

High-level design:

Responding with Essential SRHR Provision and New Delivery Mechanisms (RESPOND)

This high-level design has been jointly developed and prepared by International Planned Parenthood Federation (IPPF) and Marie Stopes International Australia (MSI Reproductive Choices)

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Acronyms

ACRONYM	MEANING
ANC	Antenatal Care
CBSS	Community Based Support System
CCS&PT	Cervical Cancer Screening and Preventative Therapy
CEI	Client Exit Interview
CLIC	Client Information Centre
CMIS	Clinic Management Information System
DFAT	Australian Government Department of Foreign Affairs and Trade
DHI	Digital Health Interventions
DHIS	Digital Health Information System
FCDO	United Kingdom Foreign, Commonwealth and Development Office
FP	Family Planning
FP/SRH	Family Planning and Sexual and Reproductive Health
HIV	Human Immuno-deficiency Virus
IDP	Internally Displaced People
IP	Infection Prevention
IPPF	International Planned Parenthood Federation
IPES	Integrated Package of Essential Services
ISM	ISM Corporation
LoE	Level of Effort
LARC	Long Acting and Reversible Contraceptives
MA	IPPF Member Association
M&E	Monitoring and Evaluation
MDT	Medical Development Team
MISP	Minimum Initial Service Package
MoH	Ministry of Health
MOU	Memorandum of Understanding
MSI	MSI Reproductive Choices
MSIA	Marie Stopes International Australia
MSTF	Multi Sector Task Force
NGO	Non-Governmental Organisation
PAC	Post-Abortion Care
PICTs	Pacific Island Countries and Territories
PNG	Papua New Guinea
PPE	Personal Protective Equipment
QoC	Quality of Care
RDQA	Routine Data Quality Assessment
RO	IPPF Regional Office
SBCC	Social and Behaviour Change Communications
SC	Steering Committee
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
SMS	Short Message Service
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UK	United Kingdom
UNDP	United Nations Development Programme
UNFPA	United Nations Populations Fund
VCAT	Value Clarification and Attitude Transformation
WISH	Women's Integrated Sexual Health Programme
WHO	World Health Organisation

1. Executive Summary – Responding with Essential SRHR Provision and New Delivery Mechanisms (RESPOND)

Programme overview

The overall goal of the RESPOND programme is to ensure populations affected by the COVID-19 pandemic in the Asia Pacific region have enhanced sexual and reproductive health and rights.

As COVID-19 continues to present unique and rapidly changing challenges in Asia and the Pacific, there is a need to restore services, particularly to marginalised populations such as young people, people living in poverty and people with disabilities. The pandemic has also highlighted challenges and limitations with existing service delivery models and the need to *build back better* to be able to respond to future crises, by strengthening, scaling up and sustaining new approaches.

Estimated impact

- Number of maternal deaths averted
- Number of unwanted pregnancies averted
- Number of unsafe abortions averted

Timeframe

The in-country activities will run for 24 months.

Budget

The budget is AUD \$33,430,000.

Output 1: high-quality and equitable SRH services provided through established service delivery channels

Key interventions

- Providing high-quality SRH services through established service delivery channels
- Strengthening organisational and health care provider capacity in provision of quality comprehensive SRH services and COVID-19 response
- Strengthening the provision of SGBV services and referral pathways for SCBV survivors
- Strengthening supply of essential SRH and infection prevention commodities and supplies
- Expanding contraceptive social marketing

Output 2: women, men and young people have access to digital health services (telemedicine) and alternative service delivery models (home-based care, self-care, etc)

Key interventions

- Exploring and scaling-up telemedicine
- Increasing availability, accessibility and acceptability of SRH self-care approaches and home delivery
- Adapting pathways of care

Output 3: women, men and young people receive quality, trusted and accessible information on SRH and COVID-19

Key interventions

- Conducting awareness-raising activities through radio, campaigns, TV, SMS and social media
- Strengthening MSI's contact centres and IPPF's remote counselling/hotlines

End of Programme Outcome

The RESPOND programme will result in higher uptake of high-quality and equitable SRH services by the most vulnerable. The programme will use innovative approaches adapted to the pandemic, and restore services that have been impacted due to COVID-19.

This includes continued service delivery through traditional channels, scale up of new delivery approaches, strengthening organisational capacity and data systems and working closely with the

Ministry of Health and other partners in countries of implementation. The programme will also provide an integrated package of services with attention to the *shadow pandemic*: an increase in SGBV.

2. Background

2.1 Situation analysis

The COVID-19 pandemic has been the fastest-moving global public health crisis in a century, causing significant mortality and morbidity, and creating additional obstacles to women's ability to access important, life-saving sexual and reproductive health (SRH) services.

Experience from past epidemics – such as Ebola and Zika – demonstrates that attempts to control outbreaks often divert resources from routine health services and exacerbate the often already limited availability of SRH services. A survey conducted by the World Health Organisation (WHO) in 2020 across 105 countries shows that family planning (FP) services were disrupted in 68% of countries, with 9% reporting severe or complete disruption.¹ According to UNFPA, an estimated 12 million women may have been unable to access FP services as a result of the COVID-19 pandemic globally, with disruption of supplies and services lasting an average of 3.6 months. As a result of these disruptions, as many as 1.4 million unintended pregnancies may have occurred before women were able to resume use of FP services.²

In the Asia Pacific region, the impact of COVID-19 on the availability of, and access to, SRH care is evident. In Timor, 24% of 156 households with women aged 15-49 surveyed by UNDP – reported having missed FP or reproductive health services³; while in Samoa FP visits fell by 47%. In April 2020, more women (24%) than men (17%) reported being unable to access medical care when they needed to in Cambodia.⁴ Since the start of the COVID-19 pandemic, there has also been a significant reduction in the uptake of maternal and new-born health services. Bangladesh reported disruption to antenatal care (ANC) services, which decreased by 41%. Nepal missed its 2020 maternal mortality reduction target⁵ and has seen notable increases in institutional stillbirth rates and neonatal mortality, as well as decreases in quality of care.⁶

The COVID-19 pandemic has also led to disruptions in supply chains nationally, regionally, and globally, including for contraceptives and essential medical supplies. Despite the manufacture of many contraceptives in the region, issues included stock-outs in Myanmar, pharmaceutical slowdowns in India and China, and increased delivery times of contraceptives from Malaysia.

Existing gender and social inequalities are being exacerbated by COVID-19 and are impacting girls and women in different ways to men and boys. In Vietnam, UNFPA-supported hotline services found that reports of sexual and gender-based violence (SGBV) increased by 20% in 2020. A study conducted by UNFPA, UN Women and Quilt.AI, shows that internet searches related to violence against women and help-seeking rose significantly during COVID-19 lockdowns in eight Asian countries (Bangladesh, India, Indonesia, Malaysia, Nepal, Philippines, Singapore and Thailand). Specifically, searches related to physical violence in the Philippines and Nepal, grew by 63% and 55% respectively between October 2019 and September 2020.⁷

The COVID-19 pandemic has magnified many of the underlying vulnerabilities within the Asia region, including lack of basic infrastructure, exposure to climate hazards, limited access to services as well as ongoing budget and political impasses. For example, Timor-Leste has been recently devastated by heavy rains which have resulted in landslides and the worst flooding in four decades. A strict lockdown

¹ Pulse survey on continuity of essential health services during the COVID-19 pandemic - Interim report, August 2020, WHO. At: https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1

² Impact of COVID-19 on Family Planning: What we know one year into the pandemic, March 2021, UNFPA. At: https://www.unfpa.org/sites/default/files/resource-pdf/COVID_Impact_FP_V5.pdf

³ Socio-economic impact assessment of COVID-19 in Timor-Leste, 2020, United Nations Timor-Leste.

⁴ Rapid Gender Analysis during COVID-19 Pandemic, September 2020, UNICEF, UN Women and CARE. At: <https://www.unicef.org/eap/media/6871/file/Rapid%20Gender%20Analysis%20during%20COVID-19%20Pandemic.pdf>

⁵ 2020 Target was 125 per 100,000 live births from the country's current rate of 239 deaths per 100,000 live births.

⁶ COVID-19 Landscape: SRHR and Gender issues in Asia, Centre for Reproductive Rights, October-December 2020. At: <http://reproductiverights.org/wp-content/uploads/2020/12/May-COVID-19-Landscape-SRHR-and-Gendered-Issues-in-Asia.pdf>

⁷ COVID-19 and violence against women: the evidence behind the talk, 2020, Quilt.AI, UN Women, Women Count, and UNFPA. At: https://asiapacific.unfpa.org/sites/default/files/pub-pdf/covid-19_and_vaw_insights_from_big_data_analysis_final.pdf

in Dili, in place since early March, was temporarily suspended on April 9 to allow for flood response, further worsening the risk of spread of COVID-19 and contributing to the community transmission the country is experiencing for the first time. In Myanmar, the political crisis and the violence surrounding the military coup are rapidly unravelling an already fragile public health sector, compromising the continuity of SRH services, and impinging on the COVID-19 response efforts.

All these changes threaten women's and girl's lives, their health, and progress in their education, economic empowerment, and gender equality efforts.

2.2 How MSI and IPPF have responded to the COVID-19 pandemic

MSI Reproductive Choices (MSI) and the International Planned Parenthood Federation (IPPF) have seen disruption to their contraception, safe abortion, and other SRH services in the past year due to lockdowns, movement restrictions and social distancing measures that have been put in place by governments to combat the spread of COVID-19.

Since the beginning of the pandemic, MSI's country programmes have rapidly adapted to ensure access to services can be maintained, tailoring their responses to local contexts and national government responses. They have advocated successfully with partners to ensure that contraception, safe abortion, and post-abortion care (PAC) are defined by governments as 'essential services' and available in the basic package of services. For instance, in Nepal, MSI played an active role in a coordinated response between the government, NGOs, and multi-lateral organisations and helped to influence the swift approval of 'Guidelines on Reproductive, Maternal, New-born, Child and Adolescent Health', which were then implemented across the country. These were specifically adapted to the pandemic: as well as allowing clients and health workers to have temporary exemptions from COVID-19 travel restrictions, the guidelines now allow medical abortion (MA) services to be provided in client's homes.

MSI's country programmes have also trialled delivering healthcare services through virtual technology (telemedicine), which enables women to receive tele-consultations and self-administer medical abortion drugs at home. Lastly, they have quickly established home-based call centres and increased their awareness raising efforts, allowing MSI to provide accurate information on both COVID-19 prevention and SRHR. This has been particularly valuable during the pandemic when young women might be stuck at home with parents, or women might be spending significant time indoors with abusive partners.

To better understand how COVID-19 has impacted women's access and rights, MSI commissioned a research with Ipsos MORI⁸. An online survey asked women (aged 16-50) in the UK, South Africa, and India about their experiences and awareness of SRH before and during the COVID-19 pandemic. The research found that barriers to access have increased and fewer women have been able to access essential SRH services, although the impact on access has not been as grave as initially expected. Importantly the research showed that even when services were still open and available, women assumed they were not, which impacted service uptake. From January to June 2020, 1.9 million fewer women have been served by MSI's programmes due to COVID-19 related disruptions. MSI estimates that this will lead to 1.5 million additional unsafe abortions, 900,000 additional unintended pregnancies, and 3,100 additional maternal deaths.

IPPF's response to the COVID-19 pandemic has been to enable the evolution of an equitable, resilient, rights-based ecosystem for SRHR and Member Associations (MAs) to provide SRH programmes in their communities. As the COVID-19 pandemic was unfolding globally in March 2020, IPPF's COVID-19 taskforce deployed global surveys of their MAs to collect evidence on the impact of COVID-19 on operations and the SRHR ecosystem. Data from these surveys informed and shaped IPPF's response. IPPF's response to COVID-19 was structured around interconnected pillars: Pillar 1: ensuring safe and effective continuity of SRH programmes in-country; Pillar 2: protect, promote and advance the rights agenda for SRH; Pillar 3: build resilience of members to weather this and other potential crises; and Pillar 4: promote evidence generation and cross learning.

The survey found that key challenges to MA operations were a result of COVID-19, such as clinic closures due to factors including staff unavailability, government mandates and movement restrictions; low client flow; safety and support to frontline workers; and supply of contraceptives. While many IPPF MAs have undertaken mitigation efforts, upstream disruptions in the SRH supply chain, especially for contraceptives, compounded by regional COVID-19 transmission dynamics is beginning to impact

⁸ <https://www.msichoices.org/media/3849/resilience-adaptation-and-action.pdf>

availability. IPPF's East and South East Asia Region reported 299 ongoing service delivery points closures in the third COVID-19 survey undertaken in November 2020 among IPPF MAs and associated health facilities. Since the survey was conducted, a second surge in South Asia is having a further severe impact on availability and resilience of SRH services in the region. Examples include limitations on mobile outreach services under new government guidelines in Nepal, and shortages of SRH commodities and personal protective equipment (PPE) in Pakistan and Bangladesh.

Given the exceptional measures taken by governments, such as widespread lockdowns, curfews and limitations of free movement and service provision, IPPF MAs have had to come up with innovative pioneering solutions to continue providing essential SRH services. As in-person medical consultations or appointments at clinics have become impossible for many, telephone, and online consultations (telemedicine) and new technological approaches such as providing information and advice through mobile applications have become widespread. A rapidly growing number of MAs have introduced or expanded the following successful models for delivery in the pandemic: telemedicine for SRH services, providing support for self-care or self-testing including for medical abortion and contraception, and offering home based care or door delivery of SRH commodities. By the end of 2020, over 90% of MAs had integrated digital health interventions for service delivery. To date more than 50 of IPPF's MAs offer home-based care or door delivery of SRH commodities. MAs are also working to bridge digital inequality gaps to try to reach clients not served before, while continuing to explore a range of measures to mitigate ongoing impacts and build long term resilience. These include diversifying channels of service delivery, and continually working to ensure clients have access to a full range of contraceptive and broader SRH services to mitigate against intermittent access to SRH care.

3. Design Process

The development and submission of this high-level design document forms the first step in the design process. Following endorsement of this document, both organisations will proceed to develop country level designs. These will provide detail on the current COVID-19 operating context and necessary response, planned activities, expected results and budget in each of the countries included in this initiative.

To expedite implementation, the country level designs will be submitted individually to DFAT as soon as they have been prepared and no later than 9 July 2021. DFAT in Canberra will provide the country-level designs to the relevant DFAT Desk/Posts for review and endorsement. Implementation is subject to approval by DFAT.

In country implementation can begin as soon as an individual country design has been approved, and must end within 24 months.

Once all country level designs have been finalised and approved, MSI and IPPF will consolidate expected results from all country-level designs and submit a finalised Results Framework by 13 August 2021.

Similarly, individual country budgets will be combined into a consolidated budget for each organisation. This budget will form the basis against which IPPF and MSI will prepare their respective financial reports.

Timeline

- 3 May: high-level design submitted
- 21 June – 9 July: country-level designs submitted as they are completed
- 21 June – 23 July: DFAT Desk/Posts review country-level designs (two weeks to review each country design after receipt)
- 13 August: complete Results Framework submitted

4. Proposed Approach

4.1 Overview

As outlined in Section 2 above, measures imposed by governments to respond to the COVID-19 pandemic have prevented SRH services being provided to clients in the usual way, and many have lost access to critical SRH services in the past year. There is a need to restore services, particularly to

marginalised populations such as young people, people living in poverty, and people with disabilities. The pandemic has also highlighted challenges and limitations with existing service delivery models and the need to *build back better* to be able to respond to future crises, by strengthening, scaling up, and sustaining new approaches.

In order to continue to support clients' access to SRH services, service providers have to adapt to a new and changing environment for health service delivery. Many SRHR organisations have shifted services in some form to digital platforms, from counselling on FP/SRHR through telemedicine centres to online booking systems for appointments and referrals or using social media and SMS for SRHR awareness and promotion of how and where clients could access services. There is a need to bring services closer to clients through expansion of community service delivery models, such as increasing the number of community volunteers and health workers, and adapting the services provided by community health workers, including self-care measures such as the introduction of self-administered Sayana Press and self-administration of misoprostol for medical abortion at home.

The proposed approach aligns with the Australian Government's development policy *Partnerships for Recovery: Australia's COVID-19 Development Response* by supporting delivery of essential sexual and reproductive health services to populations impacted by the pandemic. Our work is listed under the core action area of Health Security - and lists family planning as a key health service.

4.2 Objectives and Activities

The **ultimate outcome** of this programme is to ensure populations affected by the COVID-19 pandemic in the Asia Pacific region have enhanced SRHR.

This will be achieved by improving the utilisation of high-quality and equitable SRHR information and services by the most vulnerable, with a focus on innovative approaches and restoring services that have been impacted due to COVID-19 (**outcome**).

This will encompass continued service delivery through traditional service delivery channels, scale up of new service delivery approaches, strengthening organisational capacity and data systems, as well as working closely with the Ministry of Health (MoH) and other partners in the countries of implementation. The programme will also focus on the provision of an integrated package of SRH services with attention to the "shadow pandemic", an increase in SGBV.

The outcome will be achieved through the indicative activities described below. It should be noted that not all these activities will be implemented in all countries. The activities will be confirmed through the in-country programme design process, which will reflect national political environment and policy context, the current initiatives in place that can be scaled up, and the level of funding available in each country.

Annex 3 provides a list of proposed activities and the indicative funding amount by country. Please note, that these may change slightly during the in-country design stage.

Outcome 1: Improved utilisation of high-quality and equitable SRHR information and services by the most vulnerable, with a focus on innovative approaches and restoring services that have been impacted due to COVID-19

OUTPUT 1: High-quality and equitable SRH services provided through established service delivery channels

As COVID-19 continues to present unique and rapidly changing challenges in Asia and the Pacific, IPPF and MSI's priority is to ensure the safety and wellbeing of our clients and team members, and to ensure access to SRH services.

Both organisations will continue to provide training to clinical staff and service providers; equip their facilities and their teams with PPE and infection prevention (IP) materials and measures, such as temperature taking and symptoms screening, additional handwashing facilities, adjusting waiting areas, enhancing cleaning and disinfecting of facilities.

The need for SRH care remains throughout this pandemic and our priority is to avoid increases in maternal mortality resulting from unavailability of essential comprehensive SRH services. Through this initiative, we will look at innovative ways to reach clients with our established service delivery channels and mechanisms, embedding the lessons of the COVID-19 response learned to date.

Activity 1.1. Providing high-quality SRH services through established service delivery channels

To ensure continuity of SRH services during the COVID-19 pandemic and to reach vulnerable, underserved and isolated communities, IPPF and MSI will continue to provide comprehensive, confidential, high-quality service delivery through **established channels** such as **static facilities**, **mobile outreach** and **community-based distribution**. In Laos, Cambodia, Philippines, and Indonesia, IPPF will increase the number of mobile units and outreach service sessions. In Bangladesh, IPPF will increase service provision outreaches to internally displaced people (IDP) and Rohingya refugees in the camps and shelters of Cox Bazar.

MSI's outreach approach will combine **single providers** (MSI Ladies) and mobile outreach teams. In Vietnam, MSI will expand the current MSI Ladies model and will ensure an efficient referral system to public and private health facilities in the targeted areas. In Nepal, MSI will organise integrated SRH sites, allowing services to reach more clients at once from remote municipalities, to catch up on "pent up" unmet demand for SRH services from 2020 and to target specific groups who have been disproportionately affected by COVID-19, such as people with disabilities and youth. In Bangladesh, outreach teams will expand their geographical coverage into more rural areas to meet the unmet need of people living below the poverty line. In Timor-Leste, MSI will use temporary structures such as tents, to deliver services in collaboration with the government in remote areas, otherwise not reachable through community health centres and health posts.

Activity 1.2. Strengthening organisational and health care provider capacity (staff, private and public sector) in provision of quality comprehensive SRH services and COVID-19 response

This initiative will leverage and strengthen the capacity of healthcare providers to provide quality comprehensive and sustainable SRH services and client-centred care in the context of COVID-19 and improve organisational resilience

In Cambodia, Vietnam and Bangladesh, IPPF and MSI will offer training in comprehensive SRH counselling and service provision, IP and disease management to public and private health service providers to mitigate the impact of COVID-19 in health facilities, in line with WHO and national guidelines. Refresher training will also be delivered as appropriate to ensure providers have up-to-date skill sets and qualifications to offer a broad range of contraceptive methods to clients, including LARCs. In Vietnam, MSI will launch an online training platform for women's healthcare service providers, supporting medical staff to update their knowledge on diagnostics and treatment regularly and remotely. In Pakistan, IPPF's training will focus on task-shifting/task sharing for LARCs and Sayana Press. In the Maldives, IPPF will train service providers on IPPF's Integrated Package of Essential Services (IPES) model as well as train youth volunteers on SRH counselling, peer education and referral and linkages.

IPPF will strengthen MA capacity to respond to the impact of COVID-19 and future crises by identifying key targeted capacity improvements for organisational resilience. This will include: strengthening **Quality of Care (QoC) Assurance Systems** and development and implementation of plans of action to comply with QoC standards in the delivery of COVID-19 sensitive SRH services; **health management information system** development and adaptation (CMIS, local district health information software DHIS2) at service delivery point level to improve data quality and utilisation; and supporting **reviews of SRHR policy and guidelines on COVID-19** including policies on task shifting where applicable.

Activity 1.3. Strengthening the provision of SGBV services and referral pathways for SGBV survivors

Recognising the growing levels of SGBV in its many forms to such an extent that the United Nations have defined it as "shadow pandemic", and the amplification of entrenched social and gender inequalities across Asia and the Pacific region, MSI and IPPF will increase their efforts to address SGBV issues and implement specific interventions for prevention of SGBV and frontline service provision for SGBV survivors.

Examples of **prevention activities** include relationships counselling, engaging men and boys, partnerships with local organisations, and community-based interventions around gender inequality, harmful practices, pervasive stereotypes, and social norms. In addition, IPPF will continue to operate its SGBV helplines to respond to growing needs, specifically in Bangladesh and Pakistan.

Drawing from MSI's SGBV Guidelines and IPPF's IPES and Humanitarian Strategy, IPPF and MSI will implement a **first-line care and comprehensive referral system** for the survivors of SGBV cases.

Frontline service provision for SGBV survivors includes addressing immediate physical health needs such as first aid and the provision of core SRH services, including pregnancy tests and emergency contraception. Capacity building on the LIVES⁹ approach recommended by WHO will be provided to clinical staff and service providers. An example of capacity building initiatives planned by IPPF is the establishment of a virtual counselling service for SGBV in the Maldives. In Bhutan, IPPF will expand the existing Community-led Responsive Mechanism to address SGBV through the Multi Sector Task Force (MSTF)-Community Based Support System (CBSS) Initiative in collaboration with the MoH, which includes sensitisation campaigns on SRH, SGBV and other related social issues.

MSI and IPPF will also support and strengthen effective referral networks to support SGBV survivors for all steps beyond first-line care, such as legal aid, psychosocial support, and shelter.

Activity 1.4. Strengthening supply of essential SRH and IP commodities and supplies

MSI and IPPF will work closely with MoHs, UNFPA and other stakeholders to track SRH commodity availability, forecast for commodity needs, and create contingency plans for alternative sources. Both organisations are closely tracking possible commodity shortfalls and working to mitigate the impact on services where possible. In addition, MSI and IPPF will procure IP commodities to ensure the safety of clients and staff. In Indonesia, Laos and Sri Lanka, IPPF and MSI will strengthen commodity forecasting and procurement and build supply chain management capacity. In Nepal and Philippines, IPPF plans to build a strong tracking and monitoring mechanism of supply chain management and deliver uninterrupted supply of essential SRH and IP commodities. Recent announcements regarding the budget of UNFPA supplies, will have global impacts on SRHR commodities and this poses a risk to this program which has been identified and is being actively considered.

Activity 1.5. Expanding contraceptive social marketing

MSI will launch a commercially run contraceptive social marketing program in Fiji with future expansion into other Pacific Island Countries and Territories (PICTs) to follow. MSI subsidiary ISM has assessed the market and will expand its operations to the Pacific and offer a basket of FP commodities and complementary products at affordable prices. ISM will also expand the reach of its sales program in Cambodia. IPPF will explore the possibility of promoting contraceptive social marketing to increase accessibility and affordability of contraceptives to clients in Bangladesh, Bhutan, and Nepal. This may include social marketing through private sector partners such as polyclinics or one-stop wellness centres, which include services for maternal and child health care in addition to general SRH services in hard-to-reach districts.

OUTPUT 2: Women, men and young people have access to digital health services (telemedicine) and alternative service delivery models (home based care, self-care, etc.)

During the COVID-19 pandemic, many women and girls have been unable to get to healthcare facilities, or by doing so put themselves and others at risk of spreading COVID -19. Supporting essential health service delivery through digital health platforms (telemedicine) has proved to be effective and efficient in a number of countries, particularly to reach clients that may have challenges in accessing static facilities such as young people, people living in poverty, and people with disabilities.

Activity 2.1. Exploring and scaling-up telemedicine

Telemedicine can be used to deliver SRH supplies requiring prescription into people's homes, including medical abortion, contraceptive pills or Sayana Press injectables. It combines remote consultation with a doctor (or nurse) with the distribution of product.

In 2020, MSI programmes in South Africa and the UK (England and Wales) responded rapidly to favourable policy changes in their contexts to launch telemedicine models for early medical abortion. MSI's research in collaboration with Ipsos MORI showed that telemedicine is well received by both clients and providers in the UK, with 98% of clients rating their experience as good (14%) or very good (84%), and is successfully providing 70% of clients with post-abortion FP in South Africa.

Building on the lessons learned from these two country programmes and leveraging on the well-established contact centre networks, MSI will explore opportunities to roll-out similar telemedicine models as part of this initiative in Cambodia, Papua New Guinea (PNG), Bangladesh, and Pakistan.

⁹ WHO LIVES approach for first-line support (Listen, Inquire, Validate, Enhance safety and Support).

IPPF will also strengthen the capacity of service providers to deliver SRH services through telemedicine by developing quality assurance standard tools and job aids and training support in Nepal, Indonesia, Philippines, and Cambodia. In Laos, IPPF will serve communities who have no access to healthcare, internet, or smartphones through setting up tech-enabled services attached to its mobile clinics and associated health facilities located in the underserved communities. On-site nurses/service providers will be trained to assist patients for promoting and using tele-consultations and other established health services.

Activity 2.2. Increasing availability, accessibility, and acceptability of SRH self-care approaches and home delivery

IPPF have a broad network of **community-based distributors** who can deliver short-term FP services to clients at their home through direct community or home to home service delivery in underserved areas. Community-based distribution will be expanded and there will be a scale up of home visit services and expansion of the home visit model. In Pakistan, IPPF will continue home visits provided by Lady Health Volunteers. In Maldives, IPPF will scale up the home visit model. Service providers will be trained to provide Sayana Press to clients and misoprostol for medical abortion (where applicable). The programme will be used to pilot the expansion of self-care interventions in countries such as Pakistan and Laos. Service providers (mainly community-based distributors conducting home visits and MSI Ladies) will receive capacity building training on supporting clients for self-administration of Sayana Press, expanding community access and broadening client choice as well as self-testing for HIV and STIs, self-testing for pregnancy and self-use of misoprostol for PAC and prevention of post-partum haemorrhage. Partnerships will be established and strengthened with community health volunteers/workers under the MoH to expand reach as well as partnering with pharmacies for home delivery of commodities such as in Cambodia.

Activity 2.3. Adapting pathways of care

As the COVID-19 pandemic continues to evolve, MSI will explore opportunities to adapt existing pathways to care, such as offering a comprehensive package of SRH services as entry points to increase access; as well as tailoring service delivery to reach adolescents and young people. In Cambodia, during the pandemic, MSI's facility based SRH services have been disrupted. MSI will provide a one-stop-shop for clients requiring SRH services (from menstruation to menopause), reducing the risk of clients not seeking services because they have to access them at different locations. Similarly, in Pakistan, MSI will reach women in underserved areas through outreach teams offering breast examination, CCS&PT, ANC, early pregnancy complications, postnatal care, and miscarriage management. MSI will also make a broader SRH package and healthy lifestyle counselling available at its service delivery points, particularly its centres, with the aim of attracting younger clients.

During the pandemic, IPES service provision in static clinics in Laos, Indonesia, and Philippines were disrupted. Under this initiative, IPPF will conduct IPES service mapping of static clinics in these three countries and Action Plans will be developed in order to enable static clinics to provide the full range of IPES services.

OUTPUT 3: Women, men, and young people receive quality, trusted and accessible information on SRH and COVID-19

Under this initiative, service delivery provision will be complemented by awareness raising activities that will aim at increasing the uptake of SRH services.

Activity 3.1. Conducting awareness raising activities through radio, campaigns, TV, SMS, and social media

IPPF and MSI already undertake significant awareness raising and health promotion and information activities. Through this initiative, a variety of approaches and communication channels will be employed to ensure that women, girls, men, and boys have access to comprehensive and rights-based information about SRH and to COVID-19 related messages. Our strategy will blend the use of radio, TV, SMS, and social media platforms (Instagram, Facebook, Twitter, WhatsApp, TikTok, and Viber), with the use of mass and interpersonal communication, to disseminate tailored messages.

Specifically, through radio and television there is an ability to reach a large number of people, particularly those who live in rural and remote areas with limited access to digital and online communication platforms. For example, IPPF in Bangladesh will use radio messaging to reach IDPs and refugees within the Rohingya Refugee camps. Additionally, IPPF in the Pacific region will develop

a mobile phone platform to enable access to SRHR information and services, information on locations for SRH services, FP/SRHR counselling and commodity provision through community-based distributors.

MSI in Bangladesh and Cambodia will conduct marketing campaigns to promote the importance of SRH services, as well as how and where to access safe services. In Pakistan, MSI will run campaigns particularly promoting LARCs and permanent methods to ensure that contraception needs are met during periods of lockdowns and with restrictions on movements. This will be integrated with the government's COVID-19 messages, building the community's resilience to combat the COVID-19 emergency. MSI will continue to monitor changing communication needs within the communities where they are working, and ensure messaging evolves to meet those needs. Particularly important will be adapted messages around changing myths and misconceptions around available care, service safety, provider and survivor stigma, and vaccine hesitancy which is likely to emerge once distribution starts, as evidence suggests is the case in PNG and Timor-Leste.

Activity 3.2. Strengthening MSI's contact centres and IPPF's remote counselling/hotlines

Contact centres and hotlines are already well established in many of the implementing countries, providing quality information, consultation, and services. They can also support referrals for clients, monitor client satisfaction of services provided, enable a continuum of care through follow-ups for after-care, contribute to fraud prevention through data validation, and arrange appointments where needed. Contact centres and hotlines are also uniquely placed to reach adolescents and young people. Because of the confidentiality and the anonymity of the call or messaging chats, adolescents can raise questions around sexual satisfaction, relationships, contraceptive myths, and misconceptions, and SRH care. Women experiencing SGBV may also favour these services as they can contact them discretely.

IPPF has initiated telephone hotlines and consultation facilities in several countries including Bangladesh, Indonesia, and Pakistan which not only offer online consultation and services but also serve as referral and linkage mechanisms for clients to access specialised SRH care in MA clinics or tertiary level hospitals. In Bangladesh, telephone consultation is available in 21 districts in coordination with the Ministry of Women Affairs which also offers specialised consultation for SGBV care and support through trained service providers. In the Philippines, the hotline service YourRHotline has been so successful that it now not only provides online consultation but also door to door SRH supplies primarily for young people and also has its own shop of SRH supplies and commodities. Through this programme efforts will be made to promote the contact centres and hotlines as an alternative method of service delivery particularly for clients that may have challenges in accessing static facilities such as young people, people living in poverty, and people living with a disability. IPPF MAs in Bangladesh, Sri Lanka, Nepal and the Philippines plan to scale up and provide SRH services and emergency e-counselling using already established hotlines. In Pakistan, IPPF will expand the helpline by installing call lines at all its Youth Resource centres as well as expanding on the operational hours of the hotline. In the Maldives, the plan is to develop a virtual network and hotline aimed specifically at youth.

MSI has a network of contact centres across 28 countries. With over 300 call agents, contact centres provide a toll-free free hotline for high quality and comprehensive information on and support of SRH services in a confidential manner, irrespective of background in 1:1 phone calls, as well as WhatsApp and social media messaging chats. In 2020, MSI's contact centre and digital communication channels played a key role in ensuring information about the availability of SRH services, offering clear, practical guidance on how and where to safely access services, and combining this with practical advice on staying safe during COVID-19. Throughout the pandemic, contact centres have received growing volumes of calls and messaging chats - for example, in Timor-Leste, calls to MSI's national youth hotline requesting information about COVID-19 and mental health support have increased by 40%, and the average call length has increased by over 20%.

Under this initiative, MSI will expand the coverage of contact centres in Nepal, Bangladesh, Pakistan, Cambodia, and PNG and maximise their visibility by promoting them as a trusted and confidential source of pregnancy advice. Additionally, MSI will explore opening a toll-free, 24/7 national contact centre in Timor-Leste to provide callers with comprehensive SRH and COVID-related information and refer potential clients to MSI-affiliated facilities or non-MSI service delivery points, including public sector facilities across Timor-Leste.

Over the next 10 years, MSI's aim is for every woman and girl to be only one contact away from a safe provider and guide her to find the right solution to meet her needs. Where possible, MSI will provide

these services via our network of our centres, outreach teams and community-based services. Where this is not possible, MSI's contact centres will act as a one-stop-shop that will help clients find a safe alternative and refer them to a quality assured service delivery point. Specifically, MSI will partner across the public and private sector to develop a sustainable and integrated referral network and establish referral linkages, particularly for higher level or specialist care. For example, for specialised SGBV services, including legal and psychosocial support services, this will be done through an initial mapping of referral facilities and setting up of memorandums of understanding (MOUs) where possible.

In the countries where both MSI and IPPF are present, MSI and IPPF MAs will work closely together and create strong partnerships on the ground in order to establish cross-organisation referrals to increase access to SRHR.

4.3 About the Partners

MSI and IPPF represent the two largest non-government organisations (NGOs) focused on comprehensive SRHR globally. Together our organisations are working towards a world where every individual can make voluntary and informed decisions about their own SRH.

Founded in 1976, **MSI Reproductive Choices** (MSI) is one of the largest non-profit voluntary FP and safe abortion organisations in the world, currently working in 37 countries across the world with over 10,000 team members. MSI is committed to upholding the fundamental right of women and girls and men and boys to decide freely, and without coercion, the number and spacing of their children.

Marie Stopes International Australia (MSIA) is a member of the MSI global partnership, and acts as the support office for the Pacific Asia region. MSIA manages fundraising in Australia, both with the general public and the Australian Government, and will hold the contract for this initiative for MSI.

Established in 1952 in India, **International Planned Parenthood Federation (IPPF)** is a global healthcare provider and a leading advocate of SRHR for all, working with and for communities and individuals in 142 countries. IPPF is committed to lead a locally owned, globally connected civil society movement that provides and enables services, and champions SRHR for all, with a focus on reaching poor and marginalized women and girls, vulnerable populations such as people with disabilities, and those suffering in humanitarian emergencies. IPPF's work is guided by its core values of social inclusion, diversity, volunteerism, and accountability. As a global Federation, IPPF has a decentralised structure that aims to bring resources, expertise, and learning as close as possible to the communities we serve.

IPPF's Member Associations (MAs) are independent, nationally owned and governed organisations, and leading SRH service providers in their respective countries. MAs hold sustainable long-standing partnerships with governments, civil society, the private sector, and other NGOs. IPPF's unique strength is its status as a locally owned, globally connected network of NGOs providing help, advice, services, and supplies relating to any aspect of SRH. In order to qualify for and maintain full IPPF membership status, all MAs must adhere to 48 standards relating to programmatic and financial management, governance, constitution, and medical services.

The COVID-19 pandemic has firmly reiterated the importance of localised development for **sustainable change**. MSI and IPPF have been operating for many years, and are embedded within the communities they serve. They are trusted health partners of government and local health authorities, and engage with their ministries of health to ensure services are delivered in coordination with national health response and priorities. The organisations' models of working through in-country partners is key to ensuring the sustainability of their programmes, and to building local ownership of quality SRH services.

5. Expected Results

The proposed initiative will directly support the governments of the targeted countries in the Asia Pacific region to improve access to high-quality, voluntary and equitable SRH services and contribute to their efforts to realise their commitments towards Sustainable Development Goal (SDG) 3: "Ensuring healthy lives and promote well-being for all at all ages," and SDG 5: "Achieve gender equality and empower all women and girls."

As outlined in this high-level design, the in country-designs will explore further which approaches will be most appropriate for each country. A completed results framework will be submitted to DFAT after the in-country designs are completed. Anticipated overarching results include:

- Women, men, and young people are provided with high-quality and equitable SRH services using established service delivery mechanisms such as clinics and outreach teams;
- MSI and IPPF staff and health care providers have strengthened capacity to provide sustainable comprehensive SRH services and respond to COVID-19;
- Women, men, and young people receive quality, trusted and accessible information on SRH and COVID-19 through contact centres and remote counselling;
- Telemedicine is explored and rolled-out; and
- Contraceptives and medical abortion/PAC products are available via social marketing and community-based distributors.

6. Management and Governance

This section provides an overview of MSI/MSIA and IPPF's management and governance structures including dedicated overall programme management for this initiative and highlights the function of a proposed programme specific Steering Committee that will provide a formal mechanism to discuss and monitor programme progress.

The Steering Committee (SC) will be established with relevant representatives from DFAT, MSIA and IPPF. The SC will meet virtually or face-to-face every six months, in January 2022, July 2022 and January 2023. The SC will consider progress on activities and budget and discuss any significant risks to programme delivery. Any member of the SC can request an exceptional meeting to discuss an issue critical to the achievement of the objectives of the initiative. To support **learning between the partners**, the six-monthly Steering Committee meetings will act as a strategic mechanism to ensure lessons learned, ideas, and innovations for the programme can be shared.

Marie Stopes International Australia (MSIA) is the contract holder for the MSI component of this initiative and is an Australian NGO with full DFAT Accreditation. MSIA is governed by an independent Board of Directors which sets the strategic direction and ensures compliance with standards for clinical practice, sound financial management and institutional integrity. The Board delegates its powers as appropriate, assigning operational management to the MSIA Executive Officer and Regional Director. The overall management of the initiative will be led by a Programme Manager based in MSIA's office in Melbourne. This role will coordinate MSI's in-country activities and also coordinate with IPPF counterparts on implementation, oversight and reporting. Country programmes will be responsible for the delivery of the programme.

The MSI global partnership has a centralised structure which connects a network of subsidiaries and affiliates. MSI country programmes are aligned under a global strategy and rely upon high-quality technical assistance and management oversight provided by Regional Support Teams based in two support offices. The Support Offices are located in Melbourne and London with other regional support functions nested in country programmes. These resources support the technical, financial, operational and compliance requirements of the country programmes included in this programme. Each country programme is led by a Country Director and a Senior Management Team, based in country, with operations, advocacy, marketing, medical, technical and administrative teams in the country support office managing in-country operations, including the management of service delivery channels. The relationship between MSIA, MSI and country programmes is governed by partnership agreements which ensure that all MSI entities are run in accordance with global standards, while also complying with DFAT principles and policies

The **IPPF Secretariat** will be the contract holder with full responsibility for the delivery of IPPF's component of this shared initiative. It will provide overall coordination and management of the programme to ensure successful delivery, be responsible for the submission of all annual donor reports, and ongoing communication and visibility of the programme.

As a global Federation, IPPF has a unified a decentralised Secretariat structure that consists of a Central Office (CO) in London and six Regional Offices (ROs)¹. ROs bring resources, expertise, and learning as close as possible to the MAs and the communities we serve. IPPF's CO implements the policies and functions approved by its Board, provides technical and policy leadership to guide the work of its MAs, and ensures compliance with IPPF and donor requirements. IPPF's ROs are hubs for capacity building and systems strengthening activities across the Federation and provide technical support to MAs, monitor implementation and compliance, and coordinate regional actions and approaches.

For this specific initiative, the IPPF programme management team will be based in the ROs closest to the 20 MAs of the countries where we will work: the South Asia RO and East and South East Asia and Oceania RO. In addition, our Sub-Regional Office for the Pacific will work closely with the ROs whilst our liaison office in Australia will hold direct regular communication with DFAT on this programme.

At the country level implementation will be carried out by IPPF's MAs supported by the programme management team based in the Secretariat. The IPPF Secretariat will establish restricted funding agreements with each MA with clear roles and responsibilities for monitoring and reporting both programmatic and financial, and include a detailed workplan, budget, and specific deliverables as per agreed programme.

As part of the design process, both organisations have included the necessary costs to successfully manage their respective initiatives and ensure overall programme implementation, accountability, and oversight. These critical costs encompass programme and financial management, monitoring and evaluation (M&E), communication and SRH technical expertise provision, and have been included in the "Regional Project Management and Technical Support" budget line (see Annex 1).

Collaboration

In countries where MSI and IPPF will both be implementing activities under this initiative, opportunities to collaborate will be explored as part of the country-level design process. In addition, we will build on already existing in-country collaborations such as in Pakistan where IPPF's MA sits on the Technical Coordination Committee of the Delivering Accelerated Family Planning (DAFPAK) programme where MSI is an implementing partner. Activities may include referral of clients from one organisation's service to the others; collaboration on government engagement for key SRHR issues related to service delivery during COVID-19; coordination on the social and behaviour change communications (SBCC) content to ensure our messages are aligned and mutually reinforcing; and sharing of information and lessons from the implementation of innovative service delivery models.

At the global level, MSI and IPPF have an existing MOU which outlines the main areas for collaboration. This includes implementing large projects such as the FCDO funded Women's Integrated Sexual Health Programme (WISH) programme, joint advocacy and aligned comments on UN declarations and UNFPA supply design processes. MSIA and IPPF in Australia are also key members of the International Sexual and Reproductive Health and Rights Consortium which advocates to the Australian government around SRHR issues. This programme will build on these existing collaborative efforts and is an opportunity for us to learn from each other, share research, case studies and best practice particularly with regard to innovative approaches.

RESPOND program managers in IPPF and MSI will be in regular contact to facilitate collaboration at the global level and to ensure opportunities for in-country collaboration is explored and implemented.

7. Monitoring and Evaluation

MSI and IPPF have robust research, monitoring, evaluation, accountability and learning systems in place to track progress towards programme goals and ensure continuous data-driven management to improve programme performance.

MSI's comprehensive Monitoring and Evaluation Manual forms the basis for planning and guiding all M&E activities by programme staff throughout the programme cycle, from the design stage, including design of programme specific M&E plans and measurement frameworks, through to implementation and evaluation. Detailed field level monitoring of programme activities is the responsibility of the Programme Manager/Programme Director in co-ordination with the Country Programme Leadership Team and M&E Manager. Regional Evidence Advisors from MSI's Global Support Office and Melbourne Office provide guidance and back-up to in-country research, monitoring and evaluation (RME) staff.

MSI is committed to collecting high quality data to ensure that we can continuously understand our clients' perspectives, experience, and insights. During this initiative, MSI will employ a suite of systems and tools to collect routine data about clients and the quality of the services they receive. Key systems and tools for routine primary data collection that will be employed during this initiative are:

- **CLIC and Client.Collect** are client-level management information systems developed to collect information on demographics (age, gender, childbearing status, as well as site level poverty indicators in CLIC) as well as current contraceptive use and service uptake.
- **Client exit interviews (CEI)**: MSI will also conduct annual CEIs to gather information about the demographic profile of clients (including age, socio-economic status and disability status), past contraception use, quality of counselling, affordability of services, and client satisfaction, as well as proxy indicators for measuring ideal family size and partner/community support for clients accessing MSI services. This survey helps ensure our services are reaching the intended target population, thereby providing equity of access to those clients that need our services most.
 - o MSI has more than nine years of cumulative CEI data, which gives MSI's country programmes insights into what they are doing well and which areas require more improvement. While CEI happens once a year, MSI ensures that insights are completed and enriched by routine data which captures details on client demographics, service uptake, and other issues. MSI will also use rapid client insights to be able to capture client experience and quality of care.
- **Impact 2 tool**: Using our innovative Impact 2 FP modelling tool, MSI will provide demographic and economic impact data to review, adapt, and adjust service delivery models and will ensure key targets are being met to achieve outcomes.

All MSI country programmes will also implement and/or be subject to the following three processes that ensure client safety and experience through exceptional clinical quality:

- **Clinical governance and oversight**: Clinical quality audits using direct observation form the backbone of MSI's approach to ensuring all clients receive the highest QoC possible. The two main types of audits are: (i) Annual clinical quality internal audits are completed at each service point by MSI country programme clinical quality team members either in person or remotely using standardised checklists of key indicators relating to clinical governance, services, and other aspects of clinical quality and client safety. The information gained from these audits informs quality improvement plans for each site, with implementation jointly followed up by operations and clinical quality team staff. (ii) Clinical Audio-Visual Assessments (CAVAs) provide a framework for assessing minimum quality standards for clinical practice through observation of services and review of processes in country using a checklist with remote-friendly indicators. The support office and a sample of sites from each channel are assessed annually by a Medical Development Team (MDT)-trained assessor. Additionally, four mini-CAVAs are also conducted to selected channels of concerns to assess quality of drugs; counselling and consent; obstetric services; IP, pain management and medical emergency management.
- **Maintaining provider competency**: All country programmes must competency assess all providers annually. This includes competency in service provision as well as in counselling, IP, medical emergency management, and pain management. All service providers' training and competency assessment information must be maintained in the standard database for the purpose. The database is reviewed regularly by MDT and measured annually on the Country Programme Compliance Dashboard. Only providers assessed as level 1 competent can provide services without supervision.
- **Assuring product quality**: All country programmes must adhere to product quality guidance. Field testing of samples must be carried out according to this guidance and to conditions set out in product quality exemptions for programmes that hold valid exemptions.

IPPF is committed to a culture of performance and to demonstrating progress. It has in place a comprehensive M&E system that documents how IPPF is doing and works to make the Federation increasingly effective so as to improve its impact, accountability, and transparency on an ongoing basis.

IPPF's Monitoring and Evaluation handbook will provide the basis for planning the M&E activities across the full programme cycle to ensure effectiveness, evidence-based decision making, and improve accountability through M&E plans and measurement frameworks for implementation. The programme will have a dedicated M&E Manager and Data Coordinator at the Secretariat working closely with MA level M&E and Data Officers, guided by a monitoring and supportive supervision framework that is closely designed with staff from the Member Associations, drawing on existing mechanisms and tools available within the Federation.

IPPF will take advantage of its existing data collection processes to support implementation, including a set of global service statistics collected through the Federation's **Performance Dashboard**, global indicators on programmatic performance, participatory qualitative reviews, needs assessments, vulnerability assessments, rigorous monitoring and evaluation plans with performance indicators and surveys.

For this initiative, some of the tools which IPPF will use to collect routine quality data include:

- **DHIS2** is an online health information management system that supports data entry and storage, analysis, utilisation, and reporting across the Federation to ensure accurate and systematic measurement. Client level data will be captured using DHIS2 through Android applications and will be integrated with the organisational DHIS2 and IPPF global DHIS2 to facilitate capture of credible data, seamless integration of data management systems and M&E. Detailed disaggregated data will be collated with gender, inclusive and service delivery statistics, which will be entered at monthly intervals and integrated into a data analytics dashboard with key performance indicators to facilitate real time data analysis and informed decision making.
- **Clinic management information systems (CMIS)** are used in static clinics to capture, store, and analyse information in the local context. IPPF has a Health Information Systems Policy and a practical, step-by-step guide that supports MAs to set up, install and use manual and electronic CMIS in clinics.
- **IPPF's Vulnerability Assessment Methodology** estimates the proportion of service users who are poor and/or vulnerable. This enables MAs to measure the success of their programmes in reaching those most in need, and to inform programme strategies. The methodology is recommended as part of routine monitoring systems to inform planning, make programmes more effective in 'leaving no one behind', and strengthen the quality of reporting on the number (and proportion) of vulnerable clients.
- **IPPF's Routine Data Quality Assessment (RDQA) tool** supports MAs to conduct a self-assessment of their data quality. The objectives of the RDQA tool are to verify the quality of reported data for certain indicators at selected sites. As part of the process, MAs develop action plans to implement corrective measures for strengthening data management and reporting systems.
- **The Impact 2 tool** to calculate impact estimates of the number of unintended pregnancies and unsafe abortions averted due to contraceptive services provided by IPPF.

Feedback Mechanisms:

MSI's routine management information systems will be effectively adapted to collect key indicators to enable the organisation to monitor the delivery of digital health innovations throughout the client journey. MSI will also ensure that client feedback options are explicitly integrated into any model. For example, for services with a mandated follow-up process (e.g. MA via telemedicine) MSI will integrate a short set of questions into follow-ups to capture client perceptions of quality of care. For services without mandated follow-up, or to supplement feedback captured during routine follow-up, MSI will explore seeking client consent to enable them to re-contact clients specifically for their feedback following their service. A range of communications options such as phone calls, SMS, and social media will be integrated wherever possible. Further online options, where clients can opt-in to a survey sent-out via email, WhatsApp, SMS etc., will also be used. Finally, the contact centre will remain a core mechanism for both proactively facilitating feedback from clients, but also ensuring that unsolicited feedback coming in from clients is also passed on to, and used by, teams.

The **IPPF Secretariat** is working in consultation with our Member Associations to ensure the design of digital health interventions will incorporate accountability to affected populations through feedback mechanisms and strong monitoring systems, to ensure the models are meeting client needs. IPPF has included a specific Digital Health Intervention (DHI) Officer staff position for the RESPOND programme to support this process.

More broadly, IPPF's DHI working group, which consists of members from IPPF's COVID-19 taskforce and project specific initiatives using digital health services, are currently assessing feedback and accountability models for digital health services emerging from across the Federation. The taskforce will support the further development and roll out of mechanisms that have been demonstrated as appropriate and effective. To support this process, IPPF is recruiting a consultant to conduct a

landscape analysis and develop a Federation-wide strategy for digital SRH service delivery, including guidelines on quality assurance for digital health and accountability protocols. An example of feedback mechanisms to improve the accountability and responsiveness of digital health services that IPPF will look to build on in this programme is FPA Sri Lanka's Monitoring and Evaluation Information Management System (MEIMS). This is an auto generated feedback mechanism for clients who receive teleconsultation and other services, which requests feedback via SMS.

8. Reporting

Narrative Reporting

Recognising the collaboration of this initiative, MSIA and IPPF will submit joint bi-annual narrative reports on the progress of the initiative. The first two reports will be coordinated by MSIA and the final two reports by IPPF. Narrative progress reports will follow the requirements in accordance with the guidelines and timelines set in the agreement with DFAT.

Financial Reporting

MSIA and IPPF will submit separate financial reports against each entity's approved country budget allocations in accordance with the narrative reporting timelines.

9. Cross Cutting Issues

9.1 Gender, Disability and Other Cross Cutting Issues

Gender Equality

Gender equality is a universal human right and is central to the mission of both IPPF and MSI.

As healthcare providers and advocates for women's rights, MSI and IPPF recognise that gender inequality impacts on individual's needs, choices, and access to health information and services. The absence of available, accessible, acceptable, and high-quality SRH services threatens women's bodily integrity, their health, their freedom to make life decisions, their ability to participate fully in political, social, and economic spheres, and their overall agency.

Understanding inequalities and the power relations that exist within families, communities, and wider societies, as well as addressing how other forms of marginalisation, including based on age, sexual orientation and identity, ethnicity, race, income, migrant status, and ability, is essential to developing programmes that increase access to services, improve SRH outcomes, and reduce stigma.

To deliver its commitment to gender equality, MSI has an internal gender working group focused on delivering organisational and programme level commitments. These involve a focus on balancing gender representation in leadership positions particularly in MSI country programmes; applying a 'gender lens' to programming; and supporting staff and partners to integrate gender equality into the way MSI works and as a critical component of QoC using approaches including training, safeguarding, and first line response to SGBV.

IPPF's commitment to gender equality is guided by its Gender Equality Policy. IPPF was acknowledged in the March 2021 Global Health 50/50 report which placed IPPF in the top 5% of organisations assessed in the report. IPPF has a suite of guidelines and tools, such as IPPF's Gender Equality Strategy and the accompanying Gender Implementation Plan which identify steps to achieve the Federation's global objectives at the MA level to improve the gender-responsiveness of SRH services. IPPF also has a Gender Assessment Tool which is used to assist MAs in the design, implementation, M&E, and learning of all activities.

SRHR are integral to the effective realisation of gender equality, as SRH services based on respect and informed choice can strengthen people's agency, challenge negative gender norms, and help to improve their social and economic position.

The proposed initiative will aspire to be gender transformative and will focus on strategies to reach women and girls with appropriate, accessible, affordable, and quality SRH information and services as a means to contribute to gender equality.

During the design processes in country, our teams will consider:

- Working across governments and health systems to influence legislation, policy, and regulation in order to build supportive institutional policy frameworks for gender equality and SRHR;
- Focusing on service delivery channels and modalities that are the most effective at reaching the most marginalised women and girls; and
- Implementing targeted, context-specific SBCC interventions to shift attitudes, harmful gender and social norms.

Barriers to gender equality and the tailored approaches that will be implemented by MSI and IPPF in each country will be described in the country level designs.

Climate Change

The climate crisis poses a major threat for sustainable development and the realisation of human rights, including SRHR.

MSI is committed to delivering this programme in a sustainable way, considering its effect on the people and the environment in which it works.

MSI is one of the founders of the Population and Sustainable Development Alliance, whose mandate is to promote and support SRHR within the framework of global environmental agendas, including the international response to climate change, waste production levels, and carbon emissions. MSI is also part of the Energy Savings Opportunity Scheme, which undertakes basic energy impact assessments and advises on energy saving options. Furthermore, MSI is currently developing a strategy on its contribution and role in addressing the global climate crisis and a position paper on the links between FP and climate change, resilience, adaptation, and conservation.

In addition, MSI implements environmentally effective waste management measures with the objective of minimising waste through strong forecasting and supply chain management tools to prevent overstocking or waste as a result of expired products. MSI's provision of clinical services complies with MSI's Guidelines for Clinical Waste Management, which describe in detail the arrangement for segregating, handling, storage, and disposal of all types of waste generated in healthcare facilities or other MSI's channels. The guidelines assist country programmes in establishing a waste management plan for their programmes, considering the types of waste generated and the waste disposal resources available, and always inform and assist team members to apply correct and safe procedures. During the implementation of this initiative, MSI will ensure that all waste management measures comply with the national protocols and abide to these guidelines.

IPPF's position on SRHR, climate change, and sustainable development is articulated in policy and through its MA accreditation system and our recently launched position paper on the climate crisis and SRHR. As a major healthcare provider and advocate of SRHR, IPPF is committed to supporting communities to adapt to the effects of the climate crisis while calling for inclusive, human rights-based, and gender-transformative action to respond to the climate crisis and its impacts at all levels.

IPPF understands that the impacts of climate change on SRHR are many. They include reduced or unavailable services in areas affected by disasters, harmful impacts on maternal health due to heat exposure, and an increase the incidence of SGBV and child, early and forced marriages in situations of humanitarian crises or displacement. As the impacts of the climate crisis become more severe, adverse outcomes for SRHR will only increase. Inequalities and marginalisation are key factors in heightening vulnerability to the impacts of the climate crisis.

IPPF recognises that to reduce vulnerability and enhance resilience we need to address gender inequality and other forms of marginalisation. SRHR are critical for advancing gender equality and for overcoming marginalisation and thus for strengthening individuals' and communities' resilience and capacity to adapt to the climate crisis.

IPPF is committed to addressing and reducing its own carbon footprint and environmental impacts through environmentally sustainable organisational policies and practices. IPPF includes environmental

issues in its quality assurance program to mitigate potentially negative impacts and ensure that our work is 'green in the clinic.'

COVID-19 has seen an increase in the use of disposal items and equipment which could have a negative environmental impact. IPPF is mitigating this where possible through rationalising the opening of clinics to minimise some of the impact of waste. IPPF will adhere to existing policies and best practices on medical waste management in each programme country, including WHO's environmental practices for SRHR and IPPF's medical service delivery guidelines, which have instructions on environmentally responsible waste disposal practices.

Disability Inclusiveness

MSI and IPPF are committed to ensuring that people with disabilities, particularly women and girls, have equal access to, meaningfully engage in and benefit equally from our programmes. We recognise that people with disabilities face multiple intersecting barriers in accessing health services and information, increasing particular vulnerabilities and risks in relation to the COVID-19 pandemic.

These barriers are complex and include a range of social, cultural, and economic factors such as physical barriers or poor provider attitudes that intersect with ongoing stigma. This intersectional disadvantage shapes the way people with disabilities interact with and exercise their SRH rights and, despite having the same rights as others, people with disabilities are often overlooked, dismissed, or ignored.

We acknowledge that disability inclusion is a key component in the achievement of equal rights for all. Under the flagship FCDO-funded WISH programme, MSI and IPPF have partnered with Leonard Cheshire and Humanity and Inclusion to strengthen and mainstream disability inclusion at the programmatic and organisational level, creating and implementing policies and practices that move towards disability inclusion.

This partnership has enabled MSI and IPPF: (i) to update clinical and programmatic guidelines and tools; (ii) to develop training materials and roll out the Disability VCAT training package; (iii) to improve the way inclusivity of programming is measured; and (iv) to share lessons learned and best practices across the partnership to help country programmes and MAs designing and implementing disability inclusive interventions. For example, in Bangladesh the IPPF MA supported the government to include indicators on disability in the QoC dashboard which meant that for the first time the government of Bangladesh will have real time data on disability and SRHR. Support was also provided to different units within the FP directorate on budgeting to ensure adequate budgets were allocated for disability inclusion work.

Under the proposed initiative, we will build on these successes and ensure that women and girls with disabilities can recognise their rights, and exercise control over the decisions that affect their lives. Our approaches may include:

- Building the capacity of staff and healthcare providers by including disability inclusive modules in trainings;
- Improving service delivery to effectively reach people with disabilities, combining it with more effective communication approaches to address existing barriers; and
- Creating strong links and referral pathways with disabled person's organisations representatives across the country portfolio and strategic partners working with these groups, to cascade SRH information and integrate service delivery referrals.

9.2 Safeguarding

MSI and IPPF have relevant safeguarding processes and policies in place which are widely disseminated and understood across their country programmes.

As a global organisation that provides SRH services to millions of people each year, **MSI** recognises its responsibility and duty of care to ensure that all clients and staff are appropriately safeguarded whilst in MSI care. MSI has a robust suite of Safeguarding Policies and implementation systems to: **prevent** any form of harm, abuse, exploitation, and harassment, sexual or otherwise; to **identify and mitigate** any potential risks, to promote the **reporting** of any actual or potential risk and make reporting accessible to all clients and team members; and to **treat all reported incidents seriously** and in the best interests of the victim/survivor.

MSI's suite of safeguarding policies are underpinned by the principles of zero tolerance, empowerment, equality and diversity, and accountability and transparency. These are articulated throughout the MSI's global Code of Conduct, the Adult Safeguarding and Preventing Sexual Exploitation and Harassment Policy, and the Child Safeguarding Policy. The MSI Code of Conduct outlines the values and principles that drive our organisation and articulates the organisation's commitment to respect, equality, inclusivity, and dignity upon which our organisation is built. As part of their induction, all MSI team members sign the MSI Code of Conduct and complete online safeguarding training, with refresher training conducted annually. All Service Providers sign an additional Duty of Care statement that outlines their responsibilities for providing client centred care and ensuring all clients are treated with utmost dignity and respect. Additional safeguarding guidance is provided by the MSI Modern Slavery Policy, MSI SGBV Guidelines, and the MSI Counselling Guidelines on Informed Consent.

MSI actively promotes the "Speaking-up" Policy and its associated confidential and independent whistleblowing mechanism called 'SafeCall' to all MSI team members and clients. SafeCall offers a 24-hour multi-lingual helpline and email service through which to report any safeguarding, fraud or bribery concerns or incidents. MSI responds to all reported incidents seriously and forms an independent safeguarding decision committee to investigate incidents and ensure that the dignity and rights of our clients and team members are upheld.

IPPF wants to ensure it forms safe partnerships and is an organisation that is safe for all. It is committed to taking all reasonable steps to prevent foreseeable harm in any activity or interaction it is responsible for. In recognition of its commitment and responsibility of duty of care, IPPF's Safeguarding Framework provides a robust range of elements which include: Four safeguarding pillars, eight policies, a safeguarding team in place, safeguarding standards and a safe, confidential reporting system – IPPF SafeReport.

IPPF's safeguarding framework is built on four pillars: **Prevent, Report, Respond, and Governance and Accountability**. This includes a responsibility to ensure that MAs and partners acting on IPPF's behalf have the competency to fulfil their obligations safely and have the policies and procedures in place to prevent, report and respond to harm appropriately. IPPF's Safeguarding and Dignity at Work Taskforce has been instrumental in strengthening policies and processes across the Secretariat as well as engaging with the international development community to ensure that emerging and new best practice is adopted by the Federation as a priority. IPPF has dedicated Safeguarding Personnel including full-time Head of Safeguarding, Regional Safeguarding Advisors for the ROs and MAs and a Safeguarding Manager position in the East and South-East Asia and Oceania RO in Kuala Lumpur.

IPPF's Safeguarding Policies and Procedures comprise the Code of Conduct; Safeguarding Children and Vulnerable Adults; Respect at Work; Raising a Concern; Confidentiality and Information Sharing; Equality, Diversity and Inclusion, and Employment Principles. The IPPF Secretariat, MAs and partners must adhere to IPPF's Safeguarding Standards, which include a commitment to cascading these standards to any of their downstream partners including associate clinics.

IPPF's Safe, Confidential Helpline Reporting Mechanism (IPPF SafeReport) is a multi-lingual helpline, accessible 24 hours a day, seven days a week, across the entire Federation. The confidential service is available for anyone who wants to make a complaint about IPPF, or any service provided through partnerships. This system ensures that all concerns related to safeguarding, bullying, harassment, and fraud can be raised safely, logged centrally for oversight and learning, and responded to in a timely manner with the relevant expertise and support. IPPF has an Independent Complaints Panel (and policy) to review any complaints made in relation to the most senior staff and volunteers within the organisation, ensuring independent and objective incident management and due process.

IPPF has other policies in place that apply to the Federation collectively (MAs as well as the Secretariat). These seek to protect clients, employees, volunteers and other stakeholders from exploitation or abuse as well as ensuring they fully realise their human rights. These include Gender Equality; Meeting the SRHR of Young People; and Forced Labour and Human Trafficking.

10. Risk Assessment

MSI and IPPF have strong internal processes in place for identification and management of risks with a stringent internal audit system incorporating finance, data, and clinical quality standards. Data collection systems ensure swift detection of irregularities and fraud.

MSI and IPPF have developed a high-level global programme risk register for the DFAT programme (please see Annex 4). This risk register will be reviewed on a six monthly-basis at the programme Steering Committee meetings with an analysis of any mitigation measures taken. In addition, each organisation will establish its own specific risk assessment process as part of the programme management of their country initiatives.

Overall fiduciary risk for this investment is low, as MSI and IPPF have in place well-established systems for monitoring and reporting.

The impact of the pandemic is many-fold, and as countries scramble to contain the spread of the virus, health systems are stretched and prioritising COVID-19 response efforts. This places SRH services at a risk of being diverted or de-prioritised. MSI and IPPF, however, have strong relationships with MoHs and proven records of influence in the countries where they work. Furthermore, in some cases, both organisations have joined national COVID-19 response task forces which allow them to monitor the national situation more closely.

The pandemic situation in much of the region is volatile due to recurring waves of COVID-19 and, it may be necessary to discuss with DFAT the initiation of Minimum Initial Service Package (MISP) activities if conditions deteriorate significantly. If this case arises, the partner will discuss with DFAT and seek approval to re-programme or adjust the agreed country programming if deemed necessary. This is a 'live' risk currently in PNG where COVID-19 is seriously impacting health service delivery and could easily (re)emerge in other countries over the coming 12 months.

The recent coup in Myanmar has plunged the country back into chaos and uncertainty, and while the SRHR and general health needs in Myanmar are high, our teams have limited capacity to complete implementation of existing programs and will experience challenges in scaling up.

Funding for Myanmar has been included with the understanding that the Myanmar programme may not be able to draw on this funding until year two or the funds may need to be reallocated to another country. We will be in regular communication with the Asia regional team to assess options based on the SRH needs and MSI Myanmar's capacity to operate. If the situation permits, the team will focus on:

- **Expansion to teleconsultation programme:** There has been increased demand for teleconsultations during the COVID-19 pandemic and increasingly during the recent political crisis. MSI Myanmar could expand their teleconsultation service, with dedicated doctors providing this much needed service, to ensure that clients can access medical advice without having to travel to a medical facility.
- **Emergency clinical response:** MSI Myanmar could provide support to civil society organisations providing emergency clinical response to local populations affected by the COVID-19. This would involve working with local suppliers to source medical equipment and supplies.