

Mid Term Review Report

Transformative Agenda for Women, Adolescents and Youth in
the Pacific: Towards Zero Unmet Need for Family Planning
2018-2022

4 December 2020

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Acknowledgements

The Mid Term Review Team would like to thank the many individuals from Government Ministries and civil society organisations who dedicated time to interviews--particularly the DFAT Posts and Ministries. A wide range of additional stakeholders participated, including beneficiaries, youth, development partners and others.

The MTR Team acknowledges the significant effort put into scheduling, hosting, and information-sharing on the part of the UNFPA Pacific Sub Regional Office (PSRO) staff and Field Officers. In particular, the PSRO Suva team provided invaluable support, documentation and answers to questions. They consistently responded to the MTR Team's consultation requests. Every individual's input is very much appreciated.

Executive Summary

In 2018, the Australian Government committed AUD30 million to the UNFPA Transformative Agenda (TA) Program in six countries in the Pacific (Fiji, Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu). The TA program is high priority for the Australian Government and its performance is of strong interest to a wide range of stakeholders. The three objectives of the TA program are: 1) Increased and improved supply of integrated SRH information and services, particularly for family planning (FP); 2) Increased demand for integrated SRH information and services, particularly for FP; and 3) a more conducive and supportive environment for people to access and benefit from quality SRH, especially contraceptive choice.

The TA program is nested within the broader UNFPA Pacific Sub Regional Program (PSRO SRP6) and currently has 46 implementing partners (IP), sub recipients (SR) and regional implementing partners (RIP) across multiple Ministries, international organisations (IO) and non-government organisations (NGO). The interlocking focus of UNFPA Supplies' work ensures a range of FP commodities are available at all service delivery points (SDPs).

The Sexual and Reproductive Health (SRH) issues addressed in the six countries of focus are: increasing fertility and teenage pregnancy rates, low contraceptive prevalence rates, and high unmet need for family planning. Health system challenges contributing to sub-optimal family planning practices include: poor quality and coverage of some Sexual and Reproductive Health (SRH) services, particularly (FP); variable supplies of SRH commodities, limited capacity to implement strategies and plans; limited national health budgeting, and insufficient political commitment for FP/SRH.

This mid-term review (MTR) aims to provide an independent assessment of how effectively the program is contributing to the targeted results, and whether the program is on track to achieve the program's objectives by 2022. A team of two international consultants and six national consultants (one from each of the six countries) conducted consultations with implementing partners and stakeholders, and reviewed implementation reports to date.

The high-level questions considered and addressed through the MTR are:

- Is the program strongly relevant to Pacific development needs and specifically reducing the unmet need for FP in each of the six countries (relevance);
- Is the program on track to achieve its objectives and related program outcomes (effectiveness);
- Is the program using appropriate, effective and efficient strategies and activities to progress outcomes (efficiency); and
- Are there adequate systems and processes in place to monitor, capture and report on how outputs are contributing to the achievement of outcomes and impact (governance, reporting and M&E).

Relevance: The MTR team found that the TA Program is designed to achieve relevant and appropriate outcomes that are in line with the policies and priorities of MOHs in the TA countries and DFAT health, gender and development policies. However, due to implementation delays and challenges, it is uncertain how many of the outcome targets can be achieved within the remaining 20 months of the program. A shift to targeting and accelerating high impact interventions is necessary, including focusing on SRH/FP service delivery; continued program-wide changes to funding disbursement processes; ending low value interventions and reprogramming funding; and reorienting continuing interventions to focus on achieving outcomes.

Effectiveness: The results of the TA MEF to date show that limited results have been achieved with respect to program outputs and targets; the program is not on track to deliver its expected outcomes and is not demonstrating progress towards the program goal. Slow implementation and failure to have an inception period has compromised the effectiveness of the program. An inception period should have established the following: prepared IPs for UNFPA administrative processes; Health Facility Readiness and Service Availability (HFRSA) assessments for baseline data (two out of six still to be completed); and final indicators, baselines and targets established in the MEF. Additional challenges impacting effectiveness have included: the competing priorities of MOHs, especially in 2020 due to the COVID-19 pandemic, cyclone Harold in Vanuatu, and measles outbreaks in Samoa and Tonga; complex UNFPA administrative processes; crippling past audit findings in a small number of critical partners which affected funding disbursements; slow financial processes of some governments; and missed opportunities to scale up utilization of existing technical SRHR resources in the country.

Fund utilisation by Ministries is low. Average utilisation rates for 2018-2020 by country are: Fiji 34%; Kiribati 25%; Samoa 42%; Solomon Islands 29%; Tonga 37%; and Vanuatu 26%. The fund utilisation rate for Regional IPs is 12% (implementation in 2020 only) and for PSRO was 48% with more than 50% of this being technical positions in 2019 (see Table 7).

Efficiency: A number of factors have impeded the efficiency of the program and achievement of results. These include complex and slow recruitment of UNFPA staff and IPs for the TA program; slow disbursement of funds at multiple levels all resulting in significant non-implementation periods in 2018 and 2019; lack of time for implementation after late receipt of funds; and the UNFPA policy (until recently) of requiring unspent funds be returned to UNFPA at the end of the calendar year. This policy affected IPs from 2018 to 2019 but has since been remedied. RIPs report a long, complex and unsatisfying recruitment process, with their proposed activities significantly changed following submission of proposals. These factors have all resulted in slow implementation and limited achievement of outcomes.

Monitoring and Evaluation and Reporting: Review of the existing Monitoring and Evaluation Framework (MEF) indicates that it is not fit for purpose with multiple indicators ill-defined and/or unmeasurable, and many interventions having no corresponding indicators for measurement of progress or achievement. Of 150 indicator targets (25 indicators x 6 countries), 26 (17%) were found to be achieved or on track; some progress was achieved on 11 (7%); 41 (27%) had little progress; and 72 (48%), were not measurable due to a variety of reasons.¹ Some baseline data is still not available. Nine of the sixteen planned interventions have not yet begun or have no evidence of achievements. While indicator definitions include disaggregation by gender and age, these are not included in reporting. The TA Program would benefit from indicators to monitor UNFPA's management of the TA program. The risk management matrix has not been updated since the development of the program design document (PDD). Annual reporting is confusing as activities from PSRO's SRP6 and RMNCAH programs are included as being implemented by the TA program.

Governance: There has been good communication and collaboration between PSRO and DFAT Canberra with six monthly strategic guidance and progress reviews through the TA program Steering Committee. However, there has needed to be some accommodation on both sides as UNFPA

¹ Indicator results that were not included in the cumulative results analysis included those with: no data yet reported; results/data not yet expected at this point in time; indicator is too problematic to measure/report on/include; and/or high-impact indicators not appropriate for mid-term assessment.

commonly manages core funding for their planned program and the management of the TA program required adherence to the PDD and DFAT's quality assurance processes. Similarly, DFAT has experienced issues with UNFPA's complex administrative processes which impede progress. Technical governance through the PDD prescribed TA Technical Team (TATT) would have benefited from oversight of TA technical activities and ensured regional and national agencies' technical capabilities were capitalised upon in a coordinated and efficient manner.

In **conclusion**, it is uncertain whether the TA outcomes will be achieved by program end, due to the current underachievement of indicator targets; as well as low levels of implementation. It is unclear whether some of the most significant administrative process challenges can be satisfactorily resolved in time to improve the effective implementation of the program. DFAT may want to consider a four (4) month implementation extension to allow for quality one year work plans for both 2021 and 2022; and a further option for a twelve (12) month no-cost extension if the program makes good progress over 2021/2022. Additional time for implementation would also allow for recovery from the impact of COVID-19. Implementation of the MTR recommendations will require immediate action by PSRO and will need to be closely monitored by DFAT before a decision on a possible extension is made. DFAT could consider making this decision in April 2022 following receipt and evaluation of the 2021 Annual Report.

Recommendations:

Effectiveness

Recommendation 1: Strengthen and support intersectoral National Health Sector Committees, SRH Committees or Reproductive, Maternal, Newborn, Child, Adolescent Health (RMNCAH) Committees to maintain the role of planning and coordination for priority, needs-based FP/SRH activities across sectors. This may require hiring a temporary TA Program Coordinator or other Support Staff, contracted through the MOH using TA funds. PSRO should continue the consultations with MOHs in this regard and ensure that MOH planned FP/SRH activities are part of TA workplans. MOHs would be responsible for contracting any SRs, and for data collection and reporting. Proposed non-health related activities in other Ministries (e.g. in the Education, Women and Youth sectors), could be included in multisectoral planning but with their own workplans and with disbursement of TA funds through the usual channels (i.e. through government systems).

Recommendation 2: As part of their TA planning, it is recommended that MOHs give consideration to contracting existing in-country trainers (such as IPPF Member Associations (MAs), Medical Services Pacific in Fiji, or others) to conduct training on FP methods (particularly Long Acting Reversible Contraceptives (LARCs) and emergency contraception (EC)); and integrated SRH (youth-friendly services, Gender-Based Violence (GBV) care, disability inclusiveness) to global best practice standards. The benefit of MOH consideration of using contracted service providers is that it would reduce pressure on MOH medical staff for important, but non-critical work. A model using non-government FP trainers would also allow for follow up work and quality control efforts related to cascade training (which has inherent limitations), without overburdening government services. This will need to be a decision for each government to make based on its circumstances.

Recommendation 3: UNFPA negotiate with Nursing Councils and/or the South Pacific Board of Educational Qualifications (SPBEQ) to make all efforts towards ensuring that in-service FP/SRH training can be registered to enable a recognised certificate (across the Pacific) to be issued upon completion, as occurred in Solomon Islands for the Jadelle Rollout.

Recommendation 4: UNFPA work closely with the UNFPA Global Supplies Program to ensure that contraceptives are ‘pushed’ out to SDPs for the duration of the TA program using the ‘informed push’ using relevant data provided by SDP staff to improve access, avoid wastage and ease the workload on SDP staff. Efforts should be made to ensure that implants (including both Jadelle and Implanon), Intra-Uterine Devices (UIDs) and ECs are included in the ‘informed push’ effort. Consideration could be given to using funds no longer required for low priority interventions to bolster support for commodity availability, particularly for training and capacity building, and for ensuring commodity supply personnel are centrally engaged in MOH TA program steering committee discussions. This may require a contract amendment.

Recommendation 5: DFAT consider enabling UNFPA to place more people into in-line positions in critical ministries to expand SRH activities quickly.

Efficiency

Recommendation 6: The nine Regional IPs meet as soon as possible, and regularly thereafter, to discuss strategies and share data with a view to improving monitoring of important indicators, preventing data collection duplication, reducing the impost on MOH time; and improving the coordination and efficiency of their technical assistance.

Recommendation 7: By the end of 2020, after careful review and prioritisation of outputs, one regional (PSRO) (which includes the RIP plans) and six national master workplans (January 2021 – December 2022 – or August if DFAT cannot consider a four month implementation extension) (which includes all activities from all partners) be developed for the remainder of the program. The TA should also facilitate 24-month work plans developed by MOHs and other participating Ministries, and funds disbursed prior to February 2021 and February 2022. In addition, repayment of unspent funds should not be required during the 20-month period. Normal acquittal processes can apply but PSRO finance assistants (where they exist) should be responsible for increased support to IPs. This should be feasible if the number of IPs is reduced.

Recommendation 8: DFAT and UNFPA assess the roles and responsibilities of the PSRO SRH Specialists in field offices, as well as the RIPs, given the changed operating environment. For example, an assessment is needed of: the RIPs’ progress to date; feasibility of remote work in the COVID-19 context; what in-country resources exist; and determining if their work should continue, be paused temporarily, or strengthen the model of capacity building and support to national partners.

Recommendation 9: Due to the necessary reliance on in-country skills and resources given COVID-19 travel restrictions, PSRO and IPs and RIPs reconsider the original approach regarding SRH/FP BCC activity implementation. This may require a heavier reliance on using and strengthening existing national capacity and resources, rather than full reliance on external RIPs. HFRSA assessment data provides updates on MOH progress in developing SRH tools and resources. This data should be used to inform any future activities related to training (which may have been provided) and the development of guidelines and policies (which may already exist). See Annex 6 for HFRSA assessment data.

Recommendation 10: PSRO in-country staff be tasked with compiling an inventory of local SRH resources, guidelines, policies and training courses related to FP/SRH that already exist in the health sector (MOH, MAs, CSOs), as well as in the education, women’s and youth sectors; and assess the

extent to which these resources meet international standards, and consider the feasibility of immediate use.

Recommendation 11: The TA program needs to focus predominantly on the two outcome areas of FP *supply* and FP *demand* generation for the remainder of the program, and should set aside some of the activities focused on strengthening the enabling environment (See Annex 9). All activities should be assessed for their value in contributing to a direct impact on individual FP use. This will help ensure that unmet need for FP decreases by program end.

Monitoring and Evaluation

Recommendation 12: The MEF should be revised and finalised as an urgent priority to ensure that output, outcome and impact indicators are included and measurable; that relevant FP data can be collected and reported by the MOH Health Information Systems (HIS); and that the strategic interventions are allocated indicators to ensure advancement of these activities. Some indicators may require national tailoring to accommodate differences in SRH data currently collected by the country-level HIS.

Recommendation 13: PSRO contract a senior level monitoring, evaluation and learning (MEL) technical specialist as soon as possible to manage TA Program MEL and create and enable a results-oriented MEL institutional culture within UNFPA.

Governance

Recommendation 14: The TA Technical Team (UNFPA Technical Advisers and Programme Specialists, DFAT Canberra, DFAT Suva, IPPF, WHO, UNICEF, Council of Regional Organisations - CROP agencies etc.), meet every six months to review technical inputs into the final years of the TA program, particularly SDP SRH training, BCC strategies and dissemination,² and MOH Health Information System (HIS) strengthening.

Recommendation 15: Given the slow implementation of the TA program in the first two years of implementation, DFAT consider a four month implementation extension to enable two year work programs and also agree an option for a 12 month no-cost extension to the program for the period January to December 2023. If a 12 month no-cost extension is granted, funds for workplans for 2023 should be disbursed before February 2023 and repayment of unspent funds from 2022 should be allowed to be rolled over. The trigger for a decision on exercising the 12-month extension period would be DFAT's decision based on 2021 and 2022 performance reports and should be made no later than 30 April 2022.

² as planned in the PDD

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Transformative Agenda: Mid Term Review Report

1. Introduction

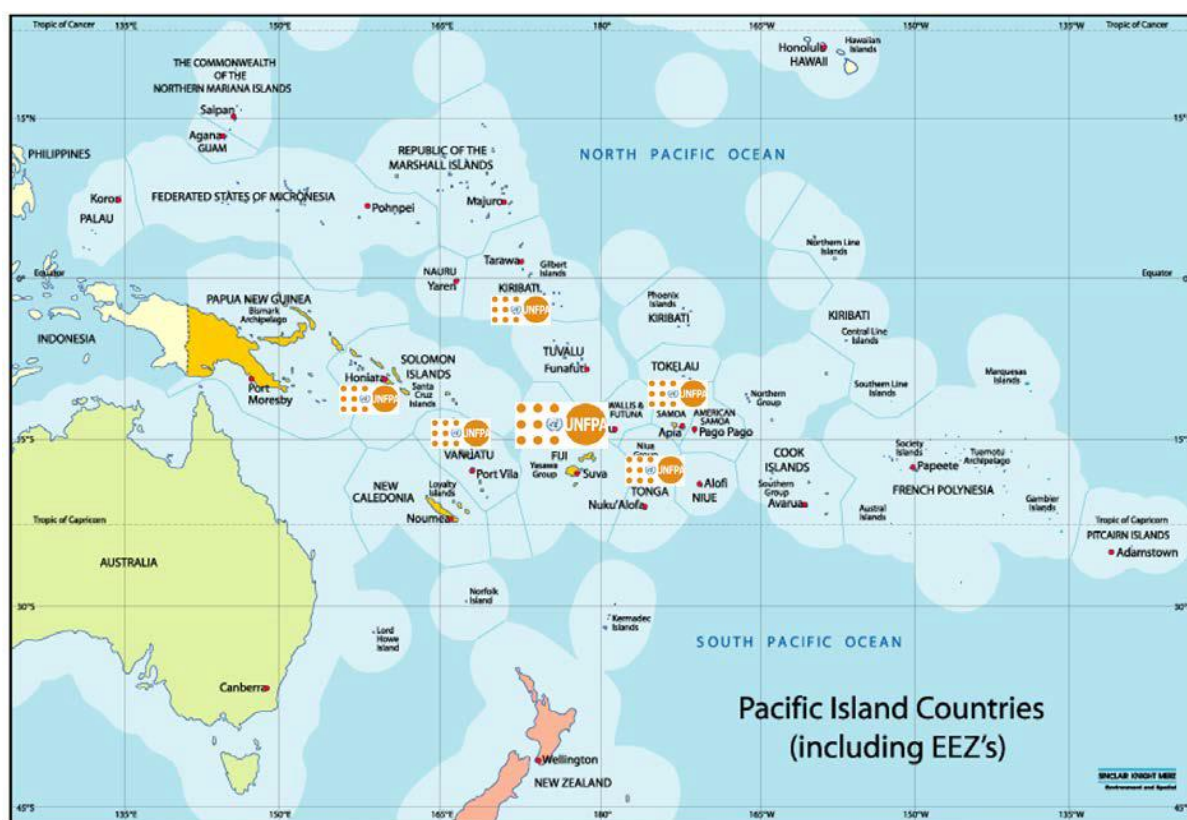


Figure 1

Source: UNFPA TA Annual Report, 2018

The Australian Department of Foreign Affairs and Trade (DFAT) has invested AUD 30 million over four years to expand access to quality sexual and reproductive health (SRH)³ in six Pacific countries with a focus on reducing unmet need for family planning. The Transformative Agenda for Women, Adolescents and Youth: Towards Unmet Need for Family Planning by 2022 (TA) is implemented in Fiji, Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu. Implementation is managed by UNFPA's Pacific Sub-regional Office (PSRO) and works with implementing partners (IPs) from both government and civil society.

The TA program is DFAT's single largest investment in sexual and reproductive health, and DFAT's largest development partnership with UNFPA. It is a high priority for the Australian Government and its performance is of strong interest to a wide range of stakeholders.

The three intended **outcomes** of the TA Program are:

1. Increased and improved supply of integrated SRH information and services, particularly for FP
2. Increased demand for integrated SRH information and services, particularly for FP
3. More conducive and supportive environment for people to access and benefit from quality SRH, especially contraceptive choice

³ Defined in *Making Reproductive Rights and SRH a Reality for All: Reproductive Rights and SRH Framework, 2008, UNFPA* as: a) Family planning; (b) Antenatal, safe delivery and post-natal care; (c) Prevention and appropriate treatment of infertility; (d) Prevention of abortion and management of the consequences of abortion; (e) Treatment of reproductive tract infections; (f) Prevention, care and treatment of STIs and HIV/ AIDS; (g) Information, education and counselling, as appropriate, on human sexuality and reproductive health; (h) Prevention and surveillance of violence against women, care for survivors of violence and other actions to eliminate traditional harmful practices, such as FGM/C; (i) Appropriate referrals for further diagnosis and management of the above.

The logic of the TA program is that: if national strategies and operational frameworks on SRH are strengthened; if sexual and reproductive health and rights (SRHR) capacity of health workers is increased; and if a sustainable and efficient supply of commodities is ensured; then countries will have improved coverage and quality of SRH services. Additionally, if Family Life Education (FLE) programs are integrated into the education system; if communities are well informed on SRH rights and are motivated; and if youth-led initiatives are promoted toward the use of SRH services; then communities will be engaged and demand for SRH will increase. Finally, enabling environment strategies that strengthen partnerships will support increased supply and demand.

The TA program is implemented through partnerships with 46 national and regional entities. The primary implementing partners (IPs) in each of the six countries are:

Fiji: Ministry of Health and Medical Services; Ministry of Youth and Sports; Ministry of Women, Children and Poverty Alleviation

Kiribati: Ministry of Health and Medical Services; Ministry of Education; Ministry of Women, Youth and Social Services; Ministry of Finance and Economic Development/National Statistics Office

Samoa: Ministry of Finance

Solomon Islands: Ministry of Development Planning and Aid Coordination, Ministry of Health and Medical Services

Tonga: Ministry of Health

Vanuatu: Ministry of Health and Medical Services; Ministry of Youth and Sports; Ministry of Education and Training; Vanuatu National Statistics Office.

The primary IPs work with a broad range of national sub-recipients (SR) contracted to carry out various aspects of their country programs. (See Annex 3 for a list of all IPs and SRs).

Non-government regional implementing partners (RIP) include: John Snow International (JSI), Australian Broadcasting Corporation (ABC), Burnet, Nossal, Family Planning New South Wales (FPNSW), International Planned Parenthood Federation Sub-regional Office of the Pacific (IPPF SROP), World Vision, CARE and Women Enabled International (WEI).

The TA program is nested within the UNFPA PSRO Sub Regional Program 6 (SRP6) 2018-2022. The New Zealand Ministry of Foreign Affairs and Trade (MFAT) Pacific Regional SRH Program (PRSRHP) operated in five of the six TA countries from 2014 to September 2020. In 2018 the PRSRHP was revised to closely align with the TA theory of change, and objectives, but with a specific focus on adolescents and youth. In addition, the UNFPA Global Supplies program services all six MOH programs in ensuring that FP commodities are available and supply chain system capacity is strengthened. There are multiple additional synergies between the TA program and other SRHR-related programs and projects within the six participating countries. Annex 4 lists and describes these entities and synergies. Annex 5 outlines synergies across related programs with shared IPs.

2. Background

Women with unmet need for family planning are those who want to stop or delay childbearing but are not using any method of contraception. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behaviour⁴.

Access to high-quality, affordable SRH services and information, including a full range of contraceptive methods, is fundamental to realising the rights and well-being of women and girls, men and boys⁵.

⁴ WHO Global Handbook on Family Planning

⁵ Family Planning: A Global Handbook for Providers, WHO 2018

The reproductive health situation in the six Pacific countries of focus is characterised by increasing fertility and teenage pregnancy rates, low contraceptive prevalence rates, and high unmet need for FP⁶. Despite the global trend of declining adolescent birth rates (ABR), Pacific countries show an upward trend (except for Samoa), with Vanuatu and Solomon Islands among the highest rates in the region. A growing proportion of young people in the Pacific report being sexually active, yet contraceptive prevalence rates are negligible among adolescent girls. Unmet need for FP for adolescent girls is significantly higher than for all women of reproductive age.

Table 1: Adolescent Birth Rates and Unmet Need for Family Planning in Six Pacific Countries
(most recent available year)

Country	Adolescent Birth Rates	% Women with Unmet Need for Family Planning
Global	44 ⁷ (2018)	12% (2015)
Fiji	28 (2016)	20% (2000)
Kiribati	51 (2019)	17.3% (2019)
Samoa	55 (2019)	38.9% (2019)
Solomon Islands	77 (2015)	34.7% (2015)
Tonga	32 (2019)	22.5% (2019)
Vanuatu	81 (2013)	24.2% (2013)

Source: National Minimum Development Indicators, in UNFPA Current RMNCAH Workforce in the Pacific Islands, 2019. 2019 figures are from the most recent Demographic Health Surveys (DHS)/Multiple Indicator Cluster Surveys (MICS) in those countries. Fiji data from MOH Health Status Report, 2016. Adolescent birth rate - pregnancies per 1,000 girls aged 15-19 years. Unmet need for FP - % of women of reproductive age, either married or in a union who have unmet need for FP

Health system challenges contributing to sub-optimal family planning practices include poor quality of SRH services; variable supplies of SRH commodities; limited capacity to implement strategies and plans; inadequate funding and insufficient political commitment.

Access to essential medicines is critical to achieving universal health coverage (UHC) and is also recognised as a key building block of a strong health system. The UNFPA Supplies Program (2018-2022) aims to strengthen national supply chain systems' capacity to reduce unmet need for FP in eight Pacific countries, including the six countries of the TA Program.

The TA Program is designed to strengthen family planning demand and supply, and promote a conducive environment that supports sustainable, evidence-based family planning interventions. Demographic and target population data, and the number of service delivery points (SDPs) to be strengthened are provided in the following table.

Table 2: Selected Demographic Data in Program Countries

Demographic Data Point	Fiji	Kiribati	Samoa	Solomon Islands	Tonga	Vanuatu
Total Population (2016) ⁸	884,887 ⁹	114,388	195,137	553,254	100,651	270,405
Total Women of Reproductive Age (¹⁰)	221,590	29,655	43,436	148,247	23,384	68,006

⁶ Design Document, Transformative Agenda for Women, Adolescents and Youth in the Pacific: Towards Zero Unmet Need for Family Planning (2018)

⁷⁷ WHO Global Strategy for Women's, Children's and Adolescent's Health (2016-2030)

⁸ Total population, WRA, adolescents, and SDP figures from UNFPA PSRO publication, "The State of the Pacific's RMNCAH Workforce, 2019"

⁹ Fiji Census Report (2017)

¹⁰ Total population, WRA, adolescents, and SDP figures from UNFPA PSRO publication, "The State of the Pacific's RMNCAH Workforce, 2019"

Total Adolescents 10-19 (M&F) (7)	153,684 ¹¹	22,776	43,679	136,954	23,439	55,542
Total Youth ages 15-24 ¹²	159,870 M: 82,143 F: 77,727	22,679 M: 11,213 F: 11,466	39,770 M: 20,413 F: 19,357	131,719 M: 67,794 F: 63,925	20,948 M: 10,725 F: 10,223	57,684 M: 28,631 F: 29,053
Total Service Delivery Points including primary, secondary/tertiary SDPs	212 14 provinces	112 22 atolls	14 11 districts	301 9 provinces	31 23 districts	271 6 provinces
Source: Current RMNCAH Workforce in the Pacific Islands (2019) UNFPA; Fiji Census Report (2017); HFRSA Assessment Results (2018, 2019, 2020) for Fiji, Kiribati, Samoa, Tonga; PDD for Solomon Islands and Tonga Note: Adolescents: ¹³ ages 10-19; Youth: ages 15-24; Young people: ages 10-24						

3. Purpose, Methodology and Limitations

The **purpose** of the MTR is to assess the continued relevance, effectiveness and efficiency of the TA program, and the progress made over the first two years of implementation towards achieving its planned objective of expanding access to SRHR in the Pacific with a focus on FP. (See Terms of Reference at Annex 1).

The MTR report aims to:

- Outline key findings supported by evidence and provide recommendations on any changes, modifications or improvements to implementation approaches and activities required to enable the program to achieve sustainable outcomes and impacts
- Focus on the structure, outcomes, duration and scope of the program within the current funding envelope
- Identify strongly performing institutions where partnerships could be expanded
- Identify under-performing partners – or partners who perform adequately but have low impact – where partnerships could be scaled back

The TA MTR used a summative approach to assess program achievements at this mid- point of implementation. This included data collection and analysis of primarily the health and education sectors. Cross cutting issues relating to gender responsiveness and human rights were reviewed. The geographical scope included all six Pacific countries as well as a regional perspective.

Six (6) National Consultants (NCs) were identified to conduct interviews with key informants in-country. They were contracted by DFAT's Specialised Health Service (SHS) and supported by the UNFPA PSRO in-country staff and the MTR Team Leader to conduct interviews with key informants.

The four phases of the MTR review were :

1. Planning Phase (3 August – 14 August)
2. Field Data Collection and Analysis Phase (17 August – 11 September)
3. Validation and Reporting Phase (7 September – 20 November)
4. Dissemination and Follow-up Phase (20 November – 2 December)

Limitations to the MTR process include: the short timeframe for consultations; limited availability of senior Ministry of Health (MOH) staff due to COVID-19 related activities; inability of international consultants to conduct in-country

¹¹ Fiji Census Report, 2017

¹² Index Mundi, https://www.indexmundi.com/kiribati/demographics_profile.html, accessed 4 Aug 2020

¹³ UNFPA.org. Adolescent and Youth Demographics: A Brief Overview. Accessed online, 3 July 2020.

<https://www.unfpa.org/sites/default/files/resource-pdf/One%20pager%20on%20youth%20demographics%20GF.pdf>

consultations and observations; necessity for the MTR team to work remotely across multiple countries and time zones; and a Monitoring and Evaluation Framework (MEF) with limited and/or unreliable data for effectively measuring results to date. (See Annex 2 for the List of Key Informants).

4. Relevance

Does TA remain strongly relevant to Pacific development needs and specifically reducing the level of unmet need in the region for FP in each of the TA countries?

Is program implementation enhanced by the technical assistance provided; and through consideration of Gender and Social Inclusion (GESI) programming and activities?

What is the compatibility, synergies and interlinkages of TA with other interventions in the same context?

The TA program remains strongly relevant to Pacific SRHR and development needs. All six countries are characterised by high unmet need for FP and persistently high rates of adolescent births (see Table 1). While all six countries have well established National MOH FP/SRH programs, reaching young and unmarried people and rural and remote populations is problematic due to a variety of both cultural and geographic/logistic reasons.

Women's economic empowerment and gender equality are priorities across Australia's foreign policy and aid program,¹⁴ especially in the Pacific. The Australian Government recognises that: investing in women's, adolescent girls' and young women's SRHR will contribute to decreasing teenage pregnancy and sexually transmitted infections including HIV; and that child marriage, coercive sex, and gender based violence are often key elements in the context in which a woman or girl becomes pregnant. All are human rights violations, as are denials of access to SRH information and essential services. Support for transformative change in the lives of women and girls across the region needs to include addressing factors that contribute to the unmet need for FP and ensuring the availability of rights-based SRH services.

While the TA program is implemented across a range of Ministry IPs and sub-recipients, the goals and objectives of the TA program rest heavily within the health sector. All of the higher-level impact indicators are within the health sector, and all but four of the 25 MEF indicators are health sector based (the other four are related to FP demand generation through Family Life Education (FLE) within the education sector). While inputs from the education, women, and youth sectors are critically important, these Ministries are not the best positioned to drive the overall SRHR effort of the TA program. The two key SRHR health sector providers in each country are currently the MOHs and the International Planned Parenthood Federation (IPPF) Member Associations (MAs). Annex 11 lists the roles and coverage of MOH and MA SRHR services in the six countries.

Each country's MOH has SRHR mandates and roles, and the IPPF MAs in each country play a role in supporting MOH SRHR programs. Annex 4 outlines the synergies with related programs - DFAT Supplies program; SPRINT, Pre-positioning program; Jodelle rollout success in Solomon Islands; MFAT Pacific SRH Program; IPPF Samoa Family Health Association (SFHA) Impact Project in Samoa; NZFPA projects in Vanuatu & Kiribati; DFAT bilateral programs. All of these programs and projects have lessons to be learned for implementation of the TA program.

The TA program has been impacted by the competing priorities of MOHs, namely Non-Communicable Diseases (NCDs) and the COVID-19 pandemic which will affect implementation and progress for the duration of the program. Ministries will always be more engaged when donor programs are directly aligned with the Ministry's own priorities and programs. The timing of the TA program does however benefit MOHs who are currently developing their role delineation policies and packages of essential services towards Universal Health Coverage (UHC). These essential packages include integrated SRH services. If the TA program supported these priority MOH activities directly with

¹⁴ DFAT Health for Development Strategy 2015-2020; Women's Economic Empowerment and Gender Equality Strategy, Australian Government, 2015

technical assistance and training of health workers at service delivery points (SDPs), it would significantly improve the relevance of the program. This includes ensuring SRH services are youth-friendly, disability-inclusive and provide gender-based violence (GBV) care.

Limited progress has been made in training for integrated SRH services in any country through the TA Program, however some countries have advanced such training through other SRH programs, e.g. the Joint UNFPA, UNICEF, WHO RMNCAH program; IPPF programs; and those funded by their own governments. For example, in Kiribati the MOH/RMNCAH, IPPF and New Zealand Family Planning support Kiribati Family Health Association (KFHA) to conduct joint outreach (clinic, education and supervision services) with MOH staff to outer islands to train SDP staff in FP methods such as Long Acting Reversible Contraception (LARCs) and Emergency Contraception (EC), as well as conduct community awareness, outreach FP services and supervision of SDP staff. Tonga MOH has trained all doctors in implant insertion and will now train nurses in this method using government funds. Solomon Islands MHMS has trained all medical assistants in GBV care and will now train 150 nurses per year.

This demonstrates that training is not required for all SDPs as suggested in the MEF, and that targets may need to be lower. Lack of verification of need at the outset of the program means that many SDPs already have a person trained in FP, disability friendly and rights-based FP services. UNFPA should, as part of the 2021-2022 work plan negotiations, reconfirm with each MOH how many people need to be trained to achieve the target, and agree how many in each year will be trained over the next two years, to WHO standards.

In summary, the TA Program is designed to achieve relevant and appropriate outcomes in line with MOH policies and priorities and DFAT health, gender and development policies. However, due to implementation delays and challenges, it is uncertain how many of the related TA outcome targets can be achieved within the remaining 20 months of the program.

5. Effectiveness

What progress is there in completing activities for last year and this year?

What progress is there in achieving outcomes and objective and what factors influence whether or not you are meeting your output and outcome targets?

Are SRH/FP commodities regularly supplied and available at health facilities?

Is program implementation enhanced by the technical assistance provided; and through consideration of Gender and Social Inclusion (GESI) programming and activities?

The TA program is designed to contribute to transformative change in the lives of women, adolescents and youth across the six countries through the program objective to move unmet need for family planning in the Pacific towards zero by 2022. It also responds to the under-achievement across the Pacific in making progress towards universal access to SRHR.

At this mid-point, the TA program is not on track to achieve outcomes by program end due to the current underachievement of indicator targets. In addition, there remain critical administrative bottlenecks that will need to be resolved to avoid continued under-delivery. PSRO initiated some important steps and actions in late 2019, however, without more process changes, slow mechanisms are likely to continue to undermine performance.

5.1 Results

In order to assess program effectiveness and progress toward meeting objectives to date, a review of the Monitoring and Evaluation Framework (MEF) was conducted. The TA MEF has a total of 25 indicators. Three of these are high-

level impact indicators, measured on a national scale every 5 or more years: adolescent birth rate (ABR), need for FP satisfied with modern methods, and modern contraceptive prevalence rate (mCPR). Three indicators reflect modern contraceptive use on an annual basis: numbers of unintended pregnancies averted each year, couple years protection (CYP), and new acceptors of modern FP methods. The remaining 19 indicators are more programmatic and represent the three outcome areas of supply, demand, and enabling environment.

Results from 2018 through Q2 of 2020 were added together to obtain cumulative results. These were compared to the targets set for that same period (not program-end). Each indicator for each country was then assessed as to its level of progress, for a total of 150 indicator results assessed (25 indicators times 6 countries = 150 indicator results). Table 3 below shows progress toward targets using “traffic light” color-coding categories. Green reflects those results deemed achieved/on track; yellow those showing some/limited progress; and red showing very little/no progress. Those in the “grey” category were those that were essentially unable to be evaluated: either had no data, did not expect results for the time period, were deemed by the evaluators as too problematic to consider, and/or were high-level impact indicators and therefore excluded from mid-term consideration.

Table 3 shows the results of the 150 indicator results against targets, broken down in two ways: 1) consideration of all 150 results; and 2) consideration of only the 78 results that were most appropriate for evaluation and excluding the “grey” category results. When considering *all* results, 17% of targets were met or on track; 7% showed some/limited progress, 27% showed little/no progress, and 48% were excluded. When considering the subset of 78 results that were best able to be evaluated, 33% were on track, 14% showed some/little progress, and 53% were not on track.

Table 3. TA MEF Indicators: Status at mid-term (2018 through Q2 2020):

<u>Progress Result</u>	<u>Quantity</u>	<u>% Total</u>	<u>% among the 78 that are rated</u>
Achieved or /on track	26	17%	33%
Some/limited progress	11	7%	14%
Little progress/not on track	41	27%	53%
No data/results not yet expected / problem indicator / impact indicator	72	48%	
Total Indicators:	150		78
# Indicators that are rated:	78		

It is important to note that not being able to evaluate 48% of indicator results at mid-term is highly problematic. All indicators, with the exception of the three high-level impact indicators, and the few that are not expected to show results before end-of-program, should be fit for purpose at inception, measurable throughout the program, and routinely utilised for monitoring progress. At mid-point, a program should be 85% - 100% on track toward midterm targets. Given the status of the indicators at mid-point, the TA program is not on track to achieve targeted results by program end.

When analysing total MEF results to date by country, Kiribati has the highest number of results achieved/on track, at eight out of 25, or 32%. Tonga is next highest, at six (24%), followed by Samoa with five (20%) and Fiji with three (12%). Vanuatu and Solomon Islands have the fewest results, at one and two respectively. It is important to note that, due to the HFSRA not yet being conducted in Vanuatu and Solomon Islands, they have the highest number of grey/unmeasurable results, at 15 and 16, respectively. To date, among the four countries with HFSRA data, it appears that Kiribati is performing the best due to higher achievements and the fewest unmeasurable data points, followed by Tonga, Samoa then Fiji. None are performing to expectation. Annex 7 provides the cumulative data table with results to date.

The factors impacting the achievement of results include: complex and slow recruitment of PSRO regional office and field staff and RIPs; slow disbursement of funds at many levels (discussed further below): from UNFPA to IPs, from governments to IPs, from IPs to SRs - all resulting in significant non-implementation periods in 2018 and 2019; lack of time for implementation after late receipt of funds; and the UNFPA policy, until recently, of requiring unspent funds be returned to UNFPA at the end of the calendar year (sometimes after only four months of implementation in 2018-2019). This affected roll over from 2018 and 2019, but has since been remedied. RIPs report a long, complex and unsatisfying one-and-a-half-year process by UNFPA to recruit them, with proposed activities and budgets significantly reduced following submission of proposals.

While PSRO financial records are coded to differentiate between the various program funds budgeted and utilised, TA IPs have joint workplans with other programs, such as the MFAT PRSRHP, and some SRP6 activities that are jointly funded by SRP6 and TA. This allows Ministries to have a single, consolidated picture of activities planned with UNFPA, which reduces the burden on government partners. However, this can make tracking, checking and approval of workplans complex for DFAT given its accountability for public funds. PSRO reporting has not provided program specific tracking, monitoring and reporting after the initial AWP phase. Annual Reports in 2018 and 2019 generated by PSRO include a blend of achievements from the TA program as well as a range of non-TA programs. Because of this blend, non-TA activities are often reported as TA achievements (as in the Draft 2019 Annual Report), which can be confusing, and which makes attribution of results to programs difficult.

The main implication of the limited achievement results is that outcomes for beneficiaries have not yet been realised, as activities have not yet reached SDP staff, women and young people. The HFRSA assessment reports confirm that all four countries assessed so far have minimum packages of essential SRH services delivered by all levels of the health system to some extent. All have positive features of service delivery and service deficits. It is critical to apply outcomes from the HFRSA assessments to country-level priorities in 2021-2022 work plans and maximise efforts to address the deficits. Annex 6 provides the HFRSA data on SRH service delivery in Fiji, Kiribati, Samoa and Tonga (not available for Solomon Islands and Vanuatu as HFRSA assessment reports are not yet completed).

5.2 Implementation Rates

The limited achievement of results is related to the long planning and budgeting processes, fund disbursement delays, poor fund utilisation, low implementation rates and the late contracting of the RIPs. Slow implementation has been a challenge due to failure to have an inception period to: consult and prepare IPs for UNFPA administrative processes; finalise an implementation plan in collaboration with key stakeholders in each country; undertake time consuming and resource intensive HFRSA assessments for baseline data (two still to be completed); and to finalise the indicators, baselines and targets in the MEF. Key issues and challenges impacting implementation also include:

- Competing priorities of MOHs, especially in 2020 due to the COVID-19 pandemic, cyclone Harold in Vanuatu and measles outbreaks in Samoa and Tonga
- Complex routine UNFPA administrative processes, crippling past audit findings in a small number of critical partners which affected disbursements and slow financial processes of some governments
- Missed opportunities to bring to scale existing technical SRHR resources in-country.

Financial management and disbursement have improved in 2019 and 2020. For example, in 2019 UNFPA allowed IPs to roll over unspent funds at the end of the year; and 10 out of 14 IPs chose to do so, ensuring continuity of programming, while the remaining 4 opted to return the funds. The processing time for FACE forms was improved; audit issues were resolved for MHMS Solomon Islands, which is now receiving fund disbursements again; and all other IPs except for one are receiving fund transfers for IP implementation.

Although disbursement delays have improved in 2020, the mismatched financial years impacted planning and implementation. Government accounts close in July/August and government planning occurs in September for the new financial year. Previously, TA program tranches were disbursed after government accounts closed which

resulted in limited implementation in the second half of the year. UNFPA now ensures that two tranches are disbursed prior to the July/August close of accounts. This situation could be further improved with the development and finalisation of annual workplans and tranches before February.

Given that results will occur on the basis of activities led and implemented primarily by MOHs, the MOH IP implementation rates are critical. However, MOH implementation rates are low for Solomon Islands (4%), and Fiji (37%). Some countries did not enter the TA program until late (Vanuatu 2019) and some deferred activities until 2019 (e.g. Fiji, Solomon Islands). In most countries, the largest allocations to MOHs to date have been for the HFRSA assessments¹⁵ whereby all SDPs¹⁶ were surveyed for the level of integrated SRH services provided, availability of FP commodities and frequency of stockouts. This was a useful exercise to set baselines on which to measure results, but occurred late in the program, with two countries (Solomon Islands and Vanuatu) yet to conduct their assessments. It is also valuable data on which to build the MOH Packages of Essential SRH Services, and on which to plan for FP and integrated SRH training.

Annex 8 provides fund allocations, expenditure, and utilisation rates by country and year; and the utilisation rates by MOHs 2018-2020. These tables show that average fund utilisation rates 2018-2020 (as of 3 August 2020)¹⁷ by country are: Fiji 34%; Kiribati 25%; Samoa 42%; Solomon Islands 29%; Tonga 37%; and Vanuatu 26%.

The TA program is primarily a health program, with multi-sectoral support. The delivery of FP/SRH commodities and services is the responsibility of the MOH. Recognising this, the MOH must lead and be the primary focal point for the TA program. A more nationally tailored approach to planning, based on the countries' specific SRH needs and existing resources, would increase engagement by MOHs, improve alignment of activities with national plans, promote ownership of TA program implementation and maximise synergies with other programs.

Therefore, priority health related activities must include:

- SDP in-service training on integrated service delivery for rights-based SRH to international standards;
- SDP in-service training on LARCS, EC, and FP counseling
- FP method mix and reliable FP commodity supply to SDPs, including LARCs and EC;
- SDP in-service training on youth-friendly service provision; GBV care and disability inclusive services;
- Effective FP BCC on a national scale which is culturally appropriate for each country;
- Strengthening the MOH HIS, especially to track FP/SRH service utilisation;
- Comprehensive Sexuality Education (CSE) and information/awareness for out of school youth; and
- Family Life Education (FLE) for in-school students.

The TA PDD provides for collaboration with partners supporting the MOH HIS to ensure that FP/SRH data is collected and disaggregated by gender, age, sub-national level and disability. Initial HIS assessments should have established what data is already collected by the respective HIS in the development of the MEF; and to strengthen the capacity of health workers at all levels to collect, report, analyse and use data to track FP/SRH progress. Close collaboration and coordination is needed with the World Health Organisation (WHO), which is active in supporting the MOH HIS in the six TA countries (often through the DFAT bilateral health programs).

Enabling environment work, such as advocacy to promote FP/SRH as a vital women's health issue, and to ease restrictions on various contraceptive methods such as ECs, should continue. Policy work, (such as cervical cancer policy development where this has not yet been done), and the development of new strategies and protocols, should only be considered if requested by MOH and if the investment will clearly and directly contribute to improved SRHR/FP. An inventory of existing SRH guidelines, tools and training manuals is needed. An acceleration strategy is

¹⁵ For example, 90% of funds spent by Fiji MOH in 2019 was for HFRSA; and 26% of Kiribati MHMS funds in 2019 spent on HFRSA (PSRO COGNOS Reports).

¹⁶ Number of SDPs across all six countries: Primary SDPs = 754; Secondary and Tertiary SDPs = 94; Total = 848
Source: PSRO Updated HFRSA Results (2019-2020)

¹⁷ Source: UNFPA PSRO Finance Division, 3 August 2020

needed to ensure a 'supply' of integrated FP/SRH services and needs to be carefully planned in conjunction with the demand generation and promotion of FP/SRH services. FP commodities personnel and program staff must be included in national steering committee planning.

Recommendation 1: Strengthen and support intersectoral National Health Sector Committees, SRH Committees or Reproductive, Maternal, Newborn, Child, Adolescent Health (RMNCAH) Committees to maintain the role of planning and coordination for priority, needs-based FP/SRH activities across sectors (as outlined above). This may require hiring a temporary TA Program Coordinator, or other Support Staff, contracted through the MOH using TA funds. PSRO should continue the consultations with MOHs in this regard and ensure that MOH planned FP/SRH activities are part of TA workplans. MOHs would be responsible for contracting any SRs, and for data collection and reporting. Proposed non-health activities of other Ministries e.g. in the Education, Women's and Youth sectors could be included in multisectoral planning but with their own workplans and with disbursement of TA funds through the usual channels (i.e. through government systems).

Recommendation 10: PSRO in-country staff be tasked with compiling an inventory of local SRH resources, guidelines, policies and training courses related to FP/SRH that already exist in the health sector (MOH, MAs, CSOs), as well as in the education, women's and youth sectors; and assess the extent to which these resources meet international standards and consider the feasibility of immediate use.

5.3 Family Planning Commodities

The HFRSA assessments and analysis of the results of the Supplies Program, highlight the problem of stockouts of FP commodities with 36-80% of SDPs experiencing stockouts in the 6 months prior to the survey¹⁸. These were caused by problems with reliable/timely delivery by suppliers (particularly during the COVID-19 pandemic); difficulties getting supplies down to the SDP level; and failure of SDP staff to complete order forms in a regular/timely manner. Some countries currently use a 'pull' model for maintaining supplies whereby national storehouses rely on orders from the service level. This should be changed to an informed 'push' model (based on the use of relevant data from SDP staff) by all MOHs (which do not already have this) for the remaining period of the TA program to ensure supply when demand increases and to ease SDP staff workload.

Implanon implant (one rod, lasts three years) and Jadelle (two rods, lasts five years) must both be provided to ensure women can choose an implant method of their choice. MOHs report that since COVID-19 restrictions they have been unable to access Implanon from UNFPA; and strict regulations are in force by the Implanon suppliers to ensure that service providers are trained before the product can be ordered/purchased. IPPF MAs in Tonga and Vanuatu have Implanon-trained staff and procure Implanon through IPPF for Samoa and Vanuatu and this is in progress in Tonga¹⁹. Pregnancy testing kits, as well as EC, are essential for all SDPs. Depo Provera Sub Cutaneous (DPSC) also promises to be an innovation in FP for women and SDP staff, as it is self-injecting and does not require cold chain storage. Distribution of these products to SDPs should be a priority as soon as Implanon and DPSC can be imported into the Pacific, and staff trained in their use.

Recommendation 4: UNFPA work closely with the UNFPA Global Supplies Program to ensure that contraceptives are 'pushed' out to SDPs for the duration of the TA program using the 'informed push' model using relevant data provided by SDP staff to improve access, avoid wastage and ease the workload on SDP staff. to improve access but avoid wastage. Efforts should be made to ensure that implants (including both Jadelle and Implanon), Intra-Uterine Devices (UIDs) and ECs are included in the 'informed push' effort. Consideration could be given to using funds no longer required for low priority interventions to bolster support for commodity availability, particularly for training

¹⁸ HFRSA assessments were carried out in Samoa in 2018; and Tonga, Fiji and Kiribati in 2019

¹⁹ Though IPPF MA staff were trained on implanon in 9 countries, currently, only VFHA staff have completed implanon certification. The other IPPF MAs have been trained, but have not been able to complete certification due to challenges in receiving stock and completing the necessary number of insertions and removals.

and capacity building, and for ensuring commodity supply personnel are centrally engaged in MOH TA program steering committee discussions. This may require a contract amendment.

5.4 Technical Assistance

Technical assistance to support planning and implementation is provided through several PSRO Suva-based Technical Specialists plus four in-country SRH Specialists (Kiribati²⁰, Solomon Islands, Vanuatu and Samoa). TA Program Finance Assistants have also been placed in Fiji, Vanuatu, Kiribati and Tonga to assist Ministries with finances and acquittals. Fifteen staff have been recruited for the TA Program with staffing accounting for 36% of expenditure in 2019 and 26% in 2020 to date (see Table 7).

The roles and responsibilities of the SRH Specialists in PSRO field offices need to be reviewed to ensure optimal use of these resources. Their technical roles currently include management decisions at country level on what activities can or cannot be included in TA work plans, and what compliance measures need to be in place. This role should be transferred to the MOH multisectoral committees. Key issues to consider in the reviewed roles include reducing the administrative burden for IPs and making sure the SRH specialists have a revised and more focused set of key performance and impact indicators to routinely monitor.

Similarly, nine (9) international RIPs have been contracted to provide multiple technical inputs including: Community training; development of CSE resources, GBV training, advocacy for GBV, training health workers, VAWG disability guidelines, MISP training, SRH in emergencies module, SRH training; National FLE curriculum development, Cervical Cancer Policy development, SRH guidelines, In-service FP training; Data use, Build Supply Chain LMIS capacity; Disability needs assessment, HFRSA material reviews, Development of SRH/VAWG guidelines; BCC community engagement, BCC strategy, Data for policy makers, VAWG awareness messages; HMIS strengthening, M&E support, Strengthen midwifery curriculum; BCC Strategy implementation; Implementation of community-based CSE; and produce and distribute IEC materials. See Table 8 for a list of RIPs and their respective roles.

The RIPs' roles began in 2020 and the feasibility of them being able to engage in-country IPs remotely, and deliver country-specific products as originally planned by program-end is doubtful, particularly with COVID-19 travel restrictions expected to continue for a considerable time.

One of the RIP roles is to train trainers to conduct in-service FP training for SDP staff to increase method mix but this has yet to be systematically conducted, particularly for LARCS and EC. Planning for this included training of 'champions' (high level MOH and MA service providers who are trained in insertion and removal of LARCs and EC, who will lead teams of master trainers in-country once training of trainers in LARCs and other FP methods has been implemented. The master trainers cascade the training down to SDP levels. This new model may face challenges if MOH senior staff are already overloaded and have competing priorities.

For these reasons, governments in TA countries may wish to consider using IPPF MAs or other SRH service providers as a valuable existing resource for some technical assistance components of the TA. Current IPPF MA SRHR expertise and service provision in all six countries includes: clinic staff²¹ trained by IPPF to be providers of integrated SRHR services (including youth-friendly, disability-inclusive, and GBV care); expertise in FP methods (choice/method mix) including implants, IUDs and EC; the addition of new FP methods such as non-scalpel vasectomy offered by some MAs (e.g. KFHA); MAs are already trainers of MOH SDP staff, especially for outreach to rural and remote areas; and MAs host MOH nurses on rotation through MA clinics (e.g. Samoa). MAs have Memoranda of Understanding with MOHs (except in Samoa), and provide service data to them.

²⁰ The SRH Specialist in Kiribati left to take up a new post in June 2020. A new staff member started in the position on December 1, 2020

²¹ Clinic services include: 15 static, 19 mobile/outreach, 12 associate clinics (outreach services provided jointly at MOH health facilities) and 18 community-based distributors. Community based distributors also provide information and condoms. Note: Associate clinics are not currently supported due to travel restrictions.

Given the current workloads of MOH staff, particularly due to COVID-19, MAs could be utilised to provide face-to-face and on the job training without delay. MAs have indicated they have capacity to do this with extra funds, including to gap-fill clinic staff from existing pools of retired nurses while they conduct training. During consultations, MOHs reported that this was happening on a small scale--usually in association with outreach to rural and remote areas--in Fiji, Kiribati, Tonga, Samoa, Solomon Islands and Vanuatu (prior to COVID-19). Some MAs are sub-recipients of TA funds already (through MOHs) but this could be expanded to FP training roles where appropriate.

Changing the delivery modality for SDP in-service training to IPPF MAs and/or other service providers, has the potential to maximise the chances of rapid, quality training as a service provider to governments) especially in reaching hard to reach populations and locations (as included in the PDD)²². Using existing in-country resources is also an efficiency measure.

Recommendation 2: As part of their TA planning, it is recommended that MOHs give consideration to contracting existing in-country trainers (such as IPPF MAs, Medical Services Pacific in Fiji, or others) to conduct training on FP methods (particularly LARCs and EC); and integrated SRH (youth-friendly services, GBV care, disability inclusiveness) to global best practice standards. The benefit of MOH consideration of using contracted service providers is that it would reduce pressure on MOH medical staff for important, but non-critical work. A model using non-government trainers would also allow for follow up work and quality control efforts related to cascade training (which has inherent limitations) without overburdening government services. This will need to be a decision for each government to make based on its circumstances.

Recommendation 3: UNFPA negotiate with Nursing Councils and/or the South Pacific Board of Educational Qualifications (SPBEQ) to make all efforts towards ensuring that in-service FP/SRH training can be registered to enable a recognised certificate (across the Pacific) to be issued on completion, as occurred in Solomon Islands for the Jadelle Rollout.

5.5 Gender and Social Inclusion

Gender Equality and Social Inclusion (GESI) has been effectively integrated into the TA program through consideration of the GBV care needed by survivors of sexual violence; the SRHR needs and rights of persons with disabilities; the rights of young people to adolescent youth-friendly SRH services (AYFS); and through ensuring that men are targeted in behaviour change communication (BCC) strategies and IEC resources promoting FP/SRH. While some training for aspects of GBV care and AYFS for SDP staff has begun (some through TA program, government funded initiatives, and through the MFAT-funded PRSRHP), these activities will be implemented late in the TA program due to the late recruitment of RPs and the impact of COVID-19 on the program.

In summary, effectiveness of the program could be improved through a shift to targeting and accelerating high impact interventions, such as focusing on SRH/FP service delivery; making program-wide changes to speed up fund disbursement and improve utilisation rates; and reorienting interventions to focus on achieving FP outcomes. Effective use of existing SRH services and BCC resources in-country should be considered, particularly given the unforeseen impact of COVID-19 limiting the travel and effective use of RPs.

²² Output 1 of the PDD, p.43-44

6. Efficiency

Is the TA being implemented in an efficient way (time, personnel, budgets and resources) and using an appropriate modality?

Is the TA using appropriate, effective and efficient strategies and activities to progress outcomes; coordinated across IPs; and does the AWP ensure quality interventions?

Is the level and balance of funding to each country and its allocation between activities and outcomes commensurate with desired outcomes and the overall program objective?

Are the opportunities and bottlenecks being addressed by the program?

Consultations and analysis of key documents identified inefficiencies in planning, disbursement, coordination, staffing, management and resource utilisation.

6.1 Planning and Disbursement

While UNFPA is to be congratulated for ensuring that all IPs and SRs are held accountable for Australian taxpayer funds through rigorous financial controls, the current processes associated with planning, preparation of AWP and budgets, approval of plans, and disbursement of funds (as per UNFPA global guidelines) are inefficient. The vast majority of stakeholders consulted were dissatisfied with the disbursement processes, delays, mismatched financial years, and complex, inflexible administrative procedures. There was limited recognition of the steps taken by UNFPA this year to reduce the burden of these processes. It will be useful for UNFPA to understand the cumulative impact of these problems across years and that it will take sustained attention, innovation and improved responsiveness to ensure program transactions are made more efficient and partners feel better supported.

The TA program provides AUD 7.5 million per year for implementing activities across six countries, through 46 Ministries, Sub Recipients and Regional IPs. Despite the large number of IPs, the following table demonstrates the low fund utilisation rate.

Table 4 outlines expenditure to date. Total funding is USD 22,765,737 (AUD 30 million). To August 2020, only 33% of the total funding has been utilised. Expenditure is expected to increase significantly by the end of 2020.

Table 4: Expenditure to Date (August 2018 - August 2020)

Year	Expenditure (USD)	% of total
2018 (Aug – Dec)	936,737 ²³	4%
2019 (Jan – Dec)	3,070,430	14%
2020 (Jan - August)	3,482,759	15%
Total:	7,489,926	33%

Source: Data provided by UNFPA PSRO

Table 5 details expenditure from funds allocated from August 2018 to August 2020. Implementation rates are expected by PSRO to significantly increase from now onwards.

²³ Note: Finance figures are drawn from the 2018 and 2019 annual reports but could vary from verified final actuals which UNFPA present at country level.

Table 5: TA Program Allocations and Expenditure 2018-2020 (USD)

Year	Funds available	Expenditure	Amount Rolled Over	Implementation Rate
2018 (Aug – Dec)	5,668,934	936,737	4,732,197	16% utilised from funds available
2019 (Jan – Dec)	5,292,613 (plus 2018 rollover, 4,732,197 = 10,024,810)	3,070,431	6,954,379	30% utilised from funds available
2020 (Jan - Aug)	Rollover from 2019 = 6,594,379	3,482,759		52% utilised from funds available
Total	10,961,547	7,489,927		68 % utilised from funds available

Source: Data provided by UNFPA PSRO

For multiple reasons capacity and time to implement is often limited. UNFPA processes for planning and preparation of AWP are cumbersome and time consuming and AWP are submitted to DFAT for final approval. Key Informants reported that inevitably further revisions to the AWP and budgets are required. Coupled with the late disbursement of funds, implementation occurs much later than anticipated. The table below presents the timing of the receipt of funds, with allocated funds often arriving late in the quarter and even into the next quarters.

Examples of this include: Fiji MOH submitted FACE form December 2018 for Q4 funds (Oct – Dec 2018); MOF Samoa submitted a FACE form 28 Nov 2018 for Q3 2018 funds; and MOH Tonga submitted a FACE form AWP 11 June 2019 for Q1 2019. This situation continued in 2019 with MOH Tonga submitting a FACE form in December 2019 which took 31 days to process (Jan 2020) for Q3 2019 funds. The situation improved in 2020 when PSRO disbursed funds for six months instead of one quarter.

The table below presents the timing of the receipt of funds, after they are requested. The time to process FACE forms has decreased between 2018 and 2020. This demonstrates greater IP capacity to submit a quality FACE form that requires less back and forth revisions between UNFPA and the IP and also a speed up internally of UNFPA processing of FACE forms due to increased internal staff capacity.

Table 6: Number of days taken from Submission of Approved FACE Form to Receipt of Funds by IP

Country	2018		2019				2020	
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Fiji	-	9	25	2.5	8	3.67	-	2
Kiribati	-	-	3.5	49.25	49	3.5	10.33	9.67
Samoa	5	20	5	67	3	2	29	6
Solomons	1	4	-	-	28.5	1	12	5
Tonga	-	-	2	1	31	0	5	1
Vanuatu	-	41	-	2.5	7.5	1	-	1.17

Source: PSRO FACE Forms for TA Funds - AUA97

There are also delays when funds are transferred from IPs to SRs. Government processes extend the waiting time for funds to be transferred from MOF or other Ministry to Ministries or SRs. The PRSRH program evaluation provided an insight into this process with MWYSA²⁴ in Kiribati waiting 11-14 days; SI MOH funds to SRs taking 11-159 days; and Tonga MOH taking 53-83 days before SRs received their funds. These ongoing delays need to be addressed in the interests of accelerating implementation. In addition to these issues, there are other 'leakages' of implementation

²⁴ Ministry of Women, Youth and Social Affairs (MWYSA)

time from each year. UNFPA needs to invest additional time to identify and prevent any other such leakages for the program to work more efficiently.

Recommendation 7: By the end of 2020, after careful review and prioritisation of outputs, one regional (PSRO) (which includes the RIP plans) and six national master workplans (January 2021 – December 2022 – or August if DFAT cannot consider a four month implementation extension) that includes all activities from all partners be developed for the remainder of the program. The TA should also facilitate 24-month work plans developed by MOHs and other participating Ministries, and funds disbursed prior to February 2021 and February 2022. In addition, repayment of unspent funds should not be required during the 20-month period. Normal acquittal processes can apply but PSRO finance assistants (where they exist) should be responsible for increased support to IPs. This should be feasible if the number of IPs is reduced.

6.2 Coordination

In October 2019, a meeting was convened by PSRO where all potential IPs gathered to discuss the program and plan for implementation. This included the RIPs. This was late in the program and contributed to limited implementation in 2018 and 2019. PSRO hosts annual meetings with IPs; and prior to COVID-19 travel restrictions, PSRO TA visits were conducted on a regular basis. Considering the large number of IPs, coordination is vital but difficult across multiple Ministries, SRs and RIPs. In addition, PSRO is managing implementation of related programs implemented by largely the same IPs (Supplies Program, SRP6 activities). The main coordination point is the PSRO DFAT Program Coordinator followed by in-country PSRO staff (SRH Specialists, Program Analysts, and Finance Assistants). Ordinarily IPs would be informed about the program through the Annual Reports but so far, only one annual report has been finalised (for the 2018 calendar year) and not provided to many IPs.

Some stakeholders consulted reported that they did not have a copy of the PDD; did not know about the program beyond their own activities, and some could not say how their activities related to FP/SRH. Reducing the number of IPs, conducting national planning through MOHs, and focusing on FP/SRH service delivery through MOHs should strengthen coordination.

Regional IPs have the difficult tasks of obtaining data remotely for their respective roles. They admit that MOHs are struggling to manage requests from nine RIPs and their representatives. Effectiveness could be improved by having regular coordination meetings with RIPs so that information can be shared, strategies discussed and synergies maximised.

Recommendation 6: The nine Regional IPs meet as soon as possible, and regularly after that, to discuss strategies and share data with the view to improving monitoring of important indicators, preventing data collection duplication, reducing the impost on MOH time; and improving the efficiency of their technical assistance.

6.3 Staffing

Fifteen (15) UNFPA technical staff were recruited to support the TA program both in PSRO Suva and in-country. These included: key specialist positions in PSRO including a DFAT TA Coordinator, four in-country SRH Specialists (Tonga, Vanuatu, Solomon Islands, and one has since left Kiribati), and four in-country Finance Assistants (Fiji, Vanuatu, Kiribati and Tonga). See list in footnote below. The in-country PSRO staff (SRH Specialists, Program Analysts and Finance Assistants) have been essential with COVID-19 travel restrictions preventing travel by PSRO Suva staff to monitor and support implementation. Table 7 shows that expenditure on staffing 2018-2020 is 27% of expenditure to date.

Table 7: Expenditure on PSRO Operations and Staffing (USD)

Year	Expenditure PSRO HR/Operations	Expenditure Staffing ²⁵	Expenditure/year	% of UNFPA Expenditure on staffing as a function of total Expenditure/year
2018 (Aug-Dec)	6,190	6,190	936,737	1%
2019 (Jan-Dec)	1,203,915	1,115,058	3,070,431	36%
2020 (Jan-August)	995,859	917,843	3,482,759	26%
Total	2,205,964	2,039,091	7,489,927	27%

Source: Data provided by UNFPA PSRO

Total amount expended on all human resources (UNFPA staff, government staff, technical consultants and Regional IPs, was calculated to be USD 2,603,037 or 35% of total expenditure to date.

Table 8: Total Expenditure on all Human Resources for TA Program 2018-Aug 2020 (USD)

Year	Expenditure on UNFPA staff	Expenditure on government staff supported by TA program	Expenditure on technical consultants contracted by UNFPA to deliver on TA outcomes	Expenditure on RIPs and consultants to deliver on TA outcomes	Total
2018 (Aug-Dec)	6,190	4,604	25,686	31,227	67,707
2019 (Jan-Dec)	1,115,058	78,105	37,231	-	1,230,394
2020 (Jan-Aug)	917,843	**8,681	*50,172	**383,623	1,304,937
Total	2,039,091	91,391	113,090	419,455	2,603,037
% of expenditure to date	27%	1%	2%	6%	35%

*Actual spent as of 4 August

**Quarters 1 & 2 (partial Q3)

Prior reference to low Government spending and bottlenecks due to disbursement issues is exacerbated by the low capacity of Ministries, particularly MOHs dealing with COVID-19 preparations. In the interests of accelerating implementation, extra staff could be provided for the duration of the program.

Recommendation 5: DFAT consider enabling UNFPA to place more people into in-line positions in critical ministries to expand SRH activities quickly.

UNFPA has budgeted USD 5.3 million²⁶ for implementation by the nine RIPs. Their activities and funding allocations to date are detailed in Table 8 below.

Table 9: Role of RIPs and Funds Allocated to date

²⁵ Includes: SRH Specialist-Samoa, Research Assistant 1, Operations Quality Analyst, SRH Specialist-Kiribati, Program/Finance Assistant-Vanuatu; Program/Finance Assistant-Kiribati; Research Assistant 2; SRH Specialist-Vanuatu; SRH Specialist-Solomon; Program/Finance Assistant-Samoa; Program/Finance Assistant-Tonga; Administrative Assistant; Program Associate; DFAT Program Coordinator; Humanitarian Specialist.

²⁶ TA Program Draft Annual Report 2019, p.13

RIP	Role in TA Program	Funding allocated to date (USD)
IPPF/SROP/MAs	Community training; CSE resources, GBV training, advocacy for GBV, training health workers, VAWG disability guidelines, MISP training, SRH in emergencies module, SRH training	628,000
FPNSW	National FLE curriculum development, Cervical Cancer Policy development, SRH guidelines, In-service FP training, M&E	1,181,879
JSI	Data use, Build Supply Chain LMIS capacity	178,469
WEI	Disability needs assessment, HFRSA material reviews, Development of SRH/VAWG guidelines	219,298
Nossal	BCC community engagement, BCC strategy, Data for policy makers, VAWG awareness messages	497,801
Burnet	HMIS strengthening, M&E support, Strengthen midwifery curriculum	528,703
ABC	BCC Strategy implementation	106,689
Care International (Vanuatu)	Implement community-based CSE	140,000
World Vision (Vanuatu)	Produce and distribute IEC materials	80,000
Total to Date:		3,560,839

The key efficiency issue with the strategy of using RIPs is not related to the funding amounts, but rather the changed implementing environment due to COVID-19. These overseas-based organisations (excluding World Vision and Care International based in Vanuatu) are finding it difficult to collect data and have had to adapt to new ways of working including engaging with local consultants to advance these tasks. Recent RIP efforts to consult Ministries (particularly MOHs) has caused some stress for MOH SRH coordinators who already have heavy workloads and are implementing their own SRH programs. The contracting of some of the RIPs did not occur until July 2020 when COVID-19 restrictions were known. The use of some RIPs may now be unfeasible and it is likely to be more efficient to utilise existing resource people and organisations in-country, especially for FP/SRH training, BCC strategy development and implementation and community based CSE (See Section 6.4 – Use of Existing In-Country Resources).

Recommendation 8: DFAT and UNFPA assess the roles and responsibilities of the PSRO SRH Specialists in field offices, as well as the RIPs, given the changed operating environment. For example, an assessment is needed of the RIPs progress to date; feasibility of remote work in the COVID-19 context; what in-country resources exist; and determining if their work should continue, be paused temporarily, or strengthen the model of capacity building and support to national partners.

6.4 Use of Existing In-country Resources

The two main SRH resources in the six countries are the MOHs and IPPF MAs, as well as a range of other actors who provide valuable contributions to FLE and BCC. While some activities are already implemented by IPPF MAs, as SRs contracted through Ministry IPs and SROP (RIP), their technical expertise and resources as providers of quality assured, integrated and rights-based SRH clinical and educational services are not fully recognised in the program despite guidance included in the PDD ²⁷. Annex 10 describes the mandated SRH roles of both MOH and MAs.

²⁷ See Output 1 of the Program Design Document, p.43-44

Existing SRH expertise and service provision by IPPF MAs has already been explained in Section 5.4 and increased use of these resources for FP/SRHR training has been recommended. In addition, MOHs in all six countries are implementing BCC activities as part of NCD programming (e.g. Tonga Health). Some of these activities are outsourced by MOHs to community-based and private sector organisations in-country who may also be able to assist with FP/SRH 'demand' strategies. Organisations have been identified in Vanuatu²⁸ which have locally produced, culturally appropriate 'demand' products ready to implement. Culturally appropriate BCC activities and IEC resources, pre-tested in each country are essential for behaviour change and increasing demand for FP/SRH services.

Recommendation 9: Due to the necessary reliance on in-country skills and resources given COVID-19 travel restrictions, PSRO and IPs and RIPs reconsider the original approach regarding SRH/FP BCC activity implementation. This may require a heavier reliance on using and strengthening existing national capacity and resources, rather than full reliance on external RIPs. HFRSA assessment data provides updates on MOH progress in developing SRH tools and resources. This data should be used to inform any future activities related to training (which may have been provided) and the development of guidelines and policies (which may already exist). See Annex 6 for HFRSA assessment data.

6.5 Funding Allocations

PSRO advised that the country level fund allocations (Table 9) are determined based on SRH need. Need could be defined as: population, women of reproductive age and number of adolescents in which case Fiji and Solomon Islands would demonstrate the greatest need. If number of SDPs to be supported was the criteria, then Fiji, Kiribati, Solomon Islands and Vanuatu would demonstrate the greatest need. If geographical distance was the criteria, Kiribati, Solomon Islands and Vanuatu would require greater allocations for travel to the SDPs. The criteria need to be clearly explained in reports, including allocations of funds and tasks to IPs/RIPs.

Table 10: Allocations by Country 2018-2020 (August)

Year	Total Alloc	Fiji	Kiribati	Samoa	Solomon Islands	Tonga	Vanuatu	RIPs	PSRO
2018	1,615,286	87,401	-	82,000	80,000	-	88,096	61,398	1,266,391
2019	3,568,781	402,298	380,780	421,303	162,982	336,926	302,400	-	3,678,092
2020 (Aug)	8,163,864	399,204	273,803	128,304	336,129	353,003	699,827	3,340,839	2,633,354
Total	15,515,931	888,903	654,583	631,607	579,111	689,929	1,090,323	3,402,237	7,577,837
% total	100%	6%	4%	4%	4%	4%	7%	22%	49%

Source: PSRO Summary of Allocation and Expenditure

Given the necessary focus of the TA program on FP/SRH service delivery, and the training needs of rural, remote and outer islands' SDP staff, countries with a large number of SDPs and remote SDPs should be prioritised e.g. Kiribati, Solomon Islands and Vanuatu. The cost of dissemination of information and IEC should be factored in, including local groups such as civil society organisations (community leaders, women's and youth groups) who can be engaged and trained.

Fund allocation for all three outcome areas was intended to be almost equal (20% on each of the three Outcome areas and 40% on PSRO costs including staffing costs)²⁹. Annex 8, Table 3 estimates the proportion of expended funds by outcome/output in 2018-2019. This shows that 26% was spent on Supply; 8% spent on Demand; 27% spent on Enabling Environment and 39% spent on management. The recommendation for an increased focus on FP Supply and Demand (see recommendation 10 below) will also require an increase in the proportion of funding for these

²⁸ Care International's 'Stori b'long Yumi' which has been endorsed by MOH, Vanuatu

²⁹ As per the Project Design Document: UNFPA human resources (31%), planning and M&E (3%) and indirect costs (8%). PDD p.72. Therefore 58% allocation for implementation of the three components.

activities. Some funding for Outcome 3 activities (Enabling Environment) could be reduced from the TA program budget, however, funding for advocacy for FP/SRH at national/political levels SRHR policy support and data collection/analysis through strengthening the MOH HIS should continue. National population monitoring through NSOs (DHS, MICS, Census etc) can be supported by other development partner programs and analysis still used for TA MEF results. Section 5.2 of this report lists priority activities; and Annex 9 lists interventions which could be retained and those which could be dropped in the interest of achieving targets and FP-related results within the remaining timeframe of the TA program.

Some of the planned activities from all output areas, if discontinued following review, could effectively be taken forward by other funding streams and programs (e.g. MISP training to continue under IPPF SPRINT II; other humanitarian interventions continue under SPR6, strengthening of national statistics agencies under SPR6 and other development partner programs; and GBV training (apart from GBV care from health facilities) under Spotlight/SPR6). Note: MISP training and kits will be provided for SDP staff as part of integrated SRHR.

Recommendation 11: The TA program needs to focus predominantly on the two outcome areas of FP *supply* and FP *demand* generation for the remainder of the program and set aside some activities focused on strengthening the enabling environment. All activities should be assessed for their value in contributing to a direct impact on individual FP use. This will help ensure that unmet need for FP decreases by program end.

6.6 Administrative Processes

Almost all stakeholders interviewed stated that UNFPA's administrative processes (as useful as they are in administering a program) can overwhelm IPs. The placement of financial assistants (G6) has assisted with financial issues but planning and reporting are still onerous and time-consuming on top of the IPs own program administrative burden. The significant time required to complete the forms and revisions reduces implementation time and has precluded some potential IPs from joining the TA program.

Due to the drawn-out process for recruiting RIPs, with some negotiations beginning in 2018 and some not finalised until July 2020, and with proposed activities and budgets considerably revised, several potential IPs and RIPs withdrew from the process. These were organisations with much to offer in the SRH sector, particularly targeting young people and locally produced IEC and BCC resources. These issues have contributed to the slow implementation, the inefficient use of financial resources and personnel, and missed opportunities to leverage against existing programs and scale-up the use of local, culturally appropriate resources.

In summary, program efficiency would be enhanced through streamlining planning and administrative processes through MOHs' existing planning and coordination mechanisms; reducing the number of IPs by focusing on MOHs and their partners; improving communication and coordination with a reduced number of IPs; ensuring SRH Specialists routinely monitor a clear set of key performance indicators; reviewing the roles of the RIPs given COVID-19 restrictions and MOH capacity to engage; and utilising existing in-country resources for the priority 'supply' and 'demand' components for the remainder of the TA program.

7. Monitoring, Evaluation and Reporting

Is the Program Design well-articulated and sufficiently well-structured to ensure UNFPA is clear on outcomes and how to achieve them?

M&E framework – is it fit for purpose; aligned with country M&E processes; activities and outputs effective to achieve outcomes and impact; need revision?

7.1 Monitoring and Evaluation Framework

Based on a detailed review, the TA MEF, is assessed as being inadequate and not fit for purpose. Forty-eight percent of indicator results are unable to be measured at mid-term. While a small number of these indicator results would not be appropriate to measure at mid-term, such as high-level impact indicators, the vast majority are unmeasurable due to being problematic indicators, and/or not having any result data collected against them. Part of the problem is a heavy reliance on the newly introduced and recently conducted HFRSA, which was relied upon for baselines well into the program, and which awaits completion in two of the six countries. See Annex 7 for updated MEF.

Key overarching issues with the MEF are:

- **Issue:** With the ultimate goal of the TA program to reduce unmet need, unmet need for FP should be an indicator, but is not. It is not possible for the program to assess progress toward “moving unmet need for FP toward zero” if it does not know where it started and what direction it is going. It is also important to note that unmet need is not the inverse/opposite of need satisfied. Unmet need for family planning is defined by WHO³⁰ as being the number of women of reproductive age (15-49) with an unmet need for family planning / number of women of reproductive age. However, progress toward achieving SDG target 3.7 - universal access to SRH care services - will be assessed using indicator 3.7.1, which is specified as the proportion of women who have their need for family planning satisfied with modern methods of contraception, among women of reproductive age (15-49 years) who express a need for family planning. This is not a quantitative indicator and rather than waiting for the next DHS, PSRO’s metadata definitions suggests that an alternative collection of this data be considered as a survey under the MOH HIS. This should be considered on a country by country basis.
 - **Action:** Revise MEF and use the Metadata collection definition to utilise the SDG 3.7.1 indicator (TA indicator 3) and consider qualitative data collection through the MOH HIS.
- **Issue:** There is no indicator measuring the critically important outcome of number of people accessing/receiving FP services. This should drive the program, as that is the primary way people can access modern contraceptives, which is the primary way unmet need will decline. The program must be able to see increases in clinical FP services on a quarterly basis.
 - **Action:** Include this in the MEF. Most MOH HIS collect this data as does IPPF MAs.
- **Issue:** The MEF in the PDD does not include the rationale and formulas applied for increases/decreases in targets over time. It would be very helpful to know how these were calculated (and the research base for using them), so that all stakeholders (donor, PSRO, IPs/SRs) are fully aware, agree, and commit to the targets. Some targets and results fluctuate widely, and appear to be extremely unrealistic in some cases (Indicators #1, #5)
 - **Action:** In revising the MEF, include the full rationale for all metrics as an Annex in Annual Reports.
- **Issue:** In some cases, in an effort by PSRO to “contextualize” results (e.g. using self-reporting of YFS rather than the data point reflecting YFS meeting international standards), the targets were not also “contextualized” accordingly, resulting in the appearance of being vastly over-achieved. The tendency to input baselines as “0%” does not take account of prior work/achievements. Not every new program starts with zero -- SDP, healthcare worker, and target population realities/data do not go back to zero -- they have an actual level they start with, regardless of programs coming and going, and should be recognised and built upon.
 - **Action:** Reflect the HFRSA results and MOH HIS data in TA MEF and develop targets accordingly.
- **Issue:** It is not evident that existing MOH FP/SRH indicators have been considered and targets from these indicators applied to the MEF.
 - **Action:** As above, reflect MOH HIS SRH data in the MEF and assist MOHs to develop realistic targets
- **Issue:** Some indicators’ wording does not fully reflect critical elements of the indicator found in the Metadata description; some are too vague or subjective to be measured; some indicators simply cannot be measured: #13, #19, #23
 - **Action:** Realign wording to be consistent with Metadata to improve accuracy; and recalculate targets where necessary with MOH

³⁰ <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/6>

- **Issue:** Several indicators rely on accurate HIS data, which can be unreliable.
 - **Action:** Collaboration is needed with projects and agencies working on the MOH HIS, such as WHO, Burnet and World Bank to ensure HIS capacity is strengthened, particularly for FP/SRH
- **Issue:** The MEF is not well maintained or fully utilised by PSRO: baselines should not be input as results in subsequent years, as it is unclear (misleading) as to whether those are new results, or a repeat of the baseline; words of explanation should not be input where result numbers are expected; important data collection information is relegated to subtle/hidden comments (see comments on MEF Progress to Date – Annex 7).
 - **Action:** As part of creating a results-based culture, PSRO should make the MEF a daily management tool that guides implementation of the program. If an intervention does not create a result that can be captured in the MEF, then it should not be implemented.

In summary, the MEF requires significant revision, including the addition of more nationally-tailored indicators that are currently being captured by country HIS systems, as well as some proxy indicators to assist with high-level impact indicators (such as adolescent birth rates from annual birth data). PSRO needs a senior level MEL expert to lead this work.

Recommendation 12: The MEF should be revised and finalised as an urgent priority, and prior to the start of the 2021-22 work plans (to guide activities), to ensure that output, outcome and impact indicators are included and measurable; that relevant FP data can be collected and reported by the MOH HIS; and that the strategic interventions each be allocated indicators to ensure advancement of these activities. Some indicators may require national tailoring to accommodate differences in SRH data currently collected by the country level HIS.

Recommendation 13: PSRO contract a senior level monitoring, evaluation and learning (MEL) technical specialist as soon as possible to manage TA Program MEL and create and enable a results-oriented MEL institutional culture within UNFPA.

8. Governance

Are arrangements providing appropriate oversight and sufficient; been adhered to; managing risks and responding to lessons learned?

What are the strengths and weaknesses of UNFPA's planning, management, implementation, risk management and reporting processes for TA; and how could they be improved?

What is the impact of and implications for COVID-19 on implementation and achievement of outcomes and accountability?

Governance in the TA program, as designed in the PDD, consists of the TA Steering Committee comprising DFAT and PSRO program management team. There has been effective communication and collaboration between PSRO and DFAT Canberra with six monthly strategic guidance and progress reviews. However, there has needed to be some accommodation on both sides as UNFPA commonly manages core funding for their planned program and the TA program required a complete reorientation of the work of UNFPA PSRO. Similarly, DFAT is not accustomed to adapting to the stringent administrative procedures required by UNFPA, which are impacting progress.

The PDD also made provision for technical governance through a TA Technical Team (TATT) with quarterly meetings to oversee TA technical activities and ensure regional agencies' technical capabilities are capitalized upon in a coordinated and efficient manner. The TATT was to comprise UNFPA Technical Advisers and Programme Specialists and DFAT representatives from Health Policy Branch, DFAT Suva Post, with co-opted members such as UNICEF, WHO, IPPF, Council of Regional Organisations in the Pacific (CROP) agencies and MFAT as needed. There is no evidence that this mechanism is functioning. Given the need to review technical inputs into the remaining years of the TA program, this team should be convened and meet at least every six months.

Recommendation 14: The TA Technical Team (UNFPA Technical Advisers and Programme Specialists, DFAT Canberra, DFAT Suva, IPPF, WHO, UNICEF, Council of Regional Organisations - CROP agencies etc.) meet every six months to review technical inputs³¹ into the final years of the TA program, particularly SDP SRH training, BCC strategies and dissemination, and MOH HIS strengthening.

Management arrangements also provided for governance relationships between the PSRO Management Team and the MOH coordination mechanisms i.e. Fiji Reproductive Health Committee, Kiribati RMNCAH Committee, Samoa Health Sector Coordination Committee, Solomon Islands' RMNCAH Committee, Tonga Reproductive Health Committee and Vanuatu RMNCAH Committee. These are all intersectoral committees which could be used to coordinate TA program planning. This arrangement was established as the planning and coordination mechanism but has not been followed since the RMNCAH program ceased (2019) and other committees lapsed. See Recommendation 1.

8.1 COVID-19 Impact

Ministries of Health should be at the forefront of TA program implementation; and are also key in the preparation and response to COVID-19. MOH staff have been re-deployed to the COVID-19 response; some staff have been laid off; and Ministries are requesting adjustment, delay or re-scheduling of planned activities. The MTR team found it, understandably, very difficult to engage MOHs in the consultations for the MTR.

PSRO anticipates that only 50% of planned implementation in 2020 will be possible; particularly with the limits on the sizes of groups for training, meetings and community mobilisation activities. The Pacific is embracing virtual meetings however, internet connectivity is challenging especially for use of videos in meetings.

All reprogramming conducted by PSRO related to COVID-19 should be reconsidered in light of the recommendations from this MTR. The ongoing COVID-19 challenge follows years of low achievement and limited implementation in the TA program.

9. Conclusion

Despite timing issues and a challenging modality for implementation, the TA program is the right program to support FP/SRH in the right Pacific countries. While it was designed as a health program as described in the PDD, it is being implemented in tandem with the UNFPA SRP6 which is much broader. This has diluted an appropriate focus on FP/SRH service delivery and the fact that results will be achieved through health sector implementation.

The first half of the program was characterised by the lack of an inception period to plan properly for implementation and finalise the M&E framework; delayed recruitment of staff; cumbersome processes and seemingly unsolvable administrative challenges; too many implementing partners; and Pacific health sectors pre-occupied with disasters, pandemics and NCDs. The second half of the program will suffer from the ongoing COVID-19 pandemic and the restrictions and workloads that accompany it, especially for the MOHs. It will take longer than twenty (20) months to get the TA program back on track.

Recommendation 15: Given the slow implementation of the TA program in the first 2 years of implementation, DFAT consider a four month implementation extension to enable 2 year work programs and also agree an option for a 12 month no-cost extension to the program for the period January to December 2023. If a 12 month no-cost extension is granted, funds for workplans for 2023 should be disbursed before February 2023 and repayment of unspent funds from 2022 should be allowed to be rolled over. The trigger for a decision on exercising the 12-month extension period would be DFAT's decision based on 2021 and 2022 performance reports and made no later than 30 April 2022.

³¹ As planned in the PDD

The TA program is a **regional program** attempting to roll out a suite of FP/SRH interventions across all six countries. This modality is difficult for UNFPA to manage and for IPs to implement, especially during the COVID restrictions. To maximise efficiency and effectiveness, more consideration needs to be given to: specific progress of each MOH ensuring that SRHR is embedded in national UHC packages and policy documents; and what resources exist in-country that could be supported to accelerate implementation. Lessons learnt for DFAT may be that FP/health programs are more effective if closer and more specific to country needs.

Annex 1: Terms of Reference

(Version 6 August 2020)

Position Title:	Mid Term Review of the \$30 million Transformative Agenda for Women, Adolescents and Youth: Towards Unmet Need for Family Planning by 2022 (Transformative Agenda)
Program:	Transformative Agenda for Women, Adolescents and Youth: Towards Zero Unmet Need for Family Planning by 2022
Term:	<p>Evaluation timeframe: 30 July to 30 November 2020</p> <ul style="list-style-type: none"> • Team Leader: up to a maximum of 60 days for the Team Leader • Technical Specialist: up to maximum of 10 days • 6 National Consultants for 6 countries: up to a maximum of 18 days for each national consultant
Reporting to:	<p>This ToR is under an SHS Type 1 Service Order whereby SHS quality assures all deliverables prior to submitting them to DFAT (unless agreed by SHS in writing).</p> <p>The SHS is responsible for the quality assurance of key deliverables. The adviser/s will submit the agreed deliverables to the SHS Advice Desk and copied to the designated SHS technical lead on the specified dates unless other arrangements are confirmed in writing. The designated SHS technical lead will liaise with the advisor to ensure the final output meets DFAT requirements. Deliverables should be submitted to the SHS no fewer than 3 working days before the agreed deadline for submission to DFAT, to allow for this process. Draft outputs are not to be circulated beyond key counterparts until the final versions have been approved by the SHS.</p> <p>The Adviser will report to:</p> <p>SHS: Jessica Gilmore, Director SHS, Jessica.Gillmore@shsglobal.com.au</p> <p>DFAT: Sally Mackay Sally.Mackay@dfat.gov.au, Assistant Director, Global Health Policy Branch</p> <p>The Assistant Secretary of the Global Health Policy Branch is Kate Wallace.</p>
Background:	<p>In June 2018, DFAT commenced a new partnership with UNFPA, the \$30 million Transformative Agenda for Women, Adolescents and Youth in the Pacific: Towards Unmet Need for Family Planning 2018-2022 (the Transformative Agenda). The Transformative Agenda is implemented in six countries – Fiji, Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu.</p> <p>The Transformative Agenda is designed to contribute to transformative change in the lives of women, adolescents and youth across the Pacific by 2022 through the program objective to move unmet need for family planning in the Pacific towards zero by 2022. PICTs with a high unmet need for family planning require both demand and supply side investments and promotion of a conducive environment that supports sustainable, evidence-based interventions. The Transformative Agenda goal and objective will be achieved through the delivery of three complementary and synergistic Program Outcomes, namely:</p> <ul style="list-style-type: none"> • Increased and improved supply of integrated SRH information and services, particularly for family planning • Increased demand for integrated SRH information and services, particularly for family Planning

- More conducive and supportive environment for people to access and benefit from quality SRH, especially contraceptive choice

The Transformative Agenda is DFAT's single largest investment in SRHR and DFAT's largest ever program with UNFPA. As such it has a high priority for the Australian Government and its performance is of strong interest to a wide range of stakeholders. The Transformative Agenda accounts for 75 percent of total resources available to UNFPA for its operations in the Pacific. As a result, this independent evaluation of the Transformative Agenda will represent an assessment of the performance of a significant majority of UNFPA's overall program across the Pacific. The TA design is nested within UNFPA's Sub Regional Plan Cycle 6 (**SRP6**) (effectively UNFPA's 'country plan' for the region).

The Transformative Agenda investment is a response to the striking under-achievement across the Pacific in making progress towards universal access to sexual and reproductive health rights (SRHR). Key SRHR indicators are either stagnant or deteriorating in many countries in the region, particularly adolescent birth rates.

The Transformative Agenda is interlocking with UNFPA Supplies' work in the Pacific region. UNFPA Supplies works in all 14 Pacific Island Countries and Territories (PICTs), providing an estimated 95% of all Family Planning commodities and providing some training for supply chain management. The Results Framework for the TA and the UNFPA Supplies Pacific Results framework share multiple common indicators. To determine progress on achieving the TA, the Team Leader will also need to review both the UNFPA Supplies Pacific Results Framework and the 2019 Annual Report.

DFAT requires an independent, clear and concise mid-term review (MTR) to assess the extent to which the program is on track at the mid-point and capable of achieving the end-of-program objective and outcome targets.

Due to the impact of COVID-19 and travel restrictions, the MTR will be a desk-based process for the Team Leader (TL) and Technical Specialist. To support the TL and Technical Specialist, 3-6 national based consultants in the 6 TA countries will be mobilised and tasked to identify and provide quantitative, and where possible, qualitative information at the direction of the TL for up to a maximum of 18 days each, subject to finalisation of the evaluation methodology. These national based consultants are likely to be the same consultants used by MFAT in its recent terminal evaluation of its Pacific Sexual and Reproductive Health Program due to the similarities between the two programs and common stakeholders across the programs. The Evaluation Methodology should build upon the work done by the parallel MFAT program (described below) and should include specific terms of reference and ways of working for national consultants.

Parallel MFAT terminal evaluation

DFAT's Transformative Agenda program has a high level of complementarity with the New Zealand Ministry of Foreign Affairs (MFAT) - funded Pacific Sexual and Reproductive Health Program (PRSRHP) (2014 – September 2020). The programs are quite similar in terms of their objectives, activity scope and target countries although MFAT's program is delivered in five countries, whereas the TA delivers in six (it excludes Fiji). Many of the issues that impacted the PRSRHP, as identified in its 2017 MTR, are common to the Transformative Agenda. MFAT is about to start a terminal evaluation of the PRSRHP, working collaboratively with the national consultants to gather data and information to inform a desk-based analysis. The MFAT consultant has previously supported DFAT's TA work through contributions to TA Steering Committee meetings and evaluation of the 2019 Annual Report.

UNFPA has tended to view MFAT's PRSRHP program and DFAT's Transformative Agenda program as funding streams for the SRP6. Both donor-funded program scopes overlap with or 'nest within' the SRP6. This has previously made determination of the contribution and performance of MFAT's program difficult and it is possible that this could be common to the DFAT MTR of the Transformative Agenda.

In order to maximise synergies, enable sharing of lessons learned and promote harmonious work between the largest SRHR development partners in the Pacific, DFAT would like to engage the MFAT consultant to provide inputs to the review (as the Technical Specialist), reporting to the MTR Team Leader.

Because of the limitations on international travel, DFAT will appoint national consultants to support the TL, at his/her direction, to collect qualitative and quantitative data, conduct interviews using the methodology developed by the TL, hold focus groups or other meetings as required. MFAT has agreed that its terminal evaluation will use this approach and the MFAT TL will train and supervise up to one national consultant in each country (potentially one consultant may be able to deploy to other Pacific countries as Pacific 'travel bubbles' open between Fiji, Kiribati and other islands). DFAT has a preference to use these same consultants to the extent practicable, but this will impact on MTR timing (TBA – awaiting advice from UNFPA).

Opportunity for concurrent review of draft report by UNFPA, MFAT

DFAT will facilitate a review of the TA draft report prior to its distribution to partner governments for their comment. DFAT's preference is to facilitate this process concurrently with review by MFAT and/or MFAT's consultant appointed to undertake the PRSRHP program, and for both parties to enable the other to have visibility of responding comments.

UNFPA Sub Regional Program

The Transformative Agenda is described as 'nesting within' UNFPA's Sub Regional Program for the Pacific (SRP6). The SRP6 aims to achieve universal access to sexual and reproductive health and reproductive rights and reduce maternal mortality and morbidity to accelerate progress on the ICPD/Sustainable Development Goals agenda, and to improve the lives of women, adolescents and youth in PICTs.

Outcome 1:

Output 1: Strengthened access to quality integrated sexual and reproductive health services for women, adolescents and youth, across the development humanitarian nexus

Output 2: Increased national capacity to design and implement community and school-based family life education programmes.

Outcome 3:

Output 1: Increased national capacity to address and promote gender equality and the empowerment of women and girls including their reproductive rights and need for ending violence against women

Output 2: Strengthened integration of ending violence against women in the national health sector

Outcome 4:

Output 1: Strengthened national statistical systems to ensure increased availability, analysis and utilization of high-quality, disaggregated ICPD/Sustainable Development Goals-related data, with

	<p>a focus on informing national and sectoral priorities, policies and programming in development and humanitarian situations.</p> <p>Output 2: Strengthened use of demographic intelligence to improve policies, programmes and advocacy</p>
Purpose and objectives:	<p>The purpose of the mid-term review is to assess the continued relevance, effectiveness and efficiency of the Transformative Agenda and the progress made towards achieving its planned objective - to move unmet need for family planning in the Pacific towards zero by 2022.</p> <p>UNFPA and DFAT previously mutually agreed to a Monitoring and Evaluation Framework that captures the intended outcomes and impact of the Transformative Agenda Program. However, it still does not have a completed baseline for 2017, and a number of the indicators cannot be collected on an annual basis.</p> <p>The MTR report will outline key findings supported by evidence and provide recommendations on any changes, modifications or improvements to implementation approaches and activities required to enable the program to achieve sustainable outcomes and impacts. Findings and recommendations will focus on the structure, outcomes, duration and scope of the program within its current funding envelope.</p> <p>The preliminary high-level questions to be considered and addressed through the MTR, for further development and confirmation with the MTR team through the Evaluation Plan (Milestone 1) are as follows:</p> <p><u>Relevance:</u></p> <p>Does the program remain strongly relevant to Pacific development needs and specifically reducing the level of unmet need in the region for family planning in each of the TA countries?</p> <p><u>Effectiveness</u></p> <ul style="list-style-type: none"> • Is the Transformative Agenda on track to achieve its overall objective and related program outcomes? • To what extent have the program outcomes already been achieved? How likely is it that end-of-program outcomes will be achieved? • What have been the major factors influencing the achievement or non-achievement of the expected objective and program outcomes? • Is the Program Design well-articulated and sufficiently well-structured to ensure UNFPA is clear on outcomes and how to achieve them? • To what extent is the investment impacting improved access to and uptake of modern methods of family planning? • To what extent is the Transformative Agenda influencing national SRH policies and programming? What has changed as a result? • Is there evidence of the Transformative Agenda influencing community attitudes to SRH acceptance and uptake?

- Is the technical assistance provided to participating countries high-quality? Is the technical assistance relevant and responsive to local needs? Is it an effective and efficient model?
- To what extent has the Transformative Agenda considered and integrated Gender and Social Inclusion (GESI) in programming and activities? Are there examples of good practice in relation to GESI? In what ways could GESI be improved across program implementation?
- How sustainable are the Transformative Agenda outcomes beyond the end of the program? What are options for improving the sustainability of these outcomes?

Efficiency

- Is the Transformative Agenda using appropriate, effective and efficient strategies and activities to progress outcomes?
- Does the current annual workplan provide a sound basis for ensuring implementing partners, including government organisations, implement quality interventions?
- Is the level and balance of funding to each country and its allocation between activities and outcomes commensurate with desired outcomes and the overall program objective?
- Is the Transformative Agenda being implemented in an efficient way (time, personnel, budgets and resources)? Have any issues emerged from which lessons can be learned?
- Is the Transformative Agenda effectively supporting strengthened coordination amongst implementing partners and key stakeholders to improve SRHR and the sustainability of Transformative Agenda interventions?
- Are the implementation modalities appropriate? What needs to be modified to make the program focused and ensure it can achieve its objective?
- Which partnerships under the program are demonstrating the most impact and performance and which partnerships are under-performing and could be scaled back to maximise efficiency with the remaining budget?
- What are the opportunities and bottlenecks that need to be addressed by program?
- Make recommendations to focus program performance against metrics that can clearly be methodically collected, and enable the program to be assessable over its remainder.

Governance, Reporting & M&E

- Is the Transformative Agenda M&E framework adequate and fit for purpose? To what extent is it aligned with country M&E processes? Are there any recommended revisions to the M&E framework and approach?
- Do UNFPA and their implementing partners have adequate systems and processes in place to monitor, capture and report on the extent to which activities and outputs are contributing to the achievement of outcomes and impacts?

	<ul style="list-style-type: none"> • Are the governance arrangements appropriate and sufficient? Have agreed Transformative Agenda governance arrangements been adhered to and are they proving appropriate for overseeing the program, responding to lessons learned and managing risks? • What are the strengths and weaknesses of UNFPA's planning, management, implementation, risk management and reporting processes for the Transformative Agenda? How could they be improved? • In light of the COVID-19 pandemic, what if any changes should be made to the way the program is implemented including its focus, modalities and partnerships? What implications does COVID-19 have for the achievement of program outcomes, and program accountability?
Duty Statement:	<p>The MTR team will consist of the following consultants:</p> <ul style="list-style-type: none"> • Team Leader with experience conducting health evaluations in the Pacific • Technical Specialist with SRH expertise and experience • 6 National Consultants with experience and knowledge of the local SRH context in the 6 countries the UNFPA Transformative Agenda operates <p>The Team Leader will be responsible for:</p> <ul style="list-style-type: none"> ○ Reviewing all key documents provided by DFAT ○ Developing the Evaluation Plan including the evaluation methodology and addressing, as appropriate, any feedback/inputs from DFAT and other partners ○ Leading and managing evaluation team inputs and responsibilities ○ Managing the MTR process to effectively utilise the expertise available within the team to meet the MTR objectives ○ Leading, managing and directing review activities and representing the review team as required ○ Remotely leading, supporting and facilitating interviews and consultations with stakeholders (as required) in the six TA countries using web-based platforms and innovative tools and working in close coordination with the national consultants ○ Leading and facilitating team discussions and reflection and ensuring the MTR team are regularly updated ○ Working closely with the national consultants to identify key stakeholders for consultation and schedule interviews and consultations ○ Ensuring MTR alignment with DFAT policies and guidance, including DFAT's M&E standards, and the requirements of the Terms of Reference ○ Collating, synthesising and analysing all primary and secondary data and information required for the MTR ○ Developing all key deliverables and managing revisions, quality assurance and finalisation of deliverables <p>The Technical Specialist will be responsible for:</p> <ul style="list-style-type: none"> ○ Reviewing key documents provided by DFAT and sharing relevant documents from the MFAT evaluation (if possible) ○ Contributing to the development of the evaluation methodology (including refinement of the key evaluation questions and sharing lessons from the MFAT PRSRHP review) with an

	<p>emphasis on using relevant knowledge and experience related to SRH to inform the MTR approach</p> <ul style="list-style-type: none">○ Participating in MTR team discussions and reflections as required○ Provide technical inputs and review of the MTR report <p>The National Consultants in will be responsible for:</p> <ul style="list-style-type: none">○ Managing in-country consultation logistics including scheduling meetings and managing communications with relevant stakeholders○ Liaising with all key partners involved in the MTR including the MTR team, UNFPA, government and other partners○ Supporting the MTR Team Leader with contextual information relevant to the local operational context○ Participating in and co-facilitating consultations and interviews with key stakeholders in-country○ Collecting and collating country level quantitative and qualitative data and information required for the MTR○ Assisting in drafting and revising Aide Memoires as directed by the Team Leader		
Performance Outcomes and Deliverables, with dates:			
	Indicative Date	Milestone	Verification Indicator
	9 August 2020	Draft MTR Plan submitted to SHS	
	10 August 2020	Draft MTR Plan submitted to DFAT	
	12 August 2020	Feedback on MTR Plan received from DFAT	
	13 August 2020	1. Final MTR Plan submitted incorporating DFAT feedback	Acceptance of evaluation plan by DFAT
	14 September 2020	Draft written Aides Memoire submitted to SHS/DFAT	
	16 September 2020	Feedback on written Aides Memoire received from DFAT	
	18 September 2020	2. Final Aides Memoire submitted	Acceptance of Aides Memoire by DFAT
	29 September 2020	First Draft MTR report submitted to SHS	
	30 September 2020	First Draft MTR report submitted to DFAT (initial comments prior to sharing with partners)	
	2 October 2020	Feedback on First Draft MTR report received from DFAT	

6 October 2020	3. Second Draft MTR submitted to UNFPA (by DFAT)	Acceptance of Second Draft MTR Report by DFAT
8 October 2020	Quick feedback on Second Draft MTR report received from UNFPA	
12 October 2020	Third Draft MTR report submitted to SHS, DFAT and TA government partners	
30 October 2020	Feedback on Third Draft MTR report received from DFAT	
4 November 2020	Fourth Draft MTR Report submitted to SHS (incorporating partner govt feedback as appropriate)	
6 November 2020	Fourth Draft MTR Report submitted to DFAT (incorporating partner govt feedback as appropriate)	
13 November 2020	Feedback on Fourth Draft MTR Report received from DFAT	
20 November 2020	4. Final MTR report submitted to SHS/DFAT	Acceptance of final MTR report by DFAT
2 December 2020	Final report circulated by DFAT to all stakeholders	

Deliverables:

1. **MTR Plan:** The MTR plan will define the scope of the MTR, identify key risks and limitations, articulate evaluation questions and describe the evaluation methodology including key questions for data collection in each of the six countries. The plan will propose a timeline against each milestone and a detailed breakdown of responsibilities of the team members.
2. **Aides Memoire:** The Aides Memoire (maximum 10 pages) will outline key findings to be submitted to all TA countries and DFAT posts for response prior to finalisation of the MTR report. Up to 10 days is allowed for responses from all recipients.
3. **Draft MTR report:** The draft report will include an executive summary (maximum two pages) and outline the evaluation purpose, scope, methodology, risks and limitations as well as provide a clear summary of findings, recommendations for programming (maximum 20 pages) and relevant attachments.
4. **Final MTR report:** The final report will incorporate any agreed changes or amendments as requested by DFAT and partners. The final report will include an executive summary

	<p>(maximum two pages), a clear summary of findings and recommendations for future programming (maximum 20 pages) and relevant attachments. This report should be suitable for publication.</p> <p>Indicative inputs for each stage of the evaluation are included in Attachment A of this TOR.</p>
Reporting and Payment:	<p>The Adviser will submit an activity report and invoice at the following points:</p> <ul style="list-style-type: none"> ○ Acceptance by DFAT of Milestone 2 ○ Acceptance by DFAT of Milestone 4 <p>The total inputs (days and reimbursables) claimed for each milestone should not exceed the indicative inputs as per the adviser inputs schedule provided in this TOR.</p>
Policy context:	<p>Advisers are expected to align their work with the <i>Foreign Policy White Paper</i>, DFAT's <i>Health for Development Strategy 2015-2020</i> and to incorporate the priorities of DFAT's cross-cutting strategies <i>Gender Equality and Women's Empowerment Strategy (2016- 2020)</i> and <i>Development for All 2016-2020 Strategy for Strengthening Disability-Inclusive Development in Australia's Aid Program</i>.</p>
Conditions:	<p>Conditions of engagement may include completing and signing the following documents:</p> <ul style="list-style-type: none"> • The Deed of Confidentiality • The Declaration of adviser status • The Child Safe Code of Conduct <p>As per the requirements an Adviser Performance Assessment will be undertaken at the completion of the assignment.</p>

Annex 2: Key Informants

Organisation	Person Consulted	Position
Department of Foreign Affairs and Trade (DFAT), Canberra		
	Sally Mackay	Assistant Director, Global Health
	Chris Sturrock	Director, Health Programs, Performance and Advisory (HPR) section, Global Health Policy Branch Human Development and Governance Division
	Jane Pepperall	Senior Health Adviser Human Development and Governance Division
	Robert Condon	Health Advisor for Kiribati
DFAT Posts		
DFAT Fiji	Paulini Nainima	Senior Program Manager, Regional Health
	Frances Bingwor	Program Manager, Regional Health
	Renee Deschamps	Counsellor
DFAT Kiribati	Kakiateiti Erikate	Health Program Manager
DFAT Samoa	Julia Wheeler	First Secretary
	Kassandra Betham	Senior Program manager
DFAT Solomon Islands	Fiona Mulhearn	Acting Counsellor, Human Development
	Debbie Sade	Gender Adviser
DFAT Tonga	Madeleine Scott	Second Secretary Development
	Monica Van Dora	Health Program Manager
DFAT Vanuatu	Kirsty Dudgeon	First Secretary
	Belinda Karae-Lewa	Program Manager
UNFPA Pacific Sub Regional Office (PSRO)		
	Jennifer Butler	Director and Representative
	Saira Shameem	Deputy Director, Deputy Representative
	Kathleen Taylor	TA Program Lead
	Moses Qasenivalu	M&E Specialist
	Pulane Tiebere	Reproductive Health Adviser
	Virisila Raitamata	Assistant Representative
	Olanike Adedeji	Technical Specialist RHCS
	Lorna Rolls	Assistant Representative
	Sandra Paredez	Population Development Adviser
	Brian Kironde	Technical Specialist, Adolescents and Youth
UNFPA PSRO Field Officers		
	Aren Teannaki	Program Analyst, Kiribati
	Shilu Adhikari	SRH Specialist, Solomon Islands
	Emily Deed	SRH Specialist, Vanuatu

Organisation	Person Consulted	Position
	Elisi Tupou	Program Analyst, Tonga
	Ibironke Oyatoye	SRH Specialist, Samoa
	Virisila Raitamata	Assistant Representative, Fiji
IPPF Member Associations		
New Zealand Family Planning	Jackie Edmond	Executive Director
	Anna Ravendron	International Program Manager
Kiribati Family Health Association (KFHA)	Norma Yeeting	Executive Director
Samoa Family Health Association (SFHA)	Liai Iosefa-Siitia	Executive Director
	Leiloa Asaasa	Program Coordinator
Solomon Islands Planned Parenthood Association (SIPPA)	Ben Angoa	Executive Director
	Huilyn Vozoto	Clinic Nurse
Tonga Family Health Association (TFHA)	Kathy Mafi	Program Manager and Master Trainer
Vanuatu Family Health Association (VFHA)	Danstan Tate	Executive Director
Regional Implementing Partners		
Care International	Megan Chisholm	Country Director, Vanuatu and Director Pacific Regional Team
IPPF Sub Regional Office of the Pacific, Suva	Karen Hill	Director, Programs and Operations Pacific
Family Planning New South Wales	Anne Stuart	Director - Planning, Education and International Program
	Nate Henderson	Manager, International Program
John Snow International (JSI)	Greg Roche	Senior Technical Advisor JSI Research & Training Institute
	Ariella Bock	Senior Technical Advisor JSI Research & Training Institute
Burnet	Caroline Homer	Co-Program Director Maternal, Child and Adolescent Health Burnet Institute
Nossal	Matt Ralston	Chief Operating Officer, Nossal Institute for Global Health
	Joanne Rowe	Researcher and Program Manager, Uni of Melbourne
	Andrea Boudville	Senior Technical Advisor, Nossal Institute for Global Health
	Brigitte Tenni	Senior Technical Advisor Nossal Institute for Global Health
	Kristin Diemer	Data Analyst, Uni of Melbourne
	Cathy Vaughn	Data Analyst, Uni of Melbourne
World Vision International	Kendra Rousseau	Country Director
	Sofia Lardis	Program Coordinator
ABC International Development	Joanne Elsom	International Development Lead
	Vipul Khosla	Design and Evaluation Lead
	Elizabeth Firkin	Communications Lead

Organisation	Person Consulted	Position
Women Enabled International	Suzannah Phillips	Deputy Director
Fiji		
Ministry of Health and Medical Services	James Fong	Acting Permanent Secretary
	Abdul Hussein	National Program Officer
Ministry of Women, Children & Poverty Alleviation Ministry of Women, Children & Poverty Alleviation	Jennifer Poole	Permanent Secretary
	Selai Koroivusere	Director
	Anareta Apole	Program Coordinator
Ministry of Youth and Sport	Philip Hereniko	Director
	Ravinesh Lakhan	Senior Research and Data Analytics Officer
	Eseteri Turagabeci	SRHR Program Officer
Kiribati		
Ministry of Health and Medical Services	Eretii Timeon	Director, Public Health
	Remwan Mantaia	Maternal Health Program Manager
	Arieta Teaero	Senior Health Information Officer, HIS
	Kaititaake Itintaake	AYFS/GBV Clinic
	Tiroia Teikake	OHealth Specialist
Ministry of Finance and Economic Planning Statistics Office	Aritita Tekaieti	Statistics Officer
Ministry of Women, Youth, Sport and Social Affairs (MWYSSA) Youth Division	Teenati Tiberete	Youth Officer
	Tetaua Viriam	Youth Officer
	Anginako Taake	Youth Officer
MWYSSA Women's Division	Tarota Bwewetara	Elimination of Sexual and Gender Based Violence Coordinator
	Teata Wilson	Domestic Violence Officer
	Melinda Christopher	SafeNet Coordinator
Ministry of Education	Lucy Kum On	Principal, Kiribati Teachers' College
	Teeta Kabiriera	Director, Curriculum Unit
	Tawaia Baantarawa	Senior Curriculum Officer
	Tewira Tune	Curriculum Development Officer; Health & PE
	Rorine Tioti	Curriculum Development Officer; Moral Education
	Raobeia Iete	Curriculum Development Officer; social science
Y Peer Network	Beia Kaotan	Coordinator, Y-Peer Coordinator
	Raeterenga Ianana	Kiribati Catholic Youth
	Johann Matang	President – Ypeer
Samoa		
Ministry of Finance	Perestine Kirifi	Acting Chief Executive Officer, Aid and Coordination Unit

Organisation	Person Consulted	Position
	Lilomaiaava Samuel Ieremia	Acting Chief Executive Officer, Economic Policy and Planning Division
Ministry of Health	Robert Thompson	Deputy Director General
	Perive Lelevaga	Principal National SRH
	Aaone Tanumafili	HIV/TB Officer
	Seiuli Timothy	Central Medical Store Manager
	Lilomaiaava Aharoni	Pharmacy Manager
Ministry of Women, Community and Social Development	Autagavaia Olive Kaio	Chief Executive Officer, Social Development Division
Ministry of Education, Sports and Culture	Samisoni Moala	Curriculum Officer, HPE Secondary
Samoa Bureau of Statistics	Taiaopo Faumuina	Acting Chief Executive Officer, Census, Survey & Demography Division
Ministry of Finance	Lilomaiaava Sam	Acting Chief Executive Officer - Economic Policy & Planning Division
Samoa Red Cross	Maulaivao Tautala	Executive Director
National Human Rights Institute	Loukinikini Vili	Director
Nuanua o le Alofa	Andrew Taofi	Program Officer
Solomon Islands		
Ministry of Health	Nemia Bainivalu	Undersecretary for Health
	Divinal Ogaoga	Director, RMNCAH Division
	Esther Nevenga	FP Focal Person, MHMS
	Nancy Pego	Adolescent Health Manager
	Baakai Kamorki	Chief Statistician and Manager, HIS
	Nashley Vozoto	GBV Focal Person, Social Welfare Office
	Timmy Manea	Director, National Pharmacy Services and Acting Manager, National Medical Stores
Solomon Island Planned Parenthood Association	Ben Angoa	Executive Director
Ministry of National Planning and Development Coordination	Samuel Aruhu	Director, Social Development and Governance Division
Ministry of Women, Youth, Children and Family Affairs	Emily Darafo'oa	Youth Research Officer
Tonga		
Ministry of Health	Ma'ake Tupou	Obstetric Specialist
	Afu Tei	SRH Nurse
	Taufa Mone	Supervising Nurse, Public Health
	Katalina Malolo	Recipient Midwife Training

Organisation	Person Consulted	Position
	Melenaite Mahe	Chief Pharmacist, Pharmacy Warehouse
UNFPA Field Office	Elisi Tupou	Program Analyst
	Talahiva Fine	Life Skills Officer
Tonga Statistics Department	Lusia Kaitapu	Data Analyst
	Veapina Uasike	Data Analyst
Ministry of Internal Affairs	Sinama Tupou	Head, Youth Division
Ministry of Finance	Tu'itamala Vaka	Director
Tonga Leitis Association	Cruella Tu'Inukuafe	Vice President, Program Manager
	Jason Heimuli	Senior Program Officer
Queen Salote School of Nursing	Tilema Cama	Lecturer
Beneficiary	Anaseini Ulakai	Youth Champion
	Elizabeth Kite	Youth Leader
Talitha	Vanessa Heleta	Director, Program Manager
	Alokuoulu Ulukivaiola	Program Officer
Vanuatu		
Ministry of Health	Len Tarivonda	Director, Department of Public Health
	Sam Mahit	Reproductive Health Focal Point
	Lolyne Jeremiah	Public Health Manager, TAFEA Province
	Lematuk Michael	Midwife, SHEFA Province
	Wilson Lilip	Central Medical Store
	Mahlon Tari	Manager HIS
DSPPAC	Viran Toviu	Senior Analyst Health and Population
Ministry of Education	Filicity Nilwo	Principal Education Officer
Ministry of Finance	Andy Calo	Director, National Statistics Office
	Charlington Leo	Senior Social and Environment Statistician
	Susie Mento	Environmental Statistician
	Aspind Amos	Administration and Finance Manager
Ministry of Youth	Joe Calo	Principal Administrator
	Regianna Iakula	Youth Data Registrar/ Finance Officer
Vanuatu Society for Disabled People	Judith Iakavai	Program Manager
	Ashiana Basil	Community Based ID Team Leader
UNFPA Vila	Emily Deed	SRH Specialist
Vanuatu Health Program	Geoff Clark	Team Leader

Annex 3: List of TA Program Implementing Partners, Sub Recipients and Regional Implementing Partners

Fiji	Kiribati	Samoa	Solomon Islands	Tonga	Vanuatu	Regional IPs
Ministry of Health (MOH)	Ministry of Health and Medical Services (MHMS)	Ministry of Finance (non-implementing) (MOF)	Ministry of Health and Medical Services (MHMS)	Ministry of Health (MOH)	Ministry of Health and Medical Services (MHMS)	John Snow International (JSI),
Ministry of Women, Children and Poverty Alleviation (MWCPA)	National Statistics Office (NSO)	Ministry of Health (MOH)	Ministry of National Planning and Development Coordination (MNPDC)	Tonga Family Health Association (TFHA)	Vanuatu National Statistics Office (VNSO)	Australian Broadcasting Corporation (ABC)
Ministry of Youth (MOY)	Ministry of Women, Youth, Sports and Social Affairs (MWYSSA)	Ministry of Women, Community and Social Development (MWCSD)	SI National Statistics Office (SINSO)	Parliament of Tonga	Vanuatu National Youth Council (VNYC)	Family Planning NSW (FPNSW)
	Ministry of Education (MOE)	Ministry of Education, Sport and Culture (MESC)	Ministry of Finance and Treasury (MOFT)	Tonga Leiti Association (TLA)	Department of Strategic Policy Planning and Aid Coordination (DSPPAC)	IPPF Sub Regional Office of the Pacific (SROP)
		Samoa Bureau of Statistics (SBS)	Ministry of Education (MOE)	Talitha	Ministry of Youth and Sports (MYS)	World Vision International (WVI)
		National Human Rights Institute (NHRI)	Ministry of Women, Youth, Children and Family Affairs (MWYCFA)			Care International (Vanuatu)
		Samoa Family Health Association (SFHA)				Nossal
		Samoa Red Cross Society (SRCS)				Burnet
		Samoa Faafafine Association (SFA)				

Annex 4: Synergies with Related Program and Projects

Program	Funds	Objectives	Related to TA – how?	Locations
UNFPA PSRO Sub Regional Program 6 (SRP6) 2018-2022	USD 30m ³²	Components: To integrate SRH services; gender equality and empowerment of women and girls; data for sustainable development	TA Program is nested inside SRP6 but outcomes and activities are different; joint reporting on implementation	14 Pacific countries including the 6 TA countries
Pacific Regional SRH Program (PRSRHP) 2014-2019 (extension to Sept 2020)	NZD 6 million	To increase SRH service supply, SRH demand, and improving the enabling environment to work towards universal access to integrated adolescent and youth SRH services and enjoyment of SRH rights	Emphasis on SRH services and FLE; joint workplans with TA Program	Kiribati, Samoa, Solomon Islands, Tonga, Vanuatu
UNFPA Supplies Program (2018-2022)	USD 3.5 million	Strengthen national supply chains	Ensure sustainable supply of a broad mix of contraceptives, and other RH commodities	TA six countries plus 8 others
IPPF SPRINT (2007-2021)	AUD 35 million	Addresses access to SRH in crisis and post-crisis settings - provide safer environments for women to give birth, HIV prevention, family planning services, prevention of sexual violence and assistance to survivors of violence.	SPRINT provides training in Minimum Initial Services Package (MISP); and supports national governments to integrate SRH into national disaster management policies	Global (incl. Pacific)

³² This total USD amount is inclusive of AUD30m DFAT Transformative Agenda: Towards zero unmet need for FP funding

Program	Funds	Objectives	Related to TA – how?	Locations
Pacific Women Shaping Pacific Development (2017-2022)	AUD 320 million (70% for country level activities)	Violence against women is reduced and survivors of violence have access to support services and to justice.	Provides strategies and activities to reduce violence against women and expanded support services	14 countries in the Pacific, including TA six countries
Vanuatu Health Program (VHP) (2019-2023)	AUD 25 million	Responds to MOH immediate priorities while working on systemic changes needed for sustainability. 4 components: 1. Corporate services; 2. PHC priorities; 3. Provincial focus (PHC); 4. Workforce development	Vanuatu government prioritises strengthening the FP program and reducing unmet need. This priority could be included in VHP to cover all SDPs in all provinces. WHO is a partner in this program, strengthening the HIS.	Vanuatu – 2 provinces at a time
Impact Project Samoa (2017-2020)	AUD 5 million	Outreach to 41 villages quarterly; Uses youth engagement strategy to reach young people; joint planning and peer education for youth with SRCS	Samoa Govt has a target of 80% women using contraceptives by 2030; SFHA could do more to support FP/SRH including training SDP staff.	Samoa
Samoa Health Program (2013-2022)	AUD 9.2 million	Focus on PHC; improve leadership and governance; improve SRH outcomes. DFAT Aid Investment Plan 2018-2019 prioritises use of civil society initiatives as a strategic priority. Includes Samoa Impact Project implemented by SFHA	SFHA Impact Program (above) aims to increase SRH services through static clinics by 5%; and increase by 2% SRH services provided through quality assured SRH outreach services	Samoa

Program	Funds	Objectives	Related to TA – how?	Locations
Solomon Islands Health Sector Support Program (HSSP) 2016-2020	AUD 66 million	To improve access to quality UHC; improved quantity and quality of PHC services; stronger health system to support service delivery; reforms to health system for sustainability	Family Health Committee helps drive the program; established MDSR reporting and GBV clinical guidelines and training (2016); stock availability system in place and monitored; one indicator is # FP contacts/1000 population; increase in contraceptive contacts seen at SDPs; and outreach activities increased. New health program by Dec 2020 with continued use of SIG systems, including general sector budget support.	Solomon Islands – all provinces
Fiji Program Support Facility (2017-2022) Public Private Partnership in the Health Sector	AUD 25 million	Work with Fijian Govt to increase capacity and efficiency of health system; support Fiji to respond to NCD epidemic; focus on cost effective PHC and prevention; midwife training; community level program in NCD and mental health; emergency preparation and response	Midwives trained in SRHR also; community program mechanisms could be used for FP/SRHR; more use of CSOs	Fiji
Tonga Health Systems Support Program (Phase 11) (2015-2020)	AUD 17 million	Includes: management of NCD in PHC; NCD health promotion; support for mental health and disability services. Additional support to be given for data collection and analysis	Strategies for implementation of NCD BCC and IEC resources could be adapted for FP/SRH. Improvements to HIS and data collection could benefit TA program if FP/SRH data collection and indicators included.	Tonga

Annex 5: Synergies across Related Programs with Shared Implementing Partners

Implementing Partners	DFAT TA Program (2018-onwards)	MFAT PRSRH Program	UNFPA Core and Other Resources during SRP6
Tonga			
Ministry of Health	X	X	X
Fiji			
Ministry of Health	X		X
Ministry of Women	X		
Ministry of Youth	X		
Kiribati			
Ministry of Health and Medical Services	X	X	X
Ministry of Finance	X		X
Ministry of Women, Youth and Social Affairs	X	X	X
Ministry of Education	X	X	X
Vanuatu			
Ministry of Health	X		X
Vanuatu National Statistics Office	X	X	
Ministry of Education and Training	X	X	
Ministry of Youth	X	X	
Solomon Islands			
Ministry of Health and Medical Services	X	X	X
Ministry of Development Planning and Aid Coordination	X		
Samoa			
Ministry of Finance	X	X	X
Regional IPs			
Secretariat of the Pacific Community (SPC)			X
UNICEF		X	X
John Snow International (JSI)	X		X
Australian Broadcasting Commission (ABC)	X		
Burnet	X		
Nossal	X		
Family Planning New South Wales (FPNSW)	X		
IPPF Sub-Regional Office of the Pacific (SROP)	X		
World Vision	X		
CARE	X		
WEI (Women Enabled International)	X		

Source: DFAT Health Policy Unit, 2020

Annex 6: Consolidated HFRSA Results

Service assessed	Fiji	Kiribati	Samoa	Tonga
No. of SDPs	212	112	14	31
FP Service Provision:				
SDP provides FP services	95%	97%	100%	100%
SDP provides trained FP staff	93%	87%	100%	90%
SDP has FP Guidelines	49%	53%	100%	83%
SDP has at least 3 FP methods (primary facility)	87%	74%	100%	92%
SDP has at least 5 FP methods (secondary/tertiary)	39%	50%	75%	75%
SDP is FP service ready	19%	17%	100%	43%
SDP has had stockouts of FP products last 6 months	59%	44%	36%	80%
New FP users/acceptors last 6 months/number of facilities	3962/189 facilities	480/88 facilities	783/14 facilities	308/25 facilities
FP Products:				
Male condoms	98%	86%	100%	100%
Female condoms	9%	33%	0%	60%
Oral Contraceptive Pills	92%	77%	100%	97%
Progestin only pills	91%	68%	100%	93%
Injectables (Depo Provera)	97%	92%	100%	100%
Emergency Contraception (EC)	57%	51%	36%	90%
Implants (Jadelle)	48%	89%	79%	13%
IUDs	24%	4%	71%	83%
Guidelines for HIS reporting:				
Staff trained in logistics management	78%	68%	71%	42%
HIS tools for data collection/reporting	95%	92%	93%	93%
FP supervision in previous 6 months	49%	12%	64%	71%
Integrated SRH Services Available:				
FP	95%	97%	100%	100%
Cervical Cancer Screening	71%	16%	7%	10%
Cervical Cancer screening guidelines	34%	16%	N/A	3%
AYFS	87%	66%	86%	87%
HIV/STI	63%	64%	71%	16%
ANC	87%	98%	100%	45%
Pregnancy test provided	15%	6%	N/A	57%
PNC	81%	97%	100%	81%
PNC FP offered at 6 weeks	91%	94%	100%	100%
GBV	74%	72%	57%	58%
Services for GBV Survivors:				
EC	46%	75%	N/A	94%
Forensic Evidence Collection	27%	33%	N/A	22%
Hepatitis vaccine	27%	16%	N/A	22%
Physical trauma assessment	92%	78%	N/A	83%
Post Exposure Prophylaxis (PEP)	34%	44%	38%	44%
Psychological first aid/counselling	82%	62%	N/A	94%
STI treatment	74%	80%	N/A	33%
Tetanus Toxoid vaccine	75%	74%	N/A	50%
Youth Friendly services for adolescent and youth:				
FP counselling	92%	96%	96%	100%

Service assessed	Fiji	Kiribati	Samoa	Tonga
HIV testing/counselling	43%	49%	49%	26%
Condoms	93%	95%	95%	89%
LARCS	48%	66%	66%	85%
STI treatment and counselling	85%	87%	87%	33%
EC	52%	85%	85%	85%
Short term contraception	77%	77%	77%	82%
Sexual GBV services	57%	68%	68%	67%
AYF services available:				
AYF service provided	87%	66%	86%	87%
Staff trained in AYF	24%	33%	71%	65%
AYF services free/subsidised	96%	89%	71%	97%
Flexible working hours	33%	61%	50%	42%
AYF guidelines	23%	13%	43%	32%
Dedicated room	64%	36%	43%	65%
IEC materials	43%	24%	29%	36%
AYF service ready (to global standard)	3%	3%	0%	7%

Annex 7: Cumulative Data Monitoring and Evaluation Framework

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
Programme Goal: Transformative change in the lives of women, adolescents and youth across the Pacific by 2022	1. Number of unintended pregnancies averted	ø	Fiji	Planned	12499	10877	14599	8950	34,426			17900	18950	20942
				Actual	5718	10877	24162		35,039		1			
			Kiribati	Planned	1599	4457	7310	5083	16,850			10165	13021	15876
				Actual	3720	1257	1072		2,329	14%	1			
			Samoa	Planned	771	855	940	512	2,307			1024	1108.5	1192.9
				Actual	1265	855	1046		1,901	82%	1			
			Solomon Islands	Planned	5619	7556	9493	5715	22,764			11430	13367	15304
				Actual	5201	7556	7532		15,088	66%	1	NA		
			Tonga	Planned	530	613	696	390	1,699			779	862	945
				Actual	958	884	552		1,436	85%	1			
			Vanuatu	Planned	2004	2119	2233	1174	5,526			2348	2463	2577
				Actual	3615	2782	4194		6,976		1			

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
	2. Adolescent Birth Rate	ø	Fiji	Planned		27.3	25.3					23.28	21.28	19.28
				Actual	28.4	28.4	NA				1			
			Kiribati	Planned		43.2	41.2					39.2	37.2	35.2
				Actual	45.2	45.2	51				1			
			Samoa	Planned		53	51					49	47	45
				Actual	56	56		55			1	55		
			Solomon Islands	Planned		74	71					68	65	62
				Actual	77	77		77			1	77		
			Tonga	Planned		30	29					28	27	26
				Actual	31.9	31.9	32				1			
			Vanuatu	Planned		79	76					73	71	68
				Actual	81	81					1	PHC		
Programme Objective: To move unmet need for family planning in the Pacific towards zero by 2022	3. Proportion of women of reproductive age (15-49) who have their need for family planning satisfied with modern methods. [UNFPA Supplies Indicator 1]	ø	Fiji	Planned		71.8	72.6					73.3	74.0	74.7

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
				Actual	71	71	MICS/DHS							
			Kiribati	Planned		39.6	41.2					42.7	44.1	45.5
				Actual	37.9	37.9	53.6				1			
			Samoa	Planned		29.3	30.6					31.8	33.0	34.1
				Actual	28.0	28.0	29.4				1	29.4		
			Solomon Islands	Planned		38.7	41.0					43.1	45.1	47.0
				Actual	36.1	36.1	PHC	36.1			1	36.1		
			Tonga	Planned		38.7	40.0					41.2	42.4	43.6
				Actual	37.4	37.4	49.3				1			
			Vanuatu	Planned		52.1	52.9					53.7	54.5	55.2
				Actual	51.2	51.2					1			
	4. Contraceptive Prevalence Rate (modern method) all women 15-49 years [UNFPA Supplies Indicator 2]	ö	Fiji	Planned		51.3	53.3					55.3	57.3	59.3
				Actual	49.3	49.3	MICS/DHS					1		
			Kiribati	Planned		14.6	15.6					16.6	17.6	18.6
				Actual	13.6	13.6	20.3				1			
			Samoa	Planned		16.1	17.1					18.1	19.1	20.1
				Actual	15.1	15.1	MICS/DHS					1	DHS/MICS2019-20	

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
			Solomon Islands	Planned		26.3	28.3					30.3	32.3	34.3
				Actual	24.3	24.3	PHC					24.3		
			Tonga	Planned		29.4	30.4					31.4	32.4	33.4
				Actual	28.4	28.4	MICS/DHS					1		
			Vanuatu	Planned		29.9	30.9					31.9	32.9	33.9
				Actual	28.9	28.9						1	PHC	
Programme Outcome 1: Increased and improved supply of integrated SRH information and services, particularly for family planning	5. Total Couple-Years Protection for contraceptives distributed by countries to lower levels including SDPs (Disaggregated by method including EC and LARCs) [UNFPA Supplies Indicator 1.3.4]	ö	Fiji	Planned	51,932	54,173	70,000	42,914				85827	101654	117481
				Actual	27,415	52,156	46,829		98,985	59%		1		
			Kiribati	Planned	17,865	21,357	35,049	24,371	80,777			48741	62433	76125
				Actual	17,865	6,029	5,138		11,167	14%		1		
			Samoa	Planned	6,000	7,200	8,400	4,800	20,400			9600	10800	12000
				Actual	6,000	4,102	5,014	1107	10,223	50%		1	1107	

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
			Solomon Islands	Planned	26,942	36,229	45,516	27,402				54803	64090	73377
				Actual	34,296	36,229	36,113	58213			1	58213		
			Tonga	Planned	2,540	2,939	3,338	1,869	8,146			3737	4136	4535
				Actual	4,594	4,238	2,649		6,887	85%	1			
			Vanuatu	Planned	17,335	20,802	24,269	13,863	58,934			27726	31203	34670
				Actual	17,335	13,339	20,108		33,447	57%	1			
	6. Number of new acceptors of modern methods of contraception by age [UNFPA Supplies Indicator 2a-Proxy Indicator]	ö	Fiji	Planned		4528	4549	2288	11365			4575	4601	4627
				Actual	TBD in 2019	TBD in 2019	11509		11509		1	HMIS	HMIS	HMIS
			Kiribati	Planned		149	300	304	754			607	923	940
				Actual	TBD in 2019	699	991		1690		1	HMIS	HMIS	HMIS
			Samoa	Planned		81	97	57	234			113	129	145
				Actual	TBD in 2019	1882	579		2461		1	HMIS	HMIS	HMIS
			Solomon Islands	Planned		835	1716	1761	4313			3522	5415	5542
				Actual	TBD in 2019	TBD in 2019	3622		3622	84%	1	HMIS	3048	HMIS
			Tonga	Planned		131	264	268	663			535	812	821
				Actual										

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
				Actual	TBD in 2019	TBD in 2019	764		764	####	1	HMIS	HMIS	HMIS
			Vanuatu	Planned		354	721	737	1812			1474	2258	2309
				Actual	TBD in 2019	TBD in 2019	648		648	36%	1	HMIS	HMIS	HMIS
	7. Percentage of (402)(754) primary service delivery points (SDPs) that have at least 3 modern FP methods on the day of visit or assessment (disaggregated for urban-rural and SDP type) including EC [UNFPA Supplies Indicator 1.3.1]	ö	Fiji	Planned		90%	90%	95%				100%	100%	100%
				Actual	TBD in 2019	65%	89%		89%	94%	1	Spot check	Spot check	
			Kiribati	Planned		85%	90%	95%				100%	100%	100%
				Actual	TBD in 2019	74%	74%		74%	78%	1	Spot check	Spot check	
			Samoa	Planned		90%	100%	100%				100%	100%	100%
				Actual	93%	83%	75%	100%	100%		1	100%	Spot check	
			Solomon Islands	Planned		85%	90%	95%				100%	100%	100%

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
				Actual	TBD in 2019	TBD in 2019	HFRSAA				<div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></d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	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
				Actual	38%	38%	100%	75%		83%	1	75%	Spot check	
			Solomon Islands	Planned		80%	100%	100%				100%	100%	100%
				Actual	TBD in 2019	TBD in 2019	HFRSAA				1	NA	Spot check	HFRSAA
			Tonga	Planned		80%	80%	90%				100%	100%	100%
				Actual	TBD in 2019	75%	75%			83%	1	Spot check	Spot check	
			Vanuatu	Planned		80%	80%	90%				100%	100%	100%
				Actual	TBD in 2019	TBD in 2019	HFRSAA				1	HFRSA	Spot check	
	9. Percentage of SDP stock-out by family planning method or product (last 3 months). [UNFPA Supplies Indicator Proposed 1]	0	Fiji	Planned	0%	0%	0%					0%	0%	0%
				Actual	TBD in 2019	59%	59%			42%	1	Spot check	Spot check	
			Kiribati	Planned	0%	0%	0%					0%	0%	0%
				Actual	TBD in 2019	44%	57%			43%	1	Spot check	Spot check	
			Samoa	Planned	0%	0%	0%					0%	0%	0%
				Actual	36%	36%	89%	58%		42%	1	58%	Spot check	HFRSAA

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
			Solomon Islands	Planned	0%	0%	0%					0%	0%	0%
				Actual	TBD in 2019	TBD in 2019	HFRSAA				1	NA	Spot check	
			Tonga	Planned	0%	0%	0%					0%	0%	0%
				Actual	TBD in 2019	77%	75%			25%	1	Spot check	Spot check	
			Vanuatu	Planned	0%	0%	0%					0%	0%	0%
				Actual	TBD in 2019	TBD in 2019	HFRSAA				1	Spot check	Spot check	
	10. Percentage of SDPs providing quality-assured, adolescent friendly, integrated SRH services.	ö	Fiji	Planned	0%	15%	30%					45%	60%	≥75%
				Actual	TBD in 2019	TBD in 2019	87%		290%		1	Spot check	Spot check	
			Kiribati	Planned	0%	15%	30%					45%	60%	≥75%
				Actual	TBD in 2019	TBD in 2019	66%	3%	220%		1	Spot check	Spot check	
			Samoa	Planned	0%	15%	30%					45%	60%	≥75%
				Actual	0%	86%	No Updates	0%	287%		1	Spot check	Spot check	
			Solomon Islands	Planned	0%	15%	30%					45%	60%	≥75%

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022					
				Actual	TBD in 2019	TBD in 2019	HFRSAA	1%	no data					1	NA	Spot check			
			Tonga	Planned	0%	15%	30%								45%	60%	≥75%		
				Actual	TBD in 2019	TBD in 2019	87%	7%	290%				1	Spot check	Spot check				
			Vanuatu	Planned	0%	15%	30%								45%	60%	≥75%		
				Actual	TBD in 2019	TBD in 2019	HFRSAA	5%	no data					1	HFRSA	Spot check			
			11. Percentage of 868 SDPs that have at least one member of staff available and fully trained in youth-friendly, disability-inclusive family planning service provision.	Yes	Fiji	Planned			0%	20%							50%	75%	100%
						Actual	TBD in 2019	TBD in 2019	0%						1	HMIS	HMIS	HMIS	
					Kiribati	Planned			0%	20%							50%	75%	100%
Actual	TBD in 2019	TBD in 2019				0%		33%		1			HMIS	HMIS	HMIS				
Samoa	Planned					0%	20%							50%	75%	100%			
	Actual	TBD in 2019			0%	0%	0%	71%		1			0%	HMIS	HMIS				
Solomon Islands	Planned			0%	20%							50%	75%	100%					

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022	
				Actual	TBD in 2019	TBD in 2019	0%					1	NA	HMIS	HMIS
			Tonga	Planned		0%	20%						50%	75%	100%
				Actual	TBD in 2019	TBD in 2019	0%		65%		1		HMIS	HMIS	HMIS
			Vanuatu	Planned		0%	20%					50%	75%	100%	
				Actual	TBD in 2019	TBD in 2019	0%				1	HFRSA	HMIS	HMIS	
	12. Percentage of all mobile services that include one member of staff providing youth-friendly, disability-inclusive SRH service provision, and able to deliver at least 3-5 modern methods of contraception.	Yes	Fiji	Planned		0%	20%					50%	75%	100%	
				Actual	TBD in 2019	TBD in 2019	0%			0%		1	HMIS	HMIS	HMIS
			Kiribati	Planned		0%	20%					50%	75%	100%	
				Actual	TBD in 2019	TBD in 2019	0%			0%		1	HMIS	HMIS	HMIS
			Samoa	Planned		0%	20%					50%	75%	100%	
Actual	TBD in 2019	TBD in 2019		0%	0%		0%		1	0%	HMIS	HMIS			

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
			Solomon Islands	Planned		0%	20%					50%	75%	100%
				Actual	TBD in 2019	TBD in 2019	0%			0%	1	NA	HMIS	HMIS
			Tonga	Planned		0%	20%					50%	75%	100%
				Actual	TBD in 2019	TBD in 2019	0%			0%	1	HMIS	HMIS	HMIS
			Vanuatu	Planned		0%	20%					50%	75%	100%
				Actual	TBD in 2019	TBD in 2019	0%			0%	1	HMIS	HMIS	HMIS
	13. By 2022, all six countries are conducting routine patient satisfaction surveys on the provision of SRH services and making the results publicly available.	Yes	Fiji	Planned	No	Yes	Yes					Yes	Yes	Yes
				Actual	No	No	Yes				1			
			Kiribati	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No				1			
			Samoa	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No	No			1	No		
			Solomon Islands	Planned	No	No	No					Yes	Yes	Yes

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
				Actual	No	No	No	No			<div><div></div><div></div><div></div><div>1</div></div>	No		
			Tonga	Planned	No	No	No				<div><div></div><div></div><div></div><div></div></div>	Yes	Yes	Yes
				Actual	No	No	No				<div><div></div><div></div><div></div><div>1</div></div>			
			Vanuatu	Planned	No	No	No				<div><div></div><div></div><div></div><div></div></div>	Yes	Yes	Yes
				Actual	No	No	No				<div><div></div><div></div><div></div><div>1</div></div>			
	14. Percentage of SDPs that are providing the ESP health services package for survivors of sexual violence.	ö	Fiji	Planned		5%	10%				<div><div></div><div></div><div></div><div></div></div>	15%	20%	≥25%
				Actual	0%	0%	4%			40%	<div><div></div><div>1</div><div></div><div></div></div>			
			Kiribati	Planned		5%	10%				<div><div></div><div></div><div></div><div></div></div>	15%	20%	≥25%
				Actual	0%	0%	2%			18%	<div><div></div><div>1</div><div></div><div></div></div>			
			Samoa	Planned		5%	10%				<div><div></div><div></div><div></div><div></div></div>	15%	20%	≥25%
				Actual	0%	0%	0%	0%		0%	<div><div></div><div>1</div><div></div><div></div></div>	0%		
			Solomon Islands	Planned		5%	10%				<div><div></div><div></div><div></div><div></div></div>	15%	20%	≥25%
				Actual	0%	0%	0%			0%	<div><div></div><div>1</div><div></div><div></div></div>	NA		
			Tonga	Planned		5%	10%				<div><div></div><div></div><div></div><div></div></div>	15%	20%	≥25%
				Actual	0%	0%	0%			0%	<div><div></div><div>1</div><div></div><div></div></div>			
			Vanuatu	Planned		5%	10%				<div><div></div><div></div><div></div><div></div></div>	15%	20%	≥25%
				Actual	0%	0%	0%			0%	<div><div></div><div>1</div><div></div><div></div></div>	HFRSA		

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
Programme Outcome 2: Increased demand for integrated SRH information and services, particularly for family planning	15. Number of in-school young people (disaggregated by disability status, sex, age and location) reached with Family Life Education.	ö	Fiji	Planned		0								
				Actual	0	0	0			0		1	EMIS	EMIS
			Kiribati	Planned		0	4000							
				Actual	0	0	9911				1		EMIS	EMIS
			Samoa	Planned		0	100							
				Actual	0	0	0	40,000				1	40,000	EMIS
			Solomon Islands	Planned		0								
				Actual	0	TBD in 2019	0			0		1	NA	EMIS
			Tonga	Planned		0								
				Actual	0	TBD in 2019	0			0		1	EMIS	EMIS
			Vanuatu	Planned		0	10,000							

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
				Actual	0	TBD in 2019	0			0		EMIS	EMIS	EMIS
	16. Number of out-of-school young people (disaggregated by disability status, sex, age and location) reached with Family Life Education.	0	Fiji	Planned			150							
				Actual			34		23%			CAR	CAR	CAR
			Kiribati	Planned			2500							
				Actual	0		250		10%			CAR	CAR	CAR
			Samoa	Planned										
				Actual			No updates		no data			1	CAR	CAR
			Solomon Islands	Planned										
				Actual			CAR		no data			1	NA	CAR
			Tonga	Planned										
				Actual			210		no data			1	CAR	CAR
			Vanuatu	Planned			500							
				Actual	0		10030		2006%			1	CAR	CAR
	17. FLE delivered in all countries meets international standards (assess through spot checks)	Yes	Fiji	Planned		No	Yes					Yes	Yes	Yes

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
	and more systematic means)													
				Actual	No	No	No		No					
			Kiribati	Planned		No	Yes					Yes	Yes	Yes
				Actual	No	No	Yes		Yes		1			
			Samoa	Planned		No	Yes					Yes	Yes	Yes
				Actual	No	No	No		No		1	No		
			Solomon Islands	Planned		No	Yes					Yes	Yes	Yes
				Actual	No	No	No		No		1	No		
			Tonga	Planned		No	Yes					Yes	Yes	Yes
				Actual	No	No	No		No		1			
			Vanuatu	Planned		No	Yes					Yes	Yes	Yes
				Actual	No	No	No		No		1			
	18. Country has operationalized school based comprehensive FLE curricula in accordance with international standards.	Yes	Fiji	Planned		No	Yes					Yes	Yes	Yes
				Actual	No	No	No		No		1			
			Kiribati	Planned		No	Yes					Yes	Yes	Yes

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
				Actual	No	No	No		No		1			
			Samoa	Planned		No	Yes					Yes	Yes	Yes
				Actual	No	No	No		No		1	No		
			Solomon Islands	Planned		No	Yes					Yes	Yes	Yes
				Actual	No	No	No		No		1			
			Tonga	Planned		No	Yes					Yes	Yes	Yes
				Actual	No	No	No		No		1			
			Vanuatu	Planned		No	Yes					Yes	Yes	Yes
				Actual	No	No	No		No		1			
	19. Proportion of young people and persons with a disability who state that they are aware of at least one BCC message over the past year.	ö	Fiji	Planned			No							
				Actual			No				1			
			Kiribati	Planned			Yes							
				Actual							1			
			Samoa	Planned			Yes							
				Actual			No				1			

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
			Solomon Islands	Planned			Yes							
				Actual			No					1	NA	
			Tonga	Planned			Yes							
				Actual			No					1		
			Vanuatu	Planned			Yes							
				Actual			No					1		
Programme Outcome 3: More conducive and supportive environment for people to access and benefit from quality SRH, especially contraceptive choice	20. By 2022, operational standards for integrated SRH services have been developed and are being implemented in all six countries [with key indicators for monitoring this to be agreed once guidelines developed]	Yes	Fiji	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No		No			1		
			Kiribati	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No		No			1		
			Samoa	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No		No			1	No	

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
			Solomon Islands	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No		No			1	No	
			Tonga	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No		No			1		
			Vanuatu	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No		No			1		
	21. All countries have cervical cancer policies and guidelines and have taken steps to implement them.	Yes	Fiji	Planned		Yes	Yes					Yes	Yes	Yes
				Actual	No	No			No			1		
			Kiribati	Planned		Yes	Yes					Yes	Yes	Yes
				Actual	No	No. Draft available to be validated in 2019	No		No			1		
			Samoa	Planned		No	Yes					Yes	Yes	Yes
				Actual	No	No		No	No			1	No	
			Solomon Islands	Planned		Yes	Yes					Yes	Yes	Yes
				Actual	No	No		No	No			1	No	
			Tonga	Planned		Yes	Yes					Yes	Yes	Yes

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
				Actual	No	No			No		1			
			Vanuatu	Planned		Yes	Yes					Yes	Yes	Yes
				Actual	No	No			No		1			
	22. More people accept and support access to and use of contraception, including for youth and people living with disabilities	Yes. An increasing number of people accept and support to and use of contraception	Fiji	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No				1			
			Kiribati	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No				1			
			Samoa	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No				1	NA		
			Solomon Islands	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No				1	NA		
			Tonga	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No				1			
			Vanuatu	Planned	No	No	No					Yes	Yes	Yes
				Actual	No	No	No				1			
	23. Number of influential SRH analytical products -	0	Fiji	Planned		0	0					0	2	≥2

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
	with potential to impact policy and practice - are produced and appropriately disseminated by UNFPA in each of the six countries.													
				Actual	0	0	0					1		
			Kiribati	Planned		0	2					2	2	≥2
				Actual	0	0	2				1			
			Samoa	Planned		0	0					2	2	≥2
				Actual	0	0	2	5	7		1			
			Solomon Islands	Planned		0	0					0	0	≥2
				Actual	0	0	0					1	0	
			Tonga	Planned		0	0					2	2	≥2
				Actual	0	0	0					1		
			Vanuatu	Planned		0	0					0	0	≥2
				Actual	0	0	0					1		
	24. Policymakers use data and evidence on SRH to inform decision making related to policy and programming	Yes	Fiji	Planned		No	No					Yes	Yes	Yes

	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
				Actual	No	No	Yes				<div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div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	Indicators	Desired Trend & Progression	Country	Status	Baseline (2017 or Near)	2018	2019	2020 Q1&2 only	Year-to-Date	%	Rated Progress	2020	2021	2022
			Samoa	Planned		No	No					No	No	Yes
				Actual	No	No	No				1	No		
			Solomon Islands	Planned		No	No					No	No	Yes
				Actual	No	No	No				1	NO		
			Tonga	Planned		No	No					No	No	Yes
				Actual	No	No	No				1			
			Vanuatu	Planned		No	No					No	No	Yes
				Actual	No	No	No				1			

Indicator Progress Results

Colour	Progress Result	Range	Quantity	% Total	% among the 78 that are rated								
	achieved or /on track	67 - 100%	26	17%	33%		Fiji		3	4	7	11	25
	some /limited progress	33 - 66%	11	7%	14%		Kiribati		8	2	7	8	25
	little progress/not on track	no / 0-32%	41	27%	53%		Samoa		5	2	6	12	25
	no data/not expected /problem indic/impact indic.		72	48%			Solomon Islands		2	1	7	15	25
Total Indicators:				150		78	Tonga		6	1	8	10	25
# Indicators that are rated:				78			Vanuatu		1	2	6	16	25
							TOTAL	78 assessed	25	12	41	72	150

Annex 8: Allocations, Expenditure and Utilisation Rates 2018-2020

Table 1 – TA Allocations (USD) and Implementation Rates 2018 -2020

Location	Allocation	Expenditure	Outstanding advance	Utilisation Rate
Fiji				
2018	87,401	26,136		30%
2019	402,298	141,894		35%
2020				
Kiribati				
2018	-	-		
2019	380,780	148,441		39%
2020	273,803	10,665	99,753	4%
Solomons				
2018	80,000	78,514		98%
2019	162,982	66,751		41%
2020	336,129	21,981	32,185	7%
Samoa				
2018	32,000	-		0%
2019	421,303	210,283		50%
2020	127,660	43,856	32,231	34%
Tonga				
2018	-	-		
2019	336,926	205,646		61%
2020	353,003	48,217	148,518	14%
Vanuatu				
2018	88,096	72,850		83%
2019	302,400	141,776		47%
2020	699,827	67,204	247,158	10%
*Includes Govt. and NGO IPs (World Vision Vanuatu and CARE Vanuatu)				
UNFPA Implementation				
2018	1,266,391	647,034		51%
2019	1,561,565	1,945,510		125%
2020	2,991,577	1,106,559		37%
SPC				
2018	61,398	59,088		96%
2019	-	-		
2020	-	-		
IPPF-SROP				
2020	628,000	3,952	125,124	1%
John Snow Inc				
2020	178,469	-	133,482	0%
Women Enabled International				
2020	219,298	42,716	95,176	19%

Nossal Institute				
2020	497,801	65,834	-	13%
Burnet Institute				
2020	528,703	45,505	-	9%
FPNSW				
2020	1,181,879	180,839	245,023	15%
ABC				
2020	95,571	-	-	0%

2020 expenditures are as of 3 August 2020

Source: PSRO Finance Division, August 2020

Table 2: Allocations and Utilisation Rates by MOHs

Country	Year	Budget	Utilisation	Utilisation Rate (all years to 2 nd Q 2020)
Fiji MHMS	2018	56,872	18,519	37%
	2019	196,320	74,828	
	2020	-	-	
	Total	253,192	93,347	
Kiribati MHMS	2018	-	-	70%
	2019	98,205	95,190	
	2020	149,175	79,211	
	Total	247,380	174,401	
Solomon Islands MHMS	2018	-	-	4%
	2019	25,050	-	
	2020	248,968	11,579	
	Total	274,018	11,579	
Samoa MOH	2018	-	-	47%
	2019	72,111	15,907	
	2020	36,823	35,756	
	Total	108,934	51,663	
Tonga MOH	2018	-	-	59%
	2019	336,926	212,042	
	2020	353,003	196,735	
	Total	689,929	408,777	
Vanuatu MOH	2018	-	-	45%
	2019	159,000	131,371	
	2020	248,461	50,064	
	Total	407,461	181,435	

Source: 2020 expenditures are as of 3 August 2020

PSRO Finance Division, August 2020

It is important to note that the expenditure rate for 2020 is included, which is only for seven months of implementation and thus decreases the overall implementation rate. This will increase at the end of 2020.

Table 3: Allocation of Funds by Outcome Area (USD)

Outcome/Output	Year	Expenditure	Expended (2018-2019)	Total Expenditure (2018-2020)	% on outcomes 2018-2019
Outcome 1: Supply					
Output 1: Strengthened delivery of high quality, integrated SRH information and services	2018	175,756	760,959	1,003,133	26%
	2019	585,203			
Output 2: Strengthened health workforce capacities	2018	134,583	242,174		
	2019	107,591			
Outcome 2: Demand					
Output 3: Increased community engagement and leadership	2018	-	101,199	286,058	8%
	2019	101,199			
Output 4: Increased national capacity for community and school based FLE	2018	-	184,859		
	2019	184,859			
Outcome 3: Enabling Environment					
Output 5: Expanded evidence-based legislation, public policy and programming	2018	137,160	303,983	1,040,491	27%
	2019	166,823			
Output 6: Increased availability, analysis and use of high-quality data	2018	356,133	736,508		
	2019	380,375			
Management ³³					
	2018	126,127	1,460,378	2,566,937 (47%)	39%
	2019	1,334,251			
	2020 (to August)	1,106,559			
	Total Expenditure 2018-2019:		3,790,060		100%

Source: *PSRO Finance Division*

³³ Planning, Monitoring & Evaluation, HR/Operations

Annex 9: Proposed Priority Interventions

This table lists the outcomes, outputs and interventions from the Program Design Document; and the proposed priority interventions and activities for the remainder of the TA program. The main criteria used to select the priority interventions are: direct FP/SRH service delivery for individuals and increasing demand for FP/SRH services.

The wording of some outputs and interventions has been changed to reflect these criteria.

Outputs and Interventions from PDD	Proposed Priority Interventions	Priority Activities
Outcome 1: Increased and improved supply of integrated SRH information and services, particularly for FP		
<p>Output 1: Strengthened delivery of high quality, integrated SRH information and services for women, adolescents and youth across the development-humanitarian continuum</p> <p>Interventions:</p> <p>1.1 Expanded and improved SRH service availability through strengthened policy and in-service training for existing health officers</p> <p>1.2 Enhancing the operational standards and referral systems for improved access to integrated, disability inclusive and youth friendly SRH services</p> <p>1.3 Strengthened mechanisms to evaluate the quality of SRH services at all levels and ensure lessons learned are applied to improved policy and regulatory frameworks</p>	<p>Output 1: Strengthened delivery of high quality, integrated SRH information and services for women, adolescents and youth</p> <p>Interventions:</p> <p>1.1 Expanded and improved SRH service availability through strengthened policy and in-service training for existing health officers</p> <p>1.2 Enhancing the operational standards and referral systems for improved access to integrated, disability inclusive and youth friendly SRH services</p> <p>1.3 Strengthened mechanisms to evaluate the quality of SRH services at all levels and ensure lessons learned are applied to improved policy and regulatory frameworks</p>	<p>HFRSA assessments in all 6 countries;</p> <p>In-service training for SDP staff – human rights, client-centred approach</p> <ul style="list-style-type: none"> - FP counselling and provision of LARC and EC - GBV screening and care - Disability inclusive services - MISP training and kits - IEC for new services - Values clarification exercises <p>Advocacy with national governments to amend local laws/regulations to enable FP service provision at PHC levels;</p> <p>Modify and expand health facility opening hours;</p> <p>All mobile services include a health worker trained in YFS, disability inclusive SRH services, and can provide 3-5 modern methods including LARCs and EC</p> <p>Support IPPF MAs to deliver SRH services and train service</p>

Outputs and Interventions from PDD	Proposed Priority Interventions	Priority Activities
1.4 Ensuring continuity of services during natural disasters.		<p>providers in integrated SRHR services and LARCs/EC</p> <p>Operational guidelines, referral systems, quality of care and coordination mechanisms in place and used.</p>
<p>Output 2: Strengthened health workforce capacities in health management and clinical skills for high quality and integrated SRH services</p> <p>Interventions:</p> <p>2.1 Assessment, adaptation/development and implementation of SRH guidelines and protocols aligned with international standards, including VAWG</p> <p>2.2 Ensure pre-service curriculum and training manuals provide comprehensive education on contraception (to ensure increased method mix) and integrated SRH services (including YFS, prevention and response to VAWG, services for people with disabilities, human rights and humanitarian response</p> <p>2.3 Enhancing health worker in-service training mechanism for delivery of quality integrated SRH services including FP and quality counselling</p>	<p>Output 2: Strengthened health workforce capacities in health management and clinical skills for high quality and integrated SRH services</p> <p>Interventions:</p> <p>2.1 Assessment, adaptation/development and implementation of SRH guidelines and protocols aligned with international standards, especially FP</p> <p>2.3 Enhancing health worker in-service training mechanism for delivery of quality integrated SRH services including FP and quality counselling</p> <p>2.4 Expand in-country capacity to manage quality integrated SRH services, including FP and youth and disability inclusive services</p>	<p>Roll-out WHO clinical guidelines for GBV care – clinical management of rape and GBV case management training:</p> <p>Review existing nursing and midwifery school curricula against international standards for integrated SRHR;</p> <p>Training for nursing and midwifery tutors;</p> <p>In-service training packages for integrated SRH service provision – counselling, FP methods including non-scalpel vasectomy, HR approaches, gender sensitivity and values clarification, GBV prevention and care, screening for cervical cancer, contraceptive surgical procedures etc;</p> <p>Review and update supervision guidelines and train supervisors;</p> <p>Annual refresher training and evaluation of training.</p>

Outputs and Interventions from PDD	Proposed Priority Interventions	Priority Activities
2.4 Expand in-country capacity to manage quality integrated SRH services, including FP VAWG prevention and response and youth and disability inclusive services in development and humanitarian settings		
Outcome 2: Increased demand for integrated SRH information and services, particularly for FP		
Output 3: Increased community engagement and leadership in support of SRH, especially for contraceptive choice Interventions: 3.1 Enhancing knowledge, attitudes and practices related to youth and disability inclusive SRH and contraception among the general population, with special emphasis on specific target audiences. 3.2 Mobilising and engaging communities and increasing community leadership to improve knowledge and demand for SRH and FP	Output 3: Increased community engagement and leadership in support of SRH, especially for contraceptive choice Interventions: 3.1 Enhancing knowledge, attitudes and practices related to youth and disability inclusive SRH and contraception among the general population, with special emphasis on specific target audiences. 3.2 Mobilise and engage communities and increase community leadership to improve knowledge and demand for SRH and FP	BCC strategies developed for target audiences and messages e.g. for men, youth, persons with disabilities and survivors of violence; Mass media for whole of community messaging; Implement through local CSOs, NGOs etc. especially IPPF MAs Train FP/SRH champions (community leaders, teachers, parents etc) to promote SRH issues; Training for community health workers in basic FP/SRH messages and services;
Output 4: Increased national capacity to design and implement community- and school-based family life education (FLE) programs that promote human rights and gender equality Interventions:	Output 4: Increased national capacity to design and implement community- and school-based family life education (FLE) programs that promote human rights and gender equality Interventions:	Work with FLE committees to build support for SRH; Technical assistance for national FLE curricula development; Work with existing CBOs to reach marginalised youth

Outputs and Interventions from PDD	Proposed Priority Interventions	Priority Activities
<p>4.1 Improving the quality and delivery of FLE programs delivered in schools and out-of-school through strengthened curricula, pedagogy, and teacher training</p> <p>4.2 Improving monitoring, evaluation and learning frameworks and the evidence-base for FLE</p> <p>4.3 FLE is integrated into national and regional strategies, plans and policies</p>	<p>4.1 Improving the quality and delivery of FLE programs delivered in schools and out-of-school through strengthened curricula, pedagogy, and teacher training</p> <p>4.2 Improving monitoring, evaluation and learning frameworks and the evidence-base for FLE</p>	<p>including those with disabilities;</p> <p>Train community-based young people;</p> <p>Support and train teachers to provide FLE;</p> <p>Establish referral pathways between schools and SRH services;</p> <p>Establish a mechanism for monitoring and evaluating the impact and effectiveness of FLE;</p>
Outcome 3: More conducive and supportive environment for people to access and benefit from quality SRH, especially contraceptive choice		
<p>Output 5: Expand evidence-based legislation, public policy and programming that support SRHR, especially for youth, violence survivors and people with disabilities</p> <p>Interventions:</p> <p>5.1 Advocacy for, and influence within, policy discussions for key SRH, VAWG, disability and population issues including disaster risk reduction policies and emergency preparedness and response</p>	<p>Output 5: Expand evidence-based legislation, public policy and programming that support SRHR, especially for youth, violence survivors and people with disabilities</p> <p>Interventions:</p> <p>5.1 Advocacy for, and influence within, policy discussions for key SRH, disability and population issues</p>	<p>Develop key SRHR policy briefs for policy makers;</p> <p>Expand relationships with MoF and World Bank to ensure sustainable funding for integrated SRH;</p> <p>Support the ongoing development and costing of minimum package of integrated SRH services for different levels of care (where this has not already been done);</p>
<p>Output 6: Increased availability, analysis and use of high quality, disaggregated, nationally prioritised population and SRH data</p> <p>Interventions:</p>	<p>Output 6: Increased availability, analysis and use of high quality, disaggregated, nationally prioritised population and SRH data</p>	<p>Support MOH HIS and partners (e.g. WHO) to strengthen SRH/VAWG data components including disaggregation by gender, age, sub-national level and disability;</p>

Outputs and Interventions from PDD	Proposed Priority Interventions	Priority Activities
<p>6.1 Strengthening capacity of the National Statistics Offices and MOH to collect and analyse RH and VAWG data through key data collection sources: HIS, DHS/MICS and Census</p> <p>6.2 Expanded use and dissemination of data and lessons learned to: report on progress of integrated SRH services, in particular FP; and use in national planning and sectoral planning, policy, monitoring and evaluation</p>	<p>Interventions:</p> <p>6.1 Strengthening capacity of the MOH to collect and analyse FP/SRH data through the HIS</p> <p>6.2 Expanded use and dissemination of data and lessons learned to: report on progress of integrated SRH services, in particular FP</p> <p>Note: The priority for the remaining TA program implementation is on strengthening MOH HIS data collections and analysis. While it is acknowledged that the NSO role in analysing demographic data from DHS/MICS etc is vital, there are alternative development partners who can support these activities.</p>	<p>Strengthen the capacity of health workers to collect, report, analyse and use FP/SRH data;</p> <p>Link data collection systems to Tupaia;</p> <p>Support policy makers' capacity to use data to inform policy and programming;</p> <p>Build an investment case for investing in FP.</p>

Annex 10: Situation Analysis of MOH and IPPF MAs in the Six Countries

This annex describes the SRH roles of the two main SRHR service providers: MOHs and IPPF MAs.

The MOH data includes: policy and program priorities; FP/SRH programming; FP methods offered; and relevant results of the HFRSA assessment (where it has been conducted).

The IPPF MA data includes clinical and educational services provided by the MA; staffing information; geographic coverage; their relationships with MOHs; and programs implemented by the MAs.

The purpose of this annex is to illustrate that much integrated SRH, particularly FP, is in existence and functioning. While MOHs have many more SDPs than IPPF MAs, the MAs are often utilised by MOHs to reach hard to reach populations and locations.

IPPF is a global service provider and advocates for SRHR for all; and empowers women and young people to advocate for change. It ensures that young people have the information, education and services they need to realise their SRHR. This is done through Comprehensive Sexuality Education (CSE) in formal and non-formal settings; and through the provision of expertise in the development of school curricula to ensure critical components are not excluded from Family Life Education (FLE). IPPF's Integrated Package of Essential Services is implemented by all Member Associations (MAs).

Components of IPPF's Integrated Package of Essential Services

1. Counselling – sex and sexuality; relationship
2. Contraception – counseling; oral contraceptive pills; condoms; injectables; at least one long-acting and reversible contraceptive (IUD or implants); at least one emergency contraceptive method
3. Safe abortion care – pre-and post- abortion counseling; at least one of: surgical abortion OR medical abortion OR incomplete abortion treatment
4. STI/RTIs – at least one STI/RTI treatment method OR at least one STI/RTI lab test;
5. HIV - pre- and/ or post-test counseling; HIV lab tests
6. Gynaecology – manual pelvic exam (auto-qualify if provides Pap Smear); manual breast exam; Pap Smear OR other cervical cancer screening method
7. Pre-natal care – confirmation of pregnancy; prenatal care
8. Gender based violence – screening for gender-based violence; clinical management of rape; referral mechanisms for clinical, psychosocial and protection services.

All IPPF MA staff are trained in FP counselling; integrated service delivery (FP, STI/HIV and ANC/PNC); provision of adolescent and youth friendly services; GBV care; and disability inclusive services.

Principles Guiding the Delivery of Essential Package of Services:

1. Integration of sexual and reproductive health services regardless of the initial point of entry.
2. Ensuring high quality, effective and efficient services by applying the *IPES Quality Assurance Toolkit*.
3. Change from a provider-centred towards a client-centred approach within a rights perspective based on client satisfaction and improvements in the health of the communities we serve.
4. Ensuring universal access to SRH and minimizing missed opportunities, with attention to:
 - The needs of vulnerable groups, especially women and girls
 - The needs of adolescents and young people, both those sexually and non sexually-active.
5. Involving the community, in particular women and girls, to lead and shape the response to sexual and reproductive needs, taking into account considerations of gender equity.
6. Facilitating respect, protection and fulfilment of human rights, which include sexual and reproductive rights, by offering client-centred services that are stigma-free and youth-friendly;

7. Adopting a broader health care model that incorporates human and sexual rights of adolescents, women, and men, gender equity, and respects culture, values of choice, dignity, diversity and equality.
8. Pursuing the continuum of care by strengthening partnership with and referral to higher level clinical, psycho-social and protection services of governmental and non-governmental agencies that support IPPF values and objectives.
9. Ensuring rational, safe and acceptable de-medicalization of SRH services through task sharing and/or shifting where applicable.

IPPF implements a **quality of care strategy** which involves:

- the provision of an integrated package of essential services in static clinics
- a system for quality improvement based on self-assessment and supportive supervision
- the use of data standards based on existing protocols and aimed at providing quality health care by analysing client-specific information

All Pacific MAs (9) operate on the basis of IPPF policies, service standards and standard data collection.

Indicators used to measure progress:

- Number of Pacific MAs providing at least 6 out of 8 IPES categories:
- Number of FP services provided, disaggregated by method
- Number of cervical cancer testing and referral services delivered
- Number of cervical cancer treatment services delivered
- Number of SRH services delivered
- Number of clients reached with SRH services
- Number of family planning clients, disaggregated by type of user
- Proportion of population in given area (determined by MAs) receiving SRHR services*
- Proportion of communities/districts/islands being reached by the MA to deliver SRH services*
- Number of Clients reached who are 'marginalised' or 'underserved'
- Proportion of clients reached who are 'marginalised' or 'underserved' %
- Average Quality of Care Audit Scores of Pacific MA clinics
- Number of clients surveyed who would recommend MA services
- Proportion of clients surveyed who would recommend MA services

MOH and MA SRHR Service Delivery

Country/MOH	MOH Situation Analysis on FP/SRH	IPPF MA Role and Integrated SRH Programming
Fiji	<p>National Strategic Health Plan 2016-2020 – relevant priority areas include: NCDs, RMNCAH, PHC.</p> <p>Pillar 1 – includes AYF services 'Expand provision of preventive and clinical services to include 13-17 year olds' and 'Expand availability and coverage of YFS targeting 15-24 years and under'</p> <p>New National Health Strategic Plan 2020-2023 in progress: relevant priorities include: PHC services, nursing and outer island services.</p>	<p>Reproductive Health Association of Fiji (RHAF)</p> <ul style="list-style-type: none"> • 1 main static clinic with a lab • 2 program offices based in the west and north of Fiji with two program officers in the offices. • Staff includes: ED, three nurses, 1 program manager, 3 program officers, data officer, finance officer, procurement and stock officer and administration/assistant finance officer, personal assistant to ED.

Country/MOH	MOH Situation Analysis on FP/SRH	IPPF MA Role and Integrated SRH Programming
	<p>FP methods offered: OCP, injectable, IUD, condom, implants</p> <p>HFRSA results: 212 SDPs (includes RHAF)</p> <ul style="list-style-type: none"> -3 modern methods – 89% -5 modern methods – 39% -Stockouts last 6 mths – 59% -Integrated SRH – 2% -GBV – 74% but only 4% to global standards - YFS – 3% - PWD access – 28% Cervical cancer screening – 71% <p>Staffing³⁴:</p> <p>Nurse Practitioner – 39</p> <p>Nurses (fulltime) – 2,661</p> <p>Nurses (part-time) – 14</p> <p>Midwives (F/T) 253</p> <p>Midwives (P/T) – 1</p> <p>Pharmacists – 70</p> <p>Lab Techs – 125</p> <p>CHW – 1,787</p>	<ul style="list-style-type: none"> • Static Clinic + 3 Mobile Outreach Clinic teams • Provision of 36 SRH services – mapped against IPPF 225 coded services from Family Planning, GBV, HIV/STI/RTI, Cervical Cancer Screening and treatment, Gynaecology etc. • Community Sexuality Education and awareness programs: with PWD, seafarers, LGBTI communities, squatters, young people, sex workers. • 22 active volunteers • Comprehensive youth and community education program (volunteers). • Humanitarian Response – Cyclone Harold and Cyclone Winston in Fiji. <p>No. of SDPs: 1 Static clinic and 3 mobile clinics.</p>
Kiribati	<p>MHMS Health Sector Plan 2016-2019, MHMS 2015</p> <p>Emphasis on the importance of relationships, partnerships and intersectoral coordination and collaboration, including NGOs.</p> <p>Relevant strategic objectives:</p> <ul style="list-style-type: none"> -Increase access to and use of high quality, comprehensive family planning services, particularly for vulnerable populations including women whose health and wellbeing will be at risk if they become pregnant. <p>Actions:</p> <ul style="list-style-type: none"> -Improve skills, quality of services and access to family planning drugs and commodities for rural and urban islands. -Reinvigorate national Reproductive Health committee to proactively monitor & evaluate the data input towards Family Planning services -Engage with development partners around support for initial implementation of the RH strategy, and initiate work to identify a sustainable funding mechanism. 	<p>Kiribati Family Health Association (KFHA)</p> <p>Clinic services:</p> <ul style="list-style-type: none"> • 1 main static clinic with a lab • Staff includes: ED, four nurses, 1 lab technician, 2 program managers, 3 program officers, data officer, finance officer, administration and youth officer. • 1 Static Clinic + 2 Mobile Outreach Clinic teams • Provision of 52 SRH services – mapped against IPPF 225 coded services from Family Planning, HIV/STI/RTI, Cervical Cancer Screening and treatment, Gynaecology, Vasectomy, Urology, Antenatal etc. • Community Sexuality Education and awareness programs: with PWD, seafarers, LGBTI communities, squatters, young people, sex workers.

³⁴ HFRSA Report for Fiji, 2020

Country/MOH	MOH Situation Analysis on FP/SRH	IPPF MA Role and Integrated SRH Programming
	<p>-Strengthen partnership with KFHA, FBOs, youth groups and other non-government organizations to expand Family Planning services and increase involvement of men.</p> <p>-Engage with other GOK ministries departments to coordinate and integrate resources & approaches to managing population growth to benefit the aspirations of all sectors.</p> <p>-Improve access to high quality and appropriate health care services for victims of gender-based violence, and services that specifically address the needs of youth.</p> <p>Actions:</p> <p>-MHMS to implement Standard Operating Procedure of Eliminating Sexual and Gender Based Violence (ESGBV) policy in line with the national policy taking into account constant reviews and updates</p> <p>-Improve health care facilities and systems or management, treatment and care of victims of GBV.</p> <p>-Build the capability and capacity of the health workforce so that it is better able to meet the health care needs of victims of GBV</p> <p>-Strengthen GBV task force activities in terms of meetings, auditing of cases, awareness, data recording and improving service delivery points.</p> <p>-Strengthen MHMS GBV coordination with national GBV stakeholders</p> <p>-MHMS to finalizing and implementing national operational guidelines for Youth Friendly Health Services and implement in coordination with multi sectors initiatives.</p> <p>-MHMS to improve planning of and expand access to YFHS.</p> <p>-Strengthen MHMS coordination on YFHS with national youth stakeholders</p> <p>-The Ministry has, with its development partners, established a Health Sector Coordinating Committee (HSCC) in order to strengthen coordination of support for, and planning and delivery of, health services in Kiribati.</p> <p>-KFHA has the oversight role for the strategic objective relating to FP.</p>	<ul style="list-style-type: none"> • 3 active community-based distributors in three outer islands • 40 active volunteers. • Laboratory: testing for gonorrhea, syphilis, candida, Pap smears, HIV. • Regular Outreach clinics e.g. to North Tarawa/Buota (YP) and Nanakai Village (for people with disabilities) • Outreach to outer islands - integrated services to outer islands: Beru, Nikanau, Miaino, South Tarawa, Aranuka, Abolang. KFHA now covers 72% of the population. Outreach team of 4 nurses, lab technician and ED meet with Island Council and church leaders; see clients (FP, STI testing, NCD) at government health centres and in households. 2 volunteer couples (catechists) assist with awareness. • Youth program: Youth volunteers (students, dropouts, unemployed) involved in mobile clinics including A/H clinic services, outreach teams to outer islands, condom distribution³⁶, school visits. Volunteers are trained in basic counselling, FP, STI/HIV. CSE training provided for youth leaders - all components taught. Volunteers submit monthly reports to KFHA. Schools (Junior secondary, secondary and tertiary – Kiribati Institute of Technology (KIT), Marine training college, USP) invite KFHA to present SRHR in drama followed by group work using cards with relationship problem scenarios - to approx. 50 students per session. • Work with Catholic Church: The training for Catholic Leaders (52) which marks the revitalization of the partnership between KFHA and the Catholic church since the banning of KFHA's programs and services from

³⁶ Youth volunteers are Community based distributors (CBDs)

Country/MOH	MOH Situation Analysis on FP/SRH	IPPF MA Role and Integrated SRH Programming
	<p>New Strategic Plan in progress.</p> <p>FP methods offered: condoms, OCP, IUD, injectable, implants, EC</p> <p>HFRSA Results – 112 SDPs (includes KFHA) SDPs with 3 modern methods FP – 74% SDPs with 5 modern methods FP – 50% SDPs with stockouts FP method last 6 mths – 44% YFS, integrated SRH – 3% (to global standard) GBV service – 72% PWD access – 3.5% Cervical cancer screening – 16%</p> <p>Indicators used for FP: (HIS) WHO Standard ABR 10-14 yrs/1000 girls ABR 15-19 yrs/1000 girls Contraceptive contacts (except condoms) at SDP/1000 popn Contraceptive contacts (all forms) at SDP/1000 popn. Disaggregated by age, location, type/method, name, island</p> <p>Staffing³⁵: Nurse Practitioner (F/T) – 90 Nurse (F/T) – 448 Nurse (P/T) – 14 Midwife (F/T) – 64 Midwife (P/T) – 8 Pharmacists – 13 Lab Techs – 7 CHW - 297</p>	<p>all Catholic premises in 2017. One of the positive results of this activity was that 50% of the population on Kiritimati Island was reached with important SRHR information through these church leaders. In addition, 787 were reached during road show and young couple's training in the island.</p> <ul style="list-style-type: none"> • The signing of MOU between KFHA and Kiritimati Urban Council (KUC) has provided a foundation on which KFHA could use to achieving its program objectives at a minimized cost. For example: The Council's willingness to provide a room within their building to be used as a KFHA's Clinic (SDP) during clinical mobile outreach. • KFHA was invited by MoE to assist with FLE curriculum. • IEC resources: A range of leaflets, posters, stickers, DVDs, and other resources are developed by KFHA staff. • KFHA staff have had NCD training provided by WHO and an update on STI by MHMS. • Healthy Families Program with FPNZ: Focused on FP and community development/outreach to South Tarawa. <p>No. of SDPs: 1 (but also 2 mobile/outreach clinical/ 3 Community based distributors).</p>
Samoa	<p>The Health Sector Plan (HSP) 2008-2018 priorities include RMNCAH and to strengthen health systems through processes between the Ministry and health sector partners.</p> <p>Samoa National SRH Policy 2018-2023 prioritises access to FP.</p> <p>4 components: 1) Safe motherhood – FP, ANC, clean/safe delivery, essential obstetric care</p>	<p>Samoa Family Health Association (SFHA)</p> <ul style="list-style-type: none"> • 3 Static clinics (Savaii, Motuatua and Savalalo) • Staff includes: ED, 7 nurses, 1 program managers, 3 program officers, data officer, finance officer, finance assistant, administration and youth officer. • 3 Mobile Outreach Clinic teams

³⁵ HFRSA Report for Kiribati, 2020

Country/MOH	MOH Situation Analysis on FP/SRH	IPPF MA Role and Integrated SRH Programming
	<p>2) Fertility regulation – FP; target is 80% women to use contraceptives by 2030 (current estimate is 37%)</p> <p>3) Prevention and control of STIs especially chlamydia</p> <p>4) GBV services.</p> <p>Relevant strategies include: Promote demand for FP Mobilise civil society Integrate SRH into public health policies Essential package of care (labour & delivery) Adolescent health interventions & YF services Advocacy for FP National cervical cancer screening HIV tests for ANC women HIV prevention for most at risk population Affordable SRH for priority target groups SRH mass media messages SRH commodities accessible Conduct SRH services Increase the capacity of health workers to provide modern methods – IUD, injectable, implants Address infertility and contraceptive choice.</p> <p>FP methods offered: condoms, IUD, injectable, implants (doctors trained), OCP, EC Plans to train nurses to insert/remove implants</p> <p>HFRSA assessment results: 14 SDPs (includes SFHA) 3 modern methods FP – 92% 5 modern methods FP – 75% Stockouts FP method last 6 mths – 36% YFS, integrated SRH – 86% but none to global standards GBV service – 57% but none to global standards PWD access – 100% Cervical cancer screening – 7%</p> <p>Former SPAGHL Committee - Samoa Parliamentary Advocacy Group for Healthy Living - comprised parliamentary members and chaired by the Speaker of the House - used to be a very active Committee</p>	<ul style="list-style-type: none"> • Provision of 42 SRH services – mapped against IPPF 225 coded services from Family Planning, HIV/STI, Gynaecology, Antenatal etc. • Community Sexuality Education and awareness programs: with PWD, Hotel workers, foreign workers, LGBTQI communities, young people, and sex workers. • 3 active community-based distributors in three outer islands • 36 active volunteers. • SFHA is the leading SRH NGO in Samoa, providing antenatal care, STI testing, counselling and treatment, family planning services and SRH education and awareness programs to schools, churches and the community; programs and services run across all inhabited islands; advocate at national and community levels for the inclusion of SRHR in policies and programs. • Youth program - volunteers, peer educators (30% of clients are YP) • Outreach to 41 villages planned in partnership with MOH; visits are planned to coincide with women's contraceptive cycles. • IEC resource development – includes BCC - modern youth messaging using AVI. During the COVID 19 situation due to restrictions, SFHA had used social media platforms and TV and radio to reach as many people as possible to access SRH services at their clinics. • Integrated program 2-3 times per year when MoH and SFHA outreach nurses, MWCSO officers, youth volunteers' outreach to schools, women's groups in rural Upolu and rural Savaii (one week in each island). • MoH and SFHA nurses jointly outreach to rural health facilities to

Country/MOH	MOH Situation Analysis on FP/SRH	IPPF MA Role and Integrated SRH Programming
	<p>Staffing³⁷: Nurses (F/T) – 160 Nurses (P/T) – 5 Midwives (F/T) – 33 Midwives (P/T) – 15 Pharmacists – 6 Lab Techs – 4 CHWs - 261</p>	<p>evaluate training of nurses and midwives, including LARC training. SFHA Impact Project managed by DFAT Post, Apia:</p> <p>Indicators to measure progress towards this goal include:</p> <ul style="list-style-type: none"> • Contribute to increasing CPR by End of Project (EOP)/2021 • Contribute to reducing unmet need for family planning by EOP/2021 • Contribute to reducing TFR by EOP/2021 • Contribute to reducing ASFR by EOP/2021 • Contribute to reducing MMR by EOP/2021 <p>No. of SDPs: 3 static clinics and 3 mobile/outreach clinical team.</p>
Solomon Islands	<p>National Development Strategy 2016-2035, April 2016 This strategy aims to improve social and economic livelihoods for all Solomon Islanders. Relevant sections include: - improving access to health and family planning services particularly for the poor in rural areas where IMR and CMR are high. - improving gender equity and support for disadvantaged and vulnerable, and addressing GBV. - ensuring all Solomon Islanders have equitable access to quality health centres; and combat communicable and NCDs. Priority policies and programs include: - improved MCH across all provinces through use of LARCs, counselling and FP training - strengthened health worker, peer educator and teachers' competency on adolescent health issues and provision of youth-friendly spaces.</p> <p>National Strategic Health Plan 2016-2020. KRA 1 Improve service coverage. KRA2 Build strong partnerships.</p>	<p>Solomon Islands Planned Parenthood Association (SIPPA)</p> <ul style="list-style-type: none"> • 4 static clinics (Honiara, Gizo, Auki and Choiseul). • Staff includes: ED, 9 nurses, 1 program manager, 3 program officers, data officer, finance officer, finance assistant, administration, and youth officer. • 3 Mobile Outreach Clinic teams • Provision of 55 SRH services – mapped against IPPF 225 coded services from Family Planning, Gynaecology, Antenatal, urology, HIV/ STI/RTI checks and treatment, gynaecological care including Pap Smears, GBV screening, counselling etc. • Community Sexuality Education and awareness programs: with PWD, LGBTQI communities, young people, and sex workers. • 10 active community-based distributors in three outer islands

³⁷ HFRSA Report for Samoa, 2018

Country/MOH	MOH Situation Analysis on FP/SRH	IPPF MA Role and Integrated SRH Programming
	<p>KRA 3 Improve service quality. KRA4 Lay the foundation for the future. Objective 1 Improve family health; Most common contraceptives - 27.3% modern method with TL most common -13.3%; injectable 8.8%; IUD 2.1%; male sterilisation 0.3%. Fear of using contraception 37%. Objective 4 Progress Young People's wellbeing. Objective 5 Scale up Prevention and care for cervical cancer. Objective 7 Build strong partnerships. Underserved populations are on Malaita, Makira, Choiseul and Central provinces. 2 priority groups – persons with disability and women exposed to violence and abuse. Overarching goal is UHC and MHMS now has a Role Delineation Policy.</p> <p>Role Delineation Policy: UHC as guiding principle; packages of services for 6 levels of care: Community centre – FP package Rural Health Centre (RHC) – FP package + RMNCAH, clinical management of rape Area Health Centre (AHC) 1 – RHC package + anaesthetic services, HIV testing & treatment AHC2 – AHC1 package + medical stores, supervision of RHCs Urban HC1 – PHC + specialist services</p> <p>FP methods offered: Pills, condoms, injectables, implants (Jadelle), IUD</p> <p>HFRSA assessment results: Not yet done</p> <p>Staffing³⁸: Nurses – 1,066 Midwives – 156</p>	<ul style="list-style-type: none"> 40 active volunteers. Communication - IEC resources on SRH; radio spots and has produced and distributed short films, songs and clips around SRHR messaging and access to SRHR. SIPPA had had conducted a 'Safe Abortion Research' 2018 -2019. <p>No. of SDPs: 4 static clinics and 3 mobile/outreach clinical team and 10 community-based distributors.</p>
Tonga	<p>National Health Strategic Plan 2015-2020 6 key results areas: Service delivery; health workforce; infrastructure, products and technology; leadership and governance; health care finance. FP not specifically mentioned.</p>	<p>Tonga Family Health Association (TFHA)</p> <ul style="list-style-type: none"> 1 static clinics (Tongatapu) and 2 clinic setups on Vavau and Haa'pai which are used for clinic services during outreach but have no permanent nursing staff (a

³⁸ State of the Pacific RMNCAH Workforce, 2019

Country/MOH	MOH Situation Analysis on FP/SRH	IPPF MA Role and Integrated SRH Programming
	<p>FP methods offered: condoms, OCP, IUD, injectable, implant, EC</p> <p>HFRSA Assessment Results (31 SDPs – includes TFHA): 3 modern methods FP – 93% 5 modern methods FP – 75% Stockouts FP method last 6 mths – 80% YFS, integrated SRH – 7 % - 86% but not to global standards GBV service – None – 58% but not to global standards PWD access – 100% Cervical cancer screening – 7%</p> <p>Staffing Community Health Centres³⁹: Health Officers – 8 Nurse Practitioners – 1 Nurses- 13</p>	<p>volunteer retired nurse sometimes fills in). 2 mobile outreach.</p> <ul style="list-style-type: none"> • Staff includes: ED, 3 nurses, 1 program manager, 3 program officers, data officer, finance officer, finance assistant, administration, and youth officer. • 2 Mobile Outreach Clinic teams • Provision of 42 SRH services – mapped against IPPF 225 coded services from Family Planning, Antenatal, HIV/ STI/RTI checks, gynaecological care including Pap Smears, counselling etc. • Community Sexuality Education and awareness programs: with PWD, LGBTQI communities and young people. • 20 Active volunteers • It has an active youth program with peer educators and the Filitonu boys' drama group. Clinic services are held at the static clinic and also at outreach sites e.g. school clinics and civil servants' offices etc. Program Manager/trainer conducts training on peer education, disability, SPRINT, GBV and SRH. <p>No. of SDPs: 1 static clinic and 2 mobile/outreach clinical team.</p>
Vanuatu	<p>Vanuatu National Population Policy 2011-2020</p> <p>Relevant Policy Goal: Policy Goal 1: Reduce fertility and unintended pregnancy particularly among target population groups - VFHA is a supporting agency</p> <p>National Health Strategy 2017-2020</p> <p>Three main strategic directions:</p>	<p>Vanuatu Family Health Association (VFHA)</p> <ul style="list-style-type: none"> • VFHA has 3 clinics (Vila, Santo and Tanna). • 40 trained peer educators in Epi, Santo, Gaua, Pentecost, Malekula, Ambae, Tanna, Paama, Aneutym, and Vila. VFHA has youth centres in 5 provinces. • ED, 1 Program Manager, Staff include 5 nurses (one male nurse), a clinic receptionist, youth officer, finance officer and M&E officer. • 10 active volunteers

³⁹ Package of Essential Health Services – Tonga; 2019

Country/MOH	MOH Situation Analysis on FP/SRH	IPPF MA Role and Integrated SRH Programming
	<ul style="list-style-type: none"> • Strengthening health service management and information systems; • Improving population access to health services through integrated planning, and fair allocation of resources; and • Strengthening collaborative action across sectors and within the health sector to create a healthier environment and address major health issues. <p>Strategy does not specifically mention FP.</p> <p>HFRSA assessment results: Not yet done</p> <p>Staffing⁴⁰:</p> <p>Nurses – 178</p> <p>Midwives - 81</p>	<ul style="list-style-type: none"> • Provision of 56 SRH services – mapped against IPPF 225 coded services from Family Planning, Antenatal, HIV/ STI/RTI checks, gynaecological care including Pap Smears, counselling, urology etc. • VFHA has a social enterprising arm that generates funding for the organisation through a set-up of clinic in Port Vila that provides medical check-up for Ni-Vanuatu who are applying for a driver's license. • VFHA youth friendly service (YFS) has been rolled out in govt health centres and VFHA staff accompany govt health staff on outreach and supervisory visits to Ekiye, Erakor, Eratap, Tokaro, Pangpang and to communities in South Santo. • VFHA is an implementing partner for UNFPA PRSRHP - rolling out training of and increase the uptake of Jadelle. Training was provided for 113 health workers at national and provincial levels. Support for FLE in selected schools and school-based clinics was also supported. VFHA is said to have the best implementation rate of the five countries involved (UNFPA PRSRHP Annual Report 2016-2017). • MoH and provincial health staff agree VFHA is the leading SRH organisation in Vanuatu and could do more with more resources. • VFHA intends doing a program with NZFPI similar to the Healthy Families Program in Kiribati supported by NZFPI. It will target remote areas in rural Santo, Banks and South Pentecost. <p>No. of SDPs: 3 static clinic and 3 mobile/outreach clinical team.</p>

⁴⁰ State of the Pacific RMNCAH Workforce, 2019

Annex 11: Acronyms

ABC	Australian Broadcasting Commission
ABR	Adolescent Birth Rate
AIDS	Acquired Immuno-deficiency Syndrome
ANC	Ante Natal Care
AWP	Annual Work Plan
AY	Adolescent and Youth
AYFHS	Adolescent and Youth-Friendly Health Services
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BCC	Behaviour Change Communication
CPR	Contraceptive Prevalence Rate
COGNOS	Spreadsheet of Activities, Budget and Utilisation by IP and Country
CROP	Council of Regional Organisations in the Pacific
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
DAC	Development Assistance Committee
DFAT	Department of Foreign Affairs & Trade (Australian Government)
DHS	Demographic Health Survey
EC	Emergency Contraception
EMONC	Emergency Obstetric and Neonatal Care
ESP	Essential Services Package
FACE	Financial Management Forms (UNFPA)
FLE	Family Life Education
FO	Field Officer (UNFPA)
FP	Family Planning
FPNSW	Family Planning New South Wales
GBV	Gender-Based Violence
GBVIE	Gender-Based Violence in Emergencies
GE	Gender Equality
GESI	Gender and Social Inclusion
HFRSA	Health Facility Readiness and Service Availability
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
HR	Human Rights
ICPD	International Conference on Population and Development
IDD	Investment Design Document
IEC	Information, Education, and Communication
IO	International Organisation
IP	Implementing Partner
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
KFHA	Kiribati Family Health Association
KII	Key Informant Interview
LARC	Long Acting Reversible Contraception

M&E	Monitoring & Evaluation
MA	Member Association (IPPF)
MCP	Multi-Country Programme
MDPAC	Ministry of Development Planning and Aid Coordination
MEF	Monitoring and Evaluation Framework
MEL	Monitoring, Evaluation and Learning
MESC	Ministry of Education, Sport and Culture
MFAT	Ministry of Foreign Affairs and Trade (New Zealand Government)
MHMS	Ministry of Health and Medical Services
MISP	Minimum Initial Service Package
MOE	Ministry of Education
MOET	Ministry of Education and Training
MOF	Ministry of Finance
MOFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
MOW	Ministry of Women
MOYS	Ministry of Youth and Sport
MTR	Mid-Term Review
MWCPA	Ministry of Women, Children and Poverty Alleviation
MWCSD	Ministry of Women, Community and Social Development
MWYCFA	Ministry of Women, Youth, Children and Family Affairs
MYS	Ministry of Youth and Sport
MWYSSA	Ministry of Women, Youth, Sports and Social Affairs
NCs	National Consultants
NCC	National Coordination Committee
NCD	Non Communicable Diseases
NGO	Non-Governmental Organization
NHRI	National Human Rights Institute
NHS	National Health Service
OECD	The Organisation for Economic Co-operation and Development
PDD	Program Design Document
PE	Peer Educator
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PICT	Pacific Island Countries and Territories
PRSRHP	Pacific Regional Sexual & Reproductive Health Programme
PSC	Program Steering Committee
PSRAP	Pacific Sub-Regional Action Plan (2018-2022)
PSRO	Pacific Sub-Regional Office (UNFPA)
PSRPD	Pacific Sub-Regional Program Document (2018-2022)
Q	Quarter (<i>note that quarters pertain to calendar years</i>)
RH	Reproductive Health
RIP	Regional Implementing Partners
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SIHSSP	Solomon Islands Health Sector Support Program

SPBEQ	South Pacific Board of Education Qualifications
SPRINT	SRH in Crisis and Post-Crisis Situations
SBS	Solomon Islands Bureau of Statistics
SDG	Sustainable Development Goals
SDP	Service Delivery Point
SFA	Samoa Faafafine Association
SFHA	Samoa Family Health Association (IPPF MA)
SHS	Specialist Health Service
SIPPA	Solomon Islands Planned Parenthood Association (IPPF MA)
SPC	Secretariat of the Pacific Community
SR	Sub-Recipient
SRCS	Samoa Red Cross Society
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRGP	Sub-Regional Office of the Pacific (IPPF)
SRP6	Sub Regional Programme for the Pacific (UNFPA 6th Cycle SRP 2018-2022)
STI	Sexually Transmitted Infection
TA	Transformative Agenda for Women, Adolescents & Youth in the Pacific (DFAT)
TASC	Transformative Agenda Steering Committee
TATT	Transformative Agenda Technical Team
TFHA	Tonga Family Health Association
TL	Team Leader
TOC	Theory of Change
TOR	Terms of Reference
TS	Technical Specialist
TWG	Technical Working Group
UHC	Universal Health Coverage
UNPS	United Nations Pacific Strategy 2018-2022
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAWG	Violence against Women and Girls
VFHA	Vanuatu Family Health Association (IPPF MA)
VHP	Vanuatu Health Program
VNSO	Vanuatu National Statistics Office
WEI	Women Enabled International
WHO	World Health Organization
WP	Work Plan
WPR	Work Plan Progress Report
WRA	Women of Reproductive Age
WVI	World Vision International