

**Pacific Regional Sexual and Reproductive Health Programme  
(PRSRHP)**

**Mid-Term Review Report**

**Prepared for**

**UNFPA Pacific Sub-Regional Office  
UNICEF Pacific  
New Zealand Ministry of Foreign Affairs & Trade**

**Prepared by**

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## Regional Map

### Kiribati, Samoa, Solomon Islands, Tonga, Vanuatu



## Acknowledgements

The Pacific Regional Sexual and Reproductive Health Programme (PRSRHP) is a five-year UNFPA Programme funded by New Zealand MFAT. The PRSRHP Mid-Term Review was conducted from March – July 2017, and included visits to all five PRSRHP countries: Kiribati, Samoa, Solomon Islands, Tonga, and Vanuatu. Multiple stakeholders participated in interviews and focus group discussions in-country, and additional interviews with regional stakeholders and UNFPA PSRO staff were conducted in Suva, Fiji.

The consultant would like to thank the many individuals from Government Ministries and civil society organisations that dedicated time to interviews--particularly the Ministries of Health and IPPF Member Associations. A wide range of additional stakeholders participated, including youth, volunteers, educators, development partners, donors, and others. Every individual's input is very much appreciated.

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## Acronyms and Abbreviations

BWP	Biennial Work Plan
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
DFAT	Department of Foreign Affairs & Trade (Australian Government)
DHS	Demographic Health Survey
EMONC	Emergency obstetric and neonatal care
FLE	Family Life Education
FO	Field Officer (UNFPA)
FP	Family Planning
GBV	Gender-based violence
HIS	Health Information System
IP	Implementing Partner
KFHA	Kiribati Family Health Association
LOU	Letter of Understanding
M&E	Monitoring & Evaluation
MA	Member Association (IPPF)
MCP	Multi-Country Programme
MDGs	Millennium development goals
MFAT	Ministry of Foreign Affairs and Trade (New Zealand Government)
MHMS	Ministry of Health and Medical Services
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health
MTR	Mid-term review
MWCSD	Ministry of Women, Community and Social Development
NCC	National Coordination Committee
NCD	Non-communicable disease
NGO	Non-governmental organization
NHS	National Health Service
PE	Peer Educator
PHC	Primary health care
PICT	Pacific island countries and territories
PRSRHP	Pacific Regional Sexual & Reproductive Health Programme
PSRO	Pacific Sub-Regional Office (UNFPA)
Q	Quarter
RF	Results Framework
RH	Reproductive Health
RMNCAH	Reproductive, maternal, new-born, child, and adolescent health
SDG	Sustainable Development Goals
SDP	Service Delivery Point
SFHA	Samoa Family Health Association (IPPF MA)
SIPPA	Solomon Island Planned Parenthood Association (IPPF MA)
SPC	Secretariat of the Pacific Community
SR	Sub-Recipient
SRHR	Sexual and Reproductive Health and Rights
SROP	Sub-Regional Office of the Pacific (IPPF)
STI	Sexually transmitted infection
TA	Technical Advisor/Advice
TFHA	Tonga Family Health Association

TOR	Terms of reference
TWG	Technical working group
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJP	United Nations Joint Programme
VFHA	Vanuatu Family Health Association (IPPF MA)
WHO	World Health Organization
WP	Work Plan
WRA	Women of Reproductive Age
YFHS	Youth friendly health services

## Introduction

The five-year, New Zealand Ministry of Foreign Affairs and Trade (MFAT)-funded Pacific Regional Sexual and Reproductive Health Programme (PRSRHP) was launched in July 2014 and is now in its third year of implementation. The United Nations Population Fund (UNFPA) Pacific Sub Regional Office (PSRO) is carrying out a mid-term review (MTR) of the Programme to assess progress and map a way forward for the rest of the programme period (ending August 2019). The mid-term review has three main objectives: 1) assess the programme's progress towards the expected 3 outcomes, 13 programme outputs, and 2 operational outputs; 2) assess the programme's strategic positioning within the development sub-regional community and national partners; and 3) inform the design of any future support to sexual and reproductive health (SRH) in the Pacific.

As a multi-country programme, the review included travel to all 5 Programme countries of Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu. A document review, key informant interviews, beneficiary group discussions, service delivery site visits, and results framework (RF) data analyses were conducted. (For a full list of documents reviewed, see Annex 8.) The review was conducted in conjunction with the 2½-year (2015-2017) Australian DFAT-funded Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) UN Joint Programme (UNJP) review. The two consultants visited Solomon Islands and Vanuatu together, and the PRSRHP consultant visited Samoa and Tonga alone. The majority of overlapping country interviews were conducted jointly. Due to time constraints, the RMNCAH review consultant represented PRSRHP MTR needs in Kiribati. It was anticipated that the two reviews would be completed at the same time, and would include a brief "Joint Report on Strengthening Synergies" between the PRSRHP and RMNCAH programmes. However, the RMNCAH review was suspended in mid-July and discussions are on going as to next steps for its completion. A brief description of the RMNCAH UNJP follows.

The RMNCAH UNJP supports UNICEF, UNFPA and WHO to implement a joint programme in Vanuatu, Kiribati and Solomon Islands. It includes three main components: 1) Improving selected RMNCAH services and health outcomes; 2) Improving country-specific policy, planning, budgeting and monitoring for RMNCAH at the national level, and at the decentralised level as appropriate; and 3) Developing an improved UN business model. The goal is to increase the effectiveness and efficiency of RMNCAH service delivery. Responsibility for the management, administration, and implementation of the joint programme rests with the Managing Agency in each country: UNICEF in Vanuatu, UNFPA in Kiribati, and WHO in the Solomon Islands. Each Managing Agency has an in-country RMNCAH Coordinator who coordinates activities, leads in advancing the RMNCAH agenda with the Ministry of Health, and drives discussion with the UN Country team. Each country also has a National RMNCAH Coordination Committee chaired by the government and consisting of health stakeholders. The PRSRHPs in all three of the RMNCAH countries are fully engaged in those countries' RMNCAH programmes and coordination committees.

For the PRSRHP MTR, the consultant spoke with well over 100 stakeholders in one-on-one and small group discussions. Three focus group discussions with Peer Educators were held. Clinics and youth centres were visited. The majority of visits were with a variety of Ministry of Health personnel, as well as Ministry of Women & Youth, Ministry of Education, and Ministry of Finance. All IPPF Member Associations Executive Directors and additional support staffs were visited. Over twenty regional stakeholders were interviewed, including donors, UN representatives, and partners. In addition, because the PRSRHP MTR was conducted in coordination with both the RMNCAH UNJP review and the IPPF Partnerships for Health and Rights MTR, data collected from documents, interviews, focus group discussions, and other observations were discussed and corroborated between the three consultants. (For a full list of persons/institutions met, see Annex 7.)

The primary users of the PRSRHP review are the UNFPA PSRO and MFAT. Other key users include

Pacific Island Countries and Territories (PICTs) governments, UNICEF, the International Planned Parenthood Federation Sub-Regional Office of the Pacific (IPPF SROP) and their PICT Member Associations (MAs), DFAT and other development partners based in the Pacific region.

## Regional Context

In the Pacific Region, a general lack of understanding of the linkages between poverty reduction, sexual and reproductive health and rights (SRHR), and population dynamics has resulted in lower priority given to sexual and reproductive health and including family planning. Some of the challenges faced by PICTs are the costs associated with making sexual and reproductive health services widely available across vast expanses and dispersed populations, compounded by socio-cultural and religious factors.

### Key Sexual and Reproductive Health Indicators and Trends in the Pacific:<sup>1</sup>

PICT	Population (000)	Population (000)	Population (000)	MMR / 100 000 live births		Trend	SBA		Trend	CPR %		Trend	Unmet for FP %		Trend	Met Need	TFR		Trend	ABR/1000		Trend	
	Last Census	2016 National Projections	2016 Projections NMDI	<2010	2010-2016		<2010	2010-2016		<2010	2010-2016		<2010	2010-2016		<2010	2010-2016	<2010		2010-2016	<2010		2010-2016
	Cooks	17.8		15.2	0		0	→		100	100		→	48		N/A	-	N/A		N/A	-		N/A
Fiji	837.3		880.4	27	19	→	99.8	99.7	→	28.9	38.4	→	20	N/A	-	N/A	2.7	N/A	-	35.7	40.1	→	
Micronesia	102.8		104.6	162	162	→	90	90	→	40	N/A	-	44	N/A	-	65.7	3.5	N/A	-	41.5	44	→	
Kiribati	103.1		115.3	215	81.4	→	79.8	86.8	→	18	N/A	-	28	N/A	-	48	N/A	3.9	-	51	49	→	
Nauru	10.1		10.8	300	171	→	97.4	N/A	-	25.1	N/A	-	23.5	N/A	-	39	3.3	3.9	→	84	94.3	→	
Niue	1.5		1.6	0	0	→	100	100	→	22.6	N/A	-	N/A	N/A	-	51.6	2.6	2.8	→	27.7	19.9	→	
Palau	19.9		17.8	0	0	→	100	100	→	21	22.3	→	N/A	N/A	-		1.7	2.1	→	17.7	33.3	→	
Marshalls	53.2		55	143	105	→	94.8	98.3	→	42.4	16	→	2.4	N/A	-	80.5	4.5	4.1	→	77	85	→	
Samoa	187.8	194.9	194	46	N/A	-	80.8	82.5	→	28.7	24.3	→	45.6	35	→	41	4.4	4.7	→	44	39	→	
Solomons	515.9	639.2	651.7	103	130	→	85.5	86.2	→	27.3	29.3	→	11.1	34.7	→	35	4.7	N/A	-	62	49.5	→	
Tokelau	1.1		1.4	0	0	→	N/A	100	-	N/A	N/A	-	N/A	N/A	-	71.3	2.1	2.1	→	42	29.8	→	
Tonga	103.0		100.6	114.4	37.1	→	98.1	97.9	→	27	28.4	→	N/A	25.2	-	53.1	3.8	4.1	→	19.6	27	→	
Tuvalu	10.8		10.1	0	0	→	97.9	N/A	-	22.4	N/A	-	24.2	N/A	-	53	3.2	3.6	→	42	28	→	
Vanuatu	234.0		289.7	86	68	→	74	89.4	→	38	34.2	→	24	24.4	→	58.4	4.4	4.2	→	66	81	→	

Progress has been made in achieving increased access to some reproductive health services, as evidenced by reduced maternal mortality ratios, increases in antenatal coverage, and percentage of births attended by skilled birth attendants (SBA). Maternal mortality ratios appear to continue on a declining trend, although precise analysis is difficult due to the low numbers of live births. Other challenges with this indicator include: most Pacific countries report facility deaths only and the extent to which home deaths are captured is not known; improper/inconsistent case definition is used, sometimes leaving out maternal deaths from indirect causes; and weak HIMS. For births attended by skilled birth attendants, the percentages are fairly high for the five Programme countries, ranging from 82.5 to 97.9; however, it is known that most attendants are not skilled in the clinical requirements to deliver emergency obstetric care.

The Contraceptive Prevalence Rate (CPR) among the 5 countries is low, ranging from 24% to 34% (where data is available). Relatedly, unmet need for family planning is generally high, ranging from 24% to 35%. Issues of gender inequality, high levels of sexual violence against women, and the increasing youth bulge are of concern. National reports show a strong association between intimate partner violence and women's ability to negotiate contraceptive use. Low demand for family planning services may be associated with preference for large families, misconceptions, and inadequate information on contraceptive choices.<sup>2</sup>

Among adolescents, high birth rates, high rates of sexually transmitted infections (STI), and a low utilization of family planning services and condoms by young unmarried females and their partners, suggest that unmet need for family planning is particularly high among young people. Adolescent birth rates among the 5 countries range from 27 (Tonga) to 81 (Vanuatu).

The HIV prevalence is low, at less than 1% for most PICTs. However, the prevalence of other STIs is high, particularly among pregnant women. The high incidence of STIs, low condom use, low comprehensive correct knowledge about HIV and AIDS, mobility of residents, and difficulties

<sup>1</sup> UNFPA in the Pacific: support for transformative change in the lives of women and girls across the region, March 2017

<sup>2</sup> 2015 Pacific regional MDGs tracking report, Pacific Islands Forum Secretariat. Suva, Fiji, 2015.

sustaining community initiatives, indicate the need for targeting young people and marginalized groups.

Quality and timely statistical information falls short of what is required to effectively monitor and evaluate programmes. Data is also inadequate to meet the needs of development and programming frameworks such as the Programme of Action of the International Conference on Population Development (PoA ICPD), Sustainable Development Goals (SDG), and the UN Pacific Strategy Resources and Results Framework (RF) monitoring and evaluation (M&E) framework. Significant technical and programmatic resources are needed to address the gaps in baseline and midline data for population and development, reproductive health, and gender programmes in the Pacific.

## **PRSRHP Response & Programme Strategies**

UNFPA is guided by the principles of the 1994 Cairo Programme of Action of the International Conference on Population and Development (ICPD). It partners with governments, civil society, and other agencies to deliver a world where every pregnancy is wanted, every childbirth is safe, and every young person's potential is fulfilled. People-centred development demands the realization of SRHR, the equality and empowerment of women and young people, and policies informed by a systematic analysis of population dynamics and their developmental implications.

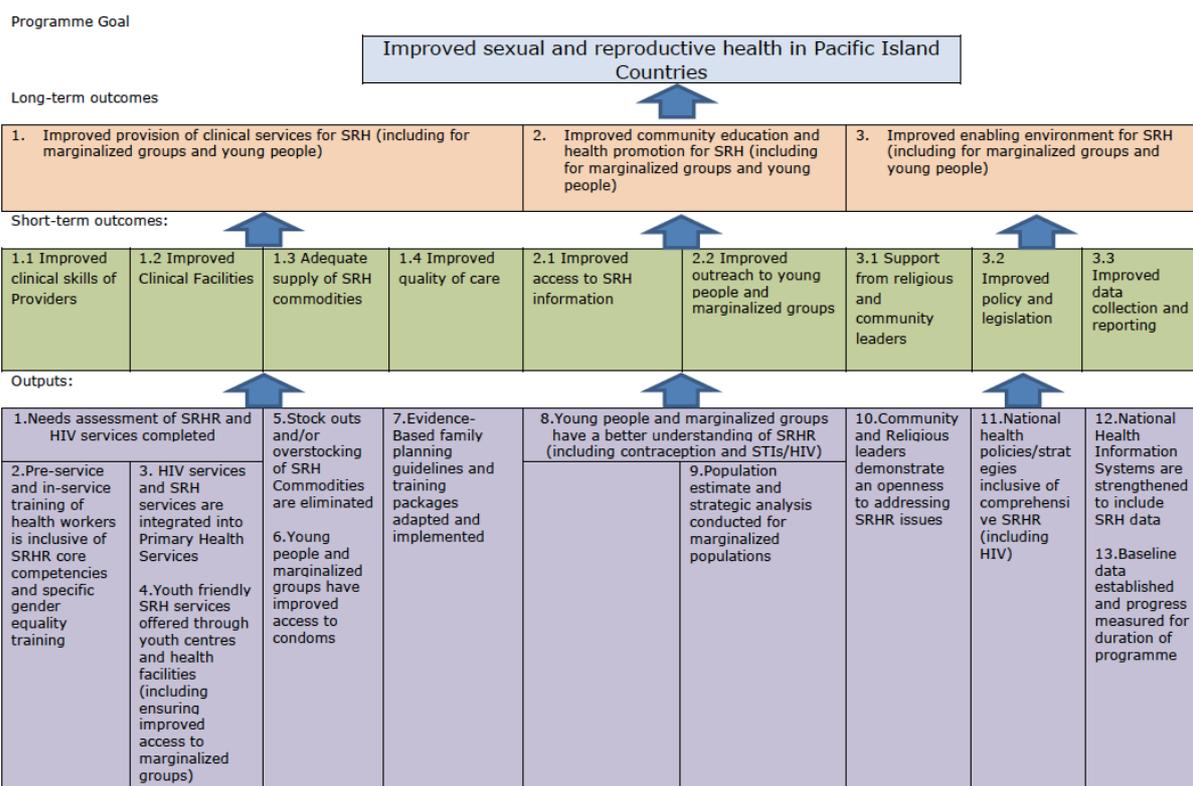
In its on-going efforts to pursue this mission in the Pacific, and being cognisant of the recommendations of the ICPD 2014 Pacific Review Report, the UNFPA PSRO, in collaboration with UNICEF Pacific and IPPF SROP, is implementing the New Zealand MFAT-funded Pacific Regional Sexual and Reproductive Health Programme (PRSRHP). The Programme partners with Pacific governments and civil society organisations (CSOs) in Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu. The programme was developed based on the needs of the programme countries, and is aligned with their national development priorities. UNFPA's programmes are nationally executed/implemented by host Governments, in areas Governments identify as key priorities for them. UNFPA's PRSRHP implementing partners (IPs) are Ministries of Health, and UNFPA aligns processes and activities to complement, support, and scale up national plans. The PRSRHP is positioned within UNFPA's overall 5<sup>th</sup> Multi Country Programme for the Pacific 2013-2017 (MCP5), and it is integrated into the broader country work plans.

The MCP5 includes four components: 1) family planning; 2) gender equality and reproductive rights; 3) young people's SRH and 4) population data availability and analysis. PRSRHP primarily focuses on young people's SRH, with linkages to the other three components. PSRO's work in the SRHR of young people promotes comprehensive sexuality education (CSE) for both in- and out-of-school youth. PSRO has promoted the scaling up of youth-friendly SRH services that respect clients' right to confidentiality.

A well-developed PRSRHP Programme is described in the proposal document, with detailed programme management, governance, and implementation arrangements and structures. Through working with Government IPs, UNFPA PSRO is responsible for overall coordination and management of the Programme, as well as for monitoring the implementation of the various components. PSRO has a full-time PRSRHP Coordinator at the regional level, and five UNFPA Field Officers (called "National Programme Coordinators" in the proposal) at the country level. Their roles are to facilitate and support PRSRHP implementation, governance, coordination, monitoring, and reporting. The Programme has a theory of change, results framework, work plan, budget, M&E plan, governance structures, reporting mechanisms, a regional PRSRHP Steering Committee, and 5 country National Coordination Committees.

Based on 5-year funding of approximately USD \$5.25 million (NZD \$6 million), the overarching goal of the PRSRHP is to improve sexual and reproductive health in PICTs. To reach this goal, three long-term outcomes focus on improved provision of clinical services, improved community education and health promotion, and an improved enabling environment for SRH. Each of these outcomes includes reaching marginalised groups and young people. Short-term outcomes, outputs, and activities all work together to support these three long-term goals.

The diagram below represents the Programme's theory of change:



The table below is a quick snapshot of the five PRSRHP countries. These select demographic and service-related numbers put perspective on the size of the countries and the scale at which PRSRHP is positioned to make an impact.

Indicator	Kiribati	Samoa	Sol. Is.	Tonga	Vanuatu
# of Populated Islands	21	4	300+	40	65
Total Population	103,058	187,820	553,254	103,036	251,784
Total Women of Reproductive Age (WRA) (est.)	23,000	45,000	141,000	27,000	62,000
Total Youth 15-24 (M&F) (est)	20,600	35,700	105,100	19,600	50,400
Total Service Delivery Points (SDPs) (874)	109	14	339	52	363
Selected SDPs included in PRSRHP (337) & (% of total)	34 (31%)	11 (79%)	100 (29%)	36 (69%)	156 (43%)

# Review Findings

## I. PROGRESS TOWARD OUTCOMES AND OUTPUTS (EFFECTIVENESS)

The MTR is charged with answering the question, “is the Programme working so far?” In other words, is it effective? Effectiveness is judged according to whether or not goals, outcomes, and outputs are on track to being achieved by programme-end. The overarching goal of the Programme is to improve sexual and reproductive health, as measured by reductions in: 1) adolescent birth rates; 2) maternal mortality ratios; 3) HIV prevalence among 15-24 year olds; and 4) STI (chlamydia) prevalence among 15-24 year olds.

It is important to keep the focus of the MTR on the target population, whose health the Programme seeks to improve. Is the Programme working for both male and female youth? Is it working for marginalised groups? And women of reproductive age? As the Programme’s theory of change indicates, the target population needs to *experience* more education and awareness from Peer Educators, school teachers, SRH advocates, and IEC efforts. They need to *experience* higher quality, better equipped, and more integrated (especially with HIV) sexual and reproductive healthcare services. More youth need to seek and experience youth-friendly services at service delivery points (SDPs). Ultimately, the target population will need to adopt the behaviours of utilising effective contraceptive and HIV/STI prevention methods. Furthermore, governments and stakeholders will need stronger SRHR policies and guidelines, stronger SRHR trainings (especially family planning), and better means of tracking SRH data and outcomes to support meeting the target population’s needs.

The PRSRHP has an extensive RF with a set of 48 indicators.<sup>3</sup> These include 4 high level goals, 18 long- and short-term outcome indicators, and 26 output indicators. The 4 high level goals are more appropriate to be assessed at programme end and therefore are not included in the following analysis of progress toward outputs and outcomes.

Overall, it is difficult to assess the Programme’s true progress based on the set of indicators as currently categorised, written, measured, and reported. A variety of factors compromise their integrity. Some outputs are categorised as outcomes, and vice-versa. Most are not written precisely enough to be interpreted and reported correctly. For example, what constitutes an “SRH service” or an “advocacy activity”? In addition, all indicators intended to represent numbers of *individual people* served by clinics or reached by PEs are unreliable, because the reality on the ground is that currently no entity reports numbers of unduplicated clients/people. Rather, they count numbers of visits/contacts. Therefore, the reported numbers over-represent the number of people because many—especially clinic clients—are seen more than once in the course of a year. Some indicators seek unquantifiable “updates” or “integration” and results are reported as “some” or “most” (these are mainly ongoing UNFPA activities/TA that have been worded as indicators).

Some indicators are worded in such a way that they misrepresent the service delivery level reported on (ex: stock-outs and condom distribution are reported at central level, not SDP). Several indicators were already fully achieved at baseline, calling into question their inclusion in the RF (ex: percent of selected SDPs offering at least 3 critical SRH services of ANC, FP, STIs). And finally, sometimes indicator results report “no data available,” or report zero when interviews in the field reported progress. For these reasons and more, it is difficult to accurately assess the Programme based on the current condition of the RF. (For a fuller discussion on these issues, see the “Validity of Design” section.) Nevertheless, it is necessary to proceed with an analysis for this MTR using the set of indicators in the RF, taken at face value.

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<sup>3</sup> Note that all references to indicators correspond to an indicator number (#) as numbered in the “PRSRHP Results Framework – Cumulative Progress for 2015-2016” in Annex 1. This is simpler than the numbering system in the original RF. While the original RF has 47 indicators, the consultant split the male and female condom indicator into two (#30, #31), creating 48 total.

The following section is the MTR's quantitative approach to evaluating effectiveness to date. Qualitative input, based on over 100 regional and national stakeholder interviews, focus group discussions, and site visits, inform this section as well. It is also important to note that quarterly and annual PRSRHP progress reports provide comprehensive country-specific and regional descriptions of progress toward outputs and outcomes to date. While it was not possible to include each country's individual context and Programme results within the scope of this report, that information has been distributed to stakeholders, and is rich with unique context, success stories, and local challenges.

**A. Effectiveness -- Extent to which outputs have been achieved; extent to which these outputs have or will contribute to the achievement of the respective outcomes.**

**1. Progress toward outputs, short-term outcomes, and long-term outcomes.**

This section will examine the extent to which progress is being made toward all indicators: outputs, short-term outcomes, and long-term outcomes. A summary of cumulative achievements to date, which is the basis for this effectiveness analysis, is provided in Annex 1 ("PRSRHP Results Framework -- Cumulative Progress for Calendar Years 2015-2016"). This cumulative report format was created by the consultant specifically for the MTR, as the Programme does not have a template that regularly tracks and monitors ongoing, cumulative progress on activities and outcomes over the years. The data itself is from the 2016/17 PRSRHP Annual Report, Appendix B, "Progress Against Results Framework."

It is important to note that the "Cumulative Progress" table is based on data for the two *calendar* years of 2015 and 2016. It does not cover the true grant period of July-June 2014/15 and 2015/16 and three-quarters of 2016/17. This is due to a few reasons: no activities were funded and therefore reported at the country level during the first half of the first Programme year (the primary activity was the SRHR Needs Assessment conducted by PSRO); only results through Dec. 2016 were available to the consultant, as there was no quarterly report for Jan-March 2017; and UNFPA data is reported on a calendar year basis. Despite these reporting period inadequacies, providing results for the two calendar years is adequate for this MTR, as Dec. 31, 2016 is indeed the true midpoint of the 5-year Programme.

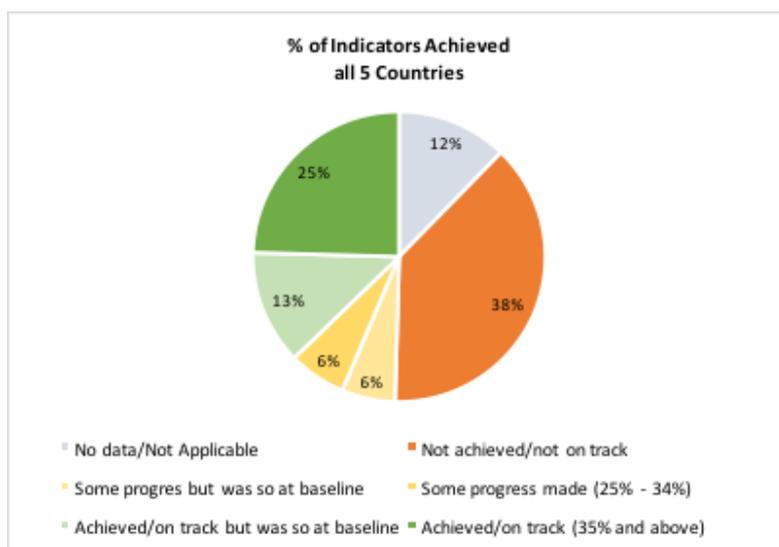
Each of the 48 RF indicators is broken down, by the consultant, into one of six categories of achievement level:

1. No data available/not applicable (i.e. not planned, therefore no data expected)<sup>4</sup>
2. Not achieved/not on track (i.e. results are below 25% achieved at the mid-term point, where 35% to 50% would be expected)
3. Some progress made, but this was also the status at baseline
4. Some progress made (i.e. results range from 25% - 34% achieved at the mid-term point)
5. Achieved/on track, but this was also the status at baseline
6. Achieved/on track (i.e. results range from 35% and above at the mid-term point, where 35% to 50% would be expected)

The four overarching goal indicators are removed from the list of 48 indicators for this analysis, as they are more appropriately measured at Programme end. Thus, the consultant analysed 44 output, short-term outcome, and long-term outcome indicators for each of the five countries. Achievement levels of the five countries *combined* are reported here:

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<sup>4</sup> "Not applicable" means that the activity (which the indicator measures) was not intended/planned to be implemented for that country (e.g. Key population estimates not planned for Solomon Islands and Tonga), therefore no data is expected. This is different from the "no data available" category, which is associated primarily with long-term outcome indicators that are not collected frequently and/or often rely on national surveys (DHS, census, etc.). "No data available" also reflects indicators for which no reporting/data was provided.



To be considered “achieved or on track to being achieved,” any given indicator must be at 35% of target met, or higher. At mid-point, one would expect nearly all indicator results to be at 35% to 50%. This expectation is based on the initial Programme budget. This budget shows that, of the 13 output areas covered by the RF and in this analysis, 8 were budgeted to be completely spent by the end of year two (6 months before the mid-point); 3 were budgeted to be half-spent by mid-point; and 2 were budgeted to be spent more or less evenly throughout the 5 years.

Based on this planning, it is reasonable to expect that the majority of indicators would have been met at the 35% to 50% level by mid-point.

The above is based on what was planned in the original proposal. One may compare the original budget the revised budget below, where more activities are now planned to be funded/conducted after mid-point (see revised budget below). It shows that of the 13 output areas covered by the RF, 2 are now budgeted to be spent by the end of year two; 3 to be half-spent or more by mid-point; and 5 to be spent more or less evenly throughout the 5 years, with another 3 unspent until mostly after year three.

Current endorsed programme budget<sup>5</sup>

PLANNED ACTIVITIES		ACTUAL EXPENDITURE			REVISED PLANNED EXPENDITURE	
		July 2014 - June 2015	July 2015 - June 2016	July 2016 - June 2017*	July 2017 - June 2018	July 2018 - June 2019
1	Needs assessment of SRHR and HIV services	105,762	13,695	-	-	-
2	Pre-service and in-service training of health workers	-	12,049	-	106,951	-
3	HIV/SRH Integration in PHC	-	10,096	18,342	21,562	-
4	YFHS offered through Youth Centres and Health Facilities	39,074	97,148	171,820	298,545	216,013
5	Stock outs and/or overstocking of SRH Commodities	9,719	58,589	-	31,692	-
6	Young people and marginalized groups improved condom access	4,887	74,323	64,798	90,000	77,971
7	Evidence-Based family planning guidelines	1,710	44,806	106,086	84,908	81,383
8	Young people and marginalized groups understand SRHR	88,448	351,358	480,344	304,273	230,021
9	Population estimate/strategic analysis -marginalized populations	-	120,000	-	-	-
10	Community and Religious leaders addressing SRHR issues	18,750	58,625	28,768	18,857	-
11	National health policies/strategies include SRHR (with HIV)	-	-	14,020	5,980	-
12	National HIS are strengthened to include SRH data	-	-	-	45,000	15,000
13	Baseline data / progress measured for duration of programme	-	-	-	-	303,396
14	Monitoring and Evaluation	10,248	13,395	47,485	140,000	60,000
15	Project Coordination and Management	36,391	112,325	110,058	190,196	184,133
<b>Subtotal</b>		<b>314,989</b>	<b>966,409</b>	<b>1,041,721</b>	<b>1,337,964</b>	<b>1,167,917</b>
AOS		25,199	77,313	83,338	107,037	93,433
<b>Total Programme</b>		<b>340,188</b>	<b>1,043,722</b>	<b>1,125,059</b>	<b>1,445,001</b>	<b>1,261,350</b>

<sup>5</sup> Summary of revised budget in July 2016 – June 2017 annual progress report

Combining the five countries' results, 25% of the indicators were achieved or on track to be achieved as a result of the PRSRHP. Several indicators (13%) were already achieved/on track at baseline, which calls into question their wording and/or relevance in being included in the RF. Nevertheless, these 13% may be added to the 25% achieved/on track. **Therefore, a total of 38% are achieved/on track.**

An additional 6% of indicators reflect achieving some level of progress (i.e. reached 25% - 34% of target), and another 6% achieved some progress, but had already done so at baseline. There is no data for 12% of the indicators—in other words, the cells are marked “NDA” (no data available). Most of this is due to the data not being collected frequently and often relying on national surveys such as DHS, Census, etc. (This 12% includes the 2% that are “not applicable” due to not being planned in 2 of the 5 countries). Remembering that “on track” reflects expectation only at mid-point (achieved at a level of 35% or above), it would be anticipated that closer to 88% of the indicators should be on track (100% less the 12% with no data available/not applicable). An additional 38% of indicators are not achieved/not on track, in that their results are below 25% achieved at the mid-term point. This includes those cells that are input with “0” as their result. **Overall, 38% of indicators have not been achieved/are not on track to the level expected at mid-term.**

There is no country Programme that stands out as significantly more successful than others when examining these indicators. In terms of numbers of indicators strictly achieved/on track, results are as follows: Kiribati 32%, Samoa 27%, Tonga 27%, Solomon Islands 23%, and Vanuatu 16%. In terms of number of indicators *not* being on track, the results are as follows: Tonga 25%, Samoa 32%, Kiribati 36%, Solomon Islands 41%, and Vanuatu 55%. While each country has its own context and unique events that impact programme implementation, it is important to note that Vanuatu experienced particularly debilitating setbacks due to Cyclone Pam that hit in March 2015.

Twelve of the 48 indicators (8 output and 4 outcome) are achieved or on track to being achieved for at least four of the five countries (these include those that were on track prior to Programme start). Eight are output indicators reflecting activity achievements, and 4 are outcome indicators. Output indicators associated with activities are discussed below.

## **2. Activities contributing toward outputs**

This section will specifically examine activities, as reflected by output indicators, and the extent to which activities are contributing toward outputs.

The Programme has a set of 15 outputs: 13 outputs associated with each of the three long-term Programme outcome goals; and two outputs related to programme administration of: 1) M&E, and 2) project coordination and governance. A set of 45 activities are delineated for the 15 outputs: 38 activities are associated with the Programme outcome goals, and 7 are associated with administration. These 7 administrative activities do not have output indicators associated with them; therefore, the following discussion is based on the 38 activities and the output indicators associated with them.

Programme activities are broad in scope, ranging from conducting needs assessments and population analyses, to developing strategies and guidelines, to training PEs and healthcare workers, to providing services and condoms, to strengthening data collection and HIS. These activities are, for the most part, captured by 26 output indicators included in the RF (#23-48). For the purposes of this MTR, a discussion of these output indicators reflects the extent to which activities are contributing to outputs.

Of the 26 output indicators that reflect implementation of activities, 8 are achieved or on track to being achieved by at least 4 of the 5 countries:

1. #23 – SRHR Needs Assessment completed
2. #27 - % selected SDPs offering at least 3 critical SRH services – ANC, FP, STIs

3. #31 -- # female condoms distributed<sup>6</sup>
4. #40 – Key population estimates established (in 3 of 3 countries, as planned)
5. #41 – Key population strategic analysis conducted (in 3 of 3 countries, as planned)
6. #42 – SRH stakeholder analysis completed<sup>7</sup>
7. #45 – Community leaders/gatekeepers and religious leaders trained
8. #46 -- Technical support provided for SRH/HIV inclusion completed and implemented

The Programme has done a good job of undertaking many of the activities that were necessary to complete early in the programme (needs assessments and population analyses, for example), as they are the basis for further developing and implementing work to be done throughout the remainder of the Programme. Nearly all of the 38 activities have at least begun in at least one country, with the exception of perhaps the establishment of community SRH Committees (output #43) and advocacy packages developed (#44). While not captured by an output indicator, UNFPA completed 4 of 5 extensive YFHS Needs Assessments (and the 5<sup>th</sup>, conducted nationally, is in the approval stages), which makes an important contribution to the extensive YFHS work planned and underway.

The Programme is designed to accommodate activity flexibility at the country level, while maintaining national plan, MCP5, and United Nations Development Assistance Framework (UNDAF)<sup>8</sup> alignment. There is a high expectation for donor-funded work to align closely with national health strategic priorities, including alignment of indicators, from outputs to outcomes. In the case of RMNCAH countries, for example, activities are aligned to strategic objectives where they best fit with corresponding indicators. In the case of Kiribati, MHMS Strategic Plan indicators were limited, so proxy indicators were negotiated with MHMS to allow measures to mutually beneficial indicators and targets. Due to this commitment to national alignment, PRSRHP activities are not described in detail and are open to adjustments. While country level work plans (WPs) generally reflect the activities listed in the Programme design documents, sometimes multiple activities are grouped into one in such a way that assessing the full extent of their implementation and achievement of the output indicator is difficult. Overall, however, country level activities reflect those in the PRSRHP design.

PRSRHP provides funding to IPs based on budgeted activities. This can be done through advancement of funds to IPs for up to two consecutive quarters. Furthermore, IPs can re-programme funds within the timeframe, and can seek further advances once reported. Despite these mechanisms, there are often delays in disbursement of funds to activity implementers. This can be due to multiple factors, including delays from the MOF to the MOH, delays in collecting support documents from outer islands, communication challenges, lead time to book inter-island transportation, the unavailability of key personnel in MOH due to heavy travel schedules, etc. Given these realities, stakeholders reported that it is essentially impossible to carry out continuous activities; rather, they are conducted in “starts and stops” with gaps in between.

While this type of ad hoc funding may work adequately for one-time activities, such as conducting an assessment or a single training, it is very challenging for service and education-related activities that would be much more effective running on a continuous basis. For example, PEs, once trained, should be mobilized on a regular basis, so they can continuously educate, refer and serve the target population. They also need continuous support so they can keep up their skills, be retained, and be used efficiently/cost-effectively. Due to funding unavailability, the PEs in Solomon Islands, Tonga, and Vanuatu have currently suspended all PRSRHP PE activities (though they may continue PE activities under other programme funding, ensuring some level of continuity). Activities that occur on a start and

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<sup>6</sup> From *Central* level.

<sup>7</sup> Note that FOs were not aware of this indicator, nor that it was completed, nor how it was completed.

<sup>8</sup> UNDAF: Select outcomes and outputs are: Country Programme Output 1: Strengthened national capacity to deliver high-quality family planning and sexual and reproductive health (SRH) services, information, commodities and community-based interventions for family resource management; and Country Programme Output 3: Strengthened national capacity to deliver high-quality SRH and information, including FP and services to prevent IV and STIs, for young people.

stop basis, coupled with being delayed and compressed into short time periods, seriously hamper successful delivery and therefore Programme effectiveness. These problems were by far the effectiveness challenges most often cited by the majority of stakeholders interviewed.

## 2. Progress toward short-term and long-term outcomes

This section will examine the extent to which the 18 short- and long-term outcomes are on track to being met. Of the 10 short-term outcome indicators included in the RF, 4 are achieved or track to being achieved in at least 4 of the 5 countries:

1. #15 -- % selected SDPs with no stock outs of contraceptives in last 6 months<sup>9</sup>
2. #16 – National authorities adapted/implemented FP protocols that meet human rights standards
3. #20 – SRH advocacy activities led/supported religious/community leaders
4. #21 – Updated evidence-based national health policy that reflects RH and HIV

It is important to note that two of the above outcome indicators and their achievement levels (#16 and #21) do not adequately capture the nature of the activities. These reflect UNFPA policy work that is ongoing, tailored to individual countries' needs and timelines, and that requires periodic updating. For example, new Medical Eligibility Criteria were released in 2015, necessitating the updating of FP guidelines. Increased method mix, particularly the addition of voluntary surgical contraception and Jadelle, has also necessitated integration of these methods in the FP guidelines and FP training manuals. It will be important to better define these indicators to capture and reflect the need for updates and TA, and the extent to which those needs have been met.

None of the 8 long-term indicators are yet achieved or on track to being achieved; in fact, roughly half of them have no data available as yet. Two countries are making solid progress on SRH service delivery outcome goals, and there has been some progress on integrating HIV into SRH services. While it is notable that 4 of the 10 short-term outcome indicators are on track, more of these should be showing adequate progress by mid-term of the Programme. While an analysis of all indicator results is not possible, select key indicators are discussed below.

## 4. Discussion of select key indicators

### #9: # young people (15-24) accessing SRH services at health facilities

This is perhaps the most important indicator in terms of reflecting potential impact on the target population. It is very concerning that only 2 of the 5 countries have reported on this indicator – Samoa and Tonga. Notably, they are well on track at mid-term (45% and 50%). It is important to remember that these reported results are strictly tied to funded activities; therefore, if no entities within the Ministry of Health (MOH) or IPPF MAs (MAs) have been funded by PRSRHP to conduct SRH healthcare delivery activities serving 15-24 year olds in a given year, no numbers will be reported. In the case of Kiribati, Solomon Islands, and Vanuatu, however, at issue is not that they are not delivering SRH services to youth – the problem is that they are not reporting it. This is likely due to their inability to disaggregate health information system (HIS) data to the extent that specific SRH services provided to this specific age group can be reported. Given the importance of this service and indicator, it is alarming that by midway through the Programme, all five countries are not reporting on providing these services that are so critical to the success of the Programme.

Another challenging element of this indicator is whether the PRSRHP is enabling these SRH health facilities/entities to serve and report *additional* clients who *would otherwise not be served*, or whether these numbers reflect *all* of those entities' clients for that time period. It is positive to observe that Samoa's numbers increased from 653 in 2014 to 1,044 in 2015; however, it is disappointing to see that

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<sup>9</sup> This is true at Central level and not SDP level and therefore should read, "no stock outs at *Central* level."

Tonga's numbers decreased from 3,438 in 2013 to 1,280 in 2015. Confusing as well is how to attribute funding to activities, and thus reporting. For example, Samoa's MA receives funding for rent and utilities – so does this mean they report *all* SRH services to that age group? Or a number somehow proportionate to the value of the rent? In addition, IPPF MAs deliver services funded by multiple funding streams, so it is difficult to know what results to attribute to PRSRHP. Again, assessing the specific impact of the PRSRHP is difficult through this indicator as it is currently written and interpreted.

It is also important to note that such SRH service activities may be carried out by MOH SDPs, MA SDPs, or both.<sup>10</sup> In the case of both Samoa and Tonga, these services were delivered/reported exclusively by their MAs. Reporting from either MOH or MA entities is problematic in that many MOH health information systems (HIS) do not capture these services by age groups at all, or by the specified age group of 15-24. The MAs have better capacity to capture such breakdowns, and some may have capacity to count unduplicated clients for some types of services, however, neither the MOH nor the MAs routinely capture unduplicated client data, which the indicator seeks (number of *people*, and not number of clinic visits or number of clinic services). Another complicating factor in counting numbers served is the fact that MOHs are supposed to *include* MA service data in their national data, which may or may not consistently occur, but could result in double-counting. PRSRHP was designed to address these SRH data collection issues, as reflected in output #12 (HIS are strengthened to include SRH data), during its first two years. Unfortunately lack of progress has impacted results reporting.

In addition, the indicator does not define what services can be counted as an SRH service, nor does it clarify what constitutes a health facility (ex: does group and/or one-on-one SRH education and/or counselling count? Are mobile clinic services counted?). Without a clear understanding of how to interpret and measure the indicator, significant under- or over-reporting could occur.

Another troubling element of the results on this indicator is that all countries report having a number of SDPs that offer YFHS (reflected in indicator #28): Kiribati 17; Samoa (had 10 in 2014 but “no data available” thereafter, which raises questions); Solomon Islands 3 (3 reported, but 6 indicated by FO); Tonga 10; and Vanuatu 14; yet only two of the countries report youth receiving such services. As mentioned, this can be due to inadequate HIS, but it can also be due to the MOH not “demanding” the data from their SRs. Perhaps the most problematic, however, is that the *intent* of the indicator was that a significant number of MOH healthcare facilities would increase their provision of SRH services to youth, yet none are reporting so. In summary, this critically important indicator, in its current condition, is significantly underperforming.

#### **#15: % selected SDPs with no stock-outs of contraceptives in last 6 months**

Reported results for indicator #15 show 100% for 4 of the 5 countries (“no data available” for Vanuatu). Through in-country interviews with three of the National/Central Medical Store Managers and HIS Managers, it became apparent that neither the Medical Store data collection systems nor the HIS have the capacity to track this indicator at the SDP level. While clinic staff may track stocks periodically or even routinely, this information does not get reported to the central level, nor into the HIS. At best, periodic spot-checks are done to prevent or address stock-outs, however, at no point in the tracking system can there be assurances that there were no stock-outs on any day at any SDPs. UNFPA PSRO confirms that they do not systematically receive reports from countries regarding stock-outs at the SDP level. UNFPA collects stock data at the Central level every 3 months.

While it is noteworthy that there have been no contraceptive stock-outs at the national level over the

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<sup>10</sup> The consultant was initially told that the data would/could be collected from the same subset of “selected SDPs” (337 in total) that several other indicators use. This reflects a subset from the MOH total 874 SDPs. However, since this indicator actually includes data from MAs, it appears the “selected SDPs” should be adjusted and articulated to include a number of MA facilities as well.

past 3 years, this does not reflect the intent of the indicator. It is also noteworthy that all 5 countries received Level 1 Supply Chain Management training for primary healthcare workers in 2013/14. While this training did include setting up a process, tools and follow-up monitoring visits by trainers, it did not ensure that systems were implemented to monitor and prevent stock-outs at the SDP level for the long-run. The intent of the indicator is to ensure that the target population never experiences a lack of her/his chosen contraceptive commodity at her/his SDP – an indicator that cannot be measured as written in the current RF. It is positive to note that countries indicated they are pursuing improvements to their commodity tracking systems at the healthcare delivery levels below central level.

#### **#18 & 36: # primary & secondary schools providing comprehensive sexuality education (CSE)**

This indicator is listed twice, as both an output and a short-term outcome indicator. After some negotiations between UNFPA and MFAT, it was determined that this activity would *not* be removed as requested by UNFPA. Activities may include curriculum review and CSE content strengthening, ongoing teacher training, and development of teacher aids. Through in-depth discussions about this work with partners in Solomon Islands, Tonga Vanuatu, and Kiribati, it is clear that there is keen interest and progress is being made in Family Life Education (FLE) in the schools. All countries have initiated implementation of FLE and the commitment is there, which is a significant accomplishment in traditional, conservative contexts. Because FLE, and particularly CSE, are sensitive topics in these PICTs, each country is proceeding at its own pace and own interpretation of what constitutes CSE.

In Solomon Islands, the movement is toward establishing “FLE Corners” in schools, aimed at providing resources and comfortable, private spaces for both students and teachers to discuss issues of sexuality. Kiribati also interested in FLE corners, similar to what they had two years ago under SPC, but currently there is no funding/activity on this. In Tonga, the MA is charged with updating the FLE curriculum for the secondary level, and the Ministry of Education (MOE) would like to see more resources and counselling skills training available for the teachers. In Vanuatu, a draft of the FLE curriculum for grades 7-13 is currently in circulation, which appears to be quite comprehensive in terms of CSE. Vanuatu has also conducted a series of “community consultations” in the provinces to garner input and support for the upcoming curriculum roll-out. They would also like to train teachers and local community members (PEs, nurses) in counselling skills to support the teachers in their work.

This indicator, as reported, is showing no results to date (all 5 countries report 0). It appears that teachers are indeed being trained, however this is not captured by an indicator. It is not clear what specific criteria define CSE for the school setting – whether national, regional, or global standards are being used, and if so, which ones. It is also not clear if there is a process for assessing to what extent current and/or upcoming revised curricula meet the criteria. There are many more steps that must be taken to make an impact on the target population: criteria are established and met; CSE curricula are produced and distributed; teachers are trained and competent; and schools require CSE (vs. an elective); and most importantly, significant numbers of students receive a minimum level/# hours class time of CSE. The indicator as written -- counting the number of schools “providing” CSE -- may not ensure that enough teachers are comfortable, competent and required to teach it to a high enough percent of the student population to make an impact. It is positive to note that UNFPA core funding is supporting an assessment of FLE programmes in 2017.

#### **#19: # young people and/or key populations reached by peer educators**

#### **# 34: # peer educators trained in SRHR**

These two PE indicators are also very important in terms of potentially reflecting significant impact on the target population, including SRHR knowledge (#8 – % of population 15-24 with knowledge of HIV/AIDS) and in terms of health-seeking behaviour (#9 - # young people accessing SRH services).

It would be logical to assume that the number of PEs trained would be correlated to the number of people reached by PEs. Results to date show the following for PE work:

<u>Country</u>	<u># PEs Trained to date</u>	<u># Youth/KP Reached by PEs to date</u>	<u>Avg. # people per PE</u>	<u>Target # &amp; % people reached</u>
Kiribati:	560 (226) <sup>11</sup>	(267) <sup>12</sup>	0 (1)	10,000 (3%)
Samoa:	50	611	12	1,750 (35%)
Solomon Is:	13	3664	282	5,000 (73%)
Tonga:	552 (needs revision)	1438	3	5,000 (29%)
Vanuatu:	0 <sup>13</sup> (40 in 2013)	1541	39 (used 40 PEs)	10,000 (15%)

It is positive to see that three of the countries are making progress toward their targets for # people reached, and one (Solomon Islands) has surpassed expectation at mid-term. Also note that multiple data points in the above chart, created from the RF, appear to need updating and/or correcting; thus making it difficult to make firm observations.

Interviews with PE programme staff and focus group discussions with PEs in four of the countries revealed a range of implementation levels. In general, seasoned PEs were animated and articulate about their roles. Newly trained PEs were shy and unsure about key messages and how they would be mobilised. PEs are utilized for a variety of activities, including for youth drop-in centres, mobile clinic, school, and outer island outreach and education, and special events such as music and sports festivals. Two of the PE programs run by MAs have not utilised their PEs for PRSRHP outreach since January 2017, due to lack of funds. Therefore, the PEs are idle for lengthy periods of time, and don't appear to be utilised for less costly local outreach (with low transportation costs). It is not clear why programmes don't take advantage of the PRSRHP output 8, activity 4: "availability of administrative support for Peer Programmes (allowance, transport, etc.)." When asked in interviews, respondents were unaware that it was listed as an activity option or did not understand that it could be used on an ongoing basis. This type of administrative support would greatly strengthen the PE programs and keep them active throughout the months and years.

Related to the PE indicators above, four countries report that 1-2 SRH/HIV trainings were conducted by PEs, and Tonga reported 14 (#17). In addition, four countries report training 2-7 PE *trainers*, and Tonga reported 122 (#35). Tonga has extremely high numbers of PEs trained (over 550) when their target was only 200 for the full 5-year period. Given these outliers, these indicators likely need further definition or certainly closer monitoring scrutiny.

It is apparent from the range of numbers above that there may be confusion as to: what constitutes a training; what constitutes being "reached"; what PE roles/expectations are once trained; and what defines being a PE trainer. Furthermore, it is certain, based on interviews with PE programme staff, that the above numbers do not reflect *unduplicated* people, both in terms of those trained and in terms of target population reached. It will be important to better define these indicators, ideally using global definitions and standards.

## 5. National partner satisfaction with quality and quantity of Programme outputs

Elements of the Programme that partners mentioned satisfaction with or appreciation for included: the successful Jaddle family planning programs; mobile outreach support; partnerships between MAs and government Ministries (MOH/Ministry of Women/Youth, MOE); SRHR and YFHS needs assessments; SRHR flip charts; past 4-month nurse/midwife training in Suva (prior to PRSRHP?); FLE learning trip to Fiji; opportunities for cross-learning between PRSRHP countries; RH commodity provision; printing of materials; and support to PE programmes.

In general, national partners reported little visibility on the full set of Programme output expectations

<sup>11</sup> Original numbers taken from RF report; correction made later, by FO

<sup>12</sup> Reported later by FO for 2015 only. Of the 267, 229 were ages 15-30.

<sup>13</sup> RF seems to be missing 2016 data, as the VFHA indicated in interviews that 23 PEs were trained in 2016

and results, and where the programme stands to date. While the RF was shared with stakeholders at annual Steering Committee meetings and work planning sessions, it is apparent that the information is either not being digested in a meaningful way, or it is not being transferred from the 1-2 Steering Committee participants to all the most relevant actors.

Some partners were frustrated with the quality of some activities when they were delayed and therefore rushed. Some partners wanted more opportunities for more significant healthcare staff professional training. They reported that they would also appreciate staffing support to cover the extra staff time required for executing, managing and reporting on the added Programme activities.

In summary, the Programme has already had some significant accomplishments, and it is making progress on a number of indicators. In many areas, true success is difficult to assess and measure. In each country, there are aspects of the Programme that are doing well, while there are also activities that have not begun, or are stalled. The purpose of this review is to analyse the overall mid-term progress made towards the objectives of the PRSRHP. While a more global overview and generalisations will miss individual country contexts and nuances, it is beyond the scope of this review to fully assess each country individually. Country-specific examples are sprinkled throughout the report, however.

For any programme, there are many potential contributors and barriers to effectiveness. These include issues around the strength and validity of programme design, programme efficiency, and programme responsiveness to changing needs and environments.

**B. Validity of Design – Appropriateness of the programme design (objectives, strategies, outputs, activities) to ensure best support and measure impact for SRH**

There are some overarching programme design elements that influence and measure any programme’s potential success, including scale, financial resources, and time.

**Scale -- number of people to be reached**

To make an impact on SRH indicators in these five Programme countries, a significant portion of youth, marginalized groups, and women of reproductive age need to be reached in each of the five countries. One of the two PRSRHP indicators in the RF that focus on numbers of people to be reached is the number of 15-24 year-olds accessing SRH services at health facilities (#9) (the other is the number of 15-24 year-olds and marginalised people reached by peer educators, #19). Numbers accessing SRH services will be analysed below:

**Targets and results for # young people accessing SRH services at health facilities:**

Country	Total Youths (est)(M&F)	Annual Target	% of est. youth to reach annually	5-yr Target	% of est. youth to reach in 5-yr. period	# Reached as of 31 Dec 2016	% of 5-year Target
Kiribati:	20,600	2,000	10%	10,000	49%	0	0
Samoa:	35,700	1,000	3%	5,000	14%	2,274	45%
Sol. Is:	105,100	3,000	3%	15,000	14%	0	0
Tonga:	19,600	1,250	6%	6,000	31%	3,020	50%
Vanuatu:	50,400	1,000	2%	5,000	10%	0	0

It is clear that some countries (especially Kiribati) are poised to reach more of the target population with SRH services than others. It is important to note, however, that under the 5-year targets, each youth would receive only *one* contact (SRH service) in the 5-year period. *Annual* targets for this indicator would aim to reach only 2% to 10% of the target population. Using this as an example, under the

current RF targets, it is questionable as to whether the scale of the programme is adequate to make the desired impact on the target population.

### **Financial resources**

The amount of resources allocated also impacts success. The total Programme budget for the 5-year period is USD \$5,220,070.<sup>14</sup> While each year's budget is tailored to its specific planned activities, the *average* annual total would come to approximately \$1,045,000. Divided by five countries, this average would come to about \$209,000 per country per year. To date, 13.2% of the funds utilized have gone to UNFPA implementation (i.e. that which is implemented by PSRO and programme management).

Many of the Programme's goals depend upon significant in-country activity implementation, requiring enough resources to accomplish them at the scale needed to make an impact. The Programme has an extensive list of 15 broad-ranging Outputs with 45 associated activities (Annex 2). It is questionable as to whether the volume and breadth of activities can be implemented, and outcomes achieved, on so few dollars per country.

### **Time**

Given the scope of the Programme and broad range of outcomes to be achieved, it is necessary to have sufficient time in terms of both sequencing of activities and longevity of programme. The fact that it was designed as a 5-year programme is a significant strength. The sequencing of budgeting and timing activities that build upon one another each year demonstrates a sound design. For example, needs assessments were planned for year 1; training, and service, facility, data, and policy strengthening were generally planned for years 1-2; and ongoing youth-friendly health services (YFHS), condom distribution, outreach, and M&E, and coordination/governance activities were planned for all 5 years. A five-year span is conducive to programme success, if the sequencing and pace are consistently on track.

## **1. Theory of Change and Results Framework**

The theory of change diagram, shown on page 11, is constructed as follows: The ultimate goal of improved SRH will be realised through the achievement of three long-term outcomes: 1) improved provision of clinical services for SRH; 2) improved community education and health promotion for SRH; and 3) improved enabling environment for SRH. Each of these outcomes includes reaching marginalised groups and young people. A set of short-term outcomes will lead to the long-term outcomes. For clinical services, the following will be improved: clinical skills, facilities, commodity supply, and quality of care. For community education and health promotion: access to information and outreach will be improved. And for the enabling environment: support from community leaders, policy, and data collection will be improved.

Multiple targeted activities and outputs are intended to produce these outcomes ("PRSRHP Outputs & Activities," Annex 2). While the theory of change is generally built upon sound logic, there is some cross-over as to what is categorised as an output, short-term outcome, and long-term outcome. The theory of change as written, supports the goal of improved SRH *provision* in PICTs, but not necessarily improved sexual and reproductive *health* among its people. Long-term outcomes pertaining to increased *utilization* of modern family planning methods and increased/improved behaviours to prevent HIV/STI are needed.

The Results Framework is built upon the theory of change, and consists of 47 indicators. Indicators reflect a range of Programme goals, outcomes, outputs, and activities. Like the theory of change, several indicators are misidentified in terms of whether they are outputs or outcomes. The RF does not include the two output categories of M&E, and Project Coordination and Governance. The RF is not

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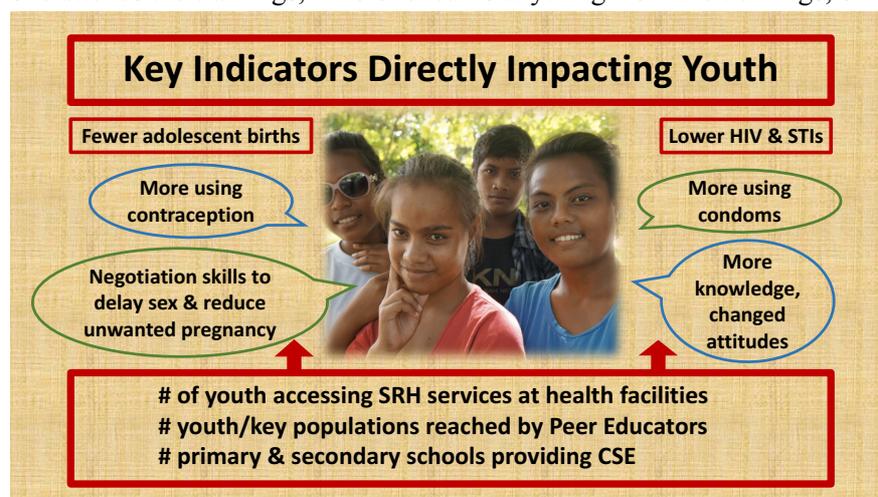
<sup>14</sup> Per 2014/15 PRSRHP Annual Report. Note that all monetary figures will be provided in USD.

laid out in such a way that the sequence of activities, outputs, short-term, and long-term goals can be tracked by category or “work stream.” This makes it difficult for stakeholders to be aware of the logic of the RF, see how specific activities and outputs impact outcomes, and track progress in their spheres of influence.

## 2. Appropriate activities, outputs and outcome indicators

As mentioned, the theory of change is heavily focused on the *provision of outputs* and less focused on their *utilization* by the target populations. There is a heavy reliance on assessments and training and policy updates intended to improve people’s SRH, but there is little to ensure that these outputs actually result in improved service delivery quality and access, and ultimately increased utilization.

Consequently, some indicators should be shifted from their output focus to their outcome focus. For example, # of SRH/HIV trainings conducted by PEs (#17) will not necessarily result in anything, if no one attends the trainings, if no one learns anything from the trainings, or if those trained do not take any



action following the training. This indicator is an *output* and not an *outcome*. More outcome goals are needed that capture increased utilization of specific SRH/clinical services, increased adoption and use of family planning and condoms, and improved attitudes, knowledge, and skills regarding pregnancy and HIV/STI prevention.

Figure 1 Slide from PRSRHP MTR Presentation

## 3. Indicators & their measurement and means of verification -- how well described?

### a. Indicator selection and development

The PRSRHP proposal defined a set of 47 indicators to be tracked throughout the life of the Programme. The four goals and some of the long-term outcome indicators were taken directly from “Indicators Metadata of the UNFPA Strategic Plan 2014-17.” A few indicators are *extrapolated* from the Metadata document, such as elements of demand generation activities, for the purpose of alignment.

Country work plans (WPs) include a range of UNFPA-related work that is broader than just the PRSRHP. WPs include only a handful of PRSRHP indicators. The process for indicator selection is as follows: UNFPA proposes select indicators to implementing partners (IPs), and final indicators are chosen/incorporated into WPs based on both national priorities and ability to achieve them within the timeframe. Selection is based on other factors as well, including: selecting those that capture more than one activity; not including those for which no activities are planned or those that cannot be measured by countries; selecting specific RMNCAH indicators instead; etc. This also explains why WP indicators, rightfully, are not the same across countries.

A significant number of the indicators listed in the individual country WPs are from the MCP5, prior to the start of the PRSRHP, and continue to remain on the WPs from year to year. This is because they reflect core, ongoing UNFPA work streams. A significant number of WP indicators are not worded in such a way that their results can be applied to the PRSRHP RF, for example: “# SDPs offering at least 3

modern methods of contraceptives” (vs. the PRSRHP “# offering at least 3 critical SRH services?”); “# teachers trained in FLE & “Community” Sexuality Education” (vs. “# schools providing CSE”); “# young people utilizing YFS Centres” (vs. “# youth accessing *SRH services*”); “# demand generation activities supported by UNFPA,” etc.

In general, despite PSRO and FOs sharing the RF at Steering Committee meetings, biennial work plan (BWP) development, and WP reviews, IPs and stakeholders report that they do not have visibility on the full RF. While updates to the RF are included in annual reports to the donor, review of this is not routinely done by IPs and stakeholders. The consultant had discussions with UNFPA FOs regarding select details of the RF included in the most recent annual report, which revealed that there were several data points that the FOs could not fully explain or back up. Even though all quarterly and annual reports are shared with FOs for review and comment, this process does not ensure that the RF is specifically reviewed in detail and endorsed by each UNFPA Field Officer (FO) each year. And while the full RF is discussed with IPs during the BWP development process, this does not appear to be adequately in-depth to ensure that a clear and appropriate set is documented in the WP, fully understood by IPs and SRs, and that ownership and accountability is embraced. Because the WPs serve as the IPs’ primary PRSRHP reference document, a clear set of indicators and their targets is important for driving the Programme. Discussion and monitoring of progress on the RF is not part of regular NCC meetings.

#### **b. Baselines**

Baseline data in the proposal version of the RF reflect what was accessible in 2013. Subsequent versions of the RF include updated baselines taken from completed SRHR needs assessments and possibly other sources. However, some of the baseline figures input in the 2016/17 RF have “(2014)” or “(2015)” written with them, reflecting and creating confusion as to what the meaning and function of baseline figures are. “(2014)” is particularly confusing, since it could reflect true baseline from the 6-month period prior to programme start in mid-2014, or it could reflect a figure potentially influenced by the Programme. Baselines and targets are included in country WPs as well. It is important to note, however, that these WP baseline figures are also confusing, as sometimes they are figures from the prior year’s results vs. prior to programme start, thus changing every year--if they are indeed updated. In fact, baselines and updates reported in the UNFPA Strategic Information System (SIS) are based on baselines from the previous year. Given these challenges, it is difficult for all concerned, to know which baseline figures to use to truly measure Programme progress.

#### **c. Targets**

The RF was discussed with the representative IPs at the first Steering Committee meeting in 2015, where initial targets were set. Targets are also reviewed by IPs at subsequent annual or biennial WP development stages. When the consultant discussed the targets with IPs, the rationale for the targets and their increases were either absent, or generally not understood. The extent to which sub-recipient (SR) partners are consulted to provide input is uncertain. Based on discussion with SRs, they generally indicated that they were not directly involved in setting specific targets, indicating that this is done at a higher level. Regardless of the inclusiveness of the initial target-setting processes, it is apparent that ongoing knowledge and monitoring of progress toward targets on a quarterly or even annual basis is not *driving* the various programme implementers. While a few select upper level IP representatives do indeed discuss and sign off on targets, the extent to which the range of implementing stakeholders are aware of their targets, believe the targets are achievable, use them to drive their activities, and take ownership of their targets, is weak.

#### **d. Indicator Reporting**

It took the consultant a considerable amount of time to understand how certain indicator results are collected and reported. Confusion was partially due to the denominator of “selected SDPs” used for several indicators, creating the impression that activities were necessarily conducted by these SDPs and

therefore reporting was generated from them. This is not the case, however, for indicator #9 -# youth accessing SRH services, where it is not the selected SDPs, but rather IPPF MAs, that are currently reporting these results. It appears that the *intent*, however, was that the Programme would impact the 337 selected SDPs rather than a much smaller number of private sector SDPs. It is also important to note that only entities that are *funded* to conduct *specific activities* are reporting results.

There are indicators, however, that report data from the central level (ex: #15 – no contraceptive stock-outs; #30 & #31 -- # male and female condoms distributed). In the case of condom distribution, it is not clear what specifically funded activities are conducted countrywide in order to justify counting all condoms distributed nationally. The intent of the output was to support innovative, peer and community based distribution efforts, however all condom distribution is counted. The disconnect between indicators and activities and reporting is confusing and problematic. It is difficult to know how to set expectations in terms of both targets and what entity(s) are accountable for meeting them.

#### **e. S.M.A.R.T. Assessment of PRSRHP Indicators**

The indicators are taken at face value from the results framework. There is no document that provides further descriptions, definitions, or instruction as to how to measure them. In looking at how well the 47 Programme indicators are defined, application of the S.M.A.R.T. model is useful (Specific, Measurable, Achievable, Responsible/Relevant, Time-related). In general, almost all of the indicators need improvement to be SMART. See Annex 3 for a detailed assessment.

#### **C. Efficiency – Extent to which PSRO’s staffing, funds, financing instruments, administrative regulatory framework and costs, expertise, timing, and procedures foster or hinder the achievement of outputs and outcomes.**

The programme design and implementation plan is based on a set of assumptions described in the proposal: that adequate resources (funds and staffing) are provided and available; PSRO TA and in-country FO technical, management, and administrative staffing and support is adequate; strong cooperation between MOF and MOH and other government branches; adequate level of MOH capacity to implement the Programme; strong cooperation between MOH and local NGOs, etc. Several of these are discussed below:

##### **1. Staffing & Programme Start-up**

The PRSRHP proposal lays out a solid plan for programme staffing:

“...the UNFPA PSRO serves under the leadership of the Director and UNFPA Representative...Deputy Director and Representative, 2 Assistant Representatives and the International Operations Manager. Good quality regional and country programmes is delivered through the comprehensive and integrated team of 4 Technical Advisers (Reproductive Health, Gender Equality, Population & Development, and HIV/Youth), 1 Communications Specialist, 1 M&E Specialist, 1 RH Commodities Specialist, 6 Programme Officers based in Suva, and a team of 12 Programme and Operations support staff as well as in-country presence in each of the programme countries. The UNFPA Director and UNFPA Representative will be the lead for the SRH programme with the full support of the management, technical and operations teams to the timely delivery of the SRH programme.”

The Programme faced significant delays in the start-up phase, due to both funding flow and staffing issues. While MFAT funding was delivered in late June for the intended July 2014 start, UNFPA internal processes resulted in a several-month delay before the funds could be accessed. Additionally, in 2013 a staff re-profiling exercise was undertaken in PSRO, which resulted in a restructure of office positions and posts that continued for the next two years. This included the placement of new FOs, which suffered a setback as not many candidates with the appropriate qualification were available locally. In terms of delayed staffing, the Programme Coordinator was hired after 11 months (after July 2014), and the Field Officers were hired ranging from 5 to 17 months after, with one FO in place

(Solomon Islands) consistently from 2007. PSRO did provide staff support throughout this start-up period, with the Coordinator serving as acting Coordinator prior to hire, support from Assistant Representatives and other staff, and supplementing with consultants. Unfortunately, there were significant staffing gaps among the PSRO Technical Advisers/Specialists as well, with key positions (RH, Gender, Population & Development, and Youth/HIV) vacant for the first 11-22 months of the Programme.

Consequently, implementing arrangements with IPs were also delayed. The five country governments were formally informed of the funding in November 2014. No new WPs were signed in 2014/15, as UNFPA's practice is to continue with ongoing BWPs. These January 2014 BWPs had already incorporated some of the anticipated elements of the upcoming PRSRHP into them. Other implementation steps progressed at a steady pace: an agreement with UNICEF was signed in September 2014, with USP in February 2015, and IPPF in March 2015. The first PRSRHP Steering Committee was held as planned, in April 2015.

The 2017 MCP5 Review supports the consultant's observations:

“Regarding **efficiency**, UNFPA has addressed the 2013 internal audit recommendations. The office restructuring process in 2014 caused delays in planned interventions due to limited human resources. Enhanced UNFPA presence in the islands and territories since 2015 has increased efficiency, however, staff require greater orientation to UNFPA management systems, more decision-making power, and more participation in knowledge management, coordination and strategic planning. Increased efficiency in central operations is still not apparent.” (pg. xii)

## **2. Coordination between PSRO sections (Programme, Operations, TA) and staff (Coordinator and Field Officers)**

The coordination and support between the PSRO sections, Coordinator, and Field Officers appears to work well. Fortnightly teleconference meetings between the FOs and Coordinator and PSRO staffs provide consistent communication and support. FOs reported frequent, and sometimes daily, email and/or telephone contact with the Coordinator, which was appreciated. The role of the Coordinator is critical, providing consistency in communication, implementation, financial and programme reporting, and more. TAs have expressed a desire to be more involved with country programmes. A periodic PSRO team focus on each country program was suggested. The management and reporting of TA requests and fulfilment of those requests needs improvement in order to better match country needs with requests. The consultant was not able to obtain a complete, up-to-date overview of the PRSRHP-specific TA provided to the national programmes. While the TA team maintains an overall TA tracking matrix, there were several gaps in reporting that most likely did not capture the full extent of TA delivered.

## **3. UNFPA presence and technical expertise in country**

Stakeholders consistently expressed their appreciation for UNFPA and the funding that is provided to support SRHR in their countries. The strength of UNFPA presence and technical expertise in each country is represented largely by the FO, and to a lesser extent PSRO's TA and monitoring visits. In general, stakeholders expressed a good working relationship with their FOs and find them very engaged and helpful in terms of coordination, facilitating communication with both internally and with PSRO, and assisting with work plans, funding disbursement requests, and reporting. Experience of the Programme Coordinator and his country visits were also positive. Overall, the MFAT and DFAT bilateral programme stakeholders interviewed expressed a lack of PSRO and FO communication, and a desire for more. Communication was generally stronger with DFAT in RMNCAH countries; for example, in the Solomon Islands there are various avenues where all donor partners meet – the monthly Health Donor Partners meeting, the Joint Annual Review Performance meeting (twice a year); the DPCCG meeting, and the RMNCAH team quarterly meeting with the Family Health Committee.

In non-RMNCAH countries, the FOs and MFAT/DFAT bilateral representatives generally did not attend common meetings.

The FOs' level of technical expertise varies, as they play a more managerial role than technical role in the Programme. Some FOs expressed a desire to become better trained in SRHR, and to get more and/or speedier technical assistance (TA) from PSRO in SRHR technical areas. The consultant notes that neither the Coordinator nor FOs have job descriptions or other human resource documents that specifically describe their roles vis-a-vis the PRSRHP. While their generic job descriptions include programme design, implementation, monitoring, reporting, advocacy, liaising with stakeholders, and environment scanning, clear delineation of PRSRHP-specific roles and responsibilities are not articulated. Therefore, the FO responsibilities, tasks, and level of effort vary across the countries. For example, in some countries the FOs report taking on a significant monitoring role, while in other countries the FOs report that they do not have a budget to support monitoring trips in the field. In some countries, the FO takes a lead role in the NCC, while in others, the FO is not invited to participate. In all countries, FOs play a major role in the facilitation of funding disbursement requests and the completion of reports. In general, there is lack of clarity as to what the FOs' specific PRSRHP roles and responsibilities are, and this can create confusion for IPs as to what theirs are. This creates inefficiencies as well as a lack of accountability.

#### **4. PSRO implementing arrangement with UNICEF**

The agreement with UNICEF was signed relatively early—in September 2014. UNICEF is charged with Outputs 8.5 (SRH IEC materials), 8.7 (SRH Sports Champions), and 9 (population studies for marginalised groups in three of the countries). Regarding IEC materials, it is difficult to ascertain the extent to which such materials cover SRHR in general, and the extent to which they have been made available to the range of potential PRSRHP users, such as PEs, FLE teachers, SRHR advocates, healthcare workers, youth-friendly clinics, etc. in the five countries. Vanuatu's MOH reported a successful IEC activity, whereby the MOH worked with Vanuatu Family Health Association, who developed the original template for posters. After clearing the MOH Health Promotion Unit, the RMNCAH unit piloted/checked with young and older beneficiaries before printing and distribution. A total of 30,000 posters were distributed to all 6 provinces in 2016.

The status of training SRH Sports Champions (indicator #39) is unclear, as the RF indicates 85 were trained in Kiribati, while the 2016 UNICEF report indicates 85 were trained in Fiji, Samoa and Tonga combined. In addition, communications with the UNICEF Sport for Development Consultant indicated that 22 were trained in Samoa and 30 in Tonga in 2016. These discrepancies may reflect a lack of communication and weak reporting mechanisms within UNICEF and/or between UNFPA and UNICEF. It is also difficult to ascertain whether the remarkably high numbers of youth reached through these Sports Champion activities were, or should be, captured in the RF or not, as the Sports Champions *could* be considered PEs or SRHR Advocates (#12), as the target age for this SRH training is 15-24.

Regarding the key population studies, UNICEF, apparently in partnership with UNDP, has completed these important population estimates and analyses (indicators #40 & #41). In general, both FOs and stakeholders in the programme countries were unfamiliar with UNICEF's SRHR-related activities and their role in the PRSRHP programme.

#### **5. PSRO implementing arrangement with IPPF SROP**

Some positive aspects of the implementing arrangement with IPPF include greater partnerships with governments, including training and joint outreach activities; the success of the Jadelle programme—particularly in Solomon Islands; condom distribution programs; increased local stakeholder awareness and partnerships; a focus on youth-friendly services; and an improved relationship with UNFPA leadership. IPPF SROP expressed looking forward to working more closely with UNFPA.

The implementation arrangement with IPPF SROP began on rough footing, as neither SROP nor the MAs were consulted by UNFPA about their potential PRSRHP roles during the proposal design phase. UNFPA's proposal articulated support from SROP and MAs, however, and IPPF found the implementing arrangement through the MOHs to be problematic, both in terms of the monitoring role of SROP and in terms of the MA roles as sub-recipients of MOHs. Essentially IPPF felt they could not be held accountable for the delays by external parties, whereas if the contract was with IPPF, internal monitoring mechanisms with MAs would be in place. There appears to have been effort made to smooth out these implementation challenges, through a signed LOU in March 2015, a UNFPA-IPPF meeting that included MA Executive Directors in November 2015, and IPPF's participation in the 2016 PRSRHP Steering Committee meeting. IPPF was not able to participate in the 2015 Steering Committee meeting due to the late invitation (1 week) and inability to mobilise international travel on such short notice. There is now a \$20,000 annually budgeted monitoring role/arrangement for IPPF SROP.

In speaking with IPPF MAs in-country, they echoed the experience of SROP, reporting that they felt they were not sufficiently consulted in the design phase and early work planning phases. MAs were surprised at the level of activities that were expected of them, and they continue to struggle to meet the expectations of multiple donors and programmes. It was pointed out during interviews that funded activities did not come with funding for staff positions to carry out the work.

While this section of the report addresses the UNFPA PSRO implementation arrangement with IPPF SROP, it is important to point out that, by Programme design, MAs are the sub-receipts and responsibility of the IPs. The implementation and WP negotiations take place between those two entities, and then UNFPA is involved to ensure they both have an understanding of the processes for fund disbursements and reporting through the IP. Ultimately it is up to the IP to make the SR selections and determine if the MAs have the capacity to deliver as SRs.

Other funding disbursement issues were raised, including crippling delays in receiving advance funds to carry out PRSRHP activities. Funds are transmitted from UNFPA to Ministries of Finance, who transmit to IPs, who then transmit funds to their sub-recipients such as MAs. If reporting from MAs to IPs is delayed, or if spending was ineligible, this must be cleared by MAs before IPs can transmit further funds. Other causes for delays can and do occur, including bottlenecks at the Ministry of Finance levels, reimbursements owed to UNFPA, and of course negative audit findings. In response to delays, some MAs have sometimes fronted the money and carried out activities prior to approval, sometimes using incorrect/inadequate financial tracking processes. This has created reimbursement, audit, and subsequent financial transaction problems.

Funding flow problems were by far the prevailing topics of discussion initiated by stakeholders in interviews. While considerable time was spent trying to understand and summarise these issues during the MTR, the consultant later learned that a UNFPA audit of 4 of the 5 countries (all but Solomon Islands) was being conducted during the time of the MTR. While the results of these audits will provide a more accurate description of the issues and their causes, the consultant offers the somewhat incomplete information gathered from interviews. In the case of the IPPF MAs, as of June 2017, two MA' funds are delayed due to problematic audit findings (Tonga and Vanuatu); two are delayed due to governments owing refunds to UNFPA (Samoa and Solomon Islands), and one has indicated "no activities" for 2017 (Kiribati). An overview from 2015-2017 is provided in the document, "PRSRHP Funding Disbursement Overview – IPPF MAs" in Annex 4.

At times, SROP has had to intervene with governments to influence speedier funding and reimbursements. Several IPPF stakeholders, and others, expressed a desire for the UNFPA to fund MAs either directly or through SROP, and not through the MOF/MOH. This was in fact the implementing arrangement a few years ago, but this process too, was complicated and cumbersome. For example, no funds could be received by IPPF SROP from UNFPA as per their financial policy; rather, funds go to the IPPF London account and then to their MAs, resulting in vulnerability to losses due to currency fluctuations, as well as lengthy delays. Financial management can be also weak at the MA level,

requiring extra support.

In general, the process of developing WPs is perceived to follow a top-down approach, to the point where the MA SRs feel they are allotted their activities and corresponding budgets rather than working collaboratively to determine appropriate activities and targets within the broader partnership and goals of the Programme. The MAs' relationships with both UNFPA and SROP, and the implementation relationships as SRs of MOHs, create confusion among the MAs as to whom they are accountable. While the reporting lines have been explained by UNFPA to IPs and SRs, MAs expressed confusion during interviews with the consultant.

## 6. Implementing arrangement between MOF and MOH and Sub-Recipients

The PRSRHP is designed to be delivered through UNFPA arrangements with a single IP in each country. The Ministries of Health (MOH) have been chosen to be the IPs. UNFPA had made the change to reducing its number of IPs in 2013, due to several reasons: the high number of IPs receiving small dollar amounts that all required monitoring and auditing; and the recommendations from the UNFPA Oversight Division in UN headquarters. The reduction consolidated funds under a single IP, which would then be monetarily high enough (i.e. over \$100,000) to meet the minimum threshold for requiring auditing. More frequent audits and spot checks ensure that IPs are accountable. The MOH is responsible for auditing the SRs, as part of their government processes.

Programme funds go from MFAT, to UNFPA, to each country's Ministry of Finance (MOF), to each country's IP (usually MOH), and finally to Sub-Recipients (SRs). SRs are primarily IPPF MAs and other government Ministries. MOHs have general LOUs with IPPF MAs. IPs also have the option of using additional SRs, as is the case in Vanuatu, where several CSOs are utilised to carry out activities. Below is a breakdown for 2016, which illustrates the percentage of Programme funds that were budgeted to go to the IPs and main SRs that year:

### 2016 Allocation of PRSRHP Funds per 2016 Country Work Plans:

	Kiribati		Samoa		Solomon		Tonga		Vanuatu	
Ministry of Health	\$136,000	69.6%	\$ 77,000	34.1%	\$ 97,726	56.8%	\$ 47,500	32.5%	\$132,000	64.1%
Ministry Education		0.0%	\$ 15,000	6.6%	\$ 17,593	10.2%		0.0%		0.0%
Ministry of Youth	\$ 35,000	17.9%	\$ 46,000	20.4%		0.0%		0.0%		0.0%
IPPF MAs	\$ 24,500	12.5%	\$ 88,000	38.9%	\$ 56,693	33.0%	\$ 98,800	67.5%	\$ 74,000	35.9%
	\$195,500	100.0%	\$226,000	100.0%	\$172,012	100.0%	\$146,300	100.0%	\$206,000	100.0%

The PRSRHP proposal provided a description of the implementation arrangement, including how to ensure IP capacity and how to mitigate risks:

“To ensure the success of the PRSRHP, UNFPA will carefully select implementation partners based on their ability to deliver high-quality programmes. UNFPA adopts a competitive Implementing Partner Capacity Assessment to select Implementing Partners, thus assessing their capacity to deliver the highest quality of service, the ability to apply innovative strategies to meet programme priorities, needs and UNFPA strategic direction in the most efficient and cost-effective manner...UNFPA will also continuously monitor the performance of its partners and periodically adjust implementation arrangements, as necessary. The UNFPA PSRO will ensure that the appropriate risk analysis is performed in conformity with the harmonized approach to cash transfers.”

The consultant asked and was not able to obtain the “Implementing Partner Capacity Assessment” to comment on the extent to which it assisted in the selection of IPs best able to deliver high-quality programmes. While MOH capacity in the role of IP varies by country, there is little evidence to indicate that the levels of “quality, innovation, efficiency and cost-effectiveness” of these IPs is particularly strong.

There is a unique case in Samoa, where the IP arrangement is significantly more complex than in the

other countries. In Samoa, the MOF Aid Coordination Office is the entity that signed the IP agreement with UNFPA, based on the decision of the Samoan Government. The MOF Aid Coordination Office has designated the sub-IPs of the MOH to be responsible for PRSRHP family planning activities, and the Ministry of Women, Community and Social Development (MWCSD) for youth-related activities, which, in the case of PRSRHP, include clinical services. Clinical services, however, are normally conducted by the National Health Service and monitored by the MOH. Consequently, the MOH and the MWCSD have a conflicting, unclear, and uncooperative relationship regarding the PRSRHP, resulting in neither taking overall leadership. The Samoa Bureau of Statistics is an additional sub-IP. Therefore, there is no one entity taking on leadership and responsibility as the IP. There is no evidence that UNFPA's level of performance monitoring and adjustments to implementation arrangements have been sufficient to address this particular weakness.

UNFPA has a standard Letters of Agreement (LOU) with the MOH of each country. These LOUs were created for the 5-year MCP5 (2013-2017), signed in May 2013. Because the PRSRHP is integrated into the existing MCP5 and related RH programmes of the MOHs, there is only one LOU and no additional LOU or signed agreements specific to the PRSRHP. Most private sector SRs (including MAs) have general MOUs with the MOH, though these too are not specific to PRSRHP. Through these general LOUs, it is expected that the MOH, as the IP, is accountable to UNFPA, and it is expected that SRs are accountable to MOH using government-specific tools for reporting, monitoring, spending, etc. MOH strategic, corporate, and or business plans are guiding documents that generally guide and align work plans with CSOs. Other than these plans, and the processes of approving budget requests and financial reporting, there doesn't appear to be specific agreements in place for IPs to monitor and hold SRs accountable for the quality and quantity of their activities, outputs and outcomes. UNFPA checks the financial reporting of MOHs and SRs as part of their monitoring visits.

In terms of programme implementation and management, UNFPA-MOH responsibilities, tasks, and expectations outlined in the LOUs are non-specific to the PRSRHP. Among other things, the IPs agree to: professional and technical competence; to select reliable individuals who will perform effectively; ensure that the same obligations remain in place when using sub-contractors; etc. The UNFPA agrees to: provide monitoring, evaluation, and oversight of WPs; liaise with stakeholders; and give overall guidance, oversight, TA as appropriate, and leadership for the implementation of the WPs.

Given the level of responsibility and expectation placed upon the MOHs as single IPs, it is surprising that there are not more specific documents detailing their roles and responsibilities with corresponding policies and procedures. While IP trainings outlining various UNFPA processes and protocols do occur, they may not be sufficient to clarify and ensure that IP responsibilities and accompanying tasks are executed effectively. The absence of these compromises effectiveness and creates a lack of efficiency and accountability.

## **7. Funding disbursements**

As mentioned, no single topic dominated the conversations with stakeholders more than the issue of problematic and delayed funding disbursements. This was by far singled out as the main challenge to the efficient and successful implementation of the Programme. In an effort to capture a snapshot of funding disbursement flows, the consultant asked both IPs and IPPF MAs to provide dates of funding requests and funding receipt for a sampling of quarters (the first quarters of 2015, 2016, and 2017). These "PRSRHP Funding Disbursement Flow" overviews are provided in Annex 4 (IPPF MAs) and Annex 5 (MOH). As is evident, delays were experienced in getting the 2015 and 2016 calendar years started, with most first advances not received until March, April or May (and even July). Transaction times from date of request to date of receipt in 2015 and 2016 averaged 5-6 weeks for both the MOH and MAs.

The calendar year of 2017 has taken a turn for the worst. As mentioned earlier, UNFPA headquarters informed PSRO of new audit criteria in the beginning of the year, which lowered the threshold on

negative findings amongst IPs that “qualify” IPs. As a result, 4 of the 5 countries had “qualified” audits, or negative findings with amounts over the allowed threshold. These audit results have necessitated a change in disbursement methods for 2017, which has been time-consuming. The consultant recommends that a summary of findings be provided to provide the most complete, up-to-date description of funding disbursement issues.

Per the consultant’s interviews prior to learning of the recent set of audits, the following was learned regarding the IPs/MOHs: only one country’s IP, Kiribati, has received funds for 2017 (in April). The other four are currently delayed: two (Tonga and Vanuatu) due to audit findings requiring resolution, and two (Samoa and Solomon Islands) due to pending return of funds by MOF/MOH to UNFPA. None of the 5 MAs have received 2017 to date.

Both the effectiveness and efficiency of the Programme is seriously compromised by these funding disbursement delays, whether the problems are originating from the SR, IP, MOF, or UNFPA. Within governments, there can be both long processes and lack of adherence to UNFPA transaction protocols. Activity implementers complained repeatedly about the impact of delays, in that great effort would be put into planning activities (ex: trainings, outreach) involving multiple participants, multiple vendors, travel, and other logistics – only to be cancelled due to advance funds not arriving in time. These activities would then have to be re-scheduled, re-planned, and executed at a later date, which sometimes pushed them into sub-optimal timeframes not only in terms of being rushed, but also being condensed into a short season filled with too many demands on the participants. This can be problematic for healthcare worker trainings, for example, in that clinical staff absences from their workstations must be staggered in order to maintain services to clients. It is also problematic in terms of wasted/lost staff time, loss of credibility, significant swings in work-flow, stress, compromised quality of work, and ultimately poorer outputs and outcomes. The lost time due to financial transaction times and funding delays results in the Programme implementation year being cut from 12 months down to 6-8 months. This of course impacts implementation rates and “absorption” capacity.

As the proposal indicates, the limited capacity of IPs for financial oversight was a known risk:

“Financial risks include absorptive capacity of implementing partners for programme funds, limited capacity for financial oversight, and mismanagement of programme funds. All of these could lead to delays in implementation of activities and/or suspension of funding. UNFPA has a number of strategies for mitigating these financial risks including capacity assessments while selecting implementing partners, financial audits, regular monitoring and reporting, capacity building and IP training, and varying modalities for disbursement of funds. (pg. 4)...The programme will undertake assessments, as needed, of where partners’ absorptive capacity can be boosted and/or identify options for outsourcing aspects. The programme can also consider supporting additional staff for partners and will closely monitor financial execution by partners through established reporting mechanisms and/or ad hoc monitoring.” (pg. 23)

Concerns and a plan for ensuring satisfactory financial transaction processes were raised in the 2014/15 Annual Report:

“1) Ensuring that all advanced **funds are spent and reported on time**. Paying special attention to the limited implementation normally encountered near the end of the calendar when most staff are out of the office on vacation; 2) Ensuring that **UNFPA financial closure processes** at the end of the calendar year does not hinder programme implementation: Ensure all funds are spent as much as possible; all unspent funds are returned in a timely manner. **Other funding modalities** will be entertained with national partners to ensure continued programme implementation. These include direct payment to vendors and reimbursement payment.”

The first PRSRHP Steering Committee also identified financial system challenges and interventions during their April 2015 meeting:

“...Need to streamline **financial processing** of funds provided to countries. It was envisaged that the Steering Committee and the National Committees would be crucial in communicating and coordinating funding disbursements, expenditure and reporting, to ensure timely processing from UNFPA through respective MOF and

MOH and sub-recipients.”

It does not appear that the hopes for the Steering Committees’ and National Coordinating Committee’s (NCC’s) roles in assisting with solutions to these financial processing matters have been realised. Given that these risks have been experienced for years, and were articulated prior to Programme start, it is surprising that they continue to persist to the extent they do today, at mid-term. It appears that the level of disruption they cause has been underestimated, and/or UNFPA’s mitigating strategies have not been implemented, or they are failing to adequately address the problems. UNFPA’s additional funding modalities of reimbursement and direct payments to vendors do not seem to be attractive or practical options for most implementers, for a variety of reasons including risk, the additional work of setting up multiple vendors in the UNFPA system, reluctance on the part of vendors to work without more payment guarantees, the cash-based systems at the Provincial level, delays in the direct payment method as well, etc. One may also question whether the time and effort required to process funds correctly and in a timely manner is “worth it” to the IPs and SRs, given the relatively small monetary amounts and where they fit in terms of priorities. Furthermore, if there is no funding allocated toward TA/staff positions that can handle this “extra” work, perhaps it is not surprising that it isn’t getting the attention it needs to be efficient. UNFPA may want to consider relaxing some of its requirements for processing funds that are under certain thresholds.

## 8. Implementation Rates

UNFPA seeks satisfactory implementation rates as evidence of successful administration of programmes. According to the “Indicators Metadata of the UNFPA Strategic Plan 2014-17,” the target for implementation rate levels for regular resources is 97%. The table below shows the utilisation and implementation rates for each country and for PSRO office/direct implementation for 2014, 2015, and 2016:

### Utilization & Implementation Rates PRSRHP (NZA23) in USD:

Country	2014	Imple men. Rate	2015	Imple men. Rate	2016	Imple men. Rate	Total 2.5 Years	% of Total Funds
<b>Kiribati</b>	-		77,339	100%	99,401	51%	176,740	7%
<b>Samoa</b>	34,412	100%	129,749	66%	144,466	49%	308,627	12%
<b>Solomon Is.</b>	74,620	24%	124,742	82%	192,190	71%	391,552	16%
<b>Tonga</b>			147,453	81%	157,982	100%	305,435	12%
<b>Vanuatu</b>	3,026		28,049	62%	101,825	72%	132,900	5%
<b>Office Impl.*</b>	382,559	11%	533,427	67%	294,145	60%	1,210,131	48%
<b>Direct Impl.*</b>								
<b>Total Utilized</b>	<b>494,617</b>		<b>1,040,759</b>		<b>990,009</b>		<b>2,525,385</b>	<b>100%</b>
<b>Ceiling</b>	508,401		1,376,499		1,364,070		<b>2,791,410</b>	
<b>Utilization Rate</b> (funds disbrsd.)	97%		80.7%		76.6%			
<b>Implemen. Rate</b> (spent, reported)	<b>97%</b>		<b>68.7%</b>		<b>54.3%</b>			

\* Office & Direct Implementation: PSRO (UNFPA) implementation and payment of national vendors.

Given the late start of the Programme in 2014 and two countries with no data, the more representative years are 2015 and 2016. One will note, however, that a commendable 97% implementation rate was achieved for 2014. Overall implementation rates were better in 2015 (68.7%) than 2016 (54.3%). Solomon Islands and Tonga experienced relatively high rates for both years. It is interesting to note that, of the total \$2.5 million utilised as of the end of 2016, \$1.2 million, or 48%, was office and direct implementation by PSRO (UNFPA). Of this, 13.2% were for regional activities implemented by PSRO and programme management. The balance of 34.8% were paid directly by UNFPA to vendors, for services supporting activities conducted by IPs. This category achieved implementation rates of 67% and 60%.

## 9. Work Plan Processes

The original program design was such that PRSRHP would align support with each of the 5 countries' national health plans and UNFPA's PSRO 5-year plan. The individual 5-year country PRSRHPs were to be based on the initial SRHR needs assessment results and baseline data/surveys, with each programme country then outlining relevant implementation plans to define which activities should be undertaken (proposal, pg. 2). The intent was to complement and scale up efforts already being undertaken by governments, UNFPA, UNICEF, IPPF MAs, and other development partners. Activities were to be refined and adapted for the country context and needs.

A strength of the Programme was that SRHR Needs Assessments for the five countries were undertaken within the first programme year (indicator #23, 100% met). Results were presented to IPs and other members at the first PRSRHP Steering Committee meeting in April 2015. RF baselines were updated by the Coordinator and targets were set at the 2015 Steering Committee. IP comments and final approvals were solicited thereafter. Printed Needs Assessment reports were distributed by FOs to country stakeholders. Beyond that, there was no specific process encouraged for FOs or stakeholders to delve further into the Needs Assessments to guide country programs. While country validation is preferred, it is not required, and was not done in all countries. When queried during interviews, few stakeholders responded that they had copies on hand, read the Assessment, or used the Assessment to inform their work. While the difficult to measure indicator #26, "% health facilities implementing recommendations from SRH Assessment" reports "some" for all 5 countries, it does not appear that this result is due to a deliberate process to study, prioritise, and systematically incorporate the recommendations into their work. While the SRHR Needs Assessment is an important and useful document, it hasn't gotten the attention it deserves. Perhaps the focus of this indicator was more on *completing* the Assessments rather than *using* them.

Because country WPs are the instruments that drive country Programmes, the process for developing them was further explored by the consultant. Country BWPs, which follow calendar years, are agreed upon with each country's IP/MOH. They are based on government annual operating plans, MCP5 and UNDAF. They cover a range of activities and budgets and include the MFAT/PRSRHP funding stream, among others. Pre-existing 2014-15 BWPs continued to be used for PRSRHP for the first 1½ years of the Programme.

In late 2015, the Coordinator conducted monitoring visits to all 5 countries to inform partners of the upcoming PRSRHP biennial activities and assist in the development of their 2016-17 BWPs. This work was followed up by the FOs. It doesn't appear, however, that the 2016-17 BWP indicators were changed significantly to reflect the PRSRHP—old indicators remained. This is due to UNFPA wanting to keep the indicator measurement manageable for IPs and to keep the focus of the ongoing UNFPA BWP. Few new PRSRHP indicators were added (ex: old indicator of "SDPs offering at least 3 modern methods of contraceptives" remains, and new PRSRHP indicator of "SDPs offering at least 3 critical SRH services of ANC, FP, STIs" has not been added). In general, the 2016-17 BWP indicators do not necessarily better reflect the PRSRHP than those created prior to the start of the Programme.

The process for developing WPs incorporating PRSRHP began with the first Steering Committee meeting in 2015, where IPs reviewed their respective PRSRHP WPs and adjusted activities and outputs. In subsequent years, the PRSRHP Coordinator sent to the countries their annual budget allocations in selected output categories, and FOs facilitated the development of the WPs with the IPs. Countries can change their WPs based on their needs and challenges. For example, some PRSRHP activities have been stopped (for example Girl Safe Spaces) or delayed (HIS assessment) because of individual country requests. It is not clear, however, to what extent countries continue to have visibility on the full set of PRSRHP activities and outputs from which they may want to continue to pick and choose to best meet their country's needs and capacities. The role and decision-making power of the Coordinator, FO, IP, government and private sector SRs, and NCC is unclear. While upper level IP decision-makers are very

involved in the WP finalisation, the general feeling among lower level staffs charged with actually executing the activities is that they have little say--this sentiment is especially true among the MAs.

Perhaps what is most lacking in the WP development process is visibility on the overall Programme design, theory of change, RF and indicators by the IPs and stakeholders. PRSRHP indicators and their baselines and targets were even more unknown, revealing a significant separation between activities and their corresponding output and outcome goals. Stakeholders are conducting activities not knowing what their targets are and what outcomes they are seeking.

Overall, PRSRHP is subject to greater influences when it comes to the development of country WPs and annual operating plans. PRSRHP is not a programme, per se, that commands separate or special attention. National planning and budgeting processes happen on an annual basis, with government, UNFPA, RMNCAH, and other high level agreements and commitments commanding the focus. The interests of PRSRHP are represented primarily by PSRO, and are worked into country plans within the context of honouring national strategies as well as ongoing UNFPA commitments. PRSRHP work planning is not a separate activity that is driven by IPs nor the NCCs. Rather, PRSRHP fits within the context of ongoing UNFPA work and its interests are largely represented and promoted by the PSRO Coordinator, who takes a pro-active role in ensuring that the Programme progresses as planned.

## **10. Multi-country approach helped or hindered delivery?**

Stakeholders cited several aspects of a multi-country approach that are beneficial to country programmes, such as the opportunity for cross-learning. Examples included sharing successes and spreading the implementation of the Jadelle program; learning from Fiji and each other about FLE/CSE programming; and sharing challenges and solutions at annual PRSRHP Steering Committee meetings. Regional trainings, workshops, and standardised documents, such as the YFHS needs assessments and their data collection format, have also contributed positively to Programme delivery. The management role of the PRSRHP Coordinator has also proven essential for providing direction, coherence, and consistency among the five country programmes.

Some areas where the multi-country approach has not been as efficient as anticipated is occasional country resistance to regional guidelines. This has been the case for the guidelines/manual on SRHR core competencies and training curricula (Output 2), where countries prefer their own national guidelines. This is also the case for the Peer Education Training Manual (Output 8.1-3), with countries preferring manuals based on local context and using local language as needed.

### **D. Relevance – Extent to which the objectives remain relevant to population needs (esp. young people and marginalised groups) and are aligned with government priorities and broader UNFPA strategies.**

#### **1. Relevance to young people, marginalised groups, gender equality**

The PRSRHP proposal states a clear focus on reaching young people and marginalized groups. This commitment to these target populations—especially young people--is clear through the multiple activities, outputs and outcomes geared specifically toward them. While there is no clear definition of young people in Programme documents, four indicators reflect the age group of 15-24. Justifiably, however, IPs are unaware of what specific age groups they should be targeting and reporting on. Countries' own national definitions of youth can vary significantly, and even go up to age 35. The UN and IPPF definition of 10-24 isn't mentioned in the Programme design. Clarity is needed to ensure that programmes are targeting, reaching, counting, and reporting the correct age groups. If it is flexible, this should be stated, negotiated, and measured accordingly. With the goal of reducing adolescent fertility, which is among 15-19 year-olds, one might assume that this is age group (and younger) is a priority; however, this was not expressed by any stakeholders.

Marginalised groups are to be included in a significant number of Programme activities as well. They are defined in the proposal, though not particularly obviously, as sex workers, men who have sex with men (MSM), and transgender people (pg. 53). At some point, “marginalized groups” terminology was changed to “key populations” in the RF, to align with global definitions.<sup>15</sup> However, global/UNAIDS definitions of key populations includes the additional vulnerable sub-populations of prisoners and intravenous drug users, which are not mentioned by the original Programme. It is not clear if UNFPA PSRO intended to *expand* the PRSRHP work to this target population, or if it was a wording change.

Neither MFAT nor the IPs have been formally informed of the terminology change, nor has a clear definition been articulated. If it is open to interpretation and up to countries to define, this needs to be communicated. The wording in related indicators needs to be made more clear and consistent, as key populations and marginalised groups are used interchangeably. Interviews with stakeholders revealed that there is almost no awareness of any Programme focus at all on marginalized groups, let alone the specific ones identified. Many guesses were made, including the disabled, those living in remote islands, the poor, incarcerated, elderly, etc.

A key Programme output was accomplished in 2016, in that the three planned “Mapping and Behavioral Study: HIV & STI Risk Vulnerability among Key Populations” were all completed. These included a focus on seafarers as well. Apart from this important accomplishment, very few PRSRHP activities are currently being carried out that specifically target key populations/marginalized groups. This reflects not only a weak programme design, but confusion and poor programme communication. It appears that the Programme is underestimating the importance of clearly identifying, defining, and then building a programme around reaching very specific target populations. Ultimately it may also reflect a sentiment on the part of the IPs and stakeholders that this particular aspect of the Programme is not important and/or not relevant.

## **2. Alignment with global & regional frameworks & NZ MFAT**

Overall, stakeholders felt that the Programme is aligned with relevant global, regional, and NZ MFAT frameworks. Of primary importance to stakeholders is alignment with the SDGs, which is strong—particularly in reducing adolescent births, maternal mortality, HIV, and unmet need for FP, as well as increased births attended by a skilled provider and improved MCH & RH services. In addition, the SDGs focus on increased protocols for discrimination-free SRH, which is included in the Programme design and several outputs related to updated policies and guidelines. UNFPA has strong processes in place to ensure that PRSRHP, and other programmes, are developed in alignment with the Millennium Development Goals (MDGs), the UNFPA Global Strategic Plan for 2014-2017, the UNDAF for the Pacific for 2013-2017, and the New Zealand Aid Programme Strategic Plan for 2015-2019. PRSRHP is aligned with Pacific regional declarations such as Moana, Yanuca Island, and Kaila. PRSRHP is well aligned with the four components of the UNFPA PSRO’s MCP5: 1) family planning; 2) gender equality and reproductive rights; 3) young people’s sexual and reproductive health; and 4) population data availability and analysis.

The New Zealand Aid Programme Strategic Plan for 2015-2019 was considered in the Programme design and is aligned as well. NZ MFAT’s aid investment priorities in the area of health include the following: enhance maternal health by increasing access to modern contraception, reproductive health services, and better nutrition for pregnant women.

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<sup>15</sup> Per Coordinator: UNAIDS definition for key populations includes sex workers, MSM, trans, prisoners and IVD users. UNAIDS has advised that marginalised or vulnerable groups (those not fully able to participate in society, making them more vulnerable to HIV infection) not be mixed with key populations. UN OHCHR labels marginalised groups to include persons with disabilities, youth, women, lesbian, gay, bisexual, transgender and intersex people, members of minority groups, indigenous people, internally displaced persons, and non-national, including refugees, asylum seekers and migrant workers.

### 3. Alignment with national policies

IPs and stakeholders at the national level consistently expressed their commitment to ensuring the Programme and their corresponding UNFPA WPs are aligned with their individual national policies and strategies, knowing that it should, in fact, be driven by these. They consistently expressed their assessment that the Programme is successful in this regard. A strength of UNFPA is the importance it places on aligning Agency strategies and multi-country work plans with national plans.

## II. STRATEGIC POSITIONING

### A. **Responsiveness – Ability of the Office to respond to changes/requests from national counterparts and shifts caused by external factors.**

Perhaps the most significant “shift” impacting the in-country Programme to date was Cyclone Pam in Vanuatu in March 2015. Most of the health facilities were destroyed, crippling SRH services for some time as the country responded to the crisis and rebuilt its infrastructure. The Programme was impacted in terms of delayed implementation, reprogramming of funds, staff shortages and burn-out, delayed capacity-building among fixed staff, and more. It is not clear as to how soon, or to what extent, the Vanuatu IP communicated to PSRO any need to revise PRSRHP activities. MOH allocations were used to support Cyclone Pam health service restoration, as emergency funds take precedence over programme funds unless requested for re-programming. If funds were indeed re-programmed, it would be important to document the process and apply any lessons learned to some type of policy and procedures document to prepare for future events such as this.

The occurrence of Cyclone Winston in Fiji in 2016 was also a significant event for PSRO, as it consumed key staff for several months in that year.

There appear to be a few upcoming national shifts that would potentially impact PRSRHP in countries, including Samoa’s plans to re-unite the MOH and the National Health Services. While this has been announced, the rollout plan and timeframe is undefined as yet. In addition, Samoa Family Health Association has recently received significant DFAT bilateral funding that will greatly expand their work and impact across the country. In addition, MFAT has committed bilateral funds to support CSE in Samoa.

The implementation of RMNCAH in June 2015 in Kiribati, Solomon Islands, and Vanuatu had an impact PRSRHP in those countries, as PRSRHP was integrated into the RMNCAH plans and budgets primarily in the area of adolescent health. For the first budget year, both UNFPA core and PRSRHP funds were included in the RMNCAH plans. For the second year, only PRSRHP funds were included, and no core, due to the following: RMNCAH budgets were considered as being sufficient and RMNCAH spending was considered priority; low implementation rates; and UNFPA core funding cuts. In this way, PRSRHP adapted well to the addition of the RMNCAH programme. An additional consequence of the inclusion of PRSRHP into RMNCAH, however, is less visibility—both in terms of its recognition as a separate programme, and in terms of specifically where it fits within overall RMNCAH budgets. It is difficult to understand the distinctions between UNFPA core funds, “other” funds, and MFAT funds, and their relationship to the UNJP joint funding budget columns of the three RMNCAH programmes.

UNFPA has recently created a new 6<sup>th</sup> cycle Multi-Country Plan – the MCP6 (2018-22) – which includes PRSRHP and places a new focus on “upstream development support.” This will include policy development and advocacy, knowledge management and capacity development. Lesser emphasis will be placed on service provision and community-based initiatives. Since the PRSRHP already includes a number of these upstream activities, it appears poised to adequately address this new focus. Reducing service provision and community-based initiatives, however, would have to be negotiated with MFAT,

as the main goals of the Programme cannot be reached without actual services being provided to the target populations. Perhaps UNFPA's approach and role in service provision could and should be adjusted, however, as Programme results in this aspect are not particularly strong to date.

Perhaps the most significant shift affecting the Programme is the reduction in UNFPA core funds. The potential impact is explained below in a communication from UNFPA to MFAT:

“The reduction of UNFPA's core resource has been identified as a high and immediate organisation risk, as it has happened and it will have profound effect on the programme's effectiveness and ability to achieve results. UNFPA has had a dramatic reduction of its core resources.... As the effects are immediate, the agency and the Pacific PSRO will not have a chance to buffer the change. This means reducing staff size and / or closing a number of field offices, so that programme support to countries is not affected. Although operation cost has been factored into current resource mobilisation efforts and discussions, this will take some time to eventuate... Inability to deal with the issue now will affect PRSRHP programme effectiveness and ability to achieve results. The lack of a field office and relevant staff will affect programme delivery in a number of ways. Lack of close monitoring and on the ground support would lead to less programme implementation and a higher risk of programme resource abuse and misuse. This also means a limited ability to monitor subtle and rapid change in national development environment which can affect programme success and relevance...UNFPA is currently increasing its attention on resource mobilisation efforts to respond to this challenge. Recently the agency was involved in high level consultations with the Australian and New Zealand governments individually...UNFPA emphasis in all current and future resource mobilisation activity will also propose an increasing allocation towards operational costs.“

While the consultant does not have any visibility on these developments and conversations, it is important to remember the critical role that UNFPA plays in assisting countries with their supplies of family planning commodities. PSRO reports that countries are being encouraged to make a transition into the provision of commodities from their national budgets, and a transition strategy is currently in the process of being discussed with countries. Some combination of government procurement and continued UNFPA support will be critically important to develop and maintain.

**B. Coordination & Added Value – Extent to which Programme, through UNFPA PSRO, has been an active, contributing member of the existing regional and national coordination mechanisms and has given synergy and added benefit to other programs.**

**1. Coordination with IPPF SROP and MAs**

As mentioned earlier, there has been confusion about the role and expectations of SROP and the MAs in the PRSRHP, as well as their relationships to the IPs. As MAs are SRs of governments, and their work is based on WPs signed by the MOH and UNFPA, there was confusion about whose role it was to monitor MA activities. It has since been clarified that IPPF SROP has funding support from PRSRHP to do so as part of their routine monitoring. However, governments will also monitor PRSRHP activities as part of their LOU signed with UNFPA. In reality, to date, there has not been significant, regular communication between SROP and PSRO. Only recently (2017) have monthly meetings begun. At the country level, however, it appears that the PRSRHP has contributed to stronger MA participation in local health/SRH/coordination committees.

In the RMNCAH country of Solomon Islands, there is current discussion between RMNCAH and NGOs, including IPPF, to move toward being on the government plan/MOH annual operating plan. As separate entities, they are not currently on the government's plan, budget, nor system, but discussions have begun.

**2. Coordination with other UN agencies and RMNCAH**

In non-RMNCAH countries, there has been very little awareness as to what the other UN agencies are

contributing specifically to the PRSRHP. In Tonga, UNICEF was not included in the PRSRHP stakeholder list and therefore no interviews were set up with UNICEF representatives. In Samoa, the FO was not aware that UNICEF is charged with the creation of IEC materials for aspects of PRSRHP. UNDP/Global Fund was not aware that the PRSRHP outputs include targeting marginalised groups for greater access to condoms and peer-based condom distribution programmes. The only UN agency allowed to represent the UN at Samoa's high-level Health Programme Advisory Committee is the WHO, to date, WHO has not played that representative role. The newly formed (late 2016) "One UN Health Group" in Samoa should aid in communication and mutual representation between the UN agencies.

In the three RMNCAH UNJP countries, there appears to be strong communication and coordination between the three UN agencies of UNFPA, UNICEF, and WHO. In addition, other UN programmes, such as UN Women, are part of the coordination and some joint programming efforts. In RMNCAH UNJP countries, there has been some concern that the UN agencies that are *not* the RMNCAH managing agency have lost some of their visibility. Concern was also expressed that the managing agency can sometimes get recognition for UNFPA/PRSRHP achievements. In addition, RMNCAH can be perceived by others as the UN managing agency's programme. The most significant coordination challenge, however, is harmonisation of the three UN agencies' funding disbursement systems. While UNFPA and UNICEF systems are similar, WHO operates with a separate system. All three have their own agency differences in terms of timeframes, flexibility, procurement rules and procedures, paperwork, etc. Interviews with IPs and SRs reflected a significant level of frustration regarding the amount of time it continues to take to learn new systems, correct errors, and wait for the multiple stages to be completed and advanced.

### **3. Coordination with other development partners in the Pacific Region**

The consultant interviewed MFAT and DFAT representatives both regionally and in each of the five countries. As mentioned earlier, communication is minimal between in-country PRSRHP and these bilateral donors, so they are generally not experiencing the coordination role of UNFPA/PRSRHP. Neither MFAT nor DFAT were knowledgeable about the PRSRHP beyond the basic concept, and some were aware that it is part of RMNCAH (where applicable). PRSRHP reports are occasionally shared, and both MFAT and DFAT expressed a desire for greater communication with PRSRHP/UNFPA. PSRO points out that MFAT can share PRSRHP reports with their country posts once the reports are cleared.

DFAT and MFAT posts expressed that they have a level of local knowledge, relationships, and expertise that could be of value to regional programs such as PRSRHP. There was interest in donor partners working more closely together on common programmes and to fill in gaps. There was interest in receiving quarterly reports, as well as participating in NCCs or annual committee meetings. They cautioned, however, that they do not have the staffing to participate very intensely. There was also interest in having PRSRHP/UNFPA participate in additional health-related partnership committees that they are currently not part of. It is important to note, because PRSRHP is MFAT-funded, that some country stakeholders mistakenly, but understandably, assume the local MFAT staffs can and do represent the Programme at partnership meetings. It is clear, however, that bilateral MFAT staffs are not in a position to represent regional MFAT programmes. Regarding DFAT, stronger local coordination is especially important, since it is funding significant health system strengthening work that dovetails with PRSRHP.

### **4. Contributions of PRSRHP Steering Committee and NCC to coordination with RMNCAH & similar/bilateral programs**

A much greater role for the Regional PRSRHP Steering Committee was anticipated than has been realised. The plan was twice yearly and potentially additional ad hoc meetings, as well as Steering Committee responsibility for overall coordination, planning, oversight, and contributions to producing

the annual report. Current practice is an annual Steering Committee meeting, and the majority of the responsibility of ongoing coordination, planning, oversight and reporting conducted by the Programme Coordinator and FOs.

The role of the NCC was also planned to be more significant than it is in current practice. It was intended that the NCCs (or other pre-established SRH committees) would be responsible to review proposals and develop annual work plans that are consistent with national policies and complementary to other SRHR, HIV and youth-focussed initiatives. It was also intended that each country would produce a programme report every 6 months through the NCC, with support from the “National Coordinator” (per proposal). While the title of National Coordinator was never mentioned during the MTR process, the in-country UNFPA FOs play this role.

In Samoa and Tonga (the two non-RMNCAH countries), the SRH Stakeholders’ Committees/NCCs meet less than quarterly. In Samoa, for example, because the MOF Aid Coordination Office IP is not taking a leadership role, there is no clarity as to what entity should or is taking the NCC leadership/convening role. The FO is not invited to participate in the Committee. Therefore, the FO’s implementation, governance, coordination, and monitoring roles are severely compromised. Neither is the FO invited to the higher-level Health Programme Advisory Committee. The assumption is that either MFAT or WHO--the single UN agency allowed--is representing UNFPA, which is not the case. In Tonga, the National SRH Committee, established in 2015, has not been meeting quarterly as intended, due to several factors: lack of TORs, a chairperson who is too high level to convene it, and confusion as to whose role it is to coordinate and convene it (FO? Secretary?). There is a separate Task Force, however, for validating WPs.

In the three RMNCAH countries, NCCs were absorbed into RMNCAH Committees. The RMNCAH Committees are active, with regular monthly meetings that include a range of participating stakeholders. Partners expressed that they value these meetings as a way to learn about each other, to coordinate activities, to get updates on progress, and to identify and fill gaps in the range of health services and target populations that RMNCAH addresses. PRSRHP/UNFPA is well recognised as the component that addresses adolescent SRH.

## **5. Overlaps and/or potential for complementarity?**

Because DFAT is involved in bilateral health sector support in each of the five countries, including health system strengthening, there appears to be some overlap in some of the work that pertains to HIS (DHIS2 piloting and expansion), demographic health surveys, gender-based violence (GBV), and support to IPPF MA service delivery. WHO also seems to be involved in HIS work, and it is not clear as to what the relationship or coordination is between PRSRHP and WHO in addressing Output 12 and indicator #47--“national health information system assessment and strengthening to include SRH.” It appears that some complementary work is developing around gender work between UN Women and UNFPA. The consultant did note overlap in Vanuatu, with UNDP’s MDG Acceleration Framework program (ended in 2016), which was working on the same adolescent reproductive health goals as PRSRHP. It was noted that an “SRHR Needs Assessment” was conducted for this programme within months of the PRSRHP SRHR Needs Assessment.

The consultant was unable to assess any overlap or opportunities for complementarity with other regional organisations. The UN currently chairs the UN Interagency Working Group on Youth, which includes the Secretariat for the Pacific Community (SPC). UNFPA may want to further explore complementarity with other organisations such as Pacific Women Shaping Pacific Development, Save the Children, and New Zealand Family Planning, as they all have a role to play in SRHR in the region and were all mentioned at some point during MTR interviews. The PRSRHP proposal indicated planned collaboration with the Pacific Youth Council (part of the SPC), including representation on the Regional Steering Committee, however participation appears to be minimal.

## 6. Added value to and/or affected MCP5, RMNCAH, similar/bilateral programs?

### a. MCP5:

The consultant echoes the assessment of the February 2017 MCP5 Review regarding UNFPA/PRSRHP's impact on the MCP5 regarding the target population:

“UNFPA interventions targeted **vulnerable and marginalized groups** and engaged with influencing groups, however, there has been no appreciable reduction of unmet family planning needs, sexually transmitted infections and adolescent pregnancies in many countries. To promote needed changes, more focus was required on people living in remote and rural areas, and key populations who face discrimination due to their sexual identities. The strong connections between working toward gender equality as critical to realizing sexual and reproductive rights (UNFPA strategic plan bullseye) are not sufficiently highlighted. Greater attention was important to incorporate gender equality messages and involve men and boys to prevent violence against women and promote condom usage.” (pg. xi)

Regarding PRSRHP/UNFPA's contribution to the MCP5's youth focus:

“UNFPA has contributed to increasing national capacities to deliver high quality **sexual and reproductive health services for young people**, however, comprehensive youth policies are missing in most countries. UNFPA effectively contributed to the knowledge base through Youth Friendly Health Services assessments, while joint UN programmes have connecting national health and NGO systems targeting youth. Five targeted countries have successfully implemented at least two programmes to prevent sexually transmitted infections, however, the reduction of the adolescent fertility rate is not on track.” (pg. xi)

“...Effective **peer education networks** have increased their coverage, however, there is still a shortage of educators in rural areas and high attrition rates. UNFPA has contributed toward increasing supply and demand for **Youth Friendly Health Services**, however, limited government commitment, funding and adherence to international standards put sustainability in question. Youth Friendly facilities provided by NGOs attract greater numbers of youth while joint task forces and memorandums are helping to integrate efforts with government health systems. The integration of critical rights based and gender equality messages needs to be ensured for all interventions targeting adolescents and youth (pg. xii).

### b. RMNCAH:

PRSRHP is particularly recognised and valued by RMNCAH partners for its youth SRH focus and for filling that gap in the RMNCAH programme. Youth friendly service work, peer education, and family life education/CSE especially add value. PRSRHP is also valued for its contributions to increased training and access to family planning, particularly through the Jadelle programmes.

Strengths and benefits of the collaboration between PRSRHP and RMNCAH identified include:

- Complementarity of programmes and filling in gaps to cover the full range of RMNCAH
- Co-funding, better programme integration, and reduced duplication
- More coordinated and cost-saving TA, monitoring, trainings, etc.
- Greater awareness, knowledge, discussion and coordination between stakeholders
- Consolidated, unified WPs providing clear documentation of which activities are supported by which entities
- Greater visibility on the RMNCAH programme's contribution to national health plans and outcomes
- Shared responsibility and commitment to overall health goals vs. own “territory”
- RMNCAH's strengthening of Provincial staffing, planning, coordination, and/or implementation capacity
- RMNCAH's funding of additional staffs to carry out and/or support the work

Challenges and disadvantages identified include:

- Incompatible and lengthy financial transaction processes requiring time to learn and correct errors, as well as delayed funding
- Burden of RMNCAH workload of additional planning, coordination, activities, financial tracking, and reporting, on the same limited MOH and SR staffs, with little to no additional capacity support
- Loss of individual agency and/or programme visibility and recognition
- Less control over funds and funding decisions
- Unequal and dominant representation of RMNCAH lead agency
- Lack of, and challenges to RMNCAH indicators

It is important to note from the comments above that there are two aspects to the RMNCAH programme: the aspect of creating a coordinated and unified national plan and budget covering the range of reproductive through adolescent health needs (RMNCAH); and the aspect of the UN agencies jointly administering the Programme (UNJP). There is broad support for the benefits of the coordinated RMNCAH plans and budgets, while concerns remain about the challenges presented by the UNJP aspect.

**c. Bilateral Programmes:**

Because MFAT has very little health-related bilateral work, the PRSRHP plays an important role in filling this space in the five countries. However, as discussed earlier, the lack of communication and coordination between the bilateral programs and PRSRHP/UNFPA has meant that the added value, to date, has been limited. DFAT bilateral work is aligned with several aspects of the PRSRHP, but again, the communication and coordination is so minimal that the effect is not measurable. Even in regional DFAT-funded RMNCAH countries, the bilateral DFAT health programmes are not routinely included in the RMNCAH plans and budgets, except for perhaps in Solomon Islands.

## Conclusions

### **PRSRHP needs a clearer identity as a Programme; a more pro-active programme management approach would likely produce stronger results.**

While the proposal document describes a well-developed PRSRHP programme and programme management structure, the UNFPA approach has been somewhat different. The management structure described in the proposal indicates that PSRO is responsible for overall coordination and management of the Programme, as well as for monitoring the implementation of the various components. This is done through various PSRO leadership, administrative, and TA staffs, a PRSRHP Coordinator at the regional level, five UNFPA FOs at the country level. Their roles are to facilitate and support PRSRHP implementation, governance, coordination, monitoring, and reporting. The Programme has a theory of change, results framework, work plan, budget, M&E plan, governance structures, reporting mechanisms, a regional PRSRHP Steering Committee, and 5 country NCCs to support the implementation and management of the Programme by UNFPA.

The UNFPA approach focusses more on the positioning of the Programme within the Agency's work of supporting the ongoing plans and commitments of MCP5, UNDAF, and others. It places more emphasis on the role of the government IPs to execute UNFPA-supported activities in alignment with their national plans and processes. Rather than PRSRHP being a distinct "stand-alone programme," it acts more as a collection of activities within a particular funding stream. These activities are carried out by Government IPs, their sub-recipient partners, UNFPA PSRO, and other UN agencies. Because it is government implemented, UNFPA has relinquished a certain level of control that might otherwise be expected of an entity fully responsible for programme implementation, management, and outcomes. The result is that leadership and accountability is diluted, and therefore outputs and outcomes are struggling to meet expectation.

If UNFPA has a strong commitment to meeting the specific set of PRSRHP outcomes within the context of this Programme, UNFPA will need to take a more pro-active approach to leading and managing the Programme, and holding IPs accountable for meeting expectations. If UNFPA prioritises its focus on supporting government's ability to address the issues that the PRSRHP targets, UNFPA will need to re-work the Programme description, theory of change, results framework, and management systems to better reflect the flexibility of the model. It will need to articulate its focus on investing in capacity building, strengthening the policy environment, meeting broader UNFPA commitments, and working toward sustainability.

### **PRSRHP is making progress toward several outcome goals.**

After a delayed start, the PRSRHP has begun to make progress toward its three long-term outcome goals. The following indicators are achieved or on track, supporting progress in the 3 outcome areas:

- 1) Improved provision of clinical services for SRH
  - #15 - % selected SDPs with no stock outs of contraceptives in last 6 months<sup>16</sup>
  - #16 - National authorities adapted/implemented FP protocols that meet human rights standards<sup>17</sup>
  - #23 - SRHR Needs Assessment completed
  - #27 - % selected SDPs offering at least 3 critical SRH services – ANC, FP, STIs<sup>18</sup>
  - #31 - # female condoms distributed<sup>19</sup>
- 2) Improved community education and health promotion for SRH
  - #40 – Key population estimates established (in 3 of 3 countries, as planned)

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<sup>16</sup> This is true at Central level and not SDP level and therefore should read, "no stock outs at *Central* level."

<sup>17</sup> Achieved prior to Programme start in 4 of 5 countries.

<sup>18</sup> Current levels achieved prior to Programme start in all 5 countries.

<sup>19</sup> From *Central* level.

- #41 – Key population strategic analysis conducted (in 3 of 3 countries, as planned)
- 3) Improved enabling environment for SRH
  - #20 – SRH advocacy activities led/supported religious/community leaders
  - #21 – Updated evidence-based national health policy that reflects RH and HIV<sup>20</sup>
  - #42 – SRH stakeholder analysis completed<sup>21</sup>
  - #45 – Community leaders/gatekeepers and religious leaders trained
  - #46 - Technical support provided for SRH/HIV inclusion completed and implemented

**Key indicators that most directly impact the target population show mixed results.**

Key indicators have been identified by the consultant, grouped by 1) those that reflect *direct* impact on the target population in terms of being reached with clinical or educational services; and 2) those that reflect an *indirect* impact but significantly contribute to the provision of services/education (note that 3 of these can also be viewed as direct impact if PEs, Sports Champions, and community leaders are also viewed as Programme beneficiaries). A review of these indicators shows mixed results:

- 1) Direct impact on the target population
  - #9 – Number of young people accessing SRH services at health facilities  
Results: 3 countries show zero results and 2 countries are on track
  - #19 – Number of young people and/or key populations reached by PEs  
Results: Zero progress in 1 country, some progress in 2, and adequate progress in 2
- 2) Indirect impact with significant contribution to provision of services/education
  - #34 – Number PEs trained in SRHR (PEs can also be viewed as beneficiaries)  
Results: 1 country no data, 1 country 9%, 1 on track, 2 greatly exceeded targets
  - #39 – Number SRH Sports Champions trained (can also be viewed as beneficiaries)  
Results: 4 countries show zero results; 1 country exceeded target
  - #45 – Number community leaders/gate keepers/religious leaders trained (also beneficiaries)  
Results: 1 country shows zero results; 2 on track; 2 greatly exceeded targets
  - #18/36 – Number of primary and secondary schools providing comprehensive sexuality education  
Results: All 5 countries show zero results (although there is activity in all countries)
  - #27 – Number of SDPs offering at least 3 critical SRH services  
Results: All 5 countries are at 75% - 100% achieved
  - #28 - Percent select SDPs offering YFHS  
Results: 1 country no data, 3 countries lag (3%, 9%, 28%), and one country is on track

Given the volume of indicators and an absence of clear work streams, the Programme needs to identify, prioritise, and closely monitor a subset of key indicators. These indicators need to *drive* the programme, rather than be treated simply as “results” to be noted at year-end or project-end. More consistent progress toward all of these key indicators is needed for the Programme to succeed.

**Scope of Programme is too broad.**

The PRSRHP is a very large collection of broad activities. It lacks the cohesion, continuity, and management elements required for a programme to reach such wide-ranging goals. As a collection of activities, the scope is too broad for the resources allocated. The range of service delivery and policy level activities, the scope of topic areas, and the target populations are too broad to be addressed effectively.

Considering the actors and implementing arrangements currently in place, UNFPA would do well to concentrate its efforts on the most relevant policy level activities and carry them through more thoroughly. UNFPA needs to go further--beyond updating policies, guidelines, and trainings—to ensure

<sup>20</sup> Was achieved prior to Programme start in 3 of the 5 countries.

<sup>21</sup> Note that FOs were not aware of this indicator, nor that it was completed, nor how it was completed.

they are fully understood, embraced, and *operationalised* by MOH and SRH service providers. Otherwise these upper level policy efforts will not result in improvements to people's SRH. The consultant does not recommend that UNFPA continue to add new assessments,<sup>22</sup> as the current ones have not gotten the time and attention they need to make an impact. Also, the Programme needs to determine whether it wants to focus on strengthening public or private sector SRH service delivery and invest accordingly, as currently the attention is split and not producing results. The Programme is spread too thin to reach the number of youth needed to create an impact. The stated inclusion of key/marginalised populations is not getting enough attention to be effective, and should be reconsidered.

### **Funding ad hoc activities is ineffective.**

Because funding is activity based and comes to implementers in "starts and stops," activities are conducted on an ad hoc basis. Consequently, there are no ongoing PRSRHP efforts that run consistently from month to month and year to year. This lack of continuity seriously impedes both Programme effectiveness and efficiency. Making improvements to people's SRHR requires consistent and ongoing education, service provision, access, and supplies. The skills of policy makers, managers, clinicians, peer educators, teachers, and community leaders require consistent attention in order to build both quality and quantity of service delivery. The Programme needs to fund more interventions that can last, uninterrupted, for the duration of the Programme. This includes consideration of funding implementing partner and/or embedded staff positions to carry them out. Although this might go against some of the sustainability principles of the current approach, it is currently being shown that ad hoc funding does not sustain activities either--funding positions, or partial positions, does not create less sustainability than the model in place. Current managers are too overburdened/understaffed to be effective, and as it is now, PRSRHP activities come to a stop when funding is delayed/stops. If the current model is designed to support the sustainability of work that has additional sources of funding, then the current suspension of activities by implementers needs to be examined with an eye toward increasing ownership and commitment.

### **More focus on outcomes is needed.**

The Programme theory of change and results framework focus heavily on *outputs* and not enough on *outcomes*. In order to realise the changes sought in improving people's SRHR, more attention must be paid to reaching and influencing the behaviour of greater numbers of people. Outcomes need to measure increased numbers of the target population preventing unintended pregnancies by using contraceptives. Outcomes need to measure increased numbers of youth using HIV/STI prevention methods. While outreach and education, clinical service provision, access to quality care, readily available reproductive health commodities, and the enabling environment all need to be strengthened, these efforts must result in more people using them effectively in order to make an impact. The Programme has an adequate 5-year timespan and needs to refocus on people-centred outcomes. A refocused/revised theory of change and RF needs to be organized into practical and meaningful work streams or spheres of influence. Stakeholders need to see the connections between their activities and outputs, and how these lead to outcomes and impact. Not only is visibility on this severely lacking, but the theory of change and RF as the *driver* of change, particularly in the process of creating WPs, is nearly non-existent and greatly needed.

### **Many indicators are misrepresentative or not reliable.**

It is difficult to assess the Programme's progress or lack of progress based on the set of indicators as currently written, measured, and reported. A variety of factors compromise their integrity, principally that they are not written precisely enough to be interpreted and reported correctly. In addition, all indicators intended to represent numbers of *individual people* served by clinics or reached by PEs are unreliable, because the reality on the ground is that currently no entity reports numbers of unduplicated

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<sup>22</sup> Such as the SRH/HIV/NCD integration assessment planned for 2017/18

clients/people; rather, they count numbers of visits/contacts. Therefore, the reported numbers over-represent the number of people because many—especially clinic clients--are seen more than once in the course of a year. Some indicators seek unquantifiable “updates” or “integration” and results are reported as “some.” Some indicators misrepresent the service delivery level as SDP when it is actually central level. Several indicators, as written, appear to have been achieved at baseline. And finally, sometimes indicators have no data, but interviews on the ground reported progress, revealing gaps in reporting. For these reasons and more, it is not possible to accurately assess the Programme based on the current condition of the RF.

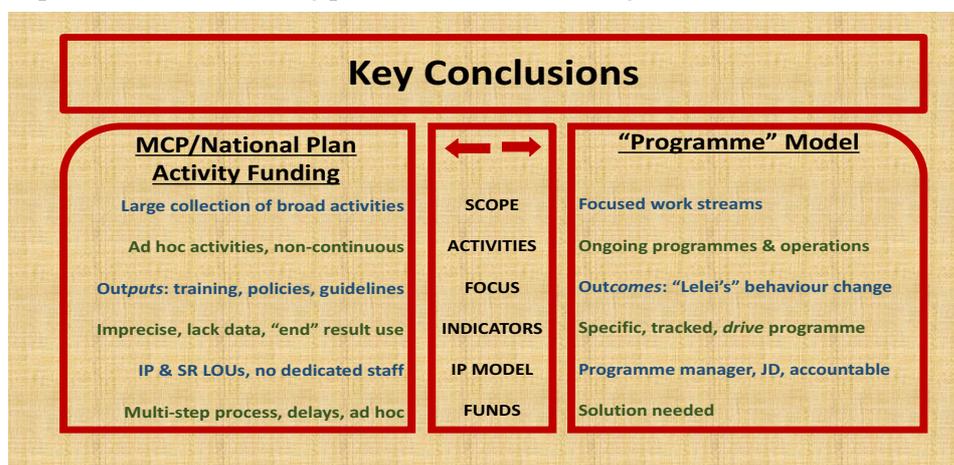
**The implementation model is not effective.**

The implementation model of the MOH as the single IP in each country, responsible for successful SR arrangements, is not working effectively. In some countries more than others, these IPs have not exhibited the professional and technical competence and level of effort required to fulfil their expected roles in delivering and overseeing high-quality, efficient, cost-effective programmes. They have not provided speedy funding disbursement processes. They have not provided sufficient oversight to SRs to enable and ensure their effectiveness. Neither has the UNFPA exhibited sufficient success in providing the “continuous performance monitoring and periodic implementation adjustments” needed. UNFPA will need to reconsider the single IP model and craft implementation arrangements that are the most effective possible to produce better SRHR results in each country. PRSRHP-specific documents are needed to clarify IP’s roles and responsibilities and ensure an understanding and commitment to them. There needs to be an in-country actor/position/entity that takes responsibility and accountability for the Programme. If stronger day-to-day support and capacity building of IPs is required for this model to be successful, then it needs to be a significant component of the Programme and its theory of change and RF, including appropriate capacity building output and outcome indicators.

**The current funding disbursement modalities are not working.**

The most serious implementation inefficiency and impediment to Programme success, by far, is the failure of the funding disbursement process. Delays experienced by implementers in receiving advance PRSRHP funds to carry out planned activities are crippling. A sampling of quarters reveals that timespans from date of fund request to date of receipt averaged 5-6 weeks in 2015 and 2016. This results in 4-6 months of lost activity implementation time each year. In 2017, the situation took a turn for the worst, with none of the five IPPF MAs receiving any Programme funds to date, and four of the 5 MOH IPs not receiving any funds to date. There are multiple causes for these delays, which would best be described based on the recent 2017 audit findings. Causes identified through interviews include individual country MOF and MOH processes, human resources/staffing structures, capacity, and motivation, as well as complicated UN policies and procedures and regulations. Given the reality of the delays, it is no wonder that implementation rates are low. And it is no wonder that Programme quality and outputs suffer. The level of risk analysis and mitigation conducted by UNFPA over the years has not prevented these funding problems from continuing. The alternative mechanisms of direct payment

and reimbursement are not viewed or experienced by IPs and SRs as viable solutions in the long-run. A solution needs to be put into place, immediately, to correct this implementation failure.



# Recommendations

## A. Programme Effectiveness

### UNFPA PSRO with MFAT:

1. **Align scale with goals and resources:** Examine the scale of the Programme to determine if targets are both resourced and set at a level that will reach enough of the target population to make the desired impact. Particularly consider numbers of youth and marginalized groups to be reached, numbers of PEs and healthcare workers, and numbers of SDPs. If resources are not sufficient to align with the scale needed, consider narrowing the focus and targeting strategies that will have the highest impact.

### UNFPA PSRO:

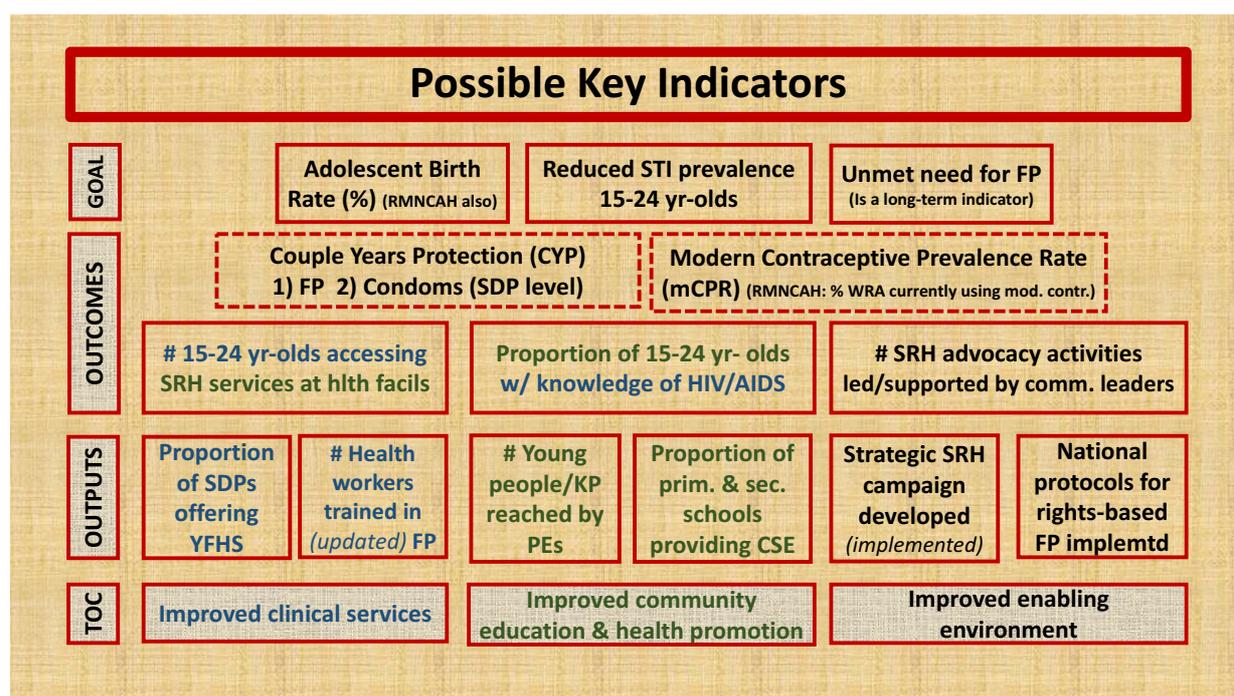
2. **Track M&E and Coordination/Governance:** Revise, track and report (in the RF) more meaningful indicators to capture important M&E and Coordination/Governance outcomes, including potential capacity building outcomes. The current list of outputs is not sufficient to ensure that these elements are sufficiently rigorous and producing results.
3. **Monitor cumulative progress: Create a template for monitoring cumulative PRSRHP progress over time, so that stakeholders at the country level and the PSRO and MFAT can monitor progress on an on-going basis.** RF and narrative reporting should correspond to each other and to the grant year (vs. calendar year) to the greatest extent possible.
4. **Create clarity and guidelines on what results can/cannot be credited to Programme funds.** Determine what activity funding levels are legitimately linked with reported activity results. Determine which SRH service and client numbers can be associated with different levels of Programme support provided to those SDPs (rent, healthcare worker training, refurbishment, PE activity at the SDP, etc.). Ensure that MA service numbers included in MOH reports are not double-counted.
5. **Identify a set of key performance indicators:** Identify, prioritise, and closely monitor a subset of key indicators that have the greatest impact on Programme success. Monitor them on a quarterly basis, at both the country level and PSRO level, and use them to *drive* the Programme. Ensure that these key indicators are aligned with RMNCAH indicators (only if current RMNCAH indicators are revised/strengthened). (See Annex 10 for an inventory of potential indicators recently generated by UNFPA PSRO.)

### UNFPA PSRO with Implementing Partners:

6. **Implement collection of minimum standard set of data points from all health facilities:** Ensure that all health care facilities/SDPs are collecting the following data points, at a minimum: client gender, client age, family planning method, quantity/dosage given, and whether client is a new FP user (new to *any* modern FP method, from *any* provider). Ensure that data collected can calculate Couple Years of Protection (CYP) at the SDP level.
7. **Divert some funding of ad hoc activities to more funding for ongoing programming and staff positions:** Support more programming that can last, uninterrupted, for the duration of the Programme, including full or partial staff positions to execute and manage it. Allow support to implementers and/or managers that are too overburdened and understaffed to be effective.

8. **Focus YFHS efforts on public sector SDPs:** YFHS cannot be limited to IPPF MAs to deliver. Target select public sector SDPs for this important aspect of the Programme. Focus efforts on healthcare worker training (particularly SRHR rights, confidentiality, values clarification) and operationalizing these trainings, and less on facility refurbishment. Ensure that there is a YFHS checklist and scoring system to determine if an SDP is indeed (quantifiably) youth-friendly or not, or allow a scale. Ensure that all SDPs that claim to be youth-friendly are reporting numbers of young people 15-24 served.
9. **Ensure that Peer Education programmes are to scale and supported year-round:** Align number of PEs trained with numbers of young people/key populations to be reached by PEs. Apply a standard definition of what it means to be a trained PE. Distinguish between newly trained PEs and re-training. Develop and strengthen components of the PE programmes that will effectively and efficiently utilize and retain PEs—especially those components that are low-cost and will contribute to the possibility of sustainability.
10. **Ensure that CSE efforts result in high numbers of students/youth receiving CSE:** Define what qualifies as an adequate level of CSE within school-based FLE curricula. Ensure that activities result in schools not only “providing” CSE, but that they are staffing, requiring, and delivering it in such a way that the vast majority of students are *receiving* it. Add an indicator that captures numbers of students reached. Consider adding an output indicator of numbers of teachers trained in CSE (per request of IPs from MTR presentation).

Below illustrates a possible set of key indicators (from PRSRHP MTR presentation 4 Aug. 2017):



## B. Validity of Design

### UNFPA PSRO:

1. **Revise theory of change:** Revise the theory of change so that it better reflects improved *health* rather than improved *provision* of healthcare. Include long-term outcomes pertaining to the prevention of unintended pregnancy (through increased utilization of contraception) and the

prevention of HIV/STI's (through improved knowledge, behaviours, skills, and condom use).

2. **Revise the Results Framework:** Revise the RF so that indicators are correctly classified as outputs, short-term outcomes, or long-term outcomes. Shift indicators from their *output* focus to their *outcome* focus. Add meaningful indicators to reflect the two output categories of M&E, and Project Coordination and Governance. Lay out the RF in such a way that logical sequences of activities, outputs, and outcomes can be tracked by category or “work stream.”
3. **Review, revise and define indicators:** Review indicators for alignment with current national indicators that are already in accordance with global standards/definitions, or take opportunity to update national indicators based on global definitions and commitments, and Pacific level commitments (Healthy Islands Indicators). Also review for alignment with MCP6 and other similar regional programmes—especially RMNCAH, DFAT, and IPPF. Once optimal indicators are selected, revise the wording to make the existing 47 indicators and/or any additional or replacement indicators S.M.A.R.T. Consult with IPPF regarding service definitions and other relevant indicator definitions. Create an accompanying document of specific definitions, descriptions, measurements, denominators, “dosage,” etc. Include examples of correct interpretations and common incorrect interpretations. Pay special attention to definitions of: SRH services; advocacy activities; YFHS (minimum components checklist); and CSE (minimum components checklist). Make sure “modern” is added to indicator when “modern contraception” is meant. Identify those indicators that are tracked on a cumulative basis and clarify. Be specific as to whether an indicator is asking to report numbers of *people* or numbers of *visits/contacts* or numbers of *services*. Adjust this according to reporting entities’ capacity to count and track unduplicated clients. Consider adding Couple Years of Protection (CYP) as an indicator (remembering that CYP is measured by contraceptives distributed to people/users at the SDP level, not at the central/warehouse level--so SDPs would have to be able to count and report this). Tighten policy-related indicators to reflect when and where updating/revision/validation/implementation is needed and how its achievement is measured. Clarify denominators and use fractions and percents rather than rates whenever appropriate (due to small PICT populations). Ensure that all actors understand and use the indicators correctly. (See Annex 10 for an inventory of potential indicators recently generated by UNFPA PSRO.)
4. **Create and distribute a set of primary PRSRHP Guiding Documents:** Compile revised TOC, RF, indicator definitions, and other guiding documents, policies, and procedures, for distribution to each FO, IP and SR to have on hand as a go-to PRSRHP handbook/tool. (This will also help with the challenges of staff turnover and loss of institutional memory.)
5. **Create, distribute, and train IPs in a standard reporting template:** This was requested during the PRSRHP MTR Validation Teleconference. IPs would like more clarity, including training, on the specific indicators and how they should be defined, measured, and reported.

#### UNFPA PSRO with Implementing Partners:

6. **Review and update/correct all baselines:** Insert correct and up-to-date baseline figures into the RF, making sure that nothing is included that reflects data collected after Programme activity/influence (i.e. July 1, 2014 or date any activity began). Educate stakeholders on the purpose, and function of baselines. Define baselines as static, from prior to Programme start, rather than allowing new annual baselines based on prior year’s performance.
7. **Review and update/correct all targets:** Review and adjust all targets. Provide rationales for increases that are easily understood (such as “10% increase each year over the prior year’s result” or “10% increase from year 1 to year 5”). This should be done by stakeholders, as they need to agree that they are achievable, and then take responsibility for meeting them.

8. **Share revised theory of change and RF with stakeholders--especially IPs and SRs:** Share with and educate stakeholders on the new user-friendly version to strengthen IP and SR ability and motivation to track progress in their spheres of influence. Create a template for stakeholders and NCCs to track progress toward goals on a quarterly and/or annual basis.
9. **Provide IPs and SRs a list of indicators from which they can choose:** Do not allow IPs and SRs to make up their own output and outcome indicators. They may create their own activity indicators, however, all of their activities should lead to and align with the pre-determined Programme outcome indicators. Ensure that indicators are included in, or attached to, WPs. Impose consequences for not reporting results.

### C. Efficiency

#### UNFPA PSRO:

1. **Remedy the problems of delayed disbursement of initial grant funds and delayed hiring of staff for future programmes, or incorporate these realities into the proposal and programme design.**
2. **Create PRSRHP-specific scopes of work or other human resources documents for FO and Coordinator positions:** Provide greater clarity on roles and responsibilities, including: IP and SR management and monitoring, WP process (including budgets, selecting indicators, setting targets), funding disbursement processes, reporting, NCCs, monitoring progress on the RF, etc.
3. **Improve tracking of PSRO TA:** To better plan, track, and assess the effectiveness of PSRO TA, explore the implementation of a technical assistance management system.
4. **Increase understanding among FOs and stakeholders as to UNICEF's role and deliverables in the Programme.** Ensure that UNICEF is participating in NCC meetings. Particular to UNICEF's IEC role, ensure that all country programmes have at least minimum, adequate, printed SRHR IEC materials widely available to youth through public and private sector activities. Add an indicator to reflect this activity and desired outcome. Further clarify UNICEF's, and other UN agencies' PRSRHP role in working with marginalised groups/key populations.
5. **Revisit the working relationship with both IPPF SROP and the MAs to clarify and solidify mutually beneficial participation in the Programme.** Problem-solve funding disbursement issues, create a more participatory work planning process, and clarify the monitoring deliverables of SROP. Institute regular meetings between SROP and PSRO. Discuss and consider adding IPPF MAs as IPs rather than SRs under the MOH.
6. **Strengthen the role of the UNFPA Field Officers:** The position of the FO needs greater authority to manage implementation and partnerships. The position needs orientation and training in UNFPA management systems and practices. It needs more decision-making power, more oversight of knowledge management, strategic planning, coordination, and implementing partner and sub-recipient accountability.
7. **Fix the funding disbursement procedures.** Current modalities (advance funds, direct payment, reimbursement) are not viable as is. Individual governments' systems need to be taken into consideration. Level of effort toward learning and correctly utilizing processes and paperwork should be proportionate to dollar amounts. Flexibility should be applied, such as: looser requirements for amounts under a certain dollar figure; staggered reconciliation so that the next time-period's advance can be received prior to reconciliation of the period immediately prior; allow less than 100% expenditure prior to release of next tranche; extend the time periods for

reconciliation from one quarter to 6 months or 1 year; increase flexibility as IPs prove themselves, etc. If flexibility options are limited, then invest in more capacity by supporting and/or embedding finance personnel in the appropriate offices/programmes. Do not rely on more of the same training or “capacity building” or motivation efforts (the idea that certain stakeholders should take it upon themselves to motivate or put pressure on those persons/entities creating delays) to solve this significant problem. Commit to a solution that can accommodate cash-based Provincial level expenditures. Commit to a solution that results in the uninterrupted flow of year-round funds (to entities passing audits).

#### **UNFPA PSRO with Implementing Partners:**

8. **Reconsider the current single IP model:** Reassess each current IPs’ capacity to act as an effective IP, based on actual past performance, and adjust implementation arrangements as necessary. Assess whether adequate PRSRHP/UNFPA resources are available to provide the capacity support required, or whether a new model is needed. Create PRSRHP-specific agreement documents for each IP that include clear roles, responsibilities, policies and procedures). Require some type of LOU/contractual document for use between IPs and SRs that reflect the expectations of both parties and the requirements of PRSRHP. Ensure that all parties involved (at both management and implementation levels) understand, agree, and take responsibility for the content of the LOUs/contractual documents.
9. **Strengthen the work planning process:** Make the process more participatory by including, at a minimum, IP and all relevant SR actors. Ensure that both management and implementation level staffs participate, understand, agree, and take responsibility for the content of the WPs. Continue to ensure that UNFPA/PRSRHP goals align with and advance country strategies and plans. Facilitate thorough examination of needs assessments (SRHR and YFHS) and population studies and analyses (key populations, community stakeholders, HIS) by stakeholders as part of the work planning process. Facilitate a thorough understanding of the PRSRHP theory of change, RF, and indicators (especially key indicators). WPs should be annual (not biennial) and should have clear sets of PRSRHP indicators attached to activities, with correct baselines and agreed upon targets and their rationale.
10. **Take greater advantage of the multi-country approach:** Provide more opportunities for cross-sharing and learning between countries. Where countries prefer a nationally tailored guideline or manual over a regional one, provide a template that includes minimum standards or essential items from which the countries can tailor their own.

#### **D. Relevance**

##### **UNFPA PSRO with MFAT and Implementing Partners:**

1. **Define “young people”:** Determine the standard age definition for “young people.” Consider 10-24; 15-19; and/or 15-24 (clarify this does not include 25). Make sure it is aligned with global, regional, and IPPF definitions to the greatest extent possible. If the target age group varies by indicator, clearly specify this. If a country is currently not able to collect data by the specified age group, start with the closest possible age range to ensure some level of reporting and tracking, until such time as they can migrate to the Programme age range definition(s) needing to be tracked.
2. **Clarify the inclusion of “marginalised groups”:** There is lack of clarity, and there fore confusion as to what populations constitute marginalised groups and/or key populations. Stakeholders need to understand and commit to including these groups in their work. UNFPA PSRO needs to clearly name this target population (“marginalised groups” or “key populations” or other name?) and provide a very clear definition, as well as how these populations should be counted. It may be

helpful to disaggregate outcomes so that young people and marginalised groups are not included in the same counts.

- 3. Increase level of focus on SRH Rights, gender equality, and gender-based violence:** While the Programme proposal speaks to addressing SRH Rights, gender equality, and gender-based violence, there are few activities and few indicators that specifically reflect these. Gender equality is to be included in SRHR-related trainings (#24), and FP protocols are to meet human rights standards including freedom from discrimination, coercion and violence (#16). In general, however, greater focus is needed on the “rights” aspect of SRHR. Consider adding activities and indicators that will ensure inclusion of this focus. (Solomon Islands requested more mention of GBV during the PRSRHP MTR Validation Teleconference.)

#### **UNFPA PSRO with Implementing Partners:**

- 4. Increase visibility on the alignment of PRSRHP indicators with SDGs and national plans.** Create a user-friendly template that demonstrates the alignment of the Programme with the frameworks most important to country stakeholders.

#### **E. Responsiveness**

##### **UNFPA PSRO with MFAT:**

- 1. Document approved changes to the regional Programme and adjust targets and expectations accordingly:** All significant programmatic changes need to be approved by the donor, documented, and communicated. This includes targets. As programme targets, timeframes, and expectations change, they can be evaluated accordingly (especially for the MTR and final evaluation).
- 2. Take stock of upcoming changes in donor prioritisations and funding decisions:** Discuss and assess the potential impacts of major known influences, such as bilateral SRHP and CSE funding to countries, decreases in UNFPA funding, the future of the RMNCAH programme, the potential impact of the MCP6, and others. MFAT and UNFPA may want to consider adjusting the PRSRHP whereby UNFPA focuses more on upper-level work with governments, and other actors focus more on service delivery level work, especially with CSOs. All effort must be made to ensure that family planning commodity availability is not compromised.
- 3. Continue to work within the RMNCAH framework:** Continue coordination with MOHs, UN agencies, and other stakeholders to sustain the comprehensive budgeting and planning approach for reproductive through adolescent health (RMNCAH). Continue to participate in national committees that work to coordinate this work. Pay special attention to ensure that the needs of adolescent SRHR are represented and not lost within the larger health agenda.

#### **F. Coordination and Added Value**

##### **UNFPA PSRO and MFAT:**

- 1. Increase communication and coordination with bilateral MFAT and DFAT partners in country:** At the PSRO level, consult with bilateral partners and solicit input and coordination opportunities whenever considering or designing a new intervention in a country. At the country-level, increase communication and coordination with MFAT, and ensure that each entity is invited to the appropriate partner committees and meetings. Examine the collaboration opportunities with DFAT in regards to supporting IPPF MAs, and DFAT’s Health Sector Support Programmes.

2. **Consider “Total Country Aid Flow Approach” for each country:** MFAT Vanuatu has been piloting this approach since mid-2016 (possibly Solomon Islands and Kiribati as well). It seeks to increase the country office’s knowledge of and involvement in all programmes in a given sector – both bilateral and regional programmes. It is based on the premise that the local post has expertise to provide relevant feedback and input in the planning, implementation, and monitoring phases of programming. The approach seeks to develop stronger relationships and communications with all relevant stakeholders, and includes provision for annual Activity Monitoring Assessments for all MFAT programmes over a certain funding level.

#### **UNFPA PSRO:**

3. **In non-RMNCAH countries, strengthen the communication and coordination between UN agencies:** Establish some type of regular joint UN meeting in country. Include a sub-group or forum for focusing health-related work, as well as one just for the UN agencies participating in PRSRHP work (UNICEF and UNDP and possibly WHO). Following the RMNCAH example, it would be beneficial to create a non-binding, for internal use only, coordinated plan and budget for UN health sector support.
4. **Strengthen regional information-sharing and potential collaboration:** As in-country stakeholders are meeting and collaborating with other CSO programmes, so should PSRO (if they are not already doing so), with entities such as Save the Children, Pacific Women, SPC, New Zealand Family Planning, and others.

#### **UNFPA PSRO with Implementing Partners:**

5. **Strengthen the NCCs in non-RMNCAH countries:** Support FOs in strengthening their roles in ensuring that strong, participatory, and productive NCC meetings are occurring on at least a quarterly basis. Assist in the creation of TORs that ensure the above and that clarify the important role of the FO as a technical partner (and not “donor”).

#### **Final Note from the Consultant (mentioned at Validation Teleconference on 4 August 2017):**

Because the programme has a focus on SRH and Rights, and because two of the four goals are to reduce adolescent birth rates and maternal mortality, and because a significant portion of pregnancies are unwanted, the consultant recommends that both public and private sector actors begin to address the issue of abortion. The consultant recommends that each country examine their respective abortion laws and current practices, to assess where opportunities lie to educate women and men on the full range of options open to women, including safe abortion, when faced with unwanted pregnancy. Abortion information, counselling, referral, and services (if possible) should be provided, to the fullest extent of the law, to ensure full SRHR and to prevent unsafe abortion.

#### **Additional country input from the PRSRHP MTR Validation Teleconference (comments that were not incorporated into the above recommendations):**

- Samoa requested more regional meetings (such as every 6 months) for implementing partners to share experiences and learn from each other
- Samoa shared data collection challenges in getting only verbal reports from some outer islands
- Samoa and Tonga would have appreciated country-specific reports
- Solomon Islands expressed concern that CSE shows “0” when they have in fact trained many teachers – perhaps the single CSE indicator of # of schools providing CSE is not enough to reflect the amount of effort going into this activity and outcome.
- Tonga would like to include donor partners at the planning process, as was the practice in previous years (pertaining to recommendation C.9--strengthening the work planning process).
- IPPF suggested more activity-level indicators to reflect work that is not captured by indicators

Annex 2

<b>PRSRHP Outputs &amp; Activities</b>	
PLANNED ACTIVITIES (April 2017)	
<b>1</b>	<b>Needs assessment of SRHR and HIV services completed</b>
1	Conduct SRHR needs assessment
<b>2</b>	<b>Pre-service and in-service training of health workers</b>
1	Regional guidelines/manual on SRHR core competencies development
2	Integration of SRHR and gender into RHTP Curriculum
3	Integration of SRHR and gender into Health Worker Training Institutions
4	Development of SRHR advocacy/orientation materials for senior officials
<b>3</b>	<b>HIV/SRH Integration in PHC</b>
1	Technical support - HIV/SRH - PHC Integration
<b>4</b>	<b>YFHS offered through Youth Centres and Health Facilities</b>
1	YFHS Assessment of selected Facilities
2	YFHS Training of Trainers
3	YFHS Training - National Level
4	Support to MoH and IPPF MA to refurbish health and/or youth facilities and provide ongoing Youth Friendly SRH Services
<b>5</b>	<b>Stock outs and/or overstocking of SRH Commodities are eliminated</b>
1	Warehouse management operations training for warehouse managers
2	Support for training and certification by CIPS/UNDP of procurement staff
<b>6</b>	<b>Young people and marginalized groups have improved access to condoms</b>
1	Condom distribution through innovative partnership(s) with private sector
2	Communication campaign promoting condom use
3	Support to Peer-based & community-based condom distribution programmes
<b>7</b>	<b>Evidence-Based family planning guidelines adapted and implemented</b>
1	National evidence-based family planning guidelines and training packages
2	Training in family planning
<b>8</b>	<b>Young people and marginalized groups have a better understanding of SRHR</b>
1	Develop Training of Trainers - Peer Education Training Manual
2	Regional Training of Training - Peer Education
3	National level Peer Education Training (annual)
4	Administrative support for Peer Programmes (allowance, transport etc.)
5	Development and production of SRH IEC materials (print and social media)
6	Support to national level theatre groups to produce and perform edutainment
7	Support for sporting events to provide young people with a safe environment to gain knowledge and discuss SRH issues
8	Create or support safe spaces for girls and young women
9	Improve the quality of Comprehensive Sexuality Education

<b>9</b>	<b>Population estimate and strategic analysis conducted for marginalized populations</b>
1	Population estimates for sex workers, MSM and transgender in Vanuatu, Samoa, and Kiribati
2	Strategic analysis conducted on innovative approaches to delivering SRH services to SWs, MSM and transgender in Vanuatu, Samoa and Kiribati
<b>10</b>	<b>Community and Religious leaders demonstrate an openness to addressing SRHR issues</b>
1	Conduct a SRHR community stakeholder analysis (strengths, weaknesses, opportunities and threats)
2	Develop appropriate advocacy packages for mobilising religious and community leaders/gate keepers
3	Conducting trainings for community leaders/gate keepers and religious leaders
<b>11</b>	<b>National health policies/strategies inclusive of comprehensive SRHR (including HIV)</b>
1	Update and/or integrate national RH and HIV policies/strategies within national health policies/strategies as relevant
2	Disseminate existing policies/strategies
<b>12</b>	<b>National Health Information Systems are strengthened to include SRH data</b>
1	Assessment of HIS for inclusion of SRH data (select countries)
2	Technical support to strengthen SRH inclusion in HIS (select countries)
<b>13</b>	<b>Baseline data established and progress measured for duration of programme</b>
1	Conduct baseline reproductive health survey (RHS) to establish baseline data in Kiribati
2	Conduct end-of-programme survey in programme countries, depending on availability of data.
3	Conduct Integrated Behavioural and Biological studies among sex workers, men having sex with men and transgender in Samoa and Kiribati.
<b>14</b>	<b>Monitoring and Evaluation</b>
1	PSC and Country Reports
2	Monitoring Activities - UNFPA/UNICEF & IPPF-SROP
3	Mid-term-Review
<b>15</b>	<b>Project Coordination and Governance</b>
1	Management / Coordination
2	National Coordination Committee (NCC) meetings
3	PRSRHP Steering Committee meetings
4	IPPF Coordination meetings

## Annex 3

### S.M.A.R.T. Assessment of PRSRHP Indicators

The indicators are taken at face value from the results framework. There is no document that provides further descriptions, definitions, or instruction as to how to measure them. In looking at how well the 47 Programme indicators are defined, application of the S.M.A.R.T. model is useful (Specific, Measurable, Achievable, Responsible, Time-related). In general, almost all of the indicators need improvement to be SMART. The observations below do not represent a systematic assessment of all 47 indicators, but rather a sampling.

**Specific: Clear about exactly what is being measured; captures essence of desired result; specific enough to measure progress towards the result.**

- Many of the indicators are loosely worded and non-specific. For example: “# young women mobilized to advocate on SRHR” (#12) – does *mobilized* mean trained? And what does *advocate* mean – does it mean lead and/or participate in outreach/education/lobbying activities?; “# SRH/HIV trainings conducted by peer educators” (#17) – does this refer to training additional PEs or training/educating the target population? “# PEs trained in SRHR” (#34) – does this include only new PEs, or does it also include numbers of existing PEs attending refresher trainings? (for example, 120 of Tonga’s 612 PEs were re-trained). What constitutes a “training?” Is a 1-hour refresher counted the same as a 5-day training?; “# SRH advocacy activities completed” (#37) – what constitutes an advocacy activity?; “SRH strategic communication campaign developed (#38) – what constitutes a strategic communication campaign? Is it enough to develop it, or must it be executed?
- % of selected SDPs offering YFHS is a particularly important indicator for the Programme (#28), however, no specificity is provided in terms of what types of facilities can be counted (Youth Drop In Centres that don’t have clinical services? (such as SFHA) and no specificity is provided in terms of what constitutes YFHS (is a standard national, regional, or global checklist being used?) and what level of compliance with YFHS standards constitutes a yes (75%? 100%?). Who has the authority to determine if a SDP offers YFHS – can it be based on self-report?

**Measurable: Changes are objectively verifiable; indicator will show clear and reliable measure of desired change**

- Many of the indicators are “yes/no” and “some/all” and therefore difficult to quantify in terms of progress. For example, “Updated evidence based national health policy that reflects RH and HIV” (#21), which is a yes/no indicator. It is unclear at what point in the process the target or outcome is achieved—does it have to be updated to a certain minimum standard? By “updated,” must it be done during the 5-year Programme, or was an updated version in 2013 adequate? Must it be validated?
- In some indicators, a crude number is targeted, for example number of schools (#18) or number of healthcare workers (#33) with no denominator, and it is therefore difficult to contextualize what percentage of that population is targeted to be reached.
- Counting numbers of people served is a problem common to most, if not all healthcare facilities. Due to an inability to track and count numbers of individual, unduplicated clients, numbers of *visits* are counted and used as a substitute for the number of people seen. Indicators, however, are asking for numbers of *people seen* (#9, #19). Therefore, the current mode of reporting visits is greatly inflating the numbers of people seen and percent of population impacted. For example, a family planning client using injectables will likely visit a clinic 4 times in a year, so her 4 visits will be counted and interpreted as 4 people. Either insisting on tracking/counting unduplicated clients, or a change in the indicator to numbers of *visits*, is needed for accurate measurement.
- It is very helpful that the numbers of “selected” service delivery points (SDPs) for multiple

indicators has been identified, providing a denominator and way to calculate % of target met for SDPs. (However, note other comments regarding confusion about the selection of the SDPs and if/how MAs are included).

- There are several indicators regarding national policies and guidelines (#s 16, 21, 32, 46) which lack clarity and/or seem to overlap, so it is difficult to know if the indicators are being met.
- Duplication: Two of the indicators are included twice: CSE in schools #18 and 36; and births attended by skilled personnel #5 and #13.

**Achievable: Reflects the changes anticipated as a result of the intervention; results must be realistic and based on credible link between outputs and outcomes**

- It is important that country stakeholders take ownership of targets they feel are achievable. There is confusion, at all levels, as to what constitutes a baseline, and therefore the use of baseline figures to determine achievable targets. The process for setting targets does not appear to be consultative. When targets are set, the rationale for an increase/decrease is not provided, or it is confusing. For example, the Samoa's BWP attempts to provide a rationale for targeted increases in numbers of youth reached from baseline numbers, however, "50% more" from baseline is not clear in terms of whether that is by the end of the Programme, biennially, or yearly.
- Some indicators were included that were already achieved at baseline.
- Some indicators appear to be unrealistic as worded, given the funding and scope of the Programme. For example, "% selected SDPs with 7 life-saving maternal/RH medicines from WHO priority list" (#14). Achievement to date is 22 of the 337 SDPs indicated, or 7% (all of which were achieved prior to Programme start). It is very possible that the indicator is not actually meant for all SDPs, as the UNFPA Indicators Metadata document defines the indicator as pertaining to only those SDPs "offering delivery services." Another example, % births attended by skilled health personnel (#5 and #13) – little to no activity is planned to impact this indicator in terms of specifically training more midwives or increasing the number of facilities that offer delivery services or educating people about the importance of seeking facility-based childbirth.

**Responsible: Indicates specifically what entities are responsible for reporting/achieving the results**  
**Relevant: An assessment of relevance may also be applied (but was not done so below): Captures the essence of the desired result; is relevant to intended outputs and outcomes and target groups; plausibly associated with the sphere of activity**

- It is helpful that multiple indicators include the entities from which data will be reported, as long as it is accurate (ex: numbers of selected SDPs).
- This principle of identifying entities could be applied to more indicators. For example, # condoms distributed (#30/31) – by what entities? # health workers trained on FP (#33) – what levels of health workers? % training facilities with SRH/Gender incorporated (#24) – what types of training facilities and how many/what is the denominator for each country? #SRH advocacy activities completed – by whom?

**Time-related: Indicator is linked to a timeframe that reflects the nature of the expected result; indicates when the expected results can be achieved**

- Several indicators reflect time-specific, one-time activities, such as conducting the SRHR needs assessment (#23) or updating a health policy (#21), presumably to be conducted just once over the lifetime of the Programme. In terms of being time-related, "updated" does not define what is considered "outdated" or how recently/frequently updates are expected.
- It appears that several indicators' results should be assessed on an annual basis, but they do not define this (ex: "providing HIV/SRH services in an integrated manner at SDPs" (#10)), so it is not known if a one-time "yes" early in the program simply carries forward each year.
- It would be helpful to identify which indicators are tracked on a cumulative basis vs. discreet annual results to be added together.

**Annex 4**

**PRSRHP Funding Disbursement Overview – IPPF Member Associations (13 June 2017)**

	<b>Kiribati KFHA</b>	<b>Samoa SFHA</b>	<b>Solomon Is. SIPPA</b>	<b>Tonga TFHA</b>	<b>Vanuatu VFHA</b>
<b>Q1 2015</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>
FF* Submitted to UNFPA for Q1 activities	3 Feb. 2015	--	10 March 2015	Q1 not avail; Q2 17 & 25 March 2015	No Q1
Funds Received by MOH	--	--	22 March (MOH sep. acct.)	--	0
Funds received by IPPF MA	March 2015 <b>(1 month)</b>	25 March <b>( ? )</b>	19 April <b>(5-6 weeks)</b>	Q2: 19 May <b>(2 months)</b>	0 <b>(?)</b>
<b>Q1 2016</b>					
FF Submitted to UNFPA for Q1	April 2016	3 Nov. 2016	13 April 2016	11 Feb 2016	Q2: 9 June 2016
Funds Received by MOH	--	--	16 May (MOH sep. acct.)	8 March	7 July
Funds received by IPPF MA	April 2016 <b>(w/in 1 mo.)</b>	<b>(None to date)</b>	23 May <b>(5-6 weeks)</b>	21 March <b>(5-6 weeks)</b>	28 July <b>(1.5 months)</b>
<b>Q1 2017</b>					Q1 2017
FF Submitted to UNFPA for Q1	No 2017 activities	Direct payment mode	20 March 2017	21 Feb 2017	27 April 2017
Funds Received by MOH (if known)	N/A	<b>Delayed</b> (Awaiting gov. refund of VAT charged)	<b>Delayed</b> (delayed refund of unspent funds via HSSP DP account)	<b>0</b> (awaiting resolution of fund mis-apppr.)	<b>0</b> (awaiting qualified audit resolution)
Funds received by IPPF MA	<b>No activities</b>	<b>None to date</b>	<b>None to date</b>	<b>None to date</b>	<b>None to date</b>
<b>Comments</b>					
<p><b>Kiribati:</b> For 2017, KFHA activities are not included under UNFPA 2017 budget and WP. The activities are reflected in the UNFPA annual WP and budget. Ideally they are not funded by UNFPA, but are funded under the NZ Aid Prgm under the Healthy Families Project. The inclusion of KFHA's activities of 2017 in the UNFPA annual WP 2017, is one way for UNFPA to effectively coordinate SRHR programme.  <b>Per FO:</b> Was not able to retrieve funds for KFHA, as mentioned. It must be direct transfer and not through MHMS. Note also that KFHA is also a partner of MHMS so there are funds which MHMS would request in consultation with KFHA for KFHA's implementation and payment made by MHMS accounts.</p> <p><b>SFHA:</b> Funds flow from MOF to MWCSO to SFHA upon receipt of reports. SFHA has not received any funds for Q3 &amp; Q4 2016, nor Q1 2017.  <b>Per FO:</b> MoF/ MWCSO usually reimburses amnts spent by SFHA (once \$ received into treas. acct). If SFHA waits for the \$ to arrive, implementation will be greatly affected. For 2017 using direct paymnt mode. Receivd paperwork from MoF for SFHA end of March for reimbursement of funds, rent, etc; these are still being vetted by UNFPA; taken 3 mos.</p> <p><b>Per SIPPA ED:</b> Doesn't recall filling out FF in 2016 or 2017--only received list of already approved activities from MOH expected to implement. Thinks MOH is respons. for FF to UNFPA. For 2017, no funds nor comms. as yet. <b>Per FO:</b> 2015 &amp; 2016 funds fast due to separate MOH acct. 2017 delayed advance to MOH due to transition to HSSP DP acct.</p> <p>MOH owed TFHA \$17.4K from 2015, by 30 Jan 2016. Not yet received. UNFPA owed TFHA \$7.8K, received \$7.4K in March 2016.</p> <p>Although funds were destined to MOH, it was kept at the Gov. Treas. (MOF). MOH only facilitated the transfer of funds from MOF to VFHA &amp; did not receive any funds. MFAT PRSRHP funds audited 25 April 2017.</p>					

\*FF = Face Form (UNFPA for used for requesting funds)

**Annex 5**
**PRSRHP Funding Disbursement Overview – Ministry of Health Implementation (7 June 2017)**

	<b>Kiribati</b>	<b>Samoa</b>	<b>Solomon Is.</b>	<b>Tonga</b>	<b>Vanuatu</b>
<b>Q1 2015</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>
FF* Submitted to UNFPA for Q1 MOH activities	May 2015	20 Jan 2015	10 Mar 2015	No FF Q1 Q2: Advance requested	N/A
Funds Rec'd by MOF	8 May 2015	26 Feb 2015	“N/A”		
Funds received by MOH	9 July 2015 <b>(2 months)</b>	Early March <b>(1.5 months)</b>	22 Mar 2015 <b>(2 weeks)</b>	---	N/A
<b>Q1 2016</b>					
FF Submitted to UNFPA for Q1 MOH activities	29 January 2016	18/21 Ap. 2016 FF delayed due to delay in WP finalisation	13 Ap. 2016	11 Feb 2016	N/A
Funds Received by MOF	12 <sup>th</sup> February 2016 (TT date)	11/19 May 2016	“N/A”	8 March 2016	
Funds received by MOH	2 <sup>nd</sup> Week April <b>(2.5 months)</b>	Late May <b>(1 month)</b>	16 May 2016 <b>(1 month)</b>	11 March <b>(1 month)</b>	N/A
<b>Q1 2017</b>					
FF Submitted to UNFPA for Q1 MOH activities	15 Mar 2017 21 Mar 2017	No FF: Direct payment mode due to outstanding VAT refund owed to UNFPA.	20 Mar 2017	No FF Q1; Q2 & 3 activities deferred until audit complete. WPs signed late due to funding redux negot.	N/A
Funds Received by MOF	24 Mar 2017		<b>Delayed</b> (transition to DP acct. Aug. 2016 w/ DFAT bilateral funds. Unspent		
Funds received by MOH	13 April 20 April  <b>(2 months)</b>	N/A  <b>None to date</b>	<b>Delayed</b> (pending MOH return of 2016 unspent funds <b>None to date</b>	<b>Delayed</b> (pending audit resolution) <b>None to date</b>	<b>Delayed</b> (Pending April 2017 audit of 2016 funds) <b>None to date</b>
<b>Comments</b>					
	<b>Kiribati:</b> Staff turnover 2015–2016; Delay in Gov. reconciliation affects approval of FF submissions; Delay in sending TT refund for remaining/unused funds due to delay in reconciliation; MHMS staff not familiar with NEPO (Nat’l Econ. Planning Off.) coding; Training needed to clarify coding system; Staff mobility by both MHMS & MoF; Busy schedules for Project Account at MoF; overwhelmed accounts officer for RMNCAH project at MHMS	<b>Samoa:</b> All funds managed by MOF & not transferred to MOH.	<b>Solomon Is:</b> 2016 delay due to MOH not being able to retire one of its 2015 payments (supporting travel to PSRH). In aligning to MOH aspiration of being “on plan, on budget and on system” UNFPA made the initial transition in Aug. 2016 using the DFAT bilateral funds to eliminate the separate account. However, UNFPA has not been able to make direct advance transfer to DP account as unspent funds from 2016 of the DFAT bilateral funds have not been received to date via advance warrant although it is being cleared by MOF.		<b>Vanuatu:</b> Though funds were destined to MOH, were kept at MOF. MOH only facilitated transfer from MOF to VFHA. MOH did not receive any funds; only received activity reports, acquittals & submitted to UNFPA. 2016 funds audited 24- 25 April 2017. Release of 2017 funds is awaiting the final audit decision

\*FF = Face Form (UNFPA form for requesting funds)

## Annex 7

# List of Persons Met & Agencies Represented PRSRHP Mid-Term Review March-June 2017

### Regional Interviews (primarily in Suva)

1. Ms. Sarah Johal, MFAT Development Manager Health (Wellington, via Skype)
2. Ms. Vamarasi Mausio, MFAT Regional Development Programme Coordinator (Suva)
3. Lyn Henderson, Assistant Director, Health & Education, Pacific Division, DFAT (in Sol. Is.)
4. Gordon Burns, Counsellor - Regional Development Cooperation, DFAT Suva
5. Paulini Sesevu, Sr. Programme Manager, DFAT Suva
6. Dr. Frances Bingwor, Programme Manager, DFAT Suva
7. Mr. Bruce Campbell, Representative and Director, UNFPA Pacific Sub-Regional Office
8. Ms. Virisila Raitamata, Assistant Representative, PSRO (*Coordinator's Supervisor*)
9. Mr. Adriu Naduva, PRSRHP Coordinator, UNFPA PSRO
10. Mr. Mosese Qasenivalu, M&E Specialist, UNFPA PSRO
11. Ms. Marija Vasileva-Blasev, Youth/HIV Technical Specialist, UNFPA PSRO
12. Dr. Pulane Tlebere, RH Advisor, UNFPA PSRO
13. Sheldon Yett, UNICEF Representative, UNICEF PSRO
14. Ms. Vathinee Jitjaturunt, Deputy Representative, UNICEF
15. Wendy Erasmus, Chief of Child Survival and Development, UNICEF PSRO
16. Dr. Frances Vulivuli, HIV Officer (past), UNICEF PSRO
17. Sharam Ram, RMNCAH Coordinator, UNICEF PSRO
18. Melissa Palombi, Sports for Development Consultant, Oceania Football Association, UNICEF
19. Michael Sami, Director, International Planned Parenthood Federation Sub-Regional Office of the Pacific (IPPF SROP)
20. Ruth Harvey, Consultant, RMNCAH UNJP review
21. Lea Shaw, Consultant, IPPF Partnerships for Health & Rights mid-term review

### Kiribati Face-to-Face Interviews (in Suva)

1. Aren Teannaki, Program Analyst, PRSRHP, UNFPA Kiribati
2. Cromwell Bacareza, Chief of UNICEF Field Office, UN Joint Presence Kiribati, UNICEF
3. Shyam Pathak, RMNCAH Coordinator, UNFPA (4/2016-3/2017)

### Kiribati Interviews Conducted by Ruth Harvey, RMNCAH Consultant, on behalf of Karen Enns (22-30 May)

1. Ms. Tiene Tooki, Secretary, Ministry of Health & Medical Services (MHMS)
2. Dr. Silina Fusimalohi, RMNCAH Coordinator, UNFPA Consultant (since 4/2017)
3. Ms. Tiroia Teikake, Chair of National RMNCAH Steering Committee/ RMNCAH Specialist MHMS
4. Ms. Tinai Iuta, Health & Nutrition Officer, UNICEF
5. Ms. Helen Murdoch, Director of Nursing Services, MHMS
6. Dr. Zeke Nukuro, WHO CLO, Health Officer
7. Rosemary Tekoua, Chief of Central Laboratory, MHMS
8. Group Meeting with Safe Motherhood, Maternal Health Team: Ms. Toata Titaake, Principle Nursing Officer, Sr. Toonga Tieei, Nurse in Charge, OB ward, TCH; Dr. Kiarere Tiaon, Registrar OB Ward, Ms. Mweritonga Tamariti, Health Promotion Officer
9. Visit to OB Ward, TCH: Dr. Ruta, Ward Clark
10. Meeting with MCH Team (EPI, Child Health/IMCI, Nutrition, Health Promotion) Mr. Beia Tabaia, EPI Coordinator, Ms. Tikua Teketange, EPI Consultant (UNICEF), Ms. Tamoia Maante,

- Cold Chain Engineer, Ms. Taene Tanu, Senior Nutritionist
11. Meeting with FP & RH Team: PNO - Ms Tiareti Mareko, Ms. Tawaa Teingiia, Family Planning Nurse, Ms. Taam Tebano Youth Nurse (former), Ms. Mering Enari, Pharmacy Focal point
  12. Mr. Peter Malavi, Midwife Coordinator and Trainer
  13. Ms. Tarateima Tewareka Acting Senior Youth Officer and Ms. Tarawaniman, Youth Officer, Ms. Tatereti Y-Peer Network Secretary, Ministry of Youth, Women and Social Affairs (MWYSA)
  14. Y-Peer Network Members, MWYSA, 5 members, trained and active, each from different community on S. Tarawa (Taraboto Tataio, Tatareti Baracti, Diana Itioia, Ataniman Boire, Konono Tingaia)
  15. Norma Yeeting, Executive Director, Kiribati Family Health Assoc., and Ms. Taema, finance officer
  16. Ioane & Mareina Aukitino, Healthy Living Facilitators, Catholic Church Community Outreach Center
  17. Meeting with Planning & Finance Officials, Ministry of Finance and Economic Development
  18. Dr. Iobi Batio, Health Specialist Consultant, Meria Russell, Health Programme Coordinator, MFAT
  19. Ms. Teiti Erikate, Health Programme Manager Australian High Commission/DFAT
  20. Site visit to Betio Hospital, renovated Maternity Ward, Sr. Tabuki
  21. Site visit to RH Clinic/ Family Health Centre (DFAT Bilateral); at TCH with dedicated GBV space and on-call team Teoraiti Tetoa, DPNO & former GBV Manager, Ms Christina, Counselor
  22. Mauea Wilson, Former Sr. Development Youth Officer, now officer, ESP Coordinator, UN Women
  23. Rosemary Tekoana HIS Unit, MHMS
  24. Head of Curriculum Development Unit, Ministry of Education, and curriculum officer
  25. Focus group Discussion: 26 Medical Assistants and Nurses from Health Clinics in S Tarawa
  26. Group Discussion with Youth Volunteers: 26 youth attached to 13 clinics in S Tarawa

### **Samoa Face-to-Face Interviews (23-28 April, 2017)**

1. Verity Smith, First Secretary Development, MFAT
2. Lagi Tuaniu, Development Programme Coordinator, Health, MFAT
3. Kassandra Betham, Health Program Manager, DFAT
4. Latoya Lee, Programme Analyst, UNFPA (FO)
5. Sara Faletoese Su'a, Program Analyst, Global Fund Programme, UNDP
6. Lita Lui, ACEO, Aid Coordinator, Ministry of Finance (MOF) & Danielle Lio, Principal Aid Coordination Officer, Aid Coordination Office, MOF
7. Rumanusina Maua, Acting CEO, MOH
8. Gualofa Matalavea Saaga, ACEO, Health Sector Coordinator, MOH
9. Darryl Anesi, ACEO, Corporate Services, MOH
10. Leveti Auvua, ACEO, Nursing & Midwifery, Nursing Division, MOH
11. Perive Lelevaga, Principal SRH, MOH
12. Naea Beth Onesemo, CEO, Ministry of Women, Community & Social Development (MWCSD)
13. Nanai Sovala, Agaiava, ACEO, MWCSD
14. Ana Leau Vaasa, Senior Youth Officer, MWCSD
15. Avaia Lautusi Tuilaepa, Principal Community Nurse, National Health Services (NHS)
16. Liai Sitia, Executive Director, Samoa Family Health Association (SFHA)
17. Ulisese (Julie) Tapavae, Clinical Manager, SFHA
18. Kalolo Sene, Youth Program Officer, SFHA

### **Solomon Islands Face-to-Face Interviews (15-19 May, 2017)**

1. Don Higgins, New Zealand High Commissioner & Dana Avram, Health & Education focal

point

2. Gina Depretto, Health focal point, DFAT
3. Dr. Tenneth Dalipanda, Permanent Secretary, MHMS
4. Dr. Divinal Ogaoga, Director, RMNCAH, MHMS
5. Dr. Sevil Huseynova, WHO Representative, WHO Solomon Islands
6. Simon Burggraff, RMNCAH Coordinator, WHO
7. Dr. Magdi Kassem, former RMNCAH Coordinator, WHO
8. Pauline Boseto McNeil, Programme Specialist, UNFPA Solomon Islands (FO)
9. UNICEF Group interview: Dr Ibrahim Daidari, Immunization & Child Health Officer; Settasak Akanimart, Child Protection Specialist & Officer in Charge; Winston Pitakomoki, Nutrition
10. Alvina Ereka, National Country Coordinator, UN Women & Doris, Essential Services Coordinator
11. Esther Tekulu, Sr. Financial controller, MHMS & Brendan Beak, Financial Mgt. Coordination Advisor for MOH
12. Bakaai Kamoriki, Chief Medical Statistician, Health Info. Unit (DHIS focal point) & Dilip Hensman, HIS TA, WHO
13. Nancy Pego, Adolescent Health & Development Coord., Reproductive & Child Health Dept, MHMS
14. MHMS Coordinator Group interview: Judith Seke, local TA on Jadelle; Betty, RH National Coord Safe Motherhood; Jenny, Nutrition; Silas, National HIV Prgm; Nancy Pego, AHD Coord.
15. Mr. George Pitakoe, Executive Director, Solomon Islands Planned Parenthood Association (SIPPA)
16. Peer Educator Focus Group: 5 SIPPA Youth Peer Educators/Community Based Educators & Distributors, (3 new & 2 veteran)
17. 2 FLE Educators, Home Economics Teachers, MEHRD – Wilma Panda (St. Johns Community High School) and Emma
18. HIV/STI Division, MHMS, Group interview: Helena Tomasi, National Facilitator & Counselor; Isaac, Community Research Facilitator; Timoti, Coordinator
19. Nashley Vozoto, GBV Programme Officer, MHMS & Hayfa, WHO TA
20. Pauline Soaki, Director, Ministry of Women, Youth, Children & Family and Goldy
21. Willie Horoto, Manager, National Medical Stores

### **Tonga Face-to-Face Interviews (23-26 May)**

1. ‘Olivia Fukofuka, Senior Development Programme Coordinator) & Katrina Ma’u (Development Programme Coordinator), MFAT
2. Debra Allan, Program Manager, Health, DFAT
3. Dr. Siale ‘Akau’ola, CEO for Health, MOH
4. Sione Hufanga, Principal Health Planning Officer and Board Chair, Tonga Family Health Association
5. Elisi Tupou, Programme Analyst, UNFPA (FO)
6. Katherine Mafi, Program Manager, TFHA & Iemaima Havea, Technical Adviser to the TFHA Executive Board
7. Mele Funaki, Finance Officer, TFHA
8. ‘Eseta Moa & Falealea Tausisi, Youth Peer Educators, TFHA
9. Dr. Reynold ‘Ofanoa, Chief Medical Officer, MOH
10. Sr. Afu Tei, Supervising Sister & RH Coordinator, & ‘Alisi Fifita, Senior Public Health Nurse, MOH
11. Melenaite Mahe, Principal Pharmacist, MOH Warehouse
12. Ponapate Taunisila, Deputy CEO for Education Department

### **Vanuatu Face-to-Face Interviews (29 May – 2 June)**

1. Ricky Lee, Development Programme Coordinator, NZ High Commission/MFAT
2. Meagan Kybert; Olive Taurakoto, Program manager, Health; & Shirley, DFAT
3. Viran Tovu, Sr. Policy Analyst, Health Sector; & Pioni Willie, MDG Acceleration Framework, Prime Minister's Office
4. Andrew Parker, Chief of UNICEF Field Office, UN Joint Presence Office
5. Shafag Rahimova, MCH Specialist & RMNCAH Coordinator, UNICEF, and David
6. Gideons Mael, Programme Analyst, PRSRHP, UNFPA (FO)
7. Apisai Tokon, RH Unit /RMNCAH Coordinator, MOH
8. Anthea Arnhambat, Acting Accounts Manager, Ministry of Finance
9. Simil Johnson, Government Statistician, Vanuatu National Statistics Office
10. Wilson Lilip, Manager, Central Medical Store, MOH
11. Scott Monteiro, Planning Unit Team Leader, Vanuatu Health Research Mechanism, MOH
12. Rachel Takoa and Michael Buttsworth (WHO), HIS Unit, MOH
13. Leisel Masingiow, Sr. Education Officer; James Melteres, Jr. Secondary Curriculum Coordinator; Felicity Nilwo, Sr. Secondary Curriculum Coordinator; Curriculum Development Unit, Ministry of Education & Training; & Annette Theophile, Sr. Lecturer & FLE Curriculum Writer, Vanuatu Institute of Teacher Education
14. Danstan Tate, Executive Director, Vanuatu Family Health Association
15. Julianne Aru, Health Programme Manager; Leias Obed, Program Nurse; & Josiah Kenny, Youth Peer Education Program, VFHA
16. Wamily Masing – Reggae faea event organizer, VFHA Peer Education Program

## Annex 8

### List of Documents Consulted for PRSRHP Mid-Term Review

1. PRSRHP Project Proposal
2. Agreement between MFAT & UNFPA
3. PRSRHP M&E Framework
4. PRSRHP 5-Year Work Plan Budget
5. PRSRHP Annual Donor Reports for New Zealand (including RF) (2014/15, 2015/16, 2016/17)
6. PRSRHP Quarterly Reports to MFAT (2015, 2016)
7. PRSRHP Steering Committee Annual Meeting Reports (2015 email and 2016 report)
8. PRSRHP Steering Committee 2016 PowerPoint Presentations (5 countries)
9. PRSRHP Steering Committee Terms of Reference, 2015
10. UNICEF PRSRHP Annual Donor Report 2016
11. Biennium Work Plans for Programme Countries (2014-15, 2016-17)
12. Biennial Work Plan Progress Reports 2016 (5 countries)
13. Job Descriptions of UNFPA Field Officers
14. LOU between UNFPA and MOH Kiribati 2013-17
15. UN Briefing Note, PRSRHP, HLC Meeting, NZMAT, March 2017
16. Sexual and Reproductive Health Rights (SRHR) Needs Assessments of PICTs (5)
17. Youth Friendly Health Services Needs Assessments (2015 & Samoa 2016)
18. MCP5 Implementation and Delivery Strategy
19. Review of the UNFPA PSRO MCP5 2013-17 (Feb. 2017)
20. Multi-Country Programme Document for the PICTs 2013 -2017
21. Indicators Metadata: UNFPA Strategic Plan, 2014-2017: Integrated Results Framework
22. UNFPA in the Pacific, Support for transformative change, 2018-2022
23. UNFPA Population and Development Profiles: Pacific Island Countries
24. Evaluation of the Sexual & Reproductive Health Management Training Programme (SRHMTP) for the Pacific Sub-Region
25. UNFPA Global Strategic Plan 2014 -2017
26. Pacific Sub Regional UNDAF 2013-2017
27. Pacific Regional ICPD Review: Review of the ICPD PoA Beyond 2014
28. Pacific MDG Tracking Report 2015
29. Global Strategy for Women's, Children's & Adolescents' Health (2016-2030) (Every Woman Every Child)
30. Sustainable Development Goals & Indicators
31. Pacific Sexual Health and Wellbeing Shared Agenda 2015-2019
32. New Zealand Aid Programme Strategic Plan 2015-19
33. Moana Declaration (2013)
34. Kaila Pacific Voices for Action on Agenda 2030 (2015)
35. Yanuca Island Declaration (2015)
36. ICPD Programme of Action