Serving the underserved:

Expanding reproductive health choices through improved access and equity in Kenya and Tanzania

Australia/Africa Community
Engagement Scheme May 2011

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INTERNATIONAL
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Acronym List

AIDS	Acquired Immuno-deficiency Syndrome
ANGO	Australian Non-Government Organisation
APAC	Australian Partnerships with African Communities
AusAID	Australian Agency for International Development
AYAD	Australian Youth Ambassador for Development
BCC	Behaviour Change Communication
CBOs	Community Based Organisations
DG	Demand Generation
EC	Emergency Contraception
FGDs	Focus Group Discussions
FP	Family Planning
GPS	Global Positioning Systems
HIV	Human Immuno-deficiency Virus
IUD	Intra-uterine Device
KAP	Knowledge Attitude and Practices
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MIS	Management Information Systems
MoH	Ministry of Health
MSI	Marie Stopes International
MSIA	Marie Stopes International Australia
MSK	Marie Stopes Kenya
MST	Maries Stopes Tanzania
NGO	Non-Government Organisation
PAC	Post Abortion Care
PNC	Post Natal Care
PNFP	Post Natal Family Planning
QTA	– Quality Technical Audit
SBA	Strength Based Approach
SRH	Sexual and reproductive health
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
WASH	Water, Sanitation and Hygiene
YFS	Youth Friendly Service

Executive Summary

The proposed project involves a partnership between Marie Stopes International Australia (MSIA), Marie Stopes Kenya (MSK) and Maries Stopes Tanzania (MST). The overall goal of this project is to contribute to increased access to and uptake of equity sensitive sexual and reproductive health (SRH) services by marginalised populations in Kenya and Tanzania. Under the Australia Africa Community Engagement Scheme (AACES) Objective 1, the project will aim to understand the nature and magnitude of health disparities created through marginalisation and deliver services that respond to these disparities. Much of this work will involve expanding service delivery through mobile outreach and social franchising. Other activity areas under Objective 1 include mainstreaming and operational research. Under AACES Objective 2, the project will seek to work in collaboration with the wider AACES program and the Australian Non-Government Organisation (ANGO) sector to engage in sectoral, thematic and programmatic policy dialogue with the Australian Agency for International Development (AusAID). Under AACES Objective 3, MSI International (MSI) will aim to increase Australian public awareness of factors contributing to unacceptably high rates of maternal mortality and morbidity in Africa. The project will last for five years (July 2011- June 2016).

The success of the proposed work to be undertaken under Objective 1 rests largely upon the participation of key project partners such as Government, the private sector and community based organisations (CBOs). The design of the project has allowed for development and strengthening of new and existing relationships with these three groups of project partners. Similarly collaboration and engagement with the AACES partnership is a critical factor in the achievement of Objectives 2 and 3. The design acknowledges the importance of engagement with these project partners and outlines mechanisms to ensure that this engagement is meaningful, productive and sustainable in terms of processes and outcomes.

Outline of the design process

The process of analysis underpinning the design of the project made use of rights based, strengths based and needs based approaches. A community based situation analysis was undertaken as part of the design process (see Annex 4). The analysis considered organisational factors, health system factors, socio-economic and political factors as well as community factors. The analysis included the following:

External environment scan: review of national maternal and child health (MCH), Human Immune-deficiency Virus (HIV) and SRH policy and strategy documents, roadmaps and evaluation documents; review of potential synergies with other AusAID Africa programmes and/or other AACES partners to identify points of intersection and overlap.

Internal environment scan: identification of gaps in MSK and MST organisational capacity; review of lessons learned across the Africa region, the identification of best practices in programming with marginalised groups; and a joint MSIA/MSK/MST design meeting.

Secondary data review: review of national and sub-national planning documents (e.g. district annual operating plans in Kenya and Tanzania), demographic and health surveys and other relevant materials.

Primary data collection: a review of MST and MSK internal data generated through its Management Information Systems (MIS) and other monitoring tools as well as stakeholder consultations conducted in the field with MSI' front line staff, women and youth groups, public and private sector service providers and other Non-Government Organisations (NGOs).

South South Exchange: Operations managers and outreach managers from Kenya and Tanzania conducted cross country program visits. This provided an opportunity for cross country learning, built project specific relationships and fostered partner ownership of the project.

Australian based consultation: The design process also involved consultations with AACES partners through AusAID hosted forums. Lessons learned from the Australian Partnerships with African

Communities (APAC) program were also considered through AusAID hosted forums. The broader ANGO SRH sector was also consulted on areas of shared concern and future potential for sharing of technical expertise. MSI maintained regular contact with the AusAID AACES design consultants through the design process. Consultation with the AACES/AusAID MCH representative occurred in Nairobi during the final design phase workshop.

The design process involved consideration of previous experiences and lessons learned locally and regionally. Both MSK and MST have a history of working with Government at local and national levels. This experience and knowledge has played a crucial role in project design in terms of realistically estimating the capacity building requirements of government health workers and ensuring project activities contribute to and complement existing health service delivery plans. Use of these existing relationships provided space for sharing of ideas and harmonisation of project approaches with current and planned Ministry of Health (MoH) activities. Open discussion resulted in a common understanding of intent and support for proposed activities and implementation arrangements. In addition to Government, MSI has also reflected more broadly upon its partnerships with local CBOs in Kenya and Tanzania to inform the project design. Exploring opportunities to develop strategic approaches to the formation of new and non-traditional partnerships has also been a key element of the design process. MSI's history of engagement with the private sector has also provided valuable lessons to inform the design and approach of this project. The experience of MSK and other African country programs has further informed the manner in which the private sector can be engaged to enhance the reach, impact and sustainability of service delivery. Experience from MSI Ethiopia in particular has suggested how complementarities across service delivery mechanisms such as outreach and social franchising can be capitalised on. The design process has also involved the leveraging of Australian expertise in disability inclusive approaches to SRH service provision through MSI's relationships with Australian state and federal SRH agencies. Support for disability mainstreaming in SRH information and service provision has been expressed by three leading Australian agencies: Sexual Health and Family Planning Australia, Family Planning Queensland and CBM. Their technical expertise will be leveraged through the life of the project. Equally, MSI's history of working with marginalised Indigenous youth in Australia has provided valuable insights into how best to access and engage youth in SRH information and service provision and in particular the fundamental importance of youth acceptability in the branding of information services and products. Much of the operational research component of the design has been informed by the experiences of MST and MSK and other country programs in Africa in providing outreach services. Outreach service provision in both countries has demonstrated to MSI that meaningful sustainability of service delivery beyond exclusive reliance upon mobile outreach can only be achieved through simultaneous engagement with public, private and civil society sectors. Likewise, aspects of the operational research component of the design have been informed by recognised gaps in MSI's experience and evidence base. Examples of this include; the effectiveness of various service delivery modalities in accessing and engaging youth, and the role of male involvement as SRH service users and barriers or enablers to female SRH uptake. Through the design process, recognition of MSI's capacity needs to effectively mainstream guidelines for SRH service provision for people living with disabilities was recognised. Rather than attempting a short term feasibility study to address this gap in experience during the design process, it was agreed that a systematic and rigorous engagement in this area would be more appropriately undertaken as a project activity. Organisational and individual capacity within MSI and its affiliate partners was developed through the design process with key lessons emerging from this. These include:

Investment in consultation: The consultation process enabled MSI and its affiliates to gain a better understanding of barriers to the provision and acquisition of FP services, particularly for marginalised populations such as youth and poor women, and to design activities responsive to these. Consultation with local health authorities and service providers also enabled greater

efficiencies in design, stronger integration of approaches and laid the foundation for meaningful partnerships at the local level.

Theory of Change: Through utilisation of Theory of Change principles, MSI and its affiliates have been able to design service delivery strategies that identify causal linkages, specify requisite incremental changes and optimise intervention synergies.

Monitoring and evaluation: Through the AACES process MSI and its affiliates have developed the capacity to integrate Monitoring and Evaluation (M&E) requirements into the project cycle and ensure feasibility. The introduction of participatory M&E methodologies has also enabled greater understanding of broader dimensions of success criteria beyond service delivery. Critical engagement with potential project M&E systems created space for team members to examine the "why, what, how and when" of M&E rather than adopting familiar yet potentially less useful approaches to the recording, interpretation and reporting of key project indicators.

Strengths based approaches: The application of a strengths based approach (SBA) to the analysis underpinning the design represented a novel and innovative departure from traditional MSI programming approaches. Through the engagement of the MSI Nairobi based design team, capacity has been built to utilise an SBA in future MSI project designs.

MSI's service delivery models have integrated HIV responses into their service provision. HIV prevention, testing and treatment services are offered by both country programs through multiple service delivery channels (see service delivery matrix Annex 5).For the purpose of this document MSI's services refers to an integrated model of FP/SRH and HIV

Situation Analysis

The situation analysis is based on a desk review and subsequent field work conducted in Kenya and Tanzania. A desk review of national level indicators and MSI's service data provided context for the selection of target regions. In Kenya, the project will operate urban bases in Mombasa and Malindi and extend service reach to Lamu, Malindi, Kilifi, Mombasa and Kwale counties. In Tanzania, MSI will operate from its Dar Es Salaam base extending service reach to Tanga and Pwani. An outreach team operating from Mtwara will focus mainly on the Mtawara region but also extend service delivery to Lindi. were identified based on field assessment and MSI's experience and ongoing work in country. A number of factors also contributed to selection such as avoidance of duplication and extending services into underserved areas. The selection of Dar es Salaam in Tanzania (the outlier in terms of unmet need) was guided by the need to have access to a high density area in which to develop test and launch mainstreaming initiatives.Following this a three week period of field work was undertaken in the project locations to ascertain current experiences of communities and SRH service providers. This involved consultation with communities through key informant interviews, focus group discussions and site visits to government and private health facilities.

The situational analysis employed an SBA in order to bring to the fore local capacities and resources or 'the best of what is'. Particular approaches to analysis included asset mapping and appreciative inquiry. The situational analysis engaged internal and external stakeholders around a set of programming options and directions namely; expanded SRH/family planning (FP) outreach services, targeting hard-to-reach populations and innovative approaches to demand creation.

Findings have been grouped under six asset domains: personal, associational, institutional, physical, financial and cultural. While the findings are not exhaustive, they are intended to demonstrate how SBA assists in placing pre-existing assets at the core of program planning. This is not to diminish the challenges existing in the coastal regions of Kenya and Tanzania in relation to FP. As one informant stated, FP is 'relaxed'. There is no sustained pressure to address commodity bottlenecks or significantly shift contraceptive prevalence.

- ***Health Systems:*** Health systems in both countries could be seen as chaotic. However, from an asset-based perspective, they may better be viewed as organic and flexible. Each region has a mixed health system comprised of private-for-profit, public, community and NGO service providers. District annual operational plans in Kenya pull together the contributions of varied health actors. Due to size and more complex administrative systems, these were not available in Tanzania. **Notable in both countries and particularly Kenya, is the evidence of collaborations and partnerships across sectors**.
- ***Institutional:*** Government planning capacity is improving and becoming embedded institutionally although it is taking time for other actors - the private-for-profit, NGO and community sectors - to articulate and incorporate their achievements into annual targets. Ambitious targets suggest that regions have robust visions for their populations. Despite shortages of essential drugs, commodities and even staff, there is institutional resilience**. Health workers employ pragmatic responses to stock outs and, in some instances, this has encouraged greater inter sectoral collaboration.**
- ***Physical:*** **Physical health assets exist in all districts and comprise health facilities, transportation and communication networks.** However their distribution and quality is uneven**.** There is concentration of resources around urban locations and major road networks. While there are a number of NGOs and CBOs operational in the project areas, including MSI' clinics and outreach teams, geographic coverage of service providers was not identified as an asset domain.
- ***Financial:*** Government planning documents and donor reports identified gaps in financing. Overwhelmingly gaps were identified in relation to non-HIV/AIDS SRH services. However, when specific interventions were unpacked, such as 'youth friendly services' (YFS), stakeholders unanimously responded **that under-utilisation of services was more of a provider attitude and client perception issue rather than purely a resource issue**. It was suggested that the issue of YFS could be addressed without excessive reliance on external resources.
- ***Personal:*** At management-level, government health personnel were generally young, dynamic and thoughtful with a development orientation and an interest in inter agency and inter sectoral collaboration. Health staff were also extremely knowledgeable about their communities and committed as *individuals.* However, there was limited optimism about targeted programming e.g. adolescent sexual health at facility level. Many health workers interviewed were from the communities within which they work. As this is not the case in all parts of Kenya and Tanzania, it is in itself an asset for health and SRH programming in particular. **The overall commitment of MoH staff would add value to any planned collaborative project.**
- ***Cultural:*** **Modern contraception is generally understood by women in Kenya and Tanzania; it is valued as a way to plan families and limit or space the number of children**. It is cited as a pragmatic response to the prevailing poverty found in the coastal regions. However, an important theme was the role of informal networks of information (story telling) on FP methods. It is widely used by women and men separately but not between them. These networks also influence which FP methods are adopted. This has created a spiral of misinformation for some FP methods while others, such as injectables, have benefited. The latter method is almost 'virtuous' in the regions visited as it is seen as a method which can be kept secret from partners. Viewing responses through a gender lens also highlighted the absence of both male involvement and partner communication for furthering FP in the coastal regions.

The situational analysis revealed a range of pragmatic responses employed by women, health workers and the health system in relation to the provision and uptake of SRH/FP services. Responses highlighted a spectrum of local 'assets', from the personal to the institutional. Recognition of these asset domains and the gaps within them played a key role in the development of the theory of change (see Annex 1) and helped identify how best to leverage and build upon these existing resources through focused action with service users and service providers.

Objectives

The overall goal of this project is to contribute to increased access to and uptake of equity sensitive SRH services by marginalised populations in Kenya and Tanzania. The project will directly contribute to the MCH outcome area under AACES. Access to FP and HIV services has been shown to have direct links to poverty reduction[1] through greater economic empowerment of women, as well as reductions in MMR and infant mortality[2]. These links form the basis for key Australian commitments to global health under Millennium Development Goals 1,3,4, 5 and 6. The project will employ a rights-based framework to SRH service provision in order to address socio-cultural, economic and informational barriers that limit access to services by marginalised groups.

Under AACES Objective 1 the project will aim to understand the nature and magnitude of health disparities created through marginalisation and deliver services that respond to these disparities. Marginalisation under this project has been defined in terms of geography, gender, age and disability. Understanding of the nature and magnitude of marginalisation will occur through stakeholder collaboration and operational research while efforts to address health disparities created through marginalisation will involve provision of quality SRH services strengthened and expanded through integrated service delivery networks. MSI engages in ongoing policy dialogue in Kenya and Tanzania and this will continue and add value to AACES activities. Within AACES MSI will focus on service delivery expansion and strengthening and providing evidence for local and regional partners engaged in policy dialogue. Policy engagement in country is not an activity or a proposed outcome of this project.

Under AACES Objective 2 the project will seek to work in collaboration with the wider AACES program and the ANGO sector to engage in sectoral, thematic and programmatic policy dialogue with AusAID. Sector specific engagement with AusAID will involve MSI convening an AACES specific MCH/SRH working group with the aim of informing more responsive MCH policy in Africa with a greater emphasis on the role of SRH and FP in improving MCH outcomes. MSI will also pursue engagement on the issues of youth, gender and disability with the aim of ensuring that SRH is afforded sufficient representation in cross cutting policy formation. Programmatic policy engagement will be undertaken in conjunction with the wider AACES partnership. MSI's objective for this engagement centres largely on promoting harmonisation of existing AusAID programs in Africa, for example expanding the Australian Youth Ambassador for Development (AYAD) program countries of operation to support the AACES program. This approach would also allow for multi-agency engagement around issues of shared concerns such as achieving greater recognition of the role of NGOs when determining sectors and geographic priorities for further AusAID engagement in Africa.

Under AACES Objective 3, MSI will aim to increase Australian public awareness of factors contributing to unacceptably high rates of maternal mortality and morbidity in Africa. As with Objective 2, MSI will participate in multi agency initiatives as well as pursue agency specific activities.

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[1] http://www.unfpa.org/rh/planning/mediakit/docs/new_docs/sheet4-english.pdf
Allen, R.H. (2007) The Role of Family Planning in Poverty Reduction. *Obstet Gynecol* Nov; 110(5): 999-1002
Zosa-Feranil, I., Green, C.P. & Cucuzza, L. (2009) *Engaging the Poor on Family Planning as a Poverty Reduction Strategy*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1 for USAID.

[2] Stover, J. & Ross, J. (2010) How increased contraceptive use has reduced maternal mortality. *Matern Child Health J.* Sep; 14(5): 687-95
Rahman, M., DaVanzo, J., & Razzaque, A. (2010) The Role of Pregnancy Outcomes in the Maternal Mortality Rates of Two Areas in Matlab, Bangladesh . *International Perspectives on Sexual and Reproductive Health* Dec; 36(4): 170-177
Ross, J., & Stover, J. (2005). *How does contraceptive use affect infant and child mortality?* Presented at the 2005 annual meeting of the population association of America, Philadelphia, March 31–April 2, 2005.

Project Strategy

MSI's experience working with marginalised and hard to reach populations in Kenya and Tanzania and more broadly across the Africa region informed the development of the project strategy and key service delivery activities. On a strategic level, MSI's simultaneous utilisation of public and private sector service delivery mechanisms has demonstrated effectiveness in providing and sustaining access to services among marginalised populations (see Annex 5). Operationally MSI's experience in social marketing and voucher based demand generation schemes in Kenya has positioned it favourably to further expand this model to target communities and to adapt the approach for introduction to specific populations in Tanzania. MSI's ongoing policy engagement with local and national Governments, CBOs and major multilateral and bilateral donors also provided a considerable experience base from which to draw upon during the design process. This policy level engagement will continue and add value to AACES activities. However within AACES, MSI will focus on service delivery expansion and strengthening. In doing so MSI hopes to contribute to the evidence base for local and regional partner CBO's engaged in policy dialogue. Direct policy engagement with Governments is not an activity or a proposed outcome of this project. MSI's experience of, and ongoing focus on evidence based programming has been instrumental in identifying key operational research questions that can assist programming and policy decisions on a sector wide basis. Experience working with underserved communities has informed the inclusion of targeted activities to address inequities in service provision. Equally MSI's experience in both countries has provided a sound contextual knowledge of cultural constraints to SRH/FP uptake. For example the role of men as gatekeepers to women accessing FP is particularly relevant to Kenya. However the willingness of Kenyan men to access MSI's circumcision outreach services as an HIV prevention strategy, suggests an opportunity to engage males on the benefits FP uptake for them and their female partner. In Tanzania common barriers to FP uptake commonly relate to lack of clear, accessible and accurate information. Much of this experience has informed the development of the theory of change. The theory of change underpinning the project design has emerged experientially and theoretically from consideration of three essential determinants of individual, social, organisational and institutional change namely; willingness, readiness and ability. This theory of change underpinning the project posits that without the presence of these three aspects the conditions, motivations and capacity of project actors to change and to affect change are suboptimal[3].

- ***Readiness*** is the subjective need or desire to achieve a given outcome.
- ***Willingness*** refers to an attitude in favour of an agreed means to achieve that outcome.
- ***Ability*** refers to the capacity of an actor or stakeholder group to take action based upon their desired outcome and agreed means to achieving it.

Readiness, willingness and ability are obvious preconditions for service uptake, organisational development and systemic improvement. While it is clear that the three elements interact, no generalised assumptions about causal ordering can be made given the diverse pathways of change for each critical stakeholder group involved in this project. The underlying assumption of this theory is that when these three determinants are present, meaningful change can occur. This assumption has been validated through MSI's operational experience in service delivery and policy engagement in Kenya and Tanzania and more broadly through its work in the Africa region.

These three determinants of change are relevant across four groups of critical stakeholders namely; clients from marginalised populations, SRH service providers (including public, private and NGO),

[3] This theory of change has been influenced by John G Cleland a, Robert P Ndugwa a & Eliya M Zulu *Family planning in sub-Saharan Africa: progress or stagnation? WHO Bulletin2011;89.* MSI further proposes that these are also useful determinants of change among organisations, donors and wider society and are thus relevant to the AACES program by providing cohesion across the three objectives

AusAID along with the wider ANGO community and the Australian public. Each of these stakeholder groups (and subgroups contained within) possess differing levels of readiness, willingness and ability to change and influence change toward improved SRH outcomes for marginalised populations in the project communities.

The foci of project activities have been selected on the basis of their potential to improve the willingness, readiness or ability of project actors to change based on the identification of achievable project outcomes from the situation analysis. Key activity areas include;

- **Expanding service provision through mobile outreach** - Provision of outreach services allows reach into communities where SRH services are absent or limited in scope and quality.
- **Capacity building of Government** - Working with government health workers to improve capacity to deliver comprehensive equity sensitive SRH services ensures greater coverage and quality that can be embedded in the national health system.
- **Private sector engagement** - Engaging private sector service providers through social franchising networks ensures greater competition between providers and thus greater quality and sustainability of services delivered. Use of the social franchise model also allows for monitoring of service delivery quality and offers an incentive to the provider to utilise ongoing training and support extended through the network.
- **Communication and awareness raising** - Engaging marginalised women and men in communication and awareness raising activities is central to improving the SRH status of project communities. Gender analysis conducted through the design process indicates that targeting males in the role as gatekeepers to female access to FP as well as potential service users will be an important focus of these activities. Promotion of greater male involvement and couple communication will be undertaken as part of social marketing activities Increased awareness of the importance of SRH rights and service availability is a key activity domain central to the achievement of AACES Objective 1.
- **Strengthening service provision through mainstreaming** - Through development of clinical guidelines on provision of youth, disability and gender inclusive SRH services, resources will be produced to strengthen the capacity of public and private sector service providers. This capacity building will involve training and ongoing support as well as monitoring of the implementation and adherence to the guidelines thus ensuring increased levels of equity in service provision. Equity responsive service provision involves increasing the knowledge and skills of service providers to reach and serve populations who experience marginalisation. These populations are identified on the basis of their age (youth) gender (women and men) geography (insufficient, absent or poor quality services unable to meet unique SRH/FP needs, in areas of residence) or disability status. This may require varying levels of clinical, technical or service delivery capacity building. Under AACES, mainstreaming of these areas will occur through MSI's mobile outreach teams and social franchises. Mainstreaming will also occur through capacity building of regional/district medical officers in Tanzania. Mainstreaming will also be extended to MSI's static clinic network in both countries during the life of the project.
- **Operational research** - In order to capture learnings from project implementation, operational research will form a key activity area under Objective 1. Areas for operational research include acceptability of service delivery modalities to particular marginalised populations and barriers and enablers to completion of referral pathways.
- **Policy engagement -** Policy engagement to improve AusAID programming in Africa will occur under AACES. MSI seeks to coordinate policy engagement with AusAID and with the wider ANGO sector with particular focus on AACES partners. Policy engagement will follow three approaches; (i) MCH/SRH specific which aims to inform a more responsive AusAID MCH

policy in Africa; (ii) Engagement with cross cutting issues such as disability and youth from an MCH/SRH perspective within the overall policy arena to be undertaken with the wider AACES partnership (iii) broader engagement around AusAID policy changes which may result in greater harmonisation of programs in Africa. While coordination of engagement with the wider AACES partnership will be a feature of many activities under this activity domain, others will be agency specific. Much of this policy engagement will emerge as the project progresses with the first year being used to plan and coordinate future initiatives. As noted above MSI will not be undertaking policy or advocacy activities with Government in Kenya or Tanzania under AACES. Evidence produced under AACES through operational research and M&E by MSI will be disseminated to local project partners such as Restless Development and Femina as well as AACES partners for use in policy dialogue with Government.

- **Australian Community Engagement** - The project will seek collaboration for contribution to greater engagement of the Australian community with development issues in Africa. Co-ordination among ACCES partners will ensure that activities avoid duplication and fragmentation of impact, and remain realistic in terms of available resources. MSI will launch targeted campaigns through use of traditional and non-traditional media while also leveraging its existing supporter base in Australia to increase the engagement of the Australian public with the work carried out under AACES.

Central to the project strategy is the engagement of critical stakeholders. 4 groups of critical stakeholders have been identified. *Clients* refer to women and men of reproductive age who the project classifies as marginalised due to geography age, gender or disability and will access information and services under the project. *Service providers* are suppliers of SRH/FP services from public, private and NGO sectors who will receive training and capability building under the project., *ANGOS and AusAID* as well as the *Australian public*. Diagrammatic representations of the linkages between critical stakeholders, domains of change, activity areas, predicted breakthroughs resulting from these activities and outcomes are presented in Annex 1. The design aligns with the current MSI strategic plan and complements the work of MSI in the region. The proposed design seeks to enhance this work through its emphasis on population specific approaches in targeting and serving the most marginalised. This intent is reflected in four key design aspects.

- At the core of the design are underserved communities. The project maintains MSI's focus on the client and emphasises the centrality of client focused service provision through the expansion and strengthening of these service delivery channels to serve poor and marginalised communities. The emphasis on specific marginalised populations evident in the design will strengthen MSI's work in the region through further engagement with marginalised populations with particular SRH service delivery needs. At the individual level people marginalised from information and service access will be highly engaged in the project through accessing information and using services. Marginalised people will also be critical to providing feedback and contribution through M&E approaches. As a constituency marginalised people will also participate through the involvement of representative groups at national and ultimately local levels.
- The design seeks to provide greater choice in SRH services. Through effective and targeted information, education and communication, community awareness of the range of SRH services will be increased. Thus individual clients will possess the necessary information to make informed and appropriate choices regarding their SRH needs. This project offers MSI the opportunity to further refine and develop methods of targeting appropriate to specific marginalised populations such as youth and people living with disabilities.
- The design seeks to extend the range of service delivery points though the use of government health facilities, mobile outreach and social franchising. The provision of

services closest to the client is a key MSI strategy to impact positively on SRH outcomes. The design simultaneously recognises the need to build capacity with project partners to achieve provision of high quality, integrated, equity sensitive SRH information and services. These partners include MSI's local country programs, the private sector and civil society and Government. Existing relationships with Government are critical to the expansion of outreach service provision and social franchising. In Kenya, project activities will be implemented under the current agreement with Government while in Tanzania a separate MoU will be developed with MoH to incude capacity building of health workers as well as service provision through outreach. The design offers increased scope to MSI's work and offers opportunity for the development of innovative models of service delivery to specific marginalised populations.

- The design recognises that for the work of MSI under AACES to be truly catalytic in improving health systems and outcomes, strategic partnerships are critical. Engagement through collaboration with the wider MSI African partner programs, the SRH sector, the NGO sector, local civil society, research institutions, the donor community including AusAID and the wider Australian public will be essential in order to inform, support and contribute to improved SRH and MCH outcomes in Africa.

MSI will also explore the potential for collaboration with other AACES projects operating in the selected countries. In Kenya, project linkages to Anglicord's training of TBA's among the Masai community will be explored. A possible area for collaboration may be working to provide access to misoprostal for post partum haemorrhage for TBA. In Tanzania, the 5 year women's empowerment study to be conducted by CARE offers potential for collaboration in data collection and dissemination.

Major activities

MSI will focus the majority of its activities towards Objective 1 under the AACES programme. Activities under this objective have been framed under the three objective areas outlined below.

Objective 1: Marginalised people have sustainable access to the services they require.

Output 1: **The provision of quality SRH services strengthened and expanded through integrated service delivery networks.**

1.1 Plan and map integrated service delivery strategies with local partners: Commencing at project inception, MSI will convene operational planning meetings under the stewardship of the respective MoH at regional/country levels. Meetings will address integrated service delivery strategies by considering available resources (MSI, public, private and community) and novel ways of working together to leverage these resources. Action plans and accompanying maps, developed using Global Positioning Systems (GPS), will be developed as part of this activity and updated over time. These documents will form the basis for review and monitoring of service delivery.

1.2 Deliver outreach services: MSI will leverage its existing outreach infrastructure as a 'priming' activity for greater integrated service delivery. Under this strategy, outreach visits will have a three-fold purpose: to map available service providers (using GPS) while concomitantly providing outreach services and capacity building for government health workers at public sector sites.[4] Subsequently, outreach visits can be used as a vehicle to deliver supportive supervision and mentorship of static service providers. As capacity is strengthened, the outreach teams will adjust their frequency and focus on expanding to other more remote sites.

1.3 Strengthen service provider networks: MSI will strengthen service provider networks at regional and county level in Tanzania and Kenya respectively. This will entail work with Government, private

[4] This will require one additional staff member attached to the outreach team who will map and recruit.

and community based SRH service providers. In Kenya, work with the private sector will commence in year one with the intention of expanding MSK's social franchising network to the coastal region. In Tanzania, year one will entail a social franchising feasibility study in order to map the most appropriate course of action in relation to the private sector.

1.4 Ensure adequate materials and equipment: MSI will ensure regular provision of commodities and supplies related to franchised SRH services. In return, franchisees will be expected to provide verifiable consumption reports and service projections. Franchisees will also be provisioned with demand generation and behaviour change communication (BCC) materials, service delivery protocols, guidelines and reporting tools. This will facilitate consistency in messaging, procedures, and reporting. Franchisees will be provided with basic equipment identified as lacking or inadequate during the assessment process. This will be provided at subsidised rates. Minor refurbishment will also be provided focusing on structural appearance and the adequacy of internal procedure space in terms of confidentiality and infection prevention.

1.5 Conduct supportive supervision and quality technical audits: MSI will undertake regular supportive supervision of project outreach activities. The MoH will be requested to join these exercises periodically in order to foster stewardship and regulatory functions. Quality Technical Audits (QTAs) will be conducted using external assessors and following MSI standard practice.

Output 2: **The capacity of MSI and its partners to deliver equity-sensitive SRH services strengthened.**

2.1 Develop youth service package and quality assurance standards: MSI will develop a YFS package that responds to the prevailing needs of youth in a given setting. This package may include the following services: Sexually transmitted infections (STI) diagnosis and treatment, provider initiated HIV counselling and testing, Emergency Contraception (EC), the provision of short and long term FP methods (focus on injectables, intra-uterine devices (IUDs) and implants), the importance of dual protection using condoms, and Post Natal Care (PNC) including counselling on Post Natal Family Planning (PNFP) and Post Abortion Care (PAC). All providers will be further trained on infection prevention, vocal local[5], referral management as well as counselling. Quality assurance standards related to youth SRH will also be developed.

2.2 Develop disability inclusive service package and quality assurance standards: MSI will develop a disability inclusive service package that responds to the prevailing needs of people living with disabilities within the project communities. A situation analysis will be conducted in year one on disability. Inputs from key MSI partners in Australia will be sought to develop the service package. Inputs from national and local disability and youth groups in Kenya and Tanzania will also be critical to the development of these guidelines.

2.3 Deliver private provider training packages: Social franchisees will receive competency based skills training in all supported services (options outlined above) as well as training in youth-friendly, disability inclusive and gender sensitive service delivery approaches. Guidance will follow national guidelines and best practice adapted to the setting. Specific actions will be agreed with partners in order to promote gender and youth responsive demand generation and service provision. Training later in the project will provide franchisees with skills to provide disability inclusive services. Actions and strategies will be incorporated into project review, monitoring, BCC and demand generation interventions. Franchisees will also be trained on business management using the pre-existing curricula.

2.4 Deliver public sector provider training packages: In Tanzania, MST will use outreach visits offering services at public health facilities as an opportunity to build the capacity of the local public sector service providers through on-the-job training and mentoring. Topics will cover different aspects of SRH service delivery, including FP, YFS and disability inclusive service delivery. As with private

[5] Vocal local is the non-pharmacological approach to pain management.

providers, disability inclusiveness will form a key component of this training on completion of activity 2.2. MST will work with MoH to develop a training plan, curriculum and certification process for this capacity building over the length of the project.

2.5 Develop referral mechanisms: MSI will promote linkages between MSI, public, private and community service points through the development of referral networks. Referral networks will be unique to the region/county and may include youth and women's groups, workplaces, educational institutions and community health units. Drawing on findings from the M&E system, MSI will focus on addressing barriers to client non-completion of referral and inactive referral networks.

2.6 Conduct operational research: The project will incorporate operational research in its design in order that lessons and evidence be generated through implementation. Operational research may consider:

- *Youth and outreach/franchising*: How can outreach/social franchising address the needs of youth? What is the viability and sustainability of a youth outreach/franchise model? Are YFSs delivered through outreach/a franchise system more effective than traditional services from independent clinics?
- *Outreach/franchising and networks*: Is outreach/social franchising for youth more effective when combined with community networks? How can referral networks be promoted and sustained? What benefits does 'active partnership' provide in terms of project outputs and outcomes?
- *Outreach and franchising:* How can outreach models complement social franchising models? When is it most optimal to transition out of outreach to more sustainable service delivery approaches such as franchising and public sector service provision?

2.8 Strengthen organisational capacity: MSK and MST will strengthen their technical capacity to reach youth, people living with disabilities, facilitate male involvement and support female empowerment. This will involve updating service standards and guidance and the development of accompanying tools and training materials. Clinicians as well as managers will also be trained on youth, gender and disability inclusive service approaches. Additional organisational strengthening will be directed towards M&E and is described under Annex 2.

***Output 3:* Awareness of and demand for SRH services and information stimulated through effective communication.**

3.1 Develop and implement SRH promotion and marketing plans: At project inception, MSI will review its health promotion strategy capitalising on available assets in the target areas and addressing gender issues (e.g. male involvement, couple communication, etc). Plans will include a range of promotional activities and will vary depending on local preferences and available resources.

3.2 Adapt and develop Demand Generation (DG) and BCC materials: The project will identify and reproduce youth and disability focused health education materials and job aids. These will be sourced from the country or region. Materials will be pre-tested and reviewed by technical partners in advance of production. All clinical service points and partners will be oriented to these and provided with an adequate supply of materials.

3.3 Conduct DG activities: DG activities will be conducted at the community level. These may include radio talk shows, event days, interpersonal communication, promotions or talks at educational institutions and workplaces. Outreach teams will also carry audiovisual presentations and materials with them so that outreach visits can be used as opportunities to conduct health education sessions. Materials will be designed to attract various target audiences such as youth, males and people living with disabilities. Involvement of male community leaders will be sought to promote FP. Social franchises will employ community mobilisers to increase awareness of the benefits of SRH service utilisation and availability of community based SRH services. These community mobilisers are sourced from the communities they serve and have a strong understanding of prevailing socio-cultural norms.

3.4 Foster linkages: The project will identify and develop 'strategic alliances' between providers of services and community, youth and disability groups. These alliances will inform the development of demand generation materials and facilitate implementation of demand generation activities. In addition they will also further the reach of demand generation activities while simultaneously promoting access to SRH information and services among the target populations. Alliances will be sought with existing CBO's representing women and people living with disabilities. Alliances will also be sought with educational institutions and workplaces so that both in- and out-of-school youth can be reached as well as with gatekeepers such as parents, religious and male community leaders (dependant on setting).

3.5 Dissemination of learning: MSI will ensure that findings from operational research are packaged for dissemination internally as well as with external stakeholders. This will involve the production of technical reports, preparation of papers for publication in peer reviewed journals and presentations in national or regional fora.

Project beneficiaries are presented below

Activities	Kenya (per annum)	Tanzania (per annum)
Information and Service delivery through outreach	10,000	10,000
Information and Service delivery through social franchising	10,000	To be confirmed post feasibility study
Capacity building of district/regional medical officers	na	90
Capacity building of private sector providers	10	To be confirmed post feasibility study

Objective 2: AusAID policy and programs in Africa are strengthened particularly in their ability to target and serve the needs of poor and vulnerable people.

MSI's approach to the work to be completed under this objective reflects the priorities of Objective 1 and the potential mix of individual work and collaboration described under Objective 3.The overall approach to this objective envisions three main areas for policy engagement.

- Sectoral: MCH/SRH in Africa
- Cross cutting: Youth gender and disability in Africa
- Programmatic: AusAID programming and policy in Africa

Outputs for this objective reflect this approach. Activities are expected to be refined and further detailed through the life of the AACES program. At this point in the program evolution it is unrealistic to present a detailed activity description. Thus the choice and sequencing of activities below might be more accurately described as essential steps to achievement of outputs rather than a detailed activity plan.

Output 4: **AusAID MCH policy is more responsive to the experience of SRH agencies in Africa.**

4.1 Map existing and potential sectoral synergies with AACES ANGOs.

At project inception, MSI will convene a planning meeting with relevant AACES partners to assess synergies in project approaches to focus on provision of SRH services as a key strategy toward improving MCH outcomes in Africa.

4.2 Identify areas for shared and agency specific sectoral policy engagement with AusAID.

MSI will identify areas of individual and shared priority for sectoral policy engagement with AusAID. This activity will inform the identification of critical ANGO partners and be informed by a critical assessment of MSI capacity to engage on policy areas of individual priority.

4.3 Develop an operational plan for ACCES MCH/SRH policy engagement.

Following on from mapping and identification of sectoral policy engagement areas MSI will develop an operational plan which will outline proposed activities to be undertaken, roles and responsibilities of MSI and partner ANGOS, timelines, budgets and suggested modifications to the M&E framework.

4.4 Ensure communication systems are sufficiently developed.

Prior to undertaking any sectoral policy engagement, assessment of the project and country partner communications capacity will be undertaken. This is an essential activity to leverage in-country policy evidence and experience as well as to ensure that challenges and successes at implementation level are heard by AusAID and other relevant policy makers such as local and national health authorities.

4.5 Formation of/participation in AACES MCH/SRH sectoral working groups.

MSI will seek to actively participate in an ACCES MCH sectoral working group. At this point in the program evolution it remains unclear if such a working group will be convened under the stewardship of ANGOs or AusAID. MSI is willing to convene and host such a working group if so required.

4.6 Ongoing engagement with wider AACES partnership and program secretariat.

MSI will maintain regular contact with the wider AACES partnership and program secretariat to keep abreast of water, sanitation and hygiene (WASH) as well as food security sector specific policy collaborations and identify potential linkages with MCH/SRH policy engagement activities. Similarly MSI will ensure that the wider AACES partnership is aware of MCH/SRH specific policy engagement initiatives.

4.7 Sharing of global good practice MCH/SRH policy of relevance to AusAID programming in Africa.

MSI participates globally on numerous MCH/SRH working groups and committees and will draw on good practice findings from around the world to share with ACCES partners and AusAID.

Output 5 **Participation in multi-agency policy engagement with AusAID on thematic issues (youth, gender and disability) in Africa.**

5.1 Ongoing engagement with AACES partners and program secretariat.

Awareness of emerging policy collaborations between AACES ANGO'S will be critical to identifying the potential value-add of MSI's participation.

5.2 Identification of areas for shared cross cutting policy engagement with AusAID.

Engagement with the wider AACES program partners and secretariat will allow sharing of lessons from mainstreaming work under Objective 1. It is anticipated that MSI will identify strategic opportunities to work in conjunction with AACES partners to engage AusAID in policy dialogue on key thematic areas. Key objective of this policy engagement would include greater recognition and representation of SRH rights in cross cutting policies on youth and people living with disability.

5.3 Ensure communication systems are sufficiently developed.

Prior to undertaking any sectoral policy engagement, assessment of the project and country partner communications capacity will be undertaken. This is an essential activity to leverage in-country policy evidence and experience as well as to ensure that the realities on the ground are heard by AusAID.

Output 6 **Participation in multi-agency policy engagement with AusAID on programmatic issues in Africa.**

6.1 Ongoing engagement with AACES partners and program resource facility.

In conjunction with AACES partner ANGOs MSI will seek to identify areas for policy engagement with AusAID around barriers to and opportunities for greater effectiveness of AusAID programs in Africa. Issues for policy engagement will be centered on shared concerns of ANGOs but may include such issues as greater geographical harmonisation of the AYAD and AACES programs.

6.2 Ongoing contribution to multi agency policy engagement with AusAID.

MSI will draw upon its experiences during the life of the project to contribute to emerging policy engagement with AusAID. Contributions will depend upon the nature and relevance of the policy dialogue been undertaken.

Objective 3: Increased opportunity for the Australian public to be informed about development issues in Africa.

Output 7 Coordinated approaches to community engagement activities ensured.

7.1 Ongoing communication with AACES partners.

Regular communication with AACES partners will allow for greater collaboration on joint community engagement initiatives as well as avoidance of duplication of effort and expenditure.

7.2 Strategic and operational plans for joint community engagement initiatives agreed.

MSI will engage with AACES ANGOs to develop sector and thematic specific community engagement plans. This level of planning will be undertaken by MSI for initiatives that directly align with MSI's sectoral and thematic foci under AACES.

7.3 Community segmentation.

MSI will undertake a community segmentation activity at project inception. This will allow for strategic targeting of subsequent public engagement activities throughout the life of the project.

Output 8 Development of AACES Photovoice campaigns.

8.1 Development of campaign platform.

MSI will develop a mainstream MCH cause-focused campaign with a three-step consumer engagement and relationship management process to generate i) awareness ii) interest and participation and iii) understanding and continued engagement. The campaign will aim to recruit cause based 'supporters' at a basic level and through ongoing relationship-management will educate and engage further. The campaign banner and platform will promote the work of the AACES program and objectives and will be purposefully broad enough to highlight linkages between Australian and African individuals and communities. MSI will invite participation from AACES partner ANGOs working in MCH/SRH. Examples of this approach would be MSI's Five by Fifteen or Make Women Matter campaigns[6].

8.2 Photovoice initiatives.

Under the campaign banner, MSI will launch targeted promotions and activities based on the Photovoice concept delivered through the AACES program. Photovoice is a visual media technique to allow the ultimate beneficiaries,(ie. marginalised people) to record and report images that represent their stories[7]. This will allow participation by both Australian and African communities. The specific nature and theme of these activities will be developed to suit the characteristics of the target audiences defined in activity 7.3.

8.3 Campaign website.

A content rich, informative campaign website will be developed and launched. Campaign promotions and supporter relationship management activities will direct the audience back to the website.

Output 9 Campaign Promotion to Target Australian Communities.

9.1 Targeted Community Outreach & Promotions.

The campaign will be promoted to target audiences through community outreach focusing on community networks, institutions and organisations. A key aspect of this will involve MSI

[6] www.mariestopes.org.uk

[7] http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102284308.html

leveraging its network of 18,000 private GPs and obstetric gynecologists across Australia to garner support and further publicity for the AACES program through their practices.

9.2 Direct Promotions.

The campaign will be promoted directly to existing MSI Australian supporters and supporters/clients of existing corporate partners and NGO partners.

9.3 Digital and Online Promotions.

Viral and social media tactics will be developed to generate word of mouth and spread the campaign.

9.4 Ongoing use of media to promote AACES activities and impacts.

Throughout the life of the project MSI will launch sectoral and geographic specific media relations activities across a range of media including women's magazines, radio, online forums, editorials and opinion columns. These activities will be undertaken by MSI with the collaboration of AACES partner NGOs where relevant.

9.5 Ongoing Supporter Relationship Management.

Once supporters have been recruited, they will be further engaged and educated on the work of the ACCES program through regular campaign updates. This might include video diaries or blogs from program team members (stories from the field), country news updates, ambassador updates and messages.

Output 10 Leveraging of MSI's Australian healthcare clinic network to promote client engagement.

10.1 MSI Australian clinical network promotes AACES activities and impacts.

Through its clinic network MSI is well positioned to promote the AACES program. This may be done through promotional videos in our 17 clinical waiting rooms across Australia, provision of information through posters and booklets and advertising of community engagement activities such as Photovoice. MSI clinical staff will also receive regular updates on the program and be well positioned to discuss the program with clients on a one-on-one basis.

Monitoring and evaluation

The proposed M&E system tracks the type and quality of service delivery activities via routine reporting of service statistics disaggregated by client age gender, FP history and socio-economic status. The M&E system also uses independent quality technical assessments to monitor the quality of service delivery. Client feedback is monitored through mystery client visits and client exit interviews across all service delivery models. These tools have been included in the M&E annex. Capacity building activities are assessed using trainee evaluations and trainer reporting. In addition to this the M&E system will seek feedback from multiple sources including clients, partner CBOs, local and central Government, and private providers via focus group discussions (FGDs), case studies, trainee evaluation, trainer reporting, direct client feedback, regular meetings and ongoing correspondence about the intended and unintended benefits, problems and impacts of project activities. Baseline data will be obtained via Knowledge Attitude and Practices (KAP) surveys, FGDs, and MSI internal reflection.

As shown in Annex 2, MSI will use its existing tools for the routine collection of project data.

M&E Approach	Tool	Purpose	Frequency
Process/ Quality Assurance	**SUN Financial System**	Routine service delivery and country program finance data reported through country partner implementation	Monthly
Process/ Quality Assurance	**Quality Technical Assessment**	Comprehensive clinical audit	Annually

Feedback system	**Client exit interviews**	Assess client satisfaction with service(s);Identifies areas for improvement	Annually
Feedback system	**Mystery client visits**	Assess quality of service provision	Annually
Overarching approach	**Management Information system**	To monitor effectiveness, efficiency, equity, access and quality of services delivered To inform project management	Monthly

The design of these tools has been informed by the perspectives of the poor and underserved who constitute the bulk of MSI's global client base and as such these data are already disaggregated by age, gender and socio-economic status for the purpose of regular internal reporting. Under the AACES project, representatives of marginalised populations such as youth, people living with disabilities and poor communities will continue to have their perspectives acknowledged and their voices heard through the proposed project M&E system. The inclusion of case studies in the repository of data collection tools has been motivated by the need to ensure that the voices of the ultimate beneficiaries of the project are clearly heard by project managers, the Australian public, AusAID and policymakers. The proposed M&E design seeks opportunities to relocate service users and public and private providers away from their traditional role of passive recipients of predesigned, rigid interventions where their involvement with M&E is limited, to being simply providers of M&E information. A possible strategy to achieve this may be the use of Photovoice as a method of M&E data collection. This will be explored during implementation. The design of the proposed M&E system largely depends upon the meaningful engagement of marginalised populations in the sense-making process at local and national levels. The inputs of these groups into the mid project review of the M&E system will be critical should adjustments of M&E activities to better capture evidence around unintended impacts or emerging areas of concern be required.

<u>Key metrics</u>

For the purpose of AACES reporting project indicators to be reported will adapt year to year as activities roll out. Based on the Year 1 work plan, two snapshot indicators will be monitored under objective 1. (1) *An increase in demand for services by marginalised people* will be measured through evaluation of demand generation activities. (2) I*ncreased capacity and focus of duty bearers to deliver inclusive and sustainable services* will be measured through analysis of data generated through service provider training. Under Objective 2 MSI will report on one snapshot indicator in year 1 P*rocesses in place to share and utilize information and research between AusAID and the AACES NGO's and between AACES NGO's*. Key evaluative questions include how MSIA has shared and utilised information from AACES partners and how AACES NGOs and AusAID have utilised information from MSIA under the AACES project?

M&E indicators will directly inform project management. This will occur through regular monthly reporting of service delivery via the MIS and also through the annual sense making process. Core AACES specific management indicators will be agreed initially at the project inception workshop and thereafter through the annual sense making process based on annual work plans. Routine MSI indicators will be reported on through the MIS (presented in Annex 2).

Information sharing

M&E information will be shared with community groups, the private sector and Government at local and central levels. This will occur through regular contact with these stakeholders as well as through their involvement in annual country level sense-making processes. For stakeholders unable to participate in annual sense-making processes, participation will be ensured via written submission and/or video conferencing. Reports and correspondence will be circulated presenting the details and conclusion of the annual sense-making process.

Information on service delivery through the private sector will be shared with social franchisees to encourage reflective practice and consider service delivery options not currently utilised. Monitoring information will also be shared with the wider AACES partnership with a particular focus on NGOs active in the MCH/SRH sector. As with other information sharing pathways included in the design this serves the dual purpose of supporting project accountability and encouraging knowledge transfer and learning. The role of the program resource facility will be central to this. Of key importance will also be sectoral working groups established under Objective 2.

Risks

Highlighted below are broad risks to the successful implementation of the project. A more detailed risk analysis containing mitigation strategies and lines of responsibility is presented in Annex 3.

1. Gaps in knowledge and experience
    - MSI's lack of experience working with disability limits progress towards outcomes.
    - MSI's lack of experience with Theory of Change programming constrains progress.
2. Location
    - Significant political or natural disaster.
3. Type of work
    - Clinical incidents resulting in injury in death of staff or client.
4. Choice of partners
    - Key representative groups for youth and people living with disability do not engage in project activities.
    - Public and private providers do not engage in mainstreaming activities.
    - Lack of participation from private providers in social franchising.
    - AACES MCH ANGOs cannot effectively collaborate on policy engagement around SRH with MSI.
5. Target groups
    - Communities do not support youth/disability focused services.
    - Project does not result in increased utilisation of SRH services among target groups.
    - Gender norms limit women's access to information and services

Sustainability and Transition/Exit strategy

Sustainability including transition/exit has been considered under the following criteria:

Service sustainability: the project specifically addresses sustainability of service provision by working with *existing* local service providers from the private and public sectors. The project seeks to increase existing capacity through the introduction of quality accreditation mechanisms and an increased competency base. This strategy aims to contribute to the sustainable delivery of an expanded, more client-responsive, SRH service delivery sector provided as close-to-client as possible given existing provider spatial distribution. Supply-side interventions have been complemented by DG interventions which, through strategic alliances developed by the project will build on existing community and organisational 'assets'. By working with existing local service providers, MSI will be able to transition outreach as static provider capacity is developed. This will allow outreach services to penetrate deeper into un-served areas. The combination of outreach and social franchising has

been selected on the basis of their suitability as preconditions for sustainability. Outreach is already being directly provided by MSI and like social franchising, it does not require the financial support of government to make it sustainable. The synergies between outreach and social franchising and how these models of service delivery strengthen health systems are further detailed in Annex 5. Long term sustainability is ensured through engaging private sector providers and building the capacity of government health workers. Equally regarding outreach MSI as service providers have operated in the selected countries for over 25 years and will continue to deliver services post AACES. Service delivery will continue to expand in reach after the project. No reliance on government budgets has been made to ensure sustainability of activities. The involvement of government is within the parameters of strengthening existing service provision. The possibility of a decrease in demand for services as more people access service has not been evidenced by MSI's work to date in either of the countries selected. Provision of a comprehensive FP service ensures that contraceptive choices evolve over the life cycle of the individual and as a result FP users are likely to change their preferred contraceptive method during their reproductive life and thus continue to use services after the initial point of contact. Furthermore the current demographic profiles of both countries indicate a considerable "youth bulge". Thus with a large population in the process of becoming sexually active, demand for FP services is unlikely to decrease during the life of the project.

Institutional sustainability: This project seeks to strengthen equity responsive SRH service provision in selected geographic areas of Kenya and Tanzania as part of a public-private-partnership model of health service delivery. The project emphasizes alignment with national SRH policies and priorities in both countries and their inculcation into front line service provision through a range of public, private and community providers. It also emphasizes integration in order to strengthen institutional linkages between service delivery points for greater quality and continuum of care for clients. Increased coordination and communication through strengthened provider and community linkages may also serve to redress perceptions of competing systems of health care, a disabler of health system organisation.

Policy sustainability: The action will consider its impact on community *process* as well as SRH *outcomes.* A focus on process, in particular local ownership, will enforce sustainability of benefits. Both process and outcomes will be documented as part of routine monitoring and conduct of operational research. Through this, the project should lead to a greater evidence base for equity sensitive and integrated SRH service models. It will add valuable understanding of community based service strategies with marginalised populations.

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AusAID Policy Requirements

Child Protection: As an AusAID accredited NGO MSIA has met child protection standards. Child protection training for MSI's Kenya and Tanzania country staff commenced under the design phase. Child protection policies are in place in both affiliate organisations and an incident reporting mechanism is under development. Capacity building around child protection will continue through life of the project through inputs from MSIA and participation by MST and MSK in AusAID run trainings through the Nairobi post. Since much of the project is focussed on SRH information and service provision to youth, ongoing development and implementation of child protection mechanisms is recognised by all stakeholders to be an integral part of project activities.

Environment: The project has considered mechanisms for reducing environmental transaction costs by focusing on low cost, client-focused services delivered as close to client as possible using existing community structures and government systems. The project further aims to maximise the number of sites supported while minimising fuel consumption by working with facilities and populations along road network trajectories. Site visits will be organised so that a number of communities and facilities

can be visited in one outing. These strategies are both cost effective and place fewer demands on an already fragile environment.

Inclusive Development: The proposed design is highly cognisant of the needs of people living with disability and people living with HIV. Both of these populations are target groups under the project design. Designing and delivering appropriate services in consultation with these populations is a key output of the MSI AACES design.

List of Annexes

Annex 1 Theory of Change

Annex 2 Detailed monitoring and evaluation framework

Annex 3 Risk Matrix

Annex 4 Situational Analysis

Annex 5 MSI Service models

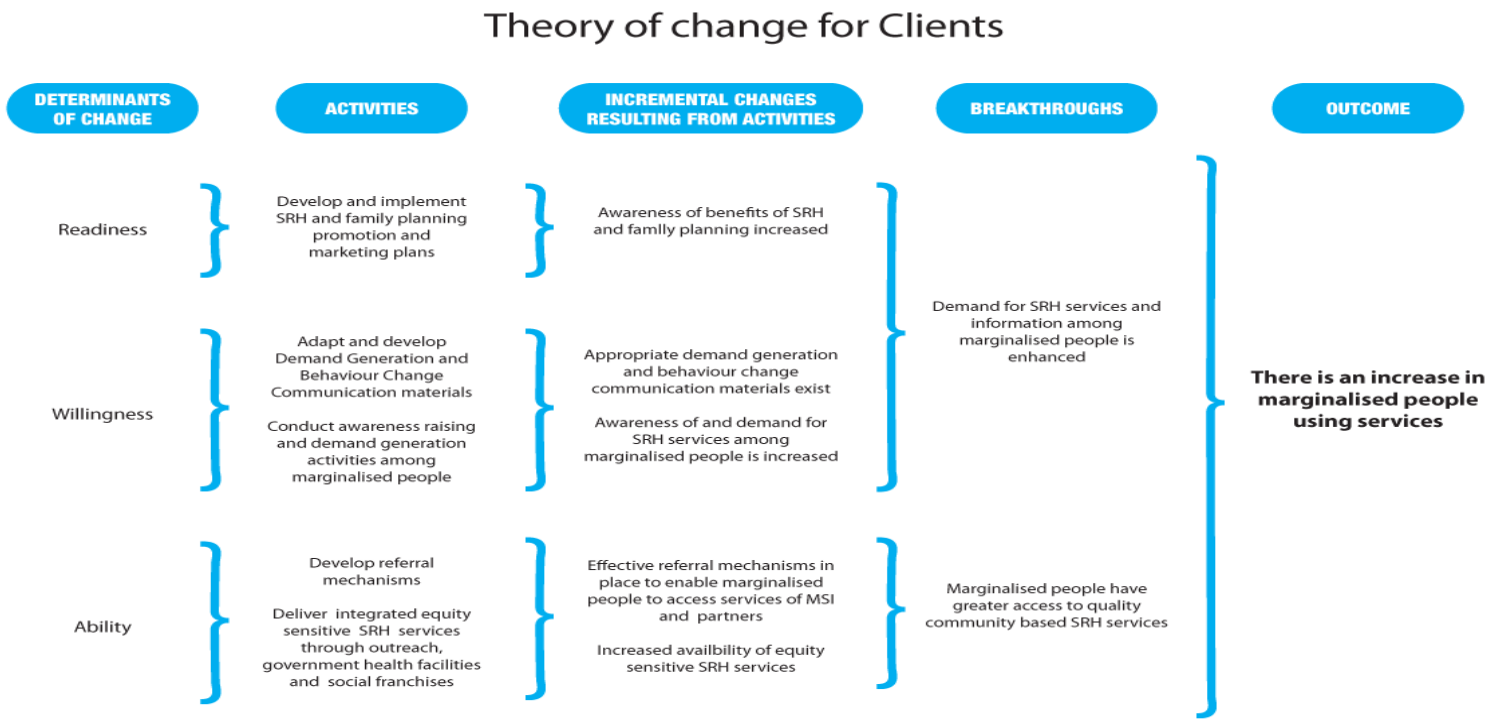
Annex 6 Operational Structure

Annex 7 Budget

Annex 8 Year 1 Activity Plan

Annex 9 AACES Contract

Annex 1 Theory of Change



MSI and its partners will work with communities in order to enhance their *Readiness Willingness* and *Ability* to demand and access equity sensitive family planning and SRH services and information. In order to achieve this, activities will focus on enhancing *Readiness*, *Willingness* and *Ability*. From the perspective of the community; ·

Readiness is the subjective need or desire by community members to reduce or limit childbearing or utilise SRH services. ·

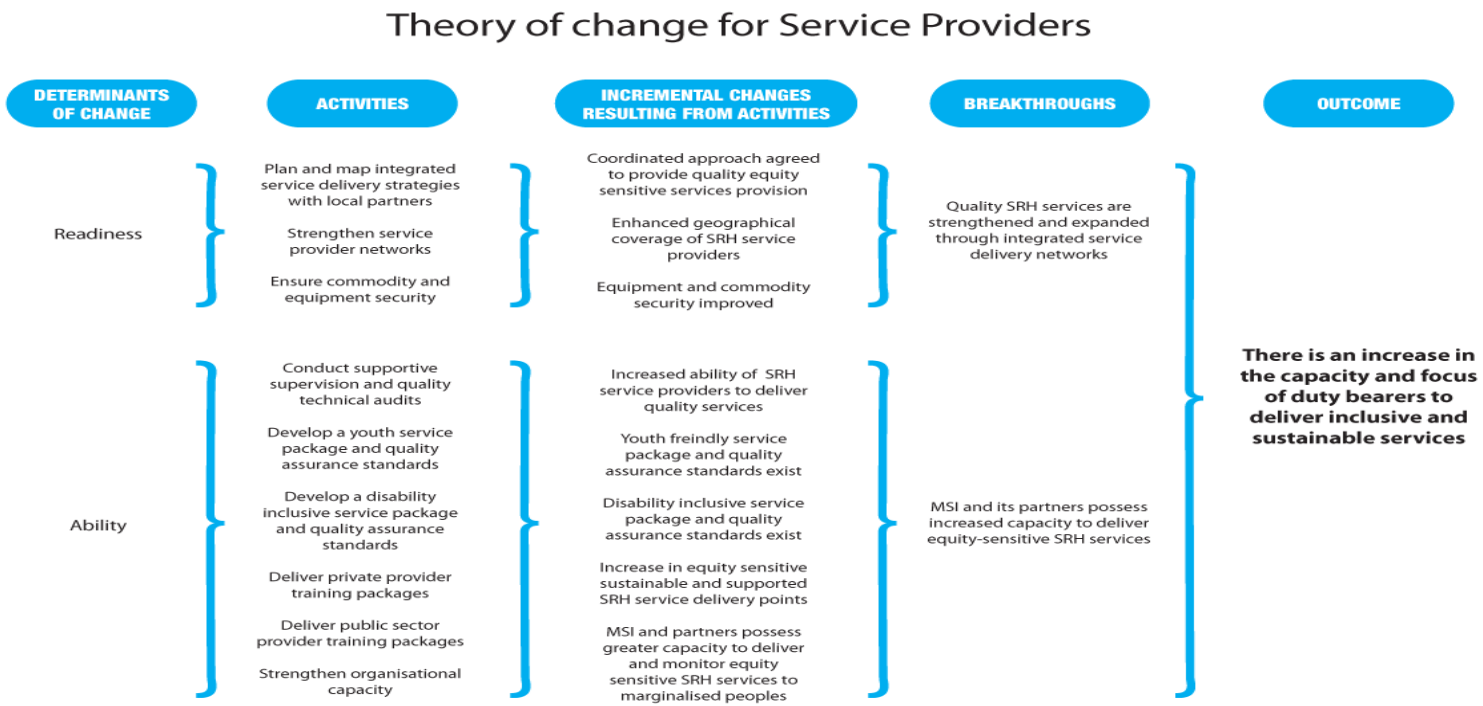
Willingness refers to community members displaying attitudes in favour of an agreed means to achieve that outcome such as contraception or service usage·

Ability refers to the capacity of community members to obtain their preferred choice of family planning/SRH information and services.

Findings from the project situational analysis suggest that existing community assets interact differently to produce differential SRH outcomes. Existing cultural assets may act to concurrently promote and constrain service uptake. While FP/SRH is seen as a pragmatic response to poverty, widespread misinformation and cultural norms detract from the *Readiness*, *Willingness* and *Ability* of communities to access services. Physical and systemic assets while robust in some regions are less so in others leading to varying levels of service access. Thus actions to enhance the *Readiness*, *Willingness* and *Ability* of community members to demand and access equity sensitive family planning and SRH services are necessary. The outcome proposed by the Theory of Change for clients directly addresses the MCH outcomes sought by AACES. Evidence of

Annex 1 Theory of Change

the linkages between FP usage and poverty reduction through greater economic empowerment of women, MMR reduction, and infant mortality reduction has been provided in the design document. The central role of FP as a contributor to and consequence of female empowerment, poverty reduction, MMR and infant mortality reduction has been recognised through key international undertakings such as MDG 5 and ICPD to which Australia is a signatory.



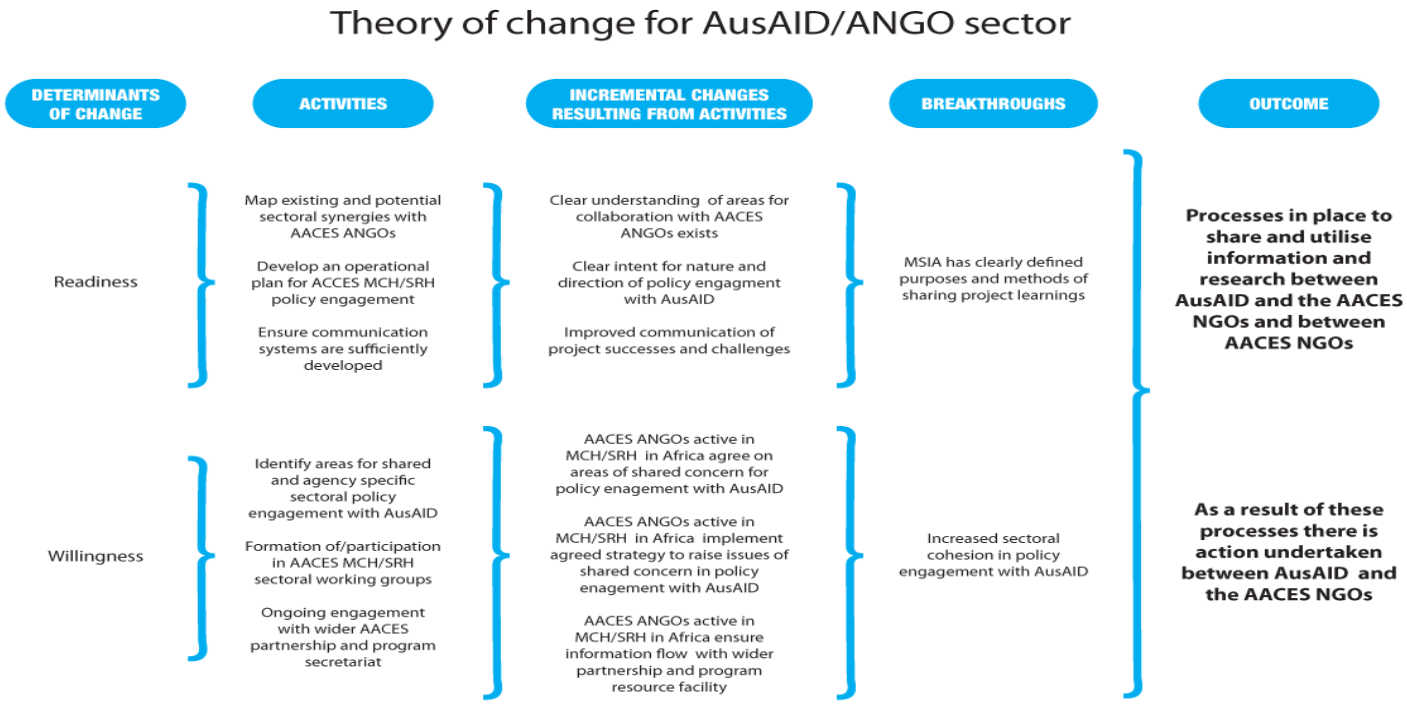
MSI and its partners will work with service providers in order to enhance their *Readiness* and *Ability* to provide equity sensitive family planning and SRH services and in doing so contribute to higher level outcomes such as poverty reduction, and reductions in infant and maternal mortality. These linkages are evidenced in the design document, From the perspective of service providers;

Readiness is the subjective need or desire by public private and NGO service providers to strengthen and expand service delivery.

Ability refers to the capacity of service providers to provide high quality equity sensitive family planning and SRH information and services.

Annex 1 Theory of Change

Willingness refers to service providers displaying attitudes in favour of the use of equity sensitive service delivery in order to achieve increased family planning/ SRH service uptake among marginalised people. As evidenced through the project situational analysis and project design consultations existing service providers are currently willing to achieve this outcome and considerable personal, systemic and institutional and assets already exist among service providers in the project locations. Therefore activities with this stakeholder group will concentrate on enhancing *Readiness* and *Ability*. The activities selected to enhance *Readiness* among service providers aim to build upon pre-existing physical, systemic and institutional assets. Activities to enhance *Ability* among service provider seek to leverage and build upon existing personal, physical systemic and institutional assets. In terms of *Ability*, it is noteworthy that technical capacity was not an asset domain identified through the situational analysis and was also the subject of dissatisfaction among service users.



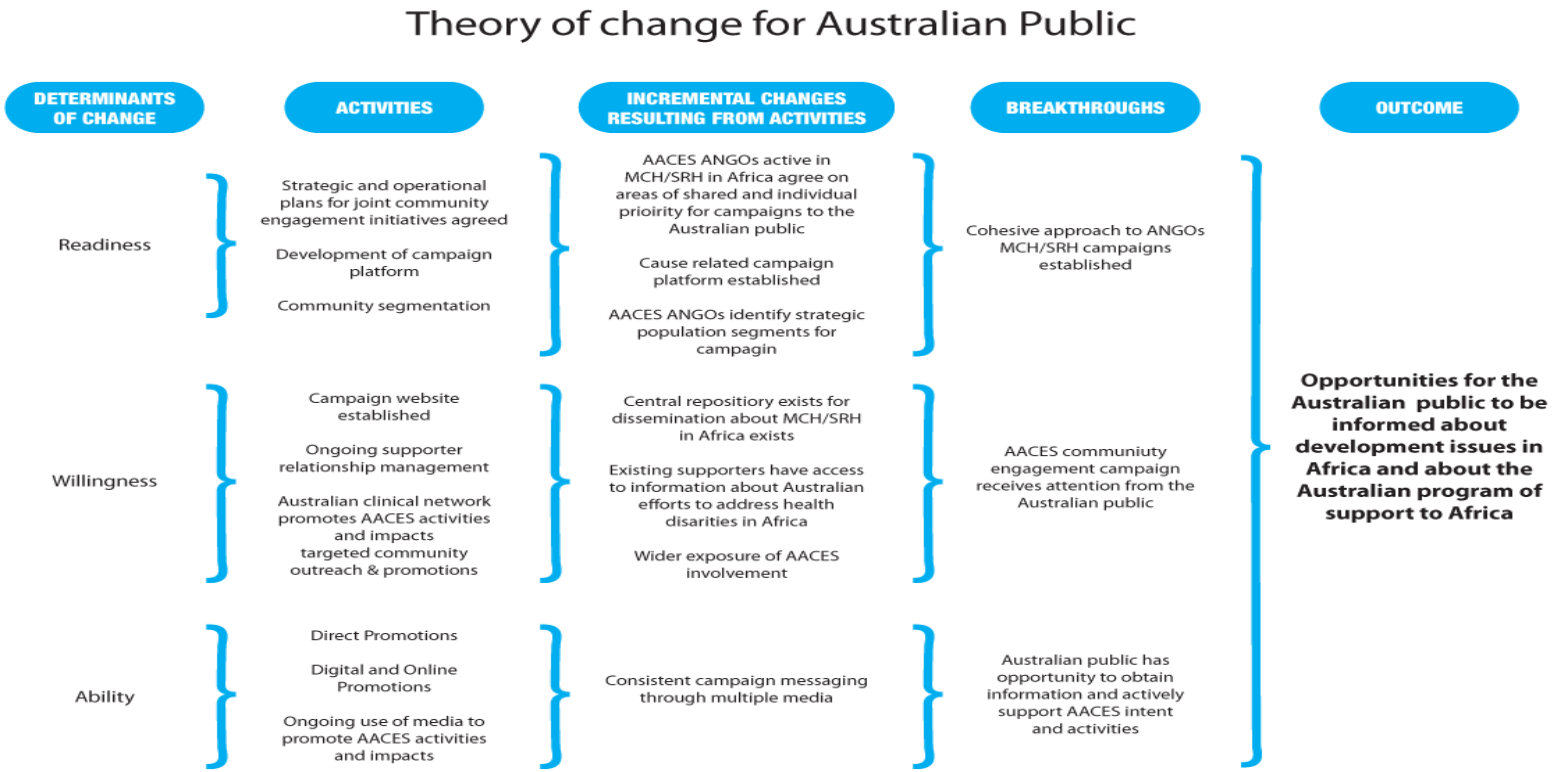
MSIA will work with the wider AACES partnership in order to engage in sectoral specific, cross cutting and programmatic policy dialogue with AusAID . In order to achieve this activities will focus on enhancing *Readiness* and *Willingness*. From the perspective of this stakeholder group;

Annex 1 Theory of Change

Readiness is the subjective need or desire by AACES ANGOS to affect meaningful improvements to AusAID policy and programming in Africa

Willingness refers to AACES ANGOs displaying attitudes in favour of an agreed means to engage with AusAID towards an agreed outcome.

Given the considerable experience and pre-existing expertise of the ANGO sector in policy dialogue action to enhance *Ability* will not be a focus of work to be carried out with this stakeholder group.



MSIA will work with the wider AACES partnership in order to develop and promote a cause based campaign to highlight the factors contributing to the unacceptably high rates of maternal morbidity and mortality in Africa. In order to achieve this, activities will focus on enhancing *Readiness*, *Willingness* and *Ability* among AACES ANGOs and the Australian public. From this perspective;

Readiness is the subjective need or desire by members of the Australian public to understand maternal health issues in the African context and the Australian response to them.

Annex 1 Theory of Change

Willingness refers members of the Australian public displaying interest in the AACES approach to improving maternal health outcomes in Africa.
Ability refers to the capacity of the Australian public to access information concerning Australian involvement in Africa through the AACES program.

Proposed Approaches to M&E

Given the wide range of activities to be implemented under the AACES program, MSI will use a mix of approaches to M&E. The three main approaches are Feedback systems, Participatory Monitoring and Evaluation (PM&E) and Quality Assurance. The main features of each approach are presented in Table 1 below.

Table 1 M&E Approaches for AACES Activities

	Feedback Systems	PM&E	Process/ Quality Assurance
Main purpose:	Generate real-time data on user perceptions during implementation	Empower local people to initiate, influence and control social actions	Oversight of activities, outputs and outcomes by managers and funders
Theory of change:	Feedback drives analysis, dialogue and improvements to an intervention's activities	PM&E is integral to the development process, building local people's skills, knowledge and confidence	Pre-determined activities lead to expected outputs, which in turn lead to outcomes and wider impacts
Design approach:	Mix of 'top-down' (organisational priorities) and 'bottom-up' (local priorities)	Bottom-up (local people determine the indicators)	Top-down (strategic objectives determine indicators)
Indicator areas:	User perceptions, within generalised frameworks	Context-specific indicators (perception-based)	Objectively verifiable indicators
Typical data:	Quantified summaries of beneficiaries' perceptions	Qualitative data of beneficiaries' experiences	Performance compared to pre-determined indicators
Influences:	PM&E, Customer satisfaction, Participatory Numbers	Participatory methods, empowerment	Management by objectives, Project Cycle Management,
Key concepts:	Theories of Change, Benchmarking, Adaptation	Participation, Learning, Adaptation	Results Chains, Theories of Change, Outcomes

Adapted from Jacobs, A., Barnett, C. and Ponsford, R., **Three approaches to monitoring: feedback systems, participatory monitoring and evaluation and logical frameworks** Draft as at 17th August 2010

Key Indicators and evaluative questions

Table 3 below presents the key indicators that will be monitored during the life of the project by outcome domain and activity. Also presented are the key positions who will assume responsibility for the analysis and reporting of M&E data.

Outcome area	Activities	Indicators/Evaluative questions	Means of Verification	Responsibility for Data Analysis and reporting
Objective 1 Marginalised people have sustainable access to the services they require				
Outcome area 1.1				
There is an increase in the capacity and focus of duty bearers to deliver inclusive and sustainable services	• Develop youth & disability service package • Deliver public sector training • Deliver private provider training	• Provider ability to deliver inclusive SRH services is strengthened • Improvement in client focus and sustainability of services delivered to marginalised populations by project providers	Service package; training reports; training plans and curriculum, participant feedback, MoH service data, FGD's, Mystery Clients, client exit interviews, joint supervision visits with MoH, participant feedback, trainer reports, GIS mapping data MIS . Annual QTA, KAP survey data.	**AACES M&E Officer, MSI Project Manager**, Social Marketing Manager, Partner Project Mangers, Mainstreaming officers, Disability and youth specialist project partners Public provider representatives, Private provider representatives
Outcome area 1.2				
There is an increase in demand for services by marginalised people	• Conduct health promotion • Conduct demand generation activities • Foster linkages	• Readiness and Willingness to use SRH services is increased among marginalised people • Increased numbers of marginalised people request SRH information and services	Project reports Project documents; Survey data, Operational research data Triangulation of referral cards and presentations MIS	**AACES M&E Officer, MSI Project Manager** ,Social Marketing Manager, Partner Project Mangers MSI Country Directors,
Outcome area 1.3				
There is an increase in marginalised people using services	• Develop /strengthen referral networks • Deliver equity sensitive	• Yearly increases in numbers of marginalised people availing of SRH services	MIS; monthly reports; project reports	**AACES M&E Officer, MSI Project Manager**, MSI Country Directors, Program

	information and services through social franchising, government and mobile outreach	provided under AACES in project areas		Outreach managers Social Franchise Manager, Research and Metrics Team, Program research officer, Partner Project Mangers, Mainstreaming officers, gender specialist project partners.
Objective 2: AusAID policy and programs in Africa are strengthened particularly in their ability to target and serve the needs of poor and vulnerable people				
Outcome area 2.1				
Processes in place to share and utilize information and research between AusAID and the AACES NGO's and between AACES NGO's	• Identify areas for shared and agency specific sectoral policy engagement with AusAID • Formation of /participation in AACES MCH/SRH sectoral working groups	• How has MSIA shared and utilised information from other AACES partners ? • How have AACES NGOs and AusAID utilised information from MSIA under the AACES project? • How effectively has MSI worked together with AusAID and other AACES partners to influence SRH policy and programs?	Annual policy engagement report ,Working group organagram, correspondence and meeting minutes, MoU, Meeting minutes, Bi-annual MSIA Management reflection	**AACES M&E Officer, MSI Project Manager**, MSI Regional Director, MSI Policy and Partnerships Manager
Outcome area 2.2				
As a result of these processes there is action undertaken between AusAID and the AACES NGOs	• Ongoing engagement with AACES partnership and program resource facility • Formation of /participation in AACES MCH/SRH sectoral	• How has MSI's approach and role in SRH sector based policy dialogue influenced AACES NGO's and AusAID's SRH policy relevant actions? • Has MSI's participatory approach to multi agency	Meeting minutes, Presentations, Project correspondence, Working group organagram, correspondence and meeting minutes MoUs, Meeting	**AACES M&E Officer, MSI Project Manager**, MSI Regional Director, MSI Policy and Partnerships Manager

	working groups	cross cutting and programmatic policy dialogue resulted in actions undertaken with AusAID?	minutes Bi-annual MSIA Management reflection	
Objective 3: Increased opportunity for the Australian public to be informed about development issues in Africa				
Outcome area 3.1				
Opportunities for the Australian public to be informed about development issues in Africa and about the Australian program of support to Africa	• Ongoing communication with AACES partners • Strategic and operational plans for joint community engagement initiatives agreed • Photovoice initiatives • Campaign website • Campaign Promotions • Ongoing use of media to promote AACES activities and impacts • Ongoing Supporter Relationship Management • MSI Australian clinical network promotes AACES activities and impacts	• Have credible and accessible campaign activities resulted in targeted segments of the Australian public obtaining information about maternal health issues in Africa and about the AACES program's response to these issues? • Has the depth of engagement among campaign supporters increased during the life of the project?	Meeting minutes, follow up correspondence MoU, Letters of Intent, campaign participant feedback, MSIA clinic network Community Engagement Liaison Officer feedback, Website administrator data, pre-test post test questionnaires.	**AACES M&E Officer, MSI Project Manager** ,MSIA Marketing and Communications Manager, MSIA website administrator

Tools for AACES M&E

These approaches have directly informed the development of MSI M&E tools. Table 2 below presents M&E tools to be used by MSI in the monitoring and evaluation of the project along with the frequency of their use and lines of responsibility for completion and timely reporting.

Tools for AACES M&E

M&E Approach	Tool	Purpose	Frequency	Responsible
Process/ Quality Assurance	**SUN Financial System**	Routine service delivery and country program finance data reported through country partner implementation	Monthly	Country Operations Directors , Head of research
Process/ Quality Assurance	**Quality Technical Assessment**	Comprehensive clinical audit	Annually	MSI and South to South TA, Operations Manager
Feedback system	**Client exit interviews**	Assess client satisfaction with service(s);Identifies areas for improvement	Annually	Country Research Units with support from Research and Metrics Team
PM&E	**KAP Studies***	Assess levels of willingness readiness and ability of participating service providers to deliver integrated equity sensitive services	Pre and post training	Country Research Units with support from Research and Metrics Team
Feedback system	**Mystery client visits**	Assess quality of service provision	Annually	Country Research Units with support from Research and Metrics Team
PM&E	**Focus group discussions***	Assess intermediate and long term impact of capacity building activities Identify factors leading to non use of services in terms of readiness willingness	Bi annually	Country Research Units with support from Research and Metrics Team

		and ability		
Feedback system	**Trainer reports/Trainee evaluations**	Assess effectiveness of training activities	Post training	MDT, Project managers
PM&E	**Joint supervision visits**	Provision of support and technical assistance to service providers. Monitoring of service quality	Semi annually	MoH, Operations managers, Outreach managers
Process/ Quality Assurance	**GIS mapping data**	Document expansion of service delivery points	Ongoing	Outreach Managers, Head of Research Operations Managers
Overarching approach encompassing all of the above	**Management Information system**	To monitor effectiveness, efficiency, equity, access and quality of services delivered To inform project management	Monthly	Country Director

* These methods do not constitute a part of MSI standard M&E tools. They will be utilized for ACCES project activity M&E

Monitoring and evaluation issues

- *How does the project draw on the existing M&E systems of the partners?*

In order to assess the short, intermediate and long term outcomes of service delivery as well as to monitor project implementation, activities carried out under AACES will draw heavily upon MSI's internal Management Information System (MIS). The MIS ensures that a standardised set of core indicators about clients, services and finances are routinely reported each month to country head offices which in turn ensure that data is incorporated into national health statistics. Through using the MIS as a key data collection and analysis tool for activities to be implemented under AACES, greater efficiency in terms of time and resources can be realised in disaggregating, analysing, documenting and reporting project outputs and outcomes. Core MIS indicators are presented below.

Annex 2 Monitoring and evaluation

Indicator		MOV	Frequency
	Overall Effectiveness / impact		
1.	Increase from x to y in contraception prevalence rates in [country]	MSI baseline & endline survey Secondary data e.g DHS REACH Calculator	Every 3 years
2.	Reduction in unsafe abortion from x to y in [country]	Impact calculator	periodic
	Equity		
3.	Increase from x% to y% of new family planning users that meet the programme criteria of "poor"	Exit interview tool	Annual
4.	Increase from x% to y% of clients who have no or less than x years of education	Exit interview tool	Annual
5.	Increase from x% to y% of first time users of modern contraception	MIS	Monthly
6.	Total family planning client visits for free services	MIS	Monthly
7.	Number/proportion of clients whose fees were waivered	MIS	Monthly
	Access		
8.	Increase from x to y in the number of client visits for family planning	MIS	Monthly
9.	Increase from x to y in the number of clients new to MSI	MIS	Monthly
10	Increase from x% to y% of first time users of family planning	MIS	Monthly
11	Reduction in unmet need for family planning from x% to y% within [target group] / [country]	Secondary data e.g. DHS	Every 3 years
	Quality		
12	Improvement in compliance with MSI Partnership global quality standards for different services from x% to y%	1.Quality Technical Assessment (QTA) 2. Mystery client	Annual
13	At least 85%-90% of clients are satisfied or very satisfied with the quality of service; Increase in satisfaction of clients with quality	Exit interview tool	Annual

	of service from x% to y%		
14	Increase from x% to y% of post abortion family planning up take	MIS	Monthly
15	Reduction from x% to y% of contraception discontinuation rates (IUDs and Implants)	Client record audit; Outreach study	Annual

- *What changes or additions were required to these systems?*

Some modifications to existing systems were required to capture AACES project specific evidence. In terms of MIS data some additional indicators will be necessary after year two of implementation to capture levels of service uptake by people living with disabilities. Methodologically, increased use of FGD's and case studies in project reporting was felt necessary to provide context for the largely quantitative data required by service delivery projects.

- *How will data be disaggregated?*

Data on beneficiaries can be disaggregated by service type, service delivery modality, age, gender, geography, socio-economic status and later in the project by disability status

- *How does the project help to address the known weaknesses or challenges partners face with M&E?*

The AACES project has provided a welcome opportunity for country partners to move beyond an exclusive reliance on service delivery statistics as a means of project M&E. The design process has allowed partners to reconceptualise how best to measure change. Methodologically, the inclusion of case studies and the potential to use electronic media to record these clearly poses opportunities to challenge accepted internal sense making processes. Use of these newer forms of project data offers opportunities for a more nuanced approach to interpretation of qualitative data than partners have been previously used at the country program level. The intent behind this is to increase the value assigned to qualitative data within MSI country programs. Gaps in capacity at the country level will be addressed through the capacity building of in country researchers by the global Research and Metrics team. In addition to ongoing support from the global RMT, MSI convenes regional and global research workshops on alternating years. These forums provide skills building opportunities as well as opportunities to procure technical assistance and in-country M&E capacity building through south south exchange

- *Identify how staff, partners and stakeholders will be involved in regular sense making processes to analyse and reflect on the underlying assumptions, theories of change, and results.*

MSI's relationships with key project stakeholders will allow for ongoing dissemination of relevant monitoring data. Internally MSI staff such as operations, outreach, social franchising and research managers will continue to receive MIS data on a monthly basis. Annual project workshops will be convened on a number of levels to consider and consolidate the meaning of M&E data relative to the stakeholders involved. It is through this process that periodic reflections on the levels of readiness willingness and ability of critical stakeholders to change and effect change will be undertaken. This process will also allow for critical reflection on anticipated incremental changes and progress toward breakthroughs as well as identification of unanticipated changes in the external environment that may affect project outcomes.

- Country specific (Africa)- In addition to routine project communications, MSI project staff and its national level stakeholders (government, private sector and CSO) will meet on an annual basis to review progress achieved towards project output and outcomes. Central to this process will be the identification of incremental changes and documenting progress towards project breakthroughs that have been anticipated by the underlying theory of change. This process will also allow the wider programs of country level partners to benefit from AACES specific learnings.

- Regional (Africa). In order to ensure cohesion across countries and to provide space for shared learnings and discussion of issues of shared concern, an annual regional meeting of MST and MSK project staff will be convened. This meeting will allow country partners to reflect upon shared areas for improvement and document successes in project implementation. Through providing a regional perspective for reflection on incremental changes and breakthroughs this meeting will directly inform and be temporally connected to the annual whole of project reflection meeting detailed below.

- Country specific Australia-MSIA will also conduct an annual project reflection process. This will largely centre around objectives two and three and will be informed through consultation with key project stakeholders in Australia including AusAID, AACES ANGOs and the AACES project resource facility. As with the in country annual meetings, this reflection will allow for a more nuanced consideration of project implementation and outcomes within the parameters of the proposed theory of change.

- Project based (Africa Australia) – An annual whole of project workshop will be convened which will draw upon reflections at national and regional level in Africa and in Australia. This workshop will provide opportunities for operational planning to be informed by project data and also to further explicate the linkages between the three objectives of the AACES project. Through the involvement of the PAG this workshop will provide an opportunity for the AACES project management team to draw upon innovations and best practice from across the wider MSI partnership as well as to share AACES project learnings with the MSI regionally across Africa and globally.

- *If required, how a baseline study will be undertaken that involves stakeholders in collection and analysis of the data*

  Baseline measurements for key indicators and evaluative questions will be obtained through a variety of tools and involve a wide range of stakeholders. Participation of service users and non-users and service providers will be sought for focus group discussions. KAP surveys will be used to measure the readiness and ability of specific marginalised populations and service providers to respectively access and deliver equity sensitive services. These data will provide baseline measurements of the barriers and enablers to service uptake among key marginalised groups such as youth and people living with disabilities. Baseline estimations of levels of information sharing and utilisation between NGO's will be qualitative and produced from MSIA management reflection and data gathering from other ACCES ANGOs. Baseline measurements of levels of engagement with maternal health issues in Africa among targeted segments of the Australian public will be obtained through online questionnaires.

- *How will risks to the project be monitored?*

  Risks indentified through the risk matrix will be regularly monitored by the Project Manager through ongoing analysis of MIS data as well as quarterly communication with partners, allowing for early identification of emerging issues. The risk matrix will also be assessed and modified through the annual sense making process.

- *When will the evaluation system be reviewed, and by whom?*
  The M&E system will be initially reviewed at the end of year one of implementation. The purpose of this review will be to ascertain that the system is providing the necessary information for project management and reporting. Any adjustments to the system at this point will be corrective rather than a fundamental change in M&E approach or methods employed. The M&E system will be formally reviewed during year three of the implementation. This review will be led by an external M&E consultant and solicit inputs from critical project stakeholders.

- *Is there any information you require from the wider AACES program and from other AACES NGOs to assist in your M&E?*
  As noted above, inputs from the wider AACES program, including AusAID and the AACES resource facility will be essential to monitoring and evaluation of objectives two and three.

- *Process for information flow, internal and external reporting?*
  MSK and MST will continue to report on key project service delivery activities monthly. Quarterly project meetings between MSIA, MST and MSK will provide opportunities to discuss issues around project service delivery, mainstreaming and operational research. Individual country programs will be responsible for presenting perspectives of their in country stakeholders through these meetings. Key personnel involved in these meetings will include operations and outreach managers from MSK and MST, research managers, finance managers and MSIA's project manager. Documentation from these meetings will form a quarterly project update to be shared among the PAG. Snapshot reporting to AusAID will occur every six months with a more detailed annual report to be produced at year end. Both snapshot and annual reports will be shared among key stakeholders in country and in Australia. The production of the annual report will be informed by the annual project sense making processes outlined at country regional and project levels. All reporting to AusAID will be the responsibility of the MSIA project manager.

M&E Activity timeline Year 1

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Partners report internally on service delivery												
Project meetings and internal quarterly reports												
Operational research*												
Snapshot reports to AusAID and external partners												
Project retreat/sense making process												
Annual Report to AusAID and external partners												

*Operational research is a project activity rather than an integral part of the M&E system. However findings from operational research will be used to inform the interpretation of M&E data.

Key

	Monthly reports via MIS
	Quarterly project meetings
	Semi-annual snapshot report to AusAID and AACES partners
	Annual retreat and sense making process
	Annual report to AusAID AND AACES partners

Annex 3 Risk Matrix

Risk	Potential Impact on the project	Likelihood	Impact	Risk (= Likelihood X Impact)	Management Strategy	Responsibility	Assessed through the M&E system?
Contextual Risks							
Significant political or natural disaster	Inability to provide SRH services to population in project areas	4	4	16	• Regular monitoring of the political environment • Ensure emergency preparedness and response capacity	Country Director, Operations Manager, Project Manager	N
Project viewed as competition to other service providers in the target areas	Reluctance of SRH service providers to partner and/or refer	1	3	3	• Ensure project is coordinated and implemented through local government structures • Geographic targeting of intervention in target regions currently not supported through other agencies • Collaborate and share information with other NGO partners through existing coordination mechanisms	Operations Manager, Project Manager	Y

Annex 3 Risk Matrix

Risk	Potential Impact on the project	Likelihood	Impact	Risk (= Likelihood X Impact)	Management Strategy	Responsibility	Assessed through the M&E system?
MoH regulate stricter guidelines for outreach service provision	Redesign of current outreach model - may result in increased costs of providing outreach SRH services	2	5	10	• MSI is an active member of government working, technical groups and committees • Ensure participation in joint activities including trainings, material development, support supervision with government	Operations Managers, Project Managers	Y
Change of Australian Government ODA policy	Funding for AACES is reduced or terminated	1	5	5	• Become an active member of SRH working groups and committees • Generate and disseminate evidence to support ODA policy	MSIA Policy and Partnership Manager	N
Negative publicity from Australian media	Objective 3 is not met.	2	5	10	• Invite media to events, • Maintain media monitor • Generate evidence to highlight project positives • Community engagement and	MSIA Communications Manager	Y

Risk	Potential Impact on the project	Likelihood	Impact	Risk (= Likelihood X Impact)	Management Strategy	Responsibility	Assessed through the M&E system?
					support networks are engaged with positive messages • Engage media in dissemination forums		
Design risks and assumptions							
Lack of experience with Theory of Change program design may constrain progress	Project redesign	1	5	10	• Ongoing investment of ToC capacity building for project managers and staff • Conduct annual sense making process • Conduct project inception workshop	Project Managers, Operations Manager Human Resources Manager	y
Increased readiness, willingness and ability do not result in increased service uptake among marginalised populations	Objectives and outcomes of project are not met	1	5	5	• Feedback systems and participatory monitoring tools	Project managers, outreach mangers, Social franchising managers	y
Key representative groups for youth and people living with disability do not engage	Objectives and outcome of the project are not met	2	5	10	• Effective internal and external communication systems developed	Project managers, Outreach managers	y

Annex 3 Risk Matrix

Risk	Potential Impact on the project	Likelihood	Impact	Risk (= Likelihood X Impact)	Management Strategy	Responsibility	Assessed through the M&E system?
in the project activities					• MoUs in place with key groups • Key groups participate in sense making process • Ongoing information sharing with key groups		
Gender norms limit women's access to information and services	Key target group not reached	1	5	5	• Demand generation materials for women developed with gender specialist input • Ongoing monitoring of service uptake • Conduct annual sense making process	Project managers Operations Managers	y
Lack of participation from private providers in social franchising	Social franchising activitied limited in reach (Kenya) or non existent (Tanzania)	1	5	5	• Stakeholder mapping will be conducted to help determine suitability of geographic locations and inform corrective actions • Engage professional health bodies in recruitment and	Project Manager, Operations Manager, Director of Social franchising	Y

Annex 3 Risk Matrix

Risk	Potential Impact on the project	Likelihood	Impact	Risk (= Likelihood X Impact)	Management Strategy	Responsibility	Assessed through the M&E system?
					selection of providers. • Existing provider providers share their experiences with potential franchise providers.		
Social franchising is not supported by Government of Tanzania	May result in project redesign	2	3	6	• Work with MoH to show SF benefits and results in improvement in key health indicators • South South exchange with Kenyan counterparts	Country Director, Operations Manager, Social franchising director	Y
Private providers do not take up Social Franchise model	Objectives and outcomes of the project are not met	3	3	9	• Work with Association of Private Health care providers to show benefits of Social Franchise model	Country Director, Operations Manager, Social franchising director, Project manager	y
Implementation risks							
MSI's lack of experience working with disability limits progress towards outcomes	Disability mainstreaming objectives not achieved	2	5	10	• Partnership with local disability groups • Technical assistance from Australian based SRH Disability	Project manager, Operations manager, Policy and Partnerships Manager	Y

Annex 3 Risk Matrix

Risk	Potential Impact on the project	Likelihood	Impact	Risk (= Likelihood X Impact)	Management Strategy	Responsibility	Assessed through the M&E system?
					organisations		
Inadequate support from local health authorities	Objectives and outcomes of the project are not met No discernable improvement in key health indicators	2	4	8	• Undertake consultative meetings with health authorities at all levels to galvanize support, interest and ownership in the project • Develop MoUs with health authorities for outreach services • Implement project steering arrangements and ensure meaningful inputs/outputs	Project Manager, Operations Manager	Y
High turnover of local franchisees limits service delivery in target communities/regions/ counties	Objectives and outcomes of the project are not met Larger amount of project funds spent on training	1	5	5	• Ensure active monitoring, quality technical and material support and a supportive network	Country Director, Operations Manager, Project Manager	Y
Communities do not support youth/disability-	Youth focus and disability objectives	2	4	8	• Work with and through community	Operations Manager,	Y

Annex 3 Risk Matrix

Risk	Potential Impact on the project	Likelihood	Impact	Risk (= Likelihood X Impact)	Management Strategy	Responsibility	Assessed through the M&E system?
focused services	of project are not met				gatekeepers and structures. • Engage with advocacy and support groups for youth/ disability	Project Manager	
Monetary/non monetary fraud i.e. Cash handling in the field Inflation of cash (outreach no cash exchanges) Misuse of assets	Project outcomes are not met MSI reputation on management of donor funds affected	2	5	10	• Cash management system in place limiting cash holdings at field level • Financial training for staff • Monitoring management controls • Acquittal process as prerequisite to cash advance issuance	Director of Operations, Project Manager, Financial Manager, International Finance Support Manager, Senior Program Support Manager	Y
Road incidents resulting in injury or death of staff or client	Clinical incidents can affect the number of people seeking SRH services from MSI outreach Road incidents may result in outreach team being off the road for a period of	2	5	10	• Road safety policy in place • Drivers trained in road safety	Director of Operations, Project Manager, Senior Program Support Manager, Medical Development Team	Y

Annex 3 Risk Matrix

Risk	Potential Impact on the project	Likelihood	Impact	Risk (= Likelihood X Impact)	Management Strategy	Responsibility	Assessed through the M&E system?
	time						
Clinical incidents resulting in injury or death of staff or client	Clinical incidents can affect the number of people seeking SRH services from MSI outreach	1	5	5	• Clinical standards in place • Regular QTA and monitoring visits • Medical Advisory Team follow up post QTA	Director of Operations, Project Manager, Senior Program Support Manager, Medical Development Team	
Irregular or inadequate commodity supply	May result in a reduction in the choice of FP available to clients and uptake of FP by clients	5	3	15	• MSI is a Member of the contraceptive security working group • Emergency purchase of FP commodities • Buffer stock through MSI Global procurement division	Director of Operations, Project Manager	Y
High turnover of project personnel	Project key deadlines are not met	2	2	4	• HR process in place to manage and support key staff members • Regular reviews of staff motivation and	Director of Projects Project manager, Human Resources	N

Annex 3 Risk Matrix

Risk	Potential Impact on the project	Likelihood	Impact	Risk (= Likelihood X Impact)	Management Strategy	Responsibility	Assessed through the M&E system?
					retention strategy • Engage staff in design, implementation, review • Succession planning		

MSI Service Delivery Models

MSI Mobile Outreach Model

What outreach involves

Mobile outreach programs, which began in 1990s, are designed to target poor, rural and underserved individuals who would otherwise have little or no access to quality family planning services or health facilities.

Outreach services are an important mechanism to bring services to communities. Trained providers deliver medical services and a local network of field educators and community leaders provide coordination, awareness and ongoing follow-up. Services provided during outreach range from provision of comprehensive STI treatment, HIV rapid tests, family planning counselling, short-term contraception, implants, intrauterine devices (IUD) insertion, tubal ligation and vasectomy.

In many cases, the government provider where MSI outreach is being conducted will already offer short term methods. Therefore MSI complements this service provision by focusing on unavailable methods (usually long acting and permanent methods LAPMs) that is, family planning methods that provide effective contraception for an extended period of time. Methods including IUD and implants have a proven record of long term effectiveness, convenience, cost-effectiveness, suitability for a wide variety of women and high user satisfaction.[1][2]

How it was developed for MSI

MSI is committed to providing services to underserved communities. This is evident with 98 percent of MSI's services being undertaken in developing countries, and nearly two-thirds of this delivered through outreach in hard-to-reach communities, where access to family planning has traditionally been very limited.

MSI's outreach model addresses the issue of access and demand by providing affordable (or free), high quality family planning services. In most MSI programs, outreach teams make use of existing public health facilities (clinics or hospitals, in some cases schools). Where no facilities are available outreach teams will work from a tent or a van. MSI's outreach team generally consists of four to five people including nurses, midwives, healthcare assistants, counsellors and a driver.

The frequency and duration of MSI outreach visits will depend on the level of demand in the community. Prior to outreach visits MSI will undertake extensive demand generation activities, through a multitude of channels including radio, community and government health workers and MSI sensitisation.

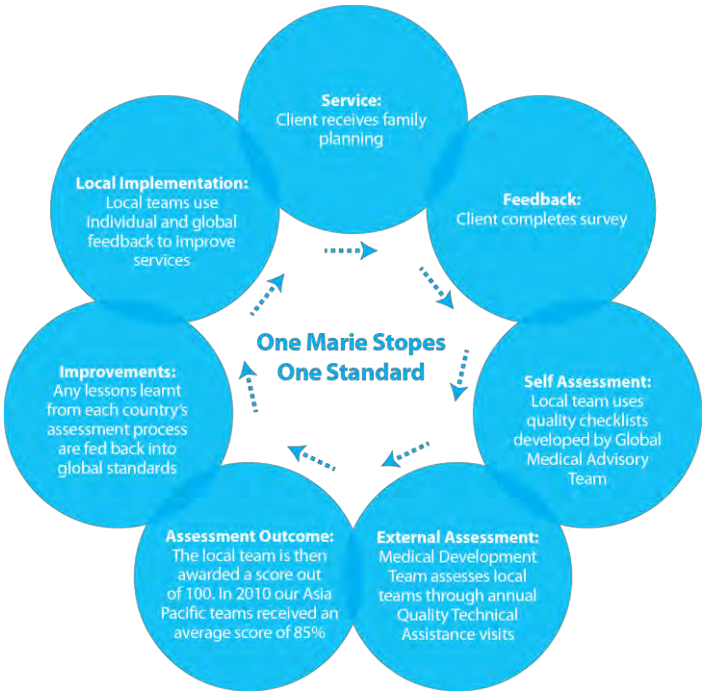
MSI may also be 'contracted in' by the Ministry of Health to provide clinical family planning services on behalf of the government. This may be due to district level health services or rural health posts not having sufficient supplies, equipment, training or human resources to provide comprehensive SRH services or be faced with competing health priorities. MSI ensures it is providing high quality services through each of its service delivery channels through a wide range of measures, including clinical standards guidelines and performing clinical audits. Since outreach mobile services take place mostly in rural settings, an additional

[1] World Health Organization (2004). Medical eligibility criteria for contraceptive use. Geneva, World Health Organization.
[2] World Health Organization (2004). Selected practice recommendations for contraceptive use. Geneva, World Health Organization.

emphasis is placed on clinical quality, particularly implementing a robust follow up system for individuals receiving services at outreach sites.

There is also an external review of the quality of each of the MSI country programs including outreach, at least once every year, these are called Quality Technical Assistance visits. These results are shared with Country Directors and relevant team members and an action plan is developed to address any identified gaps or service delivery improvements.

The MSI One Standard



Lessons learned

The outreach service model is used globally by MSI and has proven essential in the effort to address the unmet need for family planning. Evidence has shown that family planning outreach can cost effectively reduce fertility rates and increase the contraceptive prevalence rate (CPR). [3] [4] Furthermore, it can deliver high volumes of contraceptives in rural areas.[5]

In Kenya, MSI's outreach model has made a significant contribution to increasing CPR and LAPM method use. In 2008, MSI estimates 73 percent of the 225,000 female sterilisation users in the country and 18 percent of the 125,000 IUD users were provided their method by MSI, with the majority of these services provided via outreach.

[3] Srinvanan, K. (1995). Regulating Reproduction in India's Population: Efforts, Results and Recommendations. New Delhi, Sage.
[4] Ross, J., J. Stover, et al. (2005). Profiles for family planning and reproductive health programs:116 countries. Glastonbury, Futures Group.
[5] Balal, A. (2009). MSI Impact on Fertility Decline in Nepal. Marie Stopes International Case Studies. London, Marie Stopes International.

A recent study of women who received IUDs at a MSI Philippines outreach site found that 93 percent still had their IUD 24 months after insertion, demonstrating that outreach services can also achieve high continuation rates.[6]

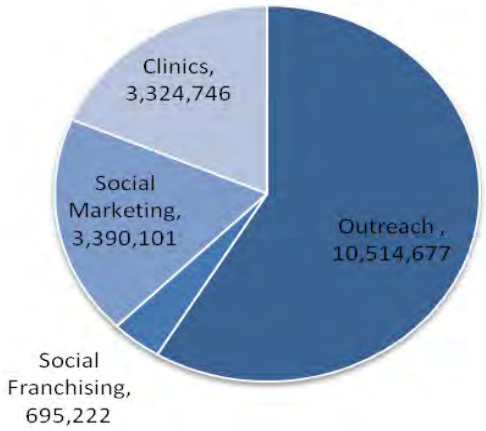
In 2009, MSI provided services to over 1.2 million women and men globally through its outreach services. These services generated almost 60 percent of MSI's 2009 Couple Years Protection (CYPs), as illustrated by the pie chart below.[7]

These MSI outreach services had the following impact, averting approximately:

- **5,650,385 unwanted pregnancies**
- **313,295 deaths of children under 5 years old**
- **21,563 maternal deaths**

As well as saving approximately **AUS$857 million in health costs** to individual households and national health budgets.

Figure 2: Global Division of CYPs according to MSI delivery channels in 2009



MSI mobile outreach services increase access and family planning uptake for the poor and underserved.

- in Malawi, MSI's outreach services are clearly targeting and serving the marginalised: 70 percent of outreach clients have little or no education and 61 percent of outreach clients report they are below the national average income.[8]
- in Uganda, outreach clients are more likely than clinic clients to have little or no education (48 percent compared to 11 percent) and 73 percent of outreach clients were also first time acceptors, again demonstrating MSI outreach services are provided to those most in need for family planning services.

[6] Marie Stopes International (2009). Discontinuation of IUDs among women receiving mobile outreach services in the Philippines, 2006-2008. London, Marie Stopes International.
[7] Marie Stopes International (2009). Global Impact Report 2009, London, Marie Stopes International.
[8] Ibid

For a successful and effective outreach program, the following criteria must be met: Contraceptive Choice, Quality, Follow up, Cost efficiency and Sustainability.

- **Contraceptive Choice** - Expand contraceptive choice to underserved women with a focus on LAPM, as women and men in rural settings typically have little access or no access to these services.
- **Quality** - Provide the highest quality of care and clinical safety, ensure complications are low or nonexistent, and exceed the expectations of our clients so that they refer additional clients for LAPM. In a recent outreach evaluation of five MSI mobile outreach programs, 78 percent of women reported they would recommend the service to a friend and in some countries nearly 100 percent.[9]
- **Follow up** - Ensure that follow up mechanisms are in place to improve continuation rates, to perform IUD or implant removals, for post procedure counselling, management of minor complications, and referral to MSI or other approved providers for complications.
- **Cost** - Maximise cost efficiency and cost effectiveness by tracking, analysing and working to decrease the cost per procedure for each MSI country program undertaking outreach.
- **Results** - MSI has demonstrated that by providing outreach, it can increase a country's use of LAPM and contribute to CPR, particularly for underserved populations in rural areas.
- **Sustainability** - MSI ensures sustainability being contracted in and working partnership with national health systems.

Core clinical services provided by both MSI partners (Kenya and Tanzania) are listed below.

Table 1: MSI Clinical Service Delivery Matrix Kenya and Tanzania	Kenya	Tanzania
Service delivery channels		
No. of Clinics	27	14
No. of Obstetrics Clinics	4	3
No. of Outreach Locations	712	896
Contraceptive Social Marketing	Y	Y
No. of Social Franchises	186	0
Interventions		
FP Counseling	●■▲	●■
Post Abortion Care	●■▲	●■
Tubal Ligation	●■	●■
IUD Insertion	●■▲	●■
Implant Insertion	●■▲	●■
Injectables	●■▲	●■
Oral Contraceptive Pills	●■▲	●■
Emergency Contraception	●■▲	●■
Condoms	●■▲	●■
Female Condoms	●■▲	●■
Vasectomy	●■	●■
Voluntary HIV Testing	●	●
STI diagnosis/treatment	●	●
Male Circumcision	●■	X
Safe Delivery	●	●
Antenatal Care/Post Natal Care	●	●■
Immunisation	●	●■
General Health Services	●■▲	●■
Call Centre	X	X
●clinic X service not offered ■ outreach, ▲other service delivery method (social marketing / franchising)		

[9] Eva, G, Ngo, T (2010) MSI Global Outreach Services: Retrospective evaluations from Ethiopia, Myanmar, Pakistan, Sierra Leone and Viet Nam, London, Marie Stopes International.

MSI Social Franchising Model

What it involves

Social Franchising was introduced to the SRH sector in the 1990's; Greenstar in Pakistan was first launched in 1995, Population Services International launched franchise networks in Cambodia and Togo in 2002. There are currently more than 20 health social franchise networks in Africa, Asia and Latin America, with MSI a significant player operating 35 percent of these franchises.

A social franchise is based upon a model of franchising commonly used within commercial sector. It typically involves the granting of a license by a social enterprise (the franchisor, often an NGO e.g. MSI) to a person or company (the franchisee) to allow them to create demand using the branding of the branding of a social enterprise.

The resulting franchise enables the franchisee to market the franchisors products or services from their outlets. In turn, the franchisee must follow standard operating procedures.

How it was developed for MSI

MSI has adopted a 'partial franchising' model for its social franchise networks. This means that only some of the franchisees services and commodities are regulated by MSI and they may offer addition services not regulated by MSI.

In most countries, MSI social franchises have been branded as part of 'BlueStar' Healthcare Network. In Kenya and Pakistan, as there were already existing networks, they have been branded AMUA and SUJAI brands respectively. MSI's franchisee model is very flexible and can be easily adapted to meet the health needs of the community.

MSI social franchisee selection follows set criteria – including geographic location, professional experience, and capacity to meet quality standards (e.g. sanitation).

In each case, MSI markets the brand through demand generation events (e.g. free services for a day), radio campaigns, leaflets, and posters. MSI has also provided onsite branding for every franchisee and in most cases, refurbished each franchisee.

Upon joining a franchise network, franchisees are required to sign a contract or make a formal agreement with MSI. Franchisees are also required to pay an annual fee to cover support costs, this will differ between countries. In Ghana, for example, annual membership is US$70 for clinics; US$50 for Pharmacies and US$30 for chemical shops and for Ethiopia, an annual membership is US$12.

In return, franchises receive high quality but subsidised commodities from MSI which they can sell to clients according to agreed pricing structure. They will also receive extensive and regular training, for example - client care and stock control. MSI also provides ongoing coordination, technical support and advice to each franchisee as well as regular monitoring and evaluation of franchisee services.

MSI experience to date with using this approach

MSI has established social franchises in nine countries across Asia and Africa – Ethiopia, Ghana, Kenya, Madagascar, Malawi, Pakistan, Philippines, Sierra Leone, and Vietnam and has over 1,100 franchised health services providers.

Table 1 below highlights how MSI has utilised different providers, regulated services or targeted specific population groups in its social franchising networks.

Country	Package of Services offered	Providers implementing franchised services	Population targeted by the franchises
Ethiopia	Marie Stopes Ligation (MSL), implants, Intrauterine Device (IUD), injectables, condoms, pills and emergency contraception (EC)	Doctors, clinical officers, midwives	Peri urban and rural low income earners
Ghana	Implants, IUD, injectables, condoms, pills and EC	Midwives, nurses, (pharmacies are referral points) and doctors	Peri urban low income earners
Kenya	Implants, IUD, injectables, condoms, pills and EC	Nurses, clinical officers and midwives	Peri urban low income earners
Madagascar	Implants, IUD, injectables, condoms, pills, EC	Doctors	Peri urban and rural low income earners
Malawi	IUD, pills and MSL	Clinical officers, medical assistants, midwives and nurses	Peri urban poor and low income earners
Pakistan	IUD, pills, injectables, condoms and EC	Doctors and midwives	Rural low income earners
Philippines	IUD, injectables, pills, pap smears, family planning counselling, MSL referrals and delivery services	Private midwives	Low income earners in peri urban areas

Sierra Leone	Implants and injectables	Doctors, nurses, clinical officers, pharmacies and chemical sellers as referral points	Urban poor and low income earners
Viet Nam	IUDs, injectables, pills and condoms	Doctors	Low income earners in peri urban areas; garment factory workers

Lessons learned

MSI's social franchise networks have proven to target and meet the current unmet need for family planning and sexual reproductive health (SRH) services. In 2010, the Philippines provided 37,000 IUDs to clients, just two years after the network was launched. And in Pakistan and Sierra Leone social franchisee networks in 2010, almost 60 per cent of their clients were first time users of any family planning method.

MSI' social franchise networks are successful in reaching and serving the underserved – the poor. In Pakistan, 48 per cent of clients visiting MSI's franchisees in 2010 had received no education.[10]

Social Franchising is also increasingly becoming a major service delivery channel for MSI country programs. In 2009 social franchising made up 28 percent of the MSI Ghana's overall CYPs (see table 2 below).

Table 2: Percentage of CYPs by delivery channel for countries with social franchising programs in 2009

Country	Clinics	Outreach	Social Franchising	Social Marketing
Ghana	40%	32%	28%	0%
Kenya	10%	72%	18%	1%
Pakistan	41%	38%	16%	5%
Sierra Leone	45%	43%	13%	0%

The following recommendations should be considered when establishing social franchise networks:

- Extensive training, both clinical and technical expertise as well as good customer service should be provided to franchisees, including refresher training,
- All branding, social marketing and communication activities should respond to the barriers to the uptake of SRH or family planning services and be pre tested with the target community or population to determine whether services will be culturally appropriate and contextually relevant,
- Monitoring and evaluation should be maintained to ensure quality and client care and satisfaction, and
- Price structure should reflect local circumstances.

[10] Marie Stopes International (2010). Social Franchising: Reaching the underserved, London, Marie Stopes International.

Rationale for extending the approach in this program

Social franchising networks successfully deliver essential SRH services to the underserved as they provides a service delivery channel through which organisations can increase coverage of high quality, effective and affordable SRH services.

Social Franchising also allows greater engagement with the private sector, which provides a major source of healthcare in the developing world. There is a strong likelihood of continued growth in this sector in the next decade.[11] In Asia and Latin America, 50 per cent of all contraceptives are provided by the private sector.[12] This trend is echoed in sub-Saharan Africa, with over 50 per cent of health expenditure being private, primarily out-of-pocket spending by households[13] and one third of all family planning methods obtained through the private sector.[14]

Table 3: Percentage of health care provided by non-public sector[15]

Countries	Non Public Sector
Ghana (2003)	56%
Kenya (2003)	45%
Nigeria (2003)	72%
Uganda (2006)	64%

By engaging with the private sector, social franchising enables SRH organisations to introduce services to underserved populations more cost-effectively and rapidly, by increasing access, quality and affordability to clients. This cost effectiveness is demonstrated in MSI Ghana social franchisee network, where the **cost per CYP in 2009 was $12.87**, compared to $22.69 per CYP for static clinics.

Social franchising allows existing services to increase the use of these services by improving their quality or through marketing them appropriately.

MSI evidence to date has shown high client satisfaction in terms of price, treatment, service and environment, regardless of a client's educational background, social-economic status or location.[16] Thanks to member benefits, experience shows that franchisee usually enjoy a profitable business and increased clientele, and that client satisfaction is higher in users of franchised clinics than in equivalent non franchised clinics.[17] MSI improves the quality of care of service delivery through training, supply chain management and continuing supportive supervision. Continuity of care for the client is promoted through strong referral networks to other franchisees, MSI centres, or government hospitals.

[11] International Finance Cooperation, The Business of Health in Africa: Partnering with the private sector to improve people's lives (2008).
[12] Winfrey, W et al. *Factors influencing the growth of the commercial sector in family planning service provision.* Washington , DC. USAID 2000 (POLICY Project Working Paper Series No. 6
[13] The World Health Report 2005; make every mother and child count. Geneva, World Health Organization, 2005
[14] Zellner S, et al. *State of the private health sector wall chart.* Bethesda, MD, Private Sector Partnerships-One Project, Abt Associates inc., 2006
[15] Ibid
[16] Based upon MSI client exit interview data, 2010
[17] Stephenson R, Tsui AO, Sulzbach S, Bardsley P, Bekele G, Giday T, et al. Franchising reproductive health services. Health Services research 2004;39:2053-80.

Membership benefits are conditional upon the delivery of quality care. If the franchisee fails to follow the set regulations determined in the initial contract, the franchise is revoked. As long as the value of the opportunity is greater than the value of breaking the rules and there is a credible threat of enforcement, franchisees follow standards and self-regulate, lowering the overall cost of monitoring. This self-regulation makes this particular system of service expansion and quality improvement cost-effective in a way that is only possible because the goals of the provider are aligned with the goals of the franchiser.

Finally, an important benefit of social franchising is its sustainability. Since social franchising works with existing and trusted local service providers, these providers are likely to continue services in the long term, even if the franchisor (SRH organisation) was to discontinue activities.

Key questions on MSI AACES service delivery models

What is the linkage between building Government capacity and mobile outreach and private sector engagement?

Taken together these elements represent key elements of national health systems. Outreach represents a "catch up" approach for populations outside the reach of existing services. Enhancing government capacity to provided SRH/FP services while developing private sector quality and reach represent a "keep up" strategy. Taken together these service delivery channels will result in immediate impact as well as sustainable improvements to the availability and quality of SRH services

What is the legal implication for Social Franchising in Tanzania?

The technical and regulatory legal requirements to introduce a new model of service delivery in Tanania will be fully explored during the feasibility study. MSI has the capacity and experience to navigate these processes.

Who are the private providers?

Existing doctors nurses and midwives who run private services

How are they selected and resourced?

Selected on the basis of their willingness to join and uphold the franchisee agreement and on their location.

How many will be supported and what is their client outreach?

Initially 10 in Kenya and depending on findings from the feasibility study number for Tanzania will be formulated in year 2. Based on service data from Kenya between 800 and 1000 clients per annum per franchise is a realistic estimate of their reach.

How do fee payments work (and how does this enhance/challenge sustainability)?

Fee payments are relevant only to social franchising. Details are provided in the service delivery annex. Fees are charged on a sliding scale and can be waived if payment is a barrier to service uptake. In SF fees are critical as cost recovery is a prerequisite to sustaining small businesses. On a systemic scale it is also arguable that charging fees leads to greater valuing of services as well as enhancing competition and thus increasing quality.

Do mobile outreach and social franchising they target different clients?

Yes they do. Social franchises typically provide services in urban or peri-urban areas while outreach services are typically targeted to rural and hard to reach communities.

Project operational structure

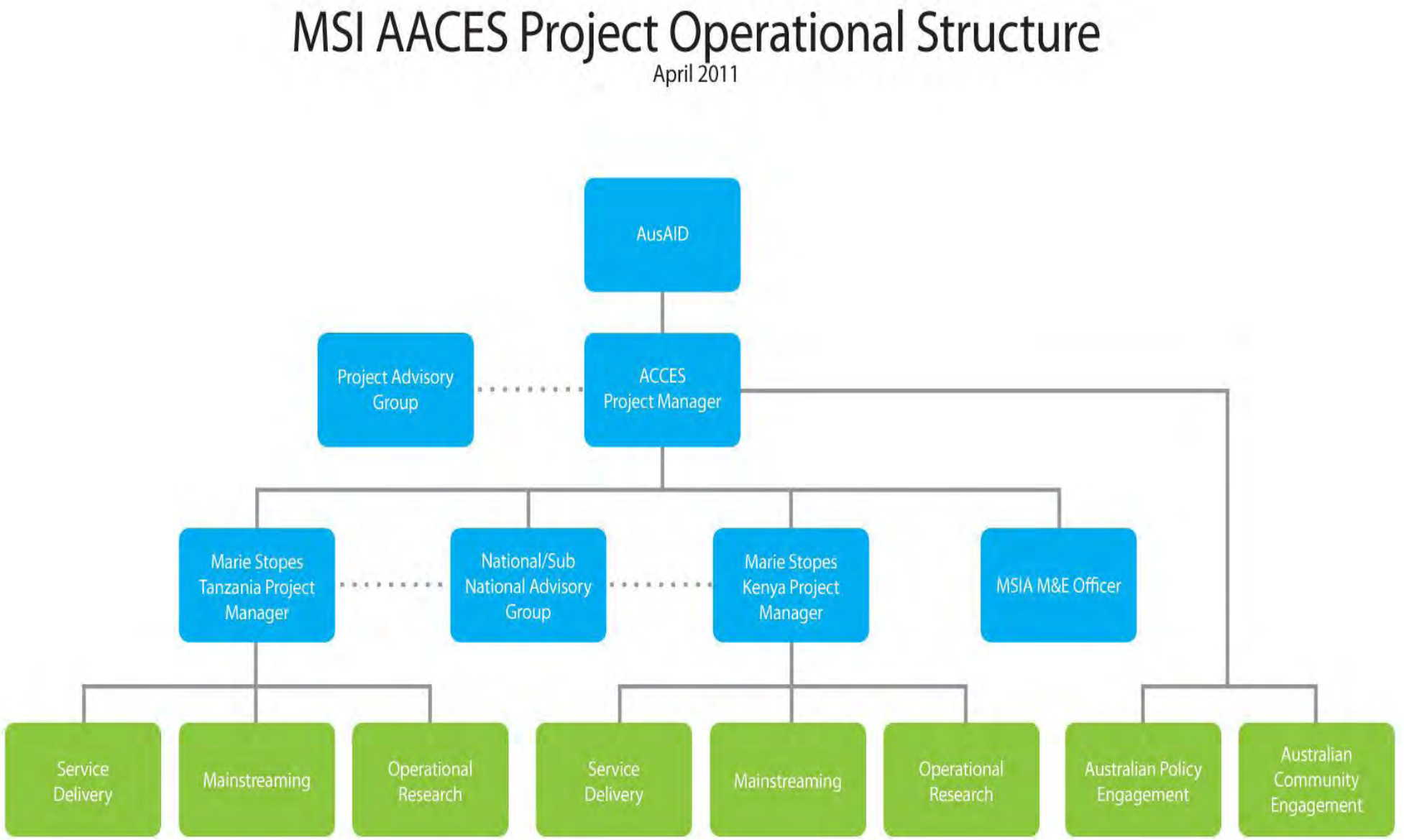
The Project Advisory Group (PAG) will ensure the ***One MSI*** quality standards are adhered to. The PAG will also assist the Australian project manager in coordination and mobilisation of technical expertise from within the MSI global partnership.

The AACES Project Manager based in Melbourne will have responsibility for 7 key functions

- Planning
- Contractual compliance (Monitoring and reporting)
- Coordinating and providing TA and training
- Coordination – internal MSI / External ACCES/AusAID policy engagement
- Community engagement
- Co-ordination of Operational research
- M&E– responsibility for the M&E framework (adjustments ,analysis, dissemination and ongoing development)

MSK and MST are in country implementers; responsible for outputs under objective 1. Within these organisations the project manager will have oversight of all activities. National and local advisory groups in country will be responsible for coordinating project activities with government and local partner organisations. These groups will provide a management feedback loop sharing lessons learned with local external stakeholders and communicating external feedback into project management processes. These groups will also be responsible for ensuring technical and legal compliance with Government regulation.
The following charts and tables present the overall MSI AACES management structure and project staff number and positions.

Annex 6 Project operational structure



Annex 6 Project operational structure

Project Staff numbers and positions

Partner Organisation	Position	% of FTE
Marie Stopes Kenya	Country Director	5%
	Clinic Services and Operations Director	5%
	Finance and Admin Director	10%
	Director of Projects	30%
	Human Resources Director	5%
	Senior Quality Assurance Advisor	10%
	National Outreach Manager	15%
	Clinical Services Manager - Eastern	5%
	Integrated Marketing Manager	10%
	BCC/ICC Coordinator	30%
	Social Franchising Manager	15%
	Social Franchising Cordinator	25%
	Finance and Admin Manager	10%
	Grants Compliance Manager	25%
	Project Accountant	15%
	Procurement Manager	10%
	Procument Officer	10%
	People and Development Assistant	10%
	Projects Administrative Assistant	30%
Marie Stopes Tanzania	Country Director	20%
	Operations Director	20%
	Finance Director	20%
	Projects Director	20%
	Human Resources Director	10%
	Project Manager	100%
	Assistant Medical Officer (2)	100%
	Nurse midwife (2)	100 %
	Lab Technologists (2)	100%
	Driver (2)	100%
	Youth Coordinator (2)	100%
	Zonal Coordinator	40%
	Outreach Manager	20%
	National MDT Coordinator	10%
	MDT Officer	20%
	Head of Communications	20%
	Advocacy Officer	50%
	Project Accountant	25%
	Assistant Accountant	50%
	Project Administrator	25%
	Procurement Manager	25%
	Human Resources Officer	20%
	Head of Research	20%
	MIS Officer	40%
	Supervision vehicle Driver (100%)	100%
	Research Assistant (30%)	30%
Marie Stopes International Australia	Regional Director	10%
	Project Manager (SPSM)	60%
	Regional Finance Manager	10%
	Senior Regional Director	5%
	M&E Officer	60%

	Programme Support Manager (Tanzania)	15%
	Senior Programme Support Manager (Kenya)	15%
	International Finance Advisor	10%
	Medical Development Support Manager	5%
	Regional Research Manager	5%
	Regional Social Marketing Manager	5%
	Regional Policy Advisor	5%

Annex 8

Maries Stopes International Australia, Year one consolidated AACES activity plan (Kenya - Tanzania - Australia)

MST
MSK
Joint MSK MST
MSIA
MSIA &AACES Partners/ ANGO's

Outputs and Year 1 Key activities	AACES Objectives			Month											
	1	2	3	1	2	3	4	5	6	7	8	9	10	11	12
***Output 1:* The provision of quality SRH services strengthened and expanded through integrated service delivery networks**															
Undertake consultative planning meetings at district level	√														
Organise project inception meeting with LGAs (MST) and DHMTs (MSK)	√														
Sign MoUs with relevant health bodies (eg RHB, DHMT)	√														
Initiate procurement of vehicles and other equipment and supplies	√														
Undertake training on GPS and mapping	√														
Map service delivery sites (public, private and community)	√														
Deliver SRH services on outreach	√														
Undertake health promotion through outreach teams	√														
Undertake social franchising feasibility study	√														
Assess and recruit private providers to the social franchise network	√														
Manage FP commodity availability for outreach	√														
Provision social franchises with highly subsidised equipment, materials and commodities as dictated by facility assessments	√														
Deliver SRH services via social franchising	√														
Conduct supportive supervision	√														
Design LGA capacity building approach	√														
Incorporate LGA capacity building into outreach	√														
***Output 2:* The capacity of MSI and its partners to deliver equity-sensitive SRH services strengthened**															
Develop youth service package and quality standards (adapt national guidance to outreach and the private sector)	√														
Deliver training on youth-friendly service package	√														
Train franchisees on selected SRH services and business management	√														
Design and undertake operational research	√														
Strengthen organisational capacity on equity-sensitive approaches (gender, youth)	√														
Recruit youth coordinators	√														

Conduct situation analysis on SRH/disability	√														
Identify multi-sectoral referral partners for youth	√														
Output 3: Awareness of and demand for SRH services and information stimulated through effective communication															
Conduct research on effective BCC methods for different target groups	√														
Develop health promotion strategy capitalising up available assets and addressing gender issues (eg male involvement, couple communication, etc)	√														
Adapt/develop DG/BCC materials	√														
Undertake youth-targeted SRH promotion	√														
Undertake health promotion, awareness raising and demand generation activities through outreach teams	√														
Develop/strengthen linkages with educational institutions and workplaces (identified through local plans)	√														
Establish project advisory group (PAG) and management committee	√														
Undertake annual PAG meetings	√														
Output 4: AusAID MCH policy is more responsive to the experience of SRH agencies in Africa															
Map existing and potential sectoral synergies with AACES ANGOs		√													
Identify areas for shared and agency specific sectoral policy engagement with AusAID		√													
Ongoing engagement with wider AACES partnership and program secretariat		√													
Develop an operational plan for ACCES MCH/SRH policy engagement		√													
Outout 5 Participation in multi-agency policy engagement with AusAID on thematic issues (youth, gender and disability) in Africa															
Ongoing engagement with AACES partners and program secretariat		√													
Identification of areas for shared cross cutting policy engagement with AusAID		√													
Output 6 Participation in multi-agency policy engagement with AusAID on programmatic issues in Africa															
Ongoing engagement with AACES partners and program secretariat		√													
Ongoing contribution to multi agency policy engagement with AusAID		√													
Output 7 Coordinated approach to community engagement activities ensured															
Ongoing communication with AACES partners			√												
Strategic and operational plans for joint community engagement initiatives agreed			√												
Community segmentation			√												
Output 8 Development of AACES Photovoice campaigns															
Development of campaign platform			√												
Campaign website			√												
Output 9 Campaign Promotion to Target Australian Communities															
Direct Campaign Promotions			√												
Digital and Online Promotions			√												
Ongoing use of media to promote AACES activities and impacts			√												
Ongoing Supporter Relationship Management			√												
Output 10 Leveraging of MSI supporter base to promote engagement with AACES work															
MSI Australian clinical network promotes AACES activities and impacts			√												