



UNFPA Asia and the Pacific COVID-19 pandemic surge response - Strengthening Sexual and Reproductive Health and Rights to meet the needs of women and girls

DATE OF SUBMISSION: 17 May 2021

GEOGRAPHIC COVERAGE: Asia and the Pacific Regional Office (APRO), Indonesia Country Office and Papua New Guinea Country Office

THEMATIC FOCUS: Sexual and Reproductive Health and Rights

TOTAL BUDGET: AU\$4,459,103

PROJECT DURATION: Agreement duration: 36 months

Each program implementation duration: 24 months

1. Background

The COVID-19 pandemic constitutes one of the largest global public health crises of our century, severely disrupting access to lifesaving sexual and reproductive health (SRH) services, and impacting our collective ability to respond at a time when women and girls need these services the most. In 2020, the global pandemic severely affected access and availability of key sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) services across the Asia-Pacific region. An analysis of health information data revealed that in several countries, the utilisation rate of key services dropped between 20% and 50% in 2020 compared to 2019, resulting in millions of people not accessing critical services such as antenatal care, facility based deliveries and family planning services. These reductions in access to services potentially resulted in additional preventable maternal deaths, thousands of unintended pregnancies, and increased numbers of adverse neonatal health outcomes, including stillbirths and neonatal deaths.

In 2021, there has been a widespread resurgence of COVID-19 case numbers and deaths across the Asia Pacific region, with several countries reporting the highest number of cases since the beginning of the pandemic, and with added concerns of how the increase in the number of infections has taken less time compared to the previous waves. The evidence of extensive transmission of different variants of concern (VOCs) in multiple countries is also of grave concern, as some variants appear to be more aggressive and transmissible.

Against this background, the COVID-19 pandemic has continued to have a severe and disproportionate impact on the health and welfare of women and girls across the Asia Pacific region, with the resurgence further stretching fragile health systems in countries, resulting in disruption of services, shortages of critical health supplies and commodities, overflowing

hospitals and critical care units, and gaps in Health Management Information system capacities. Collectively, it can only be expected that similar patterns of reduced access and utilisation of key SRMNCAH services will continue well into 2021, resulting in increasing numbers of unintended pregnancies, preventable maternal and newborn deaths, and other sexual and reproductive health related morbidities and mortalities.

These urgent priorities require resourcing and attention. The Australian Department of Foreign Affairs and Trade (DFAT) has identified AUD\$ 4.45 million in resources under its new Indo-Pacific SRHR COVID-19 Surge Initiative (SRHR C-Surge) to continue partnering with UNFPA to address these gaps. This allocation builds on the important and successful work undertaken in 2020-2021, with a AUD\$4.5 million allocation from DFAT's Humanitarian Division which focused on scaling up SRHR and Gender Based Violence response services and on remote/virtual capacity building and service delivery initiatives to help governments' health service providers maintain services in a COVID-safe way. Building on the capacity development activities supported in 2020-2021, the following proposals for 2021-2022 aim to further strengthen governments' capacities to document, analyse and respond to SRMNCAH service provision disruptions, reinforcing Health Management Information systems to inform decision making as well as addressing critical gaps in maternal health and family planning service provision.

2. Objectives

In line with the UNFPA goal to achieve universal access to sexual and reproductive health and the three transformative results of zero preventable maternal deaths, zero unmet need for family planning and zero gender based violence and harmful practices by 2030, UNFPA's key priorities in Asia and the Pacific are to support the needs of the most vulnerable women and girls, and to reduce the risk of SRH related morbidity and mortality by ensuring continuity and accessibility of quality lifesaving SRHR information and services.

The specific objectives of this project are:

- To reduce the risk of preventable SRH related morbidity, mortality and disability that could result from the resurgence of COVID-19, particularly for maternal and neonatal health;
- To ensure the continued availability of reproductive health and family planning commodities; and
- To strengthen Health Management Information System capacities to collect, analyse and make critical decisions on SRHR service provision.

3. Project approach

The COVID-19 pandemic has demonstrated that fragile health systems present a huge risk to a population's ability to access quality services, including SRMNCAH services. SRHR inequities have been exacerbated and the poorest, least educated and most marginalised populations have been the most excluded and risk being further left behind. To support

countries in ensuring that provision of essential services can continue despite the burden of the pandemic resurgence across the Asia Pacific region, there is a critical need to strengthen:

- a) Health Management Information Systems to alert Ministries of Health of service disruptions;
- b) Logistics Management Information Systems to alert of stock-out levels and disruptions to reproductive health commodities and contraceptive supplies; and
- c) Maternal and perinatal death surveillance and response systems to account for the cause of every maternal and perinatal death.

Asia Pacific Regional Office:

It is proposed for this funding to be used to continue essential capacity building for improved national service delivery in target countries with the objective of rolling out support in up to 8 high priority Indo Pacific countries, subject to absorptive capacity and based on the results of the initial assessment and analysis. Timely upskilling of programme management, clinical and technology staff for managing the recording and use of SRMNCAH data is critically needed. The project proposes to strengthen governments' capacities to document, analyse and respond to SRMNCAH service provision disruptions, including as a result of COVID-19, by reinforcing Health Management Information systems as well as addressing critical gaps in maternal health and family planning service provision. By ensuring health workers and Ministries of Health are able to quickly identify critical disruptions and gaps in service provision through the use of routine data collection systems, appropriate corrective actions can be implemented in a timely manner, limiting the potential impact of reduced availability of services.

Papua New Guinea:

In the countries of priority interest to DFAT, we also propose to implement immediate support in PNG which is experiencing a major COVID-19 outbreak and pushing health services to the brink. Of vital importance, the PNG Government's supply chain is currently failing to deliver essential SRH commodities to health service delivery points throughout the country, leaving thousands of women and girls exposed to risks of unintended pregnancies and other potentially life threatening health consequences. The proposed program will ensure strong support for early improvements in commodity receipt, distribution and reporting, while also building back better through improved functioning of the Logistics Management Information System (eLMIS) and capacity training of national and sub-national logisticians and health service providers on inventory management, data generation and use of the eLMIS.

Indonesia:

Preliminary analysis of HMIS data to understand the impact of the COVID-19 pandemic on key SRH indicators has shown a significant reduction particularly in Q2 of 2020 of antenatal care provision and facility based deliveries, as well as an increase in both maternal and neonatal mortality in Indonesia. However, data provided from the country is limited, and the HMIS in Indonesia has experienced many challenges after decentralization in 2000 where quality and reliability of data and reporting has been incomplete. The DFAT investment in Indonesia will aim to improve the HMIS to ensure better reporting and recording of SRH indicators to guide programmatic interventions and decision making, to strengthen the functionality of the maternal and perinatal death surveillance and response system (MPDSR),

and to improve emergency obstetric and newborn care (EmONC) capacity and referral mechanisms in West Java province. The West Java province has sufficient health infrastructure, which is paradoxical to why it has the highest burden of maternal mortality and has shown an increase in MMR during the COVID-19 pandemic. In addition to West Java being a priority province for the central Ministry of Health, the UNFPA-DFAT investment of technical backstopping and support to strengthening HMIS, MPDSR and EmONC capacity can serve as a good model to be replicated in other provinces with a similar context (dense population with high maternal mortality) that can leverage overall efforts in reducing MMR for the whole of Indonesia.

An additional contribution of AU\$1 million from DFAT will further enable UNFPA Indonesia to strengthen integrated SRH and GBV service delivery, including mental health and psychosocial service (MHPSS) provision, not only in West Java province but also in other provinces greatly affected by the COVID-19 pandemic. A key focus of the additional investment will be to ensure the continued access and provision of quality integrated information and services for particularly vulnerable populations, such as pregnant women, persons living with HIV (PLHIV), adolescents and youth, older persons and people with disabilities. Key national partners including line ministries and civil society organizations will be engaged for capacity building, development of technical guidelines and integrated service delivery.

4. Estimated budget

The estimated budgets for the three UNFPA concept notes are:

Asia Pacific Regional Office: AU\$1,013,803
Indonesia Country Office: AU\$1,900,900
Papua New Guinea Country Office: AU\$1,544,400
TOTAL: AU\$4,459,103

5. Basis of Payment

DFAT will provide funding through two tranches as follows payment for the full amount of the contract AU\$4,459,103, following the second signature of the EoL.

Milestone 1: Original Funding Agreement

Milestone completion indicator: second signature

Due date: 11 June 2021

Amount: \$3,459,103

Milestone 2: Amendment to Funding Agreement

Milestone completion indicator: second signature

Due date: (est.) 10 November 2021

Amount: \$1,000,000

6. Project management

If approved, the UNFPA Asia Pacific Regional Office will be the executing and managing partner responsible and accountable for the DFAT C-Surge investment. UNFPA APRO will directly implement and manage the regional data initiative, and while the Country Offices in Indonesia and PNG will be responsible for program management of their respective country initiatives, it will be under the oversight of APRO. APRO will also be responsible for all reporting, including:

- Attending a mobilisation meeting in Q3 2021 (estimated to be in August 2021)
- Ensuring that the concept notes are developed into full proposals within 2 months of the signing of the EoL for DFAT's agreement
- Providing a six monthly progress report to DFAT covering progress on all interventions during the 24 month implementation period, in line with the C-Surge reporting timelines. In order to align with the revised start date of the various components of the UNFPA C-Surge investment, this entails the below reporting timelines:

Indonesia:

1. Report 1: the 6-monthly report for the Indonesia program, covering the period 10 September 2021 until 28 February 2022, due on 30 March 2022.
2. Report 2: a mid-term report 12-month report covering the period 10 September 2021 to 30 August 2022, due on 30 September 2022 covering all interventions.
3. Report 3: the second 6-monthly report covering the period 1 September 2022 to 28 February 2023, due on 30 March 2023 covering all interventions.
4. Report 4: the final (terminal) report covering the whole 24-month program from the commencement of implementation covering all interventions, to be due 60 days after the project end date, by 1 April 2024.

APRO and PNG:

1. Report 1: the 6-monthly report designated as a Mobilisation Report, and including any reportable progress on the program, due on 30 March 2022.
2. Report 2: a mid-term report 8-month report covering the period 1 January 2022 to 30 August 2022, due on 30 September 2022 covering all interventions in accordance with requirements of a full annual report.
3. Report 3: a 6-monthly report covering the period 1 September 2022 to 28 February 2023, due on 30 March 2023 covering all interventions.
4. Report 4: the final (terminal) report covering the whole 24-month program from the commencement of implementation covering all interventions, to be due 60 days after the project end date, by 1 April 2024.

UNFPA Asia Pacific Regional Office: Strengthening Data and Accountability Systems for Advocacy and Action on Sexual and Reproductive Health

DFAT Programme Design, 2021- 2023

Programme Title	Strengthening Data and Accountability Systems for Advocacy and Action on Sexual and Reproductive Health, for improved tracking and monitoring of SRH outcomes in Asia-Pacific to support better public policy and improved health outcomes for women and girls.
Full Programme Duration	Programs starts on the date of commencement of the international positions funded by C-Surge and no later than March 2022 until Jan 2024 24 months)
Outcome for the Programme	Countries in the Asia Pacific region have strengthened Health Management information systems (HMIS) and Maternal and Perinatal Death Surveillance and Response systems (MPDSR), to improve tracking, monitoring and appropriate responses which result in better SRH outcomes particularly for women and girls.
Outputs for the Programme	<ol style="list-style-type: none"> 1. A Situational Analysis of HMIS systems is completed for selected countries and identifies critical gaps in completeness and accuracy of SRMNCAH service utilisation and outcome data and provides the basis for a roadmap for improvement. 2. The capacity of countries to collect, monitor, analyse and review SRMNCAH data is strengthened through targeted training and capacity building. 3. Maternal & Perinatal Death Surveillance and Response systems are strengthened in selected countries with a high-burden of maternal mortality, through a situational analysis of MPDSR implementation status and the development of targeted capacity building training for Ministries of Health.
Total Programme Budget	US\$787,726 (approximately AU\$1,013,803)

1. Summary

Implementing sexual and reproductive health programmes requires regular monitoring and rapid feedback of information at all levels of the health system. This allows strategies for improving the availability and quality of care to be regularly and timely adjusted. The importance of a responsive health management information system (HMIS) has been made even more evident during the COVID-19 pandemic, with the need to quickly collect and assess real time data and information at subnational levels in countries. This data, once analysed, enables countries to understand urgent changes and patterns that are happening that can enable rapid evidence-based decision-making and implementation of solutions and corrective measures in a timely and targeted manner.

UNFPA Asia Pacific Regional Office has been working jointly with other health partners to encourage countries to use real time health information systems, such as the DHIS2 platform, to enable the monitoring of sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) service usage disruptions, system disruptions and changes in outcomes of mortality and morbidity. This Programme funded by the Australian Department of Foreign Affairs and Trade has the **overall objective of strengthening selected countries' HMIS and MPDSR systems, in order to monitor trends of coverage and utilisation of key SRMNCAH services in an agile and responsive manner**, ultimately impacting the maternal and perinatal health outcomes of women and their newborns and reducing morbidity and mortality.

2. Background and Programme Rationale

In some countries of the Asia-Pacific region, the process of developing a responsive and accurate HMIS has not yet been fully completed. SMRMNCAH Programme Managers in Ministries of Health need capacity to set up, monitor and utilise those systems, to review the data quality and completeness and lead the process of regular analysis and response. To do so, they must rely on the abilities of staff and officers who collect, clean and input SRMNCAH services coverage and utilisation data, collating data collection inputs from the lower levels of the health systems at sub-national and district level. Adding to these complexities, in many countries of Asia-Pacific HMIS have yet to be fully digitalized, which adds additional challenges to timely and accurate reporting from all health facilities and subnational units in a country to the national HMIS data centre.

In the Asia and the Pacific region, countries currently using or planning to use a digital HMIS system such as DHIS2 include Afghanistan, Bangladesh, Bhutan, India, Indonesia, Lao PDR, Myanmar, Nepal, Pakistan, Solomon Islands, Sri Lanka, Timor-Leste, Tonga, Vanuatu, while Cambodia, Maldives, Mongolia and Vietnam are piloting the system. However, differences exist between countries with a more advanced set-up and utilisation of the DHIS2 platform and countries that are using it in a more limited manner (for example, focusing on national level reporting). In addition, even in countries where digital HMIS platforms are at a more advanced stage, it is unclear whether the type of indicators and data being collected are sufficiently detailed or comprehensive to ensure proper monitoring of the SRMNCAH needs of various

population groups. Thus, a situational analysis of the state of HMIS systems and indicators in selected countries of Asia-Pacific is required, followed by capacity building and timely upskilling of programme management, clinical and technology staff for managing and use of SRMNCAH data, including through the DHIS2 RMNCAH toolkit.

This capacity building programme aims to review the HMIS status and data collection pathways in approximately 8 high-burden countries of the Asia Pacific region, and to provide in-depth training to 6 priority countries, based on the review of the HMIS situational analyses. In each country, at least 5 technical officers will receive training and support, in order to improve the processes of data collection and reporting in the HMIS, so that key SRHR indicators data are collected monthly and reviewed at least quarterly to identify areas of need. In addition to the country-specific training for the 6 priority countries, a regional e-learning training on HMIS data collection and reporting will also be offered as part of this programme, targeting approximately 15 countries or 70% of the UNFPA Asia Pacific region.

In addition to functioning and responsive HMIS, Maternal Perinatal Death Surveillance and Response (MPDSR) systems are also an integral part of quality of care improvement efforts to reduce maternal deaths, as well as preventable stillbirths and neonatal deaths. Establishing effective MPDSR systems involves qualitative, in-depth investigations of the causes and circumstances surrounding maternal and perinatal deaths. The MPDSR process relies on the effective identification of reporting and assigning causes of deaths, identifying actions that may contribute to the prevention of further deaths, assigning those actions to particular groups or individuals, designating time frames for completion of those actions, and following up to ensure that those actions have been taken. During the pandemic, it has become evident that these systems, which were in many countries weak prior to COVID-19, have been further weakened due to strains on the health system, and need urgent attention.

To reinforce MPDSR systems, 6 selected countries of Asia-Pacific will be supported in analysing and critically assessing their current pathways for surveillance and response, which will lead to the development of MPDSR Improvement Action plans to be implemented at national and subnational level in collaboration with Ministries of Health and UNFPA Country offices.

3. Programme Indicators and Activities Framework

<p>Strengthening Data and Accountability Systems for Advocacy and Action on Sexual and Reproductive Health</p>
<p>Outcome: Selected countries in the Asia Pacific region have strengthened Health Management information systems (HMIS) and Maternal and Perinatal Death Surveillance and Response systems (MPDSR), with capacity to monitor trends in coverage and utilisation of key SRMNCAH services in an agile and responsive manner.</p>
<p>Outcome indicators</p>
<p>6* selected countries' HMIS systems are improved to collect data on key SRMNCAH indicators: on a monthly basis, with quarterly reviews of data</p> <p><i>*It is expected that approximately 8 countries will be targeted by the HMIS Situational Analysis, pending country confirmation (these may include: Bangladesh, Cambodia, Indonesia, Lao PDR, Nepal, Pakistan, Papua New Guinea, Philippines, Timor-Leste)</i></p> <p>Baseline 2021: 0 Target 2024: 6 countries</p>
<p>6* selected countries have strengthened Maternal and perinatal death reporting to ensure at least 80% of deaths are notified to the MPDSR system</p> <p><i>* These may include: Bangladesh, Cambodia, Indonesia, Lao PDR, Nepal, Pakistan, Papua New Guinea, Philippines, Timor-Leste</i></p> <p>Baseline 2021: 0 Target 2024: 6 countries</p>
<p>Output 1: A Situational Analysis of HMIS systems is completed by Q2, 2022 for all eight selected countries, and identifies critical gaps in completeness and accuracy of SRMNCAH service utilisation and outcome data and provides the basis for a roadmap for improvement.</p>
<p>Output indicator: Toolkit for Situational Analysis research is developed by IP Baseline 2021: No 2022: Yes 2023: N/A</p>
<p>Activities</p> <ol style="list-style-type: none"> 1. Perform initial assessment of HMIS status for up to 8 countries in the Asia Pacific to inform countries' selection 2. Contract Institution (e.g. University of Oslo, DHIS2) as Implementing partner (IP) for performing situational analysis 3. Toolkit for situational analysis is developed by IP in collaboration with UNFPA
<p>Output indicator: HMIS Situational analysis is performed in up to 8 countries Baseline 2021: 0 2022: 8 2023: N/A</p>
<p>Activities</p> <ol style="list-style-type: none"> 1. UNFPA to hire and deploy local consultants to perform data collection and assessments in up to 8 countries in partnership with the Ministry of Health 2. Situational Analysis reports are prepared by IP and UNFPA to be shared with Ministries of Health

<p>3. UNFPA validates reports and finalise HMIS improvement plans with Ministries of Health</p> <p>Output 2: The capacity of at least 15* countries to collect, monitor, analyse and review SRMNCAH data is strengthened through targeted training and capacity building.</p> <p><i>* These 15 countries will include the 8 priority countries (Bangladesh, Cambodia, Indonesia, Lao PDR, Nepal, Pakistan, Papua New Guinea, Philippines, Timor-Leste) as well as additional countries of the AP region such as Afghanistan, Bhutan, India, Iran, Myanmar, Maldives, Mongolia, Sri Lanka, and the Pacific Island Countries. Out of these 15 countries, 6 will also receive country-specific training.</i></p> <p>Output indicator: Country-specific capacity building activities and training plans are developed based on Situational Analysis for 6 countries Baseline 2021: 0 2022: 2 2023: 4</p> <p>Activities</p> <ol style="list-style-type: none"> 1. Based on the results and insights of the HMIS Situational Analysis and Improvement Roadmaps, 6 countries are selected for country-specific training 2. IP designs, researches and validates capacity building activities and training curriculum, in partnership with UNFPA 3. Country-specific rounds of training are conducted by IP for Ministries of Health staff (at least 5 technical officers) of each individual country (through online or in-person learning activities, TBD based on COVID-19 situation) for up to 6 priority countries <p>Output indicator: Virtual training and capacity building activities on HMIS/DHIS2 are conducted for selected (est. 15) countries' MoH staff Baseline 2021: 0 2022: N/A 2023: 70% of AP countries</p> <p>Activities</p> <ol style="list-style-type: none"> 1. IP develops a training package on effective data collection, monitoring and validation for HMIS systems, appropriate and useable for the majority of countries (70% or an estimated 15 countries) in the Asia Pacific region <i>(NB This will be offered to the 22 country offices across Asia and our Pacific Subregional Office in Suva, Fiji who, supports 14 Pacific island nations. We estimate around 15 countries will engage with this)</i> 2. Virtual training is conducted through e-learning platforms for selected technical officers and UNFPA staff (3 to 5 trainees per country) in 70% of Asia Pacific countries (approximately 15 countries) 3. Final report on capacity building activities and the outcomes of such training (including examples of improvement in data collection, utilisation and where/if possible, consequent health improvements for target populations) is prepared by IP and UNFPA <p>Output 3: MPDSR systems are strengthened in selected high-burden maternal mortality countries, through a situational analysis of MPDSR implementation status and the development of targeted capacity building training for Ministries of Health</p> <p>Output indicator: MPDSR pathways are reviewed and analysed in up to 4 high-burden countries (situational analysis) Baseline 2021: 0 2022: 4 2023: N/A</p> <p>Activities</p> <ol style="list-style-type: none"> 1. An Implementing Partner (IP) Institution is contracted to implement the MPDSR pathways situational analysis and research in 4 selected high-burden countries, identified through a regional
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<p><i>assessment conducted by APRO in 2021</i></p> <p>2. <i>Analyses of the MPDSR System are conducted by the IP with APRO support for each selected high-burden country, including preparation of MPDSR Improvement Plans</i></p>
<p>Output indicator: MoH staff receive capacity building support on MPDSR data collection, analysis and systems strengthening</p> <p>Baseline 2021: 0</p> <p>2022: 2</p> <p>2023: 2</p>
<p>Activities</p> <ol style="list-style-type: none"> 1. <i>After validation of MPDSR analyses results and Improvement Plans with MoH counterparts, individual countries' capacities building needs are assessed for training purposes with an expected minimum target of at least 5 personnel in each country</i> 2. <i>Training activities on MPDSR systems are conducted by the IP with APRO support as appropriate in the different countries</i> 3. <i>Final report on outcomes of training and capacity building activities is prepared by IP and UNFPA (including examples of improvement in data collection, utilisation and response plans that are developed to prevent further maternal and neonatal deaths where/if possible in the target populations)</i>

4. Management and implementation arrangements, risk assessment

The overall management of this Programme will be overseen by the UNFPA Asia-Pacific Regional Office. In particular, the programme will be led by the UNFPA Technical Advisor for Sexual and Reproductive Health, under the overall supervision of the Deputy and Regional Directors for Asia-Pacific. This position will also provide technical support and mentoring to countries engaged in the programme.

As part of the programme of work, a P3 SRHR Data Specialist will be recruited by UNFPA APRO to support the day-to-day management, planning and implementation of the different components of this programme. This will include liaising with country counterparts, including UNFPA Country Offices, and managing the work of the IPs and of any consultant required to be employed by UNFPA APRO.

The SRH Data Specialist will also be responsible for the reporting, monitoring and evaluation requirements of the programme of work.

The virtual training will be carefully prepared in consultation with country stakeholders to ensure maximum engagement and accessibility. Pre-course surveys will be conducted to establish user profiles and experience so that the training is appropriately targeted. This will also serve as a baseline to measure changes in knowledge and skills. Use of simultaneous translation will also be explored if needed as UNFPA has used this feature in several midwifery education programmes across the region with great success. Participation measures will be established with the IP and participants and is likely to include minimum attendance in virtual training sessions as well as completion of set tasks in a learning platform like Moodle. The SRHR Technical adviser in APRO and the Data Specialist will regularly check in with all participants to support access to the course and help trouble shoot difficulties with the virtual learning platforms as

needed. Post course surveys will also be conducted to establish effectiveness of training compared with pre course survey baseline.

Risk assessment and mitigation strategies

Risk	Impact	Likelihood	Mitigation strategy
The continued impact of COVID-19 might divert Ministries of Health staff capacities to engage in the HMIS and MPDSR review processes	Medium	<i>Medium</i>	APRO will work collaboratively with Ministry of Health officials in charge of these processes and work on timeframes that are realistic and manageable for them. If one country is experiencing a high burden of COVID-19 that prevents them from being able to engage then we will select a country that feels more ready. In addition, UNFPA will work collaboratively with UN partner agencies at regional and country level so that a collaborative and supportive strategy can be implemented to facilitate these processes.
Continued COVID-19 restrictions might impact the ability of APRO staff and partners to travel to selected countries to oversee the project and conduct training	Medium	<i>High</i>	Online delivery channels for conducting and disseminating research, validating results and conducting capacity building activities can be used as required. National consultants will be employed for local data collection efforts and will work collaboratively with UNFPA staff in selected countries with support and guidance from APRO.
UNFPA procurement and consultant recruitment procedures and availability might delay the selection of partner institutions or consultants	Medium	<i>Low</i>	UNFPA APRO will start the process for IP selection by the end of August 2021. Discussions have already begun with potential partners. A common TOR will be developed for recruitment of local data consultants as needed in country offices which will facilitate faster recruitment processes.
MoH and staff in countries might be reluctant to engage and share access to HMIS and MPDSR systems	Medium	<i>Low</i>	UNFPA country office staff will work collaboratively with the Ministry of Health and UN partners to ensure this work is jointly owned and prioritised.

5. Programme Timeline and Budget

Activities	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Jan 2024
P3 Recruitment													
IP selection (HMIS analysis and training)													
Country selection HMIS work													
Research Toolkit development													
Recruitment of Local Consultants													
Data Collection													
Report writing & Validation													
Country selection HMIS training													
HMIS training curricula design													
Country specific HMIS training													
Regional capacity building training													
Final report on HMIS training													
Selection of IP (MPDSR work)													
Situational analysis (MPDSR)													
Country specific capacity building													
Final report on MPDSR training													

Budget summary

	Allocated Budget	Allocated Budget
Outputs of the Programme	Year 1 (Jan 2022 - Jan 2023)	Year 2 (Jan 2023 - Jan 2024)
Situational Analysis of HMIS data collection systems	US \$100,000	
Capacity Building Programme on strengthening SRMNCAH data collection and HMIS	US \$90,000	US \$100,000
Analysis of MPDSR systems and targeted capacity development	US \$20,000	US \$50,000
Travel and other programme costs	US \$15,000	US \$15,000
SRHR Data Specialist	US \$193,863	US \$203,863
<i>Annual Budgets</i>	<i>US \$418,863</i>	<i>US \$368,863</i>
Total Programme Budget		US \$787,726



TITLE	Strengthening Maternal Health Care Systems to Accelerate Efforts in Reducing Maternal Deaths during the COVID-19 pandemic in West Java, Indonesia
PROGRAMME DURATION	Programs no later than March 2022 until Jan 2024 (24 months)
THEMATIC FOCUS	Sexual and Reproductive Health and Rights
OUTCOME	By 2023, the reduction of preventable maternal deaths in West Java has accelerated
INTERMEDIATE OUTCOME	Strengthened capacity of health system, institutions and communities to generate response for prevention of avoidable maternal and neonatal deaths.
PROGRAMME OUTPUTS	<ul style="list-style-type: none"> • Improved functionality of health management information system (HMIS) which incorporates sexual and reproductive health (SRH) data collection, management and utilization in West Java province • Skills of health workers strengthened in maternal and perinatal death surveillance and response (MPDSR) in one district in West Java • Emergency Obstetric Neonatal Care (EmONC) network and functionality mapped in one District in West Java province and an improvement plan developed and implemented
GEOGRAPHIC COVERAGE	Central level and West Java Province
TOTAL BUDGET	AU\$900,900

1. Summary:

During the period of 1 October 2021 to 30 September 2023, intervention to accelerate maternal health efforts in West Java will be conducted through the improvement of reporting and recording of sexual and reproductive health (SRH) indicators in the national Health Management Information System (HMIS), ensuring functionality of the maternal and perinatal death surveillance and response system (MPDSR), and to strengthen referral systems and mechanisms in West Java province. The programme will support the Government of Indonesia's development priorities in reducing maternal deaths in Indonesia.

Supported by DFAT, the programme will be implemented by UNFPA Indonesia with technical backstopping from the Asia Pacific Regional Office in collaboration with the Ministry of Health, selected universities, and professional organizations.

2. Background and Context

Maternal Mortality in Indonesia and Covid19 Pandemic

With a Maternal Mortality Ratio of 305 maternal deaths per 100,000 live-births, the maternal death phenomenon in Indonesia reveals a paradox. World-wide there is a direct negative association between the proportion of deliveries by SBAs and MMR. Despite a reported high proportion of deliveries by SBAs (91% -IDHS 2017), the MMR continues to be high. Poor quality of care is a major contributory factor.

In order to end preventable maternal deaths, accurate information on how many women died, where they died and how they died is essential, but the existing data is currently inadequate to enable prevention. In Indonesia, each district (health workers and subnational health offices) has been required to carry out maternal death reviews since the late 1990s, as part of the maternal and perinatal mortality and morbidity audits. However, an assessment of the review indicated a lack of efficient monitoring of the programme and its implementation varied across districts. Implementation of Maternal and Perinatal Death Surveillance and Response (MPDSR) has been demonstrated to contribute to better information for action by promoting routine identification and timely notification of maternal deaths, review of maternal deaths, implementation and monitoring of steps to prevent similar deaths in the future.

The ongoing COVID-19 pandemic has seriously affected the health systems in most countries, including in Indonesia. The Government of Indonesia has applied a lockdown policy since 10 April 2020, where the capital city of Jakarta was found to be the most affected area. In June 2020, the government gradually introduced measures to adapt to a new normal. However, not only has the trend of transmission persisted; it has also escalated during the recent resurgence of cases in 2021. The Indonesian Government, implementing a centralized data reporting mechanism through the Ministry of Health (MOH) Data Centre, reported that by 6 July 2021 there were 2.345.018 COVID-19 cases, including 61.868 deaths. The severe consequences from the pandemic is also evident in the area of sexual and reproductive health.

Data from the Health Management Information System (HMIS) reported a sharp reduction in the use of SRH facilities during the first three months of the pandemic in 2020, which was caused primarily by the fear and perceived risk of COVID-19 infection in healthcare settings, and also by the lack or reduced availability of public transport and movement restrictions. In addition, the MOH issued guidelines on prioritizing health-seeking only for emergencies in an effort to avoid putting further pressure on an overburdened health system. Some health facilities temporarily closed down because health providers became infected with COVID-19. As such, during the pandemic, pregnant women reportedly avoided going to clinics for their regular check-ups.

In the beginning of the pandemic, many hospitals were not ready with the facilities and infrastructure to handle COVID-19 maternity cases. Negative pressure isolation rooms for COVID-19 positive pregnant women were not available, and personal protective equipment (PPE) was not initially provided to SRMNCAH workers such as midwives. This caused referral hospitals to be centered only in the provincial capital

and several city districts, which resulted in delays and difficulties in referring mothers from various regional hospitals. These challenges will continue throughout the pandemic and will require solutions to go beyond the pandemic and towards a humanitarian and development continuum.

Making the case for West Java: A close look at the province with the highest burden of maternal deaths

West Java is the province with the highest population in Indonesia. Located in Java Island and neighbouring the nation's capital, the province is populated with over 49 million people in 2020. West Java is also the province with the highest burden of maternal deaths, further exacerbated by the impact of the COVID-19 pandemic. It is reported that there were 700 maternal deaths in 2018, 648 in 2019 and 745 in 2020. Ministry of Health has declared that 23 of its 25 districts are priority areas for maternal health interventions. Given that the West Java Province has sufficient health infrastructure, the increase in maternal mortality in the pandemic context is paradoxical. For this reason, this province is being targeted for this programme to understand how to improve health system capacity to address maternal mortality through investment in technical backstopping and support, rather than improvement in infrastructure. The good practice can serve as a model to be replicated in other provinces with a similar context (dense population with high maternal mortality) that can leverage the achievement of reducing MMR for the whole of Indonesia.

Current national efforts to prevent maternal deaths: identification of gaps

To strengthen the national maternal health programme, the magnitude of the problem must be understood and barriers that limit access to quality maternal health services must be identified, which is enabled when data on SRH and maternal health is timely and accurate. Data on maternal health is routinely reported through the HMIS, a reporting mechanism that starts from the community level, to district and provincial level public health centers, and then to the national level. However, the HMIS has experienced many challenges, particularly after decentralization in 2000, impacting data completeness, quality and reliability. While the data provided from the HMIS data collection is limited, it shows a significant reduction of overall maternal health services--particularly on antenatal care provision and births in health facilities (-36%) in 2020.

The current reported maternal deaths through HMIS is estimated to capture only 30% of the total maternal deaths. This demonstrates a severe systemic under-reporting. The Government of Indonesia has conveyed that having the right reporting system that will provide timely and comprehensive SRH data, including data on maternal deaths, is key in accelerating efforts to reduce maternal deaths in Indonesia.

The Maternal and Perinatal Death Surveillance and Response System (MPDSR) was introduced nationwide in 2019 by MOH, with support from UNFPA. There was also the introduction of a death notification app, called MPDN (Maternal and Perinatal Death Notification). With this tool in place, health facilities are able to report any cases of maternal/perinatal death as soon as possible. Although the application is still not widely used at this point, the system offers an opportunity for improved maternal and perinatal death data collection--enabling timely reporting and real time data--

compared to existing mechanism that mainly collects data from health facilities which does not capture the real number of deaths that might occur outside the health system. Through this intervention bridging the gap with the existing provincial civil registration system (Civil Registration and Vital Statistic - CRVS) is another way to capture the underreporting. By doing so, it is expected that the health system could screen for the deaths of women at reproductive age to find the possibility of maternal death. This linkage of the MPDSR system with the CRVS will help increase understanding of what is happening at subnational level to enable the appropriate response and system improvements.

One of the health system challenges that contributes to maternal mortality is the gaps in Basic Emergency Obstetric Care (BEmOC) and Comprehensive Emergency Obstetric Care (CEmOC) referral services. One of the gaps that were identified is on the network of BEmOC and CEmOC facilities that are not organized in a way that would enable life-saving referral. Currently, MOH is revising the BEmOC guideline which also includes the identification of health centers to be selected as BEmOC facilities by considering various criteria including the capacity, availability of resources and staff, geographical distribution, and access to hospitals. The implementation of this guideline at the subnational level, in this case in West Java Province, will be instrumental in further gap identification and response to ensure a functioning referral system for emergency obstetric care.

3. Goal and Objectives

Overall Programme Goal

The overall programme goal is to contribute to the government of Indonesia's development priorities in accelerating maternal death reduction and support the needs of the most vulnerable women and girls by ensuring accessibility of quality lifesaving SRHR services through strengthened HMIS, MPDSR and EmOC. This is in line with the UNFPA goal to achieve universal access to sexual and reproductive health and the three transformative results of zero preventable maternal deaths, zero unmet need for family planning and zero gender based violence and harmful practices by 2030.

Programme Objectives

- Improved functionality of health management information system which incorporates SRH data collection, management and utilization
- Skills of health workers strengthened in maternal and perinatal surveillance and response (MPDSR) in one district in West Java
- EMONC network and functionality mapped in one District in West Java province and an improvement plan developed and implemented

Primary beneficiary groups

- Reproductive health programme managers and health providers (doctors, midwives and community health workers)
- Women at reproductive age 15-49 years in a district with a high number of maternal deaths in West Java province.

4. Rationale of the Investment

The high level of maternal deaths reveals the weakness in health sector performance and failures to meet women's reproductive rights. The national commitment to reduce the maternal mortality ratio is high as stated in the National Medium Term Development Plan (RPJMN 2020-2024), which aims to reduce MMR from 305 deaths to 183 per 100,000 live births in 2024. The RPJMN 2020-2024 also mentioned key interventions in addressing high MMR which include plans to improve continuity of maternal and neonatal health, referral system, and recording and reporting of maternal health as main priority interventions.

In order to end preventable maternal deaths, accurate information on how many women died, where they died and how they died is essential, but is currently inadequate and incomplete. Maternal death surveillance and response (MDSR) contributes to better information for action by promoting routine identification and timely notification of maternal deaths, review of maternal deaths, implementation and monitoring of steps to prevent similar deaths in the future.

UNFPA has been supporting MOH's initiative in adapting the MDSR guidelines and its pilot implementation in 2 districts in Indonesia. The pilot implementation resulted in lessons learned for improving implementation of MDSR in the field which were summarized in the form of a policy brief. Other UNFPA's programme interventions are on strengthening policies that will have wider impact to maternal health programme including development of a roadmap for maternal mortality reduction, strengthening midwifery workforce in Indonesia through improving midwifery preservice standards and strengthening the quality and management of midwifery workforce.

The two-year interventions will be implemented in West Java province. The West Java province has sufficient health infrastructure, which is paradoxical to why it has the highest burden of maternal mortality and has shown an increase in MMR during the COVID-19 pandemic. In addition to West Java is the province where 23 out of 25 districts have high number maternal deaths and are determined as the priority areas for maternal and child health intervention by the central Ministry of Health. The West Java area also had been supported previously through donor's project such as EMAS (Expanding Maternal and Newborn Survival) by USAID from 2012 to 2016. The upcoming UNFPA-DFAT investment of technical backstopping and support to strengthening HMIS, MPDSR and EmONC capacity can serve as a good model to be replicated in other provinces with a similar context (dense population with high maternal mortality) that can leverage overall efforts in reducing MMR for the whole of Indonesia.

5. Scope of Work and Methodology

Ultimate Outcome

- By 2023, the reduction of preventable maternal deaths in West Java has accelerated.

Outcome indicator:

- Number of maternal deaths in the selected district
Baseline: TBC
Target: TBC

Intermediate Outcome:

- Strengthened mechanisms of the health system to advance maternal and neonatal programme's policy and decision making

Indicator: Health system interventions to generate response for prevention of avoidable maternal and neonatal deaths are embedded in the medium-term action plan endorsed by the district government

Baseline: None

Target: Available

To bring about transformational change, the programme will provide tailored district-specific support to a selected district¹ in West Java with high maternal mortality drawing on inequity analyses, policy advice and support to capacity building for quality health workers and comprehensive emergency obstetric care; prioritise support focus on the rights-based approach for quality family planning, adolescent sexual and reproductive health services and information.

The programme will continue to prioritize support to partners, through a health systems strengthening approach of building the capacity of the reproductive, maternal and adolescent health workforce to deliver human rights-based, comprehensive sexual and reproductive health interventions. A significant focus will be placed on building the capacity of health workers to provide essential care needed for adolescent girls, women and neonates that is safe, respectful, non-discriminatory and human rights-based, and for health care providers for promoting rights-based, increased access to most in need, and regulatory frameworks promoting client accountability.

The programme addresses maternal health services in the context of health systems strengthening, through an integrated human rights-based approach with equality, equity and non-discrimination perspectives, and an emphasis on quality of care/services. The proposed programme will provide technical support to the selected district on service guidelines, protocols and programmes especially in data systems strengthening, reporting and response, as well as referral mechanism that will contribute to increased quality of services for maternal health.

UNFPA-DFAT investment will therefore contribute in the achievement of the above outcome through implementation of evidence-based intervention to strengthen reporting, recording and review of maternal deaths as well as improve basic and comprehensive emergency obstetric and neonatal care; knowledge management, capacity building and partnerships as follows:

¹ Selection of the district will be decided jointly with the Ministry of Development Planning (BAPPENAS) and Ministry of Health. Parameters will take into consideration: (i) Key indicators related to maternal health and reproductive health; (b) vulnerability mapping; (c) commitment from the district government; and (d) Government of Indonesia (GOI) priority area for maternal health programmes

Programme Outputs:

Output 1: Improved functionality of health management information system which incorporates SRH data collection, management and utilization

Target Area: Central level and selected district in West Java province

Partners: Ministry of Health (Central level), National Planning Agency (BAPPENAS), Provincial Health Office, District Health Office, research institutes and universities

Indicators:

- Review of SRH indicators under the current HMIS system and recommendations for improvement is available.
- Prototype of an interactive dashboard within the MOH HMIS on SRH situation to enable prompt feedback for timely and quality data reporting from district to provincial to national levels is available.

Key Activities:

1.1. Bottleneck analysis of SRH indicator reporting in HMIS

An analysis to obtain an overview of the current context of HMIS in Indonesia with regards to SRH data will be conducted. Areas to be analyzed include completeness SRH data, data flow, constraints, root causes of the constraints and any future plan of MOH in HMIS improvement. The analysis will assess the HMIS context at the central, provincial and selected district and is expected to provide strategic recommendations for improvement.

1.2. Consultative and dissemination workshop

The results of analysis will be discussed in consultative and dissemination workshops with related stakeholders at the national and sub-national level. The objective of the workshops is to gather insights of the key stakeholders and obtain commitment and support for addressing the identified constraints.

1.3. Development of interactive dashboard and warning system for SRH situations as part of the MOH HMIS

Based on the findings of the bottleneck analysis, a prototype of an interactive dashboard within the MOH HMIS on SRH data will be improved. The prototype aims to improve the completeness and quality of data and will feature prompt feedback for timely and quality data reporting from district to provincial to the central MOH.

1.4. Piloting of dashboard application and warning system prototype

Piloting of the dashboard and warning system from central level (MOH) to the provincial health office level will be conducted in West Java province for 6 months. The lessons learned from the piloting will be used for improvement of the prototype prior to further replication.

Output 2: Skills of health workers strengthened in maternal and perinatal surveillance and response (MPDSR) in one district in West Java

Target Area: selected district in West Java province

Partners: Ministry of Health (Central level), National Planning Agency (BAPPENAS), Ministry of Home Affairs, Provincial Health Office, District Health Office, district hospitals and *puskesmas*, obstetric and gynecology professional organization, Indonesian Midwives Association

Indicators:

- # of maternal deaths reviewed.
- Analysis on maternal death cases at the selected district to unpack the root causes with their recommendation for preventable responses is available and disseminated.
- Lessons learned on integration of MPDSR with Civil Registration and Vital Statistic (CRVS) are available and socialized to subnational and national stakeholders for further replication.

Key Activities:

2.1. Development of training manual on MPDSR and maternal death notification application

A training manual will be developed on MPDSR and maternal death notification that can be introduced through offline and online training modalities.

2.2. Training, mentoring and monitoring of health workers, programme managers and MPDSR assessment teams on MPDSR and maternal death notification application

Training on MPDSR will be provided for health workers, maternal health programme managers and MPDSR assessment teams in the selected districts in West Java. The training will be followed by mentoring sessions to enable the trainees to be fully capable in using the application independently.

2.3. In-depth analysis on the maternal death cases at the selected district to unpack the root causes and propose recommendations for preventable actions

Technical assistance will be provided to compile and further analyze the cases of maternal deaths in the selected district based on the result of maternal death review implemented by the district MPDSR team. The review of maternal deaths at hospitals will be recorded and used as a key reference for review meetings at district level in order to identify modifiable factors to prevent maternal death in the future. The analysis will use innovative methods of qualitative data collection to better understand the root causes and determine how interventions might prevent the occurrence of maternal deaths in the future.

2.4. Operational research on integration of MPDSR and CRVS

Along with strengthening the capacity in implementing the MPDSR, an operational research to integrate MPDSR and CRVS will be implemented. Many maternal deaths go unrecorded or are misclassified because the CRVS system is weak. The research results will inform the government on how to strengthen CRVS so that every death and cause of death is recorded accurately and *vice versa* MPDRS system can obtain a more complete maternal health data from an improved CRVS system.

2.4. Dissemination workshop on integration model of MPDSR and CRVS

A workshop to share the results and lessons learned on implementation of the operational research on integration of MPDSR and CRVS (in 2.3) aims to socialize about the model and gain inputs and insight from key stakeholders. It is expected the experience will allow other opportunities for scale up by other districts and provinces.

Output 3 EMONC network and functionality mapped in one District in West Java Province and an improvement plan developed and implemented

Target Area: selected district in West Java province

Partners: Ministry of Health (Central level), National Planning Agency (BAPPENAS), Ministry of Home Affairs, Provincial Health Office, Local District Government, District Health Office, district hospitals and *puskesmas*, obstetric and gynecology professional organization, Indonesian Midwives Association, universities/ research institute

Indicators:

- Analysis on EmONC facilities network in a selected district in West Java, their capacity and functionality that include GIS mapping is available and disseminated.
- A multi-stakeholder EmONC improvement plan for a selected district in West Java with key recommendations for national level is available and disseminated.
- Health providers are able to carry out critical EmONC functions as identified in the EmONC improvement plan.
- The multi stakeholder EmONC improvement plan is implemented and monitored by the health authorities in selected districts in West Java
- Advocacy messages/policy briefs for strengthening maternal health programme in West Java is available for subnational and national advocacy.

Key Activities:

3.1. Analysis of EmONC facilities' networks

In-depth analysis on EmONC facilities network including their distribution, capacity and functionality will be conducted in the selected district in West Java. The analysis will apply GIS mapping to assess the geographical distribution of the facilities to recommend the appropriate facilities to be capacitated as the EmONC facilities. Technical backstopping from the APRO will be provided for the facilities mapping.

3.2. Development of multi-stakeholders EmONC plan for West Java

Based on the analysis of the EmONC facilities network in 3.1., an EmONC improvement plan that involves multi stakeholders at the district level will be developed. Technical assistance will be provided to ensure inclusion of priority interventions to the plan. The plan will also provide recommendations for national and provincial level.

3.3. Capacity building on the critical EmONC functions and referral mechanisms as identified in multi-stakeholders EmONC plan

Training on the critical EmONC functions and referral mechanisms based on the EmONC improvement plan (3.2.) will be conducted for health programme managers and providers in the designated EmONC facilities.

3.4. Advocacy for addressing barriers in accessing maternal health care

Advocacy messages and strategies on addressing barriers in accessing maternal health care and promoting an effective referral system in a selected district in West Java will be developed **in the form of policy briefs**.

6. Critical Assumptions

To achieve these outputs, the following conditions need to be in place:

- Infrastructure including transportation, facilities, water supply, electrical grids, electronic and digital platforms, and communication networks will improve. These are critical for health services to be effective and efficient.
- Strong commitment from stakeholders to data use, with a vision for how a stronger data system can strengthen maternal health management which includes investment on strengthening of monitoring and accountability mechanisms so that data needs are translated into practice and acted upon.
- Supply chain for commodities is not interrupted during humanitarian emergencies and dedicated and longer-term logistics personnel exist at the regional and national level to support sub-national supply chain systems.
- There is sufficient quantity and coverage of human resources, particularly midwives, for the delivery of sexual, reproductive, maternal, newborn, child and adolescent services.

Risks

- Recovery from the COVID-19 pandemic may be prolonged, creating budget deficits and continuing to have a significant socioeconomic and health impact on families.
- West Java is one of the most disaster prone provinces in Indonesia. Frequent hazards and disasters and the impacts of climate change, in addition to protracted crises, will impede progress.
- Weak supply chain management capacity and inflexible policies are not fit for humanitarian purposes.

7. Monitoring and evaluation

UNFPA's commitment to results-based and adaptive management ensures that the programme includes results monitoring, data collection, real-time monitoring, analysis and course correction and evaluations. Its monitoring plan will delineate roles and responsibilities for monitoring of each result indicator, sources and frequency of data collection, quality assurance processes and reporting guidelines. UNFPA will further develop the capacity of stakeholders involved in monitoring and corporate reporting, using available systems and tools for evidence collection, analysis and use. The

programme will undertake quality-assurance and capacity-building of partners to enhance their results-based management capacity, including supporting national and regional institutions.

The programme will undertake project evaluations to provide the necessary evidence to inform medium and long term programme planning and management of the programme, using theory-based and participatory approaches. The evaluation will also be layered, to treat pilots and models to the extent possible with the academic rigor of quasi-experimental evaluation designs that sees how all components of the initiative (advocacy, pilots/ models, policy work) have contributed to the overall intended outcomes. The evaluation design and questions will incorporate a human-rights and gender equality perspective, using the tools and guidelines used by the UNFPA. An agreed donor reporting mechanism will also be discussed.

The quarterly and annual results reporting, monitored data, and evidence from evaluations will be used by UNFPA, through ongoing adaptive learning to strategically shape policy and advisory support and inform programme design and implementation.

8. Budget

Budget Category	Budget USD	Budget AUD
Local Personnel	135,000	173,745
International Personnel	366,000	471,042
Technical Assistance	10,000	12,870
Local Travel	15,000	19,305
International Travel	0	0
Internal Workshops	10,000	12,870
External Workshops	115,000	148,005
Overhead/administration (7%)	49,000	63,063
Total	700,000	900,900

9. Management and Implementation Arrangement

The Programme will be managed by the UNFPA Indonesia Country Office (CO) under the leadership and accountability of Melania Hidayat, the Assistant Representative, with Riznawaty Imma Aryanty (Reproductive Health Programme Specialist) as the designated focal point of the programme. The day-to-day implementation of the programme will be supported by Elvira Liyanto, Maternal Health Programme Analyst and Operations unit. CO will receive dedicated guidance from UNFPA Asia-Pacific Regional Office, including Dr Tomoko Kurokawa, (Regional Humanitarian Advisor) and Catherine Breen Kamkong (Regional SRH Advisor), to ensure the timely and effective programme implementation.

The coordination structure of the programme will follow the structure of the UNFPA 10th Country Programme. The Ministry of National Development Planning/ BAPPENAS acts as the Government Coordinating Agency (GCA), and has the responsibility of coordinating the implementation of the programme

The Communication and Visibility of the project aims at:

- Ensuring project ownership by all stakeholders;
- Promoting and advocating the intervention results among project beneficiaries, stakeholders, development partners and a wider audience, thereby increasing impact and visibility for the project itself, DFAT as the donor agency and UNFPA as the implementing agency;
- Ensuring in-country coordination through communication with the DFAT in Indonesia;
- Cultivating knowledge sharing for evidence-based decision making for the programme as well as for policies and national/subnational programmes;
- Knowledge products developed by UNFPA will be available to other stakeholders and the general public and visibility will be ensured.

10. Programme Implementation Risk Assessment and Mitigation

Risks	Impact	Likelihood	Rating	Mitigation strategies
Lack of coordination between national and sub-national government on SRH programme	Moderate	Likely	High	Continuous engagement with national and subnational governments and relevant stakeholders from the design, implementation, monitoring, and evaluation of the intervention as well as in joint advocacy.
Lack of attention and resources to address SRH problems due to Covid19 pandemic and the refocusing of budget stated by the central government	Moderate	Likely	High	Discuss and map out current government's budget on maternal health programme to identify funding gaps and potential other sources
Continuing escalation of Covid19 pandemic that cause delay in direct intervention in the field	High	Unlikely	High	Strengthen the use of online platforms modalities to support implementation of interventions as well as to conduct monitoring of the progress.
No buy-in from government stakeholders to increase investment or ensure sustainability of the intervention	Moderate	Likely	Moderate	Continuous engagement with national and subnational governments and relevant stakeholders

				from the design, implementation, monitoring, and evaluation of the intervention as well as in joint advocacy for sustainability and scaling up.
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11. Proposed Work plan 1 January 2022 - 31 December 2023

Outcome: Strengthened Access to Maternal Health Care to Accelerate Efforts in Reducing Maternal Deaths during the COVID-19 pandemic in West Java, Indonesia
Output 1: Improved functionality of health management information system which incorporates SRH data collection, management and utilization
<i>Key intervention 1.1:</i> Bottleneck analysis of SRH indicator reporting in HMIS – quarter 1, 2022.
<i>Key intervention 1.2:</i> Consultative and dissemination workshop – quarter 1, 2022.
<i>Key intervention 1.3:</i> Development of interactive dashboard and warning system for SRH situations as part of MOH's HMIS – quarters 2 and 3, 2022.
<i>Key intervention 1.4:</i> Piloting of dashboard application and warning system prototype – quarter 4, 2022 and quarters 1, 2 and 3, 2023.
Output 2: Skills of health workers strengthened in maternal and perinatal surveillance and response (MPDSR) in one district in West Java
<i>Key intervention 2.1:</i> Development of training manual on MPDSR and maternal death notification application – quarters 2 and 3, 2022.
<i>Key intervention 2.2:</i> Training, mentoring and monitoring of health workers, programme managers and MPDSR assessment teams on MPDSR and maternal death notification application – quarter 4, 2022 and quarters 1, 2 and 3, 2023.
<i>Key intervention 2.3:</i> Operational research on integration of MPDSR and CRVS – quarters 3 and 4, 2022 and quarters 1, 2 and 3, 2023
<i>Key intervention 2.4:</i> Dissemination workshop on integration model of MPDSR and CRVS – quarter 4, 2023.
Output 3: EMONC network and functionality mapped in one District in West Java province and an improvement plan developed and implemented
<i>Key intervention 3.1:</i> Analysis of EmONC facilities' networks – quarters 2 and 3, 2022.
<i>Key intervention 3.2:</i> Development of multi-stakeholders EmONC plan for West Java – quarters 3 and 4, 2022.
<i>Key intervention 3.3:</i> Capacity building on the critical EmONC functions and referral mechanisms as identified in multi-stakeholders EmONC plan – quarter 4, 2022 and quarters 1, 2 and 3, 2023.
<i>Key intervention 3.4:</i> Advocacy for addressing barriers in accessing maternal health care – quarters 3 and 4, 2023.

Proposal: DFAT Support to UNFPA Indonesia Through the C-Surge Regional Initiative

Integrated Sexual Reproductive Health Services and Social Protection Provided to Vulnerable Groups during the COVID-19 Pandemic in Greater Jakarta, West Java, Banten, Yogyakarta, East Java, North Sumatera, South Sulawesi, and Nusa Tenggara Timur - Indonesia

Programme Duration: 12 Months (1 November 2021 (tentatively)- 31 December 2022)

Country: Indonesia (at national and subnational level)

Expected Results:

1. Integrated Sexual Reproductive Health Services provided for vulnerable groups in 5 districts (Greater Jakarta, West Java, East Java, and NTT)
2. Gender-based Violence (GBV) prevention and case management provided for Adolescent, Youth and affected Women in 5 selected districts (Greater Jakarta, Banten, West Java, East Java, Central Sulawesi, NTT)
3. Protection and SRH access to older women, people with disabilities and people living with HIV provided in 5 selected districts (Greater Jakarta, West Java, Banten, Yogyakarta, South Sulawesi, NTT).

Estimated Budget: AUD 1,000,000

Background

Indonesia is deeply affected by the COVID-19 pandemic with one of the highest numbers of cases and deaths in the Southeast Asia region. The pandemic resulted in a public health crisis, with an increased burden on the health system; the direct impact of COVID-19 on human development and the shifting of resources to pandemic response has impacted overall development, making it difficult to achieve many development targets.

Alongside the challenges in facing the pandemic, there have been 1,586 disasters that occurred in Indonesia which killed 499 people, injured over 12 and more than 5 million who were affected and displaced, further increasing the vulnerabilities of communities. The current situation with the pandemic has now passed the crisis phase, with increased rates of vaccinations and decreasing cases of COVID-19.

As of October 2021, the Indonesian Government has announced 4,220,206 confirmed cases of COVID-19 in all 34 provinces of Indonesia, with 31,054 active cases, 142,261 deaths, and 4,046,891 people that have recovered. The government has also reported 108,264 suspected cases. The implementation of Restrictions Towards Community Activities (*PPKM*) started from July 2021 until October 2021.

Currently more areas apply lowered levels of movement restrictions, compared to areas that continue to apply Level 4 PPKM; Level 4 of PPKM (application of the strictest measures) is being implemented in six municipalities or districts, with 107 municipalities or districts implementing Level 3 and the other 20 municipalities or districts implementing Level 2. Greater Jakarta, West Java and Central Java have the highest concentration of COVID-19 spreading and are the most densely populated areas. This PPKM policy has impacted fast reduction of daily cases of COVID-19 and has supported the improvement of access to the essential health services recently, resulting in a reduction of the bed occupancy rate in Indonesia.

The rapid assessments of the COVID-19 situation in Indonesia in particular related to thematic areas that are linked with the UNFPA transformative results of ending preventable maternal health, ending unmet need for family planning, and ending gender-based violence and harmful practices, conducted by UNFPA and BAPPENAS have resulted in key salient findings as follows:

- **The impact of COVID-19 on RH services:** (a) Health personnel occupied with the COVID-19 response may not have time to provide services, or may lack personal protective equipment to provide services safely;
(b) closure or limited services of health facilities;
(c) Women are refraining from visiting health facilities for fear of COVID-19 exposure or due to movement restrictions;
(d) Supply chain disruptions limit availability of contraceptives in many areas.
- **The impact of COVID-19 on ending gender-based violence and harmful practices including child marriage and FGM/C.** The pandemic is likely to undermine efforts to end gender-based violence through two pathways: (i) Reducing prevention and protection efforts, social services and care; and (ii) Increasing the incidence of violence.

The pandemic and the proneness to disasters has increased the risk of preventable maternal and infant deaths in Indonesia, as well as the vulnerability of women and girls to violence. During pandemic situations, there was a significant reduction of Antenatal Care (ANC) attendance in the beginning of the COVID-19, disruption in the provision of family planning services, difficult access to life-saving referral mechanisms, as most of the health sector services placed priority in handling the pandemic.

In health crisis situations, women and girls are more at higher risk of violence than men, due to existing constructed perspectives of gender imbalance in the community. Pregnant women, postpartum mothers, and new-borns are considered vulnerable groups due to their different needs. The reported maternal deaths in 2020 is 4,614. This is a significant increase in comparison to 2019 data of 4,196 maternal deaths. The COVID-19 pandemic is suspected to have contributed to this increase in maternal deaths.

Women and girls are also at high risk of sexually transmitted infections (STIs) including HIV, unintended pregnancy, maternal death and illness, mental health issues, and Gender-Based Violence (GBV), increasing the need for integrated SRH-GBV services. This is especially the case for vulnerable groups such as older persons, people living with disabilities, key populations (such as female sex workers), and people living with HIV (PLHIV):

- Given the high rates of poverty among the older persons, and only around one in eight older people receive pensions. To date, it is clear that people above 60 years old are

most at risk to COVID-19, and they are disproportionately affected by the negative social and economic consequences of the pandemic. In Indonesia, the current population size of people over 60 years old is estimated to be 28 million people. Although they account for 10.6% of all positive cases, they account for 45.1% of death tolls in the country. The pandemic has significant negative impacts on older persons in various aspects of life, including income loss, and limited access to health and care services due to the large-scale social restriction and isolation. The discontinuation of health and care services for older persons also causes a significant threat for older persons who are having multiple comorbidities and non-communicable diseases. In 2020, UNFPA and MOH developed and finalized the Guideline on Minimum Health Care for Older Persons in Health Crisis Situations. Still, the sensitisation of the guideline has not been carried out.

- In 2019, It was estimated that there are 545,188 PLHIV in Indonesia, including 527,912 adults and 17,276 children. According to the UNFPA rapid assessment, COVID-19 has negatively affected the community's socio-economic situation and their access to health services. Specifically, 47.6% of respondents had to cope with limited supply (less than one month) of ARV (Antiretroviral). It is important to address the needs of PLHIV during the COVID-19 pandemic, including their access to ARV and prevention tools to reduce their morbidity and mortality while enriching and strengthening the information and education to reduce HIV transmission. Female sex workers are one of the most vulnerable populations, given their risk to HIV and COVID-19 infection, economic challenges, as well as limited access to social and health services during the pandemic.
- The prevalence of people with disabilities is around 12 %. Disability is also a barrier to accessing basic health care. In the case of women and girls with disabilities, they face a 'double burden' of discrimination due to gender and disability, and in particular are not able to access SRH and realize their sexual and reproductive rights. Women and girls with disabilities are also at higher risk of SGBV, and are subject to additional forms of abuse and neglect such as withholding of medical care and medications, forced sterilization, etc. They are also at greater risk of COVID-19 because of the barriers to implementing basic hygiene measures and accessing public health information, and difficulty in enacting social distancing as they need additional support. It might also exacerbate existing health conditions, particularly those related to respiratory function, immune system function, heart disease or diabetes.

Programme Rationale:

This proposal contributes to The Indo-Pacific Sexual and Reproductive Health and Rights COVID-19 Response (SRHR COVID-19 Surge) investment, which includes Indonesia as one of the countries of support, that aims to address urgent unmet need for SRH services and information due to the pandemic. This initiative will be part of the current support from DFAT to the C-Surge Regional Initiative to Indonesia on SRH systems strengthening (focusing on data systems and emergency obstetrics referral mechanisms).

The initial proposed initiatives for DFAT support was framed within the context of the pandemic at the time, which was still at the crisis phase. However with the current situation of the pandemic that has shifted away from its crisis phase, the current proposed initiatives are adjusted to suit this new context. For example the initial proposal to establish Emergency Rooms for pregnant women who are COVID-19 positive is now revised to strengthen the integration of the SRH and GBV services including the provision of Mental Health and Psychosocial Support to the most vulnerable groups. The initiatives that are proposed are implemented within the context of the development - humanitarian continuum.

UNFPA Indonesia has scaled up COVID-19 SRHR and GBV response activities with funding support from the DFAT regional and Government of Japan (GOJ), where DFAT Regional programme has ended on 30 June 2021, and GOJ programme will end on 31 March 2022. For this initiative, UNFPA Indonesia prioritizes the proposed targeted areas, to build on the achievements of these existing programmes within the context of COVID-19 response and the country programme:

- Integrated sexual and reproductive health (SRH), gender-based violence (GBV) and mental health and psychosocial support (MHPSS): Greater Jakarta, Banten, West Java, East Java, Yogyakarta, Central Sulawesi, NTT);
- The work on youth in Yogyakarta on outreach for young people for sexual and reproductive health services and information, that will expand the focus through this project targeting Youth/Adolescent with disability),
- Areas that are prone to disaster (West Java, Banten, East Java, Yogyakarta, Central Sulawesi, NTT)
- Areas with high burden of maternal death (West Java, Banten, East Java, Central Sulawesi, NTT)
- Areas with high number of older person and people with disability (West Java, Banten, Yogyakarta, NTT)
- Government programme priorities targets (HIV prevention and response in Greater Jakarta, Banten and South Sulawesi; reduction of maternal deaths in West Java; and GBV health sector response in Greater Jakarta, Banten, West Java, East Java).

Proposed Programme Results:

1. Integrated Sexual Reproductive Health Services provided for vulnerable groups in 5 selected districts (Greater Jakarta, West Java, Yogyakarta, East Java and NTT) (SRH)
2. Gender-based Violence (GBV) prevention and case management provided for Adolescent, Youth and affected Women in 7 selected districts (Greater Jakarta, Banten, West Java, East Java, Central Sulawesi and NTT) (GBV)
3. Protection and SRH access to older persons, people with disabilities and people living with HIV provided in 5 selected districts (Greater Jakarta, West Java, East Java, North Sumatera, South Sulawesi)(Protection)

Output 1: Integrated Sexual Reproductive Health Services Provided to Vulnerable Groups (SRH) - AUD 382,724.

Implementing Partner: Ministry of Health, Indonesia Midwives Association, Yayasan Kerti Praja, Yayasan Pulih, National Disaster Management Agency, DoctorShare

Potential Indicators to be measured

<p># of midwifery clinics/health centers received Personal Protection Equipment and Dignity Kits for pregnant mother and midwives to support the continuation of the SRH services in targeted districts</p> <ul style="list-style-type: none"> • Baseline: 0 • Target: 500 packages of PPE level 2, 500 Dignity Kits for Pregnant Woman
<p># of midwives received counselling and psychosocial support</p> <ul style="list-style-type: none"> • Baseline: 0 • Target: 250
<p># of pregnant women reached for SRH services (including BeMONC) through Cash Voucher Assistance</p> <ul style="list-style-type: none"> • Baseline : 0 • Target : 200 pregnant woman
<p># of pregnant women received SRH,GBV, and MHPSS services in 50 midwifery clinics</p> <ul style="list-style-type: none"> • Baseline: 0 • Target: 6000
<p># of pregnant women and PLHIV infected by COVID-19 reached and received Dignity Kits, nutritional support through Cash Voucher Assistance, and psychological counselling services</p> <ul style="list-style-type: none"> • Baseline: 0 • Target:200
<p># of health centers that provided integrated MHPSS- SRH/GBV Response</p> <ul style="list-style-type: none"> • Baseline : 0 • Target : 4
<p># of rapid response personnel and volunteers from Local Disaster Management Agency (BPBD) and other relevant government and humanitarian agencies in targeted intervention areas received training on the use of vulnerable population baseline data system and disaggregated data collection tools to promote disaster preparedness and improved MISP delivery in the selected intervention areas</p> <ul style="list-style-type: none"> • Baseline: 0 • Target: 100

Key Activities:

1. Procurement of Personal Protection Equipment (PPE) for midwifery clinics
2. Procurement of Dignity Kits for Pregnant Women.
3. Strengthening RH and GBV Sub Cluster to coordinate and implement MISP and GBViE services during Covid-19 situation in Pacitan and NTT Provinces, and in 4 selected districts of West Java Province.
4. Technical assistance and support to 4 selected Puskesmas on the implementation of MISP, GBV and MHPSS during Covid-19.
5. Develop and disseminate the MHPSS/SRH/GBV education materials through online

portals for midwives and pregnant women.

6. Capacity building for first responders (Midwives, Health Providers) on the integrated SRH (including BEMONC/CEMONC), GBV and mental health and psychosocial support (MHPSS) for service delivery during the pandemic.
7. Provision of Cash Voucher Assistance for pregnant women to access the SRH services including BEMONC/CEMONC referral.
8. Provision of Cash Voucher Assistance and psychosocial support (online) for people living with HIV (PLHIV) infected by COVID-19 by HIV community organization.
9. Gathering feedback from pregnant women and PLHIV on the provision of the integrated MHPSS/GBV/SRH services through community engagement and post-distribution monitoring.
10. Development of a vulnerable population baseline data system for disaster preparedness and improved delivery of MISP, including its data collection tools.

Output 2: GBV prevention and case management provided for adolescent, youth and affected women (GBV) AUD 325,786.

Implementing Partner: Ministry of Health, Ministry of Women’s Empowerment and Child Protection, Yayasan Pulih, Yayasan Siklus Sehat Indonesia (YSSI)

Potential Indicators to be measured

<p># of young people (15 -24 years old) and women reached with SRH, GBV, COVID-19 and gender responsive mental health and psychosocial and support</p> <ul style="list-style-type: none"> • Baseline: 0 (young people) • Target: 2000 (young people)
<p># of health providers that have the capacity to provide life skill education in adolescent health posts.</p> <ul style="list-style-type: none"> • Baseline : 100 • Target : 300
<p># young people (15-24 years old) engaged in the development of social protection(including GBV prevention and management) policies for COVID-19 recovery.</p> <ul style="list-style-type: none"> • Baseline: 0 • Target: 100 (young people)
<p># of content creators that have the capacity to prevent and manage online GBV</p> <ul style="list-style-type: none"> • Baseline: 0 • Target: 50
<p># of UPT PPA/P2TP2A/FPL provided comprehensive and integrated MHPSS/GBV services to survivors</p> <ul style="list-style-type: none"> • Baseline:0 • Target: 8
<p># of reported GBV cases that were referred to and received health care during the COVID-19 pandemic (including through hotline), disaggregated by age and sex</p> <ul style="list-style-type: none"> • Baseline: • Target: 20% of GBV survivors who reporting their cases at 8 UPTPPA/P2TP2A (including through hotline) referred to at least 1 essential service

of number of reported GBV survivors who access psychosocial support
<ul style="list-style-type: none"> • Baseline:0 • Target:350
of Women living with HIV (WLHIV) - GBV survivors received Cash Voucher Assistance to access counselling
<ul style="list-style-type: none"> • Baseline: 0 • Target: 200

Key Activities:

1. Youth and women engagement through CSOs for COVID-19 response.
2. Capacity building for social media content creators/influencers on risk communication, digital rights and wellbeing of women and girls, specifically for the prevention and management of GBV and prevention of Covid-19 transmission in the digital space.
3. Provide support to the fulfillment of the SRH needs of young people during the pandemic through Adolescent Health Posts and school health programmes.
4. Strengthening multi-sector service providers capacity to provide inclusive integrated MHPSS/GBV services (including hotline, online services and outreach) to vulnerable women (women with disability, women living with HIV, GBV survivors).
5. Procurement of Dignity Kits for GBV Survivors.
6. Livelihood support programme for GBV survivors.
7. Strengthening PLHIV network capacity in delivering GBV counselling and referral for WLHIV survivors.
8. Strengthening Women Led-NGOs in delivering GBViE prevention, SRH and MHPSS in humanitarian situations.

Output 3: Protection and MHPSS/ SRH/GBV access to older women, people with disabilities (PWD), female sex workers, and people living with HIV (Protection) – AUD 217,433.

Implementing Partner: Ministry of Health, Indonesia Positive Network (JIP), Yayasan Pulih, National Commission on Violence Against Women, Indonesia Planned Parenthood Association DKI/PKBI DKI

Potential Indicators to be measured

of vulnerable groups (older persons, PWD, PLHIV) reached with SRH, GBV and COVID-19 information, education and counselling service, and SRH Services
<ul style="list-style-type: none"> • Baseline: 0 • Target: 200 older persons, 200 PLHIV and 100 PWD reached with SRH, GBV and COVID-19 information
of women living with HIV, young people living with HIV and people with disability and HIV reached with MHPSS, SRH, GBV and COVID-19 information, and received Cash/Voucher Assistance and counselling services
<ul style="list-style-type: none"> • Baseline: 0 • Target:300

<p># of CSO/networks for older persons and people with disabilities received personal protection equipment</p> <ul style="list-style-type: none"> • Baseline: 0 • Target: 5 CSO networks for disabilities, 5 CSO networks of Older Persons
<p># of service providers (government and non-government) increased their capacity on the provision of SRH, GBV and MHPSS integrated service for vulnerable groups (older persons, PWD, PLHIV, women and girls)</p> <ul style="list-style-type: none"> • Baseline: 0 • Target: 30 schools for young people with disabilities, 5 CSO networks for disabilities, 5 CSO networks of Older Persons, 5 government multi sectoral integrated services for GBV survivors (UPTPPA/P2TP2A); 5 Older Person Health Posts
<p># of CSOs working for HIV increased their capacity in Psychological First Aid</p> <ul style="list-style-type: none"> • Baseline: 0 • Target: 10 Community Based Organization for HIV
<p># of institutions provided MHPSS/SRH/GBV services to PWD and Older Persons</p> <ul style="list-style-type: none"> • Baseline: 0 • Target: 10 CSOs
<p># Vulnerable households as respondent in the KAP Survey</p> <ul style="list-style-type: none"> • Baseline: 0 • Target: 1,000 households

Key Activities:

1. Strengthening CSOs capacity and engagement for outreach (including social media campaigns on SRH, HIV, GBV and COVID-19) and provision of counselling and services for PLHIV and key population.
2. Cash Voucher Assistance for vulnerable women (PLHIV, PWD) to access SRH and counseling services (including telemedicine).
3. Capacity Building to institutions (Special Needs Schools) on psychosocial support and engagement with people with disabilities.
4. Strengthening CSOs/networks to integrate MHPSS-SRH-GBV for the needs of PWD and for older persons' rights to access the government social protection programme.
5. Strengthening government capacity and engagement for SRH and psychosocial support (outreach) to older persons through Older Person's Health Posts.
6. Strengthening CSOs capacity and engagement for outreach (including social media campaigns on SRH, HIV, GBV and COVID-19) and provision of counselling and services for older persons and PWD.
7. Knowledge Attitude and Practice (KAP) survey on Disaster Preparedness of Earthquake and Tsunami in East, Central and Java Province.
8. Support HIV CSOs to provide Psychological First Aid (PFA) and referrals for PLHIV, Young People living with HIV.
9. Strengthening CSOs capacity to integrate Aging and Disability context for HIV programme implementation.
10. Outreach to Female Sex Workers with disability on HIV prevention and access to treatment within the context of the pandemic.

Monitoring and evaluation

UNFPA's commitment to results-based and adaptive management ensures that the programme includes results monitoring, data collection, real-time monitoring, analysis and course correction and evaluations. Its monitoring plan will delineate roles and responsibilities for monitoring of each result indicator, sources and frequency of data collection, quality assurance processes and reporting guidelines. UNFPA will further develop the capacity of stakeholders involved in monitoring and corporate reporting, using available systems and tools for evidence collection, analysis and use. The programme will undertake quality-assurance and capacity-building of partners to enhance their results-based management capacity, including supporting national and regional institutions.

The programme will undertake project evaluations to provide the necessary evidence to inform medium and long term programme planning and management of the programme, using theory-based and participatory approaches. The evaluation will ensure how all components of the initiative (distribution of kits, advocacy, pilots/models, policy work) have contributed to the overall intended outcomes. The evaluation design and questions will incorporate a human-rights and gender equality perspective, using the tools and guidelines used by the UNFPA. An agreed donor reporting mechanism will also be discussed.

The quarterly and annual results reporting, monitored data, and evidence from evaluations will be used by UNFPA, through ongoing adaptive learning to strategically shape policy and advisory support and inform programme design and implementation.

Management and Implementation Arrangement

The Programme will be managed by the UNFPA Indonesia Country Office (CO) under the leadership and accountability of Melania Hidayat, the Assistant Representative, with Elisabeth Sidabutar, Humanitarian Analyst, as the designated focal point of the programme, with implementation by the humanitarian, reproductive health, gender, HIV, and youth teams within the country office. The CO will receive dedicated guidance from the UNFPA Asia-Pacific Regional Office team that is managing the C-Surge Regional Initiative, including Dr Tomoko Kurokawa, (Regional Humanitarian Advisor) and Catherine Breen Kamkong (Regional SRH Advisor), to ensure the timely and effective programme implementation.

The coordination structure of the programme will follow the structure of the UNFPA 10th Country Programme. The Ministry of National Development Planning/ BAPPENAS acts as the Government Coordinating Agency (GCA), and has the responsibility of coordinating the implementation of the programme.

Communication and Visibility

The communication and visibility of the project aims at:

- Ensuring project ownership by all stakeholders;
- Promoting and advocating the intervention results among project beneficiaries, stakeholders, development partners and a wider audience, thereby increasing impact and visibility for the project itself, DFAT as the donor agency and UNFPA as the implementing agency;
- Ensuring in-country coordination through communication with the DFAT in Indonesia;
- Cultivating knowledge sharing for evidence-based decision making for the programme as well as for policies and national/subnational programmes;
- Knowledge products developed by UNFPA will be available to other stakeholders and the general public and visibility will be ensured.

Programme Implementation Risk Assessment and Mitigation

Risks	Impact	Likelihood	Rating	Mitigation strategies
Lack of coordination between national and sub-national government on SRH and GBV programme	Moderate	Likely	High	Continuous engagement with national and subnational governments and relevant stakeholders from the design, implementation, monitoring, and evaluation of the intervention as well as in joint advocacy.
Lack of attention and resources to address SRH and GBV problems due to Covid19 pandemic and the refocusing of budget stated by the central government	Moderate	Likely	High	Discuss and map out current government's budget on SRH and GBV programmes to identify funding gaps and potential other sources
Continuing escalation of Covid19 pandemic that cause delay in	High	Likely	High	Strengthen the use of online platforms modalities to support implementation of interventions as well as to

direct intervention in the field				conduct monitoring of the progress.
No buy-in from government stakeholders to increase investment or ensure sustainability of the intervention	Moderate	Likely	Moderate	Continuous engagement with national and subnational governments and relevant stakeholders from the design, implementation, monitoring, and evaluation of the intervention as well as in joint advocacy for sustainability and scaling up.

*Budget Detail (in attachment)



Program Title	Strengthening Reproductive Health and Family Planning Supply Chain System in Papua New Guinea
Duration	Programs starts on the date of commencement of the international positions funded by C-Surge and no later than March 2022 until Jan 2024 (24 months)
Expected Outcome	Improved RH/FP commodity availability and access at all levels through a strengthened supply chain system, policy dialogue and capacity building
Expected Outputs	<ul style="list-style-type: none"> • Strengthened LMIS/eLMIS systems in the country to increase visibility and functionality into RH commodity distribution, usage and management • Pre-service Certification in Basic Pharmaceutical Management and Supply Chain Management to ensure a critical mass of logisticians at primary health care level • Annual National RH Forecasting and Quantification workshops with National and sub national SCM partners conducted • Capacity of National/sub national logistics staff and health facility pharmacy assistants/dispensers built on Reproductive Health Commodity Security, including inventory management, data generation, entry and use in the eLMIS • Annual Health Facility RHCS indicator data available
Country	Papua New Guinea
Estimated Budget	US\$1,200,000 (approximately AU\$1,548,000)

1. Background and Context

Papua New Guinea (PNG), the most populous country in the Pacific with an estimated population of over 8 million people, 850 indigenous languages and 22 provinces spread over 600 islands, has one of the worst socio-economic and health indices in the region. This reflects its weak health system and fragile socio-political and environmental landscape.

The reported Maternal Mortality Ratio (MMR) is 171/100,000 live births (DHS 2016-18), and 88% of maternal deaths are due to the lack of skilled birth attendants and the unavailability of essential life-saving medicines. Of all mothers who deliver in PNG, only 55% deliver in a health facility, 56% with a skilled birth attendant and 46% receive a postnatal check after 2 days.

The current usage of family planning remains low at 31% for married women currently using any form of modern family planning method, while 26% still have an unmet need for FP. (DHS 2016-18). The total fertility rate is high at 4.2 children/woman and adolescent birth rates for girls aged 15-19 is 12 percent (DHS 2016-18).

The average population growth rate is 3.1 per cent and the country's population is projected to reach 13 million by 2032. If the unmet need for contraception could be met, 70% of unwanted pregnancies would be prevented., resulting regionally in an overall reduction in total unintended pregnancies by 74 per cent, from 32.2 million to 8.5 million. Furthermore, addressing unmet need for family planning will offer additional health, social and economic benefits to Papua New Guineans including reducing infant and maternal mortality, promoting gender equality, reducing poverty and accelerating socioeconomic development.

One of the major factors contributing to the high unmet need is the unavailability of reproductive health commodities at health facilities. According to the 2019 UNFPA health facility survey, 60% of health facilities were stocked out on the day of the survey; and the most common causes of these stockouts included "Delay from the warehouse in supplying the commodity" which accounts for more than 75% of the causes; "Delay from the health facility to request for supplies, due to lack of capacity to raise orders"; "Low or no client demand" and "No trained staff at the health facility to provide the FP services."

Over the years, the UNFPA Supplies programme has been the major provider of financial and technical support to address PNG's RH supply chain challenges, including the provision of over 98% of the contraceptive supplies in the country. This has yielded many results but with still so much to accomplish, and some significant gaps to be filled. This is exemplified by the fact that the 2020 National Procurement Plan estimated 2.9 million USD as funding requirement for commodities in the country. UNFPA through its combined 2020/21 commodity funding support is able to provide 1.3 million USD worth of commodities, leaving a funding gap of 1.6 million USD. Without additional funding support to bridge this gap, stock outs of commodities may still persist. Additionally, with the transition of the UNFPA Supplies program to the Phase 3 Supplies Partnership program, the focus is now on supporting Governments to make a shift to domestic financing, resulting in a significant drop-in UNFPA's Supplies program funding support to PNG regarding programmatic activities. Thus, funding support to supply chain programmatic activities in the country has been reduced from 800,000 USD in 2020 to 100,000 USD in 2021.

Although the Government of PNG made a policy commitment to increase the country's Contraceptive Prevalence Rate to 45% by 2024 (National Population Policy-2015-2024), the country's technical and financial capacity to achieve this goal still needs to be strengthened. Hence, increasing and sustained investment in the country's Family Planning and RH supply chain is critical.

2. Goal

To reduce unmet need for family planning by eliminating family planning commodity stockouts in all national service delivery points

Hence, the purpose of the program is to contribute towards reducing RH/FP commodity stock outs at all levels of the health system by strengthening supply chain management in PNG.

3. Objectives

- To improve visibility and functionality into national and subnational eLMIS for efficient RH Commodity distribution.
- To increase critical human resource capacity to support sustainable RH Supplies implementation and management in the country
- To build capacity of national and sub national logistics staff and health care providers on Reproductive Health Commodity Security, including inventory management, data generation, entry and use in the eLMIS
- To strengthen in-country capacity in needs-based forecasting and quantification
- To provide annual data on key Health Facility RHCS indicators

4. Primary beneficiaries

- National Department of Health and Area Medical Store Technical Advisers and officers; Warehouse Managers and Supervisors; and Facility dispensers
- Women and men of reproductive age (15-49 years) including adolescents and people with disabilities accessing RH/FP services

5. Proposed Interventions and activities

Support the strengthening of LMIS/eLMIS Systems in the country to increase visibility and functionality into RH Commodity distribution, usage, and management

The national eLMIS software utilized in PNG is mSupply. mSupply, is one of the most widely used stock management software for health supply chains in low resource settings around the world and was identified by the National Department of Health to use as its logistics management information system in line with the National Health Plan 2011-2020 and the Pharmaceutical Services Standard and Medical Supplies Strategic Implementation Plan 2016 – 2020. mSupply allows real time reporting of end user issuance data resulting in improved quantification and forecasting of medicines including reproductive health commodities, thus reducing the risk of oversupply and expired products. The end results will be a quality procurement and supply chain management system, improved value for money and better transparency and accountability.

Having a dedicated Reproductive Health (RH) virtual store and dashboard in mSupply will allow for increased visibility, transparency, and accessibility to the commodities procured in the country including those procured by UNFPA, and the Government. This will allow for better insight on stock availability, movement, and balances as well as inventory adjustments of RH commodities, thus making it easier to produce mandatory reports and information to support Last Mile Assurance of commodities. This provides a better understanding of where the gaps/challenges are with regards to commodity movement along the pipeline; will support the identification and development of

practical solutions to reduce stock outs of RH commodities; and thus, ensure that commodities get distributed to the last mile. Hence, the following activities will be conducted:

- i. Development of RH Virtual store and Dashboard. Sustainable solutions who are the sole developers of mSupply in the country will be engaged for this.
- ii. Two staff will be recruited full time to support reproductive health commodity security. An international RH Supply Chain Specialist post (P3) with sufficient expertise and certification in supply chain and logistics management to strengthen PNG's RH commodity supply chain, build capacity at country office level, and coordinate logistics support, including in humanitarian emergencies; and a National Warehouse logistics post (G7) to improve efficiency of receipt, distribution and reporting of commodities and supplies in the eLMIS.

Activities that will be undertaken by the Staff include:

- a. Identify gaps and bottlenecks in the logistics pipeline and provide inputs on how to strengthen the supply chain
- b. Support national partners and government in the preparation of National RH Supply Plan and analyzing and disseminating data on the status, movement, and utilization of FP/RH commodities to prevent stockouts
- c. Develop a logistics capacity building plan for training and development of Country national and subnational partners (NDOH) and Implementing Partner staff responsible for managing RH commodity supply chain including in emergencies.
- d. Develop and facilitate trainings on RHCS including humanitarian logistics to NDOH and implementing partners.
- e. Build capacity of NDOH and partners' staff in areas such as forecasting, quality control, distribution, stock taking, inventory and reporting of RH commodities
- f. Provide technical support in the monitoring of the procurement of Reproductive Health Commodities to ensure uninterrupted flow of RHCs (Reproductive Health Commodities)
- g. Support the development and/or roll out of systems/standard protocols through which NDOH and Implementing Partners can operate, manage, and forecast their RH commodity needs (e.g. transportation, warehousing, distribution channels, contingency plans).
- h. Conduct warehouse assessment, spot checks and audit of RH programme supplies
- i. Ensure accurate entry of RH Stock data into the RH virtual store in mSupply
- j. Liaise with shipping agents on vessels and air schedule and coordinate logistics involved in repackaging and shipping of RH commodities.
- k. Supervise and follow up delivery of the commodities and supplies to Government and Partner warehouses
- l. Coordinate distribution of RH commodities with local health authorities i.e Store Technical Advisors and programme coordinators

Expected outputs include:

- a. Strengthened national and subnational capacities on RH inventory management, forecasting, stocktaking and reporting of RH Commodity availability and stock status.
- b. Increased visibility into stock availability, movement, and balances along the commodity pipeline

- c. Efficient dispatch and distribution of RH commodities to Area medical stores and in country RH partners
- d. Reduced Stock out of RH Commodities at Area/Regional Stores and in country RH partner stores

Strengthen in-country capacity on RH Supply Chain Management

The overarching objective of PNG's National Health Plan is to achieve "Strengthened primary health care for all, and improved service delivery for the rural majority and the urban disadvantaged". This implies that those involved in primary health care service delivery should be equipped with the necessary facilities, supplies, equipment, and capacity building to provide required services. A critical human resource cadre which is required at the primary health care level to serve the pharmaceutical sector, to link levels 1-4 of the country's health care system has been identified by NDOH. This cadre which comprises Pharmacy assistants, technicians and dispensers will serve as a critical mass of logisticians at the primary health care level to manage health commodity inventory, data generation and entry into the eLMIS. This will require both pre-service and in-service training workshops.

With observable discrepancies in the past in RH forecasting and quantification volumes often resulting in under and over procurement of RH commodities; as well as the recent cuts in externally financed RH commodity budgets, there is a need to build the capacity of national and subnational partners to develop accurate Supply Plans, in order to ensure better estimates of commodities to be procured. This process will also assist with identifying actual stock availability of RH commodities at the national and regional warehouses; commodity funding gaps and the resultant supply plan will ultimately serve as an advocacy document to mobilize domestic funding for RH commodities.

Thus, the following activities will be implemented:

- iii. Conduct trainings for 150 subnational in-service logistic health worker staff (specifically targeting Pharmacy assistants, technicians and dispensers from all provinces) on RHCS, inventory ordering and the new eLMIS. The RHCS training is a one-week long training focused on the medicine supply chain process and inventory management of medicines and medical equipment.

The main objectives of the training are to:

- a. Strengthen the systems that allow the procurement, distribution, quality storage and safe usage of essential medicines and medical devices in particular, reproductive health commodities
- b. Improve understanding of how the medicines ordering system works in Papua New Guinea.
- c. Develop the skills needed to use the medicines ordering system in Papua New Guinea.
- d. Increase understanding on the importance of health workers and their role as part of the team involved in medicines and RH commodity supply.
- e. This training programme will also contribute to the implementation of the Pharmaceutical Services Standards and Medical Supplies Strategic Implementation Plan 2016-2020 Focus Area 2 on Procurement and Supply Management Improvement.

The training will be conducted by UNFPA in partnership with the Medical Supplies Procurement and Distribution Branch of the National Department of Health. A total of 90 logistic staff will be trained in the 1st year of the project in 3 regional trainings, while 60 staff will be trained in the 2nd year in 2 regional trainings.

Below is the proposed training plan.

Training Plan for PNG Regional RHCS trainings – Year 1

Activity	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CS Training			regional training in the Highlands Region (Jiwaka) for 30 health workers	regional trainings in Momase (Morobe) and Southern Region (Central) for a total of 60 health workers
Monitoring and Supportive Supervision				Assessment of 1 st regional training participants

Training Plan for PNG Regional RHCS trainings – Year 2

Activity	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CS Training		regional training in the Islands Region (Kokopo) for 30 health workers	regional training in Momase (Madang) for 30 health workers	
Monitoring and Supportive Supervision		Assessment of 2 nd and 3 rd regional training participants		Assessment of 4 th regional training participants

Detailed budget items in Annex 1

- iv. In collaboration with the National Department of Health and the University of Papua New Guinea, support the roll-out of the pre-service Certification in Basic Pharmaceutical Management (CBPM) and Supply Chain Management programme to ensure availability of a critical mass of logisticians i.e. trained pharmacy assistants at primary health care level to manage health commodity inventory and reporting.

The Implementation of the Certificate in Basic Pharmaceutical Management (CBPM) course is highlighted in Focus Area 1: Workforce Planning and Development of the Pharmaceutical Services Standards and Medical Supplies Strategic Implementation Plan 2016 – 2020. This training is administered through the UPNG Open College and studied through distance mode. It will allow for qualified pharmacy assistants to be employed in Level 2 -4 health care facilities to manage medical supplies and equipment. The important role of this cadre of health professionals is most often overlooked, and their responsibility for managing medicines is mostly delegated to nurses and community health workers (CHW) in many health facilities throughout the country. Nurses and CHWs have primary roles for clinical care and so managing medicines become a second role that does not receive attention until there is a stock out. Also, most CHWs have limited pharmaceutical knowledge yet they have been tasked with pharmaceutical duties that are beyond their scope of training.

- v. Support the conduct of annual National RH Forecasting and Quantification workshops with National and sub national SCM partners to ensure efficient and timely procurement of a choice of quality assured and nationally approved RH/FP commodities. This is a very crucial activity as it brings together all those involved in the procurement and distribution of RH commodities to have a holistic overview of the actual needs of the country taking into consideration, population data, issuance data and consumption or service data.

Support in country monitoring of key RHCS Health facility indicators

The current high unmet need for FP in the country (24%), relatively low modern Contraceptive Prevalence Rate (31%), and anecdotal reports from health facilities about persistent RH commodity stock out, indicates the need to generate evidence-based data on key RHCS indicators, especially from the health facility level. This will not only provide information on the status of availability of RH commodities at the last mile, but also help with improving understanding of the underlying reasons for the indicator statuses. Both of which will support the development of recommendations; and policy/advocacy statements and materials needed to improve the issues that are identified.

The key activity to achieve this is:

- vi. Conduct annual Reproductive Health Facility Commodity Survey to provide key RHCS indicator data. The study will provide an overall picture of the availability and the level of stock-outs of modern contraceptives and essential lifesaving maternal and reproductive health medicines at sampled service delivery points (SDPs) to reflect on the situation in PNG. The survey will focus on obtaining:
 - General information of SDPs surveyed including proportion of the different levels of health facilities surveyed, management and distance of health facilities from source of supplies
 - Availability of Family Planning Commodities
 - Availability of Maternal and Reproductive Health Medicines
 - The Health Facilities: supply chain including cold chain; staff training and supervision; availability of job aids and guidelines; Use of Information Communication Technology.
 - Client Exit Interviews

6. Management and Implementation Arrangements

Since 1996, UNFPA has been working in Papua New Guinea to achieve universal access to sexual reproductive health, realize reproductive rights, reduce maternal and neonatal mortality and reduce the unmet need for family planning in order to improve the lives of women, adolescents and youths. Building on UNFPA's comparative advantage, with access to global/regional experience and international best practices, a broad spectrum of advisory, normative, and operational capacities will be utilized to support the implementation of the project priorities.

The overall management of the program will be overseen by UNFPA Asia Pacific Region, under the supervision of the Regional Humanitarian Advisor. The implementation of program activities will be by UNFPA Papua New Guinea Country Office in close collaboration with the 2 relevant

branches of the National Department of Health i.e., Medical Supplies, Procurement and Distribution Branch and Family Health and Population Branch. Monitoring will be conducted through weekly and monthly data gathering from the Central and Area Medical Stores through the eLMIS. At the Country Office level, the Warehouse logistic Associate, RHCS Program Analyst and RH Supply Chain Specialist will ensure direct supervision and monitoring of the project while the International Technical Specialist FP/MH/RHCS will ensure overall coordination and management of the project.

7. Estimated Budget

Strategic intervention	Budget per year (USD)	Total for 2 years (USD)
RH Virtual Store and Dashboard	35,000	70,000
Supply Chain Specialist (P3)	205,000	410,000
National warehouse logistics staff (G7)	45,000	90,000
Commodity and SCM Capacity building trainings and workshops	165,000	330,000
RHCS Health Facility Survey	150,000	300,000
TOTAL		\$1,200,200 (approximately AU\$1,548,000) *

* Based on USD-AUD exchange rate of 1.29 (Apr 27) (*Budget breakdown in Annex 1*)

8. Risk Assessment and Mitigation Strategies

Risk	Impact	Likelihood	Rating	Mitigation Strategy
COVID-19 measures and travel restrictions imposed in the country limiting movement of health workers.	Major	Possible	High	Through the RCs office, obtain necessary travel waivers to allow movement within the country
Insecurity for survey teams and data enumerators in the provinces during data collection.	Moderate	Possible	High	In high-risk areas, security escorts will accompany the teams.
Lack of available staffing at national and provincial levels to implement the activities.	Major	Unlikely	Moderate	Identify back-up human resources at national and provincial levels to support in the activity implementation. Eg. Health faculty students
Lack of reliable ICT infrastructure to ensure data accuracy.	Severe	Likely	Very high	Ensure mobile devices have been configured and tested as well as have offline functionality services.
Government and stakeholder buy-in to the development of new features in the eLMIS i.e RH virtual store and dashboard.	Severe	Unlikely	High	Ensure initial engagement and constant collaboration of all partners and stakeholders involved throughout the lifespan of the project.
Delay in expending funds due to constant changes in activity	Major	Possible	High	Ensure initial engagement and commitment to implementation of

implementation timeline from partners.				project activities by key government program managers at national and sub- national levels.
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Note: Risk Rating Matrix in Annex 2

9. Proposed Workplan

<p>Outcome: Improved RH/FP commodity availability and access at all levels through a strengthened supply chain system, policy dialogue and capacity building.</p>
<p>Output: Strengthened LMIS/eLMIS systems in the country to increase visibility and functionality into RH commodity distribution, usage and management.</p>
<p><i>Activity:</i> Develop RH Virtual store and Dashboard – quarter 4, 2021 and quarter 1, 2022.</p>
<p><i>Activity:</i> Recruit programme staff (P3 and G7) – quarter 4, 2021 and quarter 1, 2022.</p>
<p>Output: Pre-service Certification in Basic Pharmaceutical Management and Supply Chain Management to ensure a critical mass of logisticians at primary health care level.</p>
<p><i>Activity:</i> Support the pre-service Certification in Basic Pharmaceutical Management and Supply Chain Management programme in collaboration with NDOH and University of PNG – quarters 2, 3 and 4, 2022 and quarter 1, 2023.</p>
<p>Output: Annual National RH Forecasting and Quantification workshops with National and sub national SCM partners conducted.</p>
<p><i>Activity:</i> Conduct annual National RH Forecasting and Quantification workshops with National and sub national SCM partners – quarter 3, 2022 and quarter 3, 2023.</p>
<p>Output: Capacity of National/sub national logistics staff and health facility pharmacy assistants/dispensers built on Reproductive Health Commodity Security, including inventory management, data generation, entry and use in the eLMIS.</p>
<p><i>Activity:</i> Conduct trainings for subnational health workers logistic staff on RHCS, inventory ordering and the new eLMIS – quarters 2 and 3, 2022 and quarters 2 and 3, 2023.</p>
<p><i>Activity:</i> Train Logistic Managers from the 5 Area Medical Stores on eLMIS data entry, reporting and Inventory Management – quarter 2, 2022.</p>
<p>Output: Annual Health Facility RHCS indicator data available.</p>
<p><i>Activity:</i> Conduct annual Reproductive Health Facility Commodity Survey to provide key RHCS indicator data – quarters 2 and 3, 2022 and quarters 2 and 3, 2023.</p>

Annex 1: Budget Breakdown

Activity 1: Commodity and SCM Capacity Trainings and Workshops

5 Regional RHCS and eLMIS Training for Health facility pharmacy assistants/dispensers

Description	Unit Cost	Total Quantity	Budget: Year 1	Budget: Year 2	Total Cost
DSA and Accommodation	15000	5	45,000	30,000	75000
Meals	6000	5	18,000	12,000	30,000
Travel	6000	5	18,000	12,000	30,000
Venue Hire	1000	5	3,000	2,000	5,000
Stationery and Training Manuals	3000	5	9,000	6,000	15,000
Monitoring and supportive supervision	5000	5	15,000	10,000	25,000
Subtotal			108,000	72,000	180,000

2 National Forecasting and Quantification Workshop

Description	Unit Cost	Total Quantity	Budget: Year 1	Budget: Year 2	Total Cost
DSA and Accommodation	10000	2	10,000	10,000	20,000
Meals	4000	2	4,000	4,000	8,000
Travel	3500	2	3,500	3,500	7,000
Venue Hire	1000	2	1,000	1,000	2,000
Stationery and Training Manuals	2500	2	2,500	2,500	5,000
Subtotal			21,000	21,000	42,000

Pre-Service Certification in Basic Pharmaceutical Management for 40 Students

Description	Unit Cost	Total Quantity	Budget: Year 1	Budget: Year 2	Total Cost
Tuition Fees	1000	40	20,000	20,000	40,000
Residency Training	500	40	10,000	10,000	20,000

Monitoring and Supportive Supervision	5000	3	10,000	5000	15,000
Subtotal			40,000	35,000	75,000

Training of Logistic Managers from the 5 Area Medical Stores on eLMIS data entry, reporting and Inventory Management

Description	Unit Cost	Total Quantity	Budget: Year 1	Budget: Year 2	Total Cost
DSA and Accommodation	8500	1	8,500	0	8,500
Meals	3000	1	3,000	0	3,000
Travel	6000	1	6,000	0	6,000
Venue Hire	1000	1	1,000	0	1,000
Stationery and Training Manuals	2000	1	2,000	0	2,000
Monitoring and supportive Supervision	2,500	5	12,500	0	12,500
Subtotal			33,000	0	33,000

Activity 2: RHCS Health Facility Survey

Description	Unit Cost	Total Quantity	Budget: Year 1	Budget: Year 2	Total Cost
Pre-Survey Training Workshop	40,000	2	40,000	40,000	80,000
Enumeration and Field work	85000	2	85,000	85,000	170,000
Data Analysis and Reporting	25,000	2	25,000	25,000	50,000
Sub total					300,000

Annex 2: Risk Rating Matrix

		Consequences			
	Negligible	Minor	Moderate	Major	Severe
Almost Certain	Moderate	Moderate	High	Very high	Very high
Likely	Moderate	Moderate	High	High	Very high
Possible	Low	Moderate	High	High	High
Unlikely	Low	Low	Moderate	Moderate	High
Rare	Low	Low	Moderate	Moderate	High