



SPRINT IV Program 2022 – 2024

Mid-Term Review Report



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Acknowledgements

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Daniel Noriega

Executive Summary

The Asia-Pacific is the most disaster-prone region in the world¹, vulnerable to cyclones, droughts, earthquakes, storm surges, tsunamis, typhoons, and volcanic eruptions. The International Planned Parenthood Federation (IPPF) is a global leader in advocating for and delivering sexual and reproductive health (SRH) services in emergencies. It integrates humanitarian action as a global priority across the organisation and through its local, country-based Member Associations (MAs). IPPF's approach to humanitarian assistance focuses on the delivery of the Minimum Initial Service Package for Reproductive Health in Crises (MISP), an international standard which facilitates lifesaving SRH services to affected communities from the onset of crises.

Since 2007, Australia has invested in IPPF's humanitarian activities through the Sexual and Reproductive Health Program in Crisis and Post-Crisis Settings (SPRINT) Initiative which assists crisis-affected communities in the Indo-Pacific region to access essential SRH services. Through SPRINT IV 2022 - 2024, IPPF supports MAs in eight priority countries in Asia² and six in the Pacific³, and to date has provided essential lifesaving SRH services following disasters in the Philippines, Solomon Islands, Pakistan, and Indonesia. The outcomes of the current program are in four areas or pillars: Advocacy and Policy, Preparedness, Emergency Response and Recovery.

The purpose of this Mid-Term Review of the SPRINT IV program is to:

1. Provide an independent assessment of the progress towards the SPRINT IV goals/outcomes, particularly around the newly introduced Outcome 4 – Recovery.
2. Assess the effectiveness of SPRINT IV at all levels of implementation from Member Associations and key national partners, to beneficiaries and other stakeholders
3. Recommend how implementation of SPRINT IV can be improved for the remainder of the program, including by addressing any identified issues.
4. Recommend whether a costed extension should be considered, and present suggestions for further streamlining of the SPRINT IV program model to strengthen impact and efficiency gains.

The MTR commenced on 26 July 2023 and the data collection period took place between 20 August and 30 September. Three SPRINT IV countries were selected to get geographic representation of the program, covering South Asia, Southeast Asia, and the Pacific. These countries were, respectively: Nepal (COVID-19 Response), the Philippines (Typhoon Odette), and Solomon Islands (COVID-19 Response).

The field data collection exercise was conducted by the evaluator, who was supported by a different IPPF Humanitarian Team member in each country between 20 August and 10 September. The following approaches were used in the MTR:

- a) A logic-based approach;
- b) a participatory approach; and
- c) a mixed-methods approach.

Four methods for primary and secondary data collection were employed, which provided insights from all relevant target groups and allowed for triangulation of findings. Methods included a desk review and primary data collection through 33 Key Informant interviews, 22 focus group discussions and direct observation in Nepal, Philippines, and Solomon Islands. This evidence was collected into a structured evidence matrix based on the three evaluation questions (EQ).

1 WMO. 2022. Asia-Pacific is key to disaster risk reduction targets. Available at <https://public.wmo.int/en/media/news/asia-pacific-key-disaster-risk-reduction-targets>

2 Indonesia, India, Maldives, Myanmar, Nepal, Pakistan, Philippines, and Sri Lanka,

3 Fiji, Papua New Guinea (PNG), Samoa, Solomon Islands, Tonga, and Vanuatu.

Evaluation question one was ‘**How can SPRINT IV increase the impact of pillars one, two and three?**’. Under **Pillar 1. Advocacy and Policy**, the Family Planning Association of Sri Lanka’s (FPA) advocacy work led to the development of the Standard Operating Procedure (SOP) to incorporate SRH in emergency (SRHiE) to the Humanitarian Policy of the Disaster Management Plan of the Disaster Management Centre. The Family Planning Organisation of the Philippines (FPOP) successfully advocated for the inclusion of buffer SRH commodities for future responses in the ‘Disaster Risk Reduction Management’ plan.

However, developing or reviewing laws, national plans and programs is a long process and even when approved, these are not always implemented. Hence, advocating for the effective implementation of SRHiE policies is just as important.

Advocacy work is strengthened by working in partnership with other stakeholders, and by having a solid evidence base to inform decision-making. IPPF and the SPRINT MAs have developed strong partnerships for advocacy. However, significant gaps remain at the national level of evidence on the importance of delivering SRHiE in emergencies, and the impact of different types of crises on SRHR.

The work done under **Pillar 2. Preparedness** of SPRINT IV received wide praise from stakeholders regarding the preparedness level of MAs’ staff and volunteers. The capacity to deliver lifesaving SRH services in crises has been increased through training, establishing strategic partnerships and re-establishing the ‘Surge Roster’. The impact of capacity building activities can be further increased by targeting relevant stakeholders.

Since the start of SPRINT IV, in alignment with **Pillar 3. Response**, emergency responses have been implemented in Indonesia (earthquake), Pakistan (floods), the Philippines (tropical cyclone), Solomon Island (COVID-19), Vanuatu (two tropical cyclones), and Yemen (armed conflict), providing 15,579 Couple Years of Protection and averting 6,715 unintended pregnancies.

One of the reasons for the success of the program under Pillar 3 is the expertise of the MAs on the delivery of Minimum Initial Service Package for Reproductive Health in crisis settings (MISP). Another reason is the commitment of MAs to the principle of ‘Leave No One Behind’, which facilitated the successful delivery of SRH services in remote and hard to access communities, reaching vulnerable and marginalised groups.

However, the implementation of responses can be strengthened by adopting new strategies to reach target populations, including communities in vulnerable situations. This includes the implementation of an Accountability to Affected Populations mechanism and Real-Time Reviews to understand community needs and the best way to deliver services to address the identified needs. Additionally, it is important to consider diversifying supply chain sources to avoid stock-outs of commodities.

Under the current design of SPRINT IV, **Pillar 4. Recovery** has a strong focus on internal IPPF processes, aiming to increase collaboration between the humanitarian and development programs. And while the desired outcome is to support the transition from emergency to stable times and the continuation of services to affected populations, limited work has been done in this area.

The second evaluation question, ‘**What is the future of Pillar 4 – Recovery under SPRINT IV?**’ was included to address the gap between the current design of Pillar 4 and what IPPF and the MAs envision for the ‘Recovery’ phase. This phase is best suited in the Humanitarian-Development nexus, as many SPRINT priority countries frequently find themselves in a continuous state of rebuilding from the previous disaster while preparing for the next.

The vision for Pillar 4 includes supporting the following aspects:

- Transition from crisis to development

- Restoration or improvement of SRH services to the general population
- Promoting resilience
- Risk Reduction and Preparedness
- Act as bridge leading back to Pillars 1, 2 and 3

To achieve this vision, IPPF and the MAs will need to redesign Pillar 4 to strengthen the planning, implementation, and monitoring of the recovery of affected populations. A workshop with IPPF Humanitarian and SPRINT MAs will be required to revise the outcome and indicators of success, which need to be specific, measurable, achievable, relevant, and time-bound (SMART) to properly assess its success.

While the current iteration of the SPRINT program is due to be finalised in 2024, there is consensus between IPPF, MAs, and DFAT posts in Solomon Islands, Nepal, and the Philippines on the importance of extending SPRINT IV with a two-year costed extension. To support this, the third evaluation question, **‘What is the outlook for the SPRINT program in the future?’** was included to understand what the purpose of the extension would be, and how DFAT can continue supporting IPPF’s humanitarian program beyond SPRINT.

The two-year costed extension would be used to solidify the achievements of the program, increase reach to marginalised communities, build the capacity of IPPF and the MAs in the Recovery phase, and continue exploring new mechanisms for DFAT support for SRHiE through IPPF.

It is important to acknowledge that DFAT’s funding of the SPRINT program has enabled IPPF and the MAs to take a holistic approach to disaster management and response. This includes working in the ‘Preparedness’ phase, which is increasingly globally recognised as a crucial phase but is not traditionally funded by other donors. While significant improvements in capacity have taken place, there is still a need to continue supporting the efforts of these countries to deliver lifesaving SRH services. Therefore, DFAT’s continuous investment in IPPF’s Humanitarian program is highly recommended beyond SPRINT IV, to enable IPPF to continue providing Humanitarian technical expertise and support to MAs, particularly around the integration of the recovery phase.

Recommendations under each evaluation question:

1. How can SPRINT IV increase the impact of pillars one, two and three?

a. At the policy level, how can SPRINT IV strengthen SRHR in crises?

- 1) Prioritise advocating for implementation: Focus on advocating for the costed implementation of existing laws, national plans, and programs related to SRHiE. The emphasis should be on translating policy into action, ensuring that these initiatives have political will and sufficient budget to be implemented in order to achieve tangible outcomes.
- 2) Diversify advocacy efforts: Focus on increasing collaboration with stakeholders to maximise limited human resources of existing MAs, supporting government priorities aligned to SPRINT IV and ensuring participation in national consultation exercises.
- 3) Enhance evidence on the need and impact of delivering SRHiE: Showcase the impact of delivering SRH in crises and generate additional data for improved decision-making.

b. How can SPRINT IV strengthen capacity to deliver lifesaving SRH services in crises?

- 4) Enhance inclusivity and accessibility of capacity building activities: Prioritise inclusivity and accessibility by providing sensitisation training for MA staff, volunteers, and stakeholders on effectively supporting individuals/ communities in vulnerable situations. The nature of this activity

places it in the Humanitarian-Development Nexus and hence this could be done in collaboration with other initiatives and/or stakeholders.

- 5) Strengthen stakeholder engagement in preparedness activities: MAs should actively involve relevant stakeholders, including representatives from communities in vulnerable situations, in the development of the Emergency Preparedness Plans (EPP) and Emergency Response Plans (ERP).
- 6) Conduct surge roster workshops, prioritising MAs with large staff numbers and / or with numerous chapters.

c. How can SPRINT IV strengthen the delivery of lifesaving quality essential SRH care during emergencies?

- 7) MAs to conduct a stakeholder mapping exercise across their respective countries and include scenarios for responses in areas vulnerable to disasters in their EPP and ERPs
- 8) Adopt the model of conducting information sessions in affected areas during the evening and deliver services in the morning (where possible).
- 9) Consider alternative ways to provide services to people who are in vulnerable situations.
- 10) Diversify supply chain sources: While continuing the collaboration with UNFPA to address supply chain challenges in Humanitarian settings, IPPF should concurrently explore alternative supply sources to mitigate risks associated with potential commodity shortages, including the provision of buffer stock.
- 11) Strengthen safety, dignity, and confidentiality to increase reach to people in vulnerable situations.
- 12) Implement comprehensive Accountability to Affected Populations (AAP) mechanisms from the beginning of a response and ensure a Real Time Review (RTR) is conducted four to six weeks after the commencement of the response.

2. What is the future of Pillar 4 – Recovery under SPRINT IV?

- 13) **Adopt a strategic shift towards an extended intervention approach:** Given that international resources tend to diminish beyond the response phase, this underscores the importance of sustained efforts during the recovery period. Instead of limiting funding to the three to six months response, funding activities in the recovery phase will provide stability and continuity in post-crisis scenarios. This will contribute towards strengthening state and community long-term resilience, aligning seamlessly with Australia's International Development Policy. This funding could be included in the MA's work plan for the following year.
- 14) **Strengthen efforts to plan, implement and monitor the continuation of services to affected communities after the emergency:** A Recovery Plan should be discussed, designed, and agreed upon with all relevant stakeholders, including representatives from those in vulnerable situations. It should provide an agreed roadmap with responsibilities and timelines on how to transition to regular services, ensure SRH data collected by stakeholders is centralised, and incorporate a mechanism to monitor the implementation of the plan's determined activities and indicators.
- 15) **Redesign 'Pillar 4 – Recovery' to have a stronger focus on the recovery of affected populations:** This pillar should provide clear guidance on how to support the transition from emergency to stable situations⁴, while ensuring the continuation of services to affected populations, particularly new and underserved communities.

3. What is the outlook for the SPRINT program in the future?

- 16) **Provide a two-year costed extension to SPRINT IV:** Providing a two-year costed extension to the current iteration of the SPRINT program will allow IPPF and MAs not only to continue supporting preparedness activities, but to consolidate achievements and efforts, work in new areas and implement new activities. Most importantly, it will enable IPPF and MAs to redesign and implement a new Pillar 4 focusing on the recovery of affected populations.

⁴ For example, identifying relevant stakeholders

- 17) DFAT to continue investing in the IPPF Humanitarian Program:** Given that climate impacts are increasing the intensity and frequency of sudden-onset and slow-onset disasters, exacerbating SRH issues in an already disaster-prone region, and recognising the valuable contributions of IPPF in this context, it is strongly recommended that DFAT continues its ongoing support to IPPF's humanitarian work beyond the completion of SPRINT IV. To enhance the effectiveness of this support, exploring a more flexible funding approach is recommended, resembling close-to-core financing for IPPF's humanitarian programs. By allowing a portion of the funding to be partially earmarked for the Indo-Pacific region, DFAT can strategically contribute to addressing the challenges faced by women, girls and communities in vulnerable situations.
- 18) Tap into additional funding streams:** Explore conventional and non-conventional channels to secure further funding to diversify funding streams⁵, including at national level.
- 19) Increase engagement with people in vulnerable situations across the four pillars:** Based on the principles accountability to affected populations, it is recommended to involve people and / or representatives from communities in vulnerable situations in all phases of SPRINT IV.

⁵ For example approaching for-profit organisations or crowd-funding

List of acronyms

Acronym	Meaning
AAP	Accountability to Affected Populations
ARV	Antiretroviral drugs
AUD	Australian Dollar
CMR	Clinical management of rape
COVID-19	Coronavirus disease (SARS-CoV-2 virus)
CSO	Civil Society Organisation
CSWDO	City Social Welfare and Development Office, Philippines
CYP	Couple Years of Protection
DFAT	Department of Foreign Affairs and Trade, Government of Australia
DHIS2	District Health Information Software 2 (DHIS2)
DOH	Department of Health
DRR	Disaster Risk Reduction
DSWD	Department of Social Welfare and Development, Philippines
EQ	Evaluation Questions
ESEAOR	East and South-East Asia and Oceania Region (of IPPF)
FBO	Faith-Based Organisation
FGD	Focus Group Discussion
FNU	Fiji National University
FP	Family Planning
FPAN	Family Planning Association of Nepal
FPOP	Family Planning Organisation of the Philippines
GBV	Gender-Based Violence
GIDAs	Geographically Isolated and Disadvantaged Areas
HIV	Human Immunodeficiency Virus
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
IEC	Information, Education, Communication
INGO	International Non-Governmental Organisation
IPPA	Indonesian Planned Parenthood Association
IPPF	International Planned Parenthood Federation
KII	Key Informant Interview
LARC	Long-Acting Reversible Contraceptives
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
LGU	Local Government Unit
LIVES	Listen, Inquire, Validate, Enhance Safety and Support model

LNOB	Leave No One Behind
M&E	Monitoring and Evaluation
MA	Member Association
MISP	Minimum Initial Service Package for Reproductive Health in crisis settings
MOH	Ministry of Health
MoU	Memorandum of Understanding
MTR	Mid-Term Review
NGO	Non-Governmental Organisation
PER	Post-Emergency Review
PLHIV	People Living with HIV
PWD	People with Disabilities
QoC	Quality of Care
R-FPAP	Rahnuma Family Planning Association of Pakistan
RHCS	Reproductive Health Commodity Support
RMNCAH	Reproductive, Maternal, New-born, Child, and Adolescent Health Policy
RTR	Real-Time Review
SARO	South Asia Regional Office (of IPPF)
SGBV	Sexual and Gender-Based Violence
SIMEX	Simulation Exercise
SIPPA	Solomon Islands Planned Parenthood Association
SMART	Specific, Measurable, Achievable, Realistic and Timely indicators
SOGIESC	Sexual Orientation, Gender Identity, Expression, and Sex Characteristics
SOP	Standard Operating Procedure
SPRINT	Sexual and Reproductive Health in Crisis and Post Crisis Settings
SRH	Sexual and Reproductive Health
SRHiE	Sexual and Reproductive Health in Emergencies
SRHR	Sexual and Reproductive Health and Rights
SROP	Sub Regional Office of the Pacific (of IPPF)
STI	Sexually Transmitted Infection
UN	United Nations
UNFPA	United Nations Population Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VAW	Violence Against Women
VAWG	Violence Against Women and Girls
YAFHS	Youth and Adolescent Friendly Health Services
VFHA	Vanuatu Family Health Association
WRA	Women of Reproductive Age

Table of Contents

Acknowledgements	2
Executive Summary	3
List of acronyms	8
1. Background	11
2. Implementation to Date of The SPRINT IV Program	12
Pillar 1. Advocacy and Policy	13
Pillar 2. Preparedness	14
Pillar 3. Emergency response.....	16
Pillar 4. Recovery	18
3. Purpose and Methodology	19
Mid-Term Review Approach	19
Data Collection Methods	20
4. Findings, Analysis, and Recommendations	21
1. How can SPRINT IV increase the impact of pillars one, two and three?	21
a. At the policy level, how can SPRINT IV strengthen SRHR in crises?	21
b. How can SPRINT IV strengthen capacity to deliver lifesaving SRH services in crises?	24
c. How can SPRINT IV strengthen the delivery of lifesaving quality essential SRH care during emergencies?.....	26
2. What is the future of Pillar 4 – Recovery under SPRINT IV?.....	30
a. To what extent has SPRINT IV been able to support the recovery of communities affected by crises?	31
b. What is the purpose of Pillar 4 and its focus on the <i>Recovery</i> phase?	34
3. What is the outlook for the SPRINT program in the future?	35
a. Should a two-year costed extension of SPRINT IV be considered?	35
b. Does Australia need to continue investing in IPPF’s Humanitarian programming?	37
Annex 1. Terms of Reference	40
Annex 2. Revised Evaluation Questions (EQs)	48
Annex 3. Recovery efforts in two different countries.....	51
Annex 4. Considerations around climate change	53
Annex 5. Metadata for two proposed indicators for Pillar 4	55

1. Background

The Asia-Pacific is the most disaster-prone region in the world⁶, vulnerable to cyclones, droughts, earthquakes, storm surges, tsunamis, typhoons, and volcanic eruptions. During responses to these crises, sexual and reproductive health (SRH) services are often under-prioritised and under-resourced. National healthcare systems rarely prioritise SRH in stable times and this is exacerbated during crises when scarce humanitarian aid funding tends to be focused on more traditional priorities such as child health, nutrition, water, sanitation, and hygiene, leaving little investment for SRH⁷. As a result, women and girls of reproductive age and vulnerable groups are disproportionately affected and experience high rates of unintended pregnancy, unsafe abortion, maternal morbidity, HIV, and sexually transmitted infections (STIs) and sexual and gender-based violence (SGBV).

The International Planned Parenthood Federation (IPPF) is a global leader in advocating for and delivering SRH services in emergencies. It integrates humanitarian action as a global priority across the organisation and its local, country-based Member Associations (MAs). IPPF's approach to humanitarian assistance focuses on the delivery of the Minimum Initial Service Package for Reproductive Health in Crises (MISP), an international standard which guides lifesaving SRH services to affected communities from the onset of crises.

As part of its commitment to providing humanitarian assistance and supporting development in the Indo-Pacific Region through the 2020 *Partnerships for Recovery – Australia's COVID-19 development response*, and due to the success of previous iterations of the SPRINT program, the Australian Government's Department of Foreign Affairs and Trade (DFAT), invested AUD 12,600,000 on the SPRINT IV Program (2022-2024). In August 2023, Australia launched a new *International Development Policy*, setting forth a bold framework that places gender equality, disability and social inclusion, localisation, and 'listening-first' development front and centre in Australia's aid delivery. SPRINT IV is strongly aligned with these core values, prioritising capacity building of local service providers and organisations who are best placed to meet the needs of their communities. Indeed, SPRINT IV directly contributes toward the United Nations 2030 Agenda for Sustainable Development, supporting the building of robust, resilient, and responsive country-level health systems and services, with the knowledge and capacity to deliver SRH services at all stages of the humanitarian-development cycle. IPPF retains a strong focus on responding to the needs of those marginalised and underserved, in all that we do, including within humanitarian preparedness and response as exemplified through SPRINT IV.

Australia has funded the SPRINT initiative since 2007. Since then, the SPRINT initiative has responded to more than a hundred humanitarian crises and worked with partners in 99 countries. SPRINT has reached over 2,206,179 people to deliver crucial services. Through successive iterations of SPRINT, IPPF and its MAs have continued to build capacity for Humanitarian preparedness, and for responding to both protracted and rapid onset emergencies. A key element of SPRINT IV is creating an enabling environment, cementing SRHR within the humanitarian agenda, and building the capacity of the national government and civil society to provide SRH services during times of crisis.

The SPRINT IV overarching development outcome is to reduce SRH mortality and morbidity in populations affected by crises. Its goal is to improve access to lifesaving SRH services, and the ability to exercise rights, for people affected by crises in all their diversity. SPRINT IV retains key outcomes from SPRINT III (Outcomes 1, 2 and 3) which were designed to create an enabling environment, strengthen

6 WMO. 2022. Asia-Pacific is key to disaster risk reduction targets. Available at <https://public.wmo.int/en/media/news/asia-pacific-key-disaster-risk-reduction-targets>

7 Heidari, S., Onyango, M. & Chynoweth, S. (2019) Sexual and reproductive health and rights in humanitarian crises at ICPD25+ and beyond: consolidating gains to ensure access to services for all, *Sexual and Reproductive Health Matters*, 27:1, 343-345

preparedness and capacity of MAs, and ensure the delivery of essential SRH services in emergencies, and includes an additional outcome incorporated into the current program:

1. **Advocacy and Policy:** Global, national, and local policy makers are increasingly receptive to including sexual and reproductive health and rights (SRHR) in emergency planning and responses.
2. **Preparedness:** Increased Member Association (MA) and partner capacity to deliver lifesaving sexual and reproductive health services in crises.
3. **Emergency Response:** Lifesaving quality essential SRH care provided in a timely and inclusive manner with an emphasis on women, girls, and people in vulnerable situations⁸.
4. **Recovery:** Enhanced management and coordination between humanitarian and development programs to aid delivery of comprehensive services.

Through SPRINT IV, IPPF supports MAs in eight countries in Asia⁹ and six in the Pacific¹⁰, and over the past 18 months provided essential lifesaving SRH services following disasters in Indonesia, Pakistan, the Philippines, Solomon Islands and Vanuatu, and in the non-SPRINT country, Yemen.

2. Implementation to Date of The SPRINT IV Program

Since the start of SPRINT IV the program has supported SRHR services in crisis in six countries in the Indo-Pacific region and one in the Arab World region (see Figure 1 and Tables 1 for further information), covering seven emergencies with a total real expenditure of AUD 865,698 (See Table 1 below)

Figure 1: Map of countries where SPRINT IV has intervened



⁸ Includes people with disabilities, people of diverse SOGIE, pregnant and lactating women, people living with HIV, and adolescents/youth (10-24 years).

⁹ Indonesia, India, Maldives, Myanmar, Nepal, Pakistan, Philippines, and Sri Lanka

¹⁰ Fiji, Papua New Guinea (PNG), Samoa, Solomon Islands, Tonga, and Vanuatu.

In addition to the response data in Figure 1 above, other key outputs of SPRINT IV include:

- Training 2585 people in the Minimal Initial Service Package (MISP) and related humanitarian topics
- Providing services for people affected by SGBV and support to those most marginalised and vulnerable in emergencies
- Active engagement by IPPF Member Associations in humanitarian coordination mechanisms in all priority countries

Table 1 presents the seven emergency responses supported by SPRINT IV to date¹¹.

Table 1. Affected population reached by SPRINT IV and budgets: April 2022 – December 2023

Country	Type of Emergency	Time frame	Target Beneficiaries ¹²	Total # of Beneficiaries reached ¹³	% Target reached	# of Beneficiaries receiving SRH services	% Beneficiaries receiving SRH services	Budget allocated (AUD)	Budget spent (AUD)	Budget expenditure (%)
Philippines	Typhoon	20/01 – 15/06/2022	5,731	5,935	104%	5,935	100%	98,925	98,936	100%
Solomon Islands	COVID-19	26/04– 26/07/2022	17,612	24,272	138%	9,219	38%	98,549	98,549	100%
Pakistan	Floods	19/09/2022 – 28/02/2023	31,298	19,276	62%	10,987	57%	209,069	200,677	96%
Indonesia	Earthquake	08/12/2022 – 07/07/2023	19,172	17,682	88%	15,280	86%	124,491	109,956	88%
Vanuatu	Cyclones	20/03– 30/05/2023	5,000	3,036	61%	3,036	100%	99,987	90,557	91%
Yemen	Conflict	01/05 – 31/10/2023	10,300	10,719	104%	9,237	86%	167,149	167,149	100%
Vanuatu	Cyclone	06/11– 22/12/2023	3,750	1,914	51%	1,914	100%	99,874	99,874	100%
TOTAL	NA	NA	92,863	82,827	87%	53,510	81%	898,044	865,698	96%

Pillar 1. Advocacy and Policy

The desired outcome for Pillar 1 of SPRINT IV is for global, national, and local policy makers to be increasingly receptive to including SRHR in emergency planning and responses. IPPF has been collectively advocating with other international organisations for the inclusion of SRH in humanitarian settings and crisis-affected persons in global development agendas. At the global and regional level, key achievements from Pillar 1 includes:

- Delegates from the Sendai Framework for Disaster Risk Reduction 2015 – 2030 committed to make this instrument more inclusive of the voices of marginalised groups, and to better integrate

¹¹ only completed responses included

¹² Target defined in SPRINT IV Response proposal

¹³ Includes SRH awareness

disaster risk reduction (DRR) and climate change adaptation (CCA) to increase community resilience. This was part of IPPF's advocacy work at the 2022 Asia-Pacific Ministerial Conference on Disaster Risk Reduction (APMCDRR)¹⁴.

- The development of the Adolescent and Youth Sexual and Reproductive Health and Rights (AYSRHR) Global Roadmap for Action through IPPF and the MAs' advocacy work at the 2022 International Conference on Family Planning (ICFP)¹⁵.

At the national level, the advocacy achievements in the latest iteration of the SPRINT program include:

- In the Philippines, the local government in Surigao del Norte included the provision of MISP and SGBV training by the Family Planning Organisation of the Philippines (FPOP) to health staff, as well as procuring buffer SRH commodities for future responses, as part of their 'Disaster Risk Reduction Management' plan.
- Pakistan's Ministry of National Health Services approved the delivery of post-exposure prophylaxis (PrEP) treatment to survivors of SGBV and provision of antiretrovirals (ARV) to the Rahnuma Family Planning Association of Pakistan (R-FPAP). These two activities were exclusive to the Ministry in the past.
- The advocacy work by the Family Planning Association of Sri Lanka (FPASL) led to the development of the SOP to incorporate SRHiE into the Humanitarian Policy of the Disaster Management Plan of the Disaster Management Centre¹⁶.
- After participating in the national SRH simulation exercise (SimEx) training led by Vanuatu Family Health Association (VFHA), the National Disaster Management Office (NDMO) provided a much higher level of support to VFHA during the response to Tropical Cyclones Judy and Kevin in March 2023, including access to seats in the first flights and boats to the affected areas.

Pillar 2. Preparedness

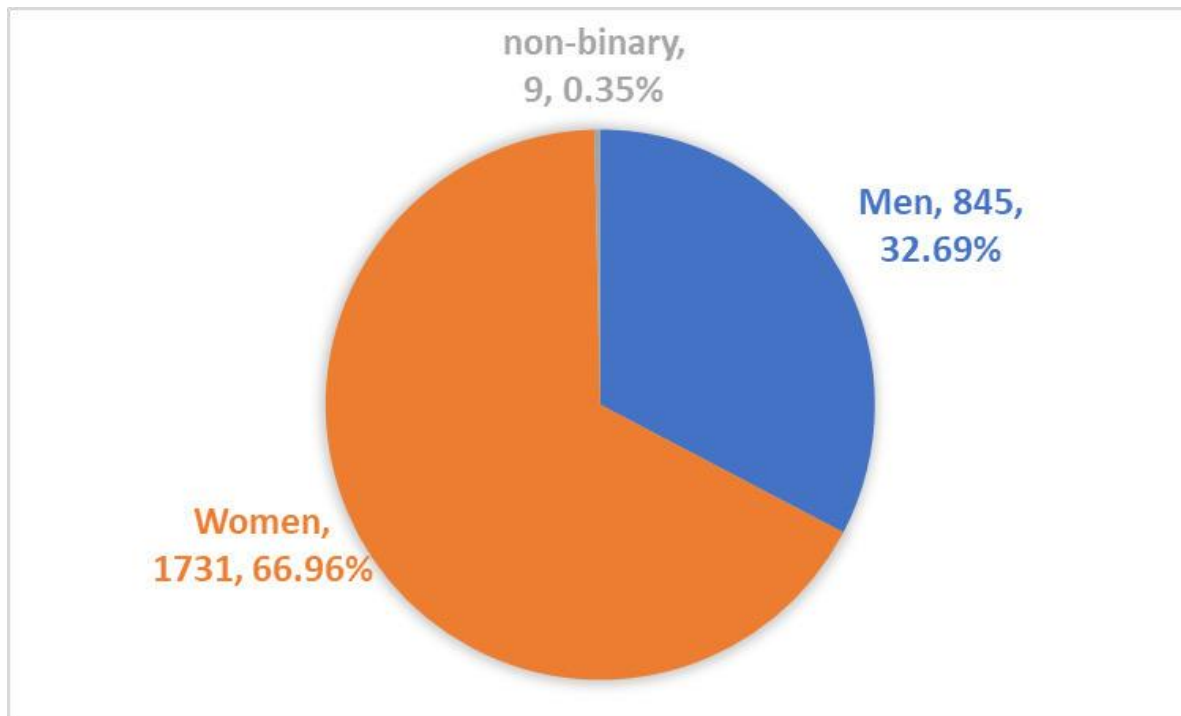
The removal of COVID-19 travel restrictions and the relatively low number of responses under SPRINT IV to date, particularly during 2023, has allowed IPPF to concentrate on continued capacity strengthening for MAs. This has included an increased number of in-person trainings at the regional, national, and sub-national levels. Since SPRINT IV commenced in April 2022, a total of 115 trainings have been delivered to 2585 (1,731 women, 845 men, 9 non-binary persons) staff and stakeholders. Figure 2. presents the gender disaggregation of these trainings.

¹⁴ <https://knowledge.aidr.org.au/resources/ajem-january-2023-outcomes-from-the-asia-pacific-ministerial-conference-on-disaster-risk-reduction/>

¹⁵ ICFP2022, Recap Report, 2022

¹⁶ Disaster Management Centre is a national authority for disaster management in Sri Lanka.

Figure 2. Gender Disaggregation of Training Participants



At the national level, preparedness achievements during SPRINT IV include:

- As a result of MISP trainings delivered by the Solomon Islands Planned Parenthood Association (SIPPA), the MOH staff now provides advice on how to better integrate SRH into the work of the Emergency Response Team from the Public Health Emergency Response Department.
- In 2022, SPRINT funds supported the participation of MAs from India, Indonesia, Maldives, and Nepal, as well as Humanitarian team members, in a Training of Trainers (ToT) on the Clinical Management of Rape (CMR), a critical component of responding to sexual and gender-based violence (SGBV) in MISP. As a result of this Regional ToT, the Indonesian Planned Parenthood Association (IPPA) trained 23 clinicians from 23 different IPPA clinics.
- The high-level capacity of the Family Planning Association of Nepal (FPAN) in MISP training has resulted in the MA partnering with Nepal's National Health Training Centre to train government and other relevant stakeholders.
- Furthermore, FPAN has partnered and strengthened collaboration with organisations representing communities in vulnerable situations. With the support of CSOs such as Blue Diamond, which represents LGBTQIA+ communities, the National Federation of the Disabled Nepal, and the Sex Workers Movement, FPAN has been able to establish peer educator teams with members of these communities.
- In the Philippines, FPOP volunteers gave feedback that they felt highly confident on how to address queries around SRH and GBV based on MA protocols and using flow charts. It is a *“very systematic process which includes the yes or no and how to respond if yes... that's when you call the relevant person... [this helps us] to avoid bias and for us to respond professionally”* (FPOP volunteer).
- IPPF conducted three nationally contextualized SRHiE simulation exercises (SimEx) in the Philippines, Sri Lanka, and Vanuatu. These exercises were based on the training package developed with RedR to test and review existing MA Standard Operating Procedures (SOPs), internal and external resources, and capacity. Key national stakeholders participated in these exercises. The impact of these trainings was observed during the field data collection exercise

and often highlighted by IPPF, MA staff and stakeholders, including Ministries of Health. *“FPOP had a high level of capacity already, even before the event [Typhoon Odette], and they have always been helpful to assist us in program implementation, provision of training and in terms of logistics... they will always be in the position to assist us”* (Preparedness Division, Emergency Bureau, Department of Health in the Philippines).

Similarly, the importance of SimEx to stakeholders is highlighted by a Solomon Islands MOH staff member who mentioned these are vital *“to prepare health workers and youth on what to do during that time, because sometimes people panic... so integrating MISP in a simulation exercise is very important, so that when a disaster happens, everyone knows what to do, to create a safe space for women when setting up the tents, how to deal with the pregnant mothers, etc.”*

Pillar 3. Emergency response

- Philippines – TC Odette (2022)
- Solomon Islands – COVID response (2022)
- Pakistan – Floods (2022)
- Indonesia – Java Earthquake (2022)
- Vanuatu – TC Judy and Kevin (2023)
- Yemen – Armed conflict (2023)
- Vanuatu – TC Lola (2023)

Table 2 presents the achievements under six different impact indicators of the program.

Table 2. Impact Indicators (2022-23)

Impact Indicators	Achievement
Couple Years of Protection provided	15,579
Unintended pregnancies averted	6,715
Live births averted	1,983
Maternal deaths averted	4
Child deaths averted	41
Direct healthcare costs saved (AUD)**	598,278

The expertise of MAs on the delivery of MISP is one of the reasons for the success of the program under Pillar 3. Providing MISP service saves lives and enables women and men to access contraceptives to prevent unintended pregnancies. The impact of SPRINT-funded responses in providing access to SRH services was recognised by local health staff. As one Solomon Islands MOH staff member noted (14 months after the end of the response), *“there’s been a significant drop in teenage pregnancies and home deliveries in the area [in the last few months] after the SPRINT IV response”*.

While all MAs prioritised the delivery of MISP services, there are differences between the services provided by different MAs and how these are promoted.

- In the Philippines FPOP obtained obstetric ultrasound services, which are able to detect foetal viability, multiple pregnancies, foetal abnormalities and reduce maternal deaths. The team were

trained by a medical doctor on the use of the ultrasound machine, strengthening their capacity to provide lifesaving care during crises.

- Also in the Philippines, supported by both SPRINT IV and RESPOND¹⁷, FPOP provided telehealth services, or telemedicine, which is *“a great way to ensure the safety and confidentiality of key populations”* (IPPF staff). The capacity to provide telehealth, however, is limited by infrastructure and geography, which means overall MAs in Asia are in a better position to offer this service than those in the Pacific.
- SIPPA was highly successful in promoting the use of family planning (FP) services by highlighting the economic and social benefits of a smaller number of children. These benefits were mentioned by women, men, and youth alike in each of the six FGDs conducted. The impact of this approach is reflected in the comment of a community leader, who affirmed that *“first it was a joke when we saw SIPPA. We always thought about condoms, but as time goes on, we now know their work is very important, in terms of FP it will help you with economy, have money for school. It is very good because it will help with the community and the country’s economy.”*
- In Nepal, FPAN provided abortion counselling and services to women who wanted to terminate their pregnancies, which was particularly high among sex workers. Of the three visited countries, only Nepal has the least restrictive laws for access to abortion services¹⁸.

Awareness sessions delivered in the three MAs visited as part of the MTR field work were also successful, with high community participation, leading to an increase in people accessing the services. There were multiple requests among interviewees in each country to continue awareness sessions to increase SRH and FP knowledge.

Under the principle of ‘Leave no one behind’, the MAs have achieved a high level of success reaching under-served communities, mainly based on their areas of expertise and/or level of engagement with key stakeholders. Some of these successes include:

- Indigenous people in the Philippines are one of the most marginalised groups in the country. The island of Mindanao, home to a number of Indigenous communities, has been subject to armed conflict for decades. Similarly, some Indigenous populations on the island were severely affected by Typhoon Odette. FPOP, in partnership with the Department of Health, reached agreements with the national army and the armed rebels to enter the affected areas to provide SRH and FP services to people that had never had access to them. Interviewed Indigenous women stated that *“they are the first generation to use FP in their community”* and now *“always tell the young people that family planning is essential.”*
- In Solomon Islands, SIPPA delivered a Basic Emergency Obstetric and Neonatal Care (BEmONC) refresher as per the request of the Ministry of Health and Medical Services (MHMS) to the teams prior to being deployed. This allowed SIPPA and the MHMS to provide antenatal care services, physical examinations, abdominal palpations, and foetal heart checks to screen for pregnancy complications and risks, including in remote islands. Additionally, a referral pathway for emergency obstetric care was established at the provincial level.
- In Nepal, FPAN reached out to sex workers to provide them with SRH services, including FP and safe abortion care. According to an interviewed sex worker, *“during [the] COVID-19 pandemic, hospitals closed, and being a sex worker during that time it was very hard... FPAN helped us access abortion services, condoms, and pills.”* After the response, many sex workers became part of FPAN’s peer educators.

¹⁷ RESPOND is a DFAT funded program which aims to enhance the sexual and reproductive health and rights (SRHR) of populations in the Indo Pacific whose access to services or rights have been affected by the COVID-19 pandemic including access to family planning services.

¹⁸ The SPRINT program operates within the framework of Australia’s Family Planning Guidelines 2009, and provides abortion services in accordance with national laws.

Through SPRINT IV MAs have continued to expand their reach to remote and hard to access areas, enabling access to SRH services for those in the most vulnerable situations. This often requires long and arduous travel and demonstrates the commitment of MA staff to ensure all people can exercise their sexual and reproductive rights. For example, to access one geographically isolated and disadvantaged area (GIDA) as they are known in the Philippines, FPOP's response team *"had to drive, get on a boat then walk up and down a hill for three hours, cross a river and then walk another hour"* (MA staff).

Meanwhile, SIPPA successfully implemented different strategies to provide dignity and privacy to different populations, particularly people of diverse sexual orientation, gender identity, expression, and sex characteristics (SOGIESC). When asked about community members of diverse SOGIESC, a village Chief in Malaita stated that *"there is no such people here, but we have heard about them from other villages."* This belief was shared by other Chiefs and community members as well, yet specific services and outreach was delivered to people of diverse SOGIESC in these villages. This highlights how effectively SIPPA implemented their protection and privacy strategies. Most of the population *"were unaware of the services [SIPPA] was providing on the beach and other areas of the island"* (SIPPA staff) for different groups, such as youth and those with diverse SOGIESC.

Some of the strategies implemented to protect the dignity and privacy of clients included:

- Providing awareness session for women, men, girls, and boys.
- Having SIPPA volunteers, which included volunteers of diverse SOGIESC, identify people of diverse SOGIESC and/or sex workers and provide them with information and resources on accessing SRH services, and explain their privacy protocols.
- Performing HIV testing in confidential areas, to ensure client privacy and dignity.
- Arranging places for nurses to meet with clients, including youth and people of diverse SOGIESC, to discuss and receive services privately.

Pillar 4. Recovery

This section highlights the achievements of SPRINT IV under Pillar 4 which aims for 'Enhanced management and coordination between humanitarian and development programs to aid delivery of comprehensive services'. This section will also address how SPRINT has been able to support the recovery of communities affected by crises, what 'Recovery' means to IPPF, MAs and stakeholders, and what the purpose of the Pillar 4 should be under the 'Recovery' phase.

The aim of Pillar 4 under SPRINT IV is to:

- Establish a Program Coordinating Group (PCG) with Humanitarian and development staff to ensure that the humanitarian and development programs are mutually supportive.
- Create joint development and humanitarian annual work plans to ensure alignment and improve efficiency.
- Integrate humanitarian preparedness into the organisational structure of MAs, including in plans, internal policies, finance, human resources, and systems.
- Ensure that humanitarian settings are properly considered in the cross-cutting work.
- Harmonise the M&E systems of the development and humanitarian programs to simplify data collection for MAs.
- Ensure that learning from the development activities is integrated into the MA's work across the entire humanitarian continuum during SPRINT IV.

In addition to the objectives mentioned above, another priority under Pillar 4 is to support the smooth transition from emergency to recovery at the MA level by establishing a 'recovery' or 'transition' plan when developing final response reports.

The IPPF Humanitarian Team organised activities to implement Pillar 4 with the aim of improving its internal coordination between the humanitarian and development programs. This is crucial to enhance effectiveness and sustainability, and ensure long-term, continuous access to quality SRH services to affected populations.

While most of the indicators under Pillar 4 were achieved in 2022, there was a significant drop in 2023, mainly due to the PCG meetings being put on hold during the Secretariat-wide realignment exercise and associated staff changes. Progress towards enhancing management and coordination between humanitarian and development programs has lapsed due to IPPF's organisational restructure. Though this process impacted on the roles and responsibilities of staff, and resulted in some positions which were members of the PCG being made redundant, the new IPPF Strategy 2028 created new roles. These include the MA Support & Development Director roles and the Architect of Cooperation positions that aim to improve coordination between the Humanitarian and Development teams.

3. Purpose and Methodology

Mid-Term Review Approach

A logic-based approach using SPRINT IV's program logic (PL) was used to understand how the four program outcome areas and their respective intermediate outcomes and outputs contribute to the program's goal of improving access to lifesaving SRH services and rights for people affected by crises in all their diversity. The four outcomes are based in the Disaster Management Cycle described in the IPPF Humanitarian Strategy (2018 – 2022)¹⁹, namely **mitigation, preparedness, response, and recovery**. These outcomes also contribute to the goals of the IPPF Strategy 2028²⁰. The use of the PL informed the design of the data collection tools, including the development of evaluation questions.

The MTR commenced on July 26, 2023, and the data collection period took place between 20 August and 30 September. Three SPRINT IV countries were selected to get geographic representation of the program, covering South Asia, Southeast Asia, and the Pacific. These countries were, respectively: Nepal (COVID-19 Response), the Philippines (Typhoon Odette), and Solomon Islands (COVID-19 Response).

The field data collection exercise was conducted by the evaluator, who was supported by a different IPPF Humanitarian Team member in each country between August 20 and September 10. The following approaches were used in the MTR:

1. A logic-based approach;
2. a participatory approach, and;
3. a mixed-methods approach.

The following evaluation questions (EQs) were used to collect data and address the purpose of the MTR (the full EQ guide can be found in Annex 1-2):

1. How can SPRINT IV increase the impact of pillars one, two and three?
 - a. At the policy level, how can SPRINT IV strengthen SRHR in crises?
 - b. How can SPRINT IV strengthen capacity to deliver lifesaving SRH services in crises?

¹⁹ IPPF, 2018. Humanitarian Strategy 2018-2022, p5

²⁰ <https://www.ippf.org/resource/come-together-ippf-strategy-2028>

- c. How can SPRINT IV strengthen the delivery of lifesaving quality essential SRH care during emergencies?
2. What is the future of Pillar 4 – Recovery, under SPRINT IV?
 - a. To what extent has SPRINT IV been able to support the recovery of communities affected by crises?
 - b. What is the purpose of Pillar 4 and its focus on the *Recovery* phase?
3. What is the outlook for the SPRINT program in the future?
 - a. Should a two-year costed extension of SPRINT IV be considered?
 - b. Does Australia need to continue investing in IPPF's Humanitarian programming?

Data Collection Methods

Four methods for primary and secondary data collection were employed, which provided insights from all relevant target groups and allowed for triangulation of findings:

a) Desk review

An extensive desk review was conducted to gain an in-depth understanding of the SPRINT IV Program and the environment in which it operates.

b) Primary data collection

The two main tools for the data collection process were the key informant interview (KIIs) and focus group discussion (FGD). These were adapted to each stakeholder group based on their knowledge, involvement and / or role within SPRINT IV. The qualitative data collection provided detailed information on the SPRINT program from the perspectives of beneficiaries and stakeholders, with over 100 people participating in this exercise. The methodologies for primary data collection are discussed in detail below:

1. **Key Informant Interviews (KII):** The evaluator conducted a total of 33 KIIs, which supplemented and provided important contextual insights to the secondary data. Key stakeholders included IPPF Humanitarian and Development staff in ESEAOR, SARO and SROP, and Member Association staff members from Nepal, Philippines, and Solomon Islands, Government representatives at national, provincial, and local level, DFAT Posts and UNFPA staff at the Asia Pacific Regional Office and the Pacific Sub-Regional Office (SROP), and representatives from marginalised and underserved communities from response areas. These interviews were conducted both face-to-face and virtually.
2. **Focus Group Discussions:** The evaluator conducted a total of 22 focus group discussions (FGDs) with 5 – 12 respondents in the three selected countries. This was significantly higher than the originally planned six FGDs due to the strong capacity of the MAs to organise discussions with beneficiaries, particularly with those communities in vulnerable situations. The FGDs provided valuable qualitative input for the MTR report narrative.
3. **Direct observation:** Site observation was conducted in Nepal, Philippines, and Solomon Islands. These countries were selected as each of them has undertaken a SPRINT IV funded response;

COVID-19 responses in Solomon Islands and Nepal²¹, and response to a super typhoon in the Philippines. The selection was also made to ensure representation of each region (Pacific, Southeast Asia, and South Asia) in which the SPRINT program operates.

The MTR draft findings were shared and validated with internal and external stakeholders including: eight SPRINT priority MAs²² during a November regional meeting; UNFPA APRO Humanitarian team, and the IPPF Secretariat (divisional director, South Asia, ESEAOR & Arab World Regional Directors & MA Support and Development Directors) for review of the report and its recommendations.

4. Findings, Analysis, and Recommendations

The following section provides an overview of key achievements and recommendations. These have been presented under each of the Evaluation Questions (EQs) and sub-evaluation questions.

1. How can SPRINT IV increase the impact of pillars one, two and three?

Overall, IPPF and the MAs have demonstrated a very strong performance under the preparedness and response pillars of the SPRINT IV. There is potential for the advocacy pillar to be strengthened further, presenting an important opportunity to cement some of the achievements of the current and previous iterations of the SPRINT program.

a. At the policy level, how can SPRINT IV strengthen SRHR in crises?

The desired outcome for Pillar 1 of SPRINT IV is for global, national, and local policy makers to be increasingly receptive to including SRHR in emergency planning and responses. The need to focus on advocacy at the policy level was highlighted by MAs and IPPF staff as a priority until December 2024 and during any costed extension, if granted. Advocacy work is crucial to increase availability and access to SRH services, address the barriers faced by key communities, and produce evidence for decision making, among others. Feedback from respondents in this review indicates that stronger focus should be placed on identifying and maximizing advocacy opportunities, working in collaboration with other key stakeholders within the humanitarian and SRHR architecture.

i. Incorporating SRHiE into Policies, Plans, Programs, and Responses

Institutionalising SRH in crises, including SGBV, by embedding and streamlining SRHR into national level policies and strategic documents such as Disaster Management Plans is perceived as achievable by MA staff and their partners. However, this is a lengthy and continuous process, as reviewing or changing policies or Disaster Management Acts might take years and advocacy is not limited to this single objective.

Additionally, the existence of a law, or national plans and programs does not automatically result in its implementation. IPPF and MAs can map existing national laws and policies and support the government in the development of guidelines for implementation. This can be further supported by collaborating with partners such as UNFPA in engaging with and sensitising economic decision-makers in the government on the impact of providing SRHiE services as an effective way to support the recovery of the country. As previously mentioned, SRH services are not usually prioritised immediately after a crisis, yet

²¹ Nepal COVID response commenced in 2021 under SPRINT III. At the time of planning the MTR field visit there had been no other emergency response in South Asia since SPRINT IV started except Pakistan where a floods response took place in 2022. Due to the time required for a visa application process for the evaluator's visit to Pakistan, Nepal was instead selected to represent the region, as one of the first countries to open their border in 2022 which allowed the IPPF Humanitarian team's visit for technical support.

²² India, Indonesia, Maldives, Nepal, Pakistan, Philippines, Sri Lanka, and Thailand

these are “key to recovery... as women are usually one of the main drivers of recovery, [hence] it is important... to look after their fundamental health” (UNFPA, 2016)²³.

There has been some success in incorporating SRHiE into national policies, plans, programs, and responses as detailed above. However, there have been missed opportunities to advocate at the national level. For example:

- The Philippine Government’s Climate Change Commission (CCC) is drafting its new ‘National Adaptation Plan’ to replace the ‘National Climate Change Action Plan (2011 – 2022)’. Multi-stakeholder consultations commenced in August 2023. While FPOP has not been involved in these consultations, it presents an opportunity for the MA to “*mainstream SRHiE and SGBV across adaptation and mitigation work at different levels [national, subnational and local] ... with the specific focus of incorporating these in both medium- and long-term strategies and strengthening policies and frameworks*” (Philippines DOH staff).
- VFHA is part of the country’s ‘Safety and Protection’ cluster but has struggled to participate in the SGBV subcluster due to lack of capacity. Meanwhile, FPOP has recently requested to join the SGBV sub-cluster and have been included by the Department of Social Welfare and Development (DSWD), the lead convener. Additional training is recommended for MAs in this position to improve their capacity to actively engage in the SGBV subcluster.

Beside highlighting the need to participate in all relevant advocacy opportunities to incorporate SRHiE into policies, plans, programs, and responses, it is recommended to:

- 1) Prioritise advocating for implementation:** Focus on advocating for the costed implementation of existing laws, national plans, and programs related to SRHiE. The emphasis should be on translating policy into action, advocating to promote political will and sufficient budget to be implemented to achieve tangible outcomes. MAs could explore working with UNFPA and potentially with DFAT Posts to support government officials, with support from key regional stakeholders such as UNFPA and DFAT Posts, to develop budgeted clear and comprehensive guidelines for SRHiE that can be easily implemented and tracked. This is particularly key after emergency responses, when local governments have recognised the importance of integrating and implementing SRH in their policies and programs. Achievements can be made at sub-national levels where relationships have been built with the government throughout the emergency response. Other opportunities include educating national and local government decision-makers on the cost effectiveness of implementing SRHiE and its impact in the recovery process.

ii. Collaboration with Stakeholders

Since the beginning of the SPRINT program, IPPF has been working with both DFAT and UNFPA to conduct advocacy work on SRHiE. There is strong interest from the MAs, and partners, to continue and/or strengthen collaboration on advocacy at the national level with these organisations and other key stakeholders.

- In all visited countries, both UNFPA and DFAT expressed interest in working more closely with the MAs at the national level to mainstream SRHiE and SGBV in emergencies into other government initiatives, such as social protection and poverty alleviation programs.
- As previously mentioned, FPAN is responsible for delivering MISP training for the Nepal MOH Training Centre. Certified staff are then registered by the government and called upon when

²³ UNFPA. 2016. Reproductive health is key to recovery process: UNFPA. Available at: <https://reliefweb.int/report/fiji/reproductive-health-key-recovery-process-unfpa>

there is a need for people trained in delivery of MISIP. This is a model that could be replicated by other MAs to increase their visibility and strengthen their sustainability.

To strengthen advocacy collaboration with stakeholders, the following recommendations are made:

- 2) Diversify advocacy efforts:** Focus on increasing collaboration with stakeholders, supporting government priorities aligned to SPRINT IV and ensuring participation in national consultation exercises. At present, participation in these key events are challenged by MAs' limited human resources and organisational capacity.
- Working with relevant stakeholders at the national level will support the inclusion of SRHiE into climate change discussions (see Annex 3), policy and strategic planning for slow-onset disasters and protracted crises, and disaster risk reduction strategies.
 - Similarly, UNFPA national offices in the visited countries have recently released their new Country Programs, which have many common priorities to those of the MAs. Advocacy work between MAs and UNFPA at the national level is already occurring, however, this could be increased by identifying shared priorities based on UNFPA new Country Plans.

iii. Evidence-Based Advocacy and Communications

A solid evidence base is required to trigger change through SRHR advocacy both by the Humanitarian and Development teams. Furthermore, communications work is essential to highlight and share evidence on the importance of SRHR service provision both in emergency and stable times. Therefore, evidence-based advocacy and communications should be conducted as part of IPPF's Humanitarian-Development nexus work. At SROP, IPPF has a Communications Officer in a nexus role, covering both the Humanitarian and Development teams. It is recommended that this work be incorporated within communications workplans of other Regional Office teams, where feasible and appropriate.

The capacity to engage in evidence-based advocacy varies among MAs, with some being stronger than others. But overall, limited evidence at the national level is a challenge to conducting effective advocacy work. The following recommendations should be considered:

- Raising awareness on the specific needs and barriers faces by populations in vulnerable situations, both during emergencies and stable times, needs to be done in collaboration with the MAs' respective Regional Offices at the nexus level.
- IPPF should support MAs to collaborate on research with DFAT Posts and UNFPA country offices aimed at producing a more comprehensive evidence-base for decision-making at national and regional levels. UNFPA and DFAT Post have expressed interest in this work.
- Limited advocacy capacity is not necessarily a result of lack of knowledge in relevant areas by the MAs. *"Capacity does exist to some extent, but time allocation [is the main issue], even if we decide to hire consultants, there has to be capacity to supervise and provide guidance"* (IPPF staff).

It is recommended to improve advocacy and communication work at the Humanitarian-Development nexus to:

- 3) Enhance evidence on the need and impact of delivering SRHiE:** Showcase the impact of delivering SRH in crises and generate additional data for improved decision-making. IPPF Secretariat and/or Humanitarian Team can support MAs to:
- Raise the profile of SPRINT-supported SRHiE responses among government decision-makers and the public by increasing the visibility of the program. Communication pieces have been developed in all responses and MAs have shared their results in conferences and other events. However, this is mostly through presentations, where the data is

projected to the audience. The information often is not available in printed form, which should be distributed to the government, stakeholders, and the community in general.

- Increase literature on SRHiE, particularly around the impact of climate change, slow-onset disasters, and protracted crisis on SRH. Both IPPF staff and DFAT Posts, as well as UNFPA expressed their interest in jointly collaborating with academic institutions to develop peer reviewed articles for evidence-based decision-making.

b. How can SPRINT IV strengthen capacity to deliver lifesaving SRH services in crises?

Through SPRINT IV and the previous iterations of the program, IPPF has built the preparedness capacity of MAs and other national stakeholders. Under SPRINT IV, the “Preparedness” Outcome is one of the two strongest performing pillars. The wide praise from stakeholders regarding the preparedness level of MAs, both of staff and volunteers, demonstrates the efforts undertaken with respect to Pillar 2. However, there are areas which can be further strengthened, including capacity building, strategic partnerships, and the surge roster.

i. Capacity Building

A total of 115 trainings have been delivered to 2585 staff and stakeholders under SPRINT IV to date. Yet, the burden placed on the Humanitarian Team to deliver fundamentals training, including SGBV and CMR, leaves limited time and energy for technical training in humanitarian-specific aspects, such as Humanitarian Principles, Safeguarding and Staff Care.

The MAs’ well-trained staff and volunteer workforce, and their presence across countries through chapters or branch clinics, are strengths and competitive advantages relative to other organisations. However, the MAs experience high staff turnover which requires the training of new staff and volunteers to maintain the same level of capacity. Additionally, refresher training is required to reinforce knowledge and clarify values. Therefore, the continuous delivery of standard training is recommended to maintain and reinforce knowledge and values, including the following:

- Minimum Initial Service Package (MISP)
- SGBV Fundamentals
- ‘Listen, Inquire, Validate Enhance Safety and support’ (LIVES)²⁴ model
- Prevention of Sexual Exploitation and Abuse (PSEA)
- Sensitisation training for MA staff, volunteers, and stakeholders for effectively supporting individuals from communities in vulnerable situations

As MISP delivery is the main objective during emergencies, trainings and refreshers to staff, volunteers and stakeholders are essential to avoid situations where *“personnel are sent to a response, but we have new staff with no knowledge of MISP”* (MA staff).

It is important to highlight that the impact of trainings is not limited to the MAs and trained stakeholders, but it can also lead to long-term benefits of SRH integration into broader emergency responses by governments, as this report demonstrates. Similarly, as seen in Vanuatu, along with improving future response processes, SimEx is also a great advocacy tool to showcase the importance of prioritising provision of lifesaving SRH services during crises.

SimEx workshops have also been requested by other MAs and stakeholders. This should be done either after completion of ‘Emergency Preparedness Plan’ and ‘Emergency Response Plan’ by MAs in

24 Developed by the World Health Organisation, the LIVES model of first-line support involves five elements (Listen, Inquire, Validate, Enhance safety, and support) to support survivors of rape

collaboration with their relevant stakeholders, or after delivering a MISP training to local actors. For the implementation of SimEx, IPPF and MAs should:

- Include government members, especially decision-makers, if possible, as these are not only great for preparedness, but can also be an advocacy tool.
- Include organisations or members from communities in vulnerable situations to increase understanding regarding their needs and build capacity at community level.
- Consider partnering with other organisations that run SimEx exercises in different locations on a yearly basis, such as the Red Cross.
- Organising these activities is a complex task, as it requires expert facilitators, significant time commitments and coordination to engage different stakeholders. Fortunately, there are financial resources available and should be used to engage a consultant or consultants to plan and implement these activities.
- Include the SimEx in their annual plan for 2024 (for MAs who have not completed the training).

To build the capacity of MAs and stakeholders to deliver lifesaving SRH services in crises, it is recommended to:

- 4) Enhance Inclusivity and Accessibility of capacity building activities:** Prioritise inclusivity and accessibility by providing sensitisation training for MA staff, volunteers, and stakeholders on effectively supporting individuals from communities in vulnerable situations. The nature of this activity places it in the Humanitarian-Development Nexus and hence this could be done in collaboration with other initiatives and/or stakeholders. Additionally, consider translating training materials and information into a local language(s), particularly in regions where English may not be widely spoken, to ensure that educational content is accessible to a broader audience.

ii. Strategic Partnerships for Preparedness and Delivery of SRH Services in Emergencies

The demonstrated competitive advantage of MAs, and their continuous presence before, during and after the crisis has facilitated strategic partnerships with governments, UN agencies, and some NGOs. This has enabled MAs to establish effective collaboration on SRHiE in preparedness and response.

However, there is an opportunity for MAs to increase and strengthen partnerships with organisations representing marginalised communities, and include them in the planning of preparedness and response activities. Including these groups in the development of national Emergency Preparedness Plans and Emergency Response Plans should be prioritised to ensure the SRHR needs of the most marginalised are met. Therefore, it is recommended to:

- 5) Strengthen stakeholder engagement in preparedness activities:** MAs should actively involve relevant stakeholders, including representatives from communities in vulnerable situations, in the development of the Emergency Preparedness Plans (EPP) and Emergency Response Plans (ERP). This inclusive approach will ensure that the plans are tailored to the specific needs and vulnerabilities of affected populations, leading to more effective and community centred SRH services during crises. Sri Lanka's MA, for example, has included underserved people including LGBTQIA+ communities, people living with HIV and persons with disabilities in the development of ERPs. Other MAs such as Indonesia and Pakistan have focused strongly on engaging and involving young people in project planning and implementation, building the capacity of students, youth volunteers and peer educators for humanitarian preparedness activities.

iii. Surge Roster

The surge capacity of IPPF and the MAs is another area with potential for strengthening under Pillar 2. The number of trained personnel in Surge Roster at IPPF level and MA level was greatly affected by the

COVID-19 pandemic. IPPF's roster was also affected by the organisational restructuring. This has resulted in a diminished surge capacity, although efforts have been made at the Humanitarian Team level to re-establish the Surge Roster to some extent. The first deployment of Surge Roster staff has already taken place, with an IPPF staff member to provide support to the response in Uganda, who will be on stand-by to provide further support to MAs if requested.

At the MA level, it was observed by an IPPF staff member that for those MAs that have Surge Rosters, their lists were *"out-of-date... and showing a list of names with not much more information."* To address this challenge, IPPF Humanitarian decided to prioritise the re-establishment and / or strengthening of Surge Rosters at the MA level. This was through conducting national Surge Roster workshops with three pilot countries – the Philippines, Indonesia, and Vanuatu MAs (FPOP, IPPA & VFHA) with provision of a manual, checklists, and tools to support the development of their rosters. Based on the positive feedback from these three pilot countries, IPPF has planned to roll out the tools to all SPRINT countries. The following recommendation is made to bolster these efforts:

- 6) Conduct Surge Roster workshops, prioritising MAs with a large number of staff and / or with numerous chapters:** The effectiveness of creating Surge Rosters in Pacific countries with limited human resources needs to be considered, as most staff members will already be involved in the response. This is less of a challenge for MAs in larger countries, where staff can be mobilised from an unaffected part of the country to an affected area.

c. How can SPRINT IV strengthen the delivery of lifesaving quality SRH care during emergencies?

Effective, timely and quality delivery of the MISP during a crisis is a key feature of the SPRINT program. The results achieved under Pillar 3 are a good reflection of the Advocacy, Preparedness and capacity building activities implemented during stable times. Along with Preparedness, the capacity to provide lifesaving SRH services in emergency responses by SPRINT IV has been identified as the program's biggest strengths. Every single client interviewed praised the response work conducted by the MAs. Praise was also expressed by stakeholders, such as government health agencies, CSOs, UNFPA and DFAT Post.

i. *Timely and Effective Responses Implemented During Crises*

To reduce the time required to launch a response, DFAT agreed to introduce a Fast Track system under SPRINT IV. The Fast Track system enables IPPF to approve a disaster response budgeted under AUD 100,000 without requiring approval from Canberra. This approach was first used during the earthquake response in Indonesia in 2022 and subsequently to approve VFHA's proposal to respond to TC Judy and Kevin in Vanuatu in March 2023. While the Fast Track system has simplified the approval process, work is still required to strengthen the MAs proposal development capacity. The average time between the 'GO' decision and finalising the proposal is 22 days. According to an IPPF staff member, *"it's always a challenge to have the initial draft, which then goes through the revision process."* This process can be time consuming, resulting in delays as IPPF does not always receive all the required information in the initial drafts.

Some of the issues that can delay the approval or implementation of an emergency response include:

- Limited information provided by the MA in the proposal on how the response will be implemented.

- Lack of familiarity with the response area, including local stakeholders and affected population. Even after a Hot Call²⁵, the MA might decide not to proceed “*because they are not familiar with the area. They are not confident and don’t know the partners*” (IPPF staff).
- Slow transfer of funds from IPPF to MAs after the approval of the response proposal, resulting in delayed responses from many MAs and requests for ‘No Cost Extension.’

To avoid delays in assessing the feasibility of a response and identifying partners in affected areas, it is recommended that:

- 7) MAs should conduct a stakeholder mapping exercise across their respective countries, identifying and assessing partners, and include scenarios for responses in areas vulnerable to disasters in their EPP and ERPs.** This would better prepare MAs and IPPF to assess the feasibility of a response, and to facilitate rapid transfer of funds to MAs.

ii. Delivery of Quality SRH Services in Crises

The type of and the location of the emergency are determining factors on how a response is implemented. Different MAs have different strategies on how to implement responses, particularly when the provision of lifesaving SRH services is required in remote areas.

Two different strategies were identified during the MTR to provide services to remote locations. The first one involves moving to a selected affected area during the day to provide information sessions in the evening, sleep in a nearby location and deliver services the following day. This approach, implemented by SIPPA, aims to inform affected populations of available SRH services at a time that they are most likely to be available, enabling them to decide whether or not to access SRH services the following day.

The second approach, observed in the Philippines, involves delivering information sessions and services in parallel, moving to one or multiple locations in a day, and then returning to the MA base location. A disadvantage of this approach is that the response teams must spend more time travelling back and forth from the affected areas. A second disadvantage is that target populations who have not already sought support may be unaware of the SRH services available to them, limiting reach to all corners of the community.

To increase the likelihood of reaching affected populations by the MAs during responses, it is recommended that MAs:

- 8) Adopt the model of conducting information sessions in affected areas during the evening and deliver services in the morning (where safe to do so²⁶):** This approach informs the population of the available services and allows them to plan accordingly the next day. This might require investing in camping equipment, such as tents, sleeping bags and cooking equipment, but will avoid having to return to the office on a daily basis.
- 9) Consider alternative ways to provide services to people in vulnerable situations:** Where possible, this can include providing pick-up transport to access the services rather than taking the response team to each location and strengthening the capacity of MAs to provide digital health interventions where feasible.

²⁵ Humanitarian Oversight Team or “HOT” call is between the Humanitarian Team and the MA impacted by crisis to discuss the need to have an emergency response (IPPF Emergency Activation System).

²⁶ with duty of care for MA frontline staff prioritised - safety and security fully assessed

iii. Improved Access to Quality SRH Services for Persons in Vulnerable Situations

As mentioned under Pillar 2, IPPF has been working with the MAs to increase reach to communities in vulnerable situations with emergency response activities, under the principle of 'Leave no one behind'. The MAs have achieved a high level of success reaching some of these communities, mainly based on their areas of expertise and/or level of engagement with key stakeholders.

However, while IPPF and the MAs have successfully increased reach to many communities in vulnerable situations, persons with disabilities continue to be largely underserved. Of the 82,834 clients reached through seven emergency responses, only 0.31% were recorded as having a disability. The capacity to reach key communities during emergencies is dependant *"on how strong the MAs partnership is with disability organisations"* (IPPF staff). Some MAs such as Sri Lanka, are strongly engaged in this work, however, further capacity building of MAs to engage in disability-inclusive services and responses is required.

iv. Logistics and Supply Management

Logistics and supply management, including prepositioning, presented one of the biggest challenges during emergencies. *"A lot of work has gone into prepositioning and supply chains, but it has not worked very well"* (IPPF Secretariat staff). Shortages in SRH commodities were reported in the Philippines, Solomon Islands, and Vanuatu during their emergency responses.

- In Solomon Islands, the limited and irregular flow of SRH supplies resulted in shortages of commodities and out-of-stock situations, leading to reduced access to medication and preferred contraceptive methods. Additionally, SIPPA had to make frequent changes to their program schedule due to lack of commodities, which resulted in frustration for target populations and possibly a diminished number of clients. By sharing supplies with partners, including the MOH, SIPPA was able to mitigate these challenges to some extent.
- Vanuatu experienced shortages and stock-outs of SRH supplies at a national level. To address this challenge, IPPF SROP sourced STI treatment drugs and other medical supplies from Fiji and sent them by courier to Vanuatu.
- In the Philippines, while shortages of FP supplies were experienced, a partnership between FPOP and the Local Government Units (LGU) allowed the FPOP to access oral contraceptive pills and Implanon that local health units had available in their stocks.

Corrective measures have been implemented, such as hiring 'Logistics Officers' to strengthen the MAs' supply chains. This measure could also be adopted at the Humanitarian Team level, as recruiting a dedicated 'Humanitarian Logistics / Supply Chain Advisor' should help minimise commodity stock-outs. Additionally, IPPF should:

- 10) Diversify Supply Chain Sources:** While continuing the collaboration with UNFPA to address supply chain challenges, IPPF should concurrently explore alternative supply sources to mitigate risks associated with potential commodity shortages in humanitarian settings, including the provision of buffer stock. This approach will help MAs establish contingency plans, ensuring they have access to essential items even in challenging circumstances.

v. Ensuring Safety and Confidentiality

Protecting the safety, dignity, and privacy of clients, particularly those from groups in vulnerable situations, is a priority under SPRINT IV. This topic was included in IPPF trainings for MA staff and volunteers, and partners, with varied results.

People of diverse SOGIESC experience stigma and discrimination in most countries, but this was particularly strong in Solomon Islands compared to Nepal and Philippines. While the previously mentioned efforts to provide dignity and confidentiality were successful in Solomon Islands, significant gaps were identified in other responses. During the Typhoon Odette response, FPOP would conduct outreach sessions for all the community, without dividing them into groups. Services would then be delivered in three lines for pregnant women, for SRH/FP and for HIV testing, all next to each other. According to a young female client, there *“was no confidentiality, so young people shied away from asking.”* The lack of privacy was also identified as a major deterrent for young people by FPOP staff and volunteers *“as [young people] didn’t want to be seen by their auntie or uncle, they wanted to access counselling, but there was a lack of privacy”* (FPOP staff).

The lack of understanding on the importance of privacy was clearly identified during the Indonesia response. During the start of the response, IPPA used half-length curtains that covered the face and upper body of the client. Yet these are not very helpful *“because even if someone sees the lower dressing of the person, they can tell who that is”* (IPPF staff). This issue was highlighted to the IPPA response team by IPPF staff during the Real Time Reviews for Indonesia’s response. *“To my surprise the following morning [after raising the issue] they now had the full curtains, meaning that they had the resources, but nobody thought privacy was important”* (IPPF staff).

Therefore, it is recommended to:

- 11) Strengthen safety, dignity, and confidentiality to increase reach of groups in vulnerable situations:** Provide SRH services to different target groups in different areas, even if operating in an open area. Staff and volunteers need to ensure all consultations cannot be overheard to maintain confidentiality.

iv. Monitoring and Evaluation

In July 2023, a budget revision was requested by IPPF and approved by DFAT, to increase the funding allocation to the Monitoring and Evaluation (M&E) budget line. This request reflected the amount required to conduct regional capacity building trainings, system-strengthening activities, strengthen country-level monitoring work, and implement emergency response real-time reviews (RTR) and post emergency reviews (PER).

During SPRINT IV three instruments have been used to improve the delivery of quality SRH services during responses: Quality of Care (QoC) tool, Real-Time-Reviews (RTRs) and the Accountability to Affected Populations (AAP) mechanism.

The QoC tool developed by the IPPF Secretariat was reviewed and adapted in 2022 for use in crises. This tool provides MAs with the flexibility to conduct self-assessments, and to continuously improve the QoC that they offer their clients. This was followed by two regional trainings, one in the Pacific and one in Southeast Asia with two staff members from each MA, with further in-country follow up training progressing in 2023. QoC training should continue throughout SPRINT IV to ensure MAs have the capacity to monitor the quality of the services provided during emergencies.

An RTR is an exercise to strengthen delivery during response by identifying what is working well and what needs to be improved, which informs an Action Plan to implement corrective action before the end of the response. Ideally, these are conducted 4-6 weeks after the start of the response. Two RTRs have been undertaken under SPRINT IV to support the responses in Indonesia and Vanuatu. These exercises provided critical feedback to the MAs, as well as on-site supportive supervision and technical support leading to improvements in response delivery. This is demonstrated by the example of changing to use full length curtains during service provision to provide additional privacy to clients in Indonesia.

According to an IPPF member, RTRs “*should be included in the response proposal and be scheduled at the beginning of the response* (IPPF staff). Along with the proposal, RTRs should be included in the budget, as the effectiveness of these reviews has been demonstrated during SPRINT III and SPRINT IV.

The aim of AAP mechanisms is to empower clients and strengthen accountability by engaging in two-way communication mechanisms between the affected community and humanitarian organisations. Every SPRINT response report includes AAP data on satisfaction with services, and reach to persons in vulnerable situations, and community feedback mechanisms are in place. However, given that there was no two-way communication between MAs and the community to improve the responses, the AAP acted more like a feedback and complaint mechanism. Feedback from clients was collected through client exit interviews for the Net Promoter Score²⁷ and by suggestion boxes. When asked if the MA had followed-up with the community about the feedback received during the responses, all the interviewed MA staff or volunteers responded that they had not.

To improve M&E of SPRINT IV responses, it is recommended that:

- 12) Comprehensive AAP mechanisms are implemented from the beginning of a response, and ensure an RTR is conducted four to six weeks after the commencement of the response:** Incorporating AAP and RTR into responses will ensure MAs move beyond collecting feedback to fully incorporating target communities in decision-making about what services they require and how best to provide them. This will also contribute to increasing the availability of qualitative data for qualitative reporting and the compilation of case studies.

2. What is the future of Pillar 4 – Recovery under SPRINT IV?

The aim of the recovery phase within the disaster management cycle is not only to restore pre-crisis SRH services levels but also to build upon earlier humanitarian programs to ensure that their inputs become assets for development. According to the World Health Organisation, the following SRH issues are exacerbated during crises recovery:

- High maternal mortality due to lower number of attended deliveries;
- Unmet needs for family planning, being either unavailable or unaffordable, leading to unsafe abortions;
- Increased risk of sexual and other forms of gender-based violence due to breakdown in social and moral systems or due to systematic use as a means to control populations;
- Transmission of HIV likely to increase when crisis subsides; SGBV as risk factor for HIV transmission;
- Lack of sexual and reproductive health services targeting adolescents despite adolescents being deprived from traditional social structures. (WHO, 2011²⁸)

During a crisis, the focus is on lifesaving interventions. Once the immediate needs of the affected populations are addressed, activities to strengthen health systems can and should be initiated. Further, strengthening the institutional capacity to pursue longer-term health development goals can begin while responding to humanitarian needs continues in parallel²⁹.

The intended outcome of the Recovery pillar is ensuring the sustainable provision of SRH services during crisis recovery. However the current design has a strong focus on internal IPPF processes, aiming to increase collaboration between the humanitarian and development programs. This heavy inward focus

²⁷ A Net Promoter Score is a survey to measure client satisfaction with the services received and how these were provided on a rating scale

²⁸ World Health Organisation (WHO), 2011. Sexual and reproductive health during protracted crises and recovery. Available on www.inec.org/sites/default/files/resources/WHO_HAC_BRO_2011.2_eng_0.pdf

²⁹ *ibid*

approach was questioned by IPPF staff regarding the relevance of the content with actual support for the 'Recovery' phase of emergencies. An IPPF staff member stated during the design phase that Pillar 4 *"was not about recovery, [but] about how [IPPF] working better together as a team, improving internal communications [and having] regular meetings among Development and Humanitarian"*.

The initial process-oriented design of Pillar 4 was a result of the commitment to extend the achievements made under SPRINT III. Under the previous program iteration, Outcome 4 aimed to ensure that 'SPRINT is well managed by highly competent staff', taking a process-oriented and internal looking focus. A similar approach was adopted under the current program within SPRINT IV. It is suggested here that this was a missed opportunity to develop an outcome-level focus on recovery within the disaster management cycle of SPRINT program implementation.

Based on the findings from the MTR, it is evident that the Recovery pillar under SPRINT IV needs significant consideration and will need to be revised to reflect the intention of Pillar 4. Specific focus should be on the smooth transition from MISP to comprehensive services and continued access to quality SRH services and information for affected populations. This process should be led by IPPF's Humanitarian Team, in collaboration with the MAs.

While some indicators to measure the success of the recovery pillar were identified, further planning will be required to develop new indicators that are specific, measurable, achievable, relevant, and time-bound (SMART). The indicators suggested during the MTR found below do not follow the SMART model:

- Ensuring SRH services are back to the capacity prior to the disaster.
- Transition plans include funding from various sources.
- MAs can integrate new activities and new budget lines to respond to the recovery needs in their Annual Plans.

The following two new indicators are proposed, with the metadata available on Annex 4:

- **"Continuity and Expansion of SRH Services."** This indicator assesses the sustained provision of SRH services beyond the immediate recovery phase and the expansion or improvement of services to meet long-term community needs. This is a simple indicator that relies on the count of services.
- **"Community Health Resilience Index."** This indicator assesses the overall resilience of the community's SRH services and health systems as they move from the recovery phase to a stable period. This is a composite indicator that requires assessing different resilience factors.

a. To what extent has SPRINT IV been able to support the recovery of communities affected by crises?

The 'Recovery Plan' or 'Exit Plan,' one of the indicators under Pillar 4, is the main tool used by MAs to guide the recovery of communities affected by crises after a response. Developing a draft recovery plan is a requirement for all SPRINT responses. The draft plan is then finalised in partnership with the relevant stakeholders towards the end of the response. All response proposals under SPRINT IV featured a recovery plan from the time this became a requirement. The focus of the recovery plans is to ensure the continuation of services to affected populations, particularly groups in vulnerable situations through the country's existing health care system.

Upon review, most MAs included the development and sharing of a recovery/handover plan with local stakeholders as an activity in their SPRINT response proposals. The actual development of recovery plans at the end of the response occurred only in Indonesia and Solomon Islands. In the Philippines, FPOP

facilitated a workshop and handover meeting with local stakeholders to share key achievements, data and lessons learnt.

The recovery plan implemented by IPPA in Indonesia linked the affected communities to the local Puskesmas (Community Health Centres) to ensure the continuation of services after the response. The Puskesmas were provided with unutilised medicines from the response, the SRH tent used by the MA, and medical equipment purchased for the response.

According to IPPA's Cianjur Post Emergency Review, the transition from accessing IPPA SRH services during the response to regular services has left the *"local communities missing the SRH tent"* (IPPF, 2023, p.13)³⁰. This is because the SRH tent was providing free SRH services 24 hours a day, seven days a week, which are now back to normal hours and clients must pay or use insurance to access the same services from government facilities. Two volunteers remained in the affected area after the response to conduct activities which were not possible under the MA's core program, including GBV awareness, local coordination, and occasional outreach activities with men who have sex with men (MSM) and PLHIV peer educators. Additionally, a Memorandum of Understanding was signed with the Semarang State University, allocating budget for MISP orientation for 15 health department officials. The end of the response was communicated both formally and informally to relevant stakeholders and the affected communities. Currently, no data has been collected to assess the results from these activities, hence conducting a follow-up visit is suggested to further understand their impact.

Of the three MAs visited during the MTR, two have been able to continue service provision to affected communities to a high level, through two different approaches. FPAN has continued providing services to new and/or underserved users from the response, despite not developing a 'Recovery Plan'. The continuation of services was possible mainly because these clients live within relative proximity to the clinics where the COVID-19 response was implemented. Meanwhile, FPOP has been able to continue the provision of services to new users by working in close collaboration with the local government. Most importantly, subsequent visits to remote areas were budgeted in the annual plan following the response to Typhoon Odette, which enabled the MA to continue their work in remote areas. These two activities were key to strengthen FPOP's recovery phase work and could be adopted by other MAs.

The results in Solomon Islands were less encouraging, as the recovery plan did not appear to have been effectively implemented. There remains a need to strengthen the continuity of SRH services in the remote and marginalised communities in the outer islands, who were supported during the response. No changes to SIPPA's annual plan were made to cover further visits and to date there has been no coordination between SIPPA and the MOH to plan and conduct joint visits to these areas. Neither FPOP nor SIPPA reported conducting monitoring activities to track the implementation of their respective transition approaches. Monitoring the implementation of recovery activities is an innovation that should be included in all responses. Annex 2 shows a comparison of the extent to which these MAs supported recovery efforts to affected communities after their respective responses.

In addition to improving the planning process for the 'Recovery Plan', by involving all relevant stakeholders, it is recommended that the recovery plan is costed and supports the integration of information gathered during the response phase into the national health information system.

Costed Plan for The Recovery Phase:

While international resources are available immediately after a disaster or crisis, these do not last beyond the response phase (CDG, 2017)³¹. International organisations may be more active during the emergency

30 IPPF (2023). IPPA Cianjur Post Emergency Review

31 Center for Global Development (CGD), 2017. Is USAID Set Up to Fail on Disaster Reconstruction?. Available on www.cgdev.org/blog/is-usaid-set-fail-disaster-reconstruction

phase of a disaster but less involved during the recovery phase. Indefinite response interventions are not sustainable, and recovery periods are often “characterized by a regression of service coverage as humanitarian activities put in place during the acute relief come to an end” (WHO, 2011, p.28). Maintaining funding during the transition phase is a major challenge to effective and resilient recovery. Therefore, SPRINT IV responses should consider providing additional funding to extend activities during the recovery phase, rather than a three to six months costed intervention. This would provide funding for recovery and resilience building activities to be implemented in the Humanitarian-Development Nexus after the response phase.

The role of IPPF and the MAs in the recovery phase is strongly aligned with Australia’s International Development Policy approach. Strengthening long-term resilience and community development, key priorities for IPPF and MAs, reflects the Australian International Development Policy focus on enhancing state and community resilience to external pressures and shocks, with the objective of building regional resilience.

Integrating SRH Into a National Health Information System:

A functioning health information system should provide access to reliable and timely data about health determinants and status at all levels of the health system. However, many of the SPRINT IV countries have weak health information systems, and these often deteriorate further during crises, with data collection halting or becoming dysfunctional.

Government-owned data related to those in vulnerable situations is often available at the local level, but not centralised at a national level. Disasters can result in electricity shortages, which can prevent local governments from accessing this information, limiting collaboration with MAs. In Surigao del Norte, for example, the City Social Welfare and Development Office (CSWDO) has the names and addresses of all registered PWDs, but this is not at the national office. After TC Odette, *“there was no electricity for almost four months, so we were unable to access the database”* (CSWDO staff).

To address gaps in data, aid agencies may launch their own information collection initiatives, which often are not disseminated or shared. As a result, data during the recovery phase is often siloed or fragmented, with stakeholders having their own information storage, rather than having a central or national information system. Instead of continuing this separate collection of information, IPPF and SPRINT MAs could be key actors in supporting necessary efforts to strengthen a national health system in the recovery phase. A crucial component of ensuring SRHR needs are met within the health system is integration of SRH information and data relevant to groups in vulnerable situations into the overall health information system.

To increase the support the recovery of communities affected by crises, the following recommendations are made:

- 13) Undergo a strategic shift, adopting an extended intervention approach:** Given that international resources tend to diminish beyond the response phase, the importance of sustained efforts during the recovery period is essential. Funding activities in the recovery phase, rather than a limiting funding to the three to six months response will provide stability and continuity in post-crisis scenarios, while strengthening state and community long-term resilience, aligning seamlessly with Australia's International Development Policy. This funding could be included in the MA’s work plan for the following year.
- 14) Strengthen efforts to plan, implement and monitor the continuation of services to affected communities after the emergency:** A Recovery Plan should be discussed, designed, and agreed upon with all relevant stakeholders, including representatives from communities in vulnerable situations. It should provide an agreed roadmap with responsibilities and timelines on how to

transition to regular services, ensure how SRH data collected by stakeholders is centralised, and incorporate a mechanism to monitor the implementation of the plan's determined activities and indicators. To simplify the process of developing a Recovery Plan, IPPF should develop a transition plan template that includes how to guide the discussions for the transition³².

b. What is the purpose of Pillar 4 and its focus on the *Recovery* phase?

In the humanitarian-development nexus, 'Recovery' plays a critical role as the phase that bridges the gap between immediate humanitarian response and long-term development efforts in the aftermath of a crisis or disaster. While Pillar 4 under the SPRINT IV project document focuses on improving the synergy between IPPF Humanitarian and Development teams, *Recovery* has a different meaning to IPPF staff, MAs, and other stakeholders, more in line with its role in the disaster management cycle. Based on this understanding, the recovery phase should support the following aspects:

- **Transition from crisis to development:** This refers to ensuring the continuation of service to affected populations, particularly new and/or underserved users, either directly through the MA or through the local health providers. In some SPRINT responses, MAs have reached areas that have had little (or no) service delivery previously. As part of the recovery phase, new and underserved users need to be linked to the local health authorities, which remains a challenge for many government agencies. Solutions for the continuation of services to these groups need to be agreed and included in the 'Recovery Plan' to support the transition process.
- **Restoration or improvement of SRH services to the general population:** This includes ensuring SRH information and data are included within health systems, and supporting national health services until these have become operational again.
- **Promoting resilience:** MAs should aim to work with governments to enhance the resilience of communities to future shocks and stresses. This involves not just restoring what was lost but also supporting infrastructure rebuilding using the build back better (BBB) approach to reduce vulnerability to future disasters and crises.
- **Act as bridge leading back to Pillars 1, 2 and 3:** Under Advocacy it might identify policy areas or challenges that need to be addressed to avoid them repeating in the future or identifying and implementing resilience-building initiatives. The lessons learnt under 'Recovery' should be systematically documented in a compendium of 'Best Practice and Lessons Learnt'. These could then be drawn upon to address identified gaps, including in DRR and Preparedness activities, and as evidence for use in advocacy efforts.
- **Risk Reduction and Preparedness:** The documented lessons learnt can also be used as evidence during advocacy efforts to incorporate SRHiE into future disaster risk reduction and resilience-building initiatives.

To ensure the above aspects are included in 'Recovery' under Pillar 4, it is recommended to:

15) Redesign 'Pillar 4 – Recovery' to have a stronger focus on the recovery of affected populations:

This pillar should provide clear guidance on how to support the transition from emergency to stable situation³³, while ensuring the continuation of services to affected populations, particularly new and underserved communities. A workshop with IPPF Humanitarian and SPRINT MAs should be conducted to revise the outcome and indicators of success, which need to be specific, measurable, achievable, relevant, and time-bound (SMART).

³² The template could provide a description of the SRHiE services that have been delivered by the MA and/or stakeholders, who will assume responsibility for their continuation during the recovery phase and beyond, how this will be done, what are the resources required and the timelines to transition them. It can also identify new services or new areas serviced, future collaboration and document lessons learnt and best practices.

³³ For example, identifying relevant stakeholders,

3. What is the outlook for the SPRINT program in the future?

There was absolute consensus on the importance of the SPRINT program among all relevant participants in the data collection for the MTR. This included DFAT posts who highlighted the unique role of MAs in their ability to provide continuous SRHiE services due to their national presence before, during and after crises. SPRINT's positive impact in providing lifesaving SRH services since commencing in 2007 was widely acknowledged, noting increased technical capacity of the IPPF Secretariat, the Humanitarian Team, MAs and external stakeholders, particularly from government health departments, to provide SRH services in crises.

With DFAT funding, SPRINT has been able to support priority countries in ways that would have not been possible otherwise, given the holistic approach of the program across the four pillars. While significant improvements in capacity have taken place, there is still a need to continue supporting the efforts of these countries to deliver lifesaving SRH services. Maintaining DFAT funding is particularly critical over the next five years to continue supporting crises responses while IPPF's Humanitarian Sustainability Plan is implemented. This will support the organisation's Strategy 2028, which highlights IPPF's continued commitment to expanding access to SRHR for people in humanitarian settings.

The five-year Sustainability Plan aims to establish sustainable frameworks and funding mechanisms for local and national organisations to prepare for and lead responses and deliver services. This includes enhancing localisation and working across the humanitarian-development nexus³⁴, continued mobilisation of restricted funding for specific responses from multiple donors, and continuation of IPPF's Stream 3 resource allocation mechanism, which was created to accommodate sudden-onset disasters, protracted conflicts, and crisis. Additionally, IPPF MAs will be encouraged to support humanitarian preparedness and response by leveraging Stream 1 core business plans to integrate preparedness and response contingency funds, while further strengthening IPPF's critical role in the development-humanitarian nexus.

a. Should a two-year costed extension of SPRINT IV be considered?

The significant reach and strong performance of the SPRINT program justifies the continued investment of DFAT in IPPF Humanitarian preparedness, response and recovery. Continuing support from DFAT aligns with the Australian International Development Policy, particularly in relation to the prioritisation of localisation, the building of robust country-level systems, strengthened humanitarian response, and action on climate change. The emphasis on a costed multi-year approach in SPRINT IV, supported by DFAT, also resonates with IPPF's Sustainability Plan for the humanitarian program over the next five years. As demonstrated by their significant contributions to IPPF's humanitarian initiatives, including the SPRINT program, DFAT's support is a strong contributor to the success of IPPF's efforts to widen access to SRH services in crisis-affected areas. The collaborative approach advocated by IPPF, involving strategic partnerships and capacity strengthening at the national level, aligns with the broader vision of building resilience and addressing humanitarian needs, making continued DFAT support a crucial component in achieving mutual objectives.

There was universal agreement among interviewees on the need for a two-year costed extension of SPRINT IV to solidify the achievements gained through the current and previous iterations of the program. As for additional activities, there were many perspectives on how this funding could be utilised, although it will require revisiting the budget allocated to each pillar post MTR and consider increasing

³⁴ IPPF works along the humanitarian-development nexus by strengthening systems, establishing partnerships, mobilising resources and engaging in preparedness, response and resilience activities through effective and close coordination across its development and humanitarian programs at country, regional and global levels.

the amount for Recovery. Some of the areas identified to be addressed during the two-year costed extension and their relevance to DFAT include:

Consolidation of Achievements and Efforts:

- MAs to work with national governments to institutionalise years of advocacy efforts by the current and previous iterations of the SPRINT program at the policy and strategic level. A priority focus should be around SRHiE inclusion and addressing gender equality, and disability equality and rights. MAs need to map all current and future policy and strategic opportunities, covering not only health, DRR and CCA government initiatives, but also women's empowerment initiatives, education programs, and social protection and poverty alleviation programs. Addressing gender equality, and disability equality and rights is also in line with DFAT's International Development Policy priorities.
- MAs with high level MISP capacity should consider capitalising on their knowledge, offering to become the official MISP trainers for the government and other organisations, as FPAN has done in Nepal. This will support local-led efforts to drive change, engage local staff in delivering a high-quality development program, and reduce possible duplication with other organisations.
- IPPF Humanitarian and MAs can also increase evidence for decision-making by strengthening the documentation and sharing of information across each stage of the disaster management cycle.

New Areas/Activities to be considered:

- As highlighted in this report, it is a priority to redesign Pillar 4 to focus on long-term recovery. This contributes to improving the resilience of the population during the recovery phase, particularly for communities in vulnerable situations, which is a priority for DFAT.
- Increasing sensitisation of stakeholders not traditionally targeted, such as police and army officers, and community gatekeepers such as community and/or religious leaders. This is key to reducing discrimination and social stigma, while advancing gender equality, and disability equality and social inclusion at the national level. This can be addressed under the Humanitarian-Development Nexus and in partnership with other initiatives.
- Logistics and supply chain management, including prepositioning of commodities for emergency responses should be strengthened by IPPF to avoid shortages in SRH commodities in the field.

Streamlining of SPRINT IV

Streamlining efforts are currently taking place, such as the integration of humanitarian indicators into the District Health Information Software 2 (DHIS2), which enables IPPF to disaggregate data on services delivered during emergencies and stable times with ease.

Incorporating humanitarian activities into development planning is another area that is being undertaken by IPPF. For example, in the Philippines FPOP has allocated contingency funds in their business plan to launch a response immediately after a disaster occurs, while an emergency proposal is being developed. This model has the potential to be scaled up and adopted by other MAs, and will require initial support for other MAs to integrate into their processes.

To further enhance the efficiency and impact of SPRINT IV during the two-year costed extension, SRHiE recovery activities should be integrated into annual planning within IPPF Secretariat and MA business plans, as well as with country stakeholders where possible to avoid duplications and bottlenecks. Delivering SRHiE should not be a siloed activity but part of the overall delivery of health services. This requires ensuring that relevant services and information are effectively integrated into the provision of care, which is crucial for addressing the specific SRH needs of affected populations during crises.

To streamline program management the level of engagement with DFAT should be reduced, such as by having a quarterly call instead of a monthly call and submitting one annual report instead of two biannual reports. This in turn would allow the Humanitarian team and MAs to invest more energy into advocacy, resource mobilisation, and other critical areas.

Changes in Country Coverage:

As for the list of countries supported by SPRINT, it was suggested to suspend Myanmar from SPRINT IV due to the political challenges of working with the collaborating partner under the current regime. Revisiting the supported partners' commitment and capacity to deliver SRH in crises was recommended, with the potential for expanding the list of priority countries for immediate response (within \$100k). The inclusion of Thailand was recommended given the limited capacity of the Myanmar MA to reach those communities with the most humanitarian need, and the high capacity and interest of the Thai MA to support displaced populations from Myanmar.

To allow for the implementation of the above areas, it is recommended to:

- 16) Provide a two-year costed extension to SPRINT IV:** Providing a two-year costed extension to the current iteration of the SPRINT program will allow IPPF and MAs not only to continue supporting preparedness activities, but to consolidate achievements and efforts, work in new areas and implement new activities. Most importantly, it would allow the redesign and implementation of a new Pillar 4 focusing on the recovery of affected populations.

b. Does Australia need to continue investing in IPPF's Humanitarian programming?

While SPRINT IV started in 2022, the program design and priorities remain highly relevant to the Australian Government and aligned to the priorities and commitments stated in the new International Development Policy, released in 2023. These include:

- Addressing humanitarian needs by delivering timely and effective humanitarian assistance, with a focus on gender equality, social inclusion and locally led action.
- Strengthening national stakeholder capacity, enabling communities to take greater responsibility and leadership in humanitarian and development programming.
- Advancing gender equality and disability equity and rights, through the SPRINT IV involvement of and focus on communities in vulnerable situations.

Post-MTR changes could further increase this alignment, particularly around building resilience and addressing the impacts of climate change. Changes could focus on IPPF supporting MAs to work with national governments towards incorporating SRHiE in state and community activities for climate change resilience and adaptation, and disaster risk reduction.

The preparedness and response capacity of the MAs to quickly activate a response team and mobilise resources to address the SRH needs of affected populations, particularly for communities in vulnerable situations, is the most essential part of the SPRINT program.

Countries and donors often face pressure to address immediate and visible crises, such as climate-related disasters or humanitarian emergencies. As a result, funding is frequently directed toward immediate relief efforts rather than longer-term preparedness activities, which may not offer the same visibility or urgency. Globally, more than 90 per cent of humanitarian funding is allocated to response, with less than 3.8% to preparedness, and 5.5% to recovery and reconstruction, despite these efforts being widely

recognised as more cost-effective in the long-term³⁵. Given the limited availability of funding, particularly around supporting preparedness activities, it is of utmost importance for the Australian Government to demonstrate leadership by continuing to supporting these areas.

By investing in preparedness, DFAT is supporting IPPF and MAs to mitigate the impact of disasters and crises, promote long-term development, and contribute to global stability. DFAT's investment in IPPF's Humanitarian programming is an excellent way to support some of the most vulnerable nations in the world. Countries in the Indo-Pacific region, besides being vulnerable to droughts, floods, extreme temperatures, earthquakes, tsunamis, and cyclones, also have limited resources to provide SRH services in crises.

To ensure the above aspects are included in 'Recovery' under Pillar 4, the following recommendations are made:

17) DFAT should continue investing in IPPF's Humanitarian Program: Given that climate impacts are increasing the intensity and frequency of sudden-onset and slow-onset disasters, exacerbating SRH issues in an already disaster-prone region, and recognising the valuable contributions of IPPF in this context, it is strongly recommended that DFAT continues its ongoing support to IPPF's humanitarian work beyond the completion of SPRINT IV. This sustained support will empower IPPF to extend its funding for humanitarian technical expertise to MAs, reinforcing their capacity to deliver high-quality SRH responses, and the seamless integration of recovery into SRHiE.

To enhance the effectiveness of this support, exploring a more flexible funding approach is recommended, resembling close-to-core funding for IPPF's humanitarian programs. By allowing a portion of the funding to be partially earmarked for the Indo-Pacific region, DFAT can strategically contribute to addressing the challenges faced by women, girls and underserved communities.

As SPRINT IV approaches its conclusion, it is suggested that DFAT and IPPF explore alternative funding modalities to ensure the sustainability of the crucial work done during the four SPRINT iterations. For example, IPPF could work with DFAT Canberra using close-to-core funding to fund 'Preparedness' and 'Recovery' work, and with DFAT Posts to support 'Advocacy' and 'Recovery' activities to sustaining IPPF's efforts in advancing SRHiE beyond the expiration of the costed extension of SPRINT IV. This forward-looking approach will fortify IPPF's ability to effectively respond to and mitigate the health impacts of SRHiE, aligning with DFAT's commitment to the region.

- 18) IPPF should tap into additional funding streams:** Explore conventional and non-conventional channels to secure further funding to diversify funding streams, including at national level. To do this, consider:
- IPPF Humanitarian recruiting a staff member dedicated to resource mobilisation to source new funding opportunities.
 - MAs entering a contracting mechanism with the local governments to provide SRH services on behalf of the government, both during emergencies and stable times.
 - Tapping into non-conventional channels of funding, including partnerships with the private sector³⁶. There is an opportunity to innovate and engage with corporations that share the belief that every woman and girl has the right to access lifesaving SRH

³⁵ Centre for Disaster Prevention, 2019. Mapping Financial Flows for Disasters

³⁶ For example, Save the Children has corporate partnerships with American Express, Disney, Google, IKEA, and Western Union, among many others.

services and live without the fear of GBV, particularly during emergencies. Crowdfunding could also be explored as an alternative, that IPPA has successfully implemented, albeit with small scale interventions.

A final cross-cutting recommendation encompassing all pillars is to:

- 19) Increase engagement with communities** in vulnerable situations across the four pillars: Based on the principles on accountability to affected populations, it is recommended to involve people and / or representatives from underserved and marginalised communities in all phases of SPRINT IV. Target groups *“should be ultimately the decision makers of what programs should be implemented in their communities.”* While actively engaging these groups might be time consuming, *“the objective, is not getting faster alone, but it is getting far”* (UNFPA staff).

Annex 1. Terms of Reference

INTRODUCTION

The Terms of Reference (ToR) outline the approach to an independent evaluation of the *Sexual and Reproductive Health in Crisis and Post-Crisis Situations (SPRINT)*, Phase 4 (SPRINT IV). This three-year program (2022-2024) is funded by the Australian Government Department of Foreign Affairs and Trade (DFAT) and implemented by the International Planned Parenthood Federation (IPPF). The evaluation will be undertaken within the period July to November 2023.

BACKGROUND

Australia is committed to empowering women and girls and advancing gender equality globally. The Australian Government has been a pioneer supporter of sexual and reproductive health and rights (SRHR) in humanitarian settings since 2007 and is recognised as a leader in this field. SPRINT is closely aligned with Australia's aid interests and policies, supporting strategic objectives of DFAT's New International Development Policy (to be released in the first half of 2023) through emergency health and humanitarian assistance that has a strong emphasis on protecting the most vulnerable. SPRINT supports DFAT's key thematic priority of gender equality and women's empowerment by working with local IPPF Member Associations (MAs) to deliver essential SRH services, including a focus on preventing and managing the consequences of sexual and gender-based violence (SGBV) for women and girls in crises. SPRINT delivers against DFAT's humanitarian priorities by supporting preparedness and effective humanitarian response to rapid and slow onset crises. It supports groups that are disproportionately affected by humanitarian crises, including women, girls, adolescents, people with disabilities, people living with HIV, people of diverse sexual orientation, gender identity and expression (SOGIE), sex workers and other groups in vulnerable situations. It also supports DFAT's disability inclusion priority as it works to ensure social inclusion in both the design and implementation of humanitarian activities. SPRINT is strongly aligned with globally agreed humanitarian policies and standards for SRHR. It supports the localisation agenda with service providers who work across the humanitarian-development nexus and are present before, during, and after a crisis.

Since 2007, the Australian-funded SPRINT initiative has invested in SRHR and prevention of and response to SGBV in humanitarian settings through IPPF. Phase 1, 2 and 3 of the program ran from 2007 to March 2022. An independent evaluation was undertaken at the mid-term of the phase 3 in 2019 (Mid-Term Review: MTR), which led to a two-year costed extension. The SPRINT IV program commenced in April 2022. SPRINT IV builds on lessons learnt and challenges identified from previous phases including the recommendations from the phase 3 MTR in 2019.

The SPRINT program has a strong focus on the Indo-Pacific region in recognition of the strategic focus of Australia's aid program and the vulnerability of this region to disasters and other crises. The SPRINT IV program is delivered in partnership between IPPF and its locally owned and led MAs in 14 focus countries (Fiji, India, Indonesia, Maldives, Myanmar, Nepal, Pakistan, Philippines, Papua New Guinea, Samoa, Solomon Islands, Sri Lanka, Tonga, and Vanuatu). As the lead partner, IPPF – through its experienced Humanitarian team, mostly located in Suva and Kuala Lumpur, –work in tandem with the MAs, providing capacity building and supportive supervision and enabling them to become leading national SRHR agencies in crises.

The goal of the SPRINT program is to improve access to lifesaving SRH services for crisis- affected populations in all their diversity through implementation of the Minimum Initial Service Package (MISP) for reproductive health in crises. The overarching purpose of the program is to contribute to reducing SRH-related mortality and morbidity, sexual and gender- based violence (SGBV), HIV and sexually transmitted infections (STI) transmission, and unintended pregnancies in disaster affected areas. The SPRINT IV has four outcome areas:

- (1) Policy advocacy – global, national and local policy makers are increasingly receptive to including SRHR in emergency planning and responses.
- (2) Preparedness - increased national capacity to deliver lifesaving SRH services in crises.
- (3) Emergency response – lifesaving quality essential SRH care provided in a timely and inclusive manner with an emphasis on women, girls, and marginalised persons.
- (4) Recovery – Enhanced management and coordination between humanitarian and development programs to aid delivery of comprehensive services.

The SPRINT IV grant agreement is for three years (April 2022 to December 2024), with an option to extend of up to 2 years. A mid-term review of the program by an external consultant is expected to inform the final year of the program's implementation to ensure its ongoing relevance, impact, effectiveness, and efficiency, and to inform possible future DFAT investments in IPPF's humanitarian programming.

PURPOSE AND INTENDED USE OF THE EVALUATION

The purpose of the evaluation is to:

1. Provide an independent assessment of the progress towards the SPRINT IV goals/outcomes, particularly around the newly introduced Outcome 4 – Recovery, including the degree to which IPPF has been able to advance the nexus between humanitarian and development efforts and measure impact accordingly.
2. Assess the effectiveness of SPRINT IV at all levels of implementation from Member Associations, key national partners, beneficiaries etc, with a particular focus on the program's capacity to meaningfully include vulnerable, marginalised and excluded groups.
3. Recommend how implementation of SPRINT IV can be improved for the remainder of the program, including addressing any identified issues.

4. Recommend whether a costed extension should be considered, and present suggestions for further streamlining of the SPRINT IV program model to drive further impact and efficiency gains.

The outcomes and recommendations of the evaluation should inform DFAT management level decision making, including whether to extend the program, and how the SPRINT IV model could be further streamlined for optimal result. . Equally, the outcomes and recommendations should benefit IPPF, particularly in enhancing its impact, effectiveness, and efficiency at all levels of SPRINT IV implementation, and may help to inform other humanitarian programming beyond SPRINT being delivered across the Federation.

IPPF will be responsible for overall management and administration of the evaluation. This will include contracting, briefing the evaluation team; managing feedback from reviews of the draft report; and liaising with the evaluation team throughout to ensure the evaluation is being undertaken as agreed. DFAT will remain closely engaged in the development of evaluation questions and evaluation plan.

EVALUATION SCOPE

The entirety of the SPRINT IV program is included in the evaluation scope. This is defined in the grant agreement, design update, and program documentation (e.g., monitoring and evaluation framework, risk management framework, annual workplans, etc).

The evaluation will also consider the impact of SPRINT IV implementation within the broader context for SRHR preparedness and response in humanitarian settings. This includes, but is not limited to:

- Its contribution to the Australian Aid Program (e.g., *New International Development Policy, scheduled for forthcoming release in 2023*)
- Its contribution to IPPF's broader objectives (e.g., *IPPF's global Strategy 2028; Business Plan 2023-2025; Niu Vaka Pacific Strategy Phase 2, 2023-2028*)
- The extent to which SPRINT interacts in a complementary way with other programs (e.g., RESPOND program, the New Zealand-funded SRHiEP¹ program, core funds) and partners (e.g., UN organisations, NGOs, etc.).

Evaluation of SPRINT impact and performance should cover the time period from the commencement of SPRINT IV in April 2022 up to the time of the evaluation being undertaken. Recommendations should cover implementation of the current grant (to 31 December 2024) and any potential extension period.

KEY EVALUATION QUESTIONS

Key evaluation questions are outlined in [Attachment A](#). This list will be modified and refined during the development and finalisation of an evaluation plan by the consultant.

¹ Sexual Reproductive Health in Emergencies Pacific

COMPOSITION OF THE EVALUATION TEAM

The Evaluation Team will consist of one to two independent consultant(s) with expertise in monitoring and evaluation, humanitarian action, SRHR and SGBV.

EVALUATION TECHNIQUES AND DATA COLLECTION

The evaluation will apply a variety of mixed-method evaluation techniques such as desk review, meetings with stakeholders, small-group discussions, field visits, informed judgement, and scoring/rating techniques. The evaluation will be based on analysis of qualitative and quantitative evidence to establish findings, conclusions, and recommendations in response to specific questions.

Desk Review

The Desk Review of program and relevant contextual documents will indicate a number of initial findings that may lead to fine tuning of the evaluation questions and plan. A preliminary list of documents for desk review is at [Attachment B](#). DFAT and IPPF will be responsible for making available key documents, both proactively and at the request of the consultant.

Consultation and stakeholder engagement

Open and transparent consultations will underpin the evaluation. In addition to consultations with nominated DFAT and IPPF personnel, consultations will be made with key partners (e.g., IPPF MAs, UNFPA, New Zealand MFAT, local key stakeholders from government, NGOs etc. in a few focus countries).

Selected key stakeholders may be given an opportunity to input on the draft report, which will be circulated for comment. All comments will be taken into consideration by the evaluation consultant in preparing the final report.

Travel / field visits

The consultant will travel to Canberra (to hold meetings with DFAT), Suva, (IPPF Pacific humanitarian team and regional humanitarian partner organisations), Kuala Lumpur (IPPF Humanitarian team) and a few SPRINT implementing countries (proposed are Nepal, Philippines, and Solomon Islands). During field visits, the evaluation consultant will meet with IPPF MA personnel, government officials, and community members (if possible) in one-to-one and small group settings. The location and number of the field sites will be representative in terms of SPRINT IV's scope and range of activities and illustrative of both successes and challenges.

CONSULTING SERVICES, DELIVERABLES AND SCHEDULING

Desk review and evaluation plan

The consultant will conduct a rapid desk review and initial set of consultations via email and/or phone/Zoom with IPPF and DFAT personnel to provide an initial assessment of the outcomes and results achieved by SPRINT IV to date, and clarification of evaluation questions. The consultant will draw on the desk-review and these initial consultations to develop a draft Evaluation Plan.

The final Evaluation Plan (approved by DFAT and IPPF) will build on and supersede these Evaluation TOR as appropriate, identifying what is feasible and appropriate to assess the

program and to make recommendations on future implementation of SPRINT. The Evaluation Plan will include:

- An evaluation design that describes an appropriate methodology for the evaluation within the time and resources available.
- Sub-questions for key evaluation questions, addressing cross cutting issues as necessary.
- Proposed data collection and analysis process, including the sampling strategy and key informant categories both in Australia and internationally.
- The consultation process will be flexible and include face-to-face, one-to-one and small group interviews, teleconferences and email with key stakeholders.
- Challenges/limitations to achieving the evaluation objectives and how these will be addressed.
- Draft itinerary and target dates for deliverables.

The consultant is accountable for ensuring that the evaluation and all evaluation documents, including the TOR, evaluation plan and evaluation document meet DFAT's Development Evaluation Policy (2020).

Reporting and publication requirements

The consultant must provide the following documents/reports within the indicated timeframes:

1. Evaluation Plan, jointly agreed by the Consultant, IPPF and DFAT in line with DFAT's Development Evaluation Policy.
2. A near-final draft of the Evaluation Report in line with DFAT's Development Evaluation Policy for DFAT and IPPF review. The Evaluation Report structure and length will be determined in the Evaluation Plan.
3. A final Evaluation Report by 30 November 2023, incorporating consideration of feedback on the draft. The final draft will be subject to DFAT peer review, revision by the Consultant, and then approval by DFAT and IPPF.

Indicative timeframe

Task/Deliverable	Timeframe
Desk review	by 17/07/2023
Draft Evaluation Plan provided for review by DFAT and IPPF	by 18/07/2023
Evaluation Plan finalized addressing comments	by 04/08/2023
Undertake data collection and field visits	07/08/2023 – 08/09/2023

Teleconference with IPPF after each country visit	As per travel schedule
Briefing on the preliminary key findings by the consultant(s) in the SPRINT monthly call	14/09/2023
Provide a first draft evaluation report for review by IPPF	by 29/09/2023
Provide a second draft evaluation report for review by DFAT	by 13/10/2023
Provide a revised draft evaluation report addressing comments	by 16/11/2023
All deliverables finalised and final evaluation report accepted by IPPF and DFAT	by 30/11/2023

INDICATIVE BUDGET

Consultant days: 30-35 days

Source: SPRINT IV Monitoring and Evaluation

Travel: Canberra (Australia), Suva (Fiji), Kuala Lumpur (Malaysia), Honiara (Solomon Islands), Manila (Philippines) and Kathmandu (Nepal). IPPF will organise and pay for travel including air fare, local transport, accommodation and per diems in accordance with the IPPF travel policy.

ATTACHMENT A: Preliminary list of key evaluation questions

This list of key evaluation questions has been developed in consideration of the MTR's purpose as described earlier and in alignment with DFAT's Design and Monitoring & Evaluation Standards (2022). The questions will be further refined as part of the development of the Evaluation Plan with the consultant(s).

1. Provide an independent assessment of the progress towards the SPRINT IV goals/outcomes, particularly around the newly introduced Outcome 4 – Recovery, including the degree to which IPPF has been able to advance the nexus between humanitarian and development efforts and measure impact accordingly.

Guiding key evaluation questions:

- Is the SPRINT investment enabling any impacts beyond its specific program objectives? How is it driving progress to support the humanitarian – development nexus in the region?
 - How well is IPPF delivering against Outcome 4 (Recovery) under SPRINT IV with regards to supporting recovery, transition, and long-term sustainable development?
2. Assess the effectiveness of SPRINT IV at all levels of implementation from Member Associations, key national partners, beneficiaries etc, with a particular focus on the program's capacity to meaningfully include vulnerable, marginalised and excluded groups.

Guiding key evaluation questions:

- To what extent are Member Associations and the IPPF Humanitarian Team successfully coordinating with key partners to deliver SPRINT IV at the national, regional, and global level?
 - How is the SPRINT IV program advancing gender equality, disability, and social inclusion at the national level? What are the remaining challenges and barriers for reaching vulnerable, marginalised and excluded populations?
3. Recommend how implementation of SPRINT IV can be improved for the remainder of the program, including addressing any identified issues.

Guiding key evaluation questions:

- Are there any challenges limiting effective program delivery, and if so, how can these be resolved?
- Is the program driving progress when it comes to addressing slow onset disasters related to the impacts of climate change?

4. Recommend whether a costed extension should be considered, and present suggestions for further streamlining of the SPRINT IV program model to drive further impact and efficiency gains.

Guiding key evaluation questions:

- Does Australia still need to invest in IPPF's Humanitarian programming, and is it supporting the Australian Government's priorities for humanitarian relief efforts and broader development?
- Should Australia's investment in SPRINT be extended through a cost extension and beyond, are there ways in which the SPRINT IV program model could be improved?

ATTACHMENT B: Preliminary list of documents for review

- Context documents
 - [IPPF Strategy 2028](#)
 - IPPF Pacific Niu Vaka Strategy 2023 – 2028
 - IPPF Business Plan and 3-year Financial Plan (2023-2025)
 - Australia's New International Development Policy (forthcoming)
 - World Humanitarian Summit and Grand Bargain commitments
 - [DFAT's Design and Monitoring and Evaluation Standards \(2022\)](#)
 - DFAT's Humanitarian Aid Quality Check template
- SPRINT IV program design, grant, and strategy documents
 - SPRINT IV program proposal and Investment Design Summary
 - SPRINT IV grant agreement
 - SPRINT IV program logic, M&E Framework, Risk Management Matrix, Visibility Strategy and Communication Plan
 - SPRINT IV Annual workplans (2022, 2023)
- SPRINT IV reports
 - 2022 – 2023 reports (2 Progress Reports and 1 Annual Report)
- Other documents as and when identified by consultant(s), DFAT and IPPF

Annex 2. Revised Evaluation Questions (EQs)

The following Evaluation Questions (EQ) address, refine and expand the list of EQs identified in the Terms of Reference (ToR) for the Mid-Term Review of SPRINT IV.

- i. **How can SPRINT IV increase the impact of pillars one, two and three?**
 - a. **At the policy level, how can SPRINT IV strengthen SRHR in crises?**
 - i. How can SRHiE during slow-onset disasters / protracted crises be included into policy / strategic planning?
 - ii. Is there clarity on what are the different types of disasters are and when a response should be triggered for each type?
 - iii. How can disaster risk reduction practice become more relevant for the management of slow-onset disasters / protracted crises?
 - iv. What actions can be taken at local level for the implementation of durable solutions to slow-onset disasters / protracted crises?
 - v. Who are the most relevant stakeholders (policy makers and practitioners) to work with at the national level?
 - vi. What can be done to strengthen SRHR in crises in a short-term (up to December 2024) within the existing budget as well as in a medium term with a possible extension of SPRINT?
 - b. **How can SPRINT IV strengthen capacity to deliver lifesaving SRH services in crises?** [*Probe on other strengthening capacity activities such as MISP training, SGBV fundamentals, BEmONC, SimEx*]
 - i. How have vulnerable and marginalised groups been engaged in preparedness activities, and how could they be further involved?
 - What is the understanding of vulnerable / marginalised groups (i.e., persons in vulnerable situations or from marginalised communities) within IPPF?
 - Have organisations representing vulnerable / marginalised groups been included in the design and of Emergency Preparedness Plans (EPPs) Emergency Response Plans (ERPs)?
 - ii. Is there clarity on what are the different types of disasters are and when a response should be triggered for each type?
 - Probe on triggers to slow onset disasters / protracted crises
 - c. **How can SPRINT IV strengthen the delivery of lifesaving quality essential SRH care during emergencies?**
 - i. What actions can be taken to reach to and increase access to SRH services for vulnerable and marginalised persons?
 - What efforts have been made to reach these populations?
 - Do data collection tools capture data on vulnerable and marginalised people?
 - How is the safety and confidentiality of these groups ensured? Do MAs have the same understanding of who belong to these groups and understanding of the importance of reaching them?
 - ii. How can the quality of the responses be improved?
 - What other mechanisms can be implemented to ensure quality?
 - What sort of follow up can be done by MAs with beneficiaries post response to build case studies to inform future programming?

2. What is the future of Pillar 4 – Recovery under SPRINT IV?

a. To what extent has SPRINT IV been able to support the recovery of communities affected by crises?

- i. What activities have been taken to ensure the continuation of SRH services after emergency?
 - How are new and / or underserved users transitioned from SRHiE to services post emergency?
 - Have transition plans been agreed with relevant stakeholders during the emergency phase to ensure a continuation of services?
 - What monitoring occurs after the transition to ensure appropriate service continuation?

b. What is the purpose of Pillar 4 and its focus on the *Recovery* phase?

- i. What are the results IPPF and MAs envision from Pillar 4?
 - What is the role of 'Recovery' in the humanitarian-development nexus?
 - How is SPRINT addressing continuation of services for users living in remote areas/ outer islands/ hard to reach locations?
 - Is the continuation of services for users living in remote areas/ outer islands/ hard to reach locations feasible under Pillar 4?
- ii. What are the results DFAT envisions from Pillar 4?
- iii. What does success look like? (What is success?)
 - How do we measure success? (Is it SMART?)
 - Who needs to be included in this outcome? (Government, CSOs, populations, etc.)
 - What are the resources required?

3. What is the outlook for the SPRINT program in the future?

a. Should a two-year costed extension of SPRINT IV be considered?

- i. What should be the aim of this extension?
 - Consolidate / solidify progress achieved?
 - Build on achievements?
 - Increase focus on focus on gender equality, social inclusion and locally led action?
 - Support new areas under the program, including those previously discussed?
 - Achieve outcomes in progress / finalise remaining activities?
 - Should any new countries be included or current ones dropped if an extension is granted?
- ii. How is the SPRINT IV program advancing gender equality, disability, and social inclusion at the national level?
 - What are the remaining challenges and barriers for reaching and engaging vulnerable, marginalised and excluded populations in all stages of the disaster management cycle?
- iii. How can SPRINT IV further support Australia's International Development Policy implementation?
- iv. How can SPRINT IV enhanced or streamlined to increase efficiency and impact?
 - Consider time, human and financial resources at IPPF (global and regional levels) and MAs (national and sub-national levels)
 - What other funding models or resources could be leveraged to support the delivery of desired results for SPRINT?

b. Does Australia need to continue investing in IPPF's Humanitarian programming?

- i. Is IPPF's Humanitarian program supporting the Australian Government's priorities for humanitarian relief efforts and broader development?
- ii. Can the successes achieved under SPRINT IV (and previous iterations) continue without DFAT funding?

Annex 3. Recovery efforts in two different countries

Solomon Islands

As part of the SIPPA's COVID-19 response, an action plan was developed to ensure the integration of comprehensive SRH services into primary health care at the end of the response. Three of the activities or goals in the plan included:

- a. Continuing collaboration with the MHMS Health teams to identify and support project sites or mobile clinic sites.
- b. Handover of client lists to the MHMS at primary health care settings external to SIPPA, to ensure continuity of SRH care is provided to clients.
- c. Continuing the provision of SRH services during stable times for new communities visited during the response.

Upon visiting the Solomon Islands, it was observed that this plan was not effectively implemented. The continuation of SRH services in the remote and marginalised communities supported during the response has been limited. According to interviewed young women in a marginalised settlement in Guadalcanal, the information and services provided by SIPPA were very good. But *“we were told they would be back in six months, and this is the first time they are back”* (young woman). This first visit the interviewee referred to was the field data collection visit, which took place over a year after the end of the response.

During the response visit, women were provided with referral cards to access free pap smear screening at SIPPA's clinic. Some were able to visit the clinic to receive a pap smear, but not everyone was able to do so due to travel costs to the clinic, among other factors such as fear of leaving the settlement and being exposed to physical and/or sexual violence.

Continuation of services has also been an issue in outer islands. After travelling with SIPPA to all outreach visits in Malaita during COVID-19, a clinical nurse from the rural health clinic has not been invited to any further outreach activities. She stated that MHMS and SIPPA must do better working together. The delivery of SRH services *“is a big need in the outer islands, because the [health] team can only reach them once a year.”*

The lack of communication has been a two-way challenge. For example, the nurse referenced above, mentioned that often the public health clinic nurses hire private boats to visit remote locations but have not informed SIPPA. Along with these trips, other opportunities for SIPPA include travelling with government departments when they go on voter registration or other activities. Furthermore, according to the same clinical nurse in Malaita, she *“never got information of the clients [supported by SIPPA], but this should be given.”* These examples suggest that communication breakdowns are occurring between the MA and the local health providers.

Philippines

To transition into the recovery phase after typhoon Odette, FPOP facilitated a workshop and handover meeting with local stakeholders. This transition exercise led to very effective collaboration with the Department of Health and the local authorities. The arrangement has enabled the continuation of SRH services to underserved users through coordination with the Local Government Units (LGUs), using

community-based volunteers and scheduling visits with the barangay³⁷ captains and the rural nurses. The Provincial Health Office has frequently invited FPOP to go back to geographically isolated and disadvantaged areas (GIDAs) to continue providing information and services. Continuation of SRH services for new users in Surigao and other urban areas was also secured by transitioning them to their local clinics and conducting service referrals where required.

Additionally, the local government included FPOP in the planning of their 'Disaster Risk Reduction Management' plan, where the MA is included to provide MISP and GBV training in future responses. The plan also included procuring additional SRH commodities to have a buffer in case of a disaster.

As part of their transition into the recovery phase, FPOP included relevant activities and budget in their following annual plan. Community participants of FGDs confirmed that FPOP had been back at least once since the end of the response. The transition into recovery has also received high support from the local government in Surigao del Norte. The Major of Sisaon partnered with FPOP to bring SRH services to GIDA communities through the '14k Serbisyo Caravan', which includes multiple government departments and CSOs to provide local, provincial, and regional services to all barangays.

Regarding the distribution of unutilised medical supplies, in the Solomon Islands, SIPPA provided these to local clinics, while FPOP kept them at the FPOP Surigao Chapter static clinic as buffer stock for continuation of SRH services.

³⁷ A small territorial and administrative district forming most of the Philippines local level of government.

Annex 4. Considerations around climate change

Climate change can have wide-ranging impacts on sexual and reproductive health (SRH) by influencing various factors, including environmental conditions, social structures, and healthcare systems, affecting communities in different ways. Hence, the impacts of climate change needs to be integrated into advocacy for SRH and future strategic planning. As one MOH staff member from Solomon Islands considered, *“When we go out for family planning, we need to integrate the message of climate change, how it will affect mothers and children accessing services in their clinics where (sic) maybe it has been flooded”*. Spikes in GBV prevalence, during crisis and due to climate-related stressors is also a concern as *“women now have to travel further on the mainland to work their fields, which leaves them more at risk”* (SI Community Leader). Action plans for climate change should be developed both at the MA and Humanitarian Team level. Some of the MAs have *“explicitly expressed interest [in climate change advocacy], but not much done thus far”* (IPPF staff). IPPF will need to lead in this area and build the capacity of MAs and strengthen collaboration with relevant stakeholders.

The impact of climate change is resulting not only in more intense natural disasters, but also in an increased number of small-scale disasters and slow-onset disasters. Some ways in which these emergencies can influence SRH indicators include:

- **Maternal and child mortality and morbidity:** Limited access to skilled birth attendants and emergency obstetric care, along with limited access to nutritious food, healthcare services, and clean water during slow-onset emergencies can contribute to complications during pregnancy and childbirth. Maternal mortality rates may rise due to inadequate maternal care.
- **Gender-based violence:** Protracted crises can exacerbate gender inequalities and contribute to an increase in gender-based violence, including sexual violence.

Other general health indicators that can be affected by slow-onset disasters include:

- **Malnutrition and Food Security:** Prolonged droughts or famines can lead to food scarcity and malnutrition. This can result in stunted growth, underweight individuals, and micronutrient deficiencies, impacting overall health and development.
- **Child Health:** Malnutrition and food insecurity during slow-onset emergencies can significantly affect child health. High rates of malnutrition can lead to increased susceptibility to diseases, higher child mortality rates, and long-term developmental issues.
- **Waterborne Diseases:** Water scarcity and compromised water quality during slow-onset emergencies can contribute to the spread of waterborne diseases, such as cholera and diarrhea. Lack of access to clean water and sanitation facilities increases the risk of infections.
- **Vector-Borne Diseases:** Changes in environmental conditions, such as altered rainfall patterns, can influence the prevalence and distribution of vector-borne diseases like malaria and dengue. This can lead to increased transmission rates in affected areas.

IPPF will need to support resource mobilisation efforts to fund responses to the latter because these *“do not receive much international funding and [IPPF] core funds do not allow for reallocation... IPPF might need to repackage our messaging to the donors [to highlight] that we are seeing more disasters on a small scale that need additional support”* (IPPF staff).

While small scale-disasters are clearer to identify, it is difficult to assess when a larger climate change response should be triggered. In general, IPPF staff agreed that this should occur when the local health capacity and / or facilities cannot cope.

Another option to determine when a climate change response is triggered is by adopting a composite or proxy indicators of challenges that *“are seen during slow onset crisis or climate change related disasters”* (IPPF staff) to be monitored and used to determine when to trigger a response. For example, a combination of different general health and SRH indicators, such as increased maternal and child mortality and morbidity, increased GBV cases, increased stunted growth and underweight individuals, high/higher rates of malnutrition, and increased vector-borne and water-borne diseases. Although not a SPRINT supported country, Kiribati has experienced a drought that has resulted in *“salination of soils, reducing food security which increased malnutrition levels for pregnant and lactating women... but there is not a lot of literature about this. I think this something we could engage in the future, a research piece so we have evidence to draw from”* (IPPF staff).

Annex 5. Metadata for two proposed indicators for Pillar 4

Indicator 1: Continuity and Expansion of SRH Services

Definition: The Continuity and Expansion of SRH Services is the degree to which Sexual and Reproductive Health services continue to be provided and are expanded or enhanced to meet the evolving needs of the population as the community transitions from the recovery phase to stable times.

Rationale: Tracking the Continuity and Expansion of SRH Services provides insights into the resilience of the healthcare system and its ability to adapt and meet the ongoing SRH needs of the community as it transitions from recovery to more stable times.

Calculation formula:

- **Numerator:** Number of SRH services sustained or expanded
- **Denominator:** Total number of SRH services provided during the recovery phase
- Divide numerator by the denominator and multiply by 100

Data Sources:

- **Health Facility Records:** If possible, gather anonymised data from health facilities to track the continuation of SRH services for beneficiaries transitioned to government health services or from the MAs' service delivery points. This includes the sustained provision of services introduced during the recovery phase and any expansion or improvement in service delivery.
- **Community Feedback and Surveys:** Collect feedback from the community regarding their perception of the continuity and expansion of SRH services. Surveys can help assess the community's awareness of available services, satisfaction with the quality of care, and identification of any gaps in service provision.

Considerations:

- **Service Expansion:** Measure the introduction of new SRH services or the expansion of existing services to address emerging needs or gaps identified during the recovery phase.
- **Integration with Primary Healthcare:** Ensure that SRH services are integrated into broader primary healthcare services to enhance sustainability and accessibility.

Indicator 2: Community Health Resilience Index

Definition: The Community Health Resilience Index would be a composite indicator that reflects the resilience of Sexual and Reproductive Health services in the community during the transition from the recovery phase to stable times. It considers various factors, including service accessibility, continuity, community engagement, and adaptation to changing needs.

Rationale: A Community Health Resilience Index can provide a comprehensive and holistic measure of the community's ability to maintain and enhance SRH services as it transitions from the recovery phase to stable times.

Calculation formula:

- **Numerator:** Weighted sum of resilience factors

- **Denominator:** Maximum possible score
- Divide numerator by the denominator and multiply by 100

Resilience Factors for consideration:

- **Service Continuity:** Assess the extent to which SRH services established or enhanced during the recovery phase are sustained without interruption.
- **Community Engagement:** Measure the degree of community involvement in decision-making processes related to SRH services and the extent to which community needs and preferences are considered.
- **Adaptation to Changing Needs:** Evaluate the flexibility and responsiveness of SRH services to evolving health needs and emerging challenges.
- **Capacity Building:** Assess the capacity of healthcare providers, facilities, and local institutions to deliver and support SRH services effectively.
- **Policy Support:** Consider the existence of supportive policies at the local and national levels that facilitate the sustainability and resilience of SRH services.

Data Sources:

- **Community Surveys:** Collect feedback from the community on their perceptions of SRH service continuity, accessibility, and responsiveness to their needs.
- **Policy Analysis:** Review existing policies related to SRH services and assess their alignment with the evolving needs of the community.