

Community Based Distribution Model
Community Based Distributors (CBDs) were recently introduced into the MSIM program to help reduce the physical and material distance for those who cannot access MSIM centres and to improve the client-provider interface. Following MSIM training, CBDs are better equipped and empowered to interact with the community on SRH issues. Typically they come to be seen as prominent community members and valuable community resources.

Recruitment of local program teams
Recruiting staff from the project sites has several advantages. Speaking the local language, understanding local customs, culture and traditions greatly facilitates effective communication with the community and creates more acceptance and utilization of services.

Client Friendly Services
Past experience of SRH service provision in Burma highlights that accessibility, acceptability; affordability, continuity, choices, convenience and confidentiality are the key elements in improving access to and utilization of RH services by communities. MSIM seeks to provide an environment that is professional, warm and inviting for all clients. Regular feedback on client perceptions of service quality are sought through anonymous and voluntary client satisfaction exit questionnaires. Additionally "mystery clients" are regularly sent into the MSIM centres to assess service quality and client-friendliness of the service providers. The client feedback forms and mystery clients continue to be important tools to improve MSIM service quality.

Building the Capacity of Service Providers
In order to provide quality SRH services that respond to the needs and rights of diverse groups of target beneficiaries, having clinical competencies is important, but not sufficient. Service providers need to be sensitive to the cultural and social context, structural factors, and

gender constructs that can either facilitate or undermine the SRH of individuals and the community. Communication and interpersonal skills need to be strengthened to ensure client friendly SRH services are provided. Equipping service providers with the most accurate information possible and supplemented this with consistent refresher and in-service training, monitoring of sessions and supportive supervision are crucial to improve and maintain capacity to deliver BCC interventions and SRH services. Critical concepts of service quality and service marketing need to be introduced to new service providers and reinforced to existing service providers to create value for clients.

Working effectively with Sex Work Populations

Experience from INGOs working in Burma with SW populations[18] as well as international experience[19] highlights the importance of building relationships with sex work gate keepers (brothel owners and owners of entertainment establishments) to help build a supportive environment for SWs to practice safer sex behaviours. Gate keepers have significant power over safe sex decision making and, if sensitised, can become powerful advocates supporting 100% condom use and rejecting clients that refuse to wear condoms. In Burma, sex work is illegal and up until 2006 police could arrest a woman carrying a condom as evidence of sex work. As seen in the problem analysis this has had flow on implications for the perceptions of condoms as a family planning method. Advocacy with the authorities on the nature and purpose of the program with SWs is very important. Additionally, BCC is significantly more effective if provided by peers, who are able to realistically explore and discuss challenges and successful strategies associated with negotiating condom use.

Males and females have different needs

MSIM's experience in Burma highlights significant cultural value differences for males and females when it comes to SRH issues, these differences are seen playing out behaviourally. For example, more males than females will attend ARH facilities that form part of many MSIM centres. However, males generally do not use the centres facilities for SRH treatment/advice. This highlights two factors. Firstly, there are barriers to female youth attending SRH centres. MSIM will conduct in-depth focus group discussions to look into these barriers and to develop approaches that enable young women to get the information and services they may need yet are sensitive to the cultural environment. Secondly, it reinforces that males have different health seeking behaviours. If STIs or RH issues are suspected, firstly they will self medicate. If symptoms persist they are more likely to visit a private GP than a SRH centre like MSIM. Therefore males have particular information needs around service availability and MSIM needs to pro-actively improve male involvement in their program. This is discussed further in the next section, Proposed Approach.

Advocacy

Local level advocacy, both formal and informal is crucial to gain firm support for activities. A single discussion is not adequate for building support and trust. These interactions need to be carried out in sustained manner, particularly when there are frequent changes among local level authorities. The complementary nature of MSIM services to the government services needs to be clearly articulated to the government. Building this understanding enables the establishment of referral networks, and creates more space for MSIM to work with local communities. Regular information sharing, building personal relationships with local level

[18] FHAM Annual Report, UNAIDS, 2005.

[19] WHO, Violence Against Sex Workers and HIV Prevention, Information Bulletin Series No.3.

government personnel and regular and transparent reporting enhance coordination with the government sector.

c. Strategy Selection/Proposed Approach

The proposed approach has been informed by:

- The local problem analysis
- Lessons learned from past MSIM experience and from the MSI Global Partnership.
- MSIA, MSIM, MSI Global Partnership and international best practice for FP and RH service provision.

Increasing SRH knowledge with a focus on Behaviour Change

Increasing knowledge of SRH was highlighted as critical for all target population groups: males and females of reproductive age, youth, and sex workers. There are a number of options available for raising knowledge:

a. ***Mass communication campaigns*** (television or radio) providing SRH health messages have the advantages of reaching a wide population, stimulating community discussion, sensitising communities to previously taboo issues, and making people aware of service outlets. However, they are not found to be *as effective* in producing an intention to change behaviours as one to one and small group peer education and exchange sessions[20]. There are also limits to mass media approaches in Burma including restrictive and lengthy approvals processes for publicly released campaigns, limited and unreliable electricity supply restricting access to TV and radio messages, multiple languages spoken in project areas, and highly variable attitudes to SRH in different parts of the country. For these reasons a nationwide campaign has not been selected. Rather, the program will work with local troupes to develop community theatre that raises awareness of SRH issues in the community in a culturally sensitive way.

b. ***Information, Education and Communication Materials***. IEC Materials are an important part of most SRH education programs. Materials need to be tailored to the local context. Highly pictorial IEC materials are useful in setting with different local languages and lower levels of literacy. Like mass communication campaigns, public IEC materials need to go through lengthy approvals processes. MSIM already has a number of existing materials on FP and SRH which could be adapted for the local situation including: pamphlets on different FP methods; STIs for men and women; Adolescent RH; VCT for HIV; SRH counselling; flannel graphs on the menstrual cycle; conception and contraception; as well as a variety of promotional materials with SRH messages. Whilst it is recognised that IEC materials alone do not produce behaviour change, they are an important element and will be utilised in this program in accordance with the *Guiding Principles* of AusAID's Family Planning Comprehensive Guide.

c. ***Behaviour Change Communication*** is an iterative process with individuals and small groups to develop a more in-depth understanding of an issue. BCC focuses on increasing knowledge, stimulating community dialogue, promoting changes in attitudes, reducing stigma and discrimination, creating demand for information and services, improving self sufficiency and encouraging health seeking behaviours[21]. Key elements of behaviour change communication involve identifying existing beliefs, values and knowledge of SRH, gender norms and community attitudes and how these effect sexual decision making. Improving knowledge and critical analysis skills helps build self esteem. This in turn is important to empower target populations to negotiate safer SRH behaviours. The

[20] Sohail, A. Van Rossem, R. *Impact of mass media campaigns on intentions to use the Female Condom in Tanzania*, International Family Planning Perspectives, September 2002.

[21] Behaviour Change Communication: A Strategic Framework, Family Health International, 2002.

proposed project will deliver one to one and small group BCC through SRH Promoters (peers and outreach workers).

d. ***Tailoring messages for youth.*** BCC is the key vehicle for knowledge transfer but international experience tells us that messages need to be tailored for particular target populations. Programs for youth that focus on delaying sexual debut, reducing the number of sexual partners, and increasing correct condom use have considerable potential to prevent teen pregnancy and reduce the incidence of disease[22]. MSIM has already adapted the "Lifeskills" curriculum which has been tailored by both UNICEF for in-school youth and Save the Children for out of school youth. The existing MSIM youth lifeskills curriculum will be adapted at the start of the program to take into account the recommendations from the gender analysis. Youth peer SRH Promoters will conduct small group awareness raising sessions using the revised curriculum, ensuring it is delivered in ways that are sensitive to the cultural environment around pre-marital sex.

Maximising the Choice of Services: An Integrated Delivery Model

Whilst the options for service delivery include the provision of single services such as providing contraceptives through social marketing, the overwhelming evidence from MSIM and the MSI global partnership suggests that an integrated service delivery model will have a greater impact in a low resource context like Burma. There is a direct link between the provision of integrated STI and FP services and increases in STI coverage. The WHO states that in Africa, the most successful examples seem to be the Marie Stopes centres that provided comprehensive services responding to a wide range of client needs…MSI integrated RH programs in Malawi, Tanzania and Zimbabwe increased STI case-load using this approach[23]. Additionally in countries considered to have a generalized HIV epidemic and low resources, such as Burma, there is considerable value in integrating FP and HIV prevention efforts[24]. Having multiple services increases the number of entry points for further service provision.

Consequently, MSIM will make available in all SRH Centres the following services:

- ***A full range of contraceptives*** including pills, injections, condoms and emergency contraceptive pills will be available at the centres. The principle behind MSI's service provision is to increase and make available a greater range of RH options for women and men. In compliance with the *AusAID's Family Planning Guidelines (2002)*, only contraceptives registered in Australia will be used. Counselling will be provided to all clients seeking FP services to help them make them aware of the full range of contraceptive choices appropriate to their individual needs, providing both informed choice and informed consent.
- ***Treatment of STIs***. MSIM follow the MoH's ***National Guidelines for the Syndromic Management of Sexually Transmitted Infections***. Syndromic management is the *minimum standard of care*. However, sole reliance on syndromic management is problematic. For example, detection of asymptomatic infections such as Chlamydia and Gonorrhoea can only be achieved through screening. MSIM centres have laboratory facilities and can undertake tests for Syphilis. MSIM will look forward to integrating new STI diagnostic tools as these become available e.g. the new urine test for Chlamydia.
- ***Voluntary Counselling and Testing for HIV***. MSIM conducts testing in accordance with UNAIDS guidelines, adopting the 'three Cs': confidentiality, informed consent and counselling. This includes pre-test counselling that helps patients to decide whether they

[22] Kane. M. M. and Colten, T. C., PathFinder International, 2005

[23] WHO: http://www.who.int/reproductive-health/gender/sexual_health.html

[24] *Integrated Family Planning & HIV/AIDS Services*, Johns Hopkins Bloomberg School of Public Health (2006) Issue 6: "Focus On".

may need a HIV test, assures them of confidentiality and helps to prepare them for either a positive or negative result. As one of only two NGOs given with permission by the government to conduct testing, MSIM will undertake the HIV tests in their centres (using rapid test diagnostic tools) with results and post test counselling provided to all clients.

- ***Maternal Care*** including routine check-ups, identification of problems and risk factors, management of anaemia, screening and treatment of uncomplicated malaria and syphilis, referral for prevention of mother-to-child transmission of HIV services. MSIM adapts DoH Guidelines which are based on WHO Integrated Management of Pregnancy and Childbirth for antenatal care.
- ***Post Abortion Care.*** Using the MSI Global Partnership Manual, MSIM will provide medical treatment, support and counselling for women suffering from complications as a result of unsafe abortion.
- ***Advanced SRH counselling.*** FP and HIV test clients have always received routine counselling. However, to accommodate the more complex behaviour change approaches proposed in the PFHAB program, more advanced skills in one-to-one and small group counselling will be introduced on behaviours which are considered risky and unsafe.

Delivering Quality Information and Services though SRH Centres and Outreach Services

Whilst it is possible to provide purely centre based services, both DFID research[25] and MSIM experience suggests that males are less likely to use centre facilities for SRH services. Outreach services, however are found to be a particularly good way of providing SRH services to men, youth and other vulnerable populations (such as SWs) who haven't traditionally been the focus of SRH activities.[26] Independent evaluations of MSI programs in South East Asia and the Mekong Region indicate that an outreach and centre based model for service delivery enables optimal reach and coverage. Demonstrating its value, this model has been replicated in countries around the world by MSI Global Partners.

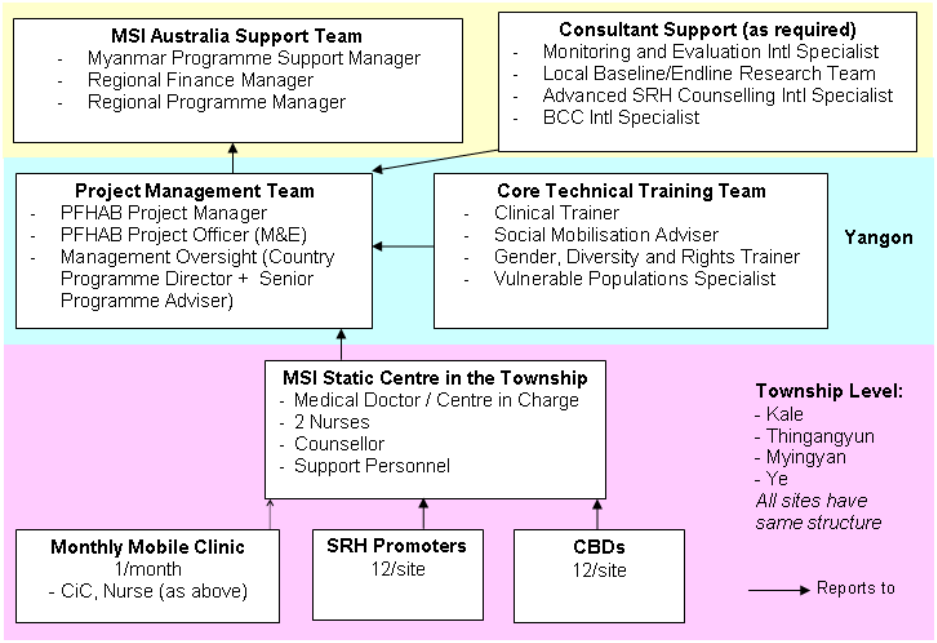
To deliver the PFHAB project, MSIM has developed both an outreach and centres based structure. Managing and guiding the project direction is the Project Management Team based in Yangon and they are supported by a Core Technical Training Team (CTTT). The CTTT consists of four technical specialists: a Clinical Trainer; a Social Mobilisation Adviser; a Gender, Diversity and Rights Trainer; and a Vulnerable Populations Specialist (Youth and SWs). This team will be responsible for developing a set of integrated SRH Guidelines that cover both behaviour change communication and clinical aspects of the program. Whilst being based in Yangon, they will spend most of their time in the field building the capacity of the field teams through formal training and ongoing mentoring.

Each of the four selected townships will have a fixed centre staffed by a medical doctor, two centres nurses, a counsellor and a technical/ administrative support team. To extend the reach of the centres, the medical staff will operate a mobile clinic in the more remote village tracts of the township once a month. Additionally, in each township, 14 SRH Promoters and 14 Community Based Distributors (CBDs) will be recruited from, and by, the local population. The SRH Promoters will work within local communities to provide target groups (Men/Women of Reproductive Age, Male/Female Youth, and SWs) with tailored SRH information and BBC. The CBDs are local distributors of FP methods (typically condoms, contraceptive pills and iron tablets) and are not health care professionals. The CBDs are a key element of MSIM's CSM program, which has been proven to improve accessibility and affordability of contraceptives.

[25] Strengthening linkages for Reproductive Health and HIV/AIDS: progress, barriers and opportunities for scaling up. DFID Health Resource Centre, August 2006.
[26] Ibid. DFID Health Resource Centre, August 2006.

This approach contributes to increased utilization of SRH services and increasing acceptance of FP, particularly in traditional societies and rural areas. Both CBDs and SRH Promoters will provide referral to centres for more long term methods or treatment of RH problems. The local employment of CBDs and SRH Promoters contributes to household income generation which helps to foster sustainability.

Diagram 2: MSIM/A Program Team Structure



A Gender Sensitive Approach

The problem analysis reveals that men have power over SRH decision making and they are more likely to engage in behaviours that put them at higher risk of contracting STIs (such as visiting SWs). The majority of the existing MSIM teams, including the clinical service provision team, outreach workers and CBDs are female. This imposes some limitations for potential male clients to openly discuss their problems and utilise services. Disproportionate underutilization of SRH services by male clients suggests that MSIM needs to put concerted effort into improving male involvement. Creating a more gender balanced workforce, enlisting appropriate and demographically targeted men as agents of change in SRH, and delivering messages and activities which promote safe and responsible behaviours of both men and women will be key to addressing this imbalance.

The program will not, on the other hand, lose sight of the overall disadvantaged position of women in communities and build on the already strong reputation of MSIM advancing women's RH rights in the community. A particular focus will be on female youth who may or may not be sexually active. These girls/women are made particularly vulnerable by strong social norms that suggest unmarried girls do not engage in sexual activity. Evidence suggests this is not necessarily the case but under such strong norms, sexually active young women are unlikely to seek support to protect their SRH and prevent unwanted pregnancy. They are also less likely to be able to negotiate safer practices with their male partners. Small group discussions with female youth using BCC methods will be important to build self esteem and female confidence in SRH decision making.

To help better understand gender and ethnic disparities and to assist the program team in building their skills to work effectively with both males and females of different ethnic groups on SRH issues, the CTTT includes a Gender, Diversity and Rights Trainer. The

Gender, Diversity and Rights Trainer will conduct a gender analysis in the first three months of the program, and will ensure gender aspects are mainstreamed into all training and guidance material. Gender and diversity principles and concepts will be discussed with all training service providers to enable them to provide gender and ethnically sensitive services. Gender, and where possible ethnically, disaggregated data will be collected in all aspects of the monitoring framework.

Selected Aid Delivery Modality

This activity design has been developed in accordance with AusAID requirements for the PFHAB. As such, a project based service delivery model is proposed. This approach is congruent with MSI program delivery around the world. MSI's global approach supports sustainability by predominantly engaging local staff with a view to creating self sustaining local NGOs.

3.0 THE ACTIVITY

This project will contribute to the *Framework for Humanitarian Assistance to Burma* (Draft). With the assistance of the PFHAB program MSIM will be able to expand its reach to increase access to areas of the population previously where SRH information and services and choices have been prohibitive through cost, distance and other constraints. By recruiting local men and women in this program MSIM will be able to empower their communities through promoting RH rights to services, which previously have been off limits to them.

Through the partnership links of CBO's and civil society initiatives and information will ensure that individuals and communities are able to play a key part in their own decision making regarding SRH and therefore a greater impact on their own lives.

Through further expansion MSIM will be in the position obtain and analyse further health data and information to contribute to a larger strategic picture for health in Burma. This type of information will in turn contribute to a greater understanding of unmet needs in relation to poverty and underlying social determinants in Burma. This information will be able to be used to provide a better understanding or strategy for Australian aid to Burma.

It is well established in international RH that strong SRH services, a core component of which is FP, can have a sustained effect on reducing poverty. Family planning activities empower women and men by increasing their ability to freely choose how many children they wish to have and when to have them, helping reduce the number of unwanted pregnancies and unsafe abortions. Having freedom to choose family size enables families to invest more in nutrition, education and health for all household members. Universal access to SRH education, information, and services improves health, saves lives, and reduce poverty.

3.1 Goal and Purpose

The project goal is to ***contribute to the improvement of the sexual and reproductive health of the Burmese population.***

The project purpose is to ***increase the adoption of safer SRH practices through the use of quality, accessible SRH services for men and women of reproductive age (15-49 years), youth (10-24 years) and SWs in Myingyan, Kale, Thingangyun and Ye.***

3.2 Component Structure

The project will be implemented in four townships in Burma: Kale in Sagaing Division, Myingyan in Mandalay Division, Thingangyun in Yangon Division and Ye in Mon State. Components, outputs and activities outlined below are designed based on participatory research and consultation with community members and MSIM service providers (as detailed

in Section 2), as well as local, national and international lessons learned. Further research, consultations and analysis of data will be undertaken in the first three months of project, the resultant information obtained will direct any further additions or modifications to activities. Due to the 6 week deadline given for the design phase, more in depth research was not possible but will be undertaken in the first 3 months of implementation.

COMPONENT 1: Capacity Building for the MSIM team

Due to the unmet need for RH information and services, limited trained personnel and constrained access to up-to-date information and resources MSIM will revise and up-grade (where warranted), existing MSIM clinical guidelines to strengthen service providers clinical skills and SRH practices (e.g. FP and HIV VCT counselling). This will empower MSIM team members and allow for sustainability of service delivery. The purpose of the CTTT is to build knowledge and drive quality in all aspects of the program.

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

Activities consist of:

1. The MSIM Project Management Team will identify and select four CTTT members from experienced SRH providers and development professionals, some of whom may be existing MSIM Team Members.
2. The CTTT members will review and modify existing SRH guidelines to develop a set of integrated comprehensive SRH guidelines. These new guidelines will cover clinical skills (FP, STI management, HIV VCT, maternal care, post abortion care and advanced SRH counselling) as well as service delivery techniques such as behaviour change communication, community education and mobilisation. The new guidelines will incorporate gender aspects and will be based on international best practices (e.g. MSI Global Partnership Manual, WHO and where applicable National).
3. The CTTT will train approximately 5 Clinical Service Providers per centre and 28 outreach workers (CBDs and SRH Promoters) in both clinical skills and one-to-one SRH counselling and behaviour change communication (refer to Diagram 2). This training will be competency based, involving an annual assessment, regular supervision and annual refresher training.
4. With the assistance of an international consultant, MSIM will establish and implement a client centred service quality and service marketing framework which will be adapted for "local service standards". Client satisfaction will be routinely assessed using client satisfaction exit questionnaires and mystery clients at all four centres. Additionally MSIM conducts annual centre audits as part of the MSIM service quality review, where client inputs are sought.
5. Centre Managers in the 5 townships centres will be trained in cost control and budget management by MSIA Regional Finance Manger through annual trainings.

COMPONENT 2: Behaviour Change Communication and Contraceptive Social Marketing

BBC involves identifying existing beliefs, values and knowledge of SRH, gender norms and community attitudes and how these effect sexual decision making. A positive outcome of BCC is building self esteem to ensure people feel confident to ensure that their priorities are safer SRH practice behaviours, such as being able to negotiate condom use for women, men and youth.

CSM improves access and availability and up-take of contraceptive information and services to men and women who are unable to access township centres because of rural isolation.

CBD networks allow and promote a wider reach of information and supplies and facilitate referral to MSIM and appropriate health services.

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.

Activities will consist of:

1. With support from MSIA and a Monitoring and Evaluation Consultant, the project team will develop a monitoring framework and design a baseline and endline survey to assess SRH knowledge, attitudes and practices (KAP). The information from the KAP study will be used to target BCC methods and for logical framework monitoring.
2. The monitoring and evaluation consultant, CTTT and Project Management Team will identify, train and supervise a team of data collectors, which may include some SRH Promoters, to undertake the baseline and endline surveys.
3. A Gender Analysis will be undertaken in the first three months of the implementation phase to assist in the identification of solutions to encourage a balance of utilisation of services by both males and females. The Gender Analysis will identify how to best target BCC messages to males and females. CTTT will assist the team to mainstream gender throughout all activities.
4. Based on analysis of the KAP study and the Gender Analysis and in compliance with *AusAID Family Planning Guidelines*, the Project Management Team and CTTT will develop and/or adapt existing IEC materials in conjunction with identified community members and CBO's, such as the Mon Literature and Culture Association, to tailor messages to be both culturally sensitive and in the languages and dialects relevant to the township. Some IEC material will be visual and pictorial to take account of low literacy and multiple dialects/languages.
5. IEC materials will be tested for effectiveness by SRH Promoters, volunteers, and community members and modified as required. This will ensure that key messages are clear, understandable, and easy for target communities to relate to. The project will not only ensure integration of HIV and RH messages but also promote the concept of the dual protection role of condoms.
6. Peer Educators from existing MSIM ARH activities will support and train the new Youth SRH Promoters on how to engage with and mobilise male and female youth on SRH issues. This will be supplemented by technical training from relevant members of the CTTT.
7. CTTT will build the capacity of and assist field teams to advocate with gatekeepers (e.g. brothel owners) and negotiators (e.g. entertainment establishment staff) to enable SWs to access SRH IEC material. Methods to gain access include the provision of free condoms to brothels and economic arguments about the value to the gate keepers and negotiators to ensure the women remain healthy and well. Once access has been gained, small group discussion sessions and one to one discussion sessions around SRH will take place. Whilst not specifically targeting these populations, the Gender Diversity and Rights trainer of CTTT will also ensure that both clinical and non-clinical team members are sensitive to diversity and different needs of different groups including MSM and IDU.
8. Different approaches will be used to reach out to sex workers; building rapport and ensuring sustained interactions with them, advocating with gate keepers who are crucial to creating an environment that enables sex workers and their clients to adopt preventive behaviours and seek treatment. In townships where there is a long established and trusting relationship between SWs and MSIM, the CTTT and SRH Promoters will assist the formation of Self Help Groups (SHG) with the aim of strengthening social support and networking amongst SWs, to build their capacity and to mobilise locally available resources. Where SW SHGs already exist, supported by other INGOs, MSIM will offer

SRH services and advice. SHG members will be trained in BCC methods so they can become peer educators in SRH issues within their own networks. Clients of SW will be reached through community education and behaviour change initiatives targeted to promote safe and responsible behaviours of men.

9. SRH Promoters will facilitate small group sessions with target populations to discuss SRH issues and promote safer SRH practices.
10. In response to raised awareness about SRH, MSIM will enhance and develop strong referral mechanisms between public, private and NGO service providers to increase access to services and information.
11. Relationships with CBOs will enable MSIM to conduct training and small group awareness raising sessions on SRH into communities that CBOs are networked into.
12. In all four townships, MSIM team members will promote community awareness of SRH issues by working with local traditional theatre troupes to conduct activities (plays, puppet shows etc) that raise awareness and encourage SRH seeking behaviours. These will generally be conducted as part of village pwe (festival) events which may be connected with religious festivals, major public holidays such as Thingyan (Water Festival) and World AIDS Day (December 1st). Specific theatre activities will be youth orientated.
13. BCC also involves one-to-one counselling on safer SRH practices and dispelling myths.
14. Project Team and community will identify and select CBD agents from the community. MSIM will support CBDs who in turn will provide affordable oral contraceptive pills, condoms and iron tablets to communities at the grass roots level. To maximise the performance of CBD agents and, minimise agent drop out and poor utilization of services, each agent is assigned to specific catchment areas and populations. In areas where women cannot leave home easily, the CBD may visit clients at home. Otherwise, the CBDs will provide the commodities through supply depots. As far as possible the CBDs will be selected from and by the communities they serve and reflect the gender and age profile of the target populations and the ethnic profile of the community.
15. Induction training by the CTTT will be provided to all CBDs and their knowledge and skills will be regularly updated through on-site refresher training and regular monitoring and supervision by the CTTT and centre management staff. CBD training focuses on the benefits of service and product use, correct methods of contraceptive use, side effects of those methods, mechanisms for referral, the distribution system, record keeping, basic information about STI and HIV, and skills and techniques for communication and community mobilization. Information is also provided on how to work with specific groups such as youth or single women.

COMPONENT 3: Integrated service delivery methods

Two new MSIM centres will be established as part of the PFHAB project, in Kale and Ye and the two existing centres in Myingyan and Thingangyun will be up-graded to enable delivery of the full range of SRH services. Comprehensive services include FP and birth spacing advice and methods, STI management, VCT for HIV, ante-natal care, post-abortion care and youth specific RH services. All services and information provided are in alignment with the *AusAID Family Planning Guidelines –refer* Annex 8.

Output 3: Delivery of comprehensive SRH services through 4 integrated service delivery centres and community based service provision

Activities will consist of:

SERVICES	SRH CENTRE	MOBILE CLINIC (1/month)	CBDs SRH Promoters
FAMILY PLANNING			CBDs: Contraceptive pills and condoms only
STI/RTI MANAGEMENT			
HIV VCT			
MATERNAL CARE			
POST ABORTON CARE			
SRH COUNSELLING			
SRH REFERRALS			
YOUTH SRH SERVICES			
AWARENESS RAISING			

Service Available

1. SRH clinical services are delivered by trained team members from each centre. The clinical team comprises of medical practitioners, nurses, counsellors and support personnel including receptionists, lab technicians, cleaners, drivers and security personnel. The clinical team are trained in all components of SRH services and employed under MoH regulations. SRH services are provided through static centres and community outreach teams. Clinical teams provide SRH services (FP, STI treatment, VCT, maternal care, post abortion care and SRH counselling) at the centres and through mobile clinic facilities and outreach (CBD/SRH Promoters). MSI Centres will not provide medicines for PMTCT but will provide the other prongs of PMCT interventions: prevention of unwanted pregnancy, prevention of HIV transmission through community based and centre based education and counselling and providing referral and support to access other organisations (NGO and Government) that do provide this service. PMTCT medical services are available within close proximity (2 hours) of all project sites. MSI will not be providing ART medicines as these complex programmes require significant resources and MSI global policy does not yet endorse ART. There are relatively few service providers of ART in Myanmar but in Thingangyun (Yangon) MSI can refer positive people to the relevant Government Hospital and NGO ART programmes. Additionally MSI can provide pre and post test counselling, and provide information on "positive living".
2. MSI is aware that PLHIV have fertility desire and SRH needs for their wellbeing. In order to address these needs, training of CTTT and field teams will include sensitizing the team on the needs and rights of PLHIV to have a safe and satisfactory sexual and reproductive life in a supportive environment. Team members will be trained to provide information and services including counselling to help PLHIV express their SRH needs, make informed choices in fertility and contraception, breast feeding and adopt safe pregnancy and delivery care seeking practices.
3. For the two new centres, the local team will survey community ability to pay for SRH services. This information feeds into the MSIM framework for costing services across the country so they are realistic and achievable to meet the needs of the population. MSIM has the option to subsidise fees based on an understanding of the local socio-economic context.
4. Upon presentation the following data is collected by centre records, e.g. client demographics, types of service required and pharmaceuticals supplied are recorded on the MSIM core monitoring Management Information System (MIS). This is collated monthly in-country and sent to MSIA for regional analysis and feeds into the global MSI MIS data. This information provides SRH service delivery data to direct in-country operations, including advocacy and strategy.
5. Laboratory services: In MSIM centres diagnostic testing is available for: HIV, Syphilis and Malaria. MSIM participates in the National External Quality Assurance Scheme for HIV testing under MoH/DoH. Twice a year the National Health Laboratory sends MSIM samples to be tested and provides feedback on MSIM's testing quality and technical support. MSIM centres also send off randomised HIV test samples for testing at the National Health Laboratory.
6. Procurement management: MSIM procures SRH supplies both internally and externally allowing the advantages of both choice and to mitigate the risk of pipeline rupture, this varies depending on what's available. MSIM has access to the MSI global pool and procurement experts in licensing and registration of such products. Through MSI global purchasing power MSIM is able to access low cost contraceptive supplies. Procurement is managed out of the Yangon Support Office by the Logistics Manager. Yangon Support Office holds a three month buffer stock of internationally procured supplies to mitigate

the risk of any pipeline, legal or import restrictions. The Centre Manager assesses supply stock monthly and orders the required stock.

7. Transportation: CBDs and SRH Promoters live within the community they service and will be provided with bicycles increase reach and frequency. These bicycles will be purchased new from local retailers, according to MSIM Procurement Guidelines. The CBDs are responsible for their own transport once the bikes are issued. The clinic based teams will rent vehicles for the mobile clinic and for travelling to more remote project sites. Due to import limitations and the consequent astounding prices for very old vehicles in Burma, this is a cost effective than purchasing vehicles.
8. Overall service management and supervision: The Centre-In-Charge is responsible for overseeing day to day running of the SRH services. Each centre has a finance person responsible for accounts and cash flow. Monitoring and support is provided from the Yangon Support Office Program Director, Clinical, Finance and Human Resource Managers. Overall monitoring will be provided by the MSIA Program Support Manager who will undertake one visit annually. MSIM uses the SUN Financial Program as the Financial Information System.

COMPONENT 4: Advocacy and Coordination

In alignment with the *Humanitarian Framework for Assistance to Burma* (draft), the need for advocacy and coordination in Burma and in the area of SRH is fundamental to providing an enabling environment for enhanced information sharing and exchange. Engaging other stakeholders in the discourse regarding RH will ensure sustainability of activities within both private and public sectors and creates vital linkages between stakeholders.

This output is designed to improve coordination within the SRH sector. In Burma there is a coordinated response to HIV and there is a RH Policy framework. HIV discussion focuses on high risk group HIV prevention and RH programming tends to focus on birth spacing. However, there is no common forum for government, NGO and private sector service providers to discuss integrated SRH issues.

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

Output 5: Public and Private sector providers have improved their capacity to deliver quality, integrated, client friendly SRH services.

Activities will consist of:

1. Quarterly coordination meetings between directors of PFHAB partner NGOs to share experience, identify complementarities, and build local links between the HIV, Health and Livelihoods programs. Meetings will review implementation, progress and share lessons learned, particularly with regards to accessing vulnerable populations, advocacy with key stakeholder.
2. PFHAB partners will also meet within Australia twice a year to review and discuss program issues to explore coordinated responses and information sharing. AusAID will be invited to attend these sessions.
3. The CTTT will advocate with UNICEF, UNFPA and the DoH to initiate a central level discussion forum on SRH issues in Burma. At the township level the CTTT will coordinate multi-stakeholder dialogue, focused on sharing information, experiences, and analysing gaps in RH services. Working within existing structures, the primary vehicle for sharing this information will be the Myanmar Medical Associations' Continued Medical Education forums.

4. MSIM will participate in township coordination committee meetings with public sector, NGO and private sector service providers to share information and improve collaboration on SRH issues.
5. The CTTT will contact private and public sector service providers for the 5 townships and assess any knowledge gaps in SRH service provision best practice. In response to identified gaps the CTTT will undertake sensitization of service providers to promote SRH rights and provide information and services.
6. Twice a year in project townships, MSIM will contribute technical updates on SRH issues as part of the Myanmar Medical Associations' Continuing Medical Education program. This is an ongoing regular meeting of medical professionals at the township level. Participants include government medical staff from public hospitals, GPs and medical professionals in partner INGOs.

The estimated number of beneficiaries of this project include:

- 30,000 men and 30,000 women of reproductive age will receive Awareness Raising and Behaviour Change Communication
- 5,000 male and 5,000 female youth will receive Awareness Raising and Behaviour Change Communication
- 500 female sex workers will receive Awareness Raising and Behaviour Change Communication
- 10,000 women will be provided with contraceptives
- 10,000 STI episodes (2,500 of men and of 7,500 of women) will be treated
- 2,000 men and 2,000 women will receive VCCT services
- 2,000 women will receive maternal care
- 400 women will receive post-abortion care
- 300 public and private sector health care providers, members of CBOs and local groups will have participated in capacity building activities
- The proportion of rural:urban clients will increase from 1:4 to equal coverage by the end of the project.

3.3 Duration/Phasing

The project will run for 5 years from 1 October 2007 to 30 September 2012. The first six months is an inception phase where two new clinics will be established and one existing clinic upgraded. Team members for the CTTT will be hired and new service providers for all centres recruited. The integrated SRH guidelines will be developed by the CTTT during this time. These guidelines form the basis for rolling out both clinical and non-clinical training to program teams in all locations. Community level activities will commence at the start of the program for the existing centre. For new centres, activities are likely to commence late in quarter 2 of the first year. During the inception phase a risk management plan (based on Annex 5) will be established and scoping for the monitoring baseline survey will be undertaken.

3.4 Resources

The total cost for design and implementation of the PFHAB funded project is AUD$1,964,692.69 over five years, with AUD 24, 492 allocated for the project design costs. Under the PFHAB AusAID agreement with MSIA, funds for the project were stated at AUD$1, 950,000 this total was to include the project design costs. There is a difference in the balance of funds for the project of AUD$39,418. Due to the expansion program of MSIM in Burma this extra funding is able to be guaranteed from MSIM/A through an independent funding source. The project is anticipated to start in October 2007 upon release of funds.

Human Resources will be sourced in country for all positions. The two Consultants will be sourced internationally. Project Technical assistance will be provided through annual visits from the MSIA Regional Manager and Program Support Manger. Financial Support (technical) will be provided by MSIA through the Regional Finance Manager and tracking and financial reporting through the SUN financial package which MSIM already uses.

Materials to implement the project will consist primarily of centre equipment and supplies. No purchase of building or motor vehicles will be undertaken. The purchase of transport equipment provided to the outreach teams (CBD's and SRH promoters) will consist of 96 bicycles as a non recurrent cost. Equipment will be sourced within Burma and supplies to the centres will be sourced where needed through the international procurement arm of MSI. Training materials will be developed in year one and modified to meet needs throughout the project. IEC materials will be developed with community members, organisations and target groups.

An asset register will be kept in accordance with AusAID policy and at end of project all resources will be kept by MSIM for future program activities.

Recurrent cost implications have been offset with the inclusion of a 5% annual inflation rate factored into the total cost of the project for all required resources including human. As is well acknowledged in Burma the inflation rate is difficult to estimate and the project design has attempted to ensure that activities will operate as initially designed under the resources and costs allocated.

Over the five year period the majority of capital expenditure will be incurred in the first two years. Human resources inputs will also be at a project high within the first year due to new centres and the implementation of the integrated service model using CBD's and SRH promoters. Government advocacy and liaison is scheduled to begin in year two allowing the collection of data through the baseline and other evidence of project success to be presented.

4.0 MANAGEMENT AND FINANCIAL ARRANGEMENTS

Coordination and Management

MSIM has established positive working relationships with the Government departments relevant to SRH operations in Burma. The NAP and the Public Health Division of the DoH are major counterparts for MSIM in addressing HIV and RH issues. The DoH partners have provided formal assistance in administration, procedural requirements and other formalities. Supportive relationships between MSIM and DoH resulted in MSIM being allowed to perform comprehensive HIV VCT services in 2006.

The Department of Population is an informal partner cooperating in research and information sharing since 2001. MSIM also shares working relationships with the United Nations agencies including UNAIDS, UNFPA and WHO. UNAIDS and UNFPA have had contractual agreements with MSIM on Adolescent Sexual Reproductive Health and HIV since 2003.

MSIM is a founding member of the Myanmar NGO Consortium on HIV and AIDS. The purpose of the Consortium is to improve the continuum of prevention, treatment, care and support for people at risk, and those infected and affected by HIV. Other members of the Consortium are Save the Children, CARE and the Myanmar Nurse and Midwife Association. These partners work together to scale up the HIV response in Burma and MSIM receives client referral from all the partners within the Consortium for RH and STI services. At the central level, MSIM is represented in the Technical and Strategic Group on HIV in Burma, a group that provides technical inputs for the national response to HIV. MSIM is also

represented in the Central Coordinating Body, a national level committee coordinating matters around the epidemic and responses against HIV, TB and Malaria

At the local level, MSIM participates in Township Coordination Committees[27] in which RH service providers participate in sharing information on upcoming activities. These are a valuable forum for this project as many key stakeholders in each township are involved.

As part of this program PFHAB NGOs will also meet on a quarterly basis in Burma to share implementation progress, identify synergies and lessons learned. Additionally semi-annual meetings between PFHAB NGOs will be conducted in Australia.

Coordination Roles and Responsibilities

The MSIM Country Program Director will be responsible for coordination with DoH and other relevant departments, UN agencies, and international and local organizations at central level. Coordination with State/Division and local level authorities and other stakeholder organizations at the corresponding levels will be advised and facilitated by the Country Program Director, Senior Program Advisor, the PFHAB Project Manager, and other senior staff within the MSIM team. The Country Program Director and Senior Program Adviser will represent MSIM in national level advocacy, policy setting, strategy formulation and technical forums. The Country Program Director will also coordinate and communicate with AusAID and other donors. The PFHAB Project Management Team will ensure internal coordination and information sharing among PFHAB partner agencies at head office level as well as at the field level.

The PHFAB Project Manager and PFHAB Project Officer will initiate and strengthen coordination with administrative authorities, local level DoH and with other with departments and organizations working in the same geographical or thematic areas. They will also facilitate field teams to establish and maintain positive working relationships with local authorities, the DoH, partner agencies (PFHAB and non-PFHAB), local networks, and key stakeholders. The CTTT will also play a role in supporting field teams in advocacy, coordination and partnership through training.

Within Australia the MSIA Program Support Manager will be responsible for coordination with the other PFHAB partners and AusAID.

Program and Financial Management Arrangements

MSIA will be responsible for the contractual management of the PFHAB program and will be the formal point of contact with the AusAID desk officer. The MSIM Yangon Support Office will provide direct project management through the PFHAB Project Manager with general program support/oversight provided by the Program Director, Senior Program Adviser, Finance and Human Resource Managers as well as logistical and administrative staff. The MSI Programme Director is the key point of contact for the AusAID post and both the post and desk officers will be invited to observe/assess activities, attend advocacy events at project sites and provide inputs as desired and as the opportunity arises. Progress on project activities will be overseen by MSIA and formally tracked through donor reports and MSIA's Global Partnership Reporting system which will provide monthly narrative, financial and statistical reports. Weekly telephone and regular email contact between MSIA's Burma Program Support Manager based in Melbourne and the MSIM Country Program Director based in Yangon will support implementation. The MSIA Program Support Manager will conduct annual visits to monitor and support PFHAB activities. The MSIA Regional Manager will support the MSIM Country Program Director in strategy and planning.

[27] Note that formal Township Coordination Committees are not always active in all townships. However, more informal coordination meetings amongst NGOs operating in a township and the Government occur in most townships.

External funds will be channelled from the MSIA bank account in USD to the MSIM bank account in Burma where they are withdrawn as Foreign Exchange Certificates (FEC). Both transactions will produce receipts, enabling regular review of cash flow and preventing large sums of money being held in Burma. MSIM has a MoU with the Government of Burma which allows an exemption for the 10% tax international organisations need to pay on funds received. The Regional Finance Manger will conduct annual visits to the project to conduct training, oversee and supervise financial aspects. Whilst in Australia, the Regional Finance Manager maintains regular communication with the finance team in Burma.

5.0 MONITORING AND EVALUATION

5.1 Measurement of Performance

Monitoring the Goal Statement

The key indicators for the Goal Statement are to contribute to:

- Reduced incidence of STIs including HIV
- Reduced maternal mortality rate
- Reduced number of unwanted pregnancies

National progress on these indicators will be drawn from official MoH, UNAIDS, UNFPA, UNDP Millennium Development Goal Country Reports. However, the latency effect with such statistics and the sensitivities in Burma around conducting and releasing accurate research and statistics may hinder timely assessment of these indicators. It must be recognised the Project will *contribute to* the Goal Statement so it is reasonable to expect *some* impact on the selected indicators, particularly in the townships where MSIM is working. However, it should be recognised that many factors contribute to changes in these high level indicators at a national level and the level of attribution of the MSIM PFHAB project in 5 townships is difficult to assess.

Monitoring the Purpose Statement

Key indicators to assess the purpose statement are:

- A 5% increase (from year 1 to year 5) of women and men of reproductive age reporting current use of modern contraceptive methods in project townships
- A 20% increase (from year 1 to year 5) on the baseline of the proportion of SW reporting condom use with the last client and consistent condom use with all clients in the past month in project townships.
- A 20% increase (from year 1 to year 5) on the baseline of the proportion of sexually active youth in project townships reporting consistent use of condoms.
- 10% annual increase of Couple Years Protection within people of reproductive age in project townships.

The first three indicators above will be assessed through the baseline (Year 1) and endline (Year 5) studies conducted in all 5 project townships. The studies will look at knowledge, attitudes and practices of the target populations and will seek to obtain both quantitative and qualitative information. The Project Management Team (PFHAB Project Manager, PFHAB Project Officer) is responsible for ensuring surveys are conducted and will engage the support of an international Monitoring and Evaluation Adviser to establish the parameters of the study and to oversee the activity. A local team of research assistants (including some SRH Promoters) will be recruited to conduct the research at the township level. The international Monitoring and Evaluation Adviser will train the research team in interview and information gathering techniques and conduct the analysis.

The fourth indicator on Couple Years of Protection can be drawn from the MSIM core monitoring information system. Couple Years Protection is the estimated protection provided

by contraceptive methods during a one year period based on the volume of contraceptives sold or distributed to clients during that period. The method utilises internationally established protocols used by UNFPA and USAID for assessment and estimates the coverage of contraceptive services.

Project Components

Detailed indicators are provided in Annex 2: The Logframe.

Monitoring Component One: Capacity Building for MSIM team

Component One focuses on the quality (clinical and client friendly) of the services provided by MSIM. This will be assessed though:

- Client Satisfaction of MSIM services. Voluntary and anonymous client satisfaction exit questionnaires based on the MSIM client service quality framework are collected at each MSI centre by the MSIM field teams. Analysis of the questionnaire findings will be undertaken by the field teams with the support of the Project Officer and CTTT. The findings will be reviewed by the Project Management Team on a quarterly basis. Additionally the Project Management Team will arrange regular "mystery clients", paid by MSIM, to assess MSIM service quality. Mystery clients will be briefed by the CTTT and Project Management Team on key qualities to look for. Mystery clients are sent to all clinics every six months. Feedback from both the mystery clients (reviewed six monthly) and the client satisfaction exit questionnaires (reviewed quarterly) will enable the Project Management Team to changes to improve MSI clinic and outreach practices.
- Annual Competency based assessments of project staff skills (clinical and counselling) to ensure teams are delivering services according to the integrated SRH guidelines will be undertaken by the Clinical Trainer with the support of other members of the CTTT. The outcomes of these assessments will be provided in the annual report and used as the basis for informing priorities in the annual training plan.
- A quarterly review of expenditure against the budget which can be extracted from the SUN financial information system by the MSIM Finance Manager. This is a proxy measure of financial management competency to ensure that all project sites are being managed in accordance with the budget.

Component Two: Behaviour Change Communication and Contraceptive Social Marketing

This component is about changing knowledge within the target populations through BCC methods and CSM. To measure effectiveness the project will review the:

- Percentage of men and women aware of at least three modern methods of FP (figures disaggregated by gender, age, location and ethnicity).
- Percentage of men and women of reproductive age aware of at least three benefits of birth spacing (figures disaggregated by gender, age, location and ethnicity).
- Percentage of female and males aware of at least three service delivery points to access modern SRH service providers. (gender, age, location and ethnicity disaggregated).
- Percentage of SWs aware of STI treatment service providers.

These indicators will be measured through the baseline (year 1) and endline (year 5) surveys and will be managed by the Project Management Team.

Component Three: Integrated service delivery methods

Component three focuses on uptake of FP, STI treatment, Maternal Care, VCT for HIV and SRH Counselling services. Key indicators include:

- Increase in the client numbers of men and women of reproductive age using MSIM SRH centre and outreach services (Gender, service, age, ethnic group, location disaggregated)

- Increase in the client numbers of youth using MSIM SRH centre and outreach services (Gender, service, age, ethnic group, location disaggregated)
- Increase in the number of SWs using MSIM services (service disaggregated)

This information can be collected through the Core MSIM MIS which provides data on service uptake rates in project townships. Data is updated from each township monthly and figures are tracked by the PFHAB Project Management Team to assess whether target populations are increasing utilisation of MSIM services. Where there is limited progress, the MSIM PFHAB Project Manager will investigate the problem and assess access barriers and/or other implementation delays.

Component 4: Advocacy and Coordination

This component is about building dialogue around the integrated nature of SRH issues. Dialogue is sought between all SRH service providers at township and central levels, as well as amongst PFHAB partners.

Key indicators are:

- Quarterly coordination amongst PFHAB partners in Burma and semi-annual coordination meetings amongst PFHAB partners in Australia highlight relevant lessons learned and identify synergies amongst partners
- 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).
- Changes in levels of knowledge of private (GP) and public sector SRH service providers will be assessed through year 1 and year 5 partner questionnaires. This information will be collated as part of the baseline/endline assessment and will be based on a Partner Defined Quality Framework that reviews clinical and non-clinical SRH knowledge.

Minutes of all coordination meetings will be kept and the key issues highlighted in the quarterly Project Reports provided to AusAID. It will be the responsibility of the PFHAB Project Manager to ensure these meetings are documented accurately.

Mid Term Review

AusAID will conduct a mid-term review across all PFHAB partners. MSIM will support AusAID both in Australia and in Burma to conduct this review.

5.2 Reporting Requirements

Quarterly Project Reports will be drafted by the PFHAB Program Manager and reviewed by both the MSIM Country Program Director and MSIA Program Support Manager prior to submission to AusAID. The reports will clearly outline progress against planned outputs and activities described in the Annual Plan. Regular monthly reports will outline any implementation issues, risks, unscheduled amendments to program activities and upcoming implementation plans. Where information is available, the reports will highlight beneficiary benefits and "stories of change" as a result of program activities.

Annual Reports will summarise the year's progress and include a summary of progress to date and an implementation strategy/work plan (including the training plan) for the coming year incorporating lessons learned from activity progress, expected outputs and results of the project in the coming year and describing the inputs required to deliver the workplan. Additionally the Annual Report will include an updated risk matrix, results of the annual financial audit, an updated family planning checklist.

6.0 FEASIBILITY & SUSTAINABILITY

This section outlines the feasibility, benefits and sustainability of the proposed project, providing ample justification for proceeding with the PFHAB project. Sustainability is fundamental to MSI's global partnership, as per the Partner Consensus Statement (2004): *MSI is a social enterprise providing 'Children by Choice not Chance' services that is compelled by donor disinterest to use business-like cost-recovery techniques to deliver affordable contraceptive services sustainably to underserved fertile couples.* The likely impact that this activity will have on the development situation and the people and organisations involved will be substantial. Access to quality SRH services, a core component of which is FP, can have a sustained effect on reducing poverty. Universal access to SRH health education, information, and services improves health, saves lives, and reduces poverty.

Consistency with the Policy and Program Framework

MSIA/M has designed and will implement this project within a wider policy environment which will affect sustainability of activity benefits. The *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 are complementary to MSIM's SRH program. The proposed project is in line with the PFHAB policy framework focusing on improving RH indicators and increasing the presence and reach of implementing partners in vulnerable communities (refer to Section 4.1).

The program is rooted in a principle of local involvement in service delivery. The MSI corporate philosophy of employing only local staff and developing self-sustaining national NGOs is a long term vision that is highly consistent with building sustainable local capacity in Burma. Additionally the program seeks to work through, and raise awareness of, local organisations (both private sector and CBOs) that will be capable of retaining and passing on the knowledge through existing local structures (market places, pharmacies, local theatre troupes etc) thereby extending the reach and longer term impact of the project.

Participation and ownership of local stakeholders

Stakeholders (men, women and youth) will actively participate by having the opportunity to influence the direction and detail of the design and implementation. Local stakeholders have been consulted since the beginning of PFHAB process through both FGD and in-depth interviews (refer Annexes 1 & 7). Additionally, two project sites have been operating for 3 years, enabling the design team to tap into local knowledge from both the service provider and client perspective. This inclusive consultation process has enabled the design team to have a much fuller appreciation of the breadth of knowledge and behaviours in the different locations and to design the project with sufficient flexibility to take into account differences in existing knowledge and practices.

Ownership and participation will be maintained throughout the project, through several mechanisms: client and community feedback (client satisfaction exit surveys and further FGD), local community members employed as SRH promoters and CBDs, and through advocacy and coordination with public and private sector providers. Additionally, stakeholders will be involved in the detailed design of project IEC material, training content and identifying the most appropriate training and service delivery approaches. Through the monitoring framework, regular program review and evaluation processes, MSIM will seek stakeholder feedback on implementation and, where feasible, act upon their recommendations. On-going ownership, participation and support by local communities and stakeholders will be maintained after major assistance from AusAID has been completed.

MSIM understands that a greater participation by women in identification, design and decision-making is a key part of a sustainability strategy. Female service providers play a major role in the design, implementation and monitoring of MSIM SRH services. MSIM will

employ a full time Gender, Diversity and Rights Trainer to undertake a gender analysis to determine the differential impact of costs and benefits on men and women.

Management and organisation, including institutional capacity

MSIM has a well developed reputation in Burma for quality SRH service provision and community outreach. A decade of experience has enabled the establishment of an excellent working relationship with DoH and other partner agencies. MSIM is directed by competent managerial leadership, led by the Country Director, Dr Sid Naing, a national who has vast experience managing large programs and donor funded projects and was formerly employed by UNAIDS Burma. Dr Sid Naing leads the MSIM SRH program which presently comprises 262 full-time team members, including twelve medical doctors, nineteen nurses and midwives, 95 ancillary team members and 25 support personnel. The support structures from both MSI Australia and the London offices provide the field based teams with up to date technical, program, administrative and financial knowledge. Management and technical support can be sought from MSIA and MSI UK at the request of the Burma Country Program Director and is routinely drawn upon to build local capacity. MSIM and MSIA have designed and will manage this project with some flexibility in implementation as lessons are learnt.

As far as possible, MSIM will support the knowledge and development of both private and public sector SRH service providers. However the endemic challenges associated with building local counterpart capacity in SRH services, particularly with the very poorly resourced (both human and material) public sector, need to be recognised. Working through existing structures such as the Myanmar Medical Association's Continued Medical Education program to build knowledge and skills is a useful and well accepted knowledge building forum at the township level. At the central level the development of a regular forum to discuss and address SRH issues will be a big step forward for Burma and will greatly enhance the sustainability of this program and other programs like it in the future.

As per the AusGuide, managing sustainability is a process aimed at maximising the flow of sustainable benefits. As part of the PFHAB program, this will be an ongoing process which will be frequently reviewed and updated as circumstances and lessons are learnt from experience. Monitoring and reporting frameworks based on tools such as the logical framework approach will assist to regularly assess the movement towards achieving sustainable outcomes.

Technical issues/appropriate technology

MSIM have taken into account technology that is appropriate in terms of technical and financial criteria, as well as social, gender and cultural acceptability. In particular, low resource technology, reliability of supply and local capacity to maintain the SRH equipment is critical to the smooth operations and sustainability of the program.

MSIM has a strong existing technical team and access to the UK and Australian Medical Development Teams as well as global information from 40 different countries. At present MSIM contraceptives are internationally procured and comply with the highest international standards. For example when procuring condom products both the manufacturer and product must comply with the latest ISO9000 series (manufacturer's quality systems) and ISO4074: 2002 standards. MSI policy stipulates that the quality of every batch of condoms is independently verified. There is a well established supply management system to ensure that medicines are in stock in the locations required. Staffing the Burma program with local medical doctors and nurses ensures they are capable of adapting technology to ensure it is locally appropriate, as well as being able to navigate the sometimes complex administrative operations associated with procurement and local authorisations.

Human and material resources

The human resource strategy adopted by MSIM is well suited to ensuring sustainable impacts from the program. Team members are hired from the project locations and care is taken to ensure their profile reflects the local language and ethnicity profile of the local area. Teams comprise members with both clinical and non-clinical backgrounds to ensure a balanced complement and both groups receive training to extend and build on their existing unique skills. As a philosophy, MSIM leans toward *paramedicalisation* of their service delivery to improve reach and accessibility of services and to reduce costs. The human resource capacity does not just reside within the MSIM organisational structure. Both formal and informal networks and partnerships are being built to strengthen other SRH service providers in the community.

Environmental impact

A combination of population growth and consumption patterns contributes to pressure on the natural environment. High population growth resulting from unmet need for contraceptives exacerbates environmental degradation, especially in vulnerable ecosystems. Worldwide unplanned pregnancies contribute twice as much to future population growth as desired pregnancies[28]. Slower population growth has in many countries increased those countries' ability to attack poverty, protect and repair the environment, and build the base for future sustainable development[29].

Economic and financial analysis (value for money)

MSI being a social enterprise, services and commodities will not be delivered or distributed for free but sold at prices calculated to ensure sustainability of the program and accessibility to the poorest members of the community. MSIM understands that demonstrated demand is a strong indicator of likely sustainability, both for economic and social sector activities. MSIM decides fee rates though regular surveys in relation to household and individual income to ensure service and product rates are affordable and meet the needs of the population. Fees will be waived for clients who are unable to pay. Discussion with focus group participants indicates that the fees currently charged by MSIM are within the financially accessible and acceptable realms of potential clients.

Income generated through fees paid will be reinvested in the ongoing operation of MSI centres. However, centres will not be fully self-funding post AusAID support. MSI London has generated discretionary income from several sources including US Foundations, bilateral donors such as the Dutch Government and UK service income. It is providing this money as a core grant to support the expansion of MSI partner organisations in developing countries, in line with MSIs international RH programme goals. The funds are being used to increase the capacity of the MSIM Team, as well as to significantly expand MSIM services by increasing the number of SRH Centres from 13 to 49 over the next five years. These funds allow MSIM flexibility and decrease their vulnerability to the external donor funding environment. At the end of the project, any gaps between ongoing operating costs, MSI's centre income and independent funding will be sought from other funding sources to keep these centres operating. MSI will maintain its policy of waiving fees for those unable to pay, thereby enabling the poorest of the poor to access services. Additionally the project is partnering with local groups dedicated to serve the most disadvantaged communities. Their engagement in the project will promote community resilience whilst also addressing the rights of all people, including the poorest and most disadvantaged, in the community.

Social and cultural feasibility

This program builds on ten years of successful SRH service delivery in Myanmar. The design is flexible and has involved local community members to assess the variations that

[28] Global Health Council, *Banking on Reproductive Health 21* (Washington, DC: Global Health Council, 2003)

[29] ICPD Program of Action, 3.14

may be required in different sites to account for local differences in existing knowledge, attitudes and practices. Significant investment has been made in building relationships both at the central level and with local counterparts. MSI has a proven ability to navigate difficult socio-political issues, to build community resilience and to protect vulnerable groups within communities. The key to managing a program of this nature in this sensitive operating environment is the time and effort expended by local teams in building those critical personal relationships through advocacy, generosity of spirit and a genuine commitment to improving the living conditions of their fellow local people.

7.0 RISK MANAGEMENT

To assess key risks, specific to the implementation of the proposed project, a detailed Risk Matrix is presented in Annex 5. The standard 5x5 matrix (also used by AusGuide) was developed by the project design team as part to identify risks, and review and rank them based on the likelihood and consequence of each individual risk event occurring. As Burma is a high risk operating environment in regard to NGO activities, and the matrix identifies a number of "High" risk events, a more detailed Risk Management workshop will be held in the first 3 months of the program to expand on the Risk Assessment and develop a risk plan. The ongoing process will feed into monitoring and reporting mechanisms for both AusAID and MSIM. Consultation and communication with stakeholders is paramount in both development of the Risk Assessment and the more developed proposed plan. Both the Plan and Risk Matrix will be updated annually. These activities will be guided by and incorporate the risk management cycle commencing with stakeholder dialogue. MSIM uses the risk management cycle for all activities in Burma to allow for continuous monitoring of risk in an often unstable operating environment

The PFHAB project will be delivered by MSIM, who are currently delivering a range of projects from multiple funding sources including the European Commission, 3 Diseases Fund, UNFPA among others. By using Risk assessment and management MSIM can assure AusAID that project activity risks have been identified and can be managed. All activities managed by MSIM are subject to an annual macro and micro risk assessment taking into account all risks in MSI's operating environment and how these may change over time. This is standard operating practice for MSIA to manage program risks throughout the region using the Australia/New Zealand Risk Management Standard 4360.

The Operating Environment for NGOs in Burma

MSIM has successfully implemented services without significant interventions from Government. Gaining and ensuring consistent access to some geographic areas is an obstacle for delivery, but also for establishing the effectiveness of the programs. At present only one proposed site (Ye in Mon State) is in a "brown zone" of the country where land is currently contested by the Junta and the insurgents. There are other INGOs (including PFHAB partners) working in this site and therefore it is possible to triangulate information on changes that may affect security. The UN Resident Representative also provides regular security briefings and updates to heads of UN and NGOs working in Burma.

Moreover, there is a proposed framework under discussion for registration and guidelines for operation of NGOs, which would involve greater control over NGO activities if fully and consistently enforced. As the environment for NGOs is considered changeable and potentially volatile, MSIM remains flexible and pragmatic when developing strategic plans. Key to managing this risk is keeping abreast of developments that affect NGOs in Burma and networking with partner NGOs to discuss operating conditions on the ground. Likewise maintaining relationships with a variety of external stakeholders both at local and central level assist MSIM to take account of changing conditions.

Another variable which affects NGOs in country is the political lobbying of donors by interest groups occurring outside of Burma. At present there appears to be some strong lobbying from groups such as the Burma Campaign in the UK to review UK Government assistance to Burma. This is in spite of their position paper released in mid 2006 which highlights the dire need for humanitarian assistance particularly in sectors such as health.

The Policy Context

The Burma government has a draft *National Reproductive Health Policy* which validates MSIM's approach to integrated and comprehensive SRH information and services. This draft policy supports the draft *National Population Policy*, which has as one of its central tenets, to ensure the availability and accessibility of birth spacing services[30]. In practice, however, there is little to indicate that either of these policies will be officially accepted. The Government has an un-stated pro-natalist policy, and has indicated that it seeks a population of 100 million. MSIM needs to advocate to the DoH that the project activities are to be implemented in support of the *Five-Year Strategic Plan for Reproductive Health in Myanmar* in a broad conceptual framework rather than singling out the specific area concerned. In fact, MSIM requires public facilities to establish a referral network for services beyond the capability and capacity of the MSIM centres.

Incentives to Participate in the Program

In the past, MSI have had few difficulties in getting service providers and communities to participate in RH activities. People have access to very few sources of information on SRH and generally welcome the opportunity to participate in program discussions. However, due to cultural and gender factors such as the stigma around condom use and perception of being seen as a SW, cultural sensitivities surrounding discussing pre-marital sex and females power with regard to decision making, it can be challenging to see behaviour change, even if knowledge increases. A focus of this program on behaviour change techniques that have been tested and adapted to the local context should reduce the likelihood of this risk occurring. However, increased utilisation of services will be monitored through the MSIM core information system.

Small incentives, such as SRH promotional materials or free services when entitled (eg a 3 monthly injection after one year of support), for those 'regular clients' and 'satisfied clients' who serve as advertisements for MSI services, will be discussed in consultation with the respective clients and will be developed as part of the "Service Marketing Plan" outlined in the project description. MSIM management is acutely aware of creating perverse incentives for participating in the programme and will ensure this is understood by project team members and reflected in the final agreed criteria for awarding incentives and the type of incentives offered. Program teams will be provided capacity building training on both technical and marketing aspects at the inception period of the project and on-the-job training will also be provided during monitoring visits. Refresher training will be considered depending upon the requirements.

Technical and Cost Risks

Given that commodity pipelines in Burma can pose operational risks, close coordination with Health and Customs authorities, MSIM experience in effective planning, understanding of local systems and utilising reliable and efficient distribution mechanism ensure and mitigate ongoing procurement issues are mitigated in relation to external pressures. This project includes the delivery of contraceptive supplies and a 3 month buffer stock is standard risk management practice to mitigate any impact of pipeline rupture. To date MSIM's procurement system has delivered supplies consistently to target populations without any outage.

[30] Five Year Strategic Plan for Reproductive Health: 2004-2008. Ministry of Health, Burma

Unpredictable exchange rates and hyperinflation may impose cost constraints. Focus group discussions in the design process suggest that MSI's current costing structures are well within clients acceptable ranges. This risk must be monitored throughout the life of the program to ensure affordability and ongoing access to commodities and will be achieved by utilising the fee assessments, and exercising the right to subsidise fees based on an understanding of the local socio-economic context.