Senate Foreign Affairs, Defence and Trade Legislation Committee
Supplementary Budget Estimates 2015, 22 October 2015

QUESTIONS ON NOTICE/IN WRITING

Question No 58

Program: DFAT

Topic: Development Assistance Funds

Question in Writing

Senator Bullock

Question

DFAT Development Assistance Funds, Contracts and Abortion

1. ***Provide copies of the following contracts listed in the Department of Foreign Affairs and Trade, 2014-2015 Senate Order on Non-Corporate Commonwealth Entity Contracts Listing Relating to the Period 1 July 2014 – 30 June 2015:***
   - ***(i) International Planned Parenthood Federation, Contribution to International Planned Parenthood (Global), $8,500,000, 1/6/2012-30/6/2016;***
   - ***(ii) International Planned Parenthood Federation, Contribution to International Planned Parenthood (Global), $5,000,000, 22/5/2015-31/12/2016;***
   - ***(iii) International Planned Parenthood Federation, Regional Partnerships for reproductive Health Program (Pacific), $4,500,000, 15/12/2014-31/12/2017;***
   - ***(iv) Family Planning NSW, Australian Non-Government Organisation Program 14-15 (Global), $300,000, 1/7/2014-30/6/2015;***
   - ***(v) Marie Stopes International Australia, Australian Non-Government Organisation Cooperation Program 14-15 (Global), $1,859,148, 1/7/2014-30/6/2015.***

QUESTIONS ON NOTICE/IN WRITING

2. For each of the above contracts please specify:

(i) for each financial year 2012-13 to 2014-15 payments made under the contract;

(ii) what payments are still outstanding; and

(iii) for the years 2015-16 to 2017-18 what payments are expected to be made.

3. Are any other contracts with International Planned Parenthood Federation; Family Planning NSW; or Marie Stopes International Australia under consideration or being negotiated?

4. Are there any other current contracts with organisations that provide abortion related services?

5. Are there any other contracts under consideration or being negotiated with organisations that provide abortion related services?

<u>DFAT Development Assistance Funds, IPPF and Family Planning Association of Nepal</u>

1 Has the Family Planning Association of Nepal been a recipient of pooled donor funding from IPPF a proportion of which has been received from Australia?

2 Does the Family Planning Association of Nepal provide abortions? What percentage of abortions performed in Nepal are provided by Family Planning Association of Nepal?

3 Is the Department aware of the peer reviewed article Frost, M., Puri M., Hinde P. (2013) "Falling sex ratios and emerging evidence of sex-selective abortion in Nepal: evidence from nationally representative survey data" BMJ Open 3 (5)?

4 If not will the department obtain and read a copy of this article?

5 In the light of the evidence for a significant incidence of sex selection abortions in Nepal, what measure, if any, have been put in place by the Family Planning Association of Nepal to ensure that

QUESTIONS ON NOTICE/IN WRITING

no abortion it provides is being carried out for the reason of sex selection?

6 ***Notwithstanding IPPF's contract being subject to the Family Planning and the Aid Program: Guiding Principles which prohibit the use of Australian funds for sex selection abortion, is it the case that the Department has no documentation that indicates that the Family Planning Association of Nepal is aware of the obligation not to spend Australian funds on sex selection abortions?***

7 ***Even if the Family Planning Association of Nepal was aware of this obligation isn't it the case that it receives a general grant from IPPF's unrestricted donor pooled funds and would have no means of distinguishing Australian derived funds from other donor derived funds?***

8. ***Can the Department guarantee that no Australian funds have been used to fund sex selection abortions in Nepal?***

Answer

1. See attached contracts. Copies of the contracts have been redacted to maintain commercial-in-confidence interests and protect the personal information of stakeholders.
2. See Annex 1 for details of yearly funding to contract partners.
3. Yes. DFAT is currently preparing to negotiate a new core funding agreement with IPPF.
4. Yes. DFAT is currently funding the following programs:
   a) Marie Stopes Timor-Leste (MSTL).
   b) Marie Stopes International (MSI) as part of the Partnering to Save Lives program in Cambodia.
   c) MSI in Papua New Guinea.
   d) MSI under the Australia Africa Community Engagement Scheme program.
5. No.

DFAT Development Assistance Funds, IPPF and Family Planning Association of Nepal

QUESTIONS ON NOTICE/IN WRITING

1. Yes.
2. Yes. The Family Planning Association of Nepal (FPAN) estimates that it performed between 11 and 14 per cent of all abortions that took place in the years 2012, 2013, and 2014. The variation in the estimated percentage reflects different total numbers of abortions published by credible sources including the Government of Nepal.
3. Yes.
4. Not applicable.
5. IPPF has confirmed that FPAN does not perform sex selection abortions under any circumstances.
6. No.
7. IPPF have confirmed that FPAN does not perform sex selection under any circumstances regardless of funding sources.
8. Relevant contracted service providers have confirmed that they do not support sex selection abortion in Nepal.

Annex 1: Yearly funding under listed contracts

	Payments made:			Outstanding payments	Expected payments 2015-16 to 2017-18
	2012-13	2013-14	2014-15		
Contribution to IPPF (Global) – SPRINT 1/6/12-30/6/16	Nil	$1m	$2 m	Nil	$2m to be paid in November 2015
Contribution to IPPF (Global) – Core Contribution 22/5/15-31/12/16	N/A	N/A	$5m	Nil	N/A
Regional Partnerships for reproductive Health Program (Pacific) 15/12/14 – 31/12/17	N/A	N/A	$2.5	Nil	$1m in 2015-16 $1m in 2016-17
Family Planning NSW*, ANCP 14-15 (Global)	N/A	N/A	$300,000	Nil	N/A

QUESTIONS ON NOTICE/IN WRITING

1/7/14-30/6/15					
MSIA ANCP 14-15 (Global)* 1/7/14-30/6/15	N/A	N/A	$1.8m	Nil	N/A

*ANCP Payments refer to funding for the NGO's overall programming received under the ANCP, which may include funding to abortion related services as well as a range of other programming.

IPPF International Planned Parenthood Federation

Partnerships for Health and Rights: Working for Sexual and Reproductive Health and Rights for all in the Pacific

Funding Proposal prepared by IPPF for

Department of Foreign Affairs & Trade

DECEMBER 2014

ANNEXURES

ACRONYMS AND ABBREVIATIONS

AAP	Australian Aid Program
ADD	Activity Design Document
AM	Associate Member (of IPPF)
ANC	Ante Natal Care
AVI	Australian Volunteers International
BPT	Branch Performance Tool
CBD	Community Based Distributor
CBP	Pacific Regional SRH Capacity Building Program (2008-2014)
CIFWA	Cook Islands Family Welfare Association
CMIS	Clinic Management Information System
CO	Central Office (of IPPF in London)
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
CYP	Couple Years Protection
DFAT	Department of Foreign Affairs and Trade (Australia)
DFID	Department for International Development (UK)
DPO	Disabled People's Organization
ED	Executive Director (of FHA)
eIMS	Electronic Information Management System (of IPPF)
EPE	End of Program Evaluation (of CBP)
ESEAOR	East and South East Asia and Oceania Region (of IPPF)
FBO	Faith Based Organization
FHA	Family Health Association (of IPPF)
FP	Family Planning
FM	Full Member (of IPPF)
FPQ	Family Planning Queensland
FPNSW	Family Planning New South Wales
FPOP	Family Planning Organization of the Philippines
GBV	Gender Based Violence
GI	Global Indicator (of IPPF)
HIV	Human Immuno-deficiency Virus
HPV	Human Papilloma Virus
ICON	International Contraceptive and SRH Marketing Ltd (of IPPF)
ICPD	International Conference on Population and Development
IEC	Information Education Communication
IPES	Integrated Package of Essential Services (of IPPF)
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine Device
KFHA	Kiribati Family Health Association
LARC	Long Acting Reversible Contraceptive
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
MA	Member Association (of IPPF)
MDG	Millennium Development Goal

M&E	Monitoring and Evaluation
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSM	Men who have sex with men
NCD	Non Communicable Disease
NGO	Non-Government Organization
NHS	National Health Service (of Samoa)
NZD	New Zealand Dollar
NZMFAT	New Zealand Ministry of Foreign Affairs and Trade (New Zealand Aid Program)
NZ FPI	New Zealand Family Planning International
PAC	Post Abortion Care
PACTAM	Pacific Technical Assistance Mechanism
PDF	Pacific Disability Forum
PDO	Pacific Disability Organization
PIC	Pacific Island Country
PIFS	Pacific Islands Forum Secretariat
PMSeU	Poor, Marginalized, Socially-excluded, Under-served
PNG	Papua New Guinea
PO	Program Officer (of SROP)
PRHSIP	Pacific Regional HIV and STI Program
PRSRHCBP	Pacific Regional Sexual and Reproductive Health Capacity Building Program
PRSRHP	Pacific Regional Sexual and Reproductive Health Program (of NZ MFAT)
PWD	People with a Disability
QI	Quality Improvement
QoC	Quality of Care
RFHAF	Reproductive Family Health Association of Fiji
RH	Reproductive Health
RO	Regional Office (of IPPF)
RTI	Reproductive Tract Infection
SARO	South Asia Regional Office (of IPPF)
SDP	Service Delivery Point
SFHA	Samoa Family Health Association
SHFPA	Sexual Health and Family Planning Australia
Sida	Swedish International Development Cooperation Agency
SIG	Solomon Islands Government
SIPPA	Solomon Islands Planned Parenthood Association
SPC	Secretariat of the Pacific Communities
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SROP	Sub Regional Office of the Pacific (of IPPF)
STI	Sexually Transmitted Infection
TFHA	Tonga Family Health Association

TuFHA	Tuvalu Family Health Association
UN	United Nations
UNFPA	United Nations Fund for Population Development
UNICEF	United Nations Children's Fund
VA	Vulnerability Assessment (Tool)
VFHA	Vanuatu Family Health Association
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

The **International Planned Parenthood Federation** (IPPF) is a Federation of 152 Member Associations, working in 172 countries. It operates 65,000 service points worldwide and its comparative advantage is that it delivers quality assured, integrated and innovative sexual and reproductive health and rights (SRHR) services which address the rights of clients. In 2012, the IPPF Pacific Family Health Associations (FHAs) provided 519,000 SRHR services – treble the number of services they provided in 2010. Of these services 89 per cent were to poor, marginalized, socially-excluded and/or under-served[1] clients – an increase of 11 per cent from 2011. Despite this success, most FHA clinics are in urban areas leaving people, particularly young people, in peri-urban and rural/remote areas without quality SRHR services. Government services are fragmented and not integrated, nor are they always quality assured; however, increasingly Ministries of Health are partnering with FHAs to ensure that poor and marginalized people receive the SRHR services they need and want.

Following the positive results of the Australia/New Zealand funded Pacific Regional SRHR Capacity Building Program (CBP) 2008-2014, the **Government of Australia**'s Department of Foreign Affairs and Trade invited IPPF to submit a proposal through its Pacific Regional Health Program. This Program supports service delivery innovation including "essential, cost-effective health services necessary to improve health outcomes of Pacific Islanders that are currently not being prioritized by Pacific Island governments". DFAT has committed to targeted financial support for FHAs through indicative funding of AUD 7.5 million split evenly over five years, with expectations that the Program will facilitate greater investment in SRHR by Pacific governments over time.

The **design process** included:

- Engaging all levels of IPPF to determine feasible and sustainable ways of advancing SRHR, particularly family planning, in the Pacific.
- Consulting FHA staff, Ministries, and other Pacific stakeholders regarding SRHR issues, needs and relevant approaches in the region.
- Agreeing on an appropriate role for FHAs – and their partners – in the eight Pacific Island Countries (PICs).
- Developing a proposal to DFAT's investment design quality standards.

A design team from all levels of IPPF was assembled to develop the Program; evidence-base for the design included:

- The results and recommendations of the CBP.
- The results of the consultations.
- The situational analysis and literature review.
- Technical expertise from IPPF central and regional personnel.

[1] Note: IPPF defines 'marginalized groups' as being young people, transgender people, sex workers, men having sex with men, people who are gay, lesbian or bi-sexual, child brides and girl mothers and for purposes of data collection marginalized is referred to as Poor, Marginalized, Socially excluded and Under-served (PMSeU). People who are remote from SRH services are also under-served.

- Lessons learned from the CBP.
- An innovative Australian-funded project in IPPF's South Asia Region on which the Program is, in part, structured.

The positive **results of the CBP** end of program evaluation concluded that: it was highly successful in building the capacity of FHAs to address significant unmet need, particularly for disadvantaged populations, including young people; 4-5 years duration was needed to demonstrate real results in the Pacific context; while capacity development for FHAs is an ongoing need, small infrastructure activities and repair/maintenance activities also contributed to improved access for key communities. The report concluded that the new capacity of FHAs be channeled into strengthening service delivery, particularly clinic and outreach services.

IPPF has identified that a **key challenge** for the Pacific is the lack of responsible planning and management of resources for SRHR within the health sector. The health sector is fragmented and this exacerbates extreme levels of inequality. The scarcity of resources is a major, but not the only, cause of this issue.

The new Program aims to **integrate** SRHR at three levels – policy, service delivery and consultation room. Two key themes of the Program will be:

i. To unite partnerships to tackle SRHR and other health inequalities, particularly with government (e.g. health), faith based organizations (e.g. churches), civil society organizations (e.g. disability) and community village groups.
ii. To deliver scaled up integrated services that reach the most marginalized (identified by the in-country consultations as people who are poor, young, geographic ally hard to reach and/or people with a disability).

Expected outcomes will include: development of a model for static clinical services; outreach activities in partnership with governments and communities; FHA systems for quality and data collection strengthened; and PIC governments held accountable for delivering SRHR for all.

The **structure of the intervention** provides for the opportunity to take forward the FHAs' strategic priorities and the IPPF's Change Goals (Unite, Deliver, Perform) in a flexible manner i.e. cutting across all functions and thematic areas. This flexibility in design and implementation has provided for integration with IPPF core programs; responding to the country contexts and the FHA needs; to design customized programs; respect for IPPF and FHA competence in setting their own priorities; opportunity to reach out to a diverse group of poor and most marginalized population; and adoption of innovative approaches and scaling up of existing approaches.

The overall **goal** of the **Partnerships for Health and Rights Program** will be: to advance equity for all through improving lifesaving sexual and reproductive health and rights in eight Pacific Island Countries - Cook Islands, Fiji, Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

Moving from service **fragmentation to integration**, the **purpose** of the Program is to provide quality, rights-based, integrated sexual and reproductive health information and services to communities in eight PICs, particularly to the poor and most

marginalized, and to advance their SRH rights. Most marginalized people are those identified as people who are poor, young, geographically hard-to-reach and/or people with a disability.

The **four key outcomes** are:

i. Cost effective, sustainable service delivery model developed and delivered through quality assured FHA static service delivery points for all, particularly the poor and most marginalized.
ii. Cost effective SRHR outreach activities implemented in partnership with governments and communities exclusively for the poor and most marginalized.
iii. FHA systems strengthened to enable integration (policy, health service and inter-sectoral) through partnerships, innovation and scale-up.
iv. PIC governments held accountable for delivering SRHR for all through advocacy for SRHR policy/programs and resource allocation for improved and expanded SRH services.

Relevance and sustainability: The Program builds on IPPF leadership and best practice in SRHR (particularly in provision of integrated SRH services, including HIV); the close relationships of FHAs with their Ministries of Health, other SRHR service providers and Civil Society Organizations; and the use of a sub-regional intermediary (IPPF's Sub Regional Office of the Pacific – SROP) to monitor and support FHAs, and champion Pacific SRHR needs. The process for the design supports national leadership and has instilled ownership and enthusiasm among key SRHR stakeholders in the Pacific. It supports the organizational and technical sustainability of FHAs through embedding IPPF quality and performance technology into FHA operations. For the Government of Australia, it provides a cost-effective service model for SRHR services to address unmet need, particularly for the poor and most marginalized populations; and policy engagement with national Governments to buy into the model. This fulfils one of the key objectives of Australia's Pacific Regional Health Strategy – "supporting Pacific Island countries to develop and deliver… quality and equitable health... services to their citizens", as well as DFAT's strong focus on gender and disability.

Effectiveness and Impact: For two of the components, the improvement of static clinic service delivery and FHA system strengthening, the Program will draw on the technical expertise of the Federation. Component 2 (outreach services) will be implemented in partnership with government, NGO and FBO service providers to increase the scale and reach of the services. Component 4 (advocacy) will be supported by SROP and ESEAOR staff although national advocacy will be as crucial as regional. The Program will improve infrastructure for static clinics and for associate facilities, which has been proven to increase client access. New (and in time, fully-integrated) services will be expanded and introduced – more long-acting, reversible contraceptives, SRHR services for people with disability, post abortion care, and screening services for victims of gender based violence (including psychosocial support and empowering communities to prevent violence against women and children). The Program will also draw on the best of the Federation, learning lessons and applying best practice from other programs such as the innovative, Australia-funded Core+ service delivery program in South Asia; IPPF's

advocacy model; and IPPF's peer providers and educators (who can provide vital information about services as well as conduct information and education activities. As members of local communities it will be essential to include them in the planning). Opportunities for Pacific FHAs to learn from each other and to draw on the expertise of high performing FHAs and regional Member Associations (MAs) will also be possible.

The FHAs will also build up and strengthen their cooperation with other NGOs in related sectors, by offering training and technical assistance in providing SRHR services. Partnerships and robust referral pathways will be established with other providers, thus improving weak and fragmented health systems and making better use of resources, often where there are severe shortages.

Effective and efficient Program management: Seven IPPF staff – based at IPPF's Pacific Sub Regional Office in Suva, Fiji – will ensure responsive, high quality, and timely management and operational implementation. The Pacific Sub Regional Office will have the authority and accountability to deliver the Program to time and budget, and will be responsible for agreeing the FHAs' Annual Work Program. IPPF and DFAT funds' cycles will be aligned to streamline administration and improve the overall impact of the FHAs. Strategic guidance and oversight will be provided by IPPF's Director General (Central Office) and the ESEAOR Regional Director.

Value for money is demonstrated through minimal staff costs with less than 5 percent of Core funds going to staffing, and maximization of the use of volunteers. IPPF Core funds will finance the running costs for FHA programs which provide the platform for core service delivery. Where necessary, clinical commodities and supplies will be procured through competitive tendering but FHAs have also established local supply lines with governments, UNFPA and through partnerships with NGOs. IPPF's global tools such as performance-based funding to FHAs, data collection, financial management, performance and quality control will also improve VFM, as well as the increasing use of associate clinics in partnership with other service providers.

Monitoring and evaluation: Frameworks have been developed to monitor both the progress of the program as well as the achievement of country-specific targets by the FHAs. SROP staff will be responsible for monitoring implementation and performance management of FHAs with the support of ESEAOR Head of Programs. An M&E Program Officer will be recruited for the SROP office and will engage with the different service channels through the FHAs. FHAs will establish effective M&E systems across partners and outreach sites, including mechanisms for ensuring and strengthening data quality. All FHAs have existing processes whereby SRHR data (particularly from clinics) is transmitted to MoH information systems. Where the Program interacts with partner organizations (e.g. associate clinics, government health centres), joint planning with existing RH coordination mechanisms, and data generated from joint activities will be channeled through established government collection points as well as to the IPPF eIMS. A mid-term review of the program including outreach activities will be conducted at PY1.5 with the view to scaling up activities. A plan for scaling-up will be developed, endorsed by government and implemented after the mid-term review based on results and funding.

In **conclusion**, the Program aspires to advance FHA service delivery beyond natural growth to transformational growth, with SROP – supported by regional and central office teams – as the catalyst for driving and supporting the FHAs. Innovation is a

cross-cutting theme in the Program and will facilitate scaling up of services, quality improvement utilizing IPPF state of the art technology, and incentive funding for innovative strategies proposed by FHAs. Advocacy for change will see FHAs as indispensable partners of Ministries and contracted to provide SRHR services to the poor and most marginalized groups through partnerships with communities and CSOs. Equity will be advanced and progress towards IPPF's Vision 2020 – sexual and reproductive health and rights for all – will be a reality through IPPF's unique connection to communities and respect for what clients want and need.

1. Program Origin and Design Process

1.1 Activity Origin

The Pacific **Family Health Associations** (FHAs), supported by International Planned Parenthood Federation's (IPPF) East and South East Asia and Oceania Region (ESEAOR) and Sub Regional Office of the Pacific (SROP) work in five priority areas:

- Provision of integrated sexual and reproductive health (SRHR) services and protection of rights.
- Quality of care.
- Working in partnership with communities, governments, other organizations and development partners.
- Strengthening health systems.
- Mainstreaming gender elements into programming.

IPPF FHAs lead the way in providing integrated, quality, comprehensive, client-friendly SRH clinical and education services in the Pacific; and reaching the poor and most marginalized[2] groups, particularly young people.

The recent five year **Pacific Regional SRH Capacity Building Program** 2008-2013 (hereto referred to as the CBP) was jointly funded by New Zealand and Australia, and responded to FHA-defined needs to improve FHA capacity to advocate for and deliver quality SRH services, particularly for the poor and most marginalized groups. The CBP was evaluated as: effectively building on IPPF leadership and best practice in SRH; well-managed by ESEAOR; significantly contributing to the ICPD Plan of Action and the Pacific MDGs; and, through the close relationships between FHAs and national Ministries of Health (MoHs), supporting national leadership, ownership and quality service delivery through cost effective, indigenous SRHR services delivered by the FHAs.

Achievements of the Program included: significant increase in contraceptive and non-contraceptive services, particularly to vulnerable groups; improved FHA governance and management structures; improved planning, reporting, monitoring and evaluation and implementation rates; and increased collaboration with national and regional stakeholders. The End of Program Evaluation concluded that following the successful capacity building support (described above), it was timely to expand service delivery and increase advocacy.

Following the evaluation of the CBP, ESEAOR undertook a mini design which considered the recommendations of the evaluation report, the identified SRHR needs of Pacific Island Countries (PICs) and FHAs, and the policies and priorities of PIC governments and development partners. The structure of the subsequent **Partnerships for Health and Rights Program** 2014-2017is modeled on the successful Australian Aid Program-funded IPPF South Asia Regional Office Core +

[2] Note: IPPF defines 'marginalized groups' as being young people, transgender people, sex workers, men having sex with men, people who are gay, lesbian or bi-sexual, child brides and girl mothers and for purposes of data collection marginalized is referred to as Poor, Marginalized, Socially excluded and Under-served (PMSeU). People who are remote from SRHR services are also under-served.

Initiative (2011-2014) which has a focus on service delivery: increasing access through wholly-owned or partnered static and outreach clinics; and strengthening FHA service delivery and management systems. In the Pacific, it will be implemented by eight IPPF Member Associations (the FHAs) - Cook Islands Family Welfare Association (CIFWA), Reproductive Family Health Association of Fiji (RFHAF), Kiribati Family Health Association (KFHA), Samoa Family Health Association (SFHA), Solomon Islands Planned Parenthood Association (SIPPA), Tonga Family Health Association (TFHA), Tuvalu Family Health Association (TuFHA) and Vanuatu Family Health Association (VFHA).

This process of strategy development coincided with the development by the Department of Foreign Affairs and Trade of a new Regional Health Strategy. The new Program will be supported by IPPF and the Australian Government under the Pacific Regional Health Program. DFAT's Regional Health Program for the Pacific will include support for the regional provision of specialized clinical and public health services in the areas of tertiary care, specialized health worker training, technical cooperation and ***service delivery innovation***[3]. This includes 'essential, cost-effective health services necessary to improve health outcomes of Pacific Islanders that are currently not being prioritized by Pacific Island governments'.

DFAT, through the Regional Health Program, will have a role as an interim financier of these services where:

i. There is unmet need, particularly by disadvantaged populations.
ii. The service is cost-effective.
iii. A viable, potentially sustainable service delivery model/ provider exists at country level.
iv. There is policy engagement with Governments to buy into the model[4].

This is in line with the AAP's Health Strategy (2011) which advocates investment in 'what works, is effective and achieves results'. The six pillars of investment by Australia are: quality services, closing the funding gap, addressing the needs of the poor and vulnerable, working with other sectors, decreasing the impact of global and regional health threats, and to maximize the impact of overseas development assistance[5]. These criteria fit with the role of the FHAs.

It is proposed that family planning provision via non-state providers (the FHAs) be supported under this approach which acknowledges that there is low contraceptive prevalence across the region, particularly for young women[6]; and that FHA service delivery provides a cost-effective and viable service delivery model. DFAT has committed to providing targeted financial support for FHAs - indicative initial funding of AUD 4.5 million split evenly over three years.

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[3] Pacific Regional Health Program Delivery Strategy 2013-2017, Australian Government: Department of Foreign Affairs and Trade; December 2013

[4] Ibid

[5] AusAID Health Strategy (2011), Australian Government

[6] I am not a lost cause! Young Women's Empowerment and Teenage Pregnancy in the Pacific, October 2013, UNFPA

DFAT has invited IPPF to submit a proposal for its funding consideration and has provided strategic issues for consideration in the design. The checklist is documented in the Investment Design Plan (Annex 1). The proposal addresses DFAT's Investment Design Quality Standards which will guide the appraisal of the proposal by DFAT.

1.2 Design Team and Mission

The objectives of the design **process** were to:

i. Engage all levels of IPPF to determine feasible ways of advancing SRHR (particularly family planning in the Pacific.
ii. Consult Pacific stakeholders in discussion of SRH needs in the region and agree on an appropriate role for IPPF/FHAs in the eight PICs.
iii. Develop a proposal to DFAT's investment design quality standards.

The process included information collection and analysis; development of a draft service delivery strengthening strategy; consultations with key stakeholders on key issues and feedback on the proposed strategy; review of the design framework by IPPF and the eight FHA Executive Directors; and documentation of the design. A team providing a mix of skills from IPPF Central Office, South Asia Regional Office (SARO), East and South East Asia and Oceania Region (ESEAOR) and the Sub Regional Office of the Pacific (SROP) was selected and a Consultant contracted to assist with the process and documentation. In addition, key resource personnel from all levels of IPPF were made available to advise on relevant thematic areas. A list of the names and roles of the members of the design team is included in the Plan (Annex 1).

1.3 Method and Consultation

An initial meeting was held to brief the team prior to the consultations. Consultations were conducted in all eight countries included in the proposal - Cook Islands, Fiji, Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. Executive Directors led the consultation process in their own countries with the Design team assisting in three countries – Samoa, Solomon Islands and Fiji. Consultations were held with FHA staff; relevant Ministries e.g. Health, Youth, Women's Affairs; key NGO partners of FHAs; DFAT Post health program staff; UN agencies; faith-based groups; medical organizations; clinic clients, young people, transgender people and people with a disability. The list of stakeholders consulted is included in Annex 2 and key results of the consultations are included as Annex 3.

Following the consultations, the team and six of the Executive Directors met in Nadi over two days to discuss the results of the consultations, revised the Program design and detailed resource needs. This process resulted in an agreed Program framework and costed outputs for the Program. The two absent Executive Directors (from KFHA and TuFHA) were consulted remotely and their costed plans received by email. The team then met over three days in Suva at the SROP office to agree the design framework and consider the budget. A Progress Report and preliminary design features were then presented to DFAT staff from Suva and Canberra. The presentation forms Annex 4.

The result of this participatory process has been a design that has ownership from FHAs and their stakeholders, as well as the benefit of a high level of technical input from all levels of IPPF e.g. quality of improvement, service and method mix; commodity security; advocacy; resource mobilization and financial systems.

2 Situation Analysis

Pacific Island Countries (PICs) are some of the world's smallest and least developed national economies; contain densely populated urban settlements and small islands; have limited access to essential resources like arable land and potable water; and have populations most vulnerable to natural disasters and climate change. The health status of most PIC populations is low and stagnating. The co-existence of maternal and child health problems and communicable diseases with non-communicable diseases means that health costs are increasing at a time when health budgets are unlikely to increase.

Of the FHAs included in the proposal, Solomon Islands and Vanuatu experience the greatest population challenges (youthful populations [7] and high fertility rates, particularly adolescent fertility[8]); and Kiribati, Tuvalu and northern Cook Islands have population imperatives with limited land available for settlement and are the most vulnerable to the impacts of climate change. The micro-states of Kiribati and Tuvalu face particularly difficult challenges: their small, isolated populations and remote locations mean that service delivery is demanding and expensive, both in terms of logistics and human resources.

2.1 Sexual and Reproductive Health in the Pacific

Challenges to improving SRH in PICs include: high population growth rates and slow rate of economic development[9]; realization of rights for vulnerable groups (women, children, young people, the elderly and people with a disability); integrating SRH services[10] (family planning, STIs and HIV); addressing gender-based violence; the high cost of transport (local and remote); and the relatively low status of women.

SRH in these eight PICs is characterized by: low contraceptive prevalence rates; high unmet family planning need; high sexually transmitted infections (STI) rates; high teenage pregnancy rates despite some improvement over the past five years; high maternal mortality rates in parts of Melanesia; and increasing reports of gender-based violence[11]. Government-provided clinical services for SRH are generally of

[7] In all eight PICs, proportion of the population <15 years is 35-40 percent (Teenage Pregnancy in the Pacific, UNFPA, 2013)

[8] Adolescent fertility rates are >50 per 1,000 young women aged 15-19 years (Teenage Pregnancy in the Pacific, UNFPA, 2013)

[9] Pacific Regional ICPD Review: Beyond 2014, UNFPA, July 2013

[10] Clients who visit IPPF's clinics are assured that an integrated package of essential services will be available, a 'one-stop shop' providing sexuality counselling; contraception; safe abortion care; and STI/RTI, HIV, gynaecological, obstetric and gender-based violence services. IPPF is rolling out globally this package of eight essential services, which are recognized by the WHO for their high impact in service delivery.

[11] Annex 7 provides data on SRH in the 9 PICs comparing 2009 data with 2013

poor quality with significant ideological barriers to access for groups such as young people and unmarried women.

From a consumer perspective, barriers to accessing services in the Pacific include cost, distance, time, lack of sensitivity of providers, cultural and religious barriers and legal and policy barriers[12]. In some PICs, rural and remote populations have no access to SRHR services. Providing SRHR services to outer islands and to marginalized groups is difficult and expensive due to: the high cost of inter-island transport and outreach vehicles; the time, cost and staffing issues in providing tailored clinical services for vulnerable groups which often require nurses (and educators) to travel long distances and leave their static clinics; and inclement weather and unreliable transport which can result in cancellations and the need to re-schedule outreach trips.

GOVERNMENT SRHR SERVICE PROVISION

A client-centred approach is lacking in many government-provided services in that all clients should have the right to access SRHR services and information, and be assured that an integrated package of services is available. FHA clinic services provide the Integrated Package of Essential Services (IPES) which is quality assured through IPPF's Quality of Care continuum (See Annex 6 – IPPF's Quality of Care Strategy).

While government clinics provide primary health care services which include family planning services, the needs of the service providers are often not met; staff do not receive high quality training; do not provide an integrated service; offer a limited range of contraceptives; and can be judgmental in their attitudes to young and unmarried people. The end of program evaluation of the CBP found that in government-run clinics and in some FHAs, the range of contraceptives, (particularly long-acting) was dependent on what staff are trained in, and what is ordered by the staff and this usually means women are not offered a full range. FHAs source SRHR commodities from the government stocks, thus limiting their range also. Most countries offer oral contraceptives, injectables and condoms. Clients have the right to a wide mix of methods, however they are frequently not offered IUDs, implants, emergency contraception and permanent forms of contraception such as vasectomy. This Program will begin to redress this (see Table 3, Section 4) and improve method mix in FHAs and model the IPPF integrated approach for associate clinics (services which partner with FHA clinics during outreach).

FHA SRHR SERVICE PROVISION

As a results of implementation of the CBP over the past five years, IPPF Global Indicators for the Pacific FHAs in 2012 demonstrated significant improvement: contraceptive services delivered by FHAs have increased in all FHAs except Tuvalu; non-contraceptive services (e.g. STI services, Pap Smears) have increased in all FHAs; the proportion of FHA clients who are PMSeU has increased, except in Tonga and Tuvalu; and the number of service delivery points has increased in all FHAs except in Tonga. The CBP enabled five FHAs to begin extending integrated services to some outer islands (KFHA, CIFWA, SFHA, TFHA, VFHA). Governance has

[12] Pacific Kaci, UNFPA October 2012

improved in all eight FHAs. This has supported FHAs to advance through IPPF accreditation processes to reach either Associate Membership or Full Membership status. As of 2014, all the eight FHAs are Full Members. This significantly improves the Pacific profile of FHAs in the ESEAO Region and increases their status and voting power within IPPF. Country information and FHA service statistics for 2012 can be found in Annex 8.

2.2 International Development Issues

DFAT has identified the core, overarching development problem in the Pacific is the **low and stagnating health status** in Pacific island countries[13] caused by:

- Poorly addressed lifestyle risk factors fuelling the NCD epidemic.
- Weak health systems that are providing only patchy coverage.
- Regional and national governance mechanisms that are not strongly focused on identifying, implementing and monitoring sound policy and spending to improve health outcomes.
- Fragmented, poorly aligned and relatively inefficient and ineffective Development Partner support for health improvement in the region.

Sexual and Reproductive Health has been identified as a key focus area due to the level of unmet need and the potential for SRHR interventions to yield far-reaching development benefits, which are considered a 'best buy' in global health, particularly for women and young people. Sexual and reproductive health is also critical to the progress of the Millennium Development Goals in the Pacific.

Gender equality is a core development outcome. The World Bank acknowledges that investments in reproductive health are a major missed opportunity for sustainable development and that improving SRHR requires addressing women's agency; making improvements in the delivery of health services; and increasing accountability in health systems[14]. Gender based violence is recognized as a critical issue in the Pacific where there are very high rates of GBV including forced sex. Many PICs retain legislation which discriminates against some sexual orientations and gender identities (e.g. Lesbian, Gay, Bisexual and Transgender Intersex) and which fails to protect people living with HIV and women's rights to make free and responsible sexual and reproductive health choices.

Teenage pregnancy is acknowledged as an important development issue which needs to be prioritized, particularly given the scale of the 'youth bulge' in the populations of the majority of PICs. UNFPA recognizes that 'investing in adolescent girls' and young women's SRHR will
contribute to preventing teenage pregnancy and sexually transmitted infections including HIV' and that 'child marriage, coercive sex, and gender based violence are

[13] Pacific Regional Health Program Delivery Strategy 2013-2017, Australian Government: Department of Foreign Affairs and Trade; December 2013

[14] K Grepin, J Klugman (2013) Closing the deadly gap between what we know and what we do: Investing in Women's Reproductive Health, World Bank Women Deliver

often key elements in the context in which a girl becomes pregnant and all are human rights violations, as are denials of access to sexual and reproductive health information and essential services'[15].

Human Immuno-Deficiency Virus (HIV) programming in the Pacific has drawn attention to other sexual health and wellbeing issues which prevent Pacific Islanders from achieving sexual and reproductive health and rights and ultimately impacts on their full potential and living healthy, productive and fulfilling lives. Such issues include transmission of STIs, gender based violence and sexual assault, unwanted pregnancy particularly among youth, gender inequality, stigma and discrimination on account of one's sexual orientation and gender identity and mental health problems related to sexual health. This has led agencies like the Secretariat of Pacific Communities to broaden HIV activities into a SRHR framework. This will bring SPC programming it into line with current FHA practice – the prevention of HIV through an integrated approach to prevention of unwanted pregnancy, the prevention of STIs including HIV.

People with Disability, particularly women are among the most 'invisible' and discriminated people in the world[16]. It is estimated that approximately 15 percent of the population of any country is living with a disability, including mental health problems. Their rights to SRHR services are not protected and they suffer from the false belief that they are asexual, unsuitable for marriage and are unable to manage their fertility or raise children. Until now their SRHR needs and access to services has not been a priority for governments. This is changing with development partners realising the need for development for all, and for disability-inclusive service delivery. This issue is closely related to Non-Communicable Disease (below) in terms of the impact of cardiovascular disease and diabetes on mobility and amputations.

Non-Communicable Disease (NCD)

NCDs are defined as including: cancer (including cancers relating to the reproductive tract – e.g. cervix, uterus, vagina, prostate, endometrium); diabetes; cardiovascular disease; and chronic respiratory illness. All are preventable.

The significant links between NCDs and SRH can be summarized as including:

- Low birth weight leads to diabetes and heart disease in later life, so antenatal care is vital in preventing low birth weight, and in preventing unwanted pregnancies. Providing maternal, newborn and child health care and information can lead to healthier life/lifestyles.
- Stopping smoking, increasing exercise, and improving healthy eating can prevent 80 per cent of heart disease, diabetes and 40 per cent of cancers. These risks are discussed in SRHR consultations before hormonal contraceptives are prescribed and to encourage preventive procedures such as Pap Smears. Obese women are more likely to experience infertility problems.

[15] I am not a lost cause! Young Women's Empowerment and Teenage Pregnancy in the Pacific, October 2013, UNFPA

[16] A Deeper Silence: The Unheard Experiences of Women with Disabilities, Sexual and Reproductive Health and Violence against Women in Kiribati, Solomon Islands and Tonga, March 2013, UNFPA and WHO

To put NCDs into perspective globally, every day 50,000 women die from NCD; every hour more than 1,000 women die from cardiovascular; and every two minutes a woman dies from pregnancy and childbirth[17]. The World Health Organization (WHO) estimates that in the Pacific region, 75 percent of deaths are due to NCDs.

There is an urgent need for health systems to reorient to provide integrated services which can: reduce maternal mortality; improve access to family planning; tackle infectious diseases; and address NCDs/lifestyles. Prevention, diagnosis and treatment have to be integrated and be provided from childhood to old age. This includes the lifetime need for integrated SRHR services. Through this Program there is an opportunity to localize the provision of IPES through the inclusion of services for NCDs.

Knowledge of how to prevent STIs, particularly human papilloma virus (HPV), is critical in the prevention of cancer of the cervix so promotion of condoms can also prevent NCDs. This is particularly important for sex workers, MSM and young people who are more vulnerable.
IPPF MAs, including the Pacific FHAs, are increasingly recognizing these links and re-orienting education and clinical services to all clients to address this growing epidemic of NCDs; as well as adapting services for those disabled by NCDs.

2.3 Stakeholder Analysis

Effective stakeholder engagement and partnerships between governments, multi-lateral organizations, non-government organizations (local and international) and the private sector are the keys to improving sexual and reproductive health and rights in the Pacific. The main SRHR stakeholders in the Pacific are IPPF (the Pacific FHAs, the Sub Regional Office of the Pacific in Suva and ESEAOR office), Ministries of Health, Ministries of Education, Ministries of women, Ministries of Community Development, the United Nations technical agencies such as UNFPA, WHO and UNICEF, and other non-government organizations who address particular aspects of SRH and who partner with FHAs such as Red Cross. Annex 5 provides details of SRHR stakeholders in the eight PICs of interest.

All eight PIC Governments, through the **Moana Declaration** of August 2013, acknowledge the access difficulties and the universal rights of all people to SRHR services, and have agreed to address the enabling environment to ensure access to SRHR for all people without discrimination, and have affirmed their commitment to inclusiveness, gender equality and sexual and reproductive health and rights (SRHR). IPPF is in the process of agreeing an MoU[18] and a cooperation agreement with the Solomon Islands Government (SIG) Prime Minister. This commits SIG to facilitating SIPPA to convene a meeting with national and provincial governments, NGOs and faith-based organizations to prepare a costed action plan to realize SRHR by 2020.

[17] Entre Nous: The European Magazine for SRH, No. 75, 2012, WHO Europe

[18] Letter of intent from Prime Minister (SIG) to Director General, IPPF, 10 March 2014.

The **Wellbeing Shared Agenda**[19] is being developed by SPC and a task force[20] of key stakeholders (including IPPF) and aims to: set and build a vision for integrating HIV and STIs into a broader sexual health agenda around priority needs of the region; facilitate the delivery of accessible and equitable sexual and reproductive health services and programs; and leverage and add value to country level programs and initiatives along key strategic directions that work towards integration and coordinate action of regional and development partners.

UNFPA is a major stakeholder in all eight PICs providing SRH commodities as well as technical assistance to MoH. It is understood that UNFPA will head up the New Zealand Ministry of Foreign Affairs and Trade's Pacific Regional SRH Program and be implementing a range of activities over the next five years. IPPF and UNFPA are working together to formalize their engagement in the Pacific. IPPF has signed an agreement for the delivery of the project.

Government leadership and ownership: Increasingly PIC governments are developing SRHR policies, reorienting services towards a more integrated approach and acknowledging the essential work of FHAs in reaching the poor and most marginalized groups and young people. This is evidenced by the inclusion of FHAs in Ministry of Health SRH Programs – and in Ministry of Education SRH curricula development – as key partners. Annex 5 provides a table of Pacific stakeholders and their roles and relationships.

The **results of the consultations** for the development of this design provided an insight into the partnerships with FHAs in the Pacific. Consultations were undertaken with all MoH and NGO partners, as well as client groups. While SRHR services are fragmented, SRHR partnerships are well developed. Key conclusions from the consultations were:

- FHAs are well respected and appreciated by their Ministries of Health and other Ministries e.g. Youth, Education and Women's Affairs particularly for their work with young people and hard-to-reach groups.
- FHAs have developed strong partnerships with other NGOs and FBOs. This augurs well for maximizing scarce health resources and utilization of joint networks for reaching vulnerable people.
- The SRHR sector is fragmented and programming is not reaching non-urban areas. There was a keen interest in reaching under-served areas and the poor and most marginalized groups.
- MoH counterparts were enthusiastic about the proposed strategy, particularly outreaching to non-urban areas, and emphasized the need for coordination with MoH reproductive health coordinators, and that FHA data from regional areas be sent to MoH by the appropriate provincial health authorities.
- There is a dearth of SRH data available, and in some countries FHAs are recognized as providing the only reliable data e.g. Samoa and Solomon Islands.
- Disability organizations are keen to have SRHR embedded into their programs so they can understand better the needs of their peers.

[19] Wellbeing Shared Agenda (V4), Public Health Division, Secretariat of the Pacific Communities, Feb 2014

[20] The Technical Working Group comprises: SPC, UNAIDS, UNICEF, UNFPA, WHO, UNDP, IFRC, IPPF and OSSHHM

- Task shifting was identified as potentially hampering the broadening of the contraceptive method mix to include more long acting reversible contraceptives, particularly intra-uterine devices and implants. In some PICs only midwives can undertake these procedures. This is seen as an urgent advocacy issue for FHAs who predominantly recruit registered nurses for their clinics. Some are now prioritizing recruitment of midwives.
- Each Pacific FHA operates within its own geographical, socio-cultural and health context and service delivery needs vary across PICs. FHA Performance also varies.

3. Strategy Selection and Rationale

3.1 Guiding Policies and Principles

The principles and policies which have determined the priorities for this design are all embedded in IPPF's overall philosophy:

- Equity[21] in access to SRHR services.
- Continuous quality improvement through IPPF's quality of care approach to implementing an integrated package of essential services.
- Integration within policy, service delivery and service networks.
- Advocacy to attain government buy-in and build leadership.
- Good governance.
- Reaching priority groups e.g. young people, people with disability, the poor and most marginalized, and those who live in non-urban areas.

IPPF invests in family planning and sex education because they are fundamental rights vital to improving health and saving lives. IPPF believes that SRH should be internationally recognized as human rights and therefore guaranteed for everyone regardless of race, age, religion, economic status and sexual orientation. IPPF's Theory of Change (in Annex 9 – Results Framework) describes such facilitating factors as:

- Being a Federation yet Member Associations are locally owned ensuring an understanding of culture.
- A rights-based approach which ensures a client-centred and high quality service.
- An integrated approach to providing combined sexual (STI, including HIV) and reproductive (family planning) health services which increases efficiency and effectiveness.
- Flexibility which allows for response to initiatives and innovation from any part of IPPF.
- Partnerships which deliver services to hard-to-reach groups and increases clout in advocacy and policy influencing.

[21] Equity – multiple dimensions including gender, age, disability, place of residence, marital and family status, HIV status, indigenous identity, sexual orientation (Post-2015 Consultation convened by UN Women and UNICEF, 2013)

As well as the previously mentioned Australian Aid Program Health Strategy (2011) and the Pacific Regional Health Delivery Strategy (2013), DFAT has Pacific programs addressing gender and disability both of which have guided this design. The **Pacific Women Shaping Pacific Development Initiative** is an Australian-funded **gender** initiative which commits to improving the political, economic and social opportunities of Pacific women. Projects are currently being implemented in Solomon Islands (working with church leaders from four of the five main churches across 30 communities/10,000 people) to change attitudes and behaviours around gender violence; and in the Cook Islands, with the Ministry of Internal Affairs to: support women in the formal and informal sectors by identifying new economic opportunities, supporting access to financial services and the integration of women living with disability into economic opportunities; and eliminate violence towards women by improving legal frameworks, law enforcement and justice systems; and improving the coordination of service providers. Both projects provide opportunities for synergy and collaboration via the respective FHAs. FHAs already incorporate gender analysis into their work plans particularly as a result of the Gender and Rights training received through the CBP Australian-supported Program. Some FHAs (SIPPA, VFHA, TFHA) are providing screening for GBV (as well as psychosocial care and support and education on preventing violence against women and children) and this Program will see it universally implemented as part of the IPPF's Integrated Package of Essential Services (IPES).

Development for All: Towards a Disability-Inclusive Australian Aid Program 2009–2014 commits to extending the benefits of development to all, and to promoting the dignity and well-being of people with disability (PWD). It acknowledges that access to SRHR information and clinical services can protect PWD, particularly women from exploitation, sexual abuse, unplanned pregnancy and STI including HIV. Stronger links with regional disability programs can assist to strengthen this support. Partnering of FHAs with local disability organizations, and inclusion of PWD in IPPF's definition of PMSEU – poor, marginalized, socially excluded and under-served – will support improved access for people with a disability accessing FHAs. More effort is needed to reach PWD in rural and remote areas. The Companion Volume to the Disability Strategy - Accessibility Design Guide: Universal design principles for Australia's aid program: *A companion volume to Development for All: Towards a disability-inclusive Australian aid program 2009–2014* will also be useful in guiding any new clinics and upgrading of FHA clinics to enhance access for PWD.

3.2 Alignment / Harmonization with Government Systems

FHAs have worked over many years to build coalitions with government and civil society organizations. Progress has been made but only two FHA (CIFWA and RFHAF) currently have a MoU with the Ministries of Health and/or Education or other relevant Ministry. All FHAs have active partnerships with their MoHs and three (SIPPA, KFHA, VFHA) are already outreaching to government-run health facilities with services and capacity building.

This new Program has the potential to forge even stronger links with Ministries through increasing the number of associate clinics and communities reached through outreach activities, and through modelling best practice in service delivery. All MoHs in the eight PICs are developing SRHR policies which include reference to utilizing

CSOs (namely FHAs) to be engaged in implementation of the new policies. A strong advocacy component has also been included.

3.3 Program Innovation

Innovation will be demonstrated throughout the new Program on many levels; innovation is supported throughout the Federation as it contributes to knowledge of what works and what does not, and provides workable models that can be replicated on a larger scale; it also inspires and builds confidence. Above all, innovation improves programming effectiveness.

FHAs have already developed ground-breaking approaches to service delivery in the Pacific, to solve some of the most difficult sexual and reproductive health and rights issues in the region.

Some have demonstrated leadership on aspects of sexual and reproductive health that they were previously unfamiliar with and have taken risks to engage new partners and received recognition for their capacity as technical experts at the country level. In Samoa, 40 per cent of the population is under 25, so a large part of SFHA's program is working with school drop-outs, and it has been successful in shifting cultural attitudes so that teenage mothers are now allowed to return to school. SFHA also works with universities, nightclubs and soccer clubs where it runs youth clinics, and installs (free) condom vending machines.

The FHA in Tonga runs 14 school-based clinics, and a drama group for school drop-outs, which tours around the country – as well as visiting New Zealand and Australia – raising awareness on health, nutrition etc. It performed sketches around World AIDS Day, for example. It's seen as a blueprint on which to model other drama and behavior-changing projects. Working with young parents, transgender clients and school drop-outs (under age 19), TFHA also teaches life skills, running income-generating projects, providing contraception and making soft loans.

Other FHAs have been instrumental in embedding sexual and reproductive health into courses at maritime colleges – making it a requirement of graduating – and working with prison services, the police, resort hotels and juvenile centres. Others reach remote island communities by piggy-backing on local government trips, partnering with other agencies – whether CSOs or private service providers, and using mobile phone technology for communicating health messages. These innovations will be further developed in the new Program to deliver information and services to isolated populations, particularly those in the micro-states of Kiribati and Tuvalu.

Innovation will also be required to step up IPPF's disability-inclusive approach to service delivery. SFHA, which already works with people with special needs and disabilities through a local NGO, Nuanua O Le Alofa, and other FHAs have encountered some discrimination and challenges around providing sexual and reproductive health to these clients. The new Program will employ innovative initiatives to reach these and other marginalized populations.

IPPF's innovative tools and processes, including its Vulnerability Assessment, Branch Performance Tool and Quality Improvement – which form part of IPPF's

comprehensive technology – will further enhance quality service delivery, as well as value for money.

Innovation will also be encouraged through opportunities for incentive funding available for FHAs who submit proposals for innovative service delivery activities.

3.4 Lessons Learned

This Program will build on the previous investment by Australia in the recent CBP which has been evaluated as being highly successful in building the capacity of FHAs to address significant unmet need, particularly for disadvantaged populations, including young people. Other lessons from the CBP included: that 4-5 years duration was needed to demonstrate real results in the Pacific context; and that while capacity development for FHAs is an ongoing need, small infrastructure activities, purchase of vehicles, outboard motors, generators and repair and maintenance activities also contributed to improved access to key communities.

The NZ-funded Healthy Families Project (2010-13) through KFHA learned that outreach clinics in urban and peri-urban areas were beneficial for poorer clients who cannot afford the bus fare to the static clinic in the centre of the island, and that outreach to education institutions assisted young people to better access to SRHR services. Outreach in urban areas as well as to remote sites are included in this design.

In the SARO Core + Initiative (2011-2014) on which this Program is modelled, the project is on track to achieve 37 percent increase in Couple Years Protection (prioritizing long-acting contraception), 33 percent increase in MCH services and 29 percent increase in SRHR services. The program has provided opportunities to:

- Contribute to IPPF's vision to double services by 2015 and triple them by 2020.
- Expand service delivery by increasing the number of service delivery points.
- Provide needs-based programming which allows MAs to plan for their own needs and priorities, and integrate the program activities into their core programs.
- Enhance partnerships with government service providers and other NGOs providing services for PMSEU thus reaching more PMSEU.
- Strengthened systems including quality of care.
- Realized IPPF's integrated package of essential services (IPES) including services to address gender-based violence.

SARO found that opportunities to generate demand were maximized through community engagement, and increased potential for engagement and partnerships with government health providers in the local areas has been noted. Governments are now interested in these new models of SRHR service delivery. Cross learning between MAs has also been a feature of the program.

3.5 Options for the Intervention

The Design Team applied the following criteria to assess the options proposed by both the initial, original Service Delivery Strengthening Strategy and those identified

during the consultations with stakeholders. The criteria are largely taken from the strategies DFAT requires IPPF to consider.

Table 1: Criteria for Strategy Selection

Criteria 1	Contributes to IPPF Change Goals – The option has the potential to improve access, the enabling environment and management systems
Criteria 2	Contributes to SRHR for all (equity) – The option targets those not reached by static clinics
Criteria 3	Focuses on integrated SRHR service delivery - The option models quality and integrated service delivery to government partners and clients
Criteria 4	Focuses on meeting the needs of the poor and most marginalized – The option provides free services to hard-to-reach groups
Criteria 5	Increases the reach of SRHR services within the eight countries - The option reaches areas and clients not reached by static clinics.
Criteria 6	Considers the situation and needs of each country - The option allows for country-specific planning.
Criteria 7	Builds strategic links between governments and FHAs

Table 2: Options weighed against Criteria

Option	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Selected Options**
(a) Business as Usual				✔		✔	✔	No
(b) Static clinic quality improvements	✔			✔		✔		Yes (in part)
(c) Outreach services	✔	✔	✔	✔	✔	✔	✔	Yes
(d) FHA systems strengthened	✔		✔					Yes (in part)
(e) Advocacy	✔		✔				✔	Yes (in part)
Options (a)+(b)+ (c)+ (d)+	✔	✔	✔	✔	✔	✔	✔	Yes

Option	1	2	3	4	5	6	7	Selected Options
(e)								

3.6 Proposed Intervention

IPPF has worked extensively across Melanesia and Polynesia since the 1980s to bring lifesaving access to contraception and other sexual and reproductive health services. In recent years IPPF has worked with the support of the Australian and New Zealand Governments to systematically increase the capacity of its partner organizations – the FHAs – such that they can become full Member Associations of the Federation by passing their accreditation. An accredited Member Association has successfully demonstrated compliance against a range of criteria that ensure they are robust and sustainable organizations including governance, management, financial systems, good employment and quality of care. Full membership allows the FHAs to enjoy a much wider range of benefits from the Federation.

Based on decades of experience in the Pacific, a recent end of program evaluation and a series of joint in-country consultations (see Annex 2 and 3), IPPF has identified that a key challenge for the Pacific is the lack of responsible planning and management of resources for SRHR means that no one institution has the oversight to ensure a total market approach. This means the health sector is fragmented which exacerbates extreme levels of inequality. The scarcity of resources is a major, but not the only, cause of this issue.

Through this proposed Program IPPF will work with FHAs to integrate SRHR at three levels – thereby reducing the fragmentation in the health sector and increasing equity for the poor and most marginalized groups. These three levels are at the:

i. Policy Level
ii. Service Delivery Level
iii. Consultation Room Level

Through this approach we aim to improve the role of the government as the steward of the health sector with support from relevant ministries – including ministries for health, women, planning, education, etc.

This Program will be called ‘Partnerships for Health and Rights: Working for SRHR for all in the Pacific’ to immediately identify its purpose. The purpose will be achieved through delivering against two key themes that, in addition to improving the levels of integration, will also contribute to the long term sustainability of the SRHR sector in each PIC. These are:

i. To unite partnerships to tackle SRHR and other health inequalities – particularly with government (e.g. health), faith based organizations (e.g.

churches), civil society organizations (e.g. disability) and community village groups.

ii. To deliver scaled up integrated services that reach the most marginalized (identified by the in-country consultations as people who are poor, young, geographically hard to reach and/or people with a disability).

Outcomes expected include: development of a model for static clinical services; outreach activities in partnership with governments and communities; FHA systems strengthened; and PIC governments held accountable for delivering SRHR for all.
The structure of the intervention provides for the opportunity to take forward the FHAs' strategic priorities and the IPPF's Change Goals in a flexible manner i.e. cutting across all functions and thematic areas. Planning and budgeting for the proposed Program will occur within the FHAs own planning and budgeting systems; and FHAs will be responsible for assigning their own targets and indicators for success. This flexibility in design and implementation has provided for integration with IPPF core programs; responding to the country contexts and the FHA needs; to design customized programs; respect for IPPF and FHA competence in setting their own priorities; opportunity to reach out to a diverse group of poor and most marginalized population; and adoption of innovative approaches and scaling up of existing approaches. In effect, it will enable rapid expansion and targeting resources to facilitate service-level growth and impact.

The intervention will provide an opportunity to further strengthen the systems at the FHA level such that they can handle a rapidly expanded program. This includes efforts to improve data capture systems (such as IPPF's Clinic Management Information System) and analysis (Vulnerability Assessment tool) for informed programming at clinic level thereby allowing greater targeting of resources to meet the poor and most marginalized. All FHAs are currently using IPPF's Quality of Care model, in this next phase of their development we will introduce during the inception phase the continuous Quality Improvement model alongside IPPF's Integrated Package of Essential Services (see Annex 6), and systems that support commodity security (including their secure storage).

IPPF will work with FHAs to increase the space available for advocacy by acting as a critical friend to the government and supporting them to improve SRHR for all. By critical, the FHA will become simultaneously indispensable, technically advanced and have the trust of the government to guide them towards more effective interventions. IPPF will work with FHAs to use their convening power and thought leadership in PICs to undertake what we call 'Practical Advocacy'. Through our information and service delivery we will identify the critical barriers that deny the most marginalized their SRHR. Typically, the legislation in most PICs is adequate; however the policies, regulations, protocols or financing is wanting. For example, does the government have a robust SRHR policy? Which methods and formulations are on government essential medical drugs lists for procurement? Are nurses routinely trained in post-partum family planning? Should we task shift/share in line with WHO guidance? Is there a budget line for reproductive health commodities and is it used? Through their existing membership of government committees or pressure groups the FHAs are well-placed to bring forward compelling evidence of the need for such practical changes that will quickly affect the lives of the most marginalized.

The FHAs will also be supported to join government delegations to attend key meetings international 'norm-setting' institutions. For example, IPPF financed the extensive participation of the FHAs at the 2014 United Nations Commission on Population and Development. This Commission, more than any previously, made a strong, clear and persuasive technical demand for the inclusion of SRHR in the final outcome document. Such international fora provide the FHAs with a non-threatening opportunity to discuss wider SRHR issues with governments while their final products can be effectively used as norm setters for advocacy changes at home.

4. Investment Program and Theory of Change

4.1 Activity Description

The overall **goal** of the **Partnerships for Health and Rights Program** will be: to advance equity for all through improving lifesaving sexual and reproductive health and rights in eight Pacific Island Countries - Cook Islands, Fiji, Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

Moving from service **fragmentation to integration**, the **purpose** of the Program is to provide quality, rights-based, integrated sexual and reproductive health information and services to communities in eight PICs, particularly to the poor and most marginalized, and to advance their SRH rights. Most marginalized people are those identified as people who are poor, young, geographically hard-to-reach and/or people with a disability.

The logic for the Program is described in the following table to output level. Indicative activities are discussed below and reflected in the budget.

Table 3: Program Logic

Goal: To advance equity for all through improving lifesaving SRHR in eight Pacific Island Countries – Cook Islands, Fiji, Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu
Purpose: To provide quality, rights-based, integrated SRH information and services to communities in eight PICs, particularly to the most marginalized, and to advance their SRH rights (most marginalized people are those identified as people who are poor, young, geographically hard-to-reach and/or people with a disability)
Strategic Objective 1: Static Clinic Service Delivery Model Developed
Outcome 1: Cost effective, sustainable service delivery model developed and delivered through quality assured FHA static service delivery points (e.g. clinics) for all, particularly the poor and most marginalized

1.1 Relevant clinic staff trained in broad range of contraceptive methods, particularly LARCs, and other SRHR services (including those that link to NCDs) to support IPPF IPES compliance.
1.2 SRHR services (including family planning) and service mix promoted.
1.3 Capacity built to deliver services specifically for people with a disability (i.e. Compliance with the Australian Aid Program's Development for All Policy).
1.4 Static service delivery points improved and/or expanded facilitating the introduction of IPPF's Quality Improvement tool.
1.5 Demand created for SRHR services among the poor and most marginalized, particularly people with a disability.
Strategic Objective 2: Outreach Services in Partnership Conducted
Outcome 2: Cost effective SRHR outreach activities implemented in partnership with governments and communities, exclusively for the poor and most marginalized
2.1 Outreach and mobile service sites mapped, approved and resourced in partnership with governments and communities (e.g. faith-based organizations; disability organizations, women's and youth groups).
2.2 Networks of trained volunteers, FHA partnerships and community stakeholders developed and engaged.
2.3 Capacity at outreach sites improved facilitating use of IPPF's Quality Improvement tool (i.e. working to meet the Australian Aid Program's Development for All Policy).
2.4 Implementation of outreach activities in partnership (through annual plans).
Strategic Objective 3: FHA Systems Strengthened
Outcome 3: FHA systems strengthened
3.1 FHAs' systems to capture and analyze qualitative and quantitative data strengthened through the introduction of IPPF's Clinic Management Information System (CMIS), the Vulnerability Assessment tool and the Branch Performance Tool to enable better targeting of finite resources to meet the needs of the poor and most marginalized.
3.2 Commodity security and management improved (through the application of the approach developed by the DFAT-funded IPPF Core+ Initiative in South Asia).
3.3 IPPF's Quality Improvement framework implemented (compliant with, and beyond the requirements of the Australian Safety and Quality Framework for Health Care).
3.4 Links with Non-Communicable Diseases (NCD) integrated into SRHR (FHA specific – drawing on evidence documented by WHO and UNFPA).
3.5 Committed FHA members and governance that reflect the diversity and the

capacity required are retained.
3.6 Innovation in service delivery rewarded
Strategic Objective 4: Advocacy for Change Implemented
Outcome 4: PIC governments held accountable for delivering SRHR for all (in compliance with IPPF's Vision 2020)
4.1 Evidence for advocacy – including IPPF's cost effective, sustainable model for the Pacific - collated and documented.
4.2 Advocacy is conducted with Pacific governments.
4.3 Creating/working with multi-stakeholder network/s for advocacy (including working with parliamentarians).
4.4 Plans for scaling-up of SRHR services developed, endorsed by government and implemented.
4.5 Regional and international norm-setting institutions engaged on advancing SRHR e.g. PIFS, SPC, WHO, UN.

4.2 Results Framework

Annex 9 describes how the elements of the Program relate to the IPPF Theory of Change and the expected short-term, medium-term and longer-term outcomes.

In summary, the indicators of success will include:

For Short-term results (by 2015):
- All FHAs move from QoC to QI model
- All FHAs CMIS introduced
- At least 4 FHAs include LARCs in method mix
- All FHAs are trained with services that are disability-inclusive

For Medium-term results (by 2016):
- Increased # SDPs
- SRHR Services doubled for PMSEU
- No stockouts
- MoH and other NGOs are active partners
- Policy changes eg essential drugs list and disability inclusiveness in services
- LARCS in method mix in at least 2 additional FHAs

For Long-term results (by 2017):
- All FHAs IPES compliant (in M&E plan)
- Integrated services, as defined by IPES, at least 50% SDPs (in M&E plan)
- Eight FHAs with MoH contracts (in M&E plan)
- Teenage pregnancy rates decreased
- CPR increased
- SRHR services doubled (from 2013 baseline) for PMSEU (in M&E plan)

4.3 Program Components

This section details outcomes, outputs and indicative activities.

The 3 year investment by the Australian government (January 2014 – December 2017) for the Partnerships for Health and Rights Program will increase the quantity and quality of services provided by the eight Pacific FHAs to its poor and most marginalized people. This will be done by FHAs through:

i. Cost effective, sustainable service delivery models, developed and delivered through quality assured FHA static service delivery points (e.g. clinics) for all, particularly the poor and most marginalized.
ii. Cost effective SRHR outreach activities implemented in partnership with governments, development partners and communities, exclusively for the poor and most marginalized.
iii. FHA systems strengthened to support integrated service delivery and strong partnerships.
iv. PIC governments held accountable for delivering SRHR for all (in compliance with IPPF's Vision 2020).

OUTCOME 1: COST EFFECTIVE, SUSTAINABLE SERVICE DELIVERY MODEL DEVELOPED AND DELIVERED THROUGH QUALITY ASSURED FHA STATIC SERVICE DELIVERY POINTS FOR ALL, PARTICULARLY THE MOST MARGINALIZED

The objective of this component is to achieve integration of SRHR services in the consultation room and within service delivery. FHA static clinics will be improved to become centres of excellence in SRHR service delivery. Specifically, by the end of the program, all FHA clinics will be: compliant in all eight aspects of IPPF's Integrated Package of Essential Services (IPES); offer a broad method mix including LARCs; undertake checks for NCDs within their clinic service; deliver services that are appropriate for marginalized groups, particularly PWD and including screening for women who are victims of sexual violence; and promote these new services to their clients and the community.

There is strong evidence that integration of services particularly FP and HIV services is an opportunity to save cost and increase efficiency through better utilization of both human and physical resources. Integrating HIV services into FP and post-natal care services increases the quality of service provision as well as improving uptake of HIV counselling and testing at these facilities. Evidence shows that clients prefer fully integrated services as this saves both time and money. FHAs will build on this evidence base to further scale up its services at the static clinic level.

Expected outcomes:

- All applicable FHAs to be providing 6 out of 8 IPES components by 2015 and 7 out of 8 by 2017.
- 60 per cent of SDPS using Quality Improvement framework by 2017.
- At least 4 contraceptive methods, including at least 1 LARC (as per IPES).
- All FHAs to introduce disability inclusive services by 2015; and moving towards full compliance by 2017.
- Availability of effective referral system from IEC activities.

- Integrated service delivery model documented by 2017.

Output 1.1: Relevant clinic staff trained in broad range of contraceptive methods, especially LARCs, and other SRHR services (including those that link to NCDs) to support IPPF IPES compliance.

IPPF has developed the implementation of an Integrated Package of Essential Services (IPES) which sets a minimum expected basket of services, within eight service categories, that all FHAs should be providing in their static clinics. These eight service categories are: counselling; contraception; safe abortion care; reproductive tract infection/sexually transmitted infection (STIs) care; HIV-related services; gynaecology; ante-natal and post-natal care; and sexual and gender-based violence related services.

This Program will show a steady increase towards full IPES compliance for all services provided at any FHAs static clinics. It will also use 2013 as the baseline for the number of IPES compliance with a target towards all FHAs full IPES compliance within five years.

Within each IPES area, checklists provide guidance on the full service to be achieved, including a full range of contraceptives – short acting and long-acting. The EPE headlined that the range of contraceptives offered by both FHA clinics and MoH reproductive health services was extremely limited and needed to include more LARCs. Currently no MoHs and only two FHAs offer and are trained to insert (and remove) implants – KFHA and CIFWA; and six of the eight FHAs offer IUDs.

This Program will support SROP staff and MAs to forecast, procure and manage supplies to ensure high-quality, affordable supplies are constantly available, thereby ensuring a stronger alignment between products and programs. Improved impact in linking programming and procurement is expected as well as an increase in the number of methods provided by FHAs, and a reduction in the number of stockouts.

Gap filling of nurse positions while the nurses are training will be crucial. Most FHAs expect this can be achieved through locum-type contracts, often using retired nurses and midwives.

The Design Team considered sources of LARC training and two options were discussed – Fiji School of Medicine SRH Course (3 months) and Philippines Ministry of Health Course which is 10 days training with a 5 day practicum organized by Family Planning Organization of the Philippines (FPOP). The practical training with real clients is vital for IUDs and implants and access to an adequate number of clients is a problem with the Fiji course, whereas Manila has access to a high number of clients through its FPOP clinics. The Philippines course is shorter which will impact less on PIC FHA clinic services and gap filling costs. ESEAOR staff are negotiating the training for up to two FHA nurses per country per year with groups of nurses from the same area undertaking the course e.g. Melanesian nurses in the same group. FHA EDs will confirm with MoH and Nursing Councils that the training will be recognized within their own countries. The Philippines Course also includes training in Post Abortion Care (PAC) which is an issue of increasing importance in the Pacific. It will be efficient to have this training simultaneously.

A post training supervision strategy has also been considered. As KFHA has recently received training for all nurses in LARCs the Program will recognize and utilize their expertise for supervision and support during the implementation of the new methods

post-training. Given the travel difficulties between Tarawa and other PICs (only 2 flights per week), the accredited clinical trainer from FPOP could also be considered for this supervision.

Indicative activities include**:**

- Selection and scheduling of clinic nurses to be trained in LARCs and PAC
- Staff gap-filling while nurses are away
- Training conducted
- Supervision/support in-country (by KFHA nurse and/or FPOP trainer)

Output 1.2 SRHR services (including family planning) and service mix promoted.

Most FHAs have information materials and other resources (e.g. DVDs, billboard, referral slips) which highlight the services they provide. These resources will need to be updated and the new contraceptives and services promoted within the clinic and to the broader community. Print material format will be developed and used to reach at least 80 per cent of the targeted population. Print material is more effective when radio and television cannot reach people living far away from the urban areas. These materials will also be used for the outreach program. Specifically targeted materials may be needed for some groups e.g. young people, PWD (in braille and audio tapes).

It is anticipated that a general leaflet describing all methods and services offered (with diagrams and pictures of contraceptive methods) be developed and produced, and that one leaflet on each method with more detail also be produced. Some FHAs are interested in making a DVD on their services also and have the skills and technical ability to do this.

Note: The concept and suggestions for design will be provided through SROP but pre- and post-testing and any translation into local language will be undertaken in each country to ensure appropriate resources are produced. The resources will be printed/produced in Fiji by SROP.

Indicative activities and resources include:

- Leaflets and DVD pre- and post-tested
- IEC resources on Method and Service mix developed
- IEC on individual methods (detail) developed
- Signage for service and method mix addressed
- Referral slips and reconciliation method produced
- Translation into local languages where necessary

Output 1.3 Capacity built to deliver services specifically for people with a disability (i.e. Compliance with the Australian Aid Program's Development for All Policy).

FHAs are increasingly asked to provide services for people with disability (PWD) and have begun planning for this. Most FHAs have strong relationships with disability groups. Some clinics will require modifications to enable better access (ramps and rearrangement of layouts/furniture etc). Information promoting FHA services will need to be adapted to allow for access by blind and deaf PWD. This can be accomplished through collaboration with local disability groups and the Pacific Disability Forum

(PDF). Inputs include: funds for small infrastructure projects and development of appropriate information resources.

FHA clinical and education staff, as well as volunteers and Board members need to be oriented regarding the sexual and reproductive needs of PWD. This will be done through workshops conducted in partnership with local disability organizations who are members of PDF.

Selected FHA clinic and education staff will receive training (and be assessed) in the SRHR needs of PWD, and particularly for young PWD. Selective competitive tendering will be undertaken from IPPF sister organizations, e.g. Family Planning Queensland[22] and New Zealand Family Planning International. Consultations with FHAs compared the benefits of this training to occur regionally or in their own countries. It was decided that in-country training was preferable so that other NGO members and nurse could benefit from the training. Staff of SROP office in Suva will negotiate with PDF to invite members of the PDF training team to participate in the in-country training where and when possible providing input into the training with a Pacific perspective on disability issues.

As part of the training, FHA staff will develop an action plan and will begin implementation. In the following year, selected FHA staff (1-2 from each FHA as suggested by the trainer) will then receive further training regionally as trainers and will be utilized to train other FHA staff as well as other partners and service providers through the outreach activities.

Trainers will be available to conduct workshops on SRHR and disability for local disability groups, and other NGO and MoH service providers, and these workshops will be included in annual planning.

Indicative activities include:

- Partner with Pacific Disability Forum for mutual training.
- FHA clinic and education services oriented to cater for PWD – e.g. infrastructure.
- Information materials on disability and child protection.
- Training of FHA/PDF/CSO/MOH staff in SRHR and disability in-country (SROP to contract trainer).
- Training of trainers for FHA staff in SRHR and disability regionally.
- Training for PDF partners and other CSOs by FHAs in disability.
- Planning and training to understand SRHR issues of other marginalized groups e.g GBV screening, STI screening for sex workers and men who have sex with men.

This output provides for consideration of the special needs of other groups. For example, women who are subjected to GBV require application of a specific protocol. Provision of GBV screening is an integral part of SRHR service provision at clinic levels. The Pacific FHAs have made some progress in promoting gender equality and ensuring gender-sensitive programs and all have gender equity policies in place. Most FHAs report that they provide orientation and on-going training to staff on the

[22] FHAs (Vanuatu, Fiji and Tonga) were trained by FPQ during the AusAID-funded SHFPA Training Project 2000-2007. This accredited disability training is highly regarded in the region as is documented in the recent UNFPA Report 'A Deeper Silence' (2013).

IPPF Sexual Rights Declaration. Despite this, the provision of GBV screening, treatment and referrals continues to be poorly implemented in the Pacific. There is a gap and potential for this service provision. Capacity can be built through this Program for FHAs to provide holistic and high quality GBV services using IPES QoC Toolkit.

Output 1.4 Static service delivery points improved and/or expanded facilitating the introduction of IPPF's Quality Improvement Tool

Preparation for the new services to progress to IPES compliance includes some refurbishment and renovation. Only one FHA (SIPPA) will be building a new clinic/youth centre; and SFHA will be establishing a new clinic on Savai'i Island and seeking financial assistance locally with rent and refurbishment. All FHA clinics will need some renovation and additional equipment for the new services. Some FHAs are setting up new, expanded or renovated laboratories.

Indicative activities include**:**

- Quotes and contractors procured for new buildings.
- Quotes and contractors procured for clinic upgrades and the work undertaken.

Output 1.5 Demand created for SRHR services among the poor and most marginalized, particularly people with disability**.**

It will be vital to orient and update volunteers, including Community Based Distributors and the Board to the new methods, services and IEC resources. This output provides for awareness and training for these communicators. The referral system will also be updated.

Indicative activities include**:**

- Awareness, info, education sessions via radio, IEC materials, training for Board, volunteers and CBDs.
- Referral system updated and followed up.

OUTCOME 2: COST EFFECTIVE SEXUAL AND REPRODUCTIVE HEALTH OUTREACH ACTIVITIES IMPLEMENTED IN PARTNERSHIP WITH GOVERNMENTS AND COMMUNITIES, EXCLUSIVELY FOR THE MOST MARGINALIZED

Evaluation of the CBP recommended that further strengthening of FHAs was needed to develop and implement effective and innovative new services that reach poor and marginalized groups, particularly young people, and people in remote and outer island communities. This builds on the current impetus for: advancing integrated SRHR services; partnering with MoH, other NGOs and local community leaders; and improving equity of access to SRHR services for all.

The objective of the outreach activities is to provide cost effective SRHR outreach activities (advocacy, information, education, clinical services) implemented in partnership with governments and communities, exclusively for the poor and most marginalized.

Output 2.1 Outreach and mobile service sites mapped, approved and resourced in partnership with governments and communities (e.g. faith-based organizations; disabled, women's and youth groups).

Most FHAs have been conducting outreach services for many years, albeit on a small scale and on an ad hoc basis due to limited funds. Table 4 below details preliminary outreach planning and describes the number of static clinics (to support outreach clinics), the actual and potential outreach sites to be visited under this Program, and the potential population to be reached – including PMSEU/young people. This planning will be finalized during the inception phase.

Some FHAs conduct outreach in collaboration with MoH health centres, schools and with other NGOs so negotiations during the inception phase will be vital in planning the services and allocating costs. It is anticipated that outreach services will combine clinical and educational services for seven FHAs. RFHAF (Fiji) has a fledgling clinic and is awaiting a MoU with the MoH, so education outreach is planned initially with expansion to clinical services later.

In some FHAs e.g. KFHA, SIPPA and VFHA, community based distributors and peer educators can provide vital information about services as well as conduct information and education activities. As members of local communities it will be essential to include them in the planning.

SIPPA is trialing a new model of outreach where villages receive outreach services over a week, with clinic services during the day and education and awareness activities at night.

For some FHAs, weather dictates the time of year when outreach can and cannot be conducted. Five FHAs (Solomon Islands, Vanuatu, Tuvalu, Cooks, and Kiribati) will require significant resources to reach their outer islands, while three FHAs (Fiji, Tonga, Samoa) have relatively less distance to cover. This is reflected in the respective budget allocations.

Table 4: Preliminary Outreach Planning by FHAs

	CIFWA	RFHAF	KFHA	SFHA	SIPPA	TFHA	TuFHA	VFHA
Existing static clinics	1 (Rarotonga)	1 (Suva – limited services)	2 (South Tarawa, Betio)	1 (Apia)	4 (Honiara, Auki, Taro, Gizo)	2 (Nuku'alofa, Vavau'u)	1 (Funafuti)	2 (Vila, Santo)
New static clinics planned				1 (Savai'i)	Lata (Temotu)			
Existing outreach	1 High School	3 Divisions (Viti and Vanua Levu)	Betio 2 outer islands	Women's and Youth Groups	76 SDPs including associate health centres in 4 provinces/islands	Not conducted	Not conducted	Around 2 clinics
Potential outreach sites	1 high schools 2 outer islands	3 Divisions Lau Islands	4 outer islands with approx. 7 satellite health centres each (MoH)	6 outreach sites on Upolu and Savaii for 1st 2 years;	Outreach from existing clinics in 4 islands/provinces first 2 yrs; then expand to new provinces	8 high schools at 14 outreach sites Tongatapu; 3 schools Vava'u at 6 outreach sites; 2 high schools at 4 outreach sites on Eua	2 secondary schools (one on outer island); 5 communities on Funafuti; 1,000 people on 7 outer islands; 5 outreach sites on Funafuti; plus 5 outer islands	6 outreach sites
Potential no. popn. to be reached	2,000	20,000	20,000	6,000	100,000	15,000	2,700	5,000

Planning will include Memoranda of Understanding with partners – MoHs, health centres, communities and local NGOs. For example, if a community does not have a health centre in which to conduct consultations, a women's group or local NGO site can be used. Good planning and preparation with the communities to be included in the outreach will enhance service delivery; and strong partnerships can be forged to enhance sustainability. It will be imperative that MoH and relevant coordinators (e.g. reproductive health coordinators) within the government health system are engaged and aware of the proposed FHA outreach services.

Planning for expanded outreach services will include procurement of some vehicles and equipment. It is anticipated that 7 vehicles will be required. All FHAs, except Fiji and Tuvalu need vehicles (with SIPPA needing two vehicles – one for Honiara and one for Auki); and three boats are required (two for VFHA and one for SIPPA) to be able to expand their outreach work. All except Cook Islands require their vehicles in the first year. Recurrent funding for maintenance and repairs will be funded through the Core Program. Fuel contracts will be negotiated with fuel agents and insurance acquired for the vehicles and boats. Procurement process will follow the standard IPPF procurement guidelines used in the CBP Program.

Indicative Activities include:

- Mapping of outreach sites.
- Negotiations and MoUs with associate services and communities for outreach.
- Procurement of vehicles/boats and equipment.

Output 2.2 Networks of trained volunteers, FHA partnerships and community stakeholders developed and engaged.

FHAs have a ready pool of volunteers and significant networks into communities. They also collaborate with other local NGOs and government health service providers. This activity will enable communication to communities regarding the time and location of outreach services, and where these services are new, some orientation as to what constitutes an integrated SRHR consultation. Mapping of locations where poor and marginalized groups, including young people, can be best accessed will also be undertaken.

As well as visits to communities, or resourcing CBDs to promote the outreach services, printed information materials will be necessary to advertise the services. These will need to be developed for specific localities and target the needs of different groups e.g. young people including rural youth, out of school youth and school students.

Once outreach sites have been agreed and partners and volunteers engaged, these will need training in SRHR to enable them to work with the communities when outreach teams are absent. Advocacy to community leaders is also vital to orient them to the services provided so they can direct people to the services.

IPPF ESEAOR SROP will provide technical assistance needs to ensure that outreach services:

i. Record service data accurately.
ii. Address quality of care protocols/guidelines for service providers.

Outreach and mobile services can also target private clinics, social franchising and pharmacies.

Once training has been conducted and a schedule of outreach prepared, this will need to be promoted through local media (on the local radio, on noticeboards, newsletters, word of mouth, sermons etc.) so people know when to attend the clinics.

Indicative activities include:

- Travel to communities to orient and train volunteers, partners and community leaders re outreach program.
- Promotion of outreach schedule (radio, IEC).

Output 2.3 Capacity at outreach sites improved facilitating use of IPPF's Quality Improvement tool (i.e. working to meet the Australian Aid Program's Development for All Policy)

Where outreach is provided through local health centres and clinics, improvements will probably be needed to enable FHA staff to model quality of care and integrated service delivery. Such improvements will include access for people with disability e.g. ramps and appropriate IEC materials.

Quotes from contractors will be sought to do the improvements (to the value of up to $2000) and equipment and commodities procured for improvements to associate clinics. Equipment needed for outreach may include generators, medical equipment, tents, portable toilets and SRH commodities (if there are stock outs of supplies provided through MoHs).

Indicative activities include:

- Quotes from contractors.
- Procurement of equipment and commodities for improvements to associate clinics.

Output 2.4 Implementation of outreach activities in partnership (through annual plans).

FHAs develop annual plans and meet to discuss these with ESEAOR and SROP staff in October every year. This process is funded through the Core Program. Plans for the DFAT Program will be endorsed by DFAT Post staff.

FHAs have an excellent and effective electronic information management system for reporting. Some have well developed clinic management information systems which record details and services provided for clients of clinics. This Program will also improve the CMIS in all FHAs and this will also benefit the outreach services. Where outreach is conducted outside the main urban areas (e.g. in provinces and outer islands) it will be

vital that clinic data is transmitted through the normal government channels e.g. through provincial hospitals or the appropriate provincial health authorities. Data will also be entered into the FHA information system (CIMS).

Indicative Activities include:

- Outreach travel plan developed and costed annually.
- Conduct outreach services providing for allowances for volunteers and staff on outreach; fuel cost or flights to travel to outreach sites.
- Data capture and transmission.
- Reporting on outreach.

Outcomes expected include**:** significant partnerships forged with existing (associated) clinics and community groups who can facilitate provision of SRHR services; increased number of clients receiving SRHR services who are poor and most marginalized (young people; people from non-urban areas; PWD).

OUTCOME 3: FHA SYSTEMS STRENGTHENED TO SUPPORT INTEGRATED SERVICE DELIVERY AND STRONG PARTNERSHIPS

The objective of this component is to strengthen FHA systems to enable integrated service delivery and strong partnerships.

Output 3.1 FHA systems to capture and analyze qualitative and quantitative data strengthened through the introduction of IPPF's Clinic Management Information System (CMIS), the Vulnerability Assessment (VA) tool and the Branch Performance Tool (BPT) to enable better targeting of finite resources to meet the needs of the poor and most marginalized.

All the eight Pacific FHAs have systems in place to capture clinic information however the quality is not consistent and reliable. This Program will strengthen the data capture system by adapting the IPPF CMIS and Vulnerability Assessment tools.

Measuring vulnerability is a guide to collecting, analyzing and utilizing data on the vulnerability status of FHAs clients. The guide was developed to support FHAs to assess the vulnerability status of their clients and to use the information for internal decision making, as well as reporting to IPPF and donors in a more systematic way. The BPT is used to measure economy and efficiency and provides relevant cost information to clinic managers.

Following the review, IPPF ESEAOR and SROP will work to customize the system to meet the needs of the Pacific FHAs taking into consideration the complexities and different contexts the eight FHAs work in.

Indicative activities include:

- CMIS person in ESEAOR visits all eight FHAs in the first six months to conduct a needs assessment and customise the system for the Pacific FHAs.
- Conduct 4 days training on the CMIS system (paper and electronic) coordinated by SROP.
- Introduce use of handheld devices for outreach data capture and transmission.

- Review of IPPF's vulnerability assessment tool and see how well it can relate to the Pacific.

A follow up of the system will be discussed in the Annual Planning Meetings of the FHAs.

Output 3.2 Commodity security and management improved (through the application of the approach developed by the DFAT-funded IPPF Core + Initiative in South Asia)

One of the key areas identified is the need to improve reproductive health commodity security – particularly contraceptive supplies. This Program will support FHAs to upgrade their storage facilities to ensure they meet the requirements needed for good quality storage.

Training on the new system to improve FHA forecast, procure and manage supplies will be conducted at country level to ensure that clinic requirements and procurement work hand in hand in terms of an increase in the number of items provided by FHAs and also the reduction in the number of stock-outs. SROP will coordinate the training during the first year of project.

Indicative activities include:

- Develop a specific plan to manage supplies including protocols.
- Improved warehousing .
- Connect forecasting to the CMIS data.

Output 3.3 IPPF's Quality Improvement framework implemented (compliant with, and beyond the requirements of the Australian Safety and Quality Framework for Health Care)

IPPF's IPES sets a minimum expected basket of services, within eight service categories, that all FHAs should be providing in their static clinics. These eight service categories are: counselling; contraception; **s**afe abortion care; **r**eproductive tract infection/sexually transmitted infection (STIs) care; HIV-related services; gynaecology; ante-natal and post-natal care; and **s**exual and gender-based violence related services. This Program will show a steady increase towards full IPES compliance for all services provided at any FHAs static clinics. It will also use 2013 as the baseline for the number of IPES compliance with a target towards all FHAs full IPES compliance within five years.

IPPF will work with Pacific FHAs to attain high quality services and serve clients better following the IPPF's Quality Improvement framework which builds on the Quality of Care Strategy. The QoC Strategy (see Annex 6) is a system for quality improvement based on self-assessment, supportive supervision and external clinical audits integrated to the IPPF Accreditation System. This program will build on the QoC undertaken in the Capacity Building Program, and the IPES Quality Improvement tool is projected to be used by most Pacific FHAsby 2017, to ensure that the highest quality of care is achieved by all static clinics at Pacific FHAs.

The first activity will be a five day training on the QI framework and to develop a strategy to follow through the work of each FHA to achieve the competencies of quality assurance. The main focus of the training is to familiarize FHAs with the content of the IPES Quality Improvement framework using the tool that is available from IPPF and also to develop action plans. The key activities of this component rest with each FHA and they are required also to conduct in-service training for all FHA team members on Quality Improvement, and undertake Review Meetings at FHA Management level on the IPES Quality Improvement process.

In-country visits will monitor progress of each country plan. A SROP staff member with technical knowledge will be recruited to coordinate this activity.

Indicative activities include:

- Source medically compliant training courses (e.g. Philippines or India MAs) and tender for services.
- Have QoC person in place in FHA.
- Organize travel and 5 day training for 16 nurses (e.g. 2 batches of 8 so that they can also relate to nurses in each FHA).
- Have the supplies in stock at the FHA.
- Change the notice board re services and have IEC material available.
- Trained staff will conduct on the job training for other FHA staff.

Following the introduction of QoC, the QI process will begin. This entails training of FHA staff to be the supportive supervisor for the QoC program. In this role, the supervisor is be able to address the needs of the service providers as well as to teach and support staff to undertake the QoC process and maintain QoC standards.

Indicative indicators include:

- Have Program Officer for QI in place.
- TOR for QI training program agreed.
- Tender for QI implementation (likely from within the Federation).
- All FHAs have the training in-country.
- All FHAs develop and have approved their action plan for roll out of QI at FHA level.
- All FHAs have started implementing the QI system.

Output 3.4 Links with Non-Communicable diseases (NCD) integrated into SRHR (FHA specific – drawing on evidence documented by WHO and UNFPA).

This output of the Program will develop and produce IEC resources specifically linking NCD and SRHR, and services will be reoriented to address NCD screening e.g. pap smears, general health checks particularly for ANC. FHAs will raise awareness among stakeholders of the risks of NCDs and the services available. Some further equipment may be required. Scaling up of services later in the Program may include HPV vaccination in partnership with governments.

Indicative activities include:

- Development, pre- and post-testing IEC materials.
- Dissemination of materials.
- Integration of NCD services into clinic service delivery.

Output 3.5 Committed FHA members and governance that reflect the diversity and the capacity required and retained.

FHA Executive Directors and Board members will devise a strategy/policy which guides the recruitment of Board members with the skills and attributes which reflect the diversity of the community as well as the services they provide. This includes training for Board members on recruiting, appointing and performance management of Executive Directors to maximize their effectiveness.

Indicative activities include:

- Development of an integrated strategy.
- Training as needed on their role in recruitment and appraisal of Executive Directors.

Output 3.6 Innovation in service delivery rewarded

As recommended in the EPE, opportunities will be provided for FHAs to compete for an annual incentive fund award for the FHA who submits the most innovative service delivery strategy. Other motivational awards will also be available through themed meetings to encourage a focus on results and sharing how these results were achieved. For example, 'FHA of the Year', 'Most Indispensable Partner of the Year', 'Advocate of the Year', and 'Making the System Work' awards. Recognition of the work of external partners such as politicians, media and government workers can also be considered by the Review Panel established to select worthy applicants.

Indicative activities include:

- Review Panel and selection criteria established
- Annual themed events to present awards

OUTCOME 4: PIC GOVERNMENTS HELD ACCOUNTABLE FOR DELIVERING SRHR FOR ALL (IN COMPLIANCE WITH IPPF'S VISION 2020)

One of the key features of this proposed five-year Program is advocacy, where the FHAs and SROP will be engaged in a set of inter-connected activities designed to bring about policy, budgetary and regulatory changes related to SRHR. For many years now, FHAs have been in the forefront of providing key reproductive health services (particularly family planning) to the most vulnerable, and such collective experience has led to the realization that SRHR needs of the people can only be met fully through a comprehensive response from government. Hence, the need for legislated policies that

will institutionalize SRHR programs (to address key gaps in SRHR service provision) and budgetary allocations.

Being the recognized SRHR service provider in each island country, FHAs are best positioned to lead such advocacy. Each FHA's credibility in pursuing an advocacy task will be backed up by real ground evidences gained through years of service provision and expertise. As such, each FHA can rally sufficient support from other stakeholders in each country setting. The recently implemented Capacity Building Program has also built the foundations for advocacy work among the FHAs.

The proposed Program will rely on the rich advocacy experiences of IPPF in the many countries where it operates. But it must be stressed that the advocacy work to be pursued in the Pacific will always adapt to the context of each island country. Advocacy issues will emanate from the actual needs and conditions of each country; evidence will be generated from each country experience and data sets; messages will be crafted and delivered using the prevailing mode and culture; and advocacy actions such as working with parliamentarians and policy-makers will follow the norms in each Pacific island country.

At the end of the Program, the series of strategic and inter-connected advocacy activities in the eight island-countries must have resulted to positive policy actions where each government has been moved to fulfil its duty to deliver and provide SRHR for all.

Output 4.1 Evidence for advocacy collated and documented.
As a key pillar of work, all FHAs will make sure that all advocacy actions are based on needs and evidence. Hence, each FHA will undertake evidence-generating activities such as research and needs assessment workshops. Having considerable and comprehensive experience in the field of SRHR service delivery, FHAs may find that evidence of what is needed, particularly that which is practically useful to enhance service delivery or barriers in the contraceptive supply chain, will already be available and may only need some form of validation. Specific research on the SRH situation will be conducted with the intent of identifying the most pressing issues and barriers and of building the evidences for advocacy messages and briefings.

Indicative activities include:

- *Country Mapping of SRHR Policies*

Under this specific activity, each FHA will produce a compendium of SRHR policies during the first year of implementation. Both legislated policies (parliament) and executive policies or guidelines (particularly under the Ministry of Health) will be included. The policy mapping will also result to the identification of the policy-making process at the parliament level and or at the executive level (how are health and SRHR guidelines drafted and approved).

These activities will mostly entail gathering of secondary data; desk review and scanning of literature in parliament and Ministry of Health and key informant interviews. The Program will set aside a small amount of funds per FHA for this type of work.

- *Conduct of Specific Research*

There will be cases when specific research of an SRHR issue will be undertaken. Example in point is the early request of Kiribati FHA to do research in the unsafe abortion patterns in their country. In such manner, evidences on how to respond scientifically to such a problem or issue will be established and can therefore be utilized for an effective evidence-based advocacy. It should be noted however, that the Program will not be able to support a costly full-blown research projects. Fund provision for short-term researches during the first and the third year of the Program implementation will be allocated to all FHAs. For researches that will require more resources, collaboration with governments or other entities will be encouraged.

Each FHA will come-up with an SRHR research list during the Program inception phase and should have come up with one research during the first year. At project mid-term, another research must have been implemented by each FHA.

- *Mapping of International Policies adhered to by Pacific Countries*

At the SROP level, desk review and scanning will be undertaken in year one to identify the international policies adhered to by the individual Pacific country. This will be best accomplished by working closely with the UNFPA Pacific office. Aside from the policies, SROP must be able to determine the international policy-making and coordinating bodies for the Pacific.

Output 4.2 Advocacy conducted with Pacific governments.

Framing the key message is crucial to achieve this output. Support will be provided for all FHAs to develop the most appropriate and effective messages and deliver them in their proper channels. While the more practical issues will entail a lot of face to face advocacy activities between the FHAs and the gate-keepers (Ministry of Health, National Drug Formulary, Contraceptive Supply Chains), the advocacy for comprehensive SRHR policies may entail other channels of communication such as the use of media and the development of advocacy materials (e.g. policy briefs).

Fund provision for these types of activities will be provided to all FHAs. It must be noted however, that advocacy materials are primarily intended to reach the policy-makers; hence it should not be confused with IEC materials that will be produced to inform or educate the public.

Each FHA will be supported in the following:

- *Face to Face Advocacy Activities*

Basically, this is “personal delivery” of the message where the advocates (FHAs) consciously seek audience with the policy-makers and engage them in a discourse about the need for a regulatory measure or policy. In a setting such as the pacific, this type of action will be most effective as the FHA is recognized by government and legislators as the key resource and partner in SRHR service delivery.

- *Media Activities*

Fund provision, albeit minimal, for media related activities will be provided to all FHAs in the course of advocacy work. This provision will be used to complement only the existing provision for IEC and media activities under component 1. Type of media activities may include media conferences to reach parliamentarians.

- *Advocacy Materials*

Specific advocacy materials will be produced to educate the policy makers on the issue. Said materials will contain the evidences for advocacy. Primarily, advocacy materials that will be produced are policy briefs and fact sheets.

The indicator of success will include the number of laws and regulations changed over the duration of the Program.

Output 4.3 Creating and working with multi-stakeholder network(s) for advocacy.
Network Building and Working with Parliamentarians will be vital in the advocacy strategy. In any advocacy endeavour, the need for critical mass is always crucial. Without mass support, advocacy will be seen as weak and at the losing end. Working with parliamentarians on the other hand, is an essential component that needs attention from the FHAs. Engaging parliamentarians will ensure that any legislative advocacy measures will be given attention. The FHAs will be measured on the number of organizations and parliamentarians that they will be able to mobilize.

Indicative activities will include:

- *Stakeholder Mapping*

At the start of the Program, all FHAs will conduct a stakeholders' mapping and analysis. Each FHA is expected to draw a political map of all the important players in the SRHR field. The political map will determine who are pro, neutral and anti SRHR policies based on historical acts done and pronouncements by individual policy-makers and organizations. This will also be done by SROP for all the regional and pacific stakeholders. Drawing a political map should not be a problem as all executive directors of the FHAs and the staffs of SROP have undergone the Advocacy Training and Workshop during the recently implemented CBP.

- *Network Building and Partnership Activities*

The Program will allocate fund provisions for all FHAs to undertake network building and partnership activities. This will include activities such as issue identification meetings and regular (monthly) network meetings.

- *Event with Country Parliamentarians*

Fund provisions for events with parliamentarians will be allocated all throughout the Program life cycle. Activities may include public forum, media conferences and issue briefing sessions.

- *Advocacy Practitioners' Meeting*

Each FHA shall organize regular advocacy practitioners and network meetings to plan and update future advocacy actions. Each FHA shall be responsible to ensure that network meetings are done to draw active participation of other NGOs and stakeholders in all the aspects of advocacy work.

Output 4.4 Plans for scaling up of SRHR services developed, endorsed by government and implemented.
The FHAs are members of national steering committees. Success of the advocacy strategy will be marked by contractual relationships between FHAs and Ministries (Mou and MoAs) with concomitant funding. This is when FHAs can really plan for expansion of services and/or scaling up of outreach activities. For some FHAs it may mark geographical expansion to outlying areas where more marginalized people can be reached; for others expansion of services within their static clinics with government support. Detailed planning will be necessary to ensure scaled up services are in line with government requirements/policy and with FHA capacity. Scaling up could also occur in partnership with CSOs, FBOs or the private sector but FHA maintaining a solid relationship with governments remains a top priority.

Output 4.5 Regional and international norm-setting institutions engaged on advancing SRHR.
SROP will be responsible to ensure that the Pacific will be well-represented in regional and international advocacy arena.

Indicative activities will include:

- Mapping of international and Pacific institutions.
- Regional and international representations.
- Country engagements on accountability.

4.4 Feasibility

The Design Team has assessed the feasibility of the design and considers that there is good potential for success based on:

- Proven cost-effectiveness of implementation by FHAs of a targeted and integrated SRHR approach.
- The capacity of FHAs to implement the Core Program as well as expand to new activities; and to spend the funds available.
- Good governance and existing networks of volunteers to assist with implementation within communities.
- Well-developed partnerships and relationships with government and non-government organizations with whom cost-sharing can become a reality.
- Evidence-based technology and systems developed by IPPF e.g. IPES, QI Tool, CMIS, VA tool, BPT and Contraceptive Guidelines and Advocacy Guidelines which can be adapted for use in the Pacific.

- The demand for SRHR services as evidenced by unmet need studies; and the fact that FHA strategies have been endorsed by PIC governments.
- Ongoing financial and management support from IPPF through provision of annual Core Funds to meet the overall running costs and staffing of the FHAs.

The design also supports phasing of activities to ensure identification of PMSEU, negotiation within communities, training and networking is undertaken so that the activities can be embedded in communities before service delivery begins.

Table 5 demonstrates that the level of resourcing is appropriate for the capacity of the FHAs. In 2012, the level of unspent Core Funds and Australian funds was minimal for FHAs.

Table 5: Comparison of Total Funds Spent 2012 with

Projected DFAT Program Funding 2014-15

FHA	CORE FUNDS (USD) 2012	AUSAID CAPACITY BUILDING PROGRAM (AUD) 2012	CORE FUNDS (AUD) 2014	PROJECTED DFAT FUNDING FOR (AUD) 2014-15
CIFWA	124,574	222,875	119,705	118,699
RFHAF	123,462	207,921	148,007	77,550
KFHA	149,747	267,882	172,292	93,940
SFHA	168,960	174,773	181,796	99,440
SIPPA	211,641	284,229	257,846	235,620
TFHA	139,401	206,156	152,219	94,490
TUFHA	148,113	159,197	151,245	70,266
VFHA	177,934	305,103	198,199	128,209
TOTAL	**USD 1,243,882**	**AUD 1,178,680**	**AUD 1,381,309**	**AUD 918,214**

VALUE FOR MONEY

IPPF as an organization has invested in significant analysis of the main cost drivers within the operations of MAs (including FHAs). Demonstrated value for money relevant to this Program includes:

- Minimal staff costs with approximately 5 percent of Core funds going to staffing; and maximization of the use of volunteers.
- IPPF Core funds finance the running costs for FHA programs which provides the platform for core service delivery.

- When necessary, clinical commodities and supplies are procured through competitive tendering but FHAs have also established local supply lines with governments. Commodity security and management will be improved through this Program (Output 3.2).
- Outreach activities cost profiles include clinical and non-clinical staff and allowances, clinical commodities, vehicle costs and fuel. IPPF is looking to develop better costing of outreach activities and community-based service delivery models through cost capture under a revised chart of accounts (currently in development). Outreach services will be increased in this Program in partnership with governments and communities (Outcome 2).
- Advocacy initiatives have a low cost base comprising mostly the time of specialist advocacy staff. IPPF's track record in achieving changes in policy in countries of high need reflects the considerable long-term impact that this investment in advocacy has (Outcome 4 in this Program).
- IPPF's use of the performance-based funding model allows for funding to an MA to increase or decrease by up to 25 percent based on their performance. In 2013, all FHAs except CIFWA received a bonus for significant increased service delivery, particularly to PMSeU. Targets for this Program expect to have services doubled by 2017 with a 2013 baseline.
- The Branch Performance Tool has helped MAs to internally review their work and identify opportunities to improve value for money. The tool can review and identify under-performing clinics so steps can be taken to improve client flows. This tool will be introduced as a mechanism to strengthen FHA systems through this Program (Output 3.1).
- The increasing use of cost effective social franchising strategies is being utilized in the Pacific (e.g. SIPPA associate clinics). FHAs partner with existing government or CSO services to use the existing infrastructure and facilities to improve the quality and reach of SRHR services (Outcome 2).
- FHAs will increase access and choice through an increased focus on the use of LARCs (Output 1.1). This should result in increased number of clients and services.
- The use of the CMIS allows management to understand the drivers of clinic performance and allows for quick access to data. This strategy is to be strengthened through this Program (Output 3.1).
- IPPF has established and robust financial systems in place. Funding is explicitly contingent on annual accounts, audits and more regular management accounting. For example, in 2012, the proportion of MA financial statements submitted on time and with unqualified external audit opinions submitted increased from 85 percent to 90 percent including all eight FHAs.

4.5 Cross Cutting Issues

Gender

Gender equity underpins every aspect of IPPF: governance structures insist a minimum of 50 percent representation of women on each FHA's governing body. The ESEAOR Office has a gender specialist to ensure FHAs' program design and implementation incorporates a gender and rights perspective and to initiate specific programs to tackle entrenched gender inequalities in the Pacific. IPPF implements mainstreaming strategies to promote, facilitate, and measure the impacts of gender equity interventions.

Gender-based violence continues to be one of the major risk factors to women's vulnerability to SRHR, and is increasingly prevalent in the Pacific. The FHAs work at the community level, with local leaders and the media, to overcome barriers based on misinformation, prejudice and gender discrimination. Strengthening their institutional capacity has helped reduce gender-related barriers and practices. Addressing SRHR needs of women is a pre-requisite to achieving gender equality and addressing gender equality is essential for improving SRHR outcomes[23].

This activity is designed to enhance access, and deliver SRHR services to rural areas, informal settlements and outer islands. This is a key strategy in the Pacific to reach women and young people to address unequal gender roles and expectations which are factors in teenage pregnancy and in unwanted pregnancy generally[24]. While FHAs are increasingly reaching men and boys, it is young women and girls who are most at risk of unwanted pregnancy and STI and HIV infections. Targeting remote areas will deliver benefits for rural women who are often disadvantaged by remoteness and isolation from services.

Training activities will disproportionately benefit women as most FHA clinic and education staff are female; while training on the SRHR needs of PWD will benefit women with a disability as they are commonly most vulnerable to exploitation and abuse. However, there will also be services targeting men, which provide education and information about the rights and free choices of women, particularly those of young and adolescent girls. All data collected will be gender and age disaggregated.

Human Rights and Child Protection

IPPF's Vision 2020 recognizes SRHR as a human right. FHAs advocate to their governments to change laws, policies and practices that increase stigma and discrimination on the grounds of sex, sexual orientation and gender identity. FHA staff and volunteers set high standards in health care services, ensure that staff are properly trained, they work with discretion and sensitivity, and protect the safety, dignity and the rights of clients, particularly young people.

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[23] K.Grepin, J. Klugman (2013) Closing the deadly gap between what we know and what we do: Investing in Women's Reproductive Health, Women Deliver, World Bank

[24] "I am not a Lost Cause: Young People and Women's Empowerment and Teenage Pregnancy in the Pacific, UNFPA October 2013.

IPPF recognizes that young people are entitled to access sexual and reproductive health information and services, and recognizes young people's evolving capacity and the need to strike a balance between protecting young people from abuse, harm and exploitation and their right to participate, express themselves and exercise their own rights. IPPF recognizes that young people are more susceptible to abuse, harm and exploitation and that at the same some groups of adults are more vulnerable than others.

To safeguard the rights of all young people and vulnerable adults, IPPF has developed a unified approach that outlines the Federation's responsibilities to promote ethical practice, prevent abuse and protect children, young people and vulnerable adults[25]. IPPF's Child Protection Operational Framework sets out IPPF's global protection policy, and supports MAs/FHAs to develop, implement and update their local protection policies and procedures. All FHAs have a Child Protection Policy and it is mandatory to report on how it is being implemented.

Through their youth-centred approach (including having young people on their boards), FHAs' reach to young people has increased dramatically over the past few years; and other groups with high unmet needs e.g. sex workers, men who have sex with men and transgender people are increasingly being reached. This design of this Program ensures that FHA staff will, during the preliminary planning phase, work strenuously with Ministries and local communities to negotiate to combat barriers that prevent marginalized groups from accessing SRHR services while protecting their rights and observing child protection protocols.

Poverty and Equity

Poverty reduction is closely related to equity. IPPF uses a definition of equity that allows for multiple dimensions including gender, age, disability, place of residence, marital and family status, HIV status, indigenous identity, sexual orientation (Post-2015 Consultation convened by UN Women and UNICEF, 2013). This strongly correlates with the overall goal of the organization – sexual and reproductive health and rights for all.

The two principal challenges for poverty reduction are: restoration of economic growth and maintaining provision of basic services, particularly in education and health. The economic benefits of investing in SRHR include increased labour participation and productivity as well as broader economic returns (through the demographic dividend)[26].

Research has also demonstrated that the decline of maternal mortality rates is associated with higher income levels, more urban population, higher levels of utilization of skilled birth attendants, lower fertility rates and the higher proportion of girls completing primary education[27]. Many of these factors are related to access to quality, integrated SRHR care.

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[25] Updated policy 4.17 on Protecting Children, Young People and Vulnerable Adults was passed by the IPPF Governing Council in May 2012.

[26] K Grepin, J Klugman (2013) Closing the deadly gap between what we know and what we do: Investing in Women's Reproductive Health, World Bank Women Deliver

[27] Ibid

The correlation between poverty and the level of infrastructure and health services is strong. IPPF/FHAs are well aware that to decrease poverty, disadvantage and isolation, access to client-friendly health services for the rural majority (in most PICs) and the poor and most marginalized is imperative. This new Program will model these services to existing service providers.

This design allows for the Program to be better targeted as an equity program, addressing poverty, gender and geographic disadvantage better, then FHAs have the capacity to at least provide funds for a minimal set of SRHR services to the most disadvantaged. More importantly it may give governments/provinces time to realize that the only way to provide health services is through a reallocation of their revenue to prioritize integrated SRHR services. In this way the new Program is positioned as an equity mechanism for targeting the disadvantaged, poverty and gender with essential SRHR services.

Disability

Key thematic areas within this design are Non-Communicable Diseases (NCD) and Sexual and Reproductive Health and Rights (SRHR). Both of these priorities are inextricably linked to disability and are linked to major emerging issues for disability programming. Not only are the SRHR needs of people with a disability (PWD) a human rights issue, but there is growing evidence that numbers of PWD in the Pacific are increasing significantly through NCD and accidents. The data below also strengthens the need for outreach activities to reach PWD with SRHR services.

According to UNESCAP, an estimated 17 percent of people in the Pacific have some form of disability. Persons with disabilities in the Pacific face many entrenched cultural and physical barriers to full participation, as well as exclusion from communities, education and the workplace. A lack of physical accessibility and social attitudes towards disability mean that persons with disability are often left out of community life[28].

The prevalence of NCDs in the Pacific is estimated to dramatically increase the number of PWD with disability from amputations from diabetes, as well as diabetic eye disease causing blindness; and disability caused by cardiovascular disease (particularly from strokes). PICs with the highest risk of NCD include: Kiribati (75 percent of the population aged 25-64yrs) and Cook Islands (72 per cent); with Samoa, Tuvalu, Tonga and Kiribati with the highest incidence of diabetes[29]. In Kiribati, it is estimated that up to 1.6 percent of the population could potentially be affected by amputations from diabetes and diabetic eye disease by 2015. Any disability can lead to SRHR vulnerability for PWD. In these PICs where PDF is supporting DPOs' development and where there are FHAs, it makes sense that a partnership can build the capacity of service providers and enhance the health and rights of PWD. Access for PWD to information on SRHR can protect them from exploitation, sexual abuse, unwanted pregnancy and STI including HIV and extend to PWD the right to enjoy a healthy life.

[28] Pacific Disability Forum website, http://www.pacificdisability.org/About-Us/Disability-in-the-Pacific.aspx

[29] NCD Statistics for the Pacific Islands Countries and Territories 2011, Healthy Pacific Lifestyle Section, Public Health Division, Secretariat of the Pacific Community

In Fiji, a baseline survey was conducted in 2008-09 in 19 districts of Fiji's four main divisions and included Rotuma. The number of people with a disability was found to be 11,402[30] (5,222 women and 6,180 men). This means that 1.4 per cent of the population surveyed are persons with disabilities (0.6 per cent of women and 0.8 per cent of men). It is known anecdotally that numbers are increasing due to increasing prevalence of heart disease, diabetes, Vitamin A deficiency and road accidents. The island of Taveuni had the highest proportion of PWD (19.25 percent); followed by Kadavu (6.96 percent) and Rotuma (4.5 percent) so proving that outreach services are needed to reach PWD.

The Kiribati National Disability Survey 2004-05 identified 3,840 PWD with a total of 4,358 disabilities[31] of which 2,122 were male and 1,718 were female. The main causes of disability were: physical (32 percent); blind (27 percent); intellectual (9.5 percent); epilepsy (4 percent); psychiatric (3.6 percent); and speech/language (.1 percent). However, these statistics are now outdated and do not include some categories of PWD such as those whose disability is increasingly caused by diabetes as discussed above.

Environment/Disaster

Increasing PIC population rates (particularly the proportion of youth), the growing need to address population and environment issues related to climate change, is justification for a strategy which will reach poor, the most marginalized and remote populations. Ultimately improved SRHR can assist to achieve national economic growth, security and stability

FHAs are situated in a region very prone to disasters. The recent earthquake and flooding in Solomon Islands has resulted in the SIPPA clinic being unfit for purpose and not likely to recover with rehabilitation. The Program will therefore include a new building for the Honiara clinic which is one of the busiest in the Pacific.

This Program will leave a significant carbon footprint by FHA staff with many trips to distant islands, but the benefits to women, girls and communities generally will ultimately outweigh the environmental disadvantages. FHAs also work closely with MoH and other NGOs to minimize environmental impact where possible.

Social Impact

Through this Program design's strong focus on preparation and negotiation of activities, it has the potential to work in an integrated way and collaboratively with many stakeholders – FHA staff, distant and urban communities, local health service providers, community leaders, local NGOs, women's groups and local authorities as well as Ministries of Health and other related Ministries e.g. Ministry of Women and Ministry of Community Development who often are responsible for outreach services.

The Program will increase awareness and understanding of the SRHR needs of people with a disability; and facilitate their improved access to FHA static clinics as well as including them in outreach services.

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[30] National Baseline Disability Survey, Making Women with Disabilities Visible, National Council for Disabled Persons, September 2010

[31] Some respondents had more than one disability

The social impact of the Program will be to enable those reached - women, men, girls, boys and couples - to prevent unwanted pregnancy and STI, including HIV infection and to enjoy sexual and reproductive health. This will have many social and economic benefits for communities and PICs in general, and for women and young people in particular. It will save lives. It will also empower girls and women to make choices about their sexual and reproductive health which impacts on their choices about education opportunities and ultimately on their role in the economy through their ability to exploit employment opportunities. Legal and psycho-social support around gender-based violence improves their self-esteem and status.

5. Management and Governance

5.1 Management Arrangements, including Personnel

STAFFING ARRANGEMENTS

IPPF's multi-disciplinary professional staffs bring expertise and depth in all areas relevant to assure the Program's success. Seven IPPF staff - based at IPPF's Pacific Sub Regional Office in Suva, Fiji - will ensure responsive, high quality, and timely management and operational implementation (Annex 13). The staff will have complementary technical skills and backgrounds that are aligned to delivering the key outputs at the regional and national levels.

The staff qualifications are described briefly here. Roles and responsibilities are defined in the Management Plan.

Strategic guidance and oversight for the Program will be provided by IPPF's Director General, Tewdros Melesse, and the Regional Director for East & South East Asia and Oceania, Nora Murat. In their respective roles, they will be supported by key regionally based staff – most notably Iemaima Havea, Head of Integrated SRHR Programs; Gessen Roccas, Director of Strategic Partnerships, Advocacy & Communications, and Vijay Kumar, Head of Finance – all at ESEAOR. Their strategic guidance and oversight will form part of IPPF's cost-share for this Program. They have the authority and accountability to ensure IPPF's Pacific Sub Regional Office has the capabilities and competencies to deliver this ambitious Program.

The Pacific Sub Regional Office will have the authority and accountability to deliver the Program to time and budget. Being native to and based in the Pacific they will be more responsive to the needs of the FHAs and the region. In particular, in line with Federation-wide guidance, the team will be responsible for agreeing the FHAs' Annual Work Programs that lead to funds being released by London. The team will also be responsible for developing and keeping the FHAs at the vanguard of the SRHR movement in their respective countries through providing technical assistance and mentoring – particularly in a) reaching the poor and most marginalized; b) institutional systems to facilitate service growth; c) continuous quality improvement – including medical; d) advocacy and partnerships; e) resource mobilization. The Pacific Sub

Regional Office will align the Program's and IPPF's core funding cycles to streamline administration and improve the overall impact of the FHAs. IPPF will finance approximately fifty per cent of the office staff costs.

CURRICULUM VITAE FOR KEY PERSONNEL

Working closely with the Pacific Sub Regional Manager, they will provide SRHR technical and programmatic direction to FHAs within the sub-region, while identifying training needs and sourcing suppliers from within and outside the Federation.

IPPF will recruit a full-time **Monitoring and Evaluation Program Officer** to support the process of continuous organizational learning and oversee program performance among the FHAs and into the wider IPPF and sexual and reproductive health and rights.

Additional **technical support** and **capacity building staff** for the Program will be drawn from technical experts across the Federation, particularly those staff included on the management structure and based in the East & South East Asia and Oceania Regional Office. The Pacific Sub Regional Manager will call for additional support based on criteria to assess cost-effectiveness. These include relevance, availability, proximity and price. Where possible, IPPF supports and encourages FHA to FHA technical assistance. Where this is not possible IPPF will gauge the feasibility of sourcing from within the Federation, as per the diagram in Annex 14.

For example, a skills and competencies assessment undertaken during the End of Project Evaluation has identified a range of specialist skills already held by FHAs which, through this Program, can be used to provide other FHAs with technical assistance. Similarly, a need has been identified to support RFHAF in Fiji to establish its clinic management systems and protocols. We have assessed that a short term secondment from a seasoned clinic manager will be the most cost-effective way to transfer these skills, as it is not feasible to second a clinic manager from within the Pacific. For this reason, options are currently being considered from IPPF's Member Associations based in Cambodia or Indonesia. These Member Associations operate at a high level of clinical excellence and at scale where they could realistically absorb the loss of one clinic manager to provide the level of practical support and mentoring required.

In recent years FHAs have brought increased capacity and technical skills to the FHAs through volunteers sourced through Australian Volunteers International (AVI) or through the Pacific Technical Assistance Mechanism (PACTAM). This is particularly useful for an operational management role with rapid program expansion, and where internal management of static services and outreach will be complex. This frees the ED for advocacy and external negotiations. In PY1 IPPF will investigate the feasibility of a formal relationship with the AVI to capitalize on the opportunities for FHAs and Australian volunteers through such a partnership e.g. through the creation of a formal Memorandum of Understanding. Currently SIPPA and TFHA have Australian Volunteers.

MANAGEMENT ARRANGEMENTS

The Program will draw upon the FHAs' substantial commitment to and experience with strengthening in-country SRHR service delivery to achieve impressive results. The Program management will ensure effective partnerships with FHAs, other IPPF Member Associations, key partners – in particular regional bodies, governments and faith based groups – other international organizations and donors. These partnerships will drive a significant improvement in the provision and integration of quality, lifesaving SRHR information, services and rights in the Pacific for the poor and most marginalized groups.

Program and Personnel Management

i. Project Structure and Organizational Chart

IPPF will manage and implement the Program. The Pacific Sub Regional Manager, Senior Program Officer, Monitoring and Evaluation Program Officer and Finance and Administration Officer will form the Program's day-to-day management team. Combined, they will ensure the Program's results are delivered to time and budget. Further technical support to strengthen the FHAs will be available from a medically-trained Program Officer for Quality Improvement and a Program Officer for National Change, who is focused on advocacy know-how. An organogram can be found in Annex 13. IPPF will augment this team by providing 100 percent financing for a Program Officer for Resource Mobilization on an initial fixed term basis.

The **Pacific Sub Regional Manager** will manage the Program overall, including communicating with DFAT Suva; serving as the primary spokesperson for the project;

creating a cohesive vision among the Program team; and ensuring that staff are accountable for delivering agreed project outputs. He will lead the project's capacity building efforts, drawing on a wide range of skills available through IPPF staff and potential partners. Reporting directly to IPPF's East & South East Asia and Oceania Regional Director will ensure improved integration of the newly accredited FHAs within IPPF's global movement.

The **Senior Program Officer** will lead technical oversight and timely implementation of Outcomes 1, 2, 3 and 4. He will lead technical responsibilities outlined in the Program to ensure that by the end of the Program period, fragmented health systems can demonstrate clearly a more integrated response to the sexual and reproductive health and rights of the poor and most marginalized populations in the eight Pacific Island countries. He will lead needs assessments and develop implementation plans for the Program working together with FHAs and, where present, DFAT offices. He will lead the preparation of regular and ad hoc reports to DFAT and work closely with the Program Officers to identify performance issues and provide support to FHAs to ensure successful delivery of key outputs.

The **Finance and Administration Officer** will, in consultation with the **Pacific Sub Regional Manager**, oversee project budgeting and financial management, including negotiation and development of sub-grants to implementing partners. She will ensure compliance with DFAT regulations and will provide guidance and capacity development to FHAs.

An internal **Program Steering Committee** will provide high level oversight and technical advice, ensuring coordination and communication about project needs and accomplishments. The Committee will review Program performance reports and facilitate both the dissemination of lessons learned and their scale-up across IPPF, enhancing the Program's long-term sustainability. Chaired by IPPF's East & South East Asia and Oceania Regional Director, the Committee will include the Heads of Integrated SRHR Programs, Strategic Partnerships and Advocacy and Finance alongside other staff, DFAT representatives and as required. The Committee will meet quarterly during year one and then semi-annually.

ii. Communication with DFAT, Canberra

IPPF welcomes DFAT's involvement in the success of the Program. DFAT will have considerable input into agreeing priorities and supporting the dissemination of lessons learned for program utilization and scale-up. DFAT will receive annual work plans and the performance monitoring plan.

IPPF is currently setting up an office in Australia which will share regional and global strategies with DFAT and other partner agencies. IPPF's Australia office, working closely with the Pacific Sub Regional Manager, will ensure we are responsive to DFAT and available to participate in discussions with the wider government and civil society community. It will also be important to keep DFAT Posts aware of Program activities to facilitate coordination with the bilateral program. Implementation plans for each outcome

at the country level will be shared with their respective Posts for review and support. FHAs will ensure that DFAT Posts are fully informed about all Program activities, facilitating South-South exchange with other Australian-funded country programs. We will review this communication structure, with the DFAT Suva and Canberra, during implementation.

iii. Plans for inception phase enabling rapid start-up

The Pacific Sub Regional Manager will initiate Program implementation immediately upon award. Within the first month after the award, the Pacific Sub Regional Team, together with other key IPPF Secretariat management, will meet with DFAT (in either Canberra or Suva) to agree a work plan for the Program's first six months, including finalizing the core staffing plan, scheduling for a launch event, finalizing an announcement to the development community regarding the Program, and a timetable for preparation of the first year work plan (and to align the Program with other FHA funding cycles). During these six months all FHAs will:

- LARCs training carried out for respective FHAs
- Initiate IPPF's Quality Improvement Model (more stringent than the QoC Model).
- Introduce IPPF's Clinic Management Information System– for better data capture and analysis, particularly on outreach.
- Improve supply management systems – to facilitate scale up and partnership.
- Introduce disability-friendly services.

This will provide a solid technical foundation for the FHAs to expand their service delivery while establishing key partnerships to improve integration across the health/SRHR sector.

PAST PERFORMANCE

Proven capacity to manage large DFAT Programs

IPPF systems are designed to manage multi-million US dollar programs from government donors, including SIDA, DFID and the Japanese Ministry of Foreign Affairs.

IPPF's first DFAT grant was awarded in 1973. Annex 15 details the history of DFAT's grant to IPPF until the present. Since then, both parties have worked together cooperatively and systematically to expand sexual and reproductive health and rights. In the Pacific, IPPF's End of Project Evaluation noted that the CBP "effectively built on IPPF leadership and best practice in SRHR; was well-managed by ESEAOR; significantly contributed to the ICPD Plan of Action and the Pacific MDGs; and, through the close relationships between FHAs and MoHs, supported national leadership, ownership and quality service delivery through cost effective, indigenous SRHR services delivered by the FHAs.

Timeliness of performance IPPF takes a robust approach to program management, with global core management systems guidelines and user guides for each program. DFID's internal 2012 assessment of its support for IPPF's service delivery program was

A++ (outputs substantially exceeded expectation within the given timeframe).[36] Our long-term funding from our donors is testimony to the effectiveness of IPPF, to the timely decisions taken by our MAs, our commitment to schedules, and ensuring we deliver results efficiently and on time.

Cost control IPPF monitors cost-effectiveness as part of our regular Program budget review with FHA/Member Association, where costing and audited financial data are scrutinized alongside reported and projected performance data. IPPF's service costing methodology allows FHAs/Member Associations to systematically identify and track costs, identifying areas to increase cost-effectiveness. We have recently seen a significant improvement in our performance, tighter cost control and greater investment in service delivery.

Satisfactory correction of problems Sensitive monitoring systems allow IPPF to pinpoint challenges and take quick and decisive action when a program goes off track. Similarly, IPPF welcomes independent donor evaluations for their additional insight. A 2006 European Commission mid-term evaluation highlighted IPPF's ability to respond quickly. The evaluation recommended that IPPF should intensify its gender strategy. IPPF's immediate response was to request a contractual waiver to allow us to amend the Program.[37] We then developed tools that focused on gender issues for use by MAs, conducted workshops and provided a six-month mentoring program delivered by an in-country gender specialist. The tools were subsequently incorporated into IPPF's global gender program. The final independent evaluation recognized IPPF's responsiveness as having strengthened gender across the program and Federation.

Satisfactory business relationship with DFAT IPPF has received DFAT funding since 1973. These funds have steadily increased over the past decade, leading the Government of Australia to become one of IPPF's largest bilateral donors. IPPF works with a range of core, program and restricted funds to innovate advocacy and service delivery approaches that achieve high standards across all key criteria including service numbers, advocacy wins, quality and cost effectiveness.

Financial management and reporting IPPF has robust financial policies and procedures. In 2013 DFAT commissioned a due diligence audit of IPPF that found IPPF to be "financially sound" and rated the Federation as "low risk" in this regard. The audit's assessment stated that "the procedures and systems for ensuring that all MAs are financially sound and that they build sufficient reserves to reduce risk are strong, and well delivered through the External Audit process. IPPF's systems are considered as robust as appropriate when compared to DFAT's requirements in this area". In 2010, DFID commissioned KPMG to undertake a pre-grant due diligence audit. Positive assessment in governance, financial and operational capacity, value for money, results and impact allowed funding to start.[39] A similar audit by SIDA recognized IPPF's strong financial management and reporting.[40] IPPF has widely proven its ability to manage and implement a financial system to meet the specific conditions required for multi-million dollar projects and contracts by a range of donor agencies. The effectiveness of IPPF's system of internal control is reflected in the positive outcome of the external audit undertaken by KPMG each year.

5.2 Governance Arrangements

While FHAs are autonomous organizations, they are supported, managed by, and report to IPPF ESEAOR office in Kuala Lumpur through the SROP office. This system is well established with effective planning, financial management, eIMS, monitoring and reporting processes in place. These systems were assessed as strong, and improved as a result of the previous capacity building program. The IPPF Federation provides a structure which enables MAs/FHAs to learn from each other and share best practice; and MAs meet regularly from the wider Asia Pacific Region.

FHAs are well supported by ESEAOR and have accredited financial and management policies in place. Accounts are audited annually. The staff of SROP in Suva, particularly the Program Officers, also support FHAs and will be responsible for monitoring the implementation of activities in this Program. While FHAs will monitor the outreach activities on a day to day basis, SROP officers will have a monitoring role for the overall Program and for reporting to ESEAOR. SROP staff will also organize any regionally-base activities and manage the production of IEC resources.

Relationships between DFAT regional staff in Suva and ESEAOR and the FHAs are well established with DFAT officers attending planning and other regional meetings, as well as meeting regularly with SROP staff and FHA Executive Directors.

FHA Executive Directors will be directly responsible for day to day implementation of activities with both clinic and education staff involved in conducting the outreach services and capacity development activities. Ongoing strategic partnerships e.g. with MoHs, UNFPA, the Australian Aid Program, and other related Pacific NGOs will be maintained which will enhance planning, effectiveness and quality assurance.

IPPF's Code of **Good Governance** has seven guiding Principles which ensures the strength and effectiveness of volunteers. The Governing Body:

1. Ensures member integrity and collective responsibility
2. Determines the organization's strategic direction and policies
3. Appoints and supports the Executive Director
4. Develops an annual work plan and monitoring and evaluation plan which allows for evaluation of their annual activities
5. Monitors and reviews the organization's performance
6. Provides effective oversight of the organization's financial health
7. Is open, responsive and accountable
8. Ensures its own review and renewal.

The Federation manages the accreditation process whereby FHAs have advanced from Observer status to Associate Member to Full Member through a series of incremental steps and criteria. Such criteria include having: a Board (made up of at least 4 volunteers), an organization structure, a constitution in place and 23 checklist other

items. All eight FHAs have met these criteria and have become associate or full members of IPPF. There are seven Full Members of IPPF – RFHAF, SIPPA, TFHA, VFHA and SFHA, with CIFWA and TuFHA becoming Full Members in 2014 – and one Associate Member (KFHA) whose full membership will be reviewed in November 2014. IPPF conducts an annual review of associate status (KFHA) in which they have to be in compliant with the principles and 23 checks as part of the accreditation.

6. Sustainability

6.1 Opportunities and Constraints

Outcomes expected from this Program are likely to be sustained due to: acknowledgement of the importance of reaching all with SRHR services (rights-based approach); the known effectiveness of FHAs; and the ongoing support of FHAs by IPPF and donors. IPPF undergoes annual review and planning processes so SRHR needs and FHA capacity are constantly being reassessed.

The proven integrated approach to service delivery and the built-in quality processes to be embedded by this Program will ensure that FHAs will be in demand by clients and other service providers. Existing and new partnerships will further ensure sustainable outcomes.

The long-term operational success of this activity will largely be measured through the ability of FHAs to be contracted by their MOHs (and other Ministries) to undertake selected niche activities including quality outreach work, and activities designed to reach poor and marginalized groups, particularly young people. This role for FHAs is well established and negotiations with MoHs are underway in most FHAs. Now that MoHs are developing SRHR policies and programs, FHAs are well placed to assist MOHs to implement innovative SRHR activities which complement government services. This augurs well for the sustainability of all FHA programs.

The down side to this is that many Pacific MoHs have limited resources and limited access to service providers with whom FHAs can partner. Given the expense incurred in providing services to remote islands, it may be a long time before these hopes are realized. MoHs and provincial authorities will be vital partners in this Program and selection of outreach sites will be made in collaboration with MOH. Advocacy activities by FHAs and SROP will impact positively on the likelihood of such contractual partnerships. Annex 16 provides analysis of the current income of FHAs from external sources including MoH and Section 7.2 below discusses the expected financial sustainability of each FHA given the differential contexts and capacity of each.

It will be vital that FHAs can use their strengthened capacity over the next five years to consolidate current service levels, maintain current and develop new partnerships to expand services and address the unmet need for family planning and other SRH services. Recognition of the varying capacities and contexts of FHAs is highlighted in Section 7.2 and this will impact on results and sustainability of outcomes. For example, Tuvalu's small population means it will be difficult for TuFHA to achieve the scale-up that FHAs in more populous countries will be able to achieve, particularly with outreach

services; CIFWA has great difficulty in maintaining its youth program with young people migrating out of the Cook Islands; RFHAF has limited capacity to establish and maintain clinical services in Fiji which will restrict participation in the clinical activities of the program. These factors will impact on individual FHA performance, results and on long-term sustainability. The fact that **all** FHAs are working towards, and close to achieving MoUs and contracts with their MoHs will significantly improve the likelihood of sustainable outcomes; and the results expected from the higher performing FHAs will contribute to the overall 'value for money' of the Program.

Progress towards such sustainable outcomes can inform the end of program evaluation and recommendations provided on future needs. Supporting the organizational and technical sustainability of FHAs through developing capacity of FHA staff, MoH service providers and other local NGOs is a great investment and ensures sustainability of outcomes even if staff leave the organizations[32].

The FHAs will build up and strengthen their cooperation with other NGOs in related sectors, by offering training and technical assistance in providing SRHR services. Partnerships and robust referral pathways will be established with other providers, thus improving weak and fragmented health systems and making better use of resources, often where there are severe shortages.

7. Monitoring and Evaluation

7.1 Results Measurement

Annex 11 provides details on how Program results will be measured and reported. Measurement of activities and outputs, quality, clinical data and who the Program is reaching will occur at implementation level via the FHA annual planning process. The Design Team has set a series of targets (including country-specific targets) which will be measured annually and at the completion of the Program against the purpose.

Existing indicators can be used to measure most results and these measurements are entered into the IPPF eIMS. This is a global mechanism which collects financial data, work plans, narrative for all reporting and clinic/education service data. This system worked well for the previous Australian supported programs.

The eIMS can measure access by PMSEU, including young people (FHAs will add a category for PWD). It also considers cross cutting issues such as gender, age, governance, disability, capacity development and sustainability. It meets the reporting requirements of IPPF and will be adapted to report to DFAT on this Program. Activity reporting from FHA staff will be entered into the eIMS; annual review reports are compiled by FHA EDs; FHA data is analysed by SROP and ESEAOR staff so that impact can be assessed[33].

[32] Lesson learned from evaluation of the previous Pacific Regional SRHR Capacity Building Program

[33] Note: FHAs are incentivised through bonuses paid for excellence in attaining results related to specific indicators. In 2013, seven of the eight FHAs received a bonus.

Performance management

SROP staff will be responsible for performance management with the support of ESEAOR Head of Programs. An M&E Program Officer will be recruited for the SROP office and will engage with the different service channels through the FHAs. FHAs will establish effective M&E systems across partners and outreach sites, including mechanisms for ensuring and strengthening data quality.

The SROP Program Officers will undertake monitoring visits to the FHAs and selected service delivery points twice per year. Field monitoring visits will include data quality verification and spot checks. Community level service providers and volunteers are supervised and supported by clinic-based staff through regular review meetings. The range of data, management and qualitative assessment tools that are currently being used, and which will be introduced during the Program will be built upon for the benefit of this Program e.g. CMIS and Vulnerability Assessment. Information generated from these tools and processes will support performance management, and feed back into external annual reports, the Mid Term Review and the Activity Completion Report.

Work planning and performance reporting

All FHA currently have existing processes to transmit SRH data (particularly from clinics) to MoH information systems. Where the Program interacts with partner organizations (e.g. associate clinics, government health centres) joint planning with existing RH coordination mechanisms, and data generated from joint activities will be channeled through established government collection points as well as to the IPPF eIMS. Any information and analysis showing trends will be disseminated back to the service providers. Documentation including success stories and best practices will be an integral part of the Program and case studies used to illustrate the annual reports. Annual review of the data will occur through the existing FHA planning process and be discussed at the annual planning meeting where all FHAs gather to share their annual plans and results. Cost effectiveness data relating to specific disadvantaged and remote populations will also be used in advocacy evidence-gathering, and provided in a format that will help PIC decision-makers to calculate equity-related trade-offs.

A mid-term review of outreach activities will be conducted at the end of PY1.5 with the view to scaling up activities; and a detailed evaluation will inform the Activity Completion Report in PY 3.

7.2 Expected Contribution by FHAs to Program outcomes

The eight Pacific FHAs operate within different contexts and are at varying stages of progress towards sustainability. Some are regarded as high performers (SIPPA, VFHA, KFHA, SFHA and CIFWA) while others struggle to maintain and expand services, to reach vulnerable groups and to address socio-cultural (especially religious) barriers which could limit achievement of results. This section[34] analyses how specific FHA interventions will contribute to program outcomes and prospects for sustainability of outcomes after the DFAT funding support ends. FHAs have considered their own

[34] This section should be read in conjunction with Annex 8 - Country Information and FHA Service Statistics

capacities and contexts and have developed realistic targets which can be achieved within this Program design. These are reflected in Annex 11 – Monitoring and Evaluation Framework.

Cook Islands - CIFWA: (Population 17,974) This is a well-respected and well-managed organization with a strong youth program and good collaboration with government (health and education) as well as effective partnerships with schools, NGOs and government. Increased funding for outreach will assist CIFWA to further develop partnerships with government and NGOs to reach outer island populations. Quality improvement of clinic services will increase access as will CIFWA plans for increasing the number of clinic staff. There are limitations to expanding reach to young people as many emigrate from the country. However, increasing outreach through schools is a feasible strategy to reach young people before they migrate. CIFWA provides outreach clinical services and peer education to students and this strategy can be expanded through this Program. Sustainability is enhanced through: historically strong links with MoH including utilisation of CIFWA's clinical staff by the main hospital's reproductive health program; further quality improvement in clinic services which will increase access; and successful resource mobilization efforts by CIFWA managers with national funding agencies.

Fiji - RFHAF: (Population 843,888) RFHAF has established itself as a leader in sexuality education, particularly for young people. The organisation is constrained by the absence of SRH clinical services which means it is reliant on referrals to SRH services. It is working towards partnering with the Ministry of Health to provide clinic services and is expected to achieve a MOU soon which will include secondment of government nurses to a RFHAF SRH clinic. Ideological issues such as promotion of condoms to young people, and religious and other cultural issues also limit achievement of results. As this program focuses on quality service delivery, RFHAF's contribution to results may be limited until clinic services can be established. This has been reflected in the Program design and allocation of resources. Sustainability of outcomes will be difficult until RFHAF can provide the SRH services requested by MoH, i.e. clinical and education services which can reach vulnerable groups such as sex workers, men who have sex with men and young people.

Kiribati - KFHA: (Population 103,058) Kiribati has some of the worst SRH (and other health) indicators in the Pacific. This is exacerbated by serious problems of: rapid population growth and density, and impacts from climate change. KFHA has benefited from strong support from NZFPA and DFAT Programs and has gone from strength to strength over the past few years. The organization is led by a talented and entrepreneurial management team which has earned the high profile it now has with development partners. Professional staff for KFHA are cherry-picked from senior government staff who are required to retire at 55 years. KFHA has achieved MoUs with the MoH as well as with 8 Island Councils. This will greatly facilitate access to communities when outreach activities are increased through the Program to more remote islands. Systems and strategies for this are well developed including working effectively with faith-based organisations and ensuring community volunteers are trained in all communities to be reached. KFHA will be a strong contributor to the results of this Program in all aspects – clinical services (including mobile), community awareness strategies, outreach and advocacy. KFHA's strong programming on offering a wide range of contraceptives (including LARCs), a rights-based approach, volunteerism and

addressing violence against women will be used as exemplars for the Program. Sustainability is assured through: excellent relationship with MoH and Islands Councils; the constant demand from development partners for assistance with project/program implementation; successful resource mobilization strategies; and the client satisfaction with the services provided.

Samoa - SFHA: (Population 194,320) SFHA is the leading SRHR NGO in Samoa and is characterized by its multi-sectoral approach with effective partnerships with a range of government departments and NGOs - Ministry of Health (MOH), Ministry for Women, Community & Social Development (MWCSD), Ministry of Education, Sports & Culture (MESC), Ministry of Police (MOP), Samoa Red Cross Society (SRCS), Civil Society Organizations (CSOs), Church Faith Organizations (CFO), Traditional Birth Attendants (TBAs). SFHA provides quality clinical and mobile SRH services thus ensuring access to vulnerable groups to address: the high unmet need for family planning and considerable opposition to contraceptives. SFHA will be a strong contributor to Program results in quality improvement of clinical/mobile services and outreach. This Program will facilitate the planned expansion to Savaii Island. Sustainability will be enhanced through SFHA's engagement by Ministries and development partners to assist with implementation of health programs; increased access to services; and through resource mobilization efforts with government and the private sector.

Solomon Islands - SIPPA: (Population 515,870) Solomon Islands is characterized by high population growth rate; diverse ethnic, cultural and language groups; large distances between islands; 80% reliance on subsistence; and susceptibility to natural disasters. SIPPA as a well-respected and high performing FHA has become the leading SRHR agency in SI with significant efforts made to engage with the Ministry of Health, Provincial Health and Education authorities, government health workers, church groups, traditional leaders, police, women and youth representatives to advocate for SRHR. SIPPA has more than doubled services to vulnerable groups through a strategy that prioritises regional clinics, mobile clinic services and associate clinics where government health services are supported and trained to provide SRHR services. This Program will enable expansion of mobile clinics around the four static clinics and geographical expansion of associate clinics to more remote island provinces. SIPPA will make a significant contribution to the Program in sharing advocacy and community engagement strategies as well as benefiting from improved quality of clinical services and broadening of the range of contraceptive methods offered. The re-building of the SIPPA premises (severely damaged in the recent earthquake/floods) will also attract more clients and increase access. Sustainability is assured through proposed contracting of SIPPA by government (national and provincial) to provide specific SRH services; increased geographical access to services; and proven client satisfaction.

Tonga - TFHA: (Population 103,000) With a small population, TFHA is not expected to meet the IPPF Vision 2020 target of doubling access to SRH services. However TFHA's strong focus on outreach services and community education will be expanded with this Program. TFHA's strong relationship with the Government of Tonga (particularly MoH) is exemplified in the National Youth Policy and National SRH Program which has historically been contracted to TFHA to manage (as well as the past Response Fund for HIV initiatives). TFHA's new CMIS will contribute to the measurement of results of the Program and features will be shared with other FHAs in need of CMIS strengthening.

Tuvalu - TuFHA: (Population 10,000) As with TFHA above, TuFHA will have difficulty in quadrupling services by 2020. However, there is great potential to expand services to the outer islands through this Program, especially to reach young people through providing SRH services to island high schools (peer education and clinic services). Increasing the range of contraceptive methods available also provides the potential to attract more clients. TuFHA's relationship with MoH includes a MoU and some financial support.

Vanuatu - VFHA: (Population 271,000) VFHA is a strong performer and has an effective strategy of community education, peer education of young people and quality clinical services including in peri-urban and rural areas where project sites piggyback government services. It is highly respected and well recognized by government, especially MoH. Recent stockouts have seen clinic statistics fall but MoH has actively improved commodity security and VFHA will benefit from this. A significant strength of VFHA is its entrepreneurial approach and in-house resources (international volunteer) for proposal writing to attract further funds for expansion projects. VFHA is keen to use the opportunity the Program provides to significantly expand outreach programs and client reach into more rural areas/provinces. The MoH has a good track record of contracting NGOs to manage implementation of national plans and VFHA is confident it will be included in implementation of planned Reproductive Health and Family Planning Policy activities.

8. Risk and Risk Management

Annex 10 – the Risk Management Matrix describes the key risk areas for the Program. Due to the fact that IPPF has recently implemented a successful Australian-supported Program, all management systems and processes are in place and working well. This reduces the risk of organizational and financial problems. A recent re-structure of the SROP office, and recruitment of staff whose skills match the program themes, will reduce the risk of management problems. The recently-appointed SROP Program Manager was a Program Officer during the last program and is familiar with DFAT and ESEAOR requirements. He also has the confidence and increased authority from ESEAOR office.

The critical external risk of technical assistance relates to reliability and availability of air and sea transport to the remote areas and inclement weather for outreach. This will be managed through flexible planning, limited planned travel during cyclone season, and by developing contingency plans for staffing of static clinic services in the event that outreach staff are stranded. Without these considerations, this risk could have impacted on FHAs ability to implement the outreach activities as scheduled.

The second external risk which could impact implementation rates and success is working in partnership with MoH and CSO/FBO. It may also limit the attribution of success to FHAs. This can be managed through effective preparation and planning, including orientation and training for partners in SRHR.

A further risk is the supply of the long acting reversible contraceptives (LARCs) that may need to be addressed, with some FHAs needing to advocate for the inclusion of LARCs into the essential medicine lists and procurement lists. These can then be obtained by MoH through UNFPA and accessible by FHAs.

FHA clinic staff have already experienced a significant increase in their workloads as a result of the improved capacity and access through the CBP. This has been managed well by FHA EDs through recruitment of stand-by staff (often retired nurses), and through effective planning.

The other risks identified which could have a severe impact are related to the regulations in PICs regarding who can administer different methods of contraception. In some countries, only midwives can insert IUDs and implants. FHA EDs have consulted with their Nursing Councils and are confident that with advocacy and agreement about supervision post-training, they can reverse this regulation. There will also be a need to have the LARC training from the Philippines recognized by the Nursing Council and MoH in each FHA. This is considered to be an issue that can be managed.

9. Budget Summary

REFER TO ANNEX 12 --- BUDGET AND IMPLEMENTATION SCHEDULE

SPRINT STAGE 2

Draft Program Design Document

December 2011

TABLE OF CONTENTS

ACRONYMS

AR	Africa Region
AusAID	Australian Agency for International Development
ARHA	Australian Reproductive Health Alliance
CAP	Consolidated Appeals Process
CCT	Country Coordination Team
CEDAW	Convention on Elimination of all Forms of Discrimination Against Women
CERF	Central Emergency Response Fund
CO	Central Office
DFID	UK Department for International Development
DRR	Disaster Risk Reduction
eIMS	electronic Integrated Management System
EmOC	Emergency Obstetric Care
EP	Emergency Preparedness
ERF	Emergency Response Fund
GenCap	Gender Standby Capacity
IASC	Inter-Agency Working Group in Crisis Situations
IAWG	Inter-Agency Working Group
IBP	Implementing Best Practice
ICRC	International Committee of the Red Cross
IDPs	Internally Displaced Populations
IFRC	International Federation of the Red Cross
INGO	International Non Government Organisation
IPPF	International Planned Parenthood Federation
ISDR	International Strategy for Disaster Reduction
ISDR	International Strategy for Disaster Reduction
KPI	Key Performance Indicator
M&E	Monitoring and Evaluation
MA	Member Association
MDG	Millennium Development Goal
MISP	Minimum Initial Service Package
MOU	Memorandum of Understanding
MSF	Medecin Sans Frontiere
NAP	National Action Plan

ProCap	Protection Standby Capacity
RA	Regional Adviser
RH	Reproductive Health
SARO	South Asia Region
SMT	Senior Management Team
SOP	Standard Operating Procedures
SPHERE	Humanitarian Charter and Minimum Standards in Humanitarian Response
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TOR	Terms of Reference
ToTs	Training of Trainers
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNSCR	United Nations Security Council Resolution
UNSW	University of New South Wales
USAID	U.S. Agency for International Development
WHO	World Health Organisation
WRC	Women's Refugee Commission

Executive Summary

Background

The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) was formed in 1995 to develop guidance on addressing sexual and reproductive health (SRH) for refugees, internally displaced people and other affected by emergencies. The resulting Inter-agency *Field Manual on Reproductive Health in Humanitarian Settings* articulated the Minimum Initial Service Package (MISP) – a set of priority activities to be implemented at the onset of an emergency. The goal the MISP is to reduce mortality, ill-health and disability through the application of a set of clinical interventions provided using an agreed approach and set of guidelines to meet SRH needs in emergencies.

The SPRINT Initiative was designed to address gaps in MISP implementation identified in a global evaluation undertaken by the IAWG in 2004. Stage 1 of the Initiative began in 2007 in the East and South East Asia and Oceania region and later extended to the Africa Region (AR). It was solely funded by AusAID, and made good progress in developing a model for further work needed to provide SRH services to crisis affected populations. SPRINT Stage 2 will build on this work, extending it to the South Asia Region (SARO) and with a greater focus on disaster risk reduction (DRR) and emergency preparedness (EP).

Problem Analysis

A comprehensive International Framework exists endorsing the need for SRH in crises and the MISP is an internationally accepted minimum standard of care. Nevertheless, implementation of the MISP is far from universal and knowledge of its provisions by humanitarian workers remains inadequate. Much remains to be done to ensure the availability of skilled health workers and the services needed to meet critical SRH needs in crises. Stage 2 of the SPRINT Initiative will develop a more refined set of objectives to meet these needs.

Program Strategy

SPRINT Stage 2 core programming components address all stages of the emergency management cycle, where **emergency responses** in acute phases of a crisis are preceded by **preparedness activities** and followed by **recovery/redevelopment** interventions.

To achieve the purpose of the program requires more than just an emergency response when a crisis arises. It also calls for investment in creating an **enabling environment** to mitigate risk of decreased access to lifesaving SRH services at the onset of a crisis. This is achieved by establishing supportive policies and systems for MISP implementation long before a crisis hits. 'Mitigation' is illustrated in SPRINT Stage 2 Intermediate Outcome 1: Disaster Risk Reduction – Enabling Environment. It also involves reliable **preparedness,** Intermediate Outcome 2, in the form of capacity development in regions at risk of disaster. '**Response**' and '**recovery**' are illustrated in Intermediate Outcome 3: Emergency Response, which will focus on support in the **acute phases** of man-made and natural disasters.

Program Description

Adhering to the principles underpinning the program will maximise the likely achievement of the proposed outcomes of the Program, with saving lives and capacity development at the core of the program.

The program will be implemented in priority countries in three regions as follows:

- **SE Asia/Oceania –** Burma, Indonesia, Papua New Guinea, Philippines, Timor-Leste and Solomon Islands.
- **South Asia** – Afghanistan, Bangladesh, Pakistan and Sri Lanka.
- **Africa** – DR Congo, Ivory Coast, Uganda, Central Africa Republic, Ethiopia, Kenya, (potentially Liberia or South Sudan to replace one of the former countries).

In case of an emergency striking other countries in these regions, SPRINT will also consider intervening to support the CCT in their implementation of the MISP.

The overall **Goal** of the Program is to improve health outcomes of crisis affected populations by reducing preventable sexual and reproductive health morbidity and mortality.

The program **Objective** is to increase timely access for crisis affected populations to life-saving sexual and reproductive health services as outlined in the MISP.

There are three intermediate outcomes**:**

- *Disaster Risk Reduction Enabling*: Governments increase funding and policy support for SRH in crisis.
- *Emergency Preparedness:* National preparedness to implement MISP is increased.
- *Emergency Response*: Country Coordination Teams can respond effectively during crisis.

The implementation of all intermediate outcomes will contribute to the achievement of the program objective, and ultimately the program goal.

Disaster Risk Reduction Enabling is the preparedness phase of the emergency management cycle. It will be implemented in all priority countries, irrespective of whether there is a crisis or not.

Emergency Preparedness activities will contribute to increased national capacity to coordinate the implementation of MISP. It will also increase the pool of people at the national and regional levels with awareness, knowledge and understanding of MISP.

Country Coordination Teams will be supported to effectively implement MISP during emergencies. It will focus on support in the acute phases of man-made and natural disasters.

To ensure effective implementation, an inter-regional Secretariat (the Hub) will oversee good program management of funds, activities and robust monitoring and evaluation systems.

Cross cutting issues

The program is consistent with a number of AusAID policies, particularly the Humanitarian Action, Disaster Risk Reduction and Gender Policies, with Strategic Health Partnership priorities on maternal health and with many existing AusAID programs in the priority countries specified in the three regions. It is also well aligned with AusAID priorities of achieving the MDGs, particularly MDGs 5 on maternal health, reducing violence against women, particularly in conflict situations, and increased funding to humanitarian crises.

Form of Aid

A grant program is recommended. The formal partnership will be with the International Planned Parenthood Federation (IPPF) with funds processed through IPPF's financial management system but SPRINT funds will be kept as a separate exercise within IPPF with separate bank accounts and management of funds decentralised through the SE Asia/Oceania Office. The Hub Director will have the responsibility for decisions on expenditure related to responses with the IPPF Regional Director, SE Asia/Oceania, having overall responsibility for approval of expenditure. This is a similar model to the UNAIDS Technical Support Facility which is also housed with the IPPF SE Asia/Oceania Office and is working efficiently.

Program Management

As with Stage 1, IPPF is the key implementation partner and will continue to provide the Initiative's institutional home. The new inter-regional Secretariat, the Hub, will be housed within the IPPF SE Asia/Oceania Office and the Regional Advisers and Regional M&E/Coordination Officers within the respective IPPF Regional Headquarters. A steering committee will guide the direction and activities of SPRINT in the overall global context of SRH in crises. A Senior Management Team (SMT) will be established once Stage 2 is implemented.

The key management stakeholders are IPPF, the Hub and AusAID. IPPF will be responsible for selecting and managing the team of advisers and provide the use of the IPPF financial management system. The Hub will support the key advisers, provide overall supervision of implementation and be responsible for reporting to AusAID. AusAID will identify an activity manager to coordinate AusAID's

inputs in managing the project and the contract with IPPF and will re-activate its internal working group on SRH in emergencies.

Duration and funding

A three year program is proposed with a budget of approximately AUD10 million. Funds will be expended reasonably evenly over the three years with slightly lesser expenditure in Year 2. Approximately 25% of the total funds will be spent on staffing.

Performance Assessment

The program will be monitored at the Output, Intermediate Outcome and Objective levels. A detailed description of the approach to monitoring and evaluation is found in Section 3.4 of the PDD.

Monitoring and review of the Program will occur through regular annual reporting as well as other mechanisms such as senior management meetings, team meetings, and reviews.

The Monitoring and Evaluation (M&E) Team (M&E Adviser, Hub Director, Regional Adviser, Regional M&E/Coordination Officer and expert consultant as needed) will establish the mechanisms for measuring achievements of the program, leading the evaluation at the same time as involving key staff and stakeholders actively in the M&E of the Program.

Data collection will be undertaken through surveys (qualitative, quantitative) including the collection of baseline information where possible, and other methodologies. Case studies will be an important source of information.

Quality control measures will be implemented to ensure: high quality data collection (quantitative and qualitative), the ability to report trend data, and that reporting on outcomes of the program can withstand scrutiny. These measures will include: development of templates for data collection and reporting, development of categories for reporting against some variables, training in data collection and adequate supervision of data collection and feedback on analysis of data collected.

At the start of the Program the M&E Team will be responsible for leading an evaluability assessment at which time indicators proposed in the PDD are verified, additional indicators are identified and data collection methodologies are confirmed.

Feasibility, sustainability and risk management

The goal of the SPRINT Initiative is to increase access to SRH information and services for populations surviving crises. However, while this is a straightforward goal, the means of achieving it is quite complex. Stage 2 will build on the lessons learned in Stage 1, in particular having a greater emphasis on capacity development and support for the country coordination teams (CCT) and a new component building the enabling environment for disaster risk reduction (DRR) and emergency preparedness (EP).

The CCTs are the key to SPRINT's operations. The original concept of simply establishing regional training programs and in-country training in order to build the capacity of individual SRH workers in emergency responses quickly evolved into the development of CCTs. CCTs are formed during SPRINT regional trainings on the MISP. Each CCT develops an action plan to advance SRH in their own setting. If these CCTs, with SPRINT support, implement their action plans and have the necessary systems in DRR and EP policies and plans in place, the MISP will automatically be included in humanitarian responses, even without any outside help.

Taking into account the lessons learned from the complexities of Stage 1, the design for Stage 2 describes the activities of the program in detail in order to establish as much clarity and guidance as possible from the outset to those responsible for the program's implementation. It also stresses the need for a high degree of flexibility given the unpredictable nature of humanitarian crises.

Essentially, while the SPRINT Initiative is aimed at humanitarian responses, it is a development program. It has evolved from a relatively simple concept of advocating for the inclusion of the MISP in humanitarian responses and training SRH experts to coordinate it, to a more complex program of support for national governments and agencies at the regional and national level that will lead to the

integration of the MISP into DRR programs and thus its automatic, and effective, implementation in emergencies.

This design has therefore had to address a complex set of issues, largely within the context of fragile environments, and involving a complex array of national governments and institutions, UN agencies and international NGOs – at their global, regional and national levels. However, while this is complicated, the advantage of it is that interaction between the SPRINT Initiative and the various government departments and agencies results in a sum greater than its parts.

The design has made every effort to reduce the complexities and present as clear a picture as possible of the processes involved in bringing about the effective implementation of the MISP. It also makes every effort to identify and address the attendant risks involved in such a complex program. Nevertheless, while goals and objectives have been kept to a realistic level and the number of countries prioritised, this remains a complex program and it is likely that a third stage will be needed to properly build the level of capacity to implement the MISP amongst all the countries at risk of conflict and natural disasters and that are of concern to AusAID programs.

No program involving humanitarian responses will ever be completely sustainable and able to operate independently. Donor funds will always be needed to assist with responses to crises. However, the SPRINT Initiative will help to ensure that there are systems in place within the priority countries of Stage 2 that will automatically come into play in a crisis response. This extends to agencies such as the United Nations Population Fund (UNFPA) and IPPF which are essentially development agencies. Their systems to date have not been geared to humanitarian responses. SPRINT is helping to build their humanitarian response capacities. This will be beneficial in the broader context, including helping those organisations to in turn help develop and maintain national government systems and provide faster and more effective humanitarian responses. In other words, SPRINT is greater than the sum of itself, and is in itself, an agent of sustainability.

1. Introduction

1.1 Sector Issues and Program Origin

Complications associated with pregnancy and childbirth are the leading causes of death and disability among women of reproductive age in developing countries. Crucially, displaced women and girls lack access to safe childbirth services, face an increased risk of unsafe abortions, are vulnerable to rape and other forms of sexual violence and to the transmission of sexually transmitted infections (STIs), including HIV/AIDS.

When priority reproductive health (RH) services are not immediately implemented at the onset of emergencies, these risks increase.

The five leading causes of maternal death are: haemorrhage, sepsis, complications resulting from unsafe abortion, prolonged or obstructed labour and hypertensive disorders. Maternal deaths are caused by three major delays: in the decision to seek care, in the transportation to a health care facility, and in receiving appropriate care once at the health care facility.[1]

Between 6-14 per cent of all displaced women between the ages of 15-49 could be pregnant at a given time, and 15 out of every 100 pregnant women will experience unpredictable obstetric complications. Without access to emergency obstetric services, many women will die or suffer long-term health consequences that are preventable. The majority of infants born to women who die of maternal causes are either stillborn or die soon after birth.[2]

For every woman or girl who dies from a pregnancy-induced cause, an additional 30 women or girls suffer from some form of injury, infection, or long-term disability. [3]

Women and girls are also vulnerable to rape and other forms of sexual violence during humanitarian crises. Between 50,000 and 60,000 women in Sierra Leone alone reported having experienced sexual violence at the hands of armed combatants. Up to 500,000 women survived rape during the genocide in Rwanda. Seventeen per cent of those women tested positive for HIV.[4] While no specific figures are available for Darfur, Medecin Sans Frontiere (MSF) reported that it treated 500 women and girls who had been raped between October 2004 and February 2005. This represents only a fraction of the total.[5]

One of the characteristics of violence against women, in particular sexual violence, is under-reporting. Survivors generally do not speak of the incident for fear of reprisals, mistrust of authorities, risk of re-victimisation or even self-blame and rejection by their family or community. Consequently, survivors are at high risk of severe and long-lasting health problems including death from injuries or suicide. Health consequences can include unwanted pregnancies, unsafe self-induced abortion, infanticide, sexually transmitted infections including HIV, and psychological trauma.[6]

In 1995, in response to the lack of Sexual and Reproductive Health (SRH) services in crises and to the outcome of the International conference on Population and Development held in Cairo, the Inter-Agency Working Group (IAWG) on Reproductive Health in Refugee Situations (now the Inter-Agency Working Group in Crisis Situations) was formed, consisting of some 40 United Nations, academic, research, non-governmental organisations and donor agencies. Its task was to develop guidance on how to address SRH for refugees, internally displaced populations (IDPs) and other populations affected by emergencies. The resulting *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* articulated the Minimum Initial Service Package (MISP) for Reproductive Health, a set of priority activities to be implemented during the onset of an emergency – both conflict and/or natural disasters.

The goal of the MISP is to reduce mortality, ill-health and disability amongst populations affected by crises, particularly women and girls. If implemented in the very early stages of a crisis, the MISP saves lives and prevents illness through clinical interventions provided using an agreed approach and set of

[1] Women's Refugee Commission 2011
[2] Macro International, Democratic and health Surveys, 2006
[3] UNFPA 2006
[4] IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings, 2005
[5] Human Rights Watch, 5 Years On: No Justice for Sexual Violence in Darfur, 2008
[6] IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings, 2005

guidelines to meet SRH needs in such environments, undertaken in a coordinated manner by trained staff. The five key components of the MISP are presented in the box below. A full description of the MISP components and sub-components is found at Annex 1.

BOX 1: KEY COMPONENTS OF THE MISP

1. **ENSURE** the health sector/cluster identifies an organization to lead implementation of the MISP.
2. **PREVENT AND MANAGE** the consequences of sexual violence.
3. **REDUCE** HIV transmission.
4. **PREVENT** excess maternal and newborn morbidity and mortality.
5. **PLAN** for comprehensive RH services, integrated into primary health care (PHC) as the situation permits.

The SPRINT Initiative was designed to address the gaps in MISP implementation at the regional and national levels identified in a global evaluation undertaken by the IAWG in 2004. The first three-year stage beginning in December 2007 (and extended to December 2011) was solely funded by the Australian Agency for International Development (AusAID), and implemented by the International Planned Parenthood Federation (IPPF). Its goal was to increase access to SRH information and services for populations surviving crises and living in post-crisis situations in the East, Southeast Asia and the Oceania Region (SE Asia/Oceania) – the region that at that time was AusAID's main sphere of interest. In response to the Australian Government's increased funding to its aid program in Africa, the Initiative was extended to the Africa Region (AR) with additional funding in the third year of the Program.

SPRINT Stage 1 achieved a great deal in laying the ground work and developing a model for further work needed to provide SRH services to crisis affected populations. SPRINT Stage 2 will build on this work, extending it to the South Asia Region (SARO) but, based on the lessons derived from the first stage, with a more refined set of objectives and a greater focus on Disaster Risk Reduction (DRR) and Emergency Preparedness (EP).

A detailed sector analysis is found at Annex 2.

1.2 Problem Analysis

Achievements

The essential elements of Stage 1 were advocacy and capacity building, particularly the training of experts in the MISP through 5-day regional training-of-trainer (ToT) courses, 3-day in-country trainings and the establishment of a regional network of field workers ready to be deployed in a crisis. Over 4,300 workers from 81 countries were trained in the MISP together with a small pool of ToTs. The program has initiated the establishment of Country Coordination Teams (CCT) in 30 countries in the SE Asia/Oceania region and 38 in the Africa Region. Policy changes have been completed or are underway in 14 countries to advance SRH in crises. The United Nations Population Fund (UNFPA), the International Federation of the Red Cross (IFRC) and other humanitarian actors have started to integrate SRH in crises into their programming.

SPRINT has thus been successful in raising the profile of SRH in crises amongst national governments, UN agencies and NGOs and the need to address all the requirements to ensure its inclusion in emergency responses. It has established good working relations with all concerned and built a solid foundation for the continued activities that are needed to ensure that the MISP is formally included and efficiently and effectively implemented, in all emergency responses.

Inadequacies in implementation of the MISP

Implementation of the MISP, however, is far from universal and despite the fact that it is an internationally accepted minimum standard of care and there is a comprehensive international framework endorsing the need for SRH services in crises, its implementation during crises has been inconsistent. In addition, assessments undertaken by the IAWG and the Women's Refugee Commission (WRC) have shown that where the MISP is implemented, knowledge of its provisions by humanitarian staff is inadequate.

In 2004, the IAWG carried out a global evaluation of SRH in humanitarian settings. It found that in stable refugee situations availability of services for safe motherhood, sexual and gender-based violence (GBV), sexually transmitted diseases (STI), including HIV/AIDs, and family planning were generally found to be favourable, with some notable gaps in most areas. Access to emergency obstetric care (EmOC) for pregnant women needed to be ensured and antenatal care needed to include all recommended elements, particularly syphilis screening and treatment and intermittent preventive treatment for malaria, where indicated. Services for STI/HIV/AIDs and, to an even greater extent, those for GBV were less comprehensive and in greater need of strengthening. The report noted particularly that services for internally displaced populations appeared to be severely lacking and in need of urgent attention if the RH needs of those populations are to be met.

The general recommendations of the IAWG report included, but were not limited to, formalizing referral networks and strengthening referral systems through strategic planning; ensuring the availability of essential drugs for treating STIs and obstetric emergencies; ensuring the availability of the equipment needed for post-abortion care; providing GBV awareness raising activities in all refugee camps and with staff working in camps; and improving data collection methods relevant to RH.

The findings from the evaluation on the use of the MISP and RH kits suggest that the MISP was better used than in the past and the RH kits were found to be generally useful. However, problems were found with distribution of the kits (poor road conditions, irregular flights, extreme heat and humidity affecting storage) which delay or prevent their use. In some situations, humanitarian actors were not familiar with the MISP and did not know its overall goal, key objectives and priority activities. There were no overall RH coordinators.

In summary, the report identified the following gaps as needing attention:

- lack of prioritisation of SRH in emergencies;
- lack of awareness of the MISP amongst humanitarian actors;
- poor implementation of the priority services outlined in the MISP;
- lack of responders qualified or trained to implement the MISP;
- lack of coordination; and
- lack of dedicated funding to implement the MISP.

As a result of the work of the IAWG, the WRC and implementation of Stage 1 of SPRINT, there has been considerable progress in defining the MISP, promoting awareness of it and successfully advocating its inclusion in national DRR and EP policies and programs. However, much remains to be done to ensure the availability of skilled health workers and the focus on acute trauma that often characterise health responses during crises, so that critical SRH needs are being met.

1.3 Lessons Learned

Program Focus and Approach

The goal of SPRINT Stage 1 was to increase access to SRH information and services for populations surviving crises and living in post-crisis situations in SE Asia/Oceania. Its objectives were to:

(i) Increase the regional capacity of key stakeholders with regard to SRH response in crisis and post-crisis situations;
(ii) Strengthen the coordination of SRH responses in crisis and post-crisis situations;
(iii) Raise awareness of the importance of addressing SRH in crisis and post-crisis situations at the national, regional and international levels;
(iv) Respond in a timely fashion to SRH needs in crisis situations; and
(v) Enhance access to SRH information and services for persons surviving crises and living in protracted post-crisis situations.

It used a three-pronged approach to achieve these objectives:

(i) Increasing national capacity to coordinate and implement the MISP in conflict and natural disasters;

(ii) Supporting advocacy to governments and organisations to integrate SRH into their emergency preparedness and response plans; and
(iii) Providing funding and technical assistance for implementation of the MISP in crises.

However, while the overall goal of Stage 1 was straightforward, the means of achieving it were quite complex. The interactions occurring between a multitude of United Nations (UN) agencies, International Non Government Organisations (INGO) and national Non Government Organisations (NGO) as well as with national Government agencies such as Ministries of Health and National Disaster Management Offices involved in the implementation presented challenges to do with lack of cohesion and understanding of what was to be done, and by whom.

Greater focus on DRR

During Stage 1 implementation, DRR and EP were identified as gaps in global policy on SRH at the May 2010 IAWG Conference. In light of the Haiti disaster, it was recognised that while global policy and guidelines exist to be applied at the onset of crises, i.e. the MISP, and during early recovery (the Granada Consensus), there is currently no global guidance on how to better mitigate life-threatening SRH risks *before* a crisis. Response efforts would be greatly enhanced by focusing on risk mitigation and preparedness. As a result, key global stakeholders including the World Health Organisation (WHO), UNFPA, United Nations High Commissioner for Refugees (UNHCR), WRC, CARE International, IFRC, the International Committee of the Red Cross (ICRC) and representatives from SPRINT formed a dedicated SRH sub-working group under the Health Thematic Platform of the United Nations International Strategy for Disaster Reduction (ISDR) to develop global policy recommendations and field guidance on SRH during the DRR and EP phase of the emergency management response cycle.

CCT Capacity Development and Support

A number of problems emerged during Stage 1 that related to training and capacity building (e.g. selection of trainees, post-training support). The CCTs were an evolutionary process (see Annex 3 for a full description). They emerged logically from the trainings in Stage 1. Their formation solved many of these problems by not relying solely on training to achieve improved capacity. However, the existence of the CCTs in turn raised other problems, including the need for ongoing support to them, how to achieve cohesion amongst them, and the authority of CCTs within their own organisations or governments.

It also became apparent during the course of Stage 1, that the term 'capacity building' was inappropriate and the concept of 'building' was not regarded as best practice. The approach taken in Stage 1 did not reflect the broader application reflected by the term "capacity development" that would be more likely to lead to more sustainable outcomes. Significant issues were the lack of a systematic way of identifying and selecting appropriate trainees, particularly for the ToTs, the preparation of all trainees prior to the training and ongoing support for them following the training to enable their continued retention and updating of skills acquired.

Role of Partners

Of concern in Stage 1 was the role of UNFPA and the lack of any formal arrangement with them. The completion report for Stage 1 found that this somewhat hampered the arrangements and that there should be a formal agreement for Stage 2 to ensure the necessary services are provided. UNFPA is basically a development agency with a very small Humanitarian Response Branch, yet they were playing a large role in SPRINT, providing one of the two lead trainers for the 5-day regional trainings and assisting with ongoing technical advice. In recent times UNFPA's own resources have suffered due to funding cuts. However, most 5-day trainings have now been carried out and with the current pool of trained trainers that are now available, the role of UNFPA will be less demanding and largely confined to technical advice. A formal agreement is now not considered necessary (See Annex 4 for description of key partners and relationships).

In Stage 1, the University of New South Wales (UNSW) and the Australian Reproductive Health Alliance (ARHA) were formal partners in the program. UNSW contributed to the growth and development of SPRINT through research being undertaken by four PhD students. This work, until it is completed, will continue to be extremely useful to SPRINT but it will now be properly incorporated into the full M&E

system developed for Stage 2. UNSW will therefore play a less significant role so no formal partnership arrangement is envisaged with them for Stage 2. ARHA recently decided to cease all operations following the loss of their role as Secretariat to the Australian Parliamentary Group on Population and Development. It had already been decided, however, that their role in SPRINT would simply be that of a grantee so their demise will have little overall bearing on the program.

Program management

A number of problems with IPPF systems were identified during Stage 1 that hampered SPRINT staff in implementing the Initiative's activities, in particular their **financial management** routines. A financial review was carried out in 2010. These problems have been addressed in Stage 1 and new systems are satisfactorily in place (see Annex 5 for IPPF's response to the financial review). In addition, the involvement with the SPRINT Initiative implementation process has meant that there has been an increase in staff in IPPF who have humanitarian experience and who have helped bring about performance-improving changes within IPPF. This has benefitted the organisation as a whole and it is intended that IPPF remain the critical partner.

Stage 1 did not establish **robust systems to allow the program to report on outcomes**. Reporting was largely limited to output or process measures. Very limited anecdotal evidence was considered sufficient to indicate "end-of-project outcomes". This was a serious limitation of the program, and was noted by AusAID.

1.5 Program response

Program Focus and Approach

Stage 2 takes into account the complexities that were observed in Stage 1 when multiple agencies and organisations are involved in the response. Stage 2 design therefore describes the activities of the program in detail in order to establish as much clarity and guidance as possible from the outset to those responsible for the program's implementation. It also stresses the need for a high degree of flexibility given the unpredictable nature of humanitarian crises.

It was envisaged in Stage 1 that collaboration between IPPF with its large number of Member Associations (MA) throughout the world and the IAWG, combined with technical guidance from UNFPA's Humanitarian Response Branch, would push forward the agenda of SRH for vulnerable populations in crisis situations. This has largely proved correct and Stage 2 will build on this approach through a more focused and strategic approach.

The approach will involve:

- A greater focus on DRR and EP;
- Greater CCT capacity development and support
  - increased support to trainees before and after training
  - more systematic selection of trainees
  - revised training module with separate advocacy package
- Better management systems
  - the development of a systematised approach across the three regions to deliver the package of support
  - the development of a systematic monitoring and evaluation system.

Extension to a third region

The program will be extended to a third region - South Asia - but with a reduced number of priority countries. While the addition of a third region ostensibly increases the workload of SPRINT, the South Asia Region (SAR) is highly prone to disasters. According to the Natural Disaster Risk Index (NDRI), 2010, Asia accounts for most of the disaster-related deaths since 1980. Bangladesh, Pakistan, Sri Lanka and Afghanistan all rank as 'at risk' of experiencing natural disasters. The SPRINT team has provided support (technical and fundraising) in a number of disasters in the SAR and IPPF MAs in those four countries are already mainstreaming humanitarian work in their activities by providing support to

refugees and IDPs in their respective countries. It therefore made sense to include SAR in Stage 2 of SPRINT.

However, to increase effectiveness, attention will be focussed on a reduced number of high priority countries in each region. These countries have been identified on the basis of their high need, their alignment with AusAID priorities, where SPRINT has already been active and the probability of achieving successful outcomes given the work already undertaken with the CCTs in those countries:

- **SE Asia/Oceania –** Burma, Indonesia, Papua New Guinea, Philippines, Timor-Leste and Solomon Islands.
- **South Asia** – Afghanistan, Bangladesh, Pakistan and Sri Lanka.
- **Africa** – Democratic Republic of the Congo, Ivory Coast, Uganda, Ethiopia and Kenya (possibly Liberia or South Sudan to replace one of the former countries).

Flexibility will nevertheless remain to assist with responses to any crises in other countries, as necessary and if resources are available.

Greater focus on DRR and EP

A major element of Stage 2, resulting from the experience of Stage 1 to better mitigate life-threatening SRH risks *before* a crisis was identified, is the strong focus on DRR and EP. Stage 2 will work with CCTs, national governments and agencies to incorporate the MISP into their DRR and EP policies and programs. This will form a significant element of Stage 2 and complete the full cycle for comprehensive emergency management (see Section 2.3 for discussion).

CCT capacity development and support

Capacity development will still largely be undertaken through training, but this intervention is to be significantly strengthened to address shortcomings identified in Stage 1. There will now be greater pre-training advocacy for organisational buy-in to the role and responsibilities of CCTs, supervisor/peer support for trainees, levelling of expectations, and assistance in correct participant/engagement selection of trainees. SPRINT will provide post-training support to trainees to help identify action needed to develop the capacity of the system to support MISP implementation. The training curriculum will also be revised to focus more on system-wide preparedness, i.e. to help develop the capacity of the system, not the individual.

Given increased responsibilities, CCTs in turn will be better supported by SPRINT, including providing assistance to achieve greater cohesion between CCTs, and improving the authority/status of CCTs within their own organisations or governments.

A broader approach to capacity building is being taken, with the term 'capacity development' being used to better reflect the work of SPRINT, and fitting more comfortably within global conversations on aid effectiveness and the importance of using partner countries' own institutions and systems. The Stage 2 workplan and system mapping/action plan are designed to identify partners already involved or with potential to be involved in the response to SRH in crises, to establish coordination systems using existing systems, to identify an advocacy agenda to push for inclusion of SRH in existing policy structures and existing organisations, and identify capacity gaps within the health/emergency management system. As such, the program is not building a parallel structure, or attempting to commence entirely new work from scratch.

Better management systems

Under the new structure for Stage 2, the IPPF Regional Offices in SE Asia/Oceania, SARO and AR will house the respective SPRINT Regional Advisers and SE Asia/Oceania will also house the inter-regional Secretariat (the Hub) which will ensure the consistent implementation of SPRINT across all three regions. This institutional arrangement for the SPRINT Initiative will provide access to resources and systems and an organisational structure dedicated to SRH.

A robust Monitoring and Evaluation (M&E) system will be established for Stage 2 that will support reporting at the outcome (including intermediate outcome/objective) level, and internal monitoring by

SPRINT of Activity rollout. An M&E Adviser will be recruited to support these efforts. The M&E process will be inclusive of all stakeholders to further support data collection to be fed into a program monitoring system. A Regional M&E/Coordination Officer will assist in field data collection as well as provide support to the Regional Advisors.

Monitoring comprehensive health systems support

For an intervention to be successful, in this instance, to improve the delivery/uptake of SRH health services in crisis situations, both demand and supply side[7] issues of the health system need to be addressed adequately. [8,9] This program addresses some elements on both sides of the equation. Table 1 below identifies some agreed elements of this framework, and indicates where this Program is contributing. The risk of course is that if other elements of this demand/supply framework are not simultaneously being addressed then the likely impact of the program itself will be compromised.

The challenging environment in which this program operates makes it more difficult to say that elements in the supply/demand framework that are not being addressed by SPRINT will be addressed by governments/organisations through other avenues. This situation will benefit from monitoring to assess if there are critical elements missing that will impact on the program's success.

Table 1: Supply and demand side mechanisms being addressed by the Program

Supply side		Demand side	
Category	**Sprint 2 focus**	**Category**	**Sprint 2 focus**
Service delivery	Yes	Demand side financing	No
Health workforce	Yes	User behaviour	Yes
Health information systems	No	Participatory approaches	No
Access to essential medicines	No	Demand side accountability	No
Financing	Surge capacity	Human rights/equity	Yes
Leadership/governance	Yes	Multiple sector/stakeholders	Yes

1.6 The International Framework

SPRINT Stage 2, and STAGE 1 before it, aligns strongly with a comprehensive international framework that raises the profile of and directs attention to women's reproductive health needs.

There are three main international legal documents that highlight an obligation to address SRH: (i) the **Universal Declaration of Human Rights**, (ii) the **Convention on the Rights of the Child,** and (iii) the **Convention on Elimination of all Forms of Discrimination Against Women (CEDAW)**. Additional to these three are the following that have been developed over the past 17 years:

- International Conference on Population and Development Programme of Action (1994);
- Guiding Principles on Internal Displacement;
- IASC Gender Handbook for Humanitarian Action;
- IASC Guidelines on Gender-based Violence Interventions in Humanitarian settings;
- UNAIDS Guidelines for HIV/AIDS interventions in emergency settings;
- Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (the 2010 revised version funded by AusAID);
- Addressing Conflict-Related Violence: Analytical Inventory of Peacekeeping Practice;
- UN Security Council Resolution 1325 on Women, Peace and Security, 2000; and
- The International Strategy for Disaster Reduction.

[7] Definitions: Supply side - service delivery inputs such as human resources and supplies provided on the basis of formal sectoral planning by technical planners and managers. Demand Side - behaviour and inputs of the recipients or intended recipients of these efforts: individuals, households and communities.

[8] WHO (2007), *Everybody's Business: Framework for Action*

[9] *Understanding the 'demand side' in service delivery: Definitions, frameworks and tools from the health sector*. Hilary Standing, Institute of Development Studies, University of Sussex, UK. March 2004

The MISP is also included as a minimum standard in The Humanitarian Charter and Minimum Standards in Humanitarian Response (the SPHERE Project) - a set of universal standards in core areas of humanitarian response - and meets the life-saving criteria for the UN Central Emergency Relief Fund. A comprehensive description of the international framework is at Annex 6.

Significantly, a ground breaking decision handed down in July of 2011 by CEDAW has for the first time recognised maternal death as a violation of human rights and establishes that governments have a human rights obligation to guarantee that all women in their countries - regardless of income or racial background - have access to timely, non-discriminatory, and appropriate maternal health services. This includes a proper referral system for emergency obstetric care, as specified in the MISP.

1.7 Consistency with the Australian development context

There is significant evidence that SPRINT continues to be clearly aligned with AusAID programs, policies and its international partnerships.

1.7.1 Alignment with existing AusAID programs

Around half of Australia's aid in 2011-12 is expected to be provided in the Asia-Pacific region. The ten countries that are expected to receive the most Australian aid in that period are Indonesia, PNG, Solomon Islands, Afghanistan, Vietnam, East Timor, Philippines, Pakistan, Bangladesh and Cambodia. SPRINT Stage 2 priority countries are aligned to where the greatest SRH in crisis needs exist, in countries that are prone to disasters and affected by conflict. These countries correspond to AusAID's priority countries, i.e. SPRINT Stage 2 will operate in 8 out of the top 10 countries receiving Australian development assistance. While Vietnam and Cambodia's needs are high, on the basis that they had suffered no conflict in the last 10 years and had less severe natural disasters during that period, they were not considered priority countries for this Stage. SPRINT will, of course, provide assistance to them, where possible, in the event of a crisis.

Aid is also increasing to Africa with a focus on East Africa, particularly those countries affected by conflict. Africa's progress on reducing infant mortality and maternal mortality has been very slow. [10] (See full details in Annex 7)

1.7.2 Alignment with AusAID Policies

Policies cutting across sectors

The SPRINT Initiative is consistent and complies with a number of AusAID policies (some of which are currently undergoing revision).

The **Humanitarian Action Policy** which notes the importance of protection of life, health, subsistence and physical security. The policy has a particular focus on increased participation by beneficiary governments and communities in all levels of activities which align with the SPRINT approach of building the capacity of national actors.

The **Disaster Risk Reduction (DRR) Policy's** goal is to reduce vulnerability and enhance resilience of communities to disasters. The policy supports the achievement of the MDGs.

SPRINT will contribute to the aims of Australia's DRR policy through its focus on life-saving interventions and emphasis on coordination. DRR forms a large part of the SPRINT's work through developing the capacity of national actors on the priority SRH activities to implement in a crisis, facilitating the development of national action plans to address national and local policies, health systems, human resources, and other key factors associated with access to SRH services in crises.

AusAID's **Peace, Conflict and Development Policy** highlights humanitarian relief, support to refugees and internally displaced persons and support for women and children as key methods to address the negative effects of conflict and potentially influence lasting peace and stability. (See Section 1.7.3 below for further information on UNSCR 1325).

The M&E component of SPRINT Stage 1 included an MOU with University of New South Wales (UNSW) which supported four in-depth research projects to build the body of evidence around SRH in

[10] http://www.ausaid.gov.au/pblications/pdf/101224%20-%Australias%20approach%20aid%in%20inAfrica%20-%20Dec%202010.pdf

humanitarian settings. Each of the research projects examined different aspects of the SPRINT Initiative and all findings have been documented and fed back into SPRINT's ongoing programming and design. This links directly with AusAID's **Development Research Strategy 2008-10**. However, it should be noted that these research projects will be completed well before the end of Stage 2, so these findings will be built formally into the M&E framework for Stage 2, particularly the capacity development elements which are central to SPRINT's operations. There will be no formal arrangement with UNSW for Stage 2.

Health sector policies

"Around 350,000 women and girls still die each year from largely preventable problems related to pregnancy and childbirth. This is the main cause of death for women aged 15 to 19 years old worldwide.[11] Through the Australian Government's **Strategic Health Partnerships** it is committed to increasing its investment through the aid program in health and HIV. The focus is on achieving key MDGs, in particular reducing child mortality, improving maternal health and combating HIV. The countries in the Asia Pacific region where it is working coincide with the SPRINT priorities – PNG, Indonesia, Solomon Islands, Pakistan, Bangladesh and East Timor.[12]

More detail on AusAID policies is found at Annex 8.

1.7.3 Alignment with AusAID Priorities

Commitment to MDGs

Women's SRH issues remain the leading cause of women's morbidity and mortality globally.

SPRINT falls within the scope of the Australian Government support for regional and multi-country activities, and its commitment towards MDGs 4 and 5 on maternal and child health, in particular in Africa. The government has committed A$1.6 billion to the **Global Strategy for Women's and Children's Health** over 5 years.

Prioritising SRH needs in crisis situations will save more lives, ensure humanitarian responses are more effective and help achieve both MDG 5 targets, namely:

- Target 5A: Reduce the maternal mortality ratio by three quarters, between 1990 and 2015;
- Target 5B: Achieve universal access to reproductive health, by 2015.

SPRINT builds the capacity of local humanitarian actors and health workers to implement the priority, life-saving services of the MISP for SRH. It also works to support advocacy to integrate SRH into national emergency preparedness and response plans. SPRINT Stage 2 will build and expand on this work, will support progress towards MDG 5 in priority countries and ensure humanitarian responses are more effective, **and will position Australia to be the leading donor globally to address the critical issue of SRH in crisis.**

Funding to conflict-affected and fragile states

Over half of Australia's major bilateral programs operate in countries that are deemed to be fragile. It is within these states that many of the world's poorest and most vulnerable live. In such settings, governments often lack the capacity to provide security and basic services for their citizens.[13]

Funding to health and humanitarian sectors

In the 2011-12 there are new sector names, receiving the following percentage of the budget:

- Health (including public health outcomes) - 17% of total budget; and
- Humanitarian, emergencies and refugees – 10% of total budget.[14]

[11] Budget Statement 2011-12, p. 87
[12] Speech by the Parliamentary Secretary for Development Assistance, Bob McMullan, at World Health Day Symposium, Melbourne, April 2008.
[13] Budget Statement 2011-12, p. 106
[14] http://cache.treasury.gov.au/budget/2011-12/content/download/ms_ausaid.pdf

Humanitarian assistance, stabilization and peace building

In 2011–12, humanitarian, emergency and refugee-related aid expenditure is estimated to increase to $325.0 million.

Australia's humanitarian, emergency and refugee programs aim to protect lives, ease suffering, maintain human dignity, and help people to recover from conflict and disasters. Developing countries are helped to prevent, prepare, respond to and reduce the risks of, natural disasters and conflict.

Violence against Women

Consistent with its 2010 election commitment, the Government will invest $96.4 million over four years to eliminate violence against women and to help women affected by violence in developing countries throughout East Asia and the Pacific.

The initiative will fund UN and civil society organisations to deliver support to women affected by violence. Activities will include establishing and improving crisis services, strengthening counselling and legal support, and sharing best practice approaches. It will include increased efforts to prevent violence against women in conflict and post-conflict environments and deal with its consequences.[15]

Australia also supports a number of specific activities aimed at ending violence against women in conflict situations (see Annex 9 – last section).

Australian National Action Plan on UNSCR1325/Women Peace and Security

UNSCR 1325 encourages Member States in **post-conflict situations,** in consultation with civil society, including women's organizations, to specify in detail women and girls' needs and priorities and design concrete strategies, in accordance with their legal systems, to address those needs and priorities, **including sexual and reproductive health and reproductive rights**.

The Australian Government has recently produced a draft whole-of-government Women, Peace and Security National Action Plan (NAP). There are a number of strategic objectives in it relevant to the SPRINT Initiative (See Annex 10 for details). SPRINT 2 is therefore well aligned with the draft NAP which will enable AusAID to contribute to achieving those objectives.

.1.7.4 AusAID's Existing Partnerships and Alliances

Alliance on Maternal Health

In September 2010, Australia joined the International **Alliance for Reproductive, Maternal and Newborn Health**. This is a five-year public/private global alliance which includes the U.S. Agency for International Development (USAID), the UK Department for International Development (DFID), The Australian Agency for International Development (AusAID), and the Bill & Melinda Gates Foundation.

The Alliance will specifically address aspects of MDGs 4 and 5, where progress has been especially slow and will ensure better health outcomes for the poorest and most vulnerable women and children.[16]

This partnership is being piloted in a number of countries but it is understood the focus is on comprehensive SRH services and it does not appear that it will cover implementation of the MISP in crisis situations. SPRINT will therefore play a complementary role in this partnership, helping to fill such gaps.

IPPF

AusAID has a 4 year, $20 million Strategic Partnership with IPPF. SPRINT is housed within IPPF and makes use of IPPF Human Resources and financial systems. This allows SPRINT staff to efficiently respond and implement the Initiative. IPPF also provides a supportive environment with senior level commitment to increasing the humanitarian agenda (Director-General, Regional Directors and all Senior Team from Central Office and Regional Offices). It also provides the widespread network of Member Associations with their varied and broad local contacts with communities, government and national organisations.

[15] Budget Statement, p. 111
[16] Kevin Rudd, Minister for Foreign Affairs

IPPF and UNFPA Partnership Framework

IPPF and UNFPA have a global partnership framework, supported by a MoU and an agreed workplan. This will also help to guide the relationship between IPPF and UNFPA for SPRINT Stage 2.

SRH capacity development and technical support has occurred through UNFPA and IPPF collaboration over the past 3 years on the SPRINT initiative, mainstreaming SRH into emergency preparedness plans and responses, as well as early recovery.

This partnership is **implemented** when SPRINT works within the existing structures of an emergency response – i.e. depending on whether the cluster system is enacted, or whether the displacement is conflict or natural.

At the regional level, UNFPA humanitarian focal points coordinate closely with SPRINT regional hubs regarding strategic engagement with country teams as well as advocacy to other agencies to prioritize SRH in emergencies.

At the national level, UNFPA is a vital member of the country coordination team and SPRINT has been critical in enabling UNFPA national staff to champion and take is often the lead agency regarding advocacy and implementation related to SRH in crises. Most of SPRINT's champions at the country level are from UNFPA.

AusAID and UNFPA Partnership framework

The Partnership Framework commits UNFPA and AusAID to alleviating humanitarian suffering and ensuring the dignity of women and children, including those with disabilities, before, during and after humanitarian emergencies and in post-emergency settings, ensuring that responses, where possible, increase resilience to future disaster events. AusAID supports UNFPA's role as global cluster participant.

Under this Partnership, AusAID is committed to continued support for building capacity of local, national and regional actors in provisions of basic reproductive health in emergency situations. An indicator in UNFPA's Development Results Framework stipulates the proportion of acute emergencies in which the MISP is provided.

More detail on AusAID's partnerships and alliances is found at Annex 11.

1.8 Rationale for AusAID Involvement

1.8.1 Achieving better outcomes for RH through Donor Harmonisation

The MISP plays a vital role in ensuring the sexual and reproductive health of women during and after emergencies. This must be a key first step in ensuring sexual and reproductive health in crises and in the recovery phase. It is also a way of moving towards universal coverage and establishing SRH as a national goal. Promoting SRH as a key part of emergency response and post-emergency recovery calls for a new role on the part of the humanitarian and developments sectors and require a re-assessment of international and national responses to health development in general. The MISP can serve as an initial tool in SRH strengthening and planning. In undertaking such planning it is essential to assess what was there before, what worked well, to identify gaps is what is available and what is required for full implementation of the MISP. Demographic profiles are necessary and assessments of availability of human resources, equipment and health facility needs. Training and capacity development needs to be undertaken. Professional relationships need to be developed between Ministries of Health and professional associations. Funding needs to be acquired for both the emergency response and for prolonged situations.

For all these processes it is necessary to involve national authorities and donors at all times. Donor harmonisation is essential if all the necessary tasks are to be addressed and successful outcomes achieved through comprehensive attention to all aspects of the planning. It is particularly important in reaching agreement on funding mechanisms such as the Consolidated Appeals Process (CAP) and to coordinate with other Standby arrangements such as the Gender Standby Capacity (GenCAP) and the Protection Standby Capacity (ProCAP).

There are at this stage, however, no other donors responding directly to this critical and overlooked area of SRH in crises. While this is a highly undesirable situation, it does provide AusAID with the opportunity to play a leadership role by building on its profile gained during support for SPRINT Stage 1. It could take this opportunity to advocate to other donors to begin providing support and play a role in coordinating such support. This fits well with AusAID's current strong focus on maternal and child health and the reduction in mortality. It should be noted that **AusAID already has what amounts to hero status amongst the 40 agencies of the IAWG through its funding of the 2010 revised version of the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings***. The manual is the essential tool for all reproductive health workers in the field during humanitarian crises.

AusAID has also been active on IAWG Working Groups, with its own internal Working Group on SRH in Crises. This internal Working Group should be re-activated to coincide with the work of SPRINT Stage 2.

1.8.2 Aid effectiveness and 'value for money'

In November 2010 the Government commissioned the first independent review of the aid program in almost 15 years - *The Independent Review of Aid Effectiveness*. The panel submitted its report on 29 April 2011. It noted that the Australian Government is committed to ensuring the aid program delivers effective programs and provides **value for money**; and that it will help ensure that our aid **saves more lives** with the money made available by taxpayers.

To improve aid effectiveness it is essential to better understand and monitor all the factors contributing to or inhibiting achievement of desired outcomes.

Improving aid efficiency involves two aspects: (i) achieving the best possible quality and quantity of inputs for the best possible price; and (ii) ensuring that those inputs produce the best quality and quantity of outputs.

SRH in crisis remains overlooked and restricts achievement of MDG 5. SPRINT Stage 2 provides critical life saving services thus ensuring our aid 'saves more lives':

- It will help ensure critical life saving interventions at the onset of a crisis (noting the disaster prone and fragile contexts where our aid is delivered) which in turn will help address MDG 5; and
- Will ensure Australia's humanitarian responses to both natural disaster and conflict situations are more effective.

The SPRINT initiative takes an inter-agency approach, building the capacity of an audience beyond UNFPA and IPPF, including CCTs composed of Ministries, UN agencies and humanitarian agencies. Therefore, SPRINT Stage 2 will make a solid contribution to the Government's goal of aid effectiveness.

Value for money will be achieved given that the real contribution to the program is well beyond the $10 million. By using the IPPF management structure and the system of CCTs together with the work of the various partners (UNFPA and WRC in particular) many activities are undertaken at no cost to SPRINT.

2. Program Description

2.1 Overview

SPRINT's overall goal is to improve health outcomes of crisis affected populations by reducing preventable sexual and reproductive health morbidity and mortality through timely access to life-saving sexual and reproductive health services as outlined in the MISP. This will be achieved by developing the capacity of CCTs to respond to emergencies, greater surge capacity, advocacy at the global, regional and national level to include SRH in policies and plans, supportive research to guide the direction of the program, through strong, collaborative partnerships, compliance with international humanitarian standards and through good program management. The end result will be that in crisis affected populations all the enabling and support systems will be in place to ensure the effective implementation of all components of the MISP.

2.2 Principles underpinning the program

The following core principles will underpin the new program:

(i) **A holistic approach**

- A holistic approach will be taken where core programming components will address all stages of the emergency management cycle where emergency responses in acute phases of a crisis are preceded by preparedness activities and followed by recovery/redevelopment interventions.

(ii) Building on evidence, achievements and best practice of SPRINT Stage 1

- SPRINT Stage 2 will build on the lessons learned in Stage 1 from the need for the greater development and support of the CCTs, the emergence of gaps in DRR and EP policies and the need to clarify the role of partners amongst the complex array of agencies involved in SRH in crises.
- Action research by four PhD students has been part of SPRINT since the very beginning and has allowed SPRINT to continuously evolve through robust feedback and organizational learning loops. The research has looked at organisational change, the barriers and enablers for successful MISP implementation, SPRINT programming in protracted settings and the fourth, of most relevance in regard to planning and monitoring, is exploring the factors between work spaces and training that impact on the effectiveness of SPRINT training. These have informed the design of SPRINT Stage 2. SPRINT Stage 2 will continue to utilise this research as well as select participatory action research through the work of the IAWG and the WRC.

(iii) **Strengthening partnerships**

- Significant partnerships have been formed in Stage 1. Except for the formal relationship with IPPF, these are of a collaborative nature with the IAWG, UNFPA, WRC and UNHCR providing technical guidance, policy direction and overall coordination. These partnerships will be strengthened through the provision of funding by SPRINT for research and more structured interaction at workshops and meetings. New partnerships will be formed where appropriate at the global, regional and national levels.

(iv) **Flexibility**

- The program will adopt a flexible approach to identifying and supporting activities during implementation so that it is responsive to emerging needs and addresses a range of issues, including some which cannot be defined at design stage.
- Flexibility in the programming of funding will be critical to responding to the needs of different countries, including the adaptation of training to meet country requirements.

(v) **Capacity Development**

- Capacity Development - understood as the process of unleashing, strengthening and maintaining capacity at the enabling environment, organisational and individual levels - underpins the program. This is consistent with the program's commitment to long term sustainability and is achieved through:
    - Working at multiple levels within focus countries: engaging in-country actors for advocacy to establish an enabling policy and funding environment, developing the capacity of key stakeholders to coordinate implementation of the MISP in a crisis, and working to strengthen system-wide capacity to ensure delivery of the activities prescribed by the MISP when a crisis occurs.
    - Working within country systems and with in-country organisations. The capacity development activities of SPRINT are led by individuals and teams in-country and supported by the SPRINT Team.
    - Strengthening the capacity development continuum by providing support before, during and after the in-country trainings.

(vi) **Intent to reach affected populations**

- While advocacy, improved coordination and capacity development are key *objectives* for SPRINT, the *purpose* is ensuring that emergency efforts reach those most affected.

(vii) **Enhancing the likelihood of sustainability**.[17]

- Developing models for replication: the Program will test models that can be replicated in other countries.
- Complementarity with government processes, policies and resources, and inclusion of government in SPRINT processes e.g. membership of CCT.
- Contribute to systemic changes/institutionalisation of processes so that implementation and continuation of program initiatives is not reliant on "champions" who come and go.
- Mobilization of additional financial resources will be an integral part of SPRINT Stage 2, thanks to a dedicated Resource Mobilization Team, which will have a multiplier effect of AusAID investment in SPRINT.

(viii) **Guided by international humanitarian standards**

- SPRINT supports the realization of guiding principles for humanitarian work:
    - **Coordinated**: This is the cornerstone of SPRINT's inter-agency country coordination team approach that ensures improved and coordinated response to SRH needs in crises.
    - **Principled.** SPRINT was developed to advance the implementation of the MISP for Reproductive Health in Crises, an accepted international standard that has to be in place regardless of political or other considerations.
    - **Appropriate.** Sexual and reproductive health is severely neglected in crises and SPRINT is prioritising an area of greatest humanitarian need.
    - **Accountable.** SPRINT engages with and is centred on beneficiaries and transparent communication with donors and partners.
    - **Informed.** SPRINT was established to bridge major humanitarian gaps identified by the international community. It is committed to establishing a body of evidence on sexual

[17] Sustainability: "*The continuation of benefits after major assistance from a donor has been completed*". AusAID: *Promoting Practical Sustainability*. Australian Agency for International Development (AusAID), Canberra, September 2000

and reproductive health in crises to inform decision making at all stages of the humanitarian response to ensure women and girls receive life-saving care.

2.3 Priority Countries

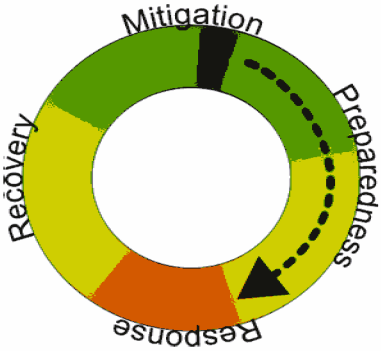
A more focused, strategic approach with select priority countries based on highest humanitarian needs will occur in Stage 2. This will allow the SPRINT Team to develop clear strategies of engagement with each priority CCT to address SRH throughout the disaster management cycle. Indicative priority countries include:

- **SE Asia/Oceania –** Burma, Indonesia, Papua New Guinea, Philippines, Timor-Leste and Solomon Islands.
- **South Asia** – Afghanistan, Bangladesh, Pakistan and Sri Lanka.
- **Africa** – DR Congo, Ivory Coast, Uganda, Central Africa Republic, Ethiopia, Kenya, (potentially Liberia or South Sudan to replace one of the former countries).

In case of an emergency striking other countries, SPRINT will also consider intervening to support the CCT in their implementation of the MISP.[18] That is, flexibility will remain to assist with responses to any crises in other countries, as necessary and if resources are available.

2.4 SPRINT Stage 2: A holistic approach to crisis response capacity

Research by the IAWG, WRC and most recently by the UNISDR Sub-Working Group on SRH under the Health Thematic Platform has informed the design for SPRINT Stage 2. All research has pointed to the need for coordinated health emergency management systems involving national, sub-national and community actions to address all elements of the disaster management cycle including disaster risk reduction, response and recovery. SRH policy and program actions, related to disaster risk reduction and emergency preparedness need to focus on strengthening SRH services within Primary Health Care systems while ensuring that crisis affected populations have access to the MISP during an emergency.



Key recommendations include (i) commitment at the national and local level to incorporate sexual and reproductive health in disaster risk management policies; (ii) including SRH in health risk assessment and early warning mechanisms; (iii) building a culture of health, safety and resilience at all levels, by providing education about the MISP; (iv) reducing underlying risk factors to reproductive health systems by identifying hazard prone communities and most vulnerable services; and (v) preparing existing SRH services to absorb impact, adapt, and respond to and recover from emergencies.

To achieve these practical ends, SPRINT Stage 2 core programming components address all stages of the emergency[19] management cycle (see diagram above), where **emergency responses** in acute phases of a crisis are preceded by **preparedness activities** and followed by **recovery/redevelopment** interventions. The latter ensures that the essential SRH services outlined by the MISP are linked to more comprehensive long term and sustainable services. SPRINT Stage 2 thus presents a holistic approach to providing SRH services in crisis situations.

To *"increase access to timely life-saving sexual and reproductive health services as outlined in the MISP"* requires more than just the emergency response when a crisis arises. It also calls for investment in creating an **enabling environment** to mitigate risk of decreased access to lifesaving SRH services at the onset of a crisis. This is achieved by establishing supportive policies for MISP implementation long before a crisis hits. 'Mitigation' is illustrated in SPRINT Stage 2 Intermediate Outcome 1: Disaster Risk Reduction – Enabling Environment. It also involves reliable **preparedness** in the form of capacity development in regions at risk of disaster. 'Preparedness' is illustrated in Intermediate Outcome 2 Preparedness – To implement MISP. '**Response**' and '**recovery**' are illustrated in Intermediate Outcome

[18] There are 30 countries in the Asia Pacific region and 38 in Africa with CCTs in place
[19] The terms *emergency* and *crisis* are used interchangeably and refer to both man-made (conflict) and natural disasters.

3: Emergency Response, which will focus on support in the **acute phases** of man-made and natural disasters. The SPRINT Response Model is presented in Annex 12.

2.5 Goal, objective and intermediate outcomes

Goal: To improve health outcomes of crisis affected populations by reducing preventable sexual and reproductive health morbidity and mortality.

Objective: To increase timely access for crisis affected populations to life-saving sexual and reproductive health services as outlined in the MISP.

Intermediate Outcomes:

(i) Disaster Risk Reduction Enabling
(ii) Emergency Preparedness
(iii) Emergency Response

Achievement of the Goal will not be measured during the lifetime of the program. The overall program hierarchy is presented below in Figure 1.

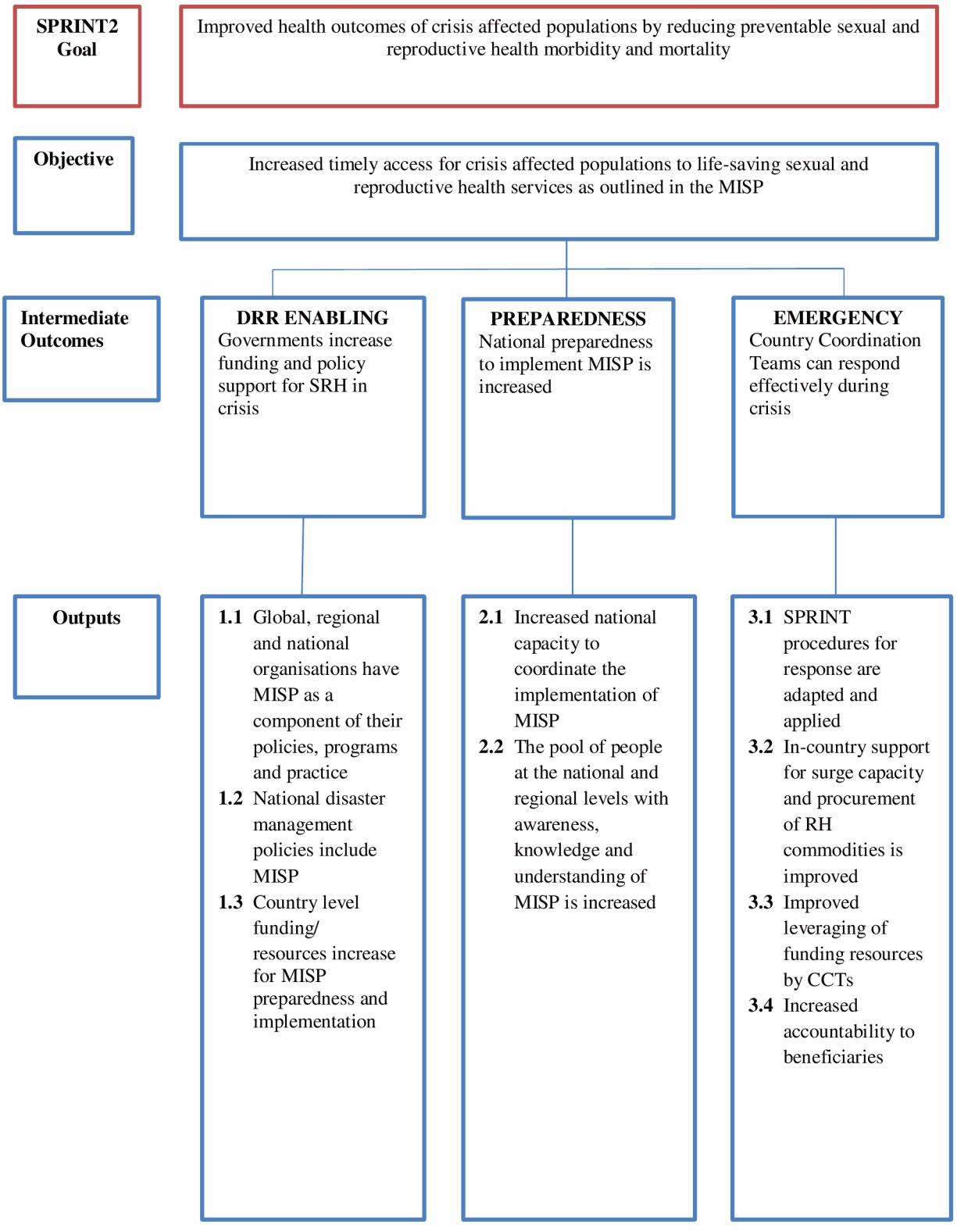


Figure 1: SPRINT 2 – Program Hierarchy

The SPRINT 2 goal and objective is a direct indication of having provided life-saving sexual and reproductive health services which measure the impact of crises on the health of women. The goal and objective is in line with the MDGs 4, 5, 6; and with the UN SG Global Strategy for Women and Children's Health and Alliance for Maternal and Child Health, to which AusAID is committed.

The section below outlines the contributing outputs for each intermediate outcome. The corresponding activities to achieve those outputs are provided.

Intermediate Outcome 1: DRR - Enabling[20]

SPRINT Stage 1 has made great strides in training key stakeholders to respond to SRH needs in crisis situations, as well as funding emergency response efforts. SRH is not sufficiently addressed, however, in disaster risk reduction and emergency preparedness efforts at the global, national or regional level. This represents a missed opportunity to strengthen SRH response and recovery at the onset of a disaster. This intermediate outcome of improving the DRR enabling environment will address this need.

Intermediate Outcome 1: DRR Enabling Governments increase funding and policy support for SRH in crisis.

Outputs:

1.1 Global, regional and national organisations have MISP as a component of their policies, programs and practice.

1.2 National disaster management policies include MISP.

1.3 Country level funding/resources increase for MISP preparedness and implementation.

Activities: (estimated cost $1,549,999)

1.1 Advocate in global, regional and national platforms for disaster risk reduction and emergency preparedness for the inclusion of MISP in strategies and/or national emergency response policy.

1.2 Engagement with the IAWG.

1.3 Engage regional and national stakeholders to integrate MISP into their programs.

1.4 SPRINT support to CCTs to apply for humanitarian funding to prepare for the implementation of the MISP.

1.5 Partnership with the WRC to strengthen global level initiatives to promote SRH in crisis.

Activity 1.1: *Advocate in global, regional and national platforms for disaster risk reduction and emergency preparedness for the inclusion of MISP in strategies and/or national emergency response policy*

Integration of SRH into global, regional, national and agency DRR processes, including EP, is vital to improve the SRH response at the onset of a crisis. In Stage 1, SPRINT participated in relevant global, regional and national level DRR networks to advocate for the inclusion of the MISP in DRR strategies and policies. Building on the experience and lessons learned in Stage 1, more in-depth technical

[20] Enabling environment definition: "An enabling environment is a set of interrelated conditions—such as legal, bureaucratic, fiscal, informational, political, and cultural—that impact on the capacity of … development actors to engage in development processes in a sustained and effective manner" (*The Enabling Environment for Implementing the Millennium Development Goals: Government Actions to Support NGOs*. Derick W. Brinkerhoff, 2004)

assistance is needed for CCTs to integrate the MISP into national emergency preparedness policies, within the priority countries.

This work will continue or be expanded through:

- Participation in global, regional and regional networks such as the UN-ISDR network (global) and Economic and Social Council for Asia and the Pacific (ESCAP) (SE Asia/Oceania regional). SPRINT2 will financially support the Women Deliver Conference ($100,000) and promote DRR and SRH at the Conference. Some $25,000 will be provided per region to participate in regional and national platforms for DRR and EP (e.g. participation in the WRC Global Summit for DRR and RH).
- RAs and Hub will identify relevant regional DRR networks in the ARO and SARO regions and determine how to gain entry into those networks. RAs and CCTs in all regions will identify relevant national DRR networks and determine how to gain entry into those networks. Once networks are joined, RAs and CCTs will identify opportunities to advocate for the MISP, such as getting slots on meeting agendas or distributing MISP materials.
- Hub, RAs and CCTs will develop advocacy and awareness raising materials on the MISP to present to networks.
- RAs will work with CCTs to identify relevant disaster management policies in which the MISP can be integrated. SPRINT will fund cost of travel for RAs to focus countries – 2 trips x 3 regions x 3 years x 6 countries ($324,000) plus cost of in-country meetings, workshops and regional meetings ($180,000).
- RAs through CCTs will coordinate engagement in policy change/revision processes with other key agencies. RAs will link AusAID representatives at Posts with CCT advocacy efforts, as needed.
- Upon request from CCTs, the Hub (including RAs) will provide technical policy advice to CCTs. This may include providing draft wording for policies; sharing global guidance documents on MISP integration into DRR policies; providing advocacy support.

Activity 1.2: *Engagement with the IAWG*

The IAWG on Reproductive Health in Crises is the internationally recognised professional network of UN, INGOs, NGOs and government agencies dedicated to providing lifesaving SRH care to those affected by crises. IAWG produces the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (the 2010 edition funded by AusAID). IAWG has successfully advocated for the inclusion of MISP into the Global Health Cluster Guide and SPHERE Standards. It also hosts a conference every eighteen months, bringing together global leaders on SRH in crisis to discuss trends, identify gaps – to share best practices and to develop a joint advocacy agenda. SPRINT sits on the IAWG Steering Committee as well as on the MISP sub-working group. SPRINT contributes to advancing this field by setting the global agenda and standards on SRH in crises.

Participatory action research has been an integral part of SPRINT Stage 1 and results from research have helped the initiative rapidly progress. They have contributed to IAWG's body of evidence on the SRH in crises. Therefore, research focused on emerging areas, such as DRR, will be part of Stage 2.

Continued engagement with IAWG in Stage 2 through the following activities is vital to SPRINT's work to create a DRR enabling environment:

- SPRINT participation in IAWG Steering Committee, and sub-working group on DRR, MISP and research on SRH in crises, through meetings, teleconferences, and conferences.
- SPRINT provides input to agenda formulation, outputs and decision making processes.
- Participatory action research focused on emerging areas, such as DRR, coordination, etc. in collaboration with external research experts.

- SPRINT will financially support the 2013 IAWG global conference ($50,000) and IAWG RH research and publications dedicated to RH ($50,000).

Activity 1.3: *Engage regional and national stakeholders to integrate MISP into their programs*

SPRINT 2 will engage with agencies such as the IFRC (including national societies) and IPPF MAs to integrate the MISP into their programming. Many of these agencies fail to systematically integrate the MISP into their emergency preparedness and response efforts due to a lack of understanding of MISP, necessary resources and logistical issues.

In SPRINT Stage I agencies such as IFRC, MERCY Malaysia, the Family Planning Association of Bangladesh, were identified as key targets to integrate SPRINT training on the MISP into appropriate projects. In SPRINT Stage 2 the Hub, RAs and CCTs will continue to identify and engage with potential stakeholders at the regional and national level through:

- Identifying global, regional and national response agencies with potential to integrate the MISP. (SPRINT will cover costs of additional trips by HUB and RAs to support ongoing MISP integration in programs in focus countries).
- Linking identified agencies to relevant trainings, resources and other key responders.
- Providing technical advice to identified and trained agencies on how to integrate the MISP into programming. This could include establishing an MOU for response between agencies, integrating MISP into pre-deployment training or into emergency preparedness work.
- Providing coordination as needed (for example, in the case of global organisations).

Activity 1.4: *SPRINT support to CCTs to apply for humanitarian funding to prepare for the implementation of the MISP*

Funding is required to enable INGOs, NGOs and relevant government ministries to incorporate MISP into preparedness strategies. These funds can be used to procure SRH supplies in advance; establish storage facilities to pre-position supplies; staff training; convene coordination meetings to pre-determine referral networks; and fund staff time to lead preparedness initiatives within key agencies/ministries. SPRINT will support CCTs and relevant agencies (as identified by the CCT) to apply for this funding. The RMA will:

- Establish a resource mobilisation strategy, which maps opportunities for additional funding, identifies and selects priority donors, feeding into a workplan for the RMA.
- Regularly scan and identify relevant preparedness funding opportunities.
- Provide assistance to RAs and CCTs to write funding proposals.
- Facilitate CCT's proposal submissions and track submission progress.

Activity 1.5: *Partnership with the WRC to strengthen global level initiatives to promote SRH in crisis*

The Women's Refugee Committee is a global leader in advocating for the SRH needs of women and girls in crises. WRC acts as an international resource on MISP implementation, as the chair for the MISP sub-working group within the IAWG - the forum through which MISP coordination at the global level occurs when crises erupt. WRC coordinated and authored, with the input of other key IAWG members, the MISP chapter of the Inter Agency Field Manual on RH in crisis, funded by AusAID. It is the only agency that assesses and produces reports on MISP implementation in crisis worldwide.

More recently, the WRC has led global advocacy for the integration of SRH into DRR. In 2010, it founded the UN ISDR RH sub-working group to ensure that SRH is incorporated into emergency preparedness and DRR efforts.

SPRINT's outcomes rely on global level advocacy, which the WRC currently provides. The WRC creates an enabling environment for SPRINT's work by producing assessments, guidance documents, manuals, and resources which are widely incorporated into SPRINT's training efforts and work with regional and national level partners. Unfortunately, there currently exists a great gap in funding for WRC's global advocacy initiatives in SRH. This past year, a major anonymous donor to the field of RH withdrew all support from research and advocacy. SPRINT 2 will provide financial support to WRC to ensure:

- WRC continues to chair the MISP working group within the Inter IAWG for Reproductive Health Care in Crisis. SPRINT plays a unique role in this forum by linking global leaders on SRH in crisis to national level networks of trained MISP coordination networks (CCTs) at the onset of crisis.
- WRC continues to chair the UN-ISDR RH sub-working group ($44,000). This will support SPRINT's efforts to promote the inclusion of SRH in national level disaster response strategies.
- WRC conducts three MISP assessments, one in each SPRINT region (SE Asia/Oceania, Africa and South Asia) to evaluate MISP implementation in crisis. Global evaluation reports will inform SPRINT work in the region as well as document SPRINT's contribution to SRH in emergency response. SPRINT will support the cost of these assessments ($122,000).
- WRC hosts a ground-breaking global consultation in collaboration with WHO, UNFPA, UNICEF and SPRINT. The consultation will bring together global leaders (donors, policy makers and implementing agencies) on SRH in crisis. The purpose will be to review the status of SRH in disaster risk reduction and emergency preparedness, commit to the new global guidelines/policy recommendations, and share learning on regional, national and community level implementation of the guidelines/policy recommendations. SPRINT's work at the regional and national level will be highlighted as best practice. SPRINT will support the cost of field testing and global consultations on the new policies and guidelines (total of $285,000).
- WRC to carry out evaluation and document case studies of successes and challenges to integration of SRH into DRR strategies ($149,000).

Intermediate Outcome 2: Preparedness

The success of training in SPRINT Stage 1, expected to be seen in CCTs supporting coordination of MISP by key partners, has occurred in many settings but not yet optimally. Feedback from participatory action research indicates that lack of clarity about the roles and responsibilities of CCTs have prevented their functioning to full potential. This is at times combined with inadequate selection of participants and weak support from respective heads of agencies.

The capacity development continuum is addressed in two ways. First, the stated objective of increasing "national" capacity encompasses all country administrative layers that may exist, e.g. states/provinces, districts, etc. A second aspect is the pre, during and post phases of training that are essential for this national capacity to be developed and sustained.

The capacity development strategy of SPRINT Stage 2 will encompass the following elements to prepare CCTs on MISP implementation:

- **Advocacy:** Pre-training advocacy is key for organisational buy-in, supervisor/peer support, levelling of expectations and to assist correct participant engagement/selection by national decision makers, heads of agencies and other potential implementing partners. The revised SPRINT curriculum will include a separate advocacy package and guidance on advocacy strategies.
- **SPRINT Coordination:** The revised SPRINT curriculum tightens its focus on coordination with adequate, appropriate selection of participants at a coordination/management level and on system-wide preparedness. For example, participants will conduct a vulnerability assessment/hazard risk assessment conducted by participants prior to the training; and a

systems mapping/action plan exercise throughout the training. New country action plans are designed as a health systems mapping exercise to allow the CCT to identify and fill gaps. Participants will work across each component of the MISP to look at health system building blocks, the policy and organisational environment, assessing both what is already in-country and gaps. This is designed to build the capacity of the system, not the individual.

- **Gap-filling:** CCTs with the support of the SPRINT Hub/RAs will work to address gaps and needs discovered in their systems mapping/action plan. CCTs formally engage (MoUs, TOR) with appropriate individuals/agencies to build on-the-ground capacity and strengthen systems needed to support the implementation of the MISP. This is intended to use existing systems and resources to ensure greater involvement with in-country NGOs and local communities. If necessary, the CCT may identify the need for sub-national CCTs to be formed. This is country specific, following the same structure and work as that outlined above.

Intermediate Outcome 2: Preparedness National[21] preparedness to implement MISP is increased.

Outputs:

2.1 Increased national capacity to coordinate the implementation of MISP.

2.2 The pool of people at the national and regional levels with awareness, knowledge and understanding of MISP is increased.

Activities: *(estimated cost $1,400,000)*

2.1 CCT Terms of Reference and Workplans developed.

2.2 Revised trainings curriculum on coordination of the MISP.

2.3 Refresher training for Trainers, in-country SPRINT Coordination training and post-training support for trainees.

2.4 Advocate and provide technical support for integration of the SPRINT curriculum on MISP coordination into national pre-service, postgraduate, on-the-job curricula, and/or regional training initiatives.

Activity 2.1: *CCT Terms of Reference and Workplans developed*

SPRINT Stage 1 developed CCTs during trainings in many countries. However, many CCTs lack a strong commitment to their role as a CCT, supporting the coordination and implementation of the MISP. There is lack of clarity about their roles and responsibilities. By developing CCT TOR that clearly defines what a CCT should be doing it is likely that commitment to the role will be improved. Signing off by the respective CCT member's line managers will be encouraged. The TOR will outline CCT's definition, roles and responsibilities, scope of the work, outcomes, leadership roles, commitment and relationships.

Country Action Plans have emerged from trainings in Stage 1. These now need to be examined to identify gaps and be further developed. Important elements of the Country Action Plans are identifying key partners, identifying who is doing what to respond to SRH in crisis, establishing coordination systems, identifying an advocacy agenda for inclusion of MISP in national disaster response and preparedness plans, including MISP in formal training curricula, identifying activities to prevent and/or

[21]The term "national" includes "sub national" levels of government, to cover the continuum of capacity development over multiple levels that may occur in a country.

address SRH challenges in humanitarian settings, monitoring implementation of the work plan, and identifying resource mobilisation activities. CCT Workplans will emerge from the revised Country Action Plans.

The Hub will be responsible for developing the template for the TORs and the Workplan. Regional Advisers and the CCT will develop the specific country TOR and Workplan. Progress against the Workplan will be tracked by the CCTs with support of the RA.

Activity 2.3: *Revised trainings curriculum on coordination of the MISP*

Feedback from trainees and new technical updates indicate a revision of the SPRINT curriculum is needed. For example, the MISP standard has undergone revision and changes have been made that need to be reflected in the curriculum. Part of this revision includes the development of pre-training activities/exercises, such as completing the MISP distance learning on line module as an indicator of readiness to undertake the training.

This activity will result in an updated curriculum being used, consequent improved knowledge and skills of trainees, and ultimately more effective programming. The Hub Capacity Development Adviser will be responsible for developing and drafting the revised trainings (cost of printing, distribution and translating the revised curriculum - $80,000). The draft will be field tested in national trainings prior to finalisation and printing.

Activity 2.4: *Refresher training for Trainers*, *in-country SPRINT Coordination training and post-training support for trainees*

Some people trained in Stage 1 in coordination of the implementation of MISP became Trainers. Feedback from the field indicates that these *Trainers require refresher training* using the updated curriculum. The modules that constitute this training will vary from one country to another. This refresher training will include a component on how to run the SPRINT curriculum and organise the training. Refresher training will be:

- A two to three day course agenda will be developed by Hub and RAs. Five regional refresher trainings over 3 years will be held – one per region and two at strategic sites – $300,000. An evaluation template and a trainers' database will be developed by the Hub.

While regional and national training on coordination for MISP implementation was undertaken in SPRINT Stage 1, the pool of MISP stakeholders needs to be increased and consolidated to get critical coverage in a country. *SPRINT Coordination trainings will be conducted in-country to establish the CCT*, add members to a CCT where necessary, re-energise existing CCTs, update knowledge and skills of CCTs, to bring the coordination team strategy to a sub-national level and to increase the pool of people at the national and regional levels. Specific activities to ensure coordination are:

- Bringing together heads/senior managers of major organisations to explain the importance of the MISP, explain training objectives, expectation in terms of time and work commitments post training, and to encourage them to send appropriate[22] people to the training. Organisation and timing of this will vary from country to country. (50 in-country trainings over 3 years averaging $19,000 per training - $950,000.)
- With support from the RAs, CCTs and other national participants trained during SPRINT Stage 1 will identify/invite participants. Trainers who have undertaken SPRINT Coordination Training and/or refresher training are mobilised to conduct the in-country trainings. Support to conduct the training will be available. The Hub will establish a template participant database with RAs entering data.

[22] Guidance on this found in the revised training curriculum

- The RA will hold country mapping/action plan to integrate MISP into DRR policies, preparedness and response activities. The RA will work with the CCT to ensure gaps identified in the country mapping/action plan are filled and proposed action is taken.
- Where needed, participants will be linked with CCTs or State/Provincial/District Coordination Teams, so that they can play a key role in the implementation of the mapping/action plan, not only at the national level, but also if required, at the provincial/state and district level.

One-time training alone is insufficient to develop capacity. In SPRINT Stage 2, there is a need to continue to strengthen the capacity development continuum by *providing support after the trainings* in order to maximise the transfer of training into action. (Total cost of post-training support over 3 years - $70,000.)

Activities will specifically result in a community of practice[23] being established. This will encourage accountability against action plans/workplans, provide a place for sharing experiences and peer-learning, and act as a support and motivating mechanism for trainees. The SPRINT Communities of Practice will be fostered through two global face-to-face Community of Practice Meetings; and on-line through social media forums and support networks.

The on-line SPRINT Community of Practice will be linked by the CCT and RA with wider Communities of Practice. This will allow SPRINT trainees exposure to and contact with the global movement for addressing SRH needs in crises. Such exposure will facilitate continual professional development and engagement, as well as providing an opportunity for SPRINT trainees to contribute to the growing global knowledge base in this area.

Activity 2.5: *Advocacy and provision of technical support for the integration of the SPRINT curriculum on MISP coordination into national pre-service, postgraduate, on-the-job curricula and/or regional training initiatives.*

To increase the pool of those trained, the program will advocate for inclusion of the SPRINT curriculum on MISP coordination into training programs that are part of national pre-service, postgraduate and on-the-job curricula and/or regional trainings. This will expand the opportunities for potential responders (health and other professionals) to receive SPRINT training. There is a need to enhance ownership and sustainability, institutionalise the training, and build it into regional responses. This may not occur in every country. This output will be determined by the CCT work plan and will contribute to sustainability by building MISP coordination training into institutions, organisations that already provide related training. Hub and RAs will provide technical support to identified institutions and agencies to support adaptation, integration and quality assurance.

[23] Community of practice*: "A community of practice is a group of peers with a common sense of purpose who agree to work together to share information, build knowledge, develop expertise and solve problems. Communities of practice are characterised by the willing participation of members, and their ongoing interaction in developing a chosen area of practice."*
"Communities of practice are learning forums where members teach and learn from each other and use each other as a sounding board. Communities of practice may focus on problem solving, knowledge sharing and innovation." (Aust. Govt DFA, 2006); http://www.finance.gov.au/e-government/better-practice-and- collaboration/docs/Guidelines_for_Establishing_and_Facilitating_CoP.pdf

Intermediate Outcome 3: Emergency Response

In SPRINT Stage 1, support for CCTs at the onset of an emergency was a primary component of the program. However, support was not delivered in a standardized, systematic way across the three regions. The scope of support at the onset of crisis varied from crisis to crisis and depended on the ability of the RA to travel in-country, the availability of funds and the institutional capacity of the teams to respond to CCT's needs.

In SPRINT Stage 2, systems will be established to ensure SPRINT delivers a standard and comprehensive package of support at the onset of an emergency in all SPRINT regions. The establishment of the SPRINT Hub will ensure that emergency response efforts are mobilized quickly, systematically and professionally. SPRINT's Hub Director, Emergency Response, Resource Mobilization and Capacity Development experts will reach out to the RA immediately after news of an erupting crisis is received.

In coordination with the RA and CCT in the affected area, the team will identify immediate needs for MISP and mobilize resources to address them. A service package will be outlined and additional surge capacity will be procured if needed. Typical emergency response packages will include:

- provision of in-country support for MISP coordination
- channelling of funds for MISP service implementation
- assistance with the procurement and distribution of emergency SRH supplies
- assistance in linking CCTs to global emergency funding streams to sustain response efforts and plan for the provision of more comprehensive SRH services once the crisis stabilizes.

Intermediate Outcome 3: Emergency Response CCT can respond effectively during crisis.

Outputs:

3.1 SPRINT procedures for response are adapted and applied.
3.2 In-country support for surge capacity and procurement of RH commodities is improved.
3.3 Improved leveraging of funding resources by CCTs.
3.4 Increased accountability to beneficiaries.

Activities: *(estimated cost $3,726,674)*

3.1 SPRINT Hub Standard Operating Procedures (SOP) for response adapted and applied.
3.2 In-country support for surge capacity and the procurement of RH commodities.
3.3 Leveraging Funding Resources.
3.4 Post emergency review.

Activity 3.1: *SPRINT Hub SOPs for response adapted and applied*

SOPs on humanitarian response are crucial to ensure effective and timely response in a crisis. The SOPs will be developed by the Hub. At the onset of a crisis, SPRINT regional advisors and the Hub, in consultation with CCTs, will adapt and apply these generic SOPs for SPRINT humanitarian response to best suit the emergency context. This will result in a more predictable, accountable and locally-adapted SPRINT intervention.

Activity 3.2: *In-country support for surge capacity[24] and the procurement of RH commodities*

At the onset of a crisis, in-country resources, including staff and commodities, are often compromised, due to damage/destruction of commodities, displacement/death of skilled staff, or lost/insufficient funding. The Hub, if requested, will ensure that proper resource timely surge capacity is available. Staff surge capacity will not displace local staff but will aim at 'twinning' with them and supporting them in their duties. Specific activities are:

- Identification of gaps in resources by CCTs, RA, Hub, in consultation with other key stakeholders through IAWG.
- *Staff:* Hub identifies and recommends skilled staff to be deployed to support local agencies and staff (where possible).
- *Commodities*: Hub to coordinate the funding for, procurement of, distribution and storage of commodities (e.g. RH kits) with other stakeholders. (Estimated total of $3,636,674 for approximately 7 mid-scale disasters over 3 years)
- *Funding:* Hub to coordinate delivery of SPRINT emergency cash funds for identified recipients.
- *Security and logistics*: Hub provides advice on security and logistics.
- *Technical assistance*: Hub, RAs and consultants ensure quality of MISP related interventions, using for instance job aids, checklists, on-the-spot refresher activities, and continuing support on the ground.
- In the recovery and rehabilitation phase, RAs, consultants, and the Hub to provide advice on ensuring that SRH is addressed taking into consideration the needs of the population, as well as gaps and opportunities in the health system.

Activity 3.3: *Leveraging Funding Resources*

Availability of funding for life-saving SRH interventions has been identified globally as a major gap. SPRINT Stage 2 provides humanitarian funding to CCT agencies for the initial response. However, most crises will require additional funding to ensure sustained intervention during the emergency and recovery phase. The Hub will assist CCTs to leverage the initial SPRINT emergency funding by applying for other sources of humanitarian funding, such as Flash Appeals, Central Emergency Response Fund (CERF), which include the MISP in their eligibility criteria. This will result in improved and more predictable funding for MISP emergency responses by CCTs. Activities to leverage funding are:

- Hub Resource Mobilisation Adviser identifies applicable funding streams, including linking with AusAID Country Posts and OCHA's Emergency Response Fund (ERF) where applicable.
- Hub/RAs/consultants will assist CCTs to draft proposals for MISP funding.
- In-country assistance to CCTs if needed: the RMA may need to work closely with the CCT to develop the funding proposal.

Activity 3.4: *Post emergency review*

Accountability to beneficiaries is a core component of quality humanitarian response.

SPRINT does not currently have an internal system in place to measure its contribution to the work of CCT during an emergency. A review system will be developed and put in place so that SPRINT can examine its effectiveness in emergency response. This review will specifically address the effectiveness of the support and the emergency funding. This activity will result in improved learning from the field and reflection on what was done, and feedback into the SPRINT internal program management.

[24] Surge capacity = surge to strengthen the capacity of country coordination teams to coordinate MISP implementation. This surge can take the form of technical support, assistance with management and coordination, and such operational support as human resources, supply and logistics, and information management.

There is also a need to externally evaluate the overall MISP response and impact on displaced communities. This evaluation will be carried out by an external evaluation body. Specific activities are:

- M&E Advisor will develop/pilot tools for this purpose, with consultant support as needed.
- M&E Advisor/consultant will go in-country to conduct assessments, write reports and disseminate. Regional M&E/Coordination Officer will support the M&E Advisor in-country. (Travel for M&E/Coordination Officer for post-emergency reviews 1x3 years - $90,000.)

2.7 Form of Aid

A grant program is recommended. The formal partnership will be with IPPF with funds processed through IPPF's financial management system. IPPF is a large enough organisation to have systematic financial controls in place that SPRINT can take advantage of and this will take the burden off SPRINT for all support costs. SPRINT funds, however, will be kept as a separate entity within IPPF with separate bank accounts and management of funds decentralised through the SE Asia/Oceania Office, not channelled through the IPPF Central Office in London. The SPRINT Hub Director will have the responsibility for decisions on grants and other expenditure related to responses with the IPPF Regional Director, SE Asia/Oceania, having overall responsibility for approval of expenditure. This is a similar model to the UNAIDS Technical Support Facility which is also housed with the IPPF SE Asia/Oceania Office and is working efficiently.

It is recommended that SPRINT remain with IPPF because it has all the necessary systems in place, it houses the project at minimal cost and it has the advantage of being the biggest organisation in the world dealing with SRH with 150 member associations spread throughout all three regions of the project. Transferring to a private contractor would considerably increase the costs and delay implementation of Stage 2 while all the necessary infrastructural needs were found and put in place. There is no other NGO with the same geographic capacity and experience and expertise in SRH. Considerable resources have already been put into IPPF by AusAID, both for their development programs and for SPRINT. By not continuing to house SPRINT in IPPF, this investment would be lost.

2.8 Budget

The overall budget is $10.1 million over 3 years, broken up as follows:

	AUD
Intermediate Outcome 1: DRR: Enabling Environment	1,549,999
Intermediate Outcome 2: Preparedness	1,400,000
Intermediate Outcome 3: Emergency Response	3,456,674
Management	3,010,000
Overheads	659,167
Total	**10,075,840**

The original budget was $7 million. A further $3 million over 3 years has been made available from an Initiative in the last Budget. The increase in funding channelled towards emergency response will allow SPRINT to have a stronger response both in coverage and quality. Details of the additional items are in the full budget description at Annex 13.

Staff and management costs

Using the IPPF structure and the system of Country Coordination Teams together with the work of the various partners (UNFPA and WRC in particular) means that many activities are at no cost to SPRINT, i.e. the total contributions to the program are much greater than $10 million.

2.9 Tranches

Tranches will be paid annually. The first will be paid in advance. Subsequent tranches will be paid when 85% of the annual budget has been spent, to be confirmed by AusAID on receipt of audited financial reports.

3. Implementation Arrangements

3.1 Management and Governance Arrangements and Structure

In SPRINT Stage 2, the different levels of SPRINT's engagement will be more clearly delineated. A inter-regional Secretariat, the *Hub,* will be established to coordinate and ensure cross fertilization among the regional secretariats, as well as participate in global fora. It will act as the focal point and main management hub.

The Hub will ensure consistent, accountable and predictable implementation of the SPRINT model across all three regions. This follows robust humanitarian processes and standards and was identified as a gap during SPRINT Stage 1. Through the Hub, SPRINT will become a more visible and credible global go-to authority in developing national capacity in DRR, preparedness and response for SRH in humanitarian settings at the country level.

In SPRINT Stage 1 it was identified that many of the responsibilities described above were falling indiscriminately to the regional Secretariats. While numerous achievements and improved practices have been demonstrated across the regions, it has been shown that more resources and professional humanitarian support are needed to meet the demands of the regional initiative and support country teams.

The Hub will provide the human resource capacity needed to deliver a more focused implementation strategy and analysis of the Initiative's impact across the regions - two areas of need identified by AusAID. In doing so, each of the Regional Advisers will be able to improve their specialized understanding of the regional context, and how to best deliver the SPRINT model and achieve outcomes in the respective regions. The **Regional Advisers** will continue to collaborate with regional partners and provide support to CCTs. **M&E/Coordination Officers** will support the Regional Advisors to successfully capture data on the work of the region as well with overall project administration.

A schematic presentation of the SPRINT Management Structure is found at Annex 14, along with a detailed overview of activities to deliver a strongly managed program. Approximate costs of SPRINT

A **Steering Committee** comprised of global partners and leaders in the field of SRH in crises, such as UNFPA and UNHCR was established for Stage 1 of SPRINT. A similar, but more formal arrangement, with AusAID representation, will continue for Stage 2. The Steering Committee will guide the direction and activities of SPRINT in the overall global context of SRH in crises and have the authority to make decisions about significant issues, including financial, affecting the functioning of the program. This will result in effective and strategic programming. AusAID will appoint either a staff member or an Adviser (contracted for approximately 2 days per month to ensure familiarity with the program) to the Steering Committee.

A **Senior Management Team (SMT)** within SPRINT will be established once Stage 2 is implemented.

In SPRINT Stage 2, the different levels of SPRINT's engagement will be more clearly delineated by the establishment of an **inter-regional Secretariat (the Hub)** to coordinate and ensure cross fertilisation amongst the regional secretariats, as well as participating in global mechanisms. The regional secretariats will continue to collaborate with regional partners and provide support to CCTs.

The Hub will consist of:

- A **Director** who will oversee the workings of the Hub, including supervising Hub staff, and be the key spokesperson for SPRINT globally, representing SPRINT at global conferences and networks. The Director will communicate directly with the IPPF SE Asia/Oceania Regional Director, the line manager for the Director, on behalf of the three regional SPRINT Offices and will be the point of contact between SPRINT and donors.
- A **Capacity Development Adviser** who will support all training efforts. The Capacity Development Adviser will conduct trainings when needed in all three regions as well as train SPRINT regional partners in advanced training techniques. The Capacity Development Adviser will keep a roster of all available trainers, linking master trainers to upcoming trainings

when/where applicable, review and revise the curriculum as needed, and develop additional training modules as needed such as refresher training course and regularly assess for training effectiveness.

- A **Monitoring and Evaluation Adviser** who will be responsible for monitoring SPRINT's objectives across all three regions, collecting evidence, analysing results and reporting on SPRINT's activities. The M&E Adviser will travel to all three sites to observe and provide technical assistance in data collection, feed into donor reports, e-newsletters, situation reports and other publications.
- An **Emergency Response Adviser** who will be responsible for developing a guide for Standard Operating Procedures (SOPs) for emergency response by CCTs; provide remote and on-site support to SPRINT Regional Advisers and CCTs to facilitate implementation of the MISP in crisis situations; support in-country implementing partners with surge capacity to address logistics, supplies staff and security issues. The Emergency Response Adviser will also participate in relevant global forms and working groups to advance emergency responses on SRH in crises.
- Administrative staff to oversee and support regional operations. This will include a **Communications Adviser** responsible for developing newsletters, web-site material, case studies, interviews, etc; and a **Resource Mobilisation Adviser** who, in collaboration with IPPF Central Office Resource Mobilization team, will develop a global resource mobilization strategy for SPRINT/SRH in humanitarian settings, advise on global resource mobilization opportunities for SPRINT and CCTs and provide remote and on-site support to SPRINT regional advisors and CCTs to raise funding for emergency preparedness and response.

A **Finance Officer** who will support the regions with the distribution and monitoring SPRINT funds. The Finance Officer will be responsible for managing contracts, distributing donor funds maintaining the overall SPRINT budget and overseeing the maintenance of regional budgets, monitoring program spending and reporting to the donors and IPPF on all budget related matters. Two **Administrative Assistants** will support the Hub Director and the Finance Officer. The TOR for the Steering Committee and the SMT are found at Annexes 15 and 16 and for key staff at Annex 17.

3.2 Roles and Responsibilities of key groups

The management stakeholders in SPRINT Stage 2 are IPPF, the Hub, and, AusAID. Roles and responsibilities are as follows:

IPPF:

- Selecting and managing a team of key Advisers;
- Providing use of the IPPF financial management system;
- IPPF SE Asia/Oceania Regional Director approves expenditure;
- Participate in the SPRINT Steering Committee.

The Hub:

- Support to key advisers;
- Overall supervision of implementation;
- Preparing reports and other documents for AusAID;
- Liaise with AusAID on decisions affecting the Program;
- Organising management meetings;
- Participation in IAWG working groups.

AusAID:

The following are suggestions by the Design Team as a guide only to AusAID. Internal decisions on processes will need to be made within AusAID. AusAID will establish the formal working level points of contact between SPRINT and AusAID.

AusAID will identify an activity manager for all aspects of the Program. This person will coordinate AusAID's inputs to meet the following responsibilities:

- Effective and efficient communication with AusAID and the Director of Hub;
- Participation as a standing member of the Steering Committee;
- Internal AusAID coordination and reporting plus financial management;
- Seeking advice on Program activities from other relevant AusAID sectoral programs, or assist the Hub Director to obtain it;
- Re-activate the internal AusAID working group on SRH in Emergencies, if appropriate;
- Monitor and report on the performance of the SPRINT Team;
- Act on recommendations from the Steering Committee;
- Manage the contract with IPPF.

3.3 Implementation Plan

Office space has already been allocated in the three IPPF Regional Offices, including for the Hub in the SE Asia/Oceania Office. Only minor items of office equipment need to be purchased.

Immediate recruitment of the Hub personnel is crucial. It is intended that advertising will commence prior to the end of Stage 1 with the initial selection process taking place but no contracts entered into until final AusAID approval is obtained for the commencement of Stage 2.

Early tasks will include: identifying networks for advocacy opportunities; developing the resource mobilisation strategy; developing the CCT TOR and workplan; preparations for training and running refresher trainings; pre-training advocacy; and initial critical M&E activities.

3.3.1 Program management

The following are key activities that will occur in the first few months of the Program:

- Program offices will be established, with appropriate staff, equipment and administrative systems in place
- IPPF SE Asia/Oceania Regional Director, the current SPRINT Team and the Hub Director, once recruited, will ensure that the new Program Team are well prepared and resourced.
- Orientation programs are in place for all personnel pre-departure and on arrival in country.
- An Orientation Workshop will bring together key stakeholders to: build relationships between AusAID, the implementation team and IPPF; discuss planning for Year 1, clarify roles and responsibilities; discuss the program.
- Rigorous management, financial and administrative systems are established to support the smooth implementation of the Program. These systems conform to AusAID requirements.
- Confirm a strategically oriented Annual Plan/Implementation Plan setting a clear direction for Year 1.
- Develop and implement Program monitoring, evaluation and reporting systems, initially holding an M&E workshop, and undertaking an evaluability assessment at which time indicators are verified and additional indicators identified, facilitated by the M&E Adviser.

3.3.2 Implementation of the technical program

The detailed Implementation Plan is found at Annex 18. A Year 1 Annual Plan will need to be finalised by the end of the second quarter of the first year. With respect to timing of activities, for all 3 Technical Components, activities are spread evenly over the 3 years, except for those needed to identify networks and policies which will enable advocacy and capacity development to take place. These will occur in the early stages of Year 1. Trainings, including refresher trainings, will take place at regular intervals throughout the 3 years.

3.4 Monitoring and Evaluation (M&E) Plan

3.4.1 Approach to M&E

An important feature of the monitoring and evaluation plan will be that it provides meaningful information at respective levels. The process of data collection and analysis will serve multiple purposes and audiences. It should ensure:

- AusAID managers can monitor progress towards intermediate and end-of-project outcomes
- External stakeholders (UN agencies, partner governments etc) are able to compare performance across nations and over time
- SPRINT managers can measure program performance and enable management for results

Of prime interest is progress against the DAC criteria of: relevance, effectiveness, efficiency, sustainability, impact, gender equality, robust M&E systems and learning. DAC criteria specific to humanitarian actions will also be considered; appropriateness, connectedness, coherence, and coverage[25]. Project inception data will build upon the Final Report for SPRINT Stage 1. Additional baseline data needs and collection strategies will be developed at inception of SPRINT Stage 2.

About 18 per cent of the budget has been allocated to M&E, which should be sufficient to ensure a robust approach. Monitoring and evaluation methods will be selected based on relevance, cost-effectiveness, common sense, and available resources. The approach to monitoring outcomes and outputs will be refined at commencement of the program (during evaluability assessment) when fuller assessments can be made about the feasibility of using the indicators discussed below. All data collected by the program is sex disaggregated, where appropriate. Consideration needs to be given as to how to monitor that the program considers the needs of the disabled.

M&E will be led by the Hub M&E Adviser, who will be responsible for establishing the mechanisms for measuring achievements of the program. Regional M&E/Coordination Officers will assist with field based data collection. The approach to monitoring will be inclusive and based on involvement of, and timely feedback to, staff, stakeholders and management to enable them to reflect on practice, and change practice if indicated.

SPRINT Stage 2 will work in selected (indicative) priority countries in three regions:

- **SE Asia/Oceania –** Burma, Indonesia, Papua New Guinea, Philippines, Timor-Leste and Solomon Islands.
- **South Asia** – Afghanistan, Bangladesh, Pakistan and Sri Lanka.
- **Africa** – DR Congo, Ivory Coast, Uganda, Central Africa Republic, Ethiopia, Kenya, (potentially Liberia or South Sudan to replace one of the former countries).

M&E will be undertaken and reported on for every priority country[26], with an M&E Matrix designed to support this level of summary reporting. This will be possible for all levels of reporting: activity, output, intermediate outcome and objective. Systems will then be developed to consolidate data to present overall program achievement.

3.4.2 Performance indicators

Key Performance Indicators (KPI) to measure impact and outcomes

Goal Level

The goal of SPRINT Stage 2 is *to improve health outcomes of crisis affected populations by reducing preventable sexual and reproductive health morbidity and mortality*. The indicators selected to measure this are reduced **maternal mortality,** reduced **neonatal mortality** and reduced **HIV and STI transmission**.

25 http://www.alnap.org/pool/files/eha_2006.pdf

[26] The priority countries are not necessarily in crisis now, but the Program will want to make sure that all elements of DRR, preparedness in these priority countries are tackled, including response when needed.

These have been selected as valid indicators of preventable sexual and reproductive health issues, including maternal and newborn health. These data stem from MDGs 4 and 5, and are universally routinely collected so they are measurable. While it is recognised that other factors can contribute to improvements in these indicators, they are considered to be valid measures of effective SRH services, including maternal and newborn health services. While achievement of the Goal will not be measured directly by the Program, the Program will capture case studies that will illustrate how SPRINT's work may contribute to these Goal indicators.

Objective

The **objective** is: *To increase timely access for crisis affected populations to life-saving sexual and reproductive health services as outlined in the MISP.* The indicator to measure what success will look like will be **CCTs' contribution to progress against the MISP checklist**, which includes 18 internationally agreed indicators. Annex 1 contains the detailed checklist and sub indicators within this. This indicator and its limitations are discussed below in Section 3.4.3.

Intermediate Outcomes

For **Intermediate Outcome 1**, success of the program will be measured by partner governments increasing funding and policy support for SRH in crisis. Potential indicators include:

- Percentage increase of national disaster management policies which include MISP in SPRINT target countries;
- New global and regional policies to support MISP are in place;
- Regional and national organisations are integrating MISP into their preparedness and response programming; and
- At the country level funding/resources increase for MISP preparedness and implementation.

Intermediate Outcome 2 is national preparedness to implement MISP. Potential indicators include:

- Improved capacity, knowledge, skills and motivation of national stakeholders of national stakeholders to coordinate the implementation of MISP; and
- Increase in the pool of people at the national and regional levels with awareness, knowledge and understanding of the MISP.

Intermediate Outcome 3 will see Country Coordination Teams responding effectively during a crisis:. The indicators to measure this are:

- CCTs perceived ability to respond effectively.
- Percentage of crises in priority countries to which there is a response.
- Beneficiaries expressing satisfaction with SRH services.

An emergency review tool will be developed during program start-up to capture indicators of an effective response, which could include, for example, dollar value of RH supplies distributed, number of people assisted, etc.

For SPRINT managers to monitor their own performance and ensure a **well-managed program**, underpinned by robust internal systems, potential indicators could include:

- Timely disbursement of funds
- Timely and accurate financial and program reporting;
- Activities implemented and outputs produced on time and within budget;
- Evidence of M&E implementation contributing to overall program response; and
- Hub and RA staff satisfaction.

Data sources

Data will not be collected at the Goal level. The nature of emergency situations is such that data collection systems usually operational at the national level will not be in place in either natural or man-made emergency situations to be able to make comparisons with non-crisis settings or produce trend data.[27]

The following table identifies data collection requirements at the Objective and Intermediate Outcome levels, and resource implications for undertaking baseline studies and end-of-program evaluation. The details of this table will be confirmed during the evaluability assessment at program start-up at which time some indicators may be deleted or replaced with others. That assessment will also clearly identify the role that all stakeholders will play in the M&E exercise. As part of the evaluability assessment this table will be expanded upon to include roles and responsibilities and resource requirements.

Table 2: Sources of data for Objective and Intermediate Outcome level indicators

Program level	Impact/Outcome indicators	Sources of data to measure outcome
Objective: To increase timely access for crisis affected populations to life-saving sexual and reproductive health services as outlined in the MISP	• CCTs' contribution to progress against the MISP checklist	• MISP checklist: 18 indicators across 5 objectives
Intermediate Outcome 1: Disaster Risk Reduction-Enabling Environment	• Percentage increase of National disaster management policies include MISP in targeted countries • New global and regional policies to support MISP are in place • Regional and national organisations are integrating MISP into their preparedness and response programming • At the country level funding/resources increase for MISP preparedness and implementation	• CCT & RA surveys • Case studies
Intermediate Outcome 2: Emergency Preparedness	• Improved capacity, knowledge, skills and motivation of national stakeholders to coordinate the implementation of MISP • Increase in the pool of people at the national and regional levels with awareness, knowledge and understanding of the MISP	• Post training surveys • Training Institution surveys
Intermediate Outcome 3: Emergency Response	• CCTs perceived ability to respond effectively • Percentage of crises in priority countries to which there is a response • Beneficiaries expressing satisfaction with SRH services	• Pre and post emergency evaluation surveys • Case Studies
SPRINT Management and Organisation	• Timely disbursement of funds • Timely and accurate financial and program reporting • Activities implemented and outputs produced on time and within budget • Evidence of M&E implementation contributing to overall program response • Hub and RA staff satisfaction	• Financial reports • Program implementation reports • M&E matrix and surveys using template to capture management data • Staff satisfaction surveys

[27] In addition, MMR and NMR are very high level indicators that are complex to operationalise, involving a multi-level and multi-agency approach and with data to be collected over years to show trends.

Data collection methodologies for impact and outcome indicators

Data will be collected for each priority country, and probably crisis situation by crisis situation, as each will vary. This will allow for each country to reflect on progress and ultimate achievements, as well as contribute to composite scores to look at overall SPRINT Stage 2 achievement. An important element of all data collection will be "remarks" which will among other things identify factors that contribute to degrees of success, thus contributing to lessons learned about the implementation of the program and possible change/modification to program rollout.

Both quantitative and qualitative data will be used in developing methods for assessment of the immediate impact/outcome of the program, i.e. at the Objective and Intermediate Outcome levels. Wherever possible, data will be quantified to provide more robust measures of achievement and change, with the ability to produce simple graphs for visual presentation including trend data. In addition, there may be the potential to undertake small scale statistical analysis.

At the Objective level, the MISP checklist will be a total of eighteen discrete variables (see Annex 1). The M&E Adviser will develop a rating scale of responses for each variable (no more than four categories for any one). At the simplest level, three responses could be provided as choices, when the discrete variable is presented as a question thus: *Do you have a RH Officer in place?* Answers could be 'No' (score 1); 'Partly progressed e.g. discussions underway' (2); and 'Yes' (3). This will capture stages of progress on each indicator to contribute to a composite score which will permit reporting on trends over the timeframe of the program. The MISP checklist is part of the internationally agreed MISP standard and is widely used by IAWG partners. The development of the rating scale of responses for each variable will be undertaken in consultation with IAWG partners. This will ensure that the tool has wider buy-in and is used beyond the purpose of SPRINT program by other partners implementing the MISP.

It is unlikely that there will be opportunity to collect conventional baseline data, given the nature of the environment in which the program is working. However, it may be possible to consider collecting data within the first four weeks of an acute phase, and again around the 12-16 week mark, to present trend data. This will be determined on a case by case basis.

It is possible that in some crises another key partner is collecting data on implementation of MISP components. The CCT with RA assistance will need to see how this information can be used, and whether that partner can be convinced to use the format developed by SPRINT. If that partner is a member of the CCT or the IAWG, it may be easier to adopt the agreed format, especially as the development of the format will be undertaken in consultation with IAWG.

Country coordination teams will join/form the RH sub working group of the Health Cluster, if enacted. Information collected in this exercise will serve as an advocacy tool for CCTs for increased attention to SRH needs within the Health Cluster. Collecting this data will also inform national and global preparedness and policy efforts aimed to improve MISP implementation at the onset of crisis.

These data are likely to be collected by the CCTs. There is the risk of bias or lack of objectivity in using this approach, as CCTs will be reporting on performance of a program in which they have a key role. This needs to be addressed during data collection training to be undertaken by the M&E Adviser, to allay concerns that CCTs are being "checked", but rather to look at the data collection process as one of learning what is happening on the ground with a view to improving/changing what is being done. RAs and the M&E Advisor will also carry out in-country M&E visits which will include focused group discussions with beneficiaries and semi-structured interviews with key stakeholders. These findings will help triangulate results of the CCT-initiated self-assessment.

At the **Intermediate Outcome** levels a mix of methodologies will be used including surveys, case studies, and extracting data from program reports (see Table 2 above). More detail on each of these is provided in Annex 19. A template will be developed for case study collection to support collection of high quality stories. This will be used in order to capture the context and complexities of the pace of change on the ground. To assist the collection of case studies, this mixed methodology approach will

provide scope for feedback and reflective management and practice, and will give rich data which could also be used in a compendium of "success stories".

KPI to monitor activities

People with responsibility for monitoring and collection of data at the Output and Activity levels will be confirmed during the evaluability assessment exercise. The M&E Adviser will be responsible for ensuring those people are fully apprised of the information requirements. The Regional M&E/Coordination Officers will assist the M&E Advisor with regional data collection mechanisms. Where needed, templates will be developed to facilitate their data collection tasks and provide reliable and consistent data.

It will be possible to develop an M&E Tool that captures the data in such a way as to be able to generate graphs on implementation progress. A scale to measure progress will be developed for the activity level, similar to the process to be developed for measuring the Objective level achievements (described above). Using this process, whereby both quantitative (rating scale) and qualitative (remarks) data are collected, SPRINT will be able to identify factors associated with "good" progress on activities and capture lessons learned.

The M&E Tool has been commenced and is found at Annex 19.

Quality control measures

Measures will be taken to ensure data that is of high quality, that data collection methodologies are rigorous and will withstand scrutiny. This will be achieved by putting in place a number of quality control measures.

Reporting templates for a variety of SPRINT reports will be developed to prompt essential areas of reporting. These will include for example: challenges, barriers, confounding or contributing factors, unexpected outcomes. Staff will be trained in their use by the M&E Team to maximise production of high quality and useful reports.

Likewise templates will be developed for country level data collection, to be subsequently entered into the consolidated SPRINT database. Those responsible for supervising and collecting data will be trained in their use by the M&E Team.

Some variable will apply a rating scale using a three or four point scale. Criteria will be developed to define each numerical value in the scale, and data collectors trained in their use.

Overall monitoring of the data collected will be an important task to ensure that data is of the highest quality. This responsibility will rest primarily with the M&E Adviser but will be shared with the M&E Team.

Monitoring and evaluating cross-cutting issues

Gender: Women who have come from societies where their rights and status are not at the level of their male counterparts may have even fewer rights and less status in crisis situations. Gender equality is an important principle underpinning this program, particularly in the DRR, capacity development and emergency response components (the MISP was initially and primarily developed to address women's and girls' SRH needs in crises), and will be a focus throughout the program, and responsibility for monitoring gender equality in the Program will occur at various times.

Data collection methodologies will be explored at program start-up, which can be both quantitative and qualitative. When applicable, all quantitative data at every level of the program will be sex disaggregated. Case studies will attempt to capture experiences of both men and women as a result of the training to which they have been exposed.

Capacity development: Capacity development cuts across all elements of the program. This will be best captured through quantitative data collections particularly in relation to training and response outcomes, and in case studies.

3.4.3 Challenges for Monitoring and Evaluation

In this new stage of SPRINT, an early key contribution of the M&E Team will be to check if proposed indicators are SMART[28] indicators, are valid measures of the stated objective and that the capacity exists within the system to provide data related to the indicators on a systematic basis across the life of the program. Much of the responsibility for data collection will rest with the CCTs. Given other demands on CCT members they will need to be well supported to collect this information.

Related to this is the complex nature of the program, the variability in responses in each country and for any given emergency, and the difficulty therefore in identifying "neat" indicators that are valid measures of the outcomes. Measuring success of Intermediate Outcome 3 particularly comes to mind. To use the indicator "number of RH kits distributed" underestimates the complexity of the operational environment. Kits are different in size, number and price, and may have limited impact with regard to MISP implementation. An extreme example is for an emergency to have a massive amount (and therefore reported number) of condom kits (which supports the HIV objective of the MISP) but limited supplies to support the other MISP objectives. A better indicator that moves away from the heterogeneity of the number of kits is to have "dollar equivalent of RH supplies distributed". In addition, number of RH kits distributed is based on the assumption that all emergencies will need these externally sourced supplies. At times, local organizations just need to reprioritise existing or locally sourced supplies to implement the MISP. The most important outcome should be that adequate supplies and equipment are in place to support the implementation of MISP services. The evaluability assessment will present the opportunity to discuss what is appropriate, and to also identify that some outcomes may indeed be very difficult if not impossible to measure.

There is potential for bias when data are being collected by CCTs and they are essentially self-reporting. This is particularly so for the Objective level indicator, which is a new approach for SPRINT. It will be important that CCTs are well trained and encouraged to be objective in their assessments. Where the CCT is composed of a group, it is envisaged that they would as a group complete the scoring, a situation that might be more likely to reduce the risk of bias. The program could undertake independent assessments but this would be at considerable cost to the program.

Timing for the collection of data will naturally vary across crises given the unpredictable nature of emergencies, and will further vary between natural and man-made crisis settings. The program will have to work out just how this reporting occurs and to what extent comparisons can be made, if at all. For example, at the Objective level, it might be possible to collect baseline data within 4-6 weeks of a natural disaster, and then again at 12-16 weeks, to see trends in progress. This will need to be assessed on a case by case basis, and will depend on the situation on the ground.

In SPRINT Stage 1 capturing the impact of training or capacity development initiatives was not well done. The post training evaluation questions as they were then framed could not have provided information that verified outcomes of training. This questionnaire is being re-designed and will be field tested in SPRINT Stage 2. The M&E Adviser needs to ensure that it captures necessary information that measures the stated indicator: *Improved capacity, knowledge, skills and motivation of national stakeholders to coordinate the implementation of MISP*.

3.4.4 Reporting requirements

The reporting requirements to be met by the SPRINT Hub include:

(i) A first six-months Inception report to illustrate that the necessary structures and personnel are in place, meetings are being held, evaluability assessment undertaken and the M&E Plan developed, and the system is working; the report to be written at 6 months and submitted at the end of the first seven months.

(ii) M&E Plan: to be part of the six month report, provided by the Hub to AusAID. This Plan confirms indicators, and provides detail of data collection methodologies, responsibilities for collection of data and analysis, frequency of collection, and approaches taken to capacity development of stakeholders/partners in M&E.

[28] SMART: Specific, Measurable, Achievable, Realistic and Timely

(iii) Annual Reports (3), including the Annual Plan, to be provided to AusAID by the Hub providing a sound assessment of progress against the Annual Plans for the preceding year; problems encountered; solutions employed; and management of risks.

(iv) Annual Plans will be included in the Annual Report provided to AusAID by the Hub at the beginning of each year. These plans may be adjusted following decisions taken by meetings of the Steering Committee.

(v) Emergency Response Outcome Report: to be submitted following each emergency response showing what was achieved and relating the achievements to the relevant SPRINT Components. Reports on responses to more protracted crises are to be included in Annual Reports.

(vi) An Activity Completion Report (ACR) will be submitted by the Hub providing a balanced assessment of activity performance against design objectives at the completion of the project when AusAID funding ceases.

3.5 Sustainability Issues

No program involved in humanitarian responses will ever be entirely sustainable. The vagaries of humanitarian crises will always make for unpredictability. Moreover, donor support will always be needed at the time of the response. However, there is a strong 'development' element to this program with the ultimate aim of creating the capability within countries and regions to have the necessary systems in place to implement the MISP in emergencies. This is the essence of sustainability.

By firmly establishing the CCTs who in turn will establish the necessary coordination systems, identify the advocacy agenda for inclusion of SRH in existing policy structures and address capacity gaps within the health/emergency management system, SPRINT will not be building a parallel structure or attempting to commence entirely new work from scratch. It will be developing the capacity of an existing structure.

There will, of course, remain the need for ongoing support to CCTs, the provision of refresher training and to train new experts. However, with the increased capability within IPPF and UNFPA to respond to humanitarian crises, their close involvement with national governments, other UN agencies and NGOs means they should be able to provide this support with little further assistance.

The SPRINT Initiative is also complementary to a wide array of AusAID policies, priorities and existing programs. By forging links with these it creates a holistic approach and a connectedness that links many of them together.

3.6 Overarching Policy Issues

Disability: Australia's policy on **Inclusive Aid** pays little attention to prevention but SPRINT is consistent with this policy with its emphasis on access to services.[29] Women with disabilities are often doubly disadvantaged through their status as women and as persons with disabilities and they are at greater risk in crisis situations both from physical violence and reduced lack of access to support systems, facilities and services. It will be important to ensure they have equal access to the services provided by the MISP during crises and that CCTs ensure they work closely with those organisations which represent people with disability in all emergency preparations.

The goal of AusAID's 2007 **Gender Policy** is the advancement of gender equality. Whilst this policy is awaiting revision, this goal remains an overarching principle of the aid program. SPRINT's focus is on women and girls. While it is not specifically aimed at advancing gender equality, its objectives of reducing maternal mortality and violence against women are some of the many pathways that ultimately improve the status of women and allow them to have great control over the quality of their own lives.

The policy clearly emphasises attaining women's rights in fragile states and conflict situations, and working towards equitable health outcomes for all, including women and girls, the focus of the SPRINT

[29] http://www.ausaid.gov.au/keyaid/disability.cfm

program on saving lives of women and girls who still die needlessly from problems arising during pregnancy and childbirth.

Since SPRINT does not directly implement projects, there are no **environmental policy** issues involved. Similarly, it does not employ contractors. Grants to support humanitarian responses go largely to UN agencies or International NGOs.

No funds pass directly through national Government systems. SPRINT utilises IPPF financial systems for receiving and paying monies which comply with all **anti-corruption** requirements.

3.7 Critical Risks and Risk Management Strategy

CCT performance: the work of the CCTs is critical to implementation of SPRINT. This pertains to their overall role in coordinating rollout of the MISP and undertaking responsibilities outlined in their workplan and their role in data collection. CCTs hold positions outside SPRINT with their own responsibilities; the CCT role is on top of this. A number of strategies will be in place to minimise these risks:

- The number of priority countries have been reduced so that RAs can provide greater support to CCTS;
- CCT TOR and workplans will assist CCTs to provide the support to coordination that is required, and allow RAs to monitor their progress against TOR and workplan;
- Incentives including technical assistance, surge capacity support, training and funding, involving the Hub as necessary;
- Advocacy to CCT line managers to allow CCTs to undertake their SPRINT roles;
- CCTs will receive training and support in data collection to maximise high quality data collection; templates for data collection and reporting will be developed;
- A feedback loop that provides reports on analysis will include all stakeholders involved in data collection.

Scope to influence change: There may be barriers that impede implementation of the SPRINT coordination effort. These could include: the SE Asia/Oceania Regional Director having (or being perceived to have) more influence on SPRINT than ARO and SARO RDs, lack of engagement and or buy-in from UNFPA, and the RH coordinator during a crisis not being a member of the CCT. The program will put in place efforts to ameliorate these risks that include:

- Management arrangements that ensure ARO and SARO Regional Directors are involved in the recruitment process, ARO and SARO Regional Directors are part of the SPRINT SMT, and the Hub Director establishes regular interregional communications;
- Hub and RAs continue to build their relationship with UNFPA at all levels, reaffirmation of the commitment to the global level MoU with UNFPA ensuring that SPRINT is included;
- CCT TOR includes guidelines for connecting to an outside RH coordinator and the onset of crisis.
- Ensure connectivity with the RH Coordinator can be facilitated with CCT TOR that include guidelines for connecting to an outside RH coordinator at the onset of crisis, and facilitating CCT linkages to RH Coordinator response efforts by engaging with international and national/regional networks

Recruitment to the new management structure: there may be difficulty in recruiting appropriate staff to fill Hub positions in a timely manner. The risk of this will be addressed by:

- Commencing the recruitment process early and advertising widely through sector networks such as IAWG; Relief Web; Idealist;
- Including incentive packages for staff relocation; and
- Undertaking a comprehensive and careful recruitment process.

Unanticipated large scale disaster/multiple disasters strike: this is an external risk outside the control of the program which potential could exhaust funds for the emergency response. Should this occur, the program will respond by:

- The Resource Mobilisation Adviser identifying additional funding streams for the crisis; and
- Negotiating contingency plans with AusAID to access additional/flexible funding during a crisis.

These risks will be monitored as part of the management of the Program, and the SMT will use its regular coordination mechanism to negotiate addressing these barriers. The risk matrix will be updated in line with the monitoring.

The detailed Risk Management Matrix is found at Annex 20.

37913/18

FUNDING ORDER

This Funding Order is issued by the Department of Foreign Affairs and Trade (DFAT) in accordance with the clause headed **Formation of Funding Agreements** of the Head Agreement No. **37913** between DFAT and Marie Stopes International Australia ("**Organisation**") **79082496697** and brings into existence a contract (**"Cooperation Agreement"**) between DFAT and the Organisation for the provision of the Services detailed below subject to the terms and conditions set out in the Head Agreement.

BACKGROUND

A. NGOs which have demonstrated systems, capacity and accountability in managing a program through the DFAT accreditation process are eligible to receive accountable funds under Full or Base Accreditation procedures as specified in the Australian NGO Accreditation Manual on the DFAT Internet site at www.dfat.gov.au.

B. This Funding Order concerns the Organisation's membership of and obligations under Full Level Accreditation of the Australian NGO Cooperation Program (ANCP).

C. ANCP is a flexible mechanism that supports NGOs' programs and strategic directions in line with the goal of the Australian aid program and is consistent with the Millennium Development Goals (MDGs).

D. The Organisation must continue to meet DFAT accreditation and effectiveness standards and meet the following eligibility criteria:

   i. have a strong corporate governance structure, be DFAT Full Level accredited NGOs and be signatories to the ACFID Code of Conduct;

   ii. have proven capacity to contribute to the development of an effective aid program at significant scale and with lasting impact;

   iii. have demonstrated ability to use ANCP funds for programs which align with the priorities of the Australian aid program, and make a significant contribution to the Monitoring, Evaluation and Learning Framework (MELF);

   iv. play an active role in strengthening the Australian NGO sector and civil society organisations in partner countries including through the dissemination of learning, analysis and evidence-based good practice; and

   v. proactively engage with DFAT and the broader development sector on policy and practice issues with sound evidence and knowledge gained from program and developing country experience which help to enhance development effectiveness.

E. The provision of funds through this funding order under the ANCP operates in accordance with the NGO Periodic Funding Head Agreement, and additional conditions as contained in this funding order, and is implemented in accordance with the ANCP Manual.

F. It should be noted that **Clauses 7** and **10** below provide additional strength in these priority cross-cutting issue areas for DFAT, and if they duplicate clauses in the existing specific NGO Head Agreement, the clauses in this funding order take precedence.

PRINCIPLES OF COOPERATION

1. INTERPRETATION

1.1 All terms used in this Funding Order have the same meaning as is given to them in the Head Agreement, unless the context otherwise requires.

2. TERM OF FUNDING ORDER

2.1 The term of this Funding Order will commence on the date that both parties sign this Funding Order and continues until all obligations have been fulfilled under the Funding Order, unless terminated earlier in accordance with the Head Agreement.

2.2 The Organisation must commence the Activity on **1 July 2014** and must complete the Activity by **30 June 2015**.

2.3 If an Organisation does not comply with the minimum eligibility criteria (defined in the Recitals and at Clause 6.2a), DFAT will refer the matter to the Committee for Development Cooperation for guidance. DFAT may elect to amend, this Funding Order in the case of non-compliance with these critiera, which would be actioned through a deed of amendment.

3. THE ACTIVITY

3.1 DFAT offers to provide the Organisation with annual accountable funds for the implementation of the Activity "**Australian NGO Cooperation Program Funding 2014-15 (Global)**" as specified in the Organisation's ANCP Annual Development Plan to be accepted by DFAT.

3.2 The parties agree that the title of the Activity to be used in all documentation, correspondence and publicity is **- Australian NGO Cooperation Program Funding 2014-15 (Global).**

3.3 The Organisation is required to submit the Annual Development Plan via ANCP Online by 30 June 2014.

3.4 Once accepted by DFAT, DFAT must be advised in writing prior to any changes to the Activity. Proposed changes must be made to the Organisation's Annual Development Plan, through ANCP Online. DFAT approval must then be issued prior to any changes formally accepted and made to the Activity.

4. REPORTING REQUIREMENTS

4.1 All reports must:

(a) conform to ANCP's Monitoring, Evaluation and Learning Framework (MELF)

(b) be comprehensive, accurate and not misleading in any respect;

(c) be prepared as directed in writing by DFAT;

(d) be provided via ANCP Online;

(e) not incorporate the Australian aid logo or Australian Government crest;

(f) be provided at the time specified in this Funding Order; and

(g) incorporate sufficient information which allows DFAT to monitor and assess the success of the Activity in achieving Government benchmarks.

4.2 Before DFAT makes payments for the relevant financial year, in addition to meeting the requirements of Clause 6.2 below, the Organisation must provide to DFAT a copy of the following reports by the due date via ANCP Online:

(a) by **30 June each year**, an Annual Development Plan that outlines the Organisation's planned activities for the following financial year;

(b) by **30 September each year**, an Annual Performance Report and financial report for the previous financial year;

(c) by **31 March each year**, its Recognised Development Expenditure (RDE) calculations and submission of audited financial statements for the NGO's most recent completed financial year.

(d) promptly when requested by DFAT from time to time, additional information regarding the Activity.

5. MONITORING AND EVALUATION

5.1 The Organisation is responsible for ensuring that quality reporting of results achieved with DFAT funding is provided through the Monitoring, Evaluation and Learning Framework (MELF).

5.2 The Organisation is responsible for monitoring and evaluation of the performance of ANCP activities and the performance of the Delivery Organisation against the MELF and the Organisation's Annual Development Plan. The Organisation shall report to DFAT on the results in the Annual Performance Report, and in exception reports as requested by DFAT. NGOs may also be expected to contribute to biennial ANCP meta-evaluations and thematic reviews.

5.3 DFAT may also undertake monitoring, review and evaluation of activities at any time. The Organisation must, and must request its Delivery Organisation staff to, facilitate any monitoring visits, provide reasonable assistance to and cooperate fully with other service providers as DFAT may reasonably request. DFAT undertakes to provide reasonable notice (where possible at least 4 weeks) to the Organisation prior to commencing a review or evaluation.

5.4 DFAT will advise the Organisation of the results of any monitoring or evaluation report by letter in hard or electronic copy. DFAT may use the information generated in the report to provide the Organisation with recommendations concerning implementation.

6. FUNDS PAYABLE TO THE ORGANISATION

6.1 The financial limitation for this Activity is A$***1,849,148*** plus GST as specified in ***Annex C, Basis of Funding.***

6.2 The provision of Funds to the Organisation is subject to:

(a) Compliance with all of the requirements set down within this Funding Order, the Head Agreement and the DFAT NGO Accreditation Guidance Manual contained as part of the DFAT Internet site at www.dfat.gov.au, as amended from time to time;

(b) annual budget processes and availability of funds;

(c) NGOs meeting performance benchmarks as defined in at Annex D; and

(d) Issuing of an appropriate tax invoice as required by **Clause 12** below.

6.3 The Organisation must ensure that the Funds are spent in accordance with the following requirements, or as otherwise agreed in writing with DFAT:

(a) The percentage of the Funds spent on administration must not exceed 10% per financial year;

(b) The percentage of the Funds spent on Design Monitoring and Evaluation (DME) must not exceed 10% per financial year; and

(c) Where the Annual Development Plan contains new or potentially higher risk projects (as advised by DFAT when the Annual Development Plan is accepted), the Organisation must not spend the Funds on these projects until DFAT has approved these projects in writing.

All other funds must be expended on activities as agreed in the Annual Development Plan in line with the ANCP Guidelines.

6.4 Over the period 2014-15, the Organisation must contribute a minimum of **A$*369,830*** of their own funds to the activities funded by DFAT under the ANCP and accurately record this in their Annual Development Plan. This contribution is calculated as a matching ratio of 5:1 against the total funds provided by DFAT under this Funding Order.

6.5 The Organisation must only spend the Funds on the Activity, as approved in each Annual Development Plan. The Organisation will be responsible to DFAT for the expenditure of the Funds in accordance with all programming and reporting requirements of the Head Agreement and this Funding Order.

6.6 If the Organisation does not spend all of the Funds by the end of the financial year in which the Funds were received (30 June), the Organisation may roll-over up to ten per cent of the Funds to the next financial year after consultation and obtaining the written agreement of DFAT. Unless otherwise agreed in writing with DFAT:

(a) any funds rolled-over from previous funding orders to the first financial year of this Funding Order cannot be rolled-over again to the next financial year; and

(b) any funds rolled over from one financial year of this Funding Order to the following financial year, cannot be rolled over again to the next financial year,

then DFAT may reduce the next tranche payment of the Funds to the Organisation by the amount of unexpended Funds which DFAT has declined approval to roll-over.

6.7 The Organisation may roll-over to the next financial year an amount greater than ten per cent of the Funds if the Organisation obtains DFAT's prior written approval to do so. If, at the end of a financial year, more than ten per cent of the Funds (including Funds rolled over from previous financial years, if any) remain unexpended, DFAT will consult with the Organisation regarding its future planned expenditure. Following this consultation, if DFAT determines that:

(a) it will not approve a roll-over of an amount greater than 10 per cent of the Funds; or

(b) it will approve a roll-over of an amount greater than 10 per cent of the Funds but it will not approve the roll-over of all of the unexpended Funds,

then DFAT may reduce the next tranche payment of the Funds to the Organisation by the amount of unexpended Funds which DFAT has declined approval to roll-over.

6.8 The Organisation must repay to DFAT within 28 days of DFAT's final acceptance of the final annual Performance Report and Financial Report any unexpended Funds if the Organisation will not be receiving further ANCP funds.

6.9 The Organisation must maintain its current status of Accreditation and its eligibility for ANCP funding for the term of this Funding Order to be eligible to receive the level of funding as set out in this Funding Order. If the Organisation ceases to hold the level of accreditation that applies on the date of signing this Funding Order or ceases to be eligible for ANCP Funding, DFAT may, by notice in writing, require the Organisation to repay to DFAT all or part of the Funds which the Organisation has not committed for expenditure.

6.10 DFAT may undertake Recognised Development Expenditure (RDE) spot checks, at any time. The Organisation must provide reasonable assistance to and cooperate fully with other service providers as DFAT may reasonably request. DFAT undertakes to provide reasonable notice (where possible at least 10 days) to the Organisation prior to commencing an RDE spot-check.

7. INTELLECTUAL PROPERTY

7.1 Clause 14 of the Head Agreement is replaced by Clause 7.2.

7.2 The Organisation hereby assigns to DFAT any intellectual property rights in materials developed or created by the Organisation in the course of performing the Activity.

8. SECURITY

8.1 The Organisation must liaise and cooperate with DFAT, the Project stakeholders and the Australian Diplomatic Mission in or having responsibility for the Partner Country, especially in relation to project security, personal safety and welfare matters.

8.2 The Organisation must use its best endeavours to ensure that all international Organisation personnel working in the Partner Country:

(a) are certified as fit and health by a legally qualified medical practitioner to work in the Partner Country and have received the necessary medical advice, including that on vaccinations and other preventive medical assistance allowing them to undertake work in-country in a safe manner; and

(b) are adequately briefed and understand the environment and culture of the Partner Country.

9. FRAUD

9.1 For the purpose of this clause, 'fraudulent activity', 'fraudulent' or 'fraud' means: Dishonestly obtaining a benefit, or causing a loss, by deception or other means.

9.2 The Organisation, its Delivery Organisations and its subcontractors must not engage in any fraudulent activity. The Organisation is responsible for preventing and detecting fraud.

9.3 The Organisation must report in writing within 5 working days to DFAT any detected, suspected, or attempted fraudulent activity involving an Initiative.

9.4 In the event of detected, suspected or attempted fraud and in consultation with DFAT, the Organisation must develop and implement a strategy to investigate, based on the principles set

out in the *Australian Government Investigations Standards*. The Organisation must undertake the investigation at the Organisation's cost.

9.5 Following the conclusion of an investigation, where the investigation finds the Organisation, an employee or a subcontractor of the Organisation, the Delivery Organisation, an employee or a subcontractor of the Delivery Organisation has acted in a fraudulent manner, the Organisation shall:

(a) where money has been misappropriated, pay to DFAT or the Project the full value of the Grant funds that have been misappropriated; or

(b) where an item of property has been misappropriated, either return the item to DFAT or the project or if the item cannot be recovered or has been damaged so that it is no longer usable, replace the item with one of equal quality;

(c) refer the matter to the relevant Partner Country police or other authorities responsible for prosecution of fraudulent activity; and

(d) keep DFAT informed, in writing, on a monthly basis, of the progress of the recovery action.

9.6 Following the conclusion of an investigation, where the investigation finds that a party other than the Organisation, an employee or subcontractor of the Organisation, the Delivery Organisation, an employee or a subcontractor of the Delivery Organisation, have acted in a fraudulent manner, the Contractor shall, at the Organisation's cost:

(a) make every effort to recover any Grant funds or funded property acquired or distributed through fraudulent activity, including without limitation, the following:

(i) take recovery action in accordance with recovery procedures, including civil litigation, available in the Partner Country;

(ii) refer the matter to the relevant Partner Country police or other authorities responsible for prosecution of fraudulent activity; and

(iii) keep DFAT informed, in writing, on a monthly basis, of the progress of the recovery action.

9.7 If the Organisation considers that after all reasonable action has been taken to recover the Grant funds or funded property and full recovery has not been achieved or recovery has only been achieved in part, the Organisation may seek approval from DFAT that no further recovery action be taken. The Organisation must provide to DFAT all information, records and documents required by DFAT to enable the DFAT delegate to make a decision on whether to approve non-recovery of Grant funds or funded property.

10. INTERNAL AUDIT

10.1 DFAT may undertake audits of the Organisation against any of the contractual requirements set out in the Head Agreement of this Funding Order.

10.2 Consistent with the Transparency Charter for the Australian Aid Program and the DFAT Internal Audit Publishing Approach, DFAT publishes audit reports on the DFAT website. All draft audit reports will be provided to the Organisation for consultation. DFAT will notify the Organisation prior to publication or release of information about a sensitive mater (e.g. fraud, corruption, counter-terrorism and child protection).

11. WORK HEALTH AND SAFETY

11.1 The Organisation must ensure that the Activity is performed in a safe manner.

11.2 The Organisation agrees, when using DFAT's premises or facilities, to comply with all reasonable directions and procedures relating to work health and safety and security in effect at those premises or in regard to those facilities, as notified by DFAT or as might reasonably be inferred from the use to which the premises or facilities are being put.

11.3 The Organisation agrees to, on request, give all reasonable assistance to DFAT, by way of provision of information and documents, to assist DFAT and its officers (as defined in the *Work Health and Safety Act 2011* (**"WHS Act"**)) to comply with the duties imposed on them under the WHS Act.

11.4 The Organisation acknowledges that DFAT may direct the Organisation to take specified measures in connection with the Organisation's work under this Agreement or otherwise in connection with the Activity that DFAT considers reasonably necessary to deal with an event or circumstance that has, or is likely to have, an adverse effect on the health or safety of persons. The Organisation must comply with the direction. The Organisation agrees that it is not entitled to an adjustment to the Funds merely because of compliance with the direction.

12. CLAIMS FOR PAYMENT

12.1 Tax invoices must be submitted when due in accordance with this Funding Order, in a form identifying the Activity title and the Funding Order number **37913/18**.

12.2 All tax invoices must be made to:

Chief Finance Officer – Australian Aid Program
Department of Foreign Affairs and Trade
GPO Box 887
CANBERRA ACT 2601

12.3 Tax invoices should be sent to the above address with a copy sent to:

ANCP Manager
NGO Programs Section
DFAT
GPO Box 887
CANBERRA ACT 2601

12.4 Tax invoices should be sent to the above address. Alternatively DFAT will accept electronic tax invoices. These can be sent to accountsprocessing@dfat.gov.au with a copy sent to the ANCP Manager at ancpau@dfat.gov.au.

12.5 Invalid invoices will be returned to Organisations. Information on what constitutes a valid tax invoice can be found at http://www.ato.gov.au/businesses/content.asp?doc=/content/50913.htm

13. ACCEPTANCE OFFER

13.1 Please indicate your acceptance of this Funding Order on the Acceptance of Offer of Funds attached and return it to DFAT. This Funding Order will not take effect until it is signed by DFAT (see **Clause 2.1**).

37913/18

Issued for and on behalf of the **Commonwealth of Australia** represented by the Department of Foreign Affairs and Trade by:

In the presence of:

Signature of witness

Name of witness
(Print)

Signature of FMA Act s32B/44 Delegate

Name GARY POWELL

Name

Position, Section A/S NGOs AND VOLUNTEERS

Position, Section

Annexures:

A	***Acceptance of Offer of Funds***
B	***Annual Development Plan (updated annually)***
C	***Basis of Funding***
D	***Benchmarks***

37913/18

Annex A

Agreement Title

FUNDING ORDER

ACCEPTANCE OF OFFER OF FUNDS

Marie Stopes International Australia, 79082496697, accepts the offer of Funds as set out above and agrees to undertake the Activity in accordance with the requirements contained in this Funding Order No. 37913/18 and the DFAT NGO Accreditation Manual, as amended from time to time.

Dated this 23rd day of June ~~200~~ 2014

Signed for and on behalf of **Marie Stopes International Australia, 79082496697** by:

MARIA DEVESON CRABBE

CEO

Name and Position
(Print)

Signature

By executing this Funding Order the signatory warrants that the signatory is duly authorised to execute this Funding Order on behalf of the Organisation.

Annex B

MARIE STOPES INTERNATIONAL AUSTRALIA ANNUAL DEVELOPMENT PLAN

(as submitted on 30 June via ANCP Online)

Annex C

BASIS OF FUNDING

AUSTRALIAN NGO COOPERATION PROGRAM 2014-15 (GLOBAL)

MARIE STOPES INTERNATIONAL AUSTRALIA

14. TOTAL AMOUNT PAYABLE

14.1 The funding outlined in this Funding Order is subject to annual budget processes and availability of funding and is not guaranteed. DFAT will inform the Organisation as soon as possible of any changes to the funding outlined in **Clause 6.1** but such changes will not require the Organisation's prior agreement. If the funding outlined in **Clause 6.1** changes, the Funding Order will be amended through a deed of amendment.

14.2 The maximum amount payable by DFAT to the Organisation over the period 2014-15 under this Funding Order shall not exceed the sum of A$**1,849,148** ("the Funds") plus applicable GST if any up to a maximum amount of A$**184,915**. The annual allocation for 2014-15FY is set out in the table below and is subject to the achievement of the following milestones and **Clause 6.2**.

Financial Year (FY)	**Tranche 1 (80% of financial year funding)**	**Tranche 2 (20% of financial year funding)**	**Total Amount**
2014-15FY	A$**1,479,319** plus GST	A$**369,830** plus GST	A$**1,849,148** plus GST

The Funds are as follows:

(a) Tranche 1 (80% of 2014-15 funding): A$**1,479,319** plus GST up to a maximum amount of $**147,932** within 30 days of DFAT receipt and acceptance of 2014-15 Annual Development Plan (see Clause 4.2(a));

(b) Tranche 2 (20% of 2014-15 funding): A$**369,830** plus GST up to a maximum amount of $**36,983** within 30 days of DFAT receipt and acceptance of the 2014-15 annual performance report and financial report of expenditure against the Annual Development Plan (see Clause 4.2 (b));

Annex D

BENCHMARKS

MARIE STOPES INTERNATIONAL AUSTRALIA- AUSTRALIAN NGO COOPERATION PROGRAM 2014-15

Benchmarks will be agreed between DFAT and the NGOs in late 2014/early 2015 and this will require an amendment to the contract related to this **Annex D**.

Department of Foreign Affairs and Trade

Complex Grant Agreement number 70971

Commonwealth of Australia represented by the Department of Foreign Affairs and Trade (**DFAT**)

International Planned Parenthood Federation (IPPF) (**Recipient**)

Details

Parties

Name	The Commonwealth of Australia represented by the Department of Foreign Affairs and Trade ABN 47 065 634 525
Short form name	**DFAT**
Name	International Planned Parenthood Federation 4 Newhams Row London SE1 3UZ United Kingdom Charity Number: 229476
Short form name	**IPPF (Recipient)**

Background

A DFAT provides grant funding to support activities for overseas development assistance.

B The Recipient applied for grant funding to perform the Activity.

C DFAT is required by law to ensure accountability for the grant funding and accordingly the Recipient is required to be accountable for all grant funding received.

D DFAT has agreed to provide an amount of grant funding to the Recipient for the purposes of the Activity, subject to the terms and conditions of this Agreement.

E The Recipient accepts the grant funding for the purposes of the Activity, and subject to the terms and conditions of this Agreement.

DFAT Complex Grant Agreement

General Conditions

Interpretation

1. Definitions and interpretation

1.1 Defined terms

In this Agreement, except where the contrary intention is expressed, the following definitions are used:

Abandoned	not having carried on any work or activities on the Activity for sixty (60) consecutive days, except where relieved of the obligation to do so under this Agreement. **Abandon** has a corresponding meaning.
Activity	the Activity described in Item 1 of the Activity Proposal.
Activity End Date	the date specified in Item 7 of **Schedule 1**.
Activity Event	any promotional event conducted by the Recipient relating to the Activity, including the award of grant funding, the attainment of a Milestone or launch of the completed Activity.
Activity Proposal	as described in **Schedule 2**.
Activity Start Date	the date specified in Item 6 of **Schedule 1**.
Administered Grant Arrangement	the Agreement between the Recipient and an Administered Grant Recipient.
Administered Grant Recipient	the recipient of a grant under an Administered Grant Scheme.
Administered Grant Scheme	a grant scheme specified in Item 9 of **Schedule 1**.
Agreement	this Agreement which is a Deed between DFAT and the Recipient, as varied from time to time in accordance with **Clause 37.4**, including the Schedules and any attachments.
Agreement Material	any Material created by, for or on behalf of the Recipient on or following the Commencement Date, for the purpose of or as a result of performing its obligations under this Agreement including any modifications that may be required under **Clause 21.6**(b).
Agreement Period	the period from the Commencement Date to the date DFAT accepts the final report provided in accordance with **Item 4** of **Schedule 4**.
Applicable Auditing Procedures	the internal and external auditing procedures in the rules and regulations applicable to the Recipient.
Application	the application submitted by, for or on behalf of the Recipient for grant funding in relation to the Activity.

Assets	(a) items described in Item 5.1 of the Activity Proposal; and (b) any items of tangible property which are purchased, leased, created or otherwise brought into existence by, for or on behalf of the Recipient either wholly or in part with use of the Funds, not including Agreement Material.
Asset Register	the register of Assets set out in Item 5 of the Activity Proposal.
Asset Threshold	means the amount set out in Item 5.2 of the Activity Proposal.
Australian Privacy Principles	the Australian Privacy Principles (APPs) as defined in the *Privacy Act 1988* (Cth).
Authority	any Commonwealth, State, Territory, local or foreign government or semi-governmental authority, court, administrative or other judicial body or tribunal, department, commission, public authority, agency, minister, statutory corporation or instrumentality, including the Partner Government.
Budget	the Budget (if any) set out in Item 4 of the Activity Proposal, as varied from time to time in accordance with this Agreement.
Business Day	a day that is a working day in the place where the act is to be performed or where the Notice is received.
Change in Control	in relation to an entity, a change in the direct or indirect power or capacity of a person to: (a) determine the outcome of decisions about the financial and operating policies of the entity; or (b) control the membership of the board of directors of the entity, whether or not the power has statutory, legal or equitable force or is based on statutory, legal or equitable rights and whether or not it arises by means of trusts, agreements, arrangements, understandings, practices, the ownership of any interest in shares or stock of the entity or otherwise, not including a change in control resulting from ordinary course trading on a stock exchange in the shares of the entity.
Commencement Date	the date specified in Item 5 of **Schedule 1**.
Commonwealth	the Commonwealth of Australia.
Confidential Information	information that is by its nature confidential and: (a) is designated by a Party as confidential; or (b) a Party knows or ought to know is confidential, but does not include information which is or becomes public knowledge other than by breach of this Agreement or any other confidentiality obligation.

DFAT	the Party specified in Item 1 of **Schedule 1**.
DFAT Material	any Material provided to the Recipient by DFAT, including the Material (if any) specified in Item 13 of **Schedule 1**.
DFAT Representative	the person identified in Item 3 of **Schedule 1**.
Depreciation	depreciation calculated for income tax purposes under, and in accordance with, the *Income Tax Assessment Act 1997* (Cth).
Force Majeure Event	has the meaning given in Clause 32.1.
Former DFAT Employee	a person who was previously employed by DFAT, whose employment ceased within the last nine (9) months and who was substantially involved in the design, preparation, appraisal, review, and or daily management of this Activity.
Fraudulent Activity, Fraud or **Fraudulent**	dishonestly obtaining a benefit, or causing a loss, by deception or other means, and includes incidents of attempted, alleged, suspected or detected fraud.
Funds	the grant funding paid by DFAT to the Recipient under this Agreement and any interest earned by, for or on behalf of the Recipient on that grant funding, proceeds from the disposal or write-off of any Asset and any exchange rate gains made on that grant funding by the Recipient.
General Conditions	Clauses 1 to 37 of this Agreement.
GST Law	has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999* (Cth).
Independent Auditor	a person who is: (a) a certified financial professional; (b) registered under the *Corporations Act 2001* (Cth) or an appropriately qualified member of the Institute of Chartered Accountants in Australia, of CPA Australia or of the National Institute of Accountants; and (c) in no way linked or associated with the Activity or the Parties.
Insolvency Event	in relation to an entity: (a) the entity disposes of the whole or any part of its assets, operations or business other than in the ordinary course of business; (b) the entity ceases to carry on business; (c) the entity ceases to be able to pay its debts as they become due; (d) proceedings are initiated with a view to obtaining an order for the winding up of the entity, or any person convenes a meeting for the purpose of considering or passing any resolution for the winding up of the entity;

	(e) the entity applies to come under, the entity receives a notice requiring it to show cause why it should not come under, an order has been made for the purpose of placing the entity under, or the entity otherwise comes under one of the forms of external administration referred to in Chapter 5 of the *Corporations Act 2001* (Cth) or Chapter 11 of the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (Cth) or equivalent provisions in State or Territory legislation or the laws of the Partner Country in relation to incorporated entities; (f) where the entity is a natural person, the entity is declared bankrupt or assigns his or her estate for the benefit of creditors; (g) where the entity is a partnership, any step is taken to dissolve that partnership; or (h) anything analogous to an event referred to in paragraph (d), (e), (f) or (g) occurs in relation to the entity.
Intellectual Property Rights	all intellectual property rights, including: (a) copyright, patents, trade marks (including goodwill in those marks), designs, trade secrets, know how, rights in circuit layouts, domain names and any right to have confidential information kept confidential; (b) any application or right to apply for registration of any of the rights referred to in paragraph (a); and (c) all rights of a similar nature to any of the rights in paragraphs (a) and (b) which may subsist in Australia or elsewhere, whether or not such rights are registered or capable of being registered.
Law	any applicable statute, regulation, by-law, ordinance or subordinate legislation in force from time to time in: (a) Australia, whether made by a State, Territory, the Commonwealth, or a local government; and (b) the Partner Country.
Material	includes property, equipment, information, data, documentation or other material in whatever form, including any software, reports, specifications, business rules or requirements, user manuals, user guides, operations manuals, training materials and instructions, and the subject matter of any category of Intellectual Property Rights.
Milestone	a milestone set out in Item 3 of the Activity Proposal in **Schedule 2**.

Modify	to add to, enhance, reduce, change, replace, vary or improve. **Modification** and **Modified** have corresponding meanings.
Moral Rights	the right of integrity of authorship (that is, not to have a work subjected to derogatory treatment), the right of attribution of authorship of a work, and the right not to have authorship of a work falsely attributed, as defined in the *Copyright Act 1968* (Cth).
Notice	a notice, demand, consent, approval or communication issued under this Agreement.
Outcomes	the outcomes for the Activity, as set out in Item 2 of the Activity Proposal.
Partner Country	the country or countries in which the Activity is to be undertaken in whole or in part.
Partner Government	the government of the Partner Country.
Party	DFAT and the Recipient who are listed in the Details section of this Agreement. **Parties** have a corresponding meaning.
Payment Claim	has the meaning given in Clause 8(a).
Payment Criteria	the payment criteria specified in Item 3 of **Schedule 3**.
Performance Improvement Plan	has the meaning given in Clause 15(b).
Performance Issue	has the meaning given in Clause 15(a).
Personal Information	has the same meaning as in the *Privacy Act 1988* (Cth).
Personnel	means DFAT or the Recipients employees, officers, agents, advisers, volunteers, contractors, subcontractors (including their respective personnel), or professional advisers , including **member associations** of the Recipient.
Pre-existing Recipient Material	Material developed by the Recipient that: (a) is in existence at the Commencement Date or is subsequently brought into existence other than as a result of the performance of the Agreement; and (b) is embodied in or attached to the Agreement Material, or otherwise necessarily related to the performance of the Activity.
Recipient	the Party specified in Item 2 of **Schedule 1**.
Recipient Representative	the person identified in Item 4 of **Schedule 1**.
Related Agreement	any other agreement between the Parties under which DFAT provides grant funding to the Recipient, whether entered into before or after this Agreement.

Relevant List	the lists of terrorist organisations made under Division 102 of the *Criminal Code Act 1995* (Cth) and the *Charter of the United Nations Act 1945* (Cth) posted at: http://www.nationalsecurity.gov.au/agd/www/nationalsecurity.nsf/AllDocs/95FB057CA3DECF30CA256FAB001F7FBD?OpenDocument and http://www.dfat.gov.au/icat/UNSC_financial_sanctions.html#3
Reports	the reports to be provided under Clause 14.2(a) and any Performance Improvement Plan.
Schedules	the schedules to this Agreement.
Similar List	any similar list to the World Bank List maintained by any other donor of development funding.
Special Conditions	the terms and conditions (if any) set out in Item 17 of **Schedule 1**.
Third Party Material	any Material made available by the Recipient for the purpose of the Agreement Material or the Activity in which a third party holds Intellectual Property Rights.
Total Funds	the amount specified in Item 1 of **Schedule 3**, as reduced in accordance with this Agreement.
Warranted Materials	(a) Pre-existing Recipient Material; (b) Third Party Material; and (c) Agreement Material.
World Bank List	a list of organisations maintained by the World Bank in its 'Listing of Ineligible Firms' or 'Listings of Firms, Letters of Reprimand' posted at: http://web.worldbank.org/external/default/main?theSitePK=84266&contentMDK=64069844&menuPK=116730&pagePK=64148989&piPK=64148984.

1.2 Interpretation

In this Agreement, except where the contrary intention is expressed:

(a) the singular includes the plural and vice versa, and a gender includes other genders;

(b) another grammatical form of a defined word or expression has a corresponding meaning;

(c) a reference to a clause, paragraph or schedule is to a clause or paragraph of, or schedule to, this Agreement;

(d) a reference to a document or instrument includes the document or instrument as novated, altered, supplemented or replaced from time to time;

(e) a reference to **AUD**, **A$**, **$A**, **dollar** or **$** is to Australian currency;

(f) a reference to time is to Canberra, Australia time;

(g) a reference to a Party is to a Party to this Agreement, and a reference to a party to a document includes the party's executors, administrators, successors and permitted assignees and substitutes;

(h) a reference to a person includes a natural person, partnership, body corporate, association, governmental or local authority or agency or other entity;

(i) a reference to a statute, ordinance, code or other law includes regulations and other instruments under it and consolidations, amendments, re-enactments or replacements of any of them;

(j) the meaning of general words is not limited by specific examples introduced by **including, for example** or similar expressions;

(k) a rule of construction does not apply to the disadvantage of a Party because the Party was responsible for the preparation of this Agreement or any part of it;

(l) if the last day on or by which an obligation must be performed or an event must occur is not a Business Day, the obligation must be performed or the event must occur on or by the next Business Day; and

(m) headings are for ease of reference only and do not affect interpretation.

2. Priority of documents

2.1 If there is any inconsistency between any of the documents forming part of this Agreement, those documents will be interpreted in the following order of priority to the extent of the inconsistency:

(a) Special Conditions;

(b) General Conditions;

(c) Schedules;

(d) any attachments to the Schedules; and

(e) documents incorporated by reference in this Agreement.

3. Duration of Agreement

3.1 This Agreement begins on the Commencement Date and continues until the end of the Agreement Period unless terminated in accordance with **Clause 322** or **Clause 344**.

Activity

4. Activity

4.1 Undertaking the Activity

(a) The Recipient must:

(i) undertake the Activity to achieve the Outcomes;

(ii) undertake the Activity diligently, effectively, safely and to a professional standard;

(iii) comply with all applicable Laws, guidelines and policies, including as set out in **Clause 16**;

(iv) ensure that in its performance of the Activity, all of the Recipient's subcontractors and Personnel, while in the Partner Country, respect and comply with the Laws and regulations in force in the Partner Country;

(v) meet the completion dates for the Milestones, as specified in the Activity Proposal;

(vi) start the Activity by the Activity Start Date and complete the Activity by the Activity End Date;

(vii) ensure that any statement or information given or made to DFAT by the Recipient from time to time under this Agreement (including information or statements contained in any Report) is true and correct (except where the information is provided to the Recipient by another person in which case the Recipient must ensure that it has made reasonable endeavours to verify the accuracy of the information);

(viii) take responsibility for the security of all of its Personnel and for taking-out and maintaining all appropriate insurances;

(ix) not, by act or omission, place DFAT in breach of its obligations under the *Work Health and Safety Act 2011* (Cth); and

(x) not engage a Former DFAT Employee in any capacity in connection with the Activity unless DFAT has approved the engagement.

(b) The Recipient must advise DFAT immediately in writing of any difficulties or delays in implementation of the Activity.

4.2 Warranties

The Recipient represents and warrants that:

(a) it has the legal right and power to enter into, perform and observe its obligations under this Agreement;

(b) the execution, delivery and performance of this Agreement has been duly and validly authorised by the Recipient;

(c) the statements and information in its Application are accurate and complete;

(d) it and its subcontractors and Personnel have the necessary experience, skill, knowledge, expertise and competence to undertake the Activity and (where appropriate) will hold such licences, permits or registrations as are required under any Law to undertake the Activity, and are fit and proper people to be involved in an activity, which is funded by the Australian Government;

(e) it is not subject to any judicial decision against it relating to employee entitlements (not including decisions under appeal) where it has not paid the claim;

(f) it is not named as not complying with the *Workplace Gender Equality Act 2012* (Cth); and

(g) if the Recipient is a trustee, it enters this Agreement personally and in its capacity as trustee and has the power to perform its obligations under this Agreement.

5. Variation to the Activity

(a) If the Recipient wants to seek a variation to the Activity, including postponement of the completion date for a Milestone or change in an intended Outcome as

specified in the Activity Proposal, the Recipient must submit a notice to DFAT in writing setting out:

(i) details of the proposed variation to the Activity or relevant Milestone completion date or change in an intended Outcome and reasons for the request;

(ii) in relation to requests to postpone a Milestone completion date, reasons why the Activity cannot be performed in such a way as to meet the given date; and

(iii) the impact the proposed variations will have on:

(A) effective delivery of the Activity;

(B) the Budget; and

(C) the Milestones.

(b) DFAT will give the Recipient a written notice accepting or rejecting the Recipient's request.

(c) Notwithstanding DFAT's acceptance of a proposed variation, it will not vary this Agreement or be binding unless and until a variation to this Agreement is made in accordance with **Clause 37.4** (Variation).

Funds

6. Use of Funds by Recipient

6.1 What Funds can be used for

(a) The Recipient must spend the Funds only for the purposes of undertaking the Activity and purposes that are incidental to the Activity, including for the independent audit of acquittal reports as set out in **Schedule 4**.

(b) The Recipient must spend the Funds only in accordance with the Budget.

(c) Any increase or decrease in the amount allocated to an item of expenditure in the Budget cannot be made without DFAT's prior written approval.

6.2 When Funds cannot be used

(a) Without limiting any other right or remedy of DFAT, DFAT may by written notice direct the Recipient not to spend Funds if the Recipient has not achieved a Milestone that was due to be achieved before the date of notification, or the Recipient is otherwise in breach of this Agreement.

(b) The Recipient must not spend any Funds that it has not already legally committed for expenditure after it receives notice from DFAT under **Clause 6.2**(a) unless and until DFAT notifies the Recipient otherwise.

6.3 Bank account

The Recipient must:

(a) ensure that Funds are held in an account:

(i) in the Recipient's name;

(ii) held at an institution regulated by the *Banking Act 1959* (Cth) or a reputable banking institution approved or regulated by the relevant banking authority or regulator in the jurisdiction in which the Activity is performed; and

(iii) which the Recipient solely controls;

(b) ensure that the account referred to in **Clause 6.3**(a) is:

(i) established solely for the purposes of accounting for, and administering, any Funds; and

(ii) an account that bears a rate of interest consistent with the interest rate of Australia as issued by the Reserve Bank of Australia or the equivalent rate set by the Reserve Bank of the Partner Country.

(c) unless the Recipient is a sole director company, ensure that two signatories, who have the Recipient's authority to do so, are required to operate the account;

(d) notify DFAT, prior to the receipt of any Funds, of details sufficient to identify the account;

(e) on notification from DFAT, provide DFAT and the institution that provides the account with an authority for DFAT to obtain any details relating to the use of the account;

(f) if the account changes, notify DFAT within **14 days** after the change occurring, providing DFAT with details of the new account, and comply with **Clause 6.3**(a) to **6.3**(e) in respect of the new account; and

(g) identify the receipt and expenditure of the Funds separately within the Recipient's accounting records so that at all times the Funds are identifiable, traceable and ascertainable.

7. Payment of Funds by DFAT

7.1 Payment

(a) Subject to this Agreement (including satisfaction of the Payment Criteria in Schedule 3) and sufficient grant funding being available to DFAT, DFAT will provide grant funding to the Recipient as set out in **Schedule 3**.

(b) DFAT's liability under this Agreement is limited to:

(i) the Total Funds; or

(ii) the amount of grant funding paid under this Agreement (and any amount of grant funding for which DFAT is liable under **Clause 32.5**(a) or **Clause 34.1**(c)(i) and (ii)),

whichever is the lesser.

7.2 Suspension

(a) Without limiting any other right or remedy of DFAT, DFAT may suspend payment of grant funding under this Agreement in whole or in part:

(i) if the Recipient has not provided a Report due to be provided before the date for payment, until the Report is provided;

(ii) if a Report provided by the Recipient is not acceptable to DFAT, until a replacement Report that is acceptable to DFAT is provided;

(iii) if the Recipient has not achieved a Milestone that was due to be achieved before the date for payment, until the Milestone is achieved;

(iv) if the Recipient has not otherwise undertaken a Milestone or the Activity to the satisfaction of DFAT, until the Recipient remedies its performance;

(v) if the Recipient has not spent Funds in accordance with the Agreement, until the Recipient has done so;

(vi) if the Recipient has not satisfied the Payment Criteria in **Schedule 3**; or

(vii) if the Recipient is in breach of this Agreement or a Related Agreement, until that breach is remedied.

(b) Despite any suspension, the Recipient must continue to perform its obligations under this Agreement, unless otherwise agreed to in writing by the Parties.

7.3 Reduction

Without limiting any other right or remedy of DFAT, DFAT may reduce the amount of any instalment of grant funding under this Agreement:

(a) if by the date for payment of the instalment the Recipient has not spent Funds in accordance with the Payment Criteria, by the amount that has not been spent; or

(b) if Funds have been spent other than in accordance with this Agreement, by the amount that was spent other than in accordance with this Agreement.

7.4 Due date for payment

Subject to this **Clause 7** and DFAT being satisfied with:

(a) the Recipient's performance of the Activity; and

(b) the achievement of the Payment Criteria,

DFAT must make payment within **30 days** of receiving a correctly rendered invoice.

7.5 Incorrect invoices, under/over payment

If an invoice is found to have been rendered incorrectly after payment, any underpayment or overpayment will be recoverable by or from the Recipient, as the case may be.

7.6 Taxes

The Recipient must pay:

(a) all stamp duty (including penalties and interest) assessed or payable in respect of this Agreement and the Activity; and

(b) subject to **Clause 9** (GST and PAYG tax), all taxes, duties and government charges imposed or levied in Australia or overseas in connection with the performance of this Agreement.

8. Claims for payment

(a) If the Recipient has achieved the Payment Criteria in respect of the applicable instalment, then not earlier than the due date specified in item 3 of Schedule 3, the Recipient must submit to DFAT a claim for payment of the relevant instalment of the grant funding (**Payment Claim**).

(b) A Payment Claim submitted under **Clause 8(a)** must include a correctly rendered invoice to DFAT in accordance with the requirements specified in **Clause 9.4** and item 4 of **Schedule 3**.

9. GST and PAYG tax

9.1 Interpretation

Unless specifically defined otherwise in this Agreement, words and expressions used in this **Clause 9** which have a defined meaning in the GST Law have the same meaning as in the GST Law.

9.2 Consideration GST exclusive

Unless otherwise expressly stated, all prices or other sums payable or consideration to be provided under this Agreement are exclusive of GST.

9.3 GST gross up

Subject to this **Clause 9**, if GST is payable by a Party ('GST Supplier') on any supply made under this Agreement, the recipient of the supply ('GST Recipient') will pay to the GST Supplier an amount equal to the GST payable on the supply ('GST Amount'), in addition to and at the same time that the consideration for the supply is to be provided under this Agreement.

9.4 Tax invoice

(a) The GST Supplier must deliver a tax invoice or an adjustment note to the GST Recipient before the GST Supplier is entitled to payment of a GST Amount under **Clause 9.3**.

(b) The GST Recipient can withhold payment of the GST Amount payable under **Clause 9.3** until the GST Supplier provides a tax invoice or an adjustment note as appropriate.

9.5 Payment of GST Amount

(a) DFAT will only pay a GST Amount in respect of any taxable supply made to it under this Agreement if:

(i) the Recipient has, in this Agreement or otherwise, provided its ABN and confirmed it is GST registered; and

(ii) DFAT has received a valid tax invoice from the Recipient for the taxable supply in accordance with **Clause 9.4**.

(b) To avoid doubt, if the Recipient indicates at Item 8 of **Schedule 1** that it is not registered or required to be registered for GST, DFAT will not pay any GST Amount to the Recipient.

9.6 GST adjustment event

If an adjustment event arises in respect of a taxable supply made by a GST Supplier under this Agreement the amount payable by the GST Recipient under **Clause 9.3** will be recalculated to reflect the adjustment event and a payment will be made by the GST Recipient to the GST Supplier or by the GST Supplier to the GST Recipient as the case requires.

9.7 Reimbursements

If a payment to a Party under this Agreement is a reimbursement or indemnification, calculated by reference to a loss, cost or expense incurred by that Party, then the payment

will be reduced by the amount of any input tax credit to which that Party is entitled on the acquisition of the supply to which that loss, cost or expense relates.

9.8 PAYG withholding tax

(a) If the Recipient's ABN is not stated in this Agreement, the Recipient must, on or before any payments are required to be made to it under this Agreement, either:

(i) advise DFAT in writing of its ABN; or

(ii) provide evidence to the reasonable satisfaction of DFAT as to why it is not required to obtain an ABN, which obligation may be discharged by providing a signed statement in the form approved by the Commissioner of Taxation from time to time and available at: http://www.ato.gov.au/Business/Australian-business-number/In-detail/Statement-by-a-supplier/Statement-by-a-supplier--not-quoting-ABN-to-an-enterprise/.

(b) If the Recipient does not satisfy its obligations under **Clause 9.8**(a), the Recipient acknowledges that DFAT may be required to deduct PAYG withholding tax in accordance with **Part 2-5** of the *Taxation Administration Act 1953* (Cth) from the relevant payments to the Recipient at the prescribed rate and remit that to the Australian Taxation Office.

10. Repayment

10.1 Misspent Funds

At any time, DFAT is entitled to recover from the Recipient the amount of any Funds which have been spent or used other than in accordance with this Agreement.

10.2 Unspent Funds

On the earlier of the Activity End Date, expiry or termination of this Agreement, DFAT is entitled to recover from the Recipient any Funds which have not been spent, or legally committed for expenditure by the Recipient in accordance with this Agreement and payable by the Recipient as a current liability (written evidence of which will be required).

10.3 Repayment notice

(a) DFAT may give the Recipient a notice requiring the Recipient to pay to DFAT (or deal with as specified by DFAT) an amount which DFAT is entitled to recover under this **Clause 10** or **Clause 12** (Assets).

(b) If DFAT gives a notice under **Clause 10.3(a)**, the Recipient must pay the amount specified in the notice in full (or deal with it as specified by DFAT) within 14 days after the date of the notice.

10.4 Interest

If the Recipient fails to make payment as required by **Clause 10.3**, the Recipient must pay DFAT interest:

(a) at the rate set out in **Schedule 3** on a daily compounding basis upon the amount specified in the notice as payable to DFAT; and

(b) from the date the payment was due, for the period it remains unpaid.

10.5 DFAT's rights

This **Clause 10** does not limit any other right or remedy of DFAT.

11. Procurement

11.1 If the Funds are being used to procure goods or services, the Recipient must implement procedures so that procurement is undertaken in a manner consistent with the principles of the Australian Commonwealth Procurement Rules (**http://www.finance.gov.au/procurement/procurement-policy-and-guidance/commonwealth-procurement-rules/index.html**), in particular the core principle of achieving value for money and the supporting principles of:

(i) encouraging competition by ensuring non-discrimination in procurement and using competitive procurement methods;

(ii) promoting use of resources in an efficient, effective, economical and ethical manner; and

(iii) making decisions in an accountable and transparent manner.

(b) If the Funds are being used to procure goods, the Recipient must ensure in its procurement of goods that the goods to be procured:

(i) are of a merchantable quality;

(ii) are free from defects in design, materials and workmanship;

(iii) are fit for purpose;

(iv) have good and marketable title and are free from encumbrances; and

(v) are delivered in good order and condition and in accordance with the Milestones.

(c) If the Funds are being used to procure services, the Recipient must ensure in its procurement of services that the services to be procured are performed:

(i) diligently, effectively, safely and to a professional standard; and

(ii) with the skill and care normally exercised by similarly qualified and competent persons in the performance of comparable work.

12. Assets

12.1 Ownership

(a) The Recipient must not use the Funds to acquire any Assets, apart from those Assets specified in Item 5.1 of the Activity Proposal.

(b) Subject to the requirements of this **Clause 12** and the terms of any lease, the Recipient will own the Assets unless otherwise specified in Item 5.3 of the Activity Proposal.

12.2 Use and dealings

(a) During the Agreement Period, the Recipient must use any Asset only for the purposes of the Activity, or other purposes consistent with the Outcomes approved by DFAT.

(b) During the Agreement Period, the Recipient must:

(i) obtain good title to all Assets (other than Assets which the Recipient leases);

(ii) hold all Assets securely and safeguard them against Fraud, theft, loss, damage, or unauthorised use;

(iii) maintain all Assets in good working order;

(iv) maintain all appropriate insurances in respect of any Assets;

(v) if required by Law, maintain registration and licensing of all Assets;

(vi) be fully responsible for, and bear all risks relating to, the use or disposal of all Assets; and

(vii) maintain an Asset Register containing the details as described in item 5.4 of the Activity Proposal and provide a copy of the Assets Register to DFAT on request.

(c) The Recipient must reconcile, the Asset Register with the Assets at least on each anniversary of the Activity Start Date and include the results of that reconciliation in the annual report to be provided to DFAT set out in Item 2 of **Schedule 4**.

(d) The Asset Register and other relevant documents such as import papers and manufacturers' warranties relating to the Assets must be available for audit or review as required by DFAT.

12.3 Sale or disposal

(a) The Recipient must not:

(i) dispose (including any write-offs) of Assets unless:

(A) the disposal is conducted on an arms-length basis; and

(B) any conflicts of interest relevant to the disposal are disclosed to DFAT pursuant to **Clause 30** (Conflict of Interest).

(b) If the Recipient sells or otherwise disposes of an Asset during the Agreement Period, the proceeds of any sale or disposal of the Assets forms part of the Funds.

(c) If the Recipient sells or otherwise disposes of an Asset during the Agreement Period, DFAT is entitled, at its discretion, to recover from the Recipient:

(i) the value of the Asset obtained from the sale or disposal of the Asset; or

(ii) the market value of the Asset.

12.4 Termination

On termination or expiry of this Agreement, DFAT may require the Recipient to use, deal with or transfer any Asset as DFAT directs in writing.

12.5 Lost or damaged Assets

If any Asset is stolen, lost, damaged or destroyed, the Recipient must:

(a) reinstate the Asset (including using the proceeds of insurance) without using any Funds (unless DFAT's prior written consent is obtained to do otherwise);

(b) notify DFAT in writing if the Asset is valued above the Asset Threshold at the time of purchase; and

(c) this **Clause 12** continues to apply to the reinstated Asset.

Grant administration

13. Grant administration (Not Used)

13.1 Application of this clause

(a) This **Clause 13** applies if Item 9 of **Schedule 1** specifies that the Recipient will administer an Administered Grant Scheme.

13.2 Grant administration

(a) In administering an Administered Grant Scheme, the Recipient must:

(i) implement procedures so that grant administration is undertaken in a manner that is consistent with the Commonwealth Grants Rules and Guidelines, in particular the Key Principles for Grants Administration;

(ii) implement systems and processes to manage the risks of the Administered Grant Scheme;

(iii) maintain complete and accurate records documenting the procedures followed in selecting Administered Grant Recipients;

(iv) ensure that all Administered Grant Arrangements satisfy the requirements of **Clause 13.3** and allow the Recipient to comply with its obligations under this **Clause 12** and this Agreement;

(v) ensure that Administered Grant Recipients are financially viable and have the necessary relevant expertise and the appropriate types and amounts of insurance to perform their obligations under the Administered Grant Arrangements; and

(vi) not enter into an Administered Grant Arrangement with an organisation that has been named as not complying with the *Workplace Gender Equality Act 2012* (Cth). [**Note to Recipients:** The Workplace Gender Equality Act 2012 (Cth) applies to employers who employ 100 or more employees in Australia and provides for certain reporting obligations by those employers. Failure to comply with this Act may mean that the Director of Workplace Gender Equality may name a person as non-compliant with this Act.]

(b) The Commonwealth Grants Rules and Guidelines are available at: http://www.finance.gov.au/publications/fmg-series/3-commonwealth-grant-guidelines.html

(c) The Recipient must promptly provide copies of Administered Grant Arrangements, if requested by DFAT at any time.

(d) The Recipient must manage and administer each Administered Grant Arrangement in accordance with this Agreement, including by monitoring each Administered Grant Recipient's performance of, and compliance with, its contractual obligations.

(e) The Recipient must, to the extent it is legally able to do so, comply with any written direction of DFAT concerning an Administered Grant Arrangement.

(f) The Recipient must not terminate an Administered Grant Arrangement unless it gives DFAT notice of the proposed termination and has consulted with DFAT in relation to the proposed termination.

(g) Where an Administered Grant Recipient is unable to perform the work, the Recipient agrees to notify DFAT immediately.

13.3 Administered Grant Arrangements

The Recipient must ensure that each Administered Grant Arrangement:

(a) facilitates compliance by the Recipient with its obligations under this Agreement;

(b) is consistent with this Agreement and will not conflict with or detract from the rights and entitlements of the Recipient under this Agreement;

(c) contains all the relevant terms of this Agreement including those relating to compliance with laws, guidelines and policies, subcontracting, intellectual property, audit and access, privacy, confidentiality, warranties and indemnities, disclosure, repayment of funds, Fraud, child protection, counter-terrorism and termination and in particular that the Recipient has a right to terminate each Administered Grant Arrangement on terms no less favourable than those accorded to DFAT by **Clause 34.1**(Termination for Convenience), in the event of this Agreement being terminated;

(d) contains obligations requiring the Administered Grant Recipient to:

(i) manage the Funds paid by the Recipient to the Administered Grant Recipient and maintain a bank account, in accordance with the requirements in **Clause 6.3** (Bank Account);

(ii) maintain records, books and accounts to meet the same requirements the Recipient must meet under **Clause 25**(Records, Books and Accounts);

(iii) during the term of the Administered Grant Arrangement provide reports (including ad-hoc reports as requested) containing the same information as the Recipient is required to provide to DFAT under **Schedule 4**; and

(e) specifies that the Administered Grant Recipient acknowledges that:

(i) it may be considered a 'Commonwealth service provider' for the purposes of the *Ombudsman Act 1976* (Cth);

(ii) it may be subject to investigation by the Ombudsman under that Act; and

(iii) DFAT will not be liable for the cost of any such investigation by the Ombudsman in connection with the Administered Grant Arrangement or this Agreement;

(f) specifies that the Administered Grant Recipient is prohibited from subcontracting the entirety of its obligations under the Administered Grant Arrangement without the prior written approval of DFAT;

(g) specifies the purposes for which the Funds are being paid ('Specified Purposes');

(h) requires the Administered Grant Recipient to repay to the Recipient any Funds which are not properly acquitted, or which remain unspent (as if **Clause 10.2** (Unspent Funds) referred to the Administered Grant Recipient instead of the Recipient) promptly on the earlier of the end date or the termination or expiry of the Administered Grant Arrangement with that Administered Grant Recipient; and

(i) requires the Administered Grant Recipient to repay to the Recipient any Funds or property which have been spent for purposes other than the Specified Purposes, or lost as a result of Fraud or misappropriation, without delay.

13.4 Repayment of administered grant funds

(a) The Recipient must immediately notify DFAT of any administered grant funds it recovers under **Clause 13.3**(h) and 13.3(**i**) above. Any such administered grant funds will constitute Funds under the terms of this Agreement and the Recipient must deal with those Funds accordingly, or as otherwise directed in writing by DFAT.

(b) On receipt of notice under **Clause 13.4**(a), DFAT may by written notice to the Recipient require the Recipient to repay to DFAT any or all of the recovered administered grant funds, and the Recipient must repay to DFAT the amounts specified in the notice within **30 days** of the date of the notice.

Performance and compliance

14. Monitoring progress

14.1 Progress meetings

The Parties will meet at the times and in the manner reasonably required by DFAT to discuss any issues in relation to this Agreement or the Activity. The Recipient must ensure that the Recipient Representative, and DFAT must ensure the DFAT Representative, is reasonably available to attend such meetings and answer any queries relating to the Activity raised by either Party.

14.2 Reporting

(a) The Recipient must provide DFAT with Reports in accordance with **Schedule 4**.

(b) When the Recipient provides DFAT with a Report, DFAT will notify the Recipient in writing within 30 days after receiving the Report that it has either:

(i) accepted the Report; or

(ii) rejected the Report, providing reasons for its rejection.

(c) If DFAT rejects a Report, excluding a Performance Improvement Plan in accordance with **Clause 15** (Performance Improvement Plan), the Recipient must reissue the Report in a form that addresses the reasons for the earlier rejection and DFAT will comply with **Clause 14.2**(b) in relation to any reissued Report. Deadline for resubmission of the Report will be mutually agreed in writing by the Parties.

(d) Acceptance of a Report by DFAT does not constitute a release of the Recipient in respect of any matter, an admission or acceptance that the Recipient's performance complies with this Agreement, or acceptance of the accuracy of the Report.

14.3 Evaluation

(a) DFAT may at any time undertake, or engage an expert to undertake a review or evaluation of the Activity or DFAT's grant programs.

(b) In relation to any review or evaluation of the Activity or DFAT's grant programs, the Recipient must within 14 days after a request by DFAT (or any expert):

(i) provide all reasonable assistance to DFAT (and any expert);

(ii) respond to all reasonable requests from DFAT (and any expert); and

(iii) provide any information reasonably required by DFAT (and any expert).

15. Performance Improvement Plan

(a) If there is a potential failure or failure to meet a Milestone, perform the Activity or achieve the Outcomes in accordance with this Agreement, other than due to a Force Majeure Event (in this **Clause 15** a 'Performance Issue'), the Recipient must immediately notify DFAT of the Performance Issue.

(b) If the Recipient notifies DFAT of a Performance Issue in accordance with **Clause 15** (a), or if DFAT notifies the Recipient of a Performance Issue, then without limitation to any of DFAT's rights or the Recipient's obligations under this Agreement, the Recipient must, if requested by DFAT, within **7 days** (or such longer period as determined by DFAT) prepare and submit to DFAT a report ('Performance Improvement Plan') identifying:

(i) the nature and extent of the Performance Issue;

(ii) the consequences of the Performance Issue and in particular the Milestones and Outcomes that are likely to be affected; and

(iii) steps the Recipient will take to rectify the Performance Issue,

Performance Improvement Plan

(c) After receiving the Recipient's Performance Improvement Plan in accordance with **Clause 15**(b), DFAT will within **30 days** review the Performance Improvement Plan and give the Recipient notice that:

(i) DFAT approves the Performance Improvement Plan; or

(ii) DFAT does not approve the Performance Improvement Plan.

(d) If DFAT rejects the Performance Improvement Plan, the Recipient must amend and resubmit its proposed Performance Improvement Plan (again within the timeframe determined in accordance with **Clause 15**(b)), to take account of any concerns that DFAT may have with it, including in relation to matters such as the steps proposed to be taken by the Recipient, and the timeframe in which any steps are proposed to occur.

(e) If a Performance Improvement Plan is rejected and resubmitted, the process described in **Clauses 15(c)** and **(d)** will apply to the resubmitted Performance Improvement Plan.

(f) Once a Performance Improvement Plan is approved by DFAT, the Recipient must complete all of the steps and activities in the approved Performance Improvement Plan within the timeframes specified in the approved Performance Improvement Plan.

(g) If the Recipient:

(i) does not submit a Performance Improvement Plan that DFAT is prepared to approve; or

(ii) does not comply with the requirements of any approved Performance Improvement Plan,

then DFAT may immediately suspend payment in accordance with **Clause 7.2**(a)(ii) (Suspension) or terminate this Agreement in accordance with **Clause 34.2** (Termination for default).

(h) The exercise of DFAT's rights under this **Clause 15**, including the approval of a Performance Improvement Plan, will:

(i) not operate as a waiver of the obligations (or any breach thereof) that the Recipient may have under this Agreement; and

(ii) not limit DFAT's rights or remedies it may have against the Recipient in connection with the Performance Issue (for example, to claim damages for breach or terminate this Agreement).

16. Compliance with Laws

(a) The Recipient must, and must ensure that its subcontractors and Personnel, have regard to and comply with, relevant and applicable Laws, guidelines and policies, including those in Australia and in the Partner Country.

(b) The Recipient must ensure:

(i) that individuals or organisations involved in implementing the Activity are in no way linked, directly or indirectly, to organisations and individuals associated with terrorism, including 'terrorist organisations' as defined in **Division 102** of the *Criminal Code Act 1995* (Cth) and listed in regulations made under that Act and regulations made under the *Charter of the United Nations Act 1945* (Cth); and

(ii) that the Funds are not used in any way to provide direct or indirect support or resources to organisations and individuals associated with terrorism.

(c) The Recipient must in carrying out its obligations under this Agreement:

(i) comply with Laws in relation to sanctions, including the *Charter of the United Nations Act* 1945 (Cth) and regulations made under the Act and the *Autonomous Sanctions Act 2011* (Cth) and regulations made under that Act; and

(ii) ensure that Funds provided under this Agreement do not provide direct or indirect support or resources to organisation and individuals for whom Australia has imposed sanctions under the *Charter of the United Nations Act* 1945 (Cth) and regulations made under that Act or the *Autonomous Sanctions Act 2011* (Cth) and regulations made under that Act.

(d) If during the Agreement Period, the Recipient discovers any link whatsoever with any organisation or individual listed in **sub-clauses 16**(b) and **16**(c) above, it must inform DFAT immediately.

(e) The Recipient must have regard to the Australian Government guidance "*Safeguarding your organisation against terrorism financing: a guidance for non-profit organisations*", available at http://www.nationalsecurity.gov.au/agd/WWW/nationalsecurity.nsf/Page/What_Governments_are_doing_Risk_of_Misuse_-_Terrorism_Financing.

(f) If, during the Agreement Period, the Recipient discovers that it or its subcontractors or Personnel have any link whatsoever with any organisation or individual associated with terrorism it must inform DFAT immediately.

(g) If, during the Agreement Period, the Recipient or any of its subcontractors or Personnel are:

(i) listed on a World Bank List or Similar List or subject to any proceedings or an informal process which could lead to them becoming so listed;

(ii) temporarily suspended from tendering for World Bank grants by the World Bank pending the outcome of a sanctions process or from tendering by a donor of development funding other than the World Bank; and/or

(iii) the subject of an investigation (whether formal or informal) by the World Bank or another donor of development funding,

the Recipient must inform DFAT immediately.

(h) The Recipient warrants that the Recipient and its subcontractors and Personnel have not made or caused to be made, or received or sought to receive, any offer, gift or payment, consideration or benefit of any kind, which would or could be construed as an illegal or corrupt practice, either directly or indirectly to any Party, as an inducement or reward in relation to the execution of this Agreement.

(i) The Recipient must not, and must ensure that its subcontractors and Personnel do not:

(i) make or cause to be made, or receive or seek to receive, any offer, gift or payment, consideration or benefit of any kind, which would or could be construed as an illegal or corrupt practice, either directly or indirectly to any party, as an inducement or reward in relation to this Agreement; or

(ii) bribe public officials.

17. Child protection

(a) The Recipient must, and must ensure that its subcontractors and Personnel comply with the Child Protection Policy for the DFAT – Australian Aid Program, accessible at http://www.dfat.gov.au.

(b) DFAT may conduct a review of the Recipient's compliance with DFAT's Child Protection Policy referred to in **sub-clause 17**(a). DFAT will give reasonable notice to the Recipient and the Recipient must participate co-operatively in any such review.

18. Compliance with DFAT policies

(a) The Recipient must, and must ensure that its subcontractors and Personnel comply with all DFAT policies as listed on DFAT's website http://aid.dfat.gov.au, including the Family Planning and the Aid Program: Guiding Principles dated 1 August 2009, listed at http://dfat.gov.au/about-us/publications/Pages/family-planning-and-the-aid-program-guiding-principles.aspx

(b) A list, as amended from time to time, of Australian laws and guidelines that may apply to the delivery of developmental aid to foreign countries can be found on the DFAT website: http://aid.dfat.gov.au. This list is not exhaustive and is provided for information only.

(c) The provision of the list referenced at **sub-clause 18**(b) above does not relieve the Recipient from complying with the obligations contained in this **Clause 18**.

(d) The Recipient must have regard to and comply with the Statement of International Development Practice Principles in **Schedule 5**.

19. Acknowledgement and publicity

19.1 Acknowledgment by Recipient

The Recipient must, in all publications, promotional and advertising materials, public announcements, events and activities in relation to the Activity, or any products, processes or inventions developed as a result of it, acknowledge the financial and other support received from DFAT, in the manner specified in the DFAT publication 'Visibility and Recognition: Guidelines for NGOs' (available on DFAT's website) or otherwise approved by DFAT prior to its use.

19.2 DFAT rights

(a) DFAT reserves the right to publicise and report on the awarding of the grant funding under this Agreement, and may do this by, amongst other means, including the Recipient's name, any subcontractor's name, the amount of the Total Funds and a brief description of the Activity on websites and in media releases, general announcements about the DFAT's grant programs and annual reports.

(b) Without limiting any other right of DFAT, DFAT may disclose information about this Agreement, the Recipient or the Activity to any State or Territory government of Australia or a Partner Government.

19.3 Announcements

(a) The Recipient must, before making a public announcement in connection with this Agreement or any transaction contemplated by it, provide DFAT with **21 days** prior written notice, except if required by Law or a regulatory body (including a relevant stock exchange).

(b) If the Recipient is required by Law or a regulatory body to make a public announcement in connection with this Agreement or any transaction contemplated by this Agreement, the Recipient must, to the extent practicable, first consult with and take into account the reasonable requirements of DFAT.

19.4 Activity Events

(a) The Recipient must not undertake, or participate in any way in, any Activity Event, without providing DFAT with 21 days prior written notice.

(b) The Recipient must:

(i) notify DFAT of a proposed Activity Event at least **21 days** before the proposed date for the Activity Event and submit all details of the Activity Event to DFAT in the format required by DFAT;

(ii) invite a representative of DFAT to the Activity Event; and

(iii) if required by DFAT, provide the DFAT representative an opportunity to speak at the Activity Event.

(c) The Recipient must notify DFAT of any change to Activity Event details as soon as possible.

Subcontracting

20. Subcontractors

(a) The Recipient must notify DFAT of the details of its subcontractors on request from DFAT.

(b) The Recipient must obtain any subcontractor's express consent for the disclosure to DFAT of the subcontractor's identity (and their Personal Information, if the subcontractor is an individual). The consent obtained must extend to allowing DFAT to disclose for reporting purposes the subcontractor's identity and the existence and nature of the subcontract.

(c) The Recipient must not enter into a subcontract with a subcontractor named as an organisation that has not complied with the *Workplace Gender Equality Act 2012* (Cth). [***Note to Recipients**: The Workplace Gender Equality Act 2012 (Cth) applies to employers who employ 100 or more employees in Australia and provides for certain reporting obligations by those employers. Failure to comply with this Act may mean that the Director of Workplace Gender Equality may name a person as non-compliant with this Act.*]

(d) The Recipient must ensure that any subcontractor complies with all Laws and:

(i) **Clause 16** (Compliance with Laws);

(ii) **Clause 17** (Child protection);

(iii) **Clause 18** (Compliance with DFAT policies);

(iv) **Clause 23** (Confidentiality);

(v) **Clause 24** (Protection of Personal Information);

(vi) **Clause 25** (Records, books and accounts);

(vii) **Clause 26** (Audit and access);

(viii) **Clause 29** (Insurance);

(ix) **Clause 30** (Conflict of interest); and

(x) **Clause 31** (Fraud).

(e) The Recipient is fully responsible for:

(i) undertaking the Activity and performing this Agreement even if the Recipient subcontracts any aspect of the Activity; and

(ii) the performance of all of the Recipient's obligations under this Agreement.

and will not be relieved of that responsibility because of any:

(iii) involvement by DFAT or any third party in the performance of the Activity; or

(iv) payment of any Funds.

Information management

21. Intellectual Property Rights

21.1 Pre-existing Recipient Material and Third Party Material

(a) This **Clause 21** does not affect the ownership of the Intellectual Property Rights in any DFAT Material, Pre-existing Recipient Material or Third Party Material.

(b) The Recipient must obtain all necessary copyright and other Intellectual Property Right permissions before making any Pre-Existing Recipient Material or Third Party Material available as a part of the Agreement Material or Activity.

21.2 Selecting an ownership model for Intellectual Property Rights in Agreement Material

(a) The ownership model for Intellectual Property Rights in Agreement Material is the model set out in Item 10 of **Schedule 1**.

(b) If no ownership model is selected in Item 10 of **Schedule 1**, **Clause 21.3** applies and **Clause 21.4** in its entirety, does not apply to this Agreement.

(c) Each Party must, at its own cost, do all things and execute all documents necessary or convenient to give effect to the ownership model.

21.3 Recipient ownership of Intellectual Property Rights in Agreement Material

(a) All Intellectual Property Rights in the Agreement Material vest in the Recipient on creation.

(b) Unless otherwise specified in Item 11 of **Schedule 1**:

(i) the Recipient grants to, or must obtain for, DFAT, a perpetual, irrevocable, world-wide, royalty free, non-exclusive licence (including the right to sublicense) to use, reproduce, adapt, Modify, distribute and communicate:

(A) the Agreement Material; and

(B) any Third Party Material and Pre-Existing Recipient Material,

required to receive the full benefit of the Agreement Material and the Activity, and for any other DFAT or Commonwealth purpose; and

(ii) to the extent that the Recipient needs to use any of the DFAT Material for the purpose of performing its obligations under this Agreement, DFAT grants to the Recipient for the Agreement Period, subject to any conditions or restrictions specified in item 13 of Schedule 1 and any direction by DFAT, a revocable, world-wide, royalty-free, non-exclusive, non-transferable licence (including the right to sublicense) to use, reproduce, adapt, Modify and communicate such Material solely for the purpose of performing the Activity.

21.4 DFAT ownership of Intellectual Property Rights in Agreement Material

(a) All Intellectual Property Rights in the Agreement Material vest in DFAT on creation.

(b) Unless otherwise specified in Item 12 of **Schedule 1**, to the extent that:

(i) DFAT needs to use any of the Pre-Existing Recipient Material or Third Party Material to receive the full benefit of the Activity, and for any other

DFAT or Commonwealth purpose, the Recipient grants to, or must obtain for, DFAT, a perpetual, irrevocable, world-wide, royalty free, non-exclusive licence (including the right to sublicense) to use, reproduce, adapt, Modify and communicate that Pre-Existing Recipient Material or Third Party Material; or

(ii) the Recipient needs to use any of the:

(A) DFAT Material; or

(B) Agreement Material,

for the purpose of performing its obligations under this Agreement, DFAT grants to the Recipient for the term of this Agreement, subject to any conditions or restrictions specified in Item 13 of **Schedule 1** and any direction by DFAT, a revocable, world-wide, royalty-free, non-exclusive, non-transferable licence (including the right to sublicense) to use, reproduce, adapt, Modify, distribute and communicate such Material solely for the purpose of performing the Activity.

21.5 Warranty

The Recipient warrants that:

(a) the Warranted Materials and DFAT's use of the Warranted Materials will not infringe the Intellectual Property Rights of any person; and

(b) it has the necessary rights to vest the Intellectual Property Rights and grant the licences as provided for in this **Clause 21**.

21.6 Remedy for breach of warranty

If someone claims, or DFAT reasonably believes that someone is likely to claim, that all or part of the Warranted Materials infringe their Intellectual Property Rights, the Recipient must, in addition to the indemnity under **Clause 28** and to any other rights that DFAT may have against it, promptly, at the Recipient's expense:

(a) use its best efforts to secure the rights for DFAT to continue to use the affected Warranted Materials free of any claim or liability for infringement; or

(b) replace or modify the affected Warranted Materials so that the Warranted Materials or the use of them does not infringe the Intellectual Property Rights of any other person without any degradation of the performance or quality of the affected Warranted Materials.

22. Moral Rights

22.1 Obtaining consents

To the extent permitted by applicable Laws and for the benefit of DFAT, the Recipient must use its best endeavours to ensure that:

(a) each of the Personnel used by the Recipient in the production or creation of the Agreement Material gives, in a form acceptable to DFAT; and

(b) any holder of Moral Rights in Third Party Material included in the Agreement Material gives,

genuine consent in writing, to the use of the Agreement Material for the Specified Acts, even if such use would otherwise be an infringement of their Moral Rights.

22.2 Specified Acts

(a) In this **Clause 22**, unless otherwise specified in Item 14 of **Schedule 1**, **Specified Acts** means:

(i) failing to attribute or falsely attributing the authorship of any Agreement Material, or any content in the Agreement Material (including literary, dramatic, artistic works and cinematograph films within the meaning of the *Copyright Act 1968* (Cth));

(ii) materially altering the style, format, colours, content or layout of the Agreement Material and dealing in any way with the altered Agreement Material;

(iii) reproducing, communicating, adapting, publishing or exhibiting any Agreement Material; and

(iv) adding any additional content or information to the Agreement Material.

(b) For the purposes of this **Clause 22**, Agreement Material includes any Pre-existing Recipient Material and Third Party Material to the extent that it is included in, forms part of or is attached to the Agreement Material.

23. Confidentiality

23.1 Prohibition on disclosure

(a) Subject to **sub-clause 23.2** below, a Party must not, without the prior written consent of the other Party, disclose any Confidential Information of the other Party to a third party.

(b) In giving written consent to the disclosure of Confidential Information, a Party may impose such conditions as it thinks fit, and the other Party agrees to comply with these conditions.

23.2 Exceptions to obligations

The obligations on the Parties under **sub-clause 23.1** above will not be taken to have been breached to the extent that Recipient Confidential Information:

(a) is disclosed by a Party to its Personnel or advisers solely in order to comply with obligations, or to exercise rights, under this Agreement;

(b) is disclosed to a Party's internal management personnel, solely to enable effective management or auditing of activities related to this Agreement;

(c) is disclosed by DFAT, to the responsible Minister, a House or a Committee of the Parliament of the Commonwealth of Australia;

(d) is shared by DFAT within DFAT, or with another Commonwealth agency, State or Territory Government or Partner Government, where this serves the Commonwealth's legitimate interests, the State's or Territory's legitimate interests or the Partner Government's legitimate interests;

(e) is authorised or required by Law to be disclosed or required in connection with legal proceedings; or

(f) is in the public domain otherwise than due to a breach of this Agreement.

23.3 Transfer of data

The Recipient must not transfer, transmit or disclose Confidential Information of DFAT and Personal Information or allow Confidential Information of DFAT and Personal Information to be taken, transferred, transmitted, accessed or disclosed outside Australia, except to the Partner Country, or allow parties outside Australia to have access to it, without the prior approval of DFAT.

23.4 Return of information

The Recipient must use any Confidential Information of DFAT held, acquired or which the Recipient may have had access to in connection with this Agreement only for the purposes of fulfilling its obligations under this Agreement. Upon expiry or earlier termination of this Agreement the Recipient must either destroy or deliver to DFAT all Confidential Information of DFAT, as required by DFAT.

24. Protection of Personal Information

24.1 Privacy

The Recipient must:

(a) use and disclose Personal Information provided by DFAT or collected by the Recipient under this Agreement only for the purposes of performing its obligations under this Agreement;

(b) not do any act or engage in any practice that would breach an Australian Privacy Principle if done or engaged in by DFAT and must not do or omit to do anything that causes DFAT to be in breach of an Australian Privacy Principle (see http://www.oaic.gov.au/);

(c) comply with any directions, guidelines, determinations or recommendations of the Information Commissioner, Privacy Commissioner or Freedom of Information Commissioner, to the extent that they are not inconsistent with the requirements of this Agreement and promptly notify DFAT in writing of any such occurrence; and

(d) ensure that any subcontract entered into for the purpose of fulfilling the Recipient's obligations under this Agreement contains provisions to ensure that the subcontractor has the same awareness and obligations as the Recipient has under this **Clause 24**, including this requirement in relation to subcontracts.

24.2 Disclosure

Subject to **Clause 23** (Confidentiality) and this **Clause 24**, the Recipient acknowledges that the Commonwealth of Australia may disclose or publish details about this Agreement or Activity. The details may include (but are not limited to) organisation name, the value of the Activity's Funding, and the location where the Activity is being delivered or performed.

25. Records, books and accounts

25.1 Recipient to keep records, books and accounts

The Recipient must:

(a) at all times maintain, and must ensure that its subcontractors maintain, full, true, separate and up-to-date records, books and accounts in relation to the Activity, Funds and this Agreement, including operational records, financial records and

records in relation to the Funds. Such records, books and accounts must, without limitation:

(i) record all operational activities in relation to the Activity, including to enable the prevention, detection and investigation of Fraud as required by **Clause 31**(Fraud and Anti-Corruption);

(ii) record all receipts and expenses related to the Activity, including those involving foreign exchange transactions;

(iii) enable all receipts and expenses related to the Activity to be identified and reported in accordance with this Agreement;

(iv) enable the amounts payable by DFAT under this Agreement to be determined;

(v) be kept in a manner that permits them to be conveniently and properly audited or reviewed;

(vi) enable the extraction of all information relevant to this Agreement; and

(b) retain and require its subcontractors to retain for a period of seven years after the expiry or termination of this Agreement, all records, books and accounts relating to the Activity, the Funds and this Agreement.

25.2 Costs

The Recipient must bear its own costs of complying with this **Clause 25**.

25.3 Survival

This **Clause 25** applies for the Agreement Period and for a period of seven years from the expiry or termination of this Agreement.

26. Audit and access

26.1 Right to conduct audits or reviews

(a) DFAT or a representative may conduct audits or reviews relevant to the performance of the Recipient's obligations under this Agreement. Audits or reviews may be conducted of:

(i) the use of the Funds;

(ii) the Assets;

(iii) the Recipient's operational practices and procedures as they relate to this Agreement;

(iv) the accuracy of the Recipient's invoices and Reports;

(v) the Recipient's compliance with its confidentiality and privacy obligations under this Agreement;

(vi) the Recipient's compliance with Laws, guidelines and policies including the policies listed at **Clause 16** (Compliance with Laws) and **18** (Compliance with DFAT Policies);

(vii) the Recipient's compliance with its child protection policy obligations under **Clause 17** (Child Protection);

(viii) the Recipient's compliance with its Fraud control strategy and policies including Fraud prevention, reporting and investigation obligations under this Agreement;

(ix) Material (including records, books and accounts) in the possession of the Recipient relevant to the Activity or this Agreement; and

(x) any other matters determined by DFAT to be relevant to the Activity or this Agreement.

(b) If DFAT decides to conduct or commission audits or reviews, it will give reasonable notice to the Recipient. The Recipient must participate co-operatively in any audit or review conducted by DFAT or a representative.

26.2 Access by DFAT

(a) DFAT may, at reasonable times and on giving reasonable notice to the Recipient:

(i) access the premises of the Recipient and premises where the Activity is being undertaken to the extent relevant to the performance of this Agreement;

(ii) require the provision by the Recipient, its Personnel or subcontractors of records and information in a data format and storage medium accessible by DFAT by use of DFAT's existing computer hardware and software;

(iii) inspect and copy documentation, records, books and accounts, however stored, in the custody or under the control of the Recipient, its Personnel or subcontractors; and

(iv) require assistance in respect of any inquiry into or concerning the Activity or this Agreement. For these purposes an inquiry includes any administrative or statutory review, audit or inquiry (whether within or external to DFAT), any request for information directed to DFAT, and any inquiry conducted by Parliament or any Parliamentary committee.

(b) The Recipient must provide access to its computer hardware and software to the extent necessary for DFAT to exercise its rights under this **Clause 26**, and provide DFAT with any reasonable assistance requested by DFAT to use that hardware and software.

26.3 Conduct of audit and access

DFAT must use reasonable endeavours to ensure that:

(a) audits or reviews performed pursuant to **sub-clause 26.1** above; and

(b) the exercise of the general rights granted by **sub-clause 26.2** by DFAT,

do not unreasonably delay or disrupt in any material respect the Recipient's performance of its obligations under this Agreement or its business.

26.4 Costs

Unless otherwise agreed in writing, each Party must bear its own costs of any reviews and/or audits.

26.5 DFAT officers and experts

The rights of DFAT under **sub-clause 26.2(a)(i)** to **26.2(a)(iii)** apply equally to:

(a) the Auditor-General, Information Commissioner, Privacy Commissioner and Freedom of Information Commissioner and their delegates, for the purpose of performing their statutory functions or powers; and

(b) any expert engaged for the purposes of **Clause 14.3** (Evaluation).

26.6 Recipient to comply with DFAT officers' requirements

The Recipient must do all things necessary to comply with the Auditor-General's, Information Commissioner's, Privacy Commissioner's or Freedom of Information Commissioner's or his or her delegate's requirements, notified under **sub-clause 26.2** above, provided such requirements are legally enforceable and within the power of the Auditor-General, Information Commissioner, Privacy Commissioner or Freedom of Information Commissioner, or his or her respective delegate.

26.7 No reduction in responsibility

The requirement for, and participation in, audits or reviews does not in any way reduce the Recipient's responsibility to perform its obligations in accordance with this Agreement.

26.8 Subcontractor requirements

The Recipient must ensure that any subcontract entered into for the purpose of this Agreement contains an equivalent clause granting the rights specified in this **Clause 26**.

26.9 No restriction

Nothing in this Agreement reduces, limits or restricts in any way any function, power, right or entitlement of the Auditor-General, Information Commissioner, Privacy Commissioner or Freedom of Information Commissioner, other Commonwealth Commissioner or their delegates. The rights of DFAT under this Agreement are in addition to any other power, right or entitlement of the Auditor-General, Information Commissioner, Privacy Commissioner or Freedom of Information Commissioner or their delegates.

26.10 Survival

This **Clause 26** applies for the Agreement Period and for a period of seven years from the expiry or termination of this Agreement.

Risk management

27. Risk management

(a) The Recipient is responsible for, accepts must manage all the risks of and associated with the Activity.

(b) The Recipient must maintain appropriate risk mitigation measures which may include preparing, maintaining and using risk registers.

28. Indemnity

(a) The Recipient at all times indemnifies and holds harmless DFAT, its officers and employees (referred to in this **Clause 28** as "those indemnified") from and against any loss or liability, including:

(i) loss of, or damage to, property of DFAT;

(ii) claims by any person in respect of personal injury or death;

(iii) claims by any person in respect of loss of, or damage to, any property; and

(iv) costs and expenses, including the costs of defending or settling any claim referred to in **sub-Clauses 28 (a)(ii)** or **28(a)(iii)**,

arising out of or as a consequence of:

(v) the unlawful, negligent or wilfully wrongful, act or omission of the Recipient, its subcontractors or Personnel in the conduct of the Activity;

(vi) the Warranted Materials (including the use of the Warranted Materials by DFAT or its Personnel) infringing or allegedly infringing the Intellectual Property Rights of any person;

(vii) a breach of **Clause 23** (Confidentiality) or **Clause 24** (Protection of Personal Information); or

(viii) without limiting the preceding paragraphs, any breach of this Agreement by the Recipient, its Personnel or subcontractors.

(b) The Recipient's liability to indemnify those indemnified under **Clause 28** (a) will be reduced proportionally to the extent that any negligent act or omission of those indemnified contributed to the loss.

29. Insurance

29.1 Obligation to maintain insurance

(a) In connection with the Activity, the Recipient must have and maintain for the Agreement Period, valid and enforceable appropriate insurance policies relevant to the performance of the Activity including where appropriate, the amount of any professional indemnity insurance specified in Item 15 of **Schedule 1**.

(b) If it is specified in Item 15 of **Schedule 1** that the Recipient is required to have and maintain professional indemnity insurance, the Recipient must continue to maintain such insurance for a period of seven years following the expiry or termination of the Agreement.

29.2 Confirmation of insurance

The Recipient must, on request by DFAT, provide current relevant confirmation of insurance documentation for example, a certificate of currency from its insurers or insurance brokers certifying that it has insurance as required by **Clause 29.1**.

30. Conflict of interest

30.1 Warranty

The Recipient warrants that, to the best of its knowledge after making diligent inquiry, at the date of signing this Agreement, no conflict of interest exists or is likely to arise in the performance of its obligations under this Agreement.

30.2 Notification of a conflict of interest

If, during the Activity a conflict of interest arises, or appears likely to arise, the Recipient must:

(a) notify DFAT immediately in writing;

(b) make full disclosure of all relevant information relating to the conflict; and

(c) take such steps as DFAT requires to resolve or otherwise deal with the conflict.

31. Fraud and anti-corruption

31.1 Bribery of Foreign Officials and Facilitation Payment

For the purposes of this **Clause 31**, the definition of 'Fraud' includes:

(a) **bribery of foreign officials** which includes providing or offering a benefit to a foreign public official, or causing a benefit to be provided or offered to a foreign public official, where the benefit is not legitimately due. The benefit must be intended to influence a foreign public official in the exercise of their official duties for the purpose of obtaining or retaining business or a business advantage or other benefit which is not legitimately due; and

(b) **facilitation payment** which means making or receiving any payments outside the terms of agreements, contracts or established procedures paid in order to expedite or secure the performance of a routine action which is legitimately required without payment.

31.2 Warranty

(a) The Recipient warrants that, to the best of its knowledge, at the date of signing this Agreement it has disclosed all current allegations or investigations in relation to Fraudulent Activity to DFAT.

(b) The Recipient warrants that it did not make or cause to be made, receive or seek to receive, any offer, gift or payment, consideration or benefit of any kind, which would or could be construed as an illegal or corrupt act, either directly or indirectly to any party, as an inducement or reward in relation to the execution of this Agreement.

(c) The Recipient must not bribe public officials, including foreign officials, and must ensure that all Recipient Personnel do not bribe public officials including foreign officials.

31.3 Prevention of Fraud and anti-corruption

(a) The Recipient must not, and must ensure that its subcontractors and Personnel do not, engage in any Fraudulent Activity.

(b) The Recipient is responsible for preventing and detecting Fraud.

(c) Within one month following the Commencement Date, the Recipient must prepare a fraud risk assessment and zero tolerance fraud control strategy for the Activity. The risk assessment and strategy must contain appropriate fraud prevention, detection, investigation and reporting processes and procedures that comply with the Commonwealth Fraud Control Framework (http://www.ag.gov.au). The Recipient's strategies must include:

(i) preparation and implementation of a Fraud control strategy, policy and relevant procedures applicable to the Recipient, its subcontractors and Personnel;

(ii) development of guidance on anti-corruption and bribery and delivery of materials and training to the Recipient's subcontractors and Personnel;

(iii) provision of mandatory fraud control awareness training to all of the Recipient's subcontractors and Personnel and implementation of procedures to track attendance; and

(iv) development and implementation of procedures to record and maintain books, accounts and records relating to the Activity that are required to be kept in accordance with **Clause 25** (Records, books and accounts).

31.4 Investigation of Fraud and anti-corruption

(a) The Recipient must report in writing within **five Business Days** to DFAT any suspicion or detection of Fraudulent Activity involving the Activity including any Fraudulent Activity involving or relating to the Recipient's subcontractors and Personnel.

(b) In the event of a Fraud and in consultation with DFAT, the Recipient must develop and implement a strategy to investigate the Fraud, based on the principles set out in the Australian Government Investigations Standards (http://www.ag.gov.au/RightsAndProtections/FOI/Pages/Freedomofinformationdisclosurelog/AustralianGovernmentInvestigationStandards2011andAustralianGovernmentInvestigationsStandards2003.aspx). The Recipient must undertake the investigation at the Recipient's cost.

(c) In addition to the investigation carried out by the Recipient under **sub-clause 31.4** (b) above, DFAT or its nominee may conduct its own investigation. If DFAT exercises its rights under this clause, the Recipient must provide all reasonable assistance that may be required at the Recipient's sole expense.

(d) Following the conclusion of an investigation (whether by the Recipient or by DFAT) if the investigation finds that:

(i) the Recipient, its subcontractors or Personnel have acted in a Fraudulent manner, the Recipient must:

(A) where money has been misappropriated, pay to DFAT the full value of the Funds that have been misappropriated or reinstate such amount to the use of the Activity;

(B) where an Asset has been misappropriated, either return the item to DFAT or for use in the Activity or if the Asset cannot be recovered or has been damaged so that it is no longer usable, replace the Asset with one of equal value at the time of original purchase and of at least equal quality to the Asset at the time of original purchase;

(C) refer the matter to the relevant Partner Country police or other authorities responsible for prosecution of Fraudulent Activity, unless an exemption has been sought and granted by the relevant DFAT delegate; and

(D) keep DFAT informed, in writing, on a monthly basis, of the progress of the investigation and recovery action; or

(ii) a Party other than the Recipient, its subcontractors or Personnel have acted in a Fraudulent manner, the Recipient must, at the Recipient's cost make every effort to recover any Funds or Assets acquired or distributed through Fraudulent Activity, including the following:

(A) take recovery action in accordance with recovery procedures, including civil litigation, available in the Partner Country;

(B) refer the matter to the relevant Partner Country police or other authorities responsible for prosecution of fraudulent activity, unless

an exemption has been sought and granted by the relevant DFAT delegate; and

(C) keep DFAT informed, in writing, on a monthly basis, of the progress of the recovery action.

(e) If the Recipient considers that after all reasonable action has been taken to recover the Funds or Assets and full recovery has not been achieved or recovery has only been achieved in part, the Recipient may seek approval from DFAT that no further recovery action be taken.

(f) The Recipient must provide to DFAT all information, records and documents required by DFAT to enable DFAT to make a decision on whether or not to approve non-recovery of losses arising from Fraudulent Activity or misappropriated Funds or Assets.

31.5 Subcontractor and Personnel requirements

The Recipient must ensure that any subcontract entered into for the purpose of this Agreement contains an equivalent clause granting the rights specified in this **Clause 31**.

31.6 Survival

This **Clause 31** survives termination or expiration of this Agreement in relation to:

(a) any Fraudulent Activity which was not detected by the Recipient before the date of termination or expiry of this Agreement;

(b) any Fraudulent Activity detected by the Recipient before the date of termination or expiry of this Agreement but which the Recipient had not begun to investigate under **sub-clause 31.4** above;

(c) any investigation commenced by the Recipient under clause 31.4, but not completed, before the date of termination or expiry of this Agreement;

(d) any investigation commenced by DFAT under **sub-clause 31.4** above, but not completed, before the date of termination or expiry of this Agreement; and

(e) any investigation completed by the Recipient under **sub-clause 31.4** above, or by DFAT under **sub-clause 31.4**, but where:

(i) Funds have been lost to Fraudulent Activity or misappropriated and the full value of misappropriated funds have not been paid to DFAT or the account of the Activity;

(ii) Assets or other DFAT-funded property has been lost to Fraudulent Activity or misappropriated but the property has not been returned to DFAT or the account of the Activity; or

(iii) Assets or other DFAT-funded property cannot be recovered or has been damaged so that it is no longer usable and has not been replaced by property of equal value at the time of original purchase and of at least equal quality to the property at the time of original purchase.

Dispute resolution and termination

32. Force Majeure Events

32.1 Occurrence of Force Majeure Event

A Party (**Affected Party**) is excused from performing its obligations under this Agreement to the extent it is prevented by circumstances which:

(a) are beyond its reasonable control (other than, in respect of the Recipient only, lack of funds for any reason or any strike, lockout or labour dispute) including acts of God, natural disasters, acts of war, riots and strikes outside the Affected Party's organisation; and

(b) could not have been prevented or overcome by the Affected Party (or, where the Affected Party is the Recipient) exercising a standard of care and diligence consistent with that of a prudent and competent person operating within the relevant industry ((a 'Force Majeure Event').

32.2 Notice of Force Majeure Event

When a Force Majeure Event arises or is reasonably perceived by the Affected Party as an imminent possibility, the Affected Party must give notice of those circumstances to the other Party as soon as possible, identifying the effect they will have on its performance. The Affected Party must make all reasonable efforts to minimise the effects of such circumstances on the performance of this Agreement.

32.3 Payment

DFAT is not obliged to pay the Recipient any grant funding for so long as a Force Majeure Event prevents the Recipient from performing its obligations under this Agreement.

32.4 Termination

If non-performance or diminished performance by the Recipient due to a Force Majeure Event continues for a period of more than **60 days**, DFAT may, at any time after the period, terminate this Agreement immediately by giving the Recipient written notice.

32.5 Consequences of termination

If this Agreement is terminated under **sub-clause 32.4** above:

(a) DFAT is liable only for:

(i) payments under **Clause 7** (Payment of Funds by DFAT) in accordance with this Agreement before the effective date of termination, but only to the extent that those monies have been spent, or legally committed for expenditure by the Recipient in accordance with this Agreement and are payable by the Recipient as a current liability, by the date the Recipient receives the notice of termination (written evidence of which will be required); and

(ii) where the Recipient has undertaken work on but not completed a Milestone by the date the Recipient receives the notice of termination, grant funding in accordance with this Agreement to the extent that those monies have been spent, or legally committed for expenditure by the Recipient in accordance with this Agreement and payable by the Recipient as a current liability, on that Milestone by the date the Recipient receives the notice of termination (written evidence of which will be required); and

(b) each Party will bear its own costs and neither Party will incur further liability to the other.

33. Dispute resolution

33.1 No arbitration or court proceedings

If a dispute arises in relation to this Agreement ('Dispute'), a Party must comply with this **Clause 33.3** before starting arbitration or court proceedings, except proceedings for urgent interlocutory relief. After a Party has sought or obtained any urgent interlocutory relief, that Party must follow this **Clause 33.3**.

33.2 Notification

A Party claiming a Dispute has arisen must give the other Party notice setting out details of the Dispute.

33.3 Parties to resolve Dispute

During the **60 days** after a notice is given under **sub-clause 33.2** (or longer period if the Parties agree in writing), each Party must use its reasonable efforts through a meeting of senior management representatives (or their nominees) to resolve the Dispute.

33.4 Breach of this clause

If a Party breaches **sub-clauses 33.1** to **33.3** above, the other Party does not have to comply with those clauses in relation to the Dispute.

33.5 Exception

For the purpose of this **Clause 33.3**, a Dispute does not include a dispute arising in relation to DFAT:

(a) suspending payment of grant funding under **Clause 7.2** (Suspension);

(b) reducing the amount of an instalment of grant funding under **Clause 7.3** (Reduction) ;

(c) requiring payment under **Clause 10** (Repayment); or

(d) terminating this Agreement or reducing the scope of the Activity under **Clause 33.4** (Termination).

34. Termination

34.1 Termination for convenience

(a) Without limiting any other rights or remedies DFAT may have arising out of or in connection with this Agreement, DFAT may, by notice, terminate this Agreement or reduce the scope of the Activity for any reason.

(b) On receipt of a notice of termination or reduction the Recipient must:

(i) take all available steps to minimise loss resulting from that termination or reduction and to protect Agreement Material; and

(ii) in the case of a reduction in scope, continue to undertake any part of the Activity not affected by the notice (unless the Recipient, acting reasonably, notifies DFAT that it is not commercially viable to do so).

(c) If this Agreement is terminated under this **sub-clause 34.1**, DFAT is liable only for:

(i) payments under **Clause 7** (Payment of funds by DFAT) in accordance with this Agreement before the effective date of termination, but only to the extent that those monies have been spent, or legally committed for expenditure by the Recipient in accordance with this Agreement and are payable by the Recipient as a current liability, by the date the Recipient receives the notice of termination (written evidence of which will be required);

(ii) where the Recipient has undertaken work on but not completed a Milestone by the date the Recipient receives the notice of termination, grant funding in accordance with this Agreement to the extent that those monies have been spent, or legally committed for expenditure by the Recipient in accordance with this Agreement and payable by the Recipient as a current liability, on that Milestone by the date the Recipient receives the notice of termination (written evidence of which will be required); and

(iii) subject to **sub-clause 34.1**(e), reasonable costs actually incurred by the Recipient and directly attributable to the termination.

(d) If the scope of the Activity is reduced, DFAT's liability to pay the grant funding under this Agreement abates in accordance with the reduction in the Activity.

(e) DFAT is not liable to pay compensation under **sub-clause 34.1**(c)(iii) that exceeds an amount equal to the Total Funds less any amounts paid or due, or becoming due, to the Recipient under this Agreement.

(f) The Recipient is not entitled to compensation for loss of prospective profits.

34.2 Termination for default

(a) Without limiting any other rights or remedies DFAT may have arising out of or in connection with this Agreement, DFAT may terminate this Agreement or reduce the scope of the Activity effective immediately by giving notice to the Recipient if:

(i) the Recipient breaches a material provision of this Agreement where that breach is not capable of remedy;

(ii) the Recipient breaches any provision of this Agreement and fails to remedy the breach within 14 days after receiving notice requiring it to do so;

(iii) in the opinion of DFAT, a conflict of interest exists which would prevent the Recipient from performing its obligations under this Agreement;

(iv) in DFAT's reasonable opinion, one or more of the circumstances described in **Clause 15**(g)(Performance Improvement Plan) apply;

(v) the Recipient:

(A) Abandons the Activity;

(B) notifies DFAT of an intention to Abandon the Activity; or

(C) states an intention to Abandon the Activity,

and does not, when requested by DFAT, demonstrate to DFAT's satisfaction within **14 days** that the Recipient will proceed with the Activity;

(vi) in DFAT's reasonable opinion, it is unlikely that the Recipient will be able to achieve a Milestone to DFAT's satisfaction;

(vii) DFAT is satisfied that any statement made in the Application is incorrect, incomplete, false or misleading in a way which would have affected the original decision to approve the provision of the grant funding under this Agreement;

(viii) the organisation is listed in the World Bank list or Similar List;

(ix) the organisation is listed on a Relevant List;

(x) a Related Agreement is terminated by DFAT for default by the Recipient;

(xi) there is a Change in Control of the Recipient; or

(xii) an Insolvency Event occurs in relation to the Recipient.

(b) Without limitation, for the purposes of **Clause 34.2**(a)(i), each of the following constitutes a breach of a material provision:

(i) breach of warranty under **Clause 4.2** (Warranties);

(ii) a failure to comply with **Clause 6.1** (What Funds can be used for);

(iii) a failure to comply with **Clause 16** (Compliance with Laws) including a failure to notify DFAT **under sub-clause 16** (g);

(iv) a failure to comply with **Clause 17** (Child protection);

(v) a failure to comply with **Clause 18** (Compliance with DFAT policies);

(vi) a failure to comply with **Clause 20** (Subcontractors);

(vii) a failure to comply with **Clause 21** (Intellectual Property Rights);

(viii) a failure to comply with **Clause 24** (Protection of Personal Information);

(ix) a failure to comply with **Clause 29** (Insurance);

(x) a failure to notify DFAT of a conflict of interest under **Clause 30** (Conflict of interest); and

(xi) a breach of warranty or a failure to comply with **Clause 31** (Fraud and anti-corruption).

(c) If the scope of the Activity is reduced under this **sub-clause 34.2**:

(i) DFAT's liability to pay the grant funding under this Agreement abates in accordance with the reduction in the Activity; and

(ii) the Recipient must continue to undertake any part of the Activity not affected by the notice (unless the Recipient, acting reasonably, notifies DFAT that it is not commercially viable to do so).

34.3 DFAT rights

Without limiting any of DFAT's other rights or remedies, on termination of this Agreement:

(a) subject to **sub-clauses 32.5** and **34.1**(c), DFAT is not obliged to pay to the Recipient any outstanding amount of grant funding under this Agreement; and

(b) DFAT is entitled to exercise any right to recover from the Recipient, including under **Clause 10** (Repayment) and **Clause 12** (Assets).

34.4 Termination does not affect accrued rights

Termination of this Agreement does not affect any accrued rights or remedies of a Party.

General obligations

35. Survival

The following clauses survive the expiry or termination of this Agreement:

(a) **Clause 6** (Use of Funds by Recipient);

(b) **Clause 9** (GST);

(c) **Clause 10** (Repayment);

(d) **Clause 12** (Assets);

(e) **Clause 13.4** (Repayment of administered grant funds);

(f) **Clause 14.2** (Reporting);

(g) **Clause 14.3** (Evaluation);

(h) **Clause 19** (Acknowledgment and publicity);

(i) **Clause 21** (Intellectual Property Rights);

(j) **Clause 22** (Moral Rights);

(k) **Clause 23** (Confidentiality);

(l) **Clause 24** (Protection of Personal Information);

(m) **Clause 25** (Records, books and accounts);

(n) **Clause 26** (Audit and access);

(o) **Clause 28** (Indemnity);

(p) **Clause 29** (Insurance);

(q) **Clause 31** (Fraud and anti-corruption);

(r) **Clause 34.3** (DFAT rights); and

(s) **Clause 37.2** (Amounts due to DFAT),

together with any provision of this Agreement which expressly or by implication from its nature is intended to survive the expiry or termination of this Agreement.

36. Notices and other communications

36.1 Service of Notices

A Notice must be:

(a) in writing, in English and signed by a person duly authorised by the sending Party; and

(b) hand delivered or sent by prepaid post, facsimile or email to the recipient's address for Notices specified in Item 16 of **Schedule 1**, as varied by any Notice given by the recipient to the sender.

36.2 Effective on receipt

A Notice given in accordance with **Clause 36.1** delivered by hand, prepaid post or facsimile takes effect when it is taken to be received (or at a later time specified in it), and is taken to be received:

(a) if hand delivered, on delivery;

(b) if sent by prepaid post, on the third Business Day after the date of posting (or on the seventh Business Day after the date of posting if posted to or from a place outside Australia); or

(c) if sent by facsimile, when the sender's facsimile system generates a message confirming successful transmission of the entire Notice unless, within one Business Day after the transmission, the recipient informs the sender that it has not received the entire Notice,

but if the delivery, receipt or transmission is not on a Business Day or is after **5.00pm** (AEST) on a Business Day in the place where the Notice is taken to be received, the Notice is taken to be received at **9.00am** (AEST) on the next Business Day in the place where the Notice is taken to be received.

36.3 Notices by email

(a) A Notice relating to a matter under **Clause 32.4** (Termination) or **Clause 33.3** (Dispute Resolution) must not be sent by email.

(b) Subject to **sub-clause 36.3**(c) below, a Notice given in accordance with **sub-clause 36.1** above delivered by email is taken to be received on the first to occur of:

(i) receipt by the sender of an email acknowledgement from the recipient's information system showing that the notice has been delivered to the email address specified in the recipient's address for Notices specified in Item 16 of **Schedule 1** as varied by any Notice given by the recipient to the sender;

(ii) the time that the notice enters an information system which is under the control of the recipient; and

(iii) the time that the notice is first opened or read by the intended addressee.

(c) If the sender receives an out of office reply that states the recipient is out of the office until a later date, the Notice will only be taken to be given on that later date. If the result is that a Notice would be taken to be given or made on a day that is not a Business Day in the place to which the Notice is sent or is after **5.00pm** (AEST) on a Business Day in the place where the Notice is sent, it will be taken to have been duly given or made at the start of business on the next Business Day in that place.

37. Miscellaneous

37.1 No security

The Recipient must not without the prior written consent of DFAT use any of the following as any form of security for the purpose of obtaining or complying with any

form of loan, credit, payment or other interest, or for the preparation of, or in the course of any litigation:

(a) the Funds;

(b) this Agreement or any of DFAT's obligations under this Agreement; or

(c) any Assets or Intellectual Property Rights in Agreement Material.

37.2 Amounts due to DFAT

(a) Without limiting any other of DFAT's rights or remedies, any amount owed or payable to DFAT (including by way of refund), or which DFAT is entitled to recover from the Recipient, under this Agreement will be recoverable by DFAT as a debt due and payable to DFAT by the Recipient.

(b) DFAT may set-off any money due for payment by DFAT to the Recipient under this Agreement against any money due for payment by the Recipient to DFAT under this Agreement or a Related Agreement.

37.3 Notice of certain events

The Recipient must notify DFAT immediately if an Insolvency Event or a Change in Control occurs in relation to the Recipient.

37.4 Variation

No agreement or understanding varying or extending this Agreement is legally binding upon either Party unless the agreement or understanding is in writing in the form of a deed of amendment and signed by both Parties.

37.5 Approvals and consents

Except where this Agreement expressly states otherwise, a Party may, in its discretion, give conditionally or unconditionally or withhold any acceptance, approval or consent under this Agreement.

37.6 Assignment and novation

The Recipient may only assign its rights or novate its rights and obligations under this Agreement with the prior written consent of DFAT.

37.7 Costs

Each Party must pay its own costs of negotiating, preparing and executing this Agreement.

37.8 Counterparts

This Agreement may be executed in counterparts. All executed counterparts constitute one document.

37.9 No merger

The rights and obligations of the Parties under this Agreement do not merge on completion of any transaction contemplated by this Agreement.

37.10 Entire agreement

This Agreement constitutes the entire agreement between the Parties in connection with its subject matter and supersedes all previous agreements or understandings between the Parties in connection with its subject matter.

37.11 Further action

The Recipient must do, at its own expense, everything reasonably necessary (including executing documents) to give full effect to this Agreement and any transaction contemplated by it.

37.12 Severability

A term or part of a term of this Agreement that is illegal or unenforceable may be severed from this Agreement and the remaining terms or parts of the terms of this Agreement continue in force.

37.13 Waiver

Waiver of any provision of or right under this Agreement:

(a) must be in writing signed by the Party entitled to the benefit of that provision or right; and

(b) is effective only to the extent set out in any written waiver.

37.14 Relationship

(a) The Parties must not represent themselves, and must ensure that their officers, employees, agents and subcontractors do not represent themselves, as being an officer, employee, partner or agent of the other Party, or as otherwise able to bind or represent the other Party.

(b) This Agreement does not create a relationship of employment, agency or partnership between the Parties.

37.15 Governing law and jurisdiction

This Agreement is governed by the law of the Australian Capital Territory and each Party irrevocably and unconditionally submits to the non-exclusive jurisdiction of the courts of the Australian Capital Territory.

37.16 False or misleading information

The Recipient acknowledges that giving false or misleading information is a serious offence.

37.17 No reliance

The Recipient:

(a) acknowledges that DFAT is not liable for any advice, comments, consultation, assistance, information or material made available by DFAT before the Commencement Date in connection with the Recipient applying for grant funding **(Information)**;

(b) acknowledges that the Information may not be accurate or complete and that the Recipient is responsible for making its own enquiries;

(c) warrants that it has not, in deciding whether or not to enter into this Agreement, relied on any Information or representation (whether oral or in writing), other than as expressly set out in this Agreement, or any other conduct of DFAT or any of its Personnel; and

(d) waives any right to make any claims in relation to any loss or damage suffered or incurred, whether directly or indirectly, arising out of or in connection with any use of or reliance on the Information.

37.18 No further grant funding

The Recipient acknowledges that the provision of grant funding under this Agreement for the Activity does not entitle the Recipient to any other or further grants.

Schedule 1 – Agreement details

Item number	Description	Clause reference	Details
1.	**DFAT**	**1.1**	Commonwealth of Australia as represented by the Department of Foreign Affairs and Trade ABN 47 065 634 525 Department of Foreign Affairs and Trade – Australian Aid Program GPO Box 887 CANBERRA ACT 2601 AUSTRALIA
2.	**Recipient**	**1.1**	International Planned Parenthood Federation of 4 Newhams Row, SE1 3UZ United Kingdom
3.	**DFAT Representative**	**1.1 and 14.1**	1. Director, Health Program and Performance, Health and Environmental Safeguards Branch 2. Assistant Director, Health Program and Performance, Health and Environmental Safeguards Branch 3. Health Program Officer, Health Program and Performance, Health and Environmental Safeguards Branch.
4.	**Recipient Representative**	**1.1 and 14.1**	1. Senior Advisor, Resource Mobilization
5.	**Commencement Date**	**1.1 and 3**	The date this Agreement is signed by the last Party.
6.	**Activity Start Date**	**1.1 and 3**	22 May 2015
7.	**Activity End Date**	**1.1 and 3**	31 December 2016
8.	**GST registration status**	**9.5(b)**	The Recipient is not registered for GST
9.	**Administered Grant Scheme**	**13**	Not applicable
10.	**Ownership of Intellectual Property Rights**	**21.2**	**Clause 21.4** (DFAT ownership of Intellectual Property Rights in Agreement Material) is to apply.
11.	**Recipient ownership of Intellectual Property in Agreement Material**	**21.3**	Not applicable
12.	**DFAT ownership of Intellectual Property Rights in Agreement Material**	**21.4**	*In addition to the licences granted in **Clause** 21.4(b)(i) and (ii), DFAT grants the Recipient a revocable, world-wide, royalty-free, non-exclusive licence to use, reproduce, adapt and*

Item number	Description	Clause reference	Details
			otherwise exploit the Agreement Material for development assistance purposes (teaching and research) only and not for commercial profit. *The following must appear in all material which reproduces the Agreement Material: DFAT does not guarantee the accuracy, reliability, currency, completeness of any information contained in the material. Furthermore, DFAT accepts no liability whatsoever arising from any use of the material. Users should exercise their own skill and care with respect to their use of the material.* *For advice on any amended wording please contact Procurement and Commercial Law Section.*
13.	**DFAT Material**	1.1	Nil
14.	**Moral Rights – Specified Acts**	22	Nil
15.	**Insurance**	29	NA
16.	**Address for Notices**	366	**DFAT:** Health Program Officer, Health Program and Performance Officer, Health and Environmental Safeguards Branch **Postal address:** Department of Foreign Affairs and Trade – Australian Aid Program R.G. Casey Building John McEwen Crescent Barton ACT 0221 AUSTRALIA **Physical address:** 255 London Circuit CANBERRA ACT 2601 AUSTRALIA **Email:** @dfat.gov.au **Recipient:** Senior Advisor, Resource Mobilization, **Postal address:** 4 Newhams Row, London SE1 3UZ United Kingdom **Physical address:** 4 Newhams Row, London SE1 3UZ United

Item number	Description	Clause reference	Details
			Kingdom **Email:** @ippf.org
17.	**Special Conditions**	**1.1 and 2**	Program Implementation a.) DFAT funding to the Recipient may only be used to support the implementation of the IPPF Strategic Framework 2005-2015 and a successive Strategic Framework 2016-2022. b.) DFAT funding to the Recipient is to support implementation of IPPF activities, with a primary focus on activities in Asia and the Pacific. c.) Prior to receiving funding, the Recipient must write to DFAT (via email) to clearly articulate how DFAT core funding will support Asia and the Pacific. d.) The Recipient and its personnel, including Member Associations, must comply with the instruction that the Grant may not be used to advocate with legislators for changes in national abortion laws The Recipient and its Personnel must comply with current DFAT Family Planning Guiding Principles, as listed at http://dfat.gov.au/about-us/publications/Pages/family-planning-and-the-aid-program-guiding-principles.aspx Monitoring and Evaluation e.) The Recipient must participate in regular monitoring and review meetings with DFAT, including an Annual Meeting, at such time and location as mutually agreed with DFAT. The Annual Meeting shall be held to discuss the Recipient's Work Plan and priorities, areas for collaboration and review of the Recipient's results. f.) The Recipient will continue to review each Member Association's adherence to 65 essential standards and responsibilities of membership under the newly revised accreditation process. Reporting g.) The Recipient must submit an Annual

Item number	Description	Clause reference	Details
			Performance Report to DFAT no later than 30 June 2016. This report must include a list of results achieved through DFAT funding in both Asia and the Pacific during the agreement period. h.) The Annual Performance Report must include statistics on the following indicators: • Number of sexual and reproductive health services provided • Estimated number of distinct clients assisted • Estimated number of unintended pregnancies averted • Estimated number of unsafe abortions averted (contraception plus safe abortion) • Estimated percentage and dollar-figure amount of IPPF funds used for safe abortion services i.) The Recipient must also submit a Regional Performance Report by 15 April 2016. j.) The Recipient must also submit an Asia Pacific Final Acquittal Report to DFAT, no later than 30 May 2016. The Final Acquittal Report shall be based on the statement of accounts and cover revenue and expenditure for the entire operation including all sources of financing. k.) The Recipient must ensure that all reports submitted meet the DFAT monitoring and evaluation standards. <u>Financial Accounting</u> l.) The Recipient must provide DFAT with an update on progress it has made in implementing recommendations of the ESEAOR due diligence report by the 30th of September 2015. <u>Counter Terrorism</u> m.) The Recipient must include counter terrorism measures in its next policy review, beginning in November 2015.

Schedule 2 – Activity Proposal

1. Activity description (clause 1.1)

See the attached IPPF Frameworks (2005-2015 and 2016-2022)

2. Outcomes (clauses 1.1 and 4.1(a)(i))

See the attached IPPF Frameworks (2005-2015 and 2016-2022)

3. Milestones (clauses 1.1 and 4.1(a)(v))

	Milestone	Completion date
1.	**Description** **Reports to be provided by the Recipient as part of this Milestone** Annual Performance Report	30 June 2016
2.	**Description** **Reports to be provided by the Recipient as part of this Milestone** Final Acquittal Report	30 May 2016
3.	**Description** **Reports to be provided by the Recipient as part of this Milestone** Regional Performance Report	15 April 2016

4. Budget (clauses 1.1 and 6.1)

Item	Description	Price (ex GST)	
1	2015 core payment	$5 million AUD	

5. Assets (clauses 1.1 and 12)

5.1 Assets to be acquired with the Funds

None Specified

5.2 Asset Threshold

AUD$2,000 (inclusive of GST) (or equivalent)

5.3 Ownership of Assets

Default position to apply.

5.4 Asset Register

The Recipient must maintain the Asset Register which must record:

(a) non-consumable items of a portable nature with a value below the Asset Threshold;

(b) all Assets with a value at or above the Asset Threshold;

(c) Asset description;

(d) purchase price or total lease cost;

(e) date of purchase or lease and date of payment;

(f) reason for acquisition;

(g) type and term of lease (if applicable);

(h) date of receipt of the Asset at the Activity site;

(i) identification number for the Asset;

(j) location of Asset;

(k) disposal date;

(l) disposal method; and

(m) reason for disposal.

6. Personnel positions

Personnel	Role	Directly working with / contact with children
	Youth Access Gender and Rights Officer, Central Office London	Yes
	Youth & Adolescent Advisor, Regional Offices - Arab Regional Office	Yes
	Youth & Adolescent Advisor - South Asia Regional Office	Yes
	Associate Director, Youth, HIV & GBV Programs – Western Hemisphere Region	Yes
	Associate Director, Youth, HIV & GBV Programs – Western Hemisphere Region	Yes

Schedule 3 – Funds

1. Total Funds (clause 1.1)

Subject to this Agreement, the maximum amount of grant funding payable by DFAT under this Agreement is $5 million (excluding GST). No other amount of grant funding is payable by DFAT.

2. Interest rate (clause 10.4)

The general interest charge rate as defined in section 8AAD of the *Taxation Administration Act 1953* (Cth).

3. Payment (clauses 1.1, 7 and 8)

Subject to this Agreement, DFAT will pay the grant funding to the Recipient in instalments as set out in the table below.

No.	Payment Criteria	Payment Claim Due Date	Instalment (GST exclusive)
1.	• Upon signing, and subject to DFAT receiving a valid invoice, and written documentation as noted in Schedule 1, Item 17 - 1.1 - c above.	*30 May 2015*	$5 million
		Total	$5 million

4. Invoicing requirements (clause 8)

(a) To be a correctly rendered invoice the invoice must include:

(i) the agreement number and Activity title;

(ii) the payment event number(s) notified by DFAT;

(iii) the amount of grant funding to be paid by DFAT together with any substantiating material required;

(iv) the name of the DFAT Representative;

(v) be accompanied by any supporting documentation and other evidence specified in item 3 of Schedule 3 for that instalment; and

(vi) such other information as DFAT requires.

(b) Where Australian GST applies to this Agreement all invoices must be in the form of a valid tax invoice. Invalid tax invoices will be returned to the Recipient. Information on what constitutes a valid tax invoice can be found at: http://www.ato.gov.au/businesses/content.asp?doc=/content/50913.htm

(c) Invoices must be submitted to:

Chief Finance Officer
Department of Foreign Affairs and Trade
R.G. Casey Building
John McEwen Crescent
Barton ACT 0221 AUSTRALIA

or

accountsprocessing@dfat.gov.au and a copy sent to the DFAT Representative.

Schedule 4 – Reporting

1. Milestone reports

(a) The Recipient must provide a Milestone report as required by the item 3 of Schedule 2.

(b) Each Milestone report must include:

(i) the name of the Recipient and all subcontractors;

(ii) a contact name, telephone number and email address;

(iii) the Activity title and number;

(iv) the Milestone and period to which the report relates;

(v) a Budget update (including cost to completion);

(vi) a statement of the Funds provided or spent ;

(vii) the amount remaining in the account referred to in clause 6.3;

(viii) a technical report of the Milestone activities, including:

(A) a description and analysis of the technical progress of the Activity;

(B) evidence that the activities within the Milestone have been achieved;

(C) any major issues or risks which have arisen in the course of achieving the Milestone and the effect they will have on the Activity and what will be done to address any ongoing issues or risks; and

(D) any proposed changes to the Activity; and

(ix) copies of any published reports, promotional material, media publicity, pamphlets or other documentation relevant to the Activity.

2. Annual reports

(a) The Recipient must provide an annual progress report as required by item 3 of Schedule 2 and if not specified at item 3 of Schedule 2, within [60 days] of each anniversary of the Commencement Date.

(b) Each annual progress report must include:

(i) the name of the Recipient and all subcontractors;

(ii) the Activity title and number;

(iii) the period to which the report relates;

(iv) a Budget update (including cost to completion);

(v) a statement of the Funds provided or spent;

(vi) the amount remaining in the account referred to in clause 6.3;

(vii) the reconciliation of Assets required under clause 12.2(c) and a copy of the Assets Register; and

(viii) a description and analysis of the progress of the Activity, including:

(A) whether the Activity is proceeding in accordance with the Budget and, if it is not, an explanation of why the Budget is not being met, the effect this will have on the Activity and the action the Recipient proposes to take to address this;

(B) progress on achieving the Outcomes;

(C) any major issues or developments which have arisen and the effect they will have on the Activity; and

(D) any proposed changes to the Activity.

(c) If the Recipient administers an Administered Grant Scheme, the annual report must include a summary of all new Administered Grant Arrangements the Recipient will enter into, or has entered into, in relation to the upcoming calendar year, including details of:

(i) the identity of the Administered Grant Recipient;

(ii) the value of the Administered Grant Arrangement;

(iii) the subject matter of the Administered Grant Arrangement; and

(iv) the expected completion date for the Administered Grant Arrangement.

3. Acquittal reports

(a) The Recipient must provide acquittal reports:

(i) as required by item 3 of Schedule 2; and

(ii) by 30 May 2016.

(b) Each acquittal report must include the following:

	Content	Prepared by
(i)	audited financial statements in accordance with the Applicable Auditing Procedures in respect of the Funds (separately and in the context of the Recipient's overall financial position), which must include a definitive statement as to whether the financial information for the Activity represents the financial transactions fairly and is based on proper accounts and records.	an Independent Auditor
(ii)	where there are any qualifications or limitations on the audit, a letter to the Recipient, or a report providing an outline of the reasons for the qualifications or limitations and the remedial action recommended.	an Independent Auditor
(iii)	a certificate: (A) that all Funds were spent for the purpose of the Activity and in accordance with this Agreement and that the Recipient has complied with this Agreement; and (B) the amount remaining in the account referred to in clause 6.3.	the CEO or CFO of the Recipient

4. Final report

(a) Unless stated otherwise in item 3 of Schedule 2, the Recipient must within 60 days of the completion of the Activity provide a report which includes:

(i) the name of the Recipient and all subcontractors;

(ii) the Activity title and number;

(iii) a statement of the Funds provided and spent;

(iv) the amount (if any) remaining in the account referred to in clause 6.3;

(v) a description and analysis of the progress of the Activity, including:

(A) evidence that the Activity has been completed, and the Milestones have been achieved;

(B) details of the extent to which the Activity achieved the Outcomes;

(C) any highlights, breakthroughs or difficulties encountered; and

(D) conclusions or recommendations (if any) arising from the Activity;

(vi) copies of any published reports, promotional material, media publicity, pamphlets or other documentation relevant to the Activity; and

(vii) reconciliation of Assets and a copy of the Asset Register.

5. Ad hoc reports

The Recipient must provide ad-hoc reports as requested by DFAT from time to time at the time and in the manner reasonably required by DFAT in relation to any significant developments concerning the Activity or any significant delays or difficulties encountered in undertaking the Activity.

Schedule 5 – Statement of International Development Practice Principles

This Statement of International Development Practice Principles (**The Principles**) promotes the active commitment of all non-accredited, not-for-profit organisations funded by DFAT to the fundamentals of good development practice, and to conducting their activities with integrity, transparency and accountability.

The Principles are founded on a premise of 'do no harm' and drawn from good practice principles in the international development not-for-profit sector and international development community more broadly. In line with Aid Effectiveness principles, when planning interventions, not-for-profit organisations are encouraged to consider: what other agencies are doing in the chosen area of focus; where their organisation can add value; and how they can join with others to increase the impact and sustainability of their activities.

Where relevant, DFAT encourages eligible Australian organisations to work towards becoming Australian Council for International Development (ACFID) Code of Conduct signatories.

International Development Principles

Lessons drawn from best practice NGO and civil society programs recognise the importance of working in partnerships, building creative and trusting relationships with people of developing countries and supporting basic program standards which:

- give priority to the needs and interests of the people they serve and involve beneficiary groups to the maximum extent possible in the design, implementation and evaluation;
- promote an approach that includes all people in a community and ensures the most vulnerable, including people with disability, women and children, are able to access, and benefit equally, from, international development assistance;
- encourage self help and self-reliance among beneficiaries;
- avoid creating dependency through the facilitation of active participation and contributions (as appropriate) by the most vulnerable;
- respect and foster all universally agreed international human rights, including social, economic, cultural, civil and political rights;
- are culturally appropriate and accessible;
- seek to enhance gender equality;
- recognise and put in place processes to mitigate against the vulnerability of not for profit organisations to potential exploitation by organised crime and terrorist organisations;
- have appropriate mechanisms in place to actively prevent, and protect children from harm and abuse;
- integrate environmental considerations and mitigate against adverse environmental impacts; and
- promote collaborative approaches to development challenges including through working in partnerships and avoiding duplication of effort.

All non-accredited, not for profit organisations receiving grant funding from DFAT commit to apply these principles of good development practice, and adhere to the organisational integrity and accountability standards set out on the following page.

Organisational Integrity and Accountability for Development

DFAT grant funds and resources are designated for the purposes of international aid and development (including development awareness). They can not be used to promote a particular religious adherence, missionary activity or evangelism, or to support partisan political objectives, or an individual candidate or organisation affiliated to a particular political movement. DFAT reserves the right to undertake an independent audit of an organisation's accounts, records and assets related to a funded activity, at all reasonable times.

In all of its activities and particularly in its communications to the public, DFAT expects not-for-profit organisations it works with to accord due respect to the dignity, values, history, religion, and culture of the people it supports and serves, consistent with principles of basic human rights.

Not-for-profit organisations working with DFAT should:

- not be a willing party to wrongdoing, corruption, bribery, or other financial impropriety in any way in any of its activities;
- take prompt and firm corrective action whenever and wherever wrongdoing is found among its Governing Body, paid staff, contractors, volunteers and partner organisations;
- have internal control procedures which minimise the risk of misuse of grant funds and processes and systems that ensure grant funds are used effectively to maximise development results;
- establish reporting mechanisms that facilitate accountability to members, donors and the public;
- have adequate procedures for the review and monitoring of income and expenditure and for assessing and reporting on the effectiveness of their aid;
- have a policy to enable staff confidentially to bring to the attention of the Governing Body evidence of misconduct on the part of anyone associated with the Recipient, including misconduct related to the harm and abuse of children;
- be aware of terrorism-related issues and use their best endeavours to ensure that grant funds do not provide direct or indirect support or resources to organisations and individuals associated with terrorism and/or organised crime; and
- ensure that individuals or organisations involved in implementing activities on behalf of the Recipient are in no way linked, directly or indirectly, to organisations and individuals associated with terrorism and/or organised crime.

DFAT Grant Agreement Requirements

Each DFAT grant agreement also comes with obligations for both DFAT and the Recipient being funded. These are spelt out in detail in the grant agreement. The Principles will not affect or diminish the obligations or liabilities of the Recipient under the grant agreement as outlined in the grant agreement conditions.

Broadly speaking, any Recipient funded by the Australian Government, through DFAT, is required to comply with relevant and applicable laws, regulations and policies, including those in Australia and in the country/ countries in which they are operating. In particular, the Recipient needs to observe the contractual requirements regarding Child Protection and Counter Terrorism.

Additional Information and Related Links

Further information on DFAT's Child Protection Policy, Counter Terrorism and other applicable laws and policies can be found on DFAT's website at:

http://aid.dfat.gov.au

Further information on terrorist organisations listed under Division 102 of the Criminal Code Act 1995 (Cth) and the DFAT Consolidated List of persons and entities subject to UN sanctions regimes maintained in accordance with the Charter of the United Nations Act 1945 (Cth) can be found at:

http://www.dfat.gov.au/icat/UNSC_financial_sanctions.html#3
http://www.nationalsecurity.gov.au/agd/www/nationalsecurity.nsf/AllDocs/95FB057CA3DECF30CA256FAB001F7FBD?OpenDocument

Further information on DFAT Accreditation and the ACFID Code of Conduct can also be found at:

http://aid.dfat.gov.au
http://www.acfid.asn.au/code-of-conduct

Further information on Aid Effectiveness can be found at:

http://www.oecd.org/department/0,3355,en_2649_3236398_1_1_1_1_1,00.html
http://www.oecd.org/document/18/0,3343,en_2649_3236398_35401554_1_1_1_1,00.html

Signing page

EXECUTED as a deed.

Signed, sealed and delivered for and on behalf of the **Commonwealth of Australia represented by the Department of Foreign Affairs and Trade** by its duly authorised delegate in the presence of

Signature ~~of witness~~

Name of witness (print)

Date 19.5.15

Signature of delegate

Blair Exell

Name of delegate (print)

PAS DPD

Position of delegate and section (print)

The common seal of *International Planned Parenthood Federation* is fixed to this document in accordance with its constitution in the presence of

Signature of ~~director~~

TEWODROS MELESSE

Name of director (print)

22 MAY 2015.

Date

Signature of director/~~company secretary~~
(Please delete as applicable)

Name of director/company secretary (print)

ADOLESCENTS HIV/AIDS ABORTIO
ADVOCACY ADOLESCENTS HIV/AI
ACCESS ADVOCACY ADOLESCENT
ABORTION ACCESS ADVOCACY AD
HIV/AIDS ABORTION ACCESS ADV
ADOLESCENTS HIV/AIDS ABORTIO
ADVOCACY ADOLESCENTS HIV/AI
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ABORTION ACCESS ADVOCACY AD
HIV/AIDS ABORTION ACCESS ADV

IPPF'S STRATEGIC FRAMEWORK 2005-2015

A FRAMEWORK OF OPPORTUNITY

International Planned Parenthood Federation

Published in 2004 by
IPPF, Regent's College,
Inner Circle, Regent's Park,
London NW1 4NS
United Kingdom
www.ippf.org

Designed by Spencer du Bois

IPPF is incorporated by UK Act of Parliament and is a UK Registered Charity No 229476

Our Vision
IPPF envisages a world in which every woman, man and young person has access to the information and services they need; in which sexuality is recognized both as a natural and precious aspect of life and as a fundamental human right; a world in which choices are fully respected and where stigma and discrimination have no place.

Our Mission
- IPPF aims to improve the quality of life of individuals by campaigning for sexual and reproductive health and rights through advocacy and services, especially for poor and vulnerable people.
- We defend the right of all young people to enjoy their sexual lives free from ill-health, unwanted pregnancy, violence and discrimination.
- We support a woman's right to choose to terminate her pregnancy legally and safely.
- We strive to eliminate STIs and reduce the spread and impact of HIV/AIDS.

Our core values
- IPPF believes that sexual and reproductive rights should be guaranteed for everyone because they are internationally recognized basic human rights.
- We are committed to gender equality, and to eliminating the discrimination which threatens individual well-being and leads to the widespread violation of health and human rights, particularly those of young women.
- We value diversity and especially emphasize the participation of young people and people living with HIV/AIDS in our governance and in our programmes.
- We consider the spirit of volunteerism to be central to achieving our mandate and advancing our cause.
- We are committed to working in partnership with communities, governments, other organizations and donors.

What is IPPF?
The International Planned Parenthood Federation (IPPF) is a global network of Member Associations in 148 countries and the world's foremost voluntary, non-governmental provider and advocate of sexual and reproductive health and rights.

INTRODUCTION

As IPPF seeks renewed energy and focus to bring about positive and lasting change in people's lives, we are pleased to present to you the ten-year *IPPF Strategic Framework, 2005-2015*. The product of a Federation-wide consensus, this framework brings together the ideas and experience of IPPF Member Associations, senior volunteers, Regional Offices and Central Office, and has been approved by the Governing Council. By combining an understanding of our past with a vision for our future, this new plan presents a "framework of opportunity" that Member Associations can interpret to develop the most appropriate response to specific sexual and reproductive health challenges. The *Strategic Framework* is not intended to impose a rigid set of rules or constraints. Rather, it embraces the diversity of situations Member Associations and regions face. While providing this flexibility, the framework unites the Federation in a common vision on which we are compelled to act if we are to meet the needs of women, men and young people throughout the world.

The *Strategic Framework* has been forged through a process of evaluation – evaluation of the progress made on our previous strategy (Vision 2000) and the analysis of the changing environment and needs in which we operate. The result is a focus on the "unfinished business" of sexual and reproductive health. While IPPF recognizes that the vision and commitments of the International Conference on Population and Development (ICPD) represent a true international consensus, these goals are far from being achieved and require renewed financial and political support if they are to be realized. Similarly, the challenge to significantly reduce poverty, as called for by the UN Millennium Development Goals (MDGs), can only be met through good sexual and reproductive health – notably through universal access to sexual and reproductive health information and services by 2015.

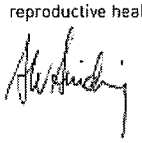
In addressing these outstanding concerns, the *Strategic Framework* emphasizes five strategic priorities on which we will focus:

- Adolescents/Young People
- HIV/AIDS
- Abortion
- Access
- Advocacy

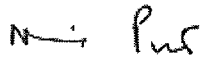
By creating capacity at the ground level to achieve the objectives laid out in the following pages, we can turn our vision into a reality. In doing so, Member Associations will not stand alone and can be assured of the full support of the Secretariat in what is to be a coordinated move forward at every level of the Federation. This includes the development of four supporting strategies to reinforce the framework and its application at the grassroots level: 1) governance and accreditation 2) resource mobilization 3) capacity-building and 4) monitoring and evaluation.

A crucial element of this framework is the measurement of its implementation and impact. For this we have developed a series of Global Indicators for each of the five strategic priorities. Gathered across the Federation, these indicators will enable us to review, monitor and evaluate our performance against the key goals as a more effective way of reporting on our successes, measuring progress, and assessing the human impact of our work.

As ever, the spirit of volunteerism remains at the heart of our leadership and our mandate. The contributions of many dedicated individuals allows IPPF to continue to develop and promote innovative and effective programmes. The *Strategic Framework* enables us to combine our enormous diversity with a clear and, we believe, compelling singular vision of our work, enabling IPPF to remain at the forefront of the worldwide movement for sexual and reproductive health and rights for all.



Dr Steven Sinding
Director-General



Dr Nina Puri
President

ADOLESCENTS/YOUNG PEOPLE

Goal

All adolescents and young people are aware of their sexual and reproductive rights, are empowered to make informed choices and decisions regarding their sexual and reproductive health, and are able to act on them.

Objectives

1. To strengthen commitment to and support for the sexual and reproductive health and rights and needs of adolescents/young people.
2. To promote participation of adolescents/young people in governance and in the identification, development and management of programmes that affect them.
3. To increase access to comprehensive, youth-friendly, gender-sensitive sexuality education.
4. To increase access to a broad range of youth-friendly services.
5. To reduce gender-related barriers and practices which affect the sexual and reproductive health and rights of young women.

Programme Strategies

1. To strengthen commitment to and support for the sexual and reproductive health and rights, and needs of adolescents/young people.

a] Advocacy:

- for positive attitudes towards young people's sexuality, recognizing their specific rights, and sexual and reproductive health needs
- for a supportive and enabling environment for upholding the sexual and reproductive health and rights of young people
- for resources
- for increased provision of sexual and reproductive health information, education and services, for all young people
- for legal change/supportive legislation
- promote the Convention on the Rights of the Child

b] Empowerment and mobilization of young people to be advocates for the advancement of their own rights.

c] Work in partnership with youth organizations, civil society organizations, the private sector and governments.

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2. To promote participation of adolescents/young people in governance and in the identification, development and management of programmes that affect them.

a] Advocacy:

- promote IPPF as a youth-oriented organization
- promotion of young people's involvement in policy and decision-making in their communities
- promotion of young people's involvement in national and international arena/events

b] Sensitize adults to work with young people as equitable partners.

c] Ensure active participation of young people in governance, programme management and research at all levels of IPPF and beyond.

d] Review/establish governance structures at all levels to facilitate youth involvement.

e] Institutionalize youth participation and in different capacities (volunteers, staff).

f] Promote and support youth initiatives.

g] Initiate and promote leadership programmes for young people.

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3. To increase access to comprehensive, youth-friendly, gender-sensitive sexuality education.

a] Advocate for and provide education, which promotes a positive approach to young people's sexuality and promotes a non-prescriptive, evidence-based, rights-based approach.

b] Identify and implement programmes to reach young people with diverse needs and sexual orientations.

c] Piloting, evaluating and scaling up innovative approaches aimed at the provision of integrated sexual and reproductive health and rights information, sexuality education and life skills for young people.

d] Partnerships and dialogue with parents, teachers, local authorities, etc.

e) Participation of young people in the development and implementation of information and education provision.

f) Develop evidence-based, good practice guidelines on sexuality education.

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4. To increase access to a broad range of youth-friendly services.

a) Provision of comprehensive youth-friendly high quality services that meet the specific needs of men and women (including abortion-related services, EC, HIV/AIDS).

b) Piloting, evaluating and scaling up innovative approaches aimed at the provision of integrated sexual and reproductive health services that meet the diverse needs and sexual orientations of young people.

c) Establishment of effective referral systems/partnerships for young people.

d) Youth participation in the development, implementation and monitoring and evaluation of services.

e) Capacity-building/sensitizing/motivation for service providers to ensure staff commitment.

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5. To reduce gender-related barriers and practices which affect the sexual and reproductive health and rights of young women.

a) Advocate for and mobilize civil society to challenge gender-related barriers and practices that restrict young women's sexual and reproductive health and rights.

b) Create opportunities which will empower young women, enhance their decision-making skills and enable them to participate in mainstream development debates.

c) Engage boys and men in addressing gender equality.

HIV/AIDS

Goal

Reduction in the global incidence of HIV/AIDS and the full protection of the rights of people infected and affected by HIV/AIDS.

Objectives

1. To reduce social, religious, cultural, economic, legal and political barriers that make people vulnerable to HIV/AIDS.
2. To increase access to interventions for the prevention of STIs and HIV/AIDS through integrated, gender-sensitive sexual and reproductive health programmes.
3. To increase access to care, support and treatment for people infected, and support for those affected by HIV/AIDS.
4. To strengthen the programmatic and policy linkages between sexual and reproductive health and HIV/AIDS.

Programme Strategies

1. To reduce social, religious, cultural, economic, legal and political barriers that make people vulnerable to HIV/AIDS.

a) Knowledge management (including research) to understand social, religious, cultural, economic, legal and political barriers that impede the prevention of HIV/AIDS and that result in increased stigma associated with HIV/AIDS.

b) Awareness raising and sensitization on HIV/AIDS and related issues at all levels, through a variety of different channels.

c) Advocacy to create an enabling environment for the promotion and exercise of human rights, including sexual and reproductive rights.

d) Actively seek partnerships (with governments, NGOs, CBOs, UN agencies, IBRD etc.) to maximize the impact of awareness raising and advocacy interventions.

e) Participation in and strengthening of networks dealing with HIV/AIDS such as the Country Coordination Mechanisms (CCMs).

f) Involvement in the development of policies and legislation.

g) To advocate for the integration of sexual and reproductive health and HIV/AIDS into poverty alleviation strategies.

h) Actively promote the integration of sexual and reproductive health and HIV/AIDS policies and programmes.

i) Involvement of stakeholders including people living with HIV/AIDS (PLWAs).

2. To increase access to interventions for the prevention of STIs and HIV/AIDS through integrated, gender-sensitive sexual and reproductive health programmes.

a) Accessing, interpreting and disseminating evidence about programmes and interventions.

b) Behaviour change communication (BCC) for sexual and reproductive health and HIV/AIDS that is evidence-based and sensitive to culture and gender.

c) Integration of STIs and HIV/AIDS prevention in sexuality education.

d) Promotion of dual protection.

e) Promotion of joint and individual responsibility for protection against HIV and unwanted pregnancy.

f) Integration of STIs and HIV/AIDS related services such as STI management, voluntary counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) in wider sexual and reproductive health services (clinical as well as outreach).

g) Addressing sexual and reproductive health needs of HIV positive women.

h) Integration of sexual and reproductive health services into STIs and HIV/AIDS programmes.

i) Development and consolidation of partnerships, in particular for the establishment of referral networks.

j) Ensuring availability of male and female condoms.

k) Capacity/competency building for integrating sexual and reproductive health into HIV/AIDS-related services.

3. To increase access to care, support and treatment for people infected and support for those affected by AIDS.

a) Advocacy to increase access to care, support and treatment of PLWA, including anti-retrovirals (ARVs).

b) Dissemination and country adaptation of policies, standards, protocols, etc. related to HIV/AIDS.

c) Situation analysis of provision of services and care for PLWA in-country.

d) Development and consolidation of partnerships: mapping of providers of services and care, establishment of referral networks.

e) Depending on country context, service provision for PLWAs which may include:

- voluntary counselling and testing (VCT)
- prevention of mother-to-child transmission (PMTCT)
- sexual and reproductive health services for HIV positive individuals
- palliative care
- prevention and treatment of opportunistic infections and other HIV/AIDS-related conditions
- psycho-social support for HIV positive, well individuals (nutrition, healthy lifestyle, etc.)
- psycho-social support for persons affected by HIV
- home-based care
- legal support
- treatment including anti-retrovirals (ARV)

f) Community participation approaches (including home-based care) with active involvement of PLWAs.

4. To strengthen the programmatic and policy linkages between sexual and reproductive health and HIV/AIDS.

a) To advocate improved integration of sexual and reproductive health and HIV/AIDS policies and programmes and to monitor such integration.

b) To improve capacity to respond to the sexual and reproductive health and HIV/AIDS integration issues and opportunities.

ABORTION

Goal

A universal recognition of a woman's right to choose and have access to safe abortion, and a reduction in the incidence of unsafe abortion.

Objectives

1. To strengthen public and political commitment for the right to choose and to have access to safe abortion.
2. To increase access to safe abortion.
3. To expand the provision of abortion-related services as an integral part of sexual and reproductive health services.
4. To raise awareness among the general public, policy-makers and key professional groups on the public health and social justice impact of unsafe abortion.

Programme Strategies

1. To strengthen public and political commitment for the right to choose and to have access to safe abortion.

a] Definition and operationalization of the right to choose and to have access to safe abortion, with linkage to human rights.

b] Development, periodic reviews and dissemination of IPPF policy, position papers and statements on abortion-related issues.

c] Sensitization of volunteers and staff at all levels of IPPF and capacity-building for advocacy.

d] Awareness-generation and mobilization of public opinion.

e] Development of strategic partnerships (networking, alliances, coalitions, consortiums, etc.) with NGOs, women's groups, professional groups and organizations, human rights groups and religious groups.

f] Evidence-based advocacy with governments, politicians, judiciary, health professionals and opinion-leaders to recognize, protect and fulfil these rights – either through legalization or decriminalization.

g] IPPF to play an active role in the global debate.

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2. To increase access to safe abortion.

a] Documentation and dissemination of information about the legal status of abortion and availability of safe abortion services to the general public, service providers and other relevant stakeholders.

b] Promotion of sensitive, non-judgmental, affordable and high quality services.

c] Provision of abortion services to the fullest extent permitted by the law, with special attention to young women and under-served and marginalized groups.

d] Referrals to public and private service facilities.

e] Development of strategic partnerships and provision of support and training in service delivery.

f] Provision of referrals for post-abortion care, treatment of complications and contraceptive services.

g] Advocacy with governments to expand access to abortion-related service delivery within the public, NGO and private sectors.

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3. To expand the provision of abortion-related services as an integral part of sexual and reproductive health services.

a] Advocacy for abortion-related services to be part of sexual and reproductive health services.

b] Provision of safe, sensitive, non-judgmental and affordable abortion-related services, with special attention to young women and under-served and marginalized groups.

c] Establishment of standards of care for abortion-related services and development of guidelines and protocols for implementation.

d] Introduction of simple, appropriate and innovative options for the delivery of abortion-related services, including medical abortion.

e] Capacity-building and development for the provision of abortion-related services.

f] Documentation and sharing of experiences and models of good practice in abortion-related programmes.

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4. To raise awareness among the general public, policy-makers and key professional groups on the public health and social justice impact of unsafe abortion.

a) Development and maintenance of a global database on abortion-related information by IPPF.

b) Assessment, documentation and dissemination of the incidence and impact of unsafe abortion on the health and well-being of women, their families and marginalized groups.

c) Use of case studies of the circumstances surrounding women's experience of unsafe abortion, and abortion-related research.

d) Collaboration with key partners (media, health professionals, NGOs, women's organizations, human rights groups and community leaders) to generate a network of supportive and informed opinion-leaders.

ACCESS

Goal

All people, particularly the poor, marginalized, the socially-excluded and under-served are able to exercise their rights, to make free and informed choices about their sexual and reproductive health, and have access to sexual and reproductive health information, sexuality education and high quality services including family planning.

Objectives

1. To reduce socio-economic, cultural, religious, political and legal barriers to accessing sexual and reproductive health information, education and services.
2. To strengthen political commitment and support for reproductive health programmes.
3. To empower women to exercise their choices and rights in regard to their sexual and reproductive lives.
4. To increase male commitment to sexual and reproductive health.
5. To improve access to sexual and reproductive health information and sexuality education using a rights-based approach.
6. To improve access to high quality sexual and reproductive health services using a rights-based approach.

Programme Strategies

1. To reduce socio-economic, cultural, religious, political and legal barriers to accessing sexual and reproductive health information, education and services.

a) Strengthening and establishing new partnerships with NGOs, including women's and youth groups, religious leaders, civil society groups, private sector, media and other stakeholders.

b) Influencing policy-makers and parliamentarians to reduce barriers.

c) Promoting active stakeholder participation in identifying barriers and developing/implementing/evaluating strategies to remove these barriers.

d) Campaigning in support of sexual and reproductive health and rights.

2. To strengthen political commitment and support for sexual and reproductive health programmes.

a) Influencing governments, politicians, decision-makers and other influential groups to introduce and/or strengthen mechanisms (such as Sector-Wide Approaches and Poverty Reduction Strategies) to make the delivery of sexual and reproductive health information and services available to all defined groups.

b) Promoting/supporting the development and implementation of effective and high quality national sexual and reproductive health programmes for all defined groups.

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3. To empower women to exercise their choices and rights in regard to their sexual and reproductive lives.

a) Promoting gender equity and equality.

b) Developing and promoting innovative programmes to address gender-based violence and harmful practices.

c) Ensuring all women's ability, regardless of age and marital status to make their own decisions regarding their sexual and reproductive health and rights.

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4. To increase male commitment to sexual and reproductive health.

a) Working with men to identify and address their sexual and reproductive health needs, including male methods of family planning.

b) Ensuring that men fully understand and support men and women's sexual and reproductive rights and gender equity and equality.

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5. To improve access to sexual and reproductive health information and sexuality education using a rights-based approach.

a) Providing accurate and up-to-date information on sexual and reproductive health and rights.

b) Using and promoting innovative approaches to ensure access to sexual and reproductive health information based on the needs of specific groups.

c) Promoting comprehensive sexuality education using innovative and age and gender-specific approaches.

d) Adopting appropriate responses to abstinence-only programmes.

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6. To improve access to appropriate high quality sexual and reproductive health services using a rights-based approach.

a) Advancing high quality, integrated sexual and reproductive health services to marginalized and under-served groups.

b) Promote the availability and acceptability of all contraceptive methods, including Emergency Contraception.

c) Creating and/or scaling up good quality, successful models of outreach, mobile, satellite and community-based sexual and reproductive health services including family planning to under-served and marginalized populations.

d) Strengthening and expanding strategic partnerships for the delivery of sexual and reproductive health services including referrals.

e) Responding to the sexual and reproductive health needs of groups affected by emergency situations resulting from political instability and natural disasters.

ADVOCACY

Goal

Strong public, political and financial commitment to and support for sexual and reproductive health and rights at the national and international level.

Objectives

1. To strengthen recognition of sexual and reproductive health and rights, including policy and legislation which promotes, respects, protects and fulfils these rights.
2. To achieve greater public support for government commitment and accountability for sexual and reproductive health and rights.
3. To raise the priority of sexual and reproductive health and rights on the development agenda resulting in an increase in resources.

Programme Strategies

1. To strengthen recognition of sexual and reproductive health and rights, including policy and legislation which promotes, respects, protects and fulfils these rights.

a) Build relationships with governments, key policy-makers and other influential groups (including women's groups, NGOs, think-tanks, multi-laterals, parliamentarians, academics, civil servants etc.), and work with them to take action in support of sexual and reproductive health and rights – existing and new partnerships.

b) Develop detailed policy positions and tailor clear messages based on these positions for identified target groups.

c) Advocate with governments and groups using evidence-based information (including IPPF's own programmes) to formulate policy and demonstrate the importance and impact of sexual and reproductive health and rights and motivate them to take action.

d) Analyze opposition messages and tactics and formulate messages and strategies that anticipate, respond to and counteract them.

e) Work in partnership with civil society to leverage influence on governments and influential groups and to complement each other's comparative advantage.

f) Develop good media relations to increase positive coverage of sexual and reproductive health and rights.

g) Coordinate mobilization around key events, conferences, meetings, and designated days to raise the profile of sexual and reproductive health and rights issues and IPPF's work.

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2. To achieve greater public support for government commitment and accountability for sexual and reproductive health and rights.

a) Build relationships with the public and involve them in support of sexual and reproductive health and rights at all levels.

b) Develop clear, targeted, simple and consistent messages for the public across IPPF with agreed key messages relating to the five strategic priorities.

c) Work with targeted media in an effective and innovative way to raise awareness and disseminate information and messages to mobilize support for sexual and reproductive health and rights.

d) Social mobilization with community groups (e.g. peer advocacy, meetings, events, community leaders) to develop a personal commitment and public support for the concept of sexual and reproductive health and rights.

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3. To raise the priority of sexual and reproductive health and rights on the development agenda resulting in an increase in resources.

a) Advocate with governments, donors, multi-laterals, private sector and civil society groups to demonstrate that sexual and reproductive health and rights are vital to poverty alleviation (Millennium Development Goals) and development.

b) Monitor and disseminate information about governments' performances with respect to commitments and investments in sexual and reproductive health and rights.

c) Work with targeted media in an effective and innovative way to raise awareness and disseminate information and messages to mobilize support for sexual and reproductive health and rights.

d) Build relationships with governments, NGOs and other key influential groups to demonstrate the linkages and importance of sexual and reproductive health and rights to the wider development agenda (MDGs/Poverty Reduction Strategies) and by this achieve greater allocation of resources.

e) Raise resources from general public.

f) Highlight the importance of adequate sexual and reproductive health commodity supplies.

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IPPF Strategic Framework, 2016-2022

November 2014 – Approved Version

The Strategic Framework sets the priorities that will allow the Federation to deliver impact as an SRHR movement by 2022. It guides national Member Associations and partners in formatting their own strategies that respond to the specific country context and available resources. It provides focus to the Secretariat in setting operational plans that support our Member Associations. All levels of the Federation are encouraged to maximize their contribution in order to deliver on our strategic mission.

Global Trends that are influencing and guiding our strategic thinking:

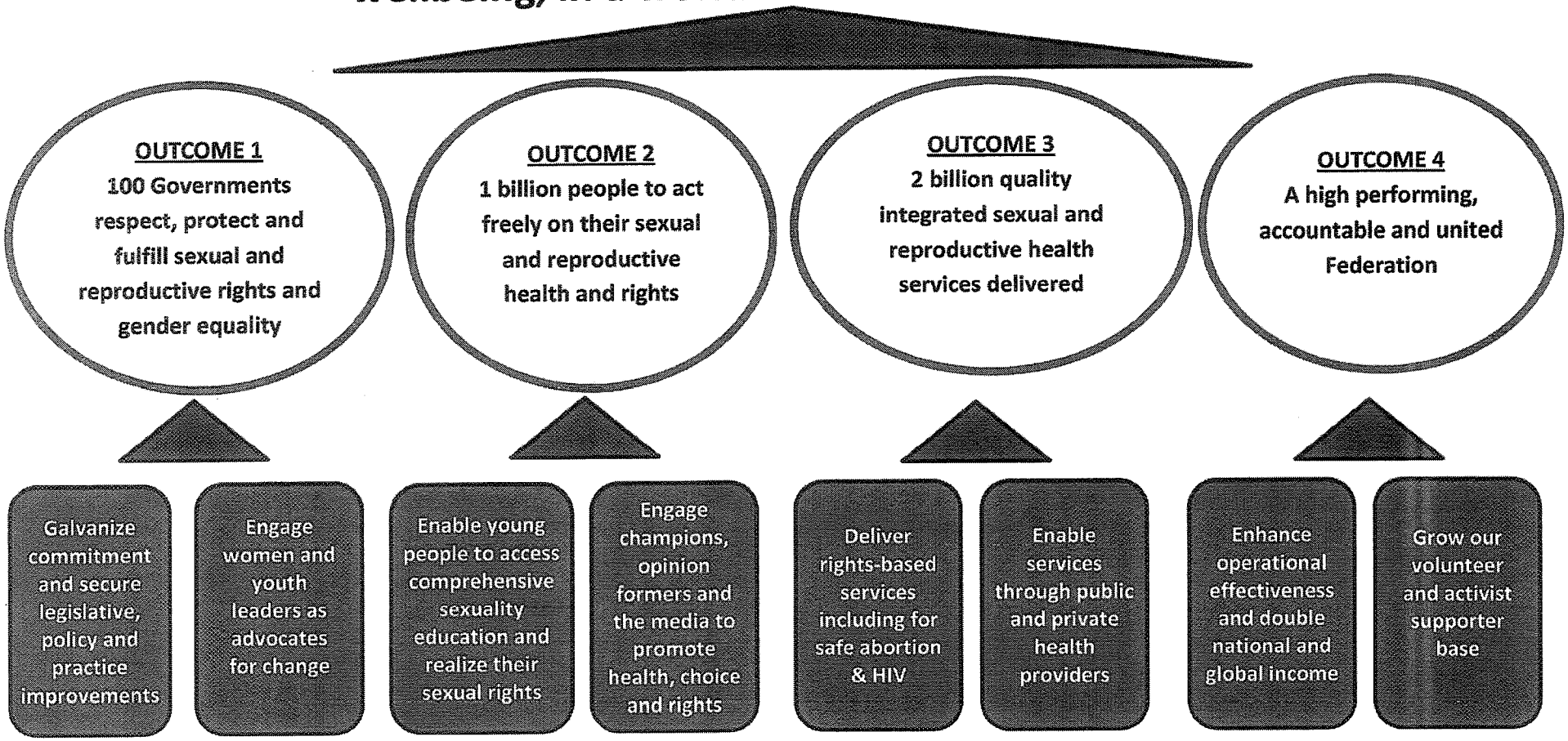
- **Largest youth generation;** the expectations and potential of the largest youth generation ever in particular to addressing their sexual and reproductive health and rights unmet needs
- **Discrimination against women and girls**; there remains significant unequal rights and opportunities for women which is preventing their empowerment
- **Opposition**; conservatism and a well-organized and resourced opposition are threatening sexual and reproductive health and rights in many countries
- **Social and economic inequality**; whilst poverty reduces, negative aspects of social and economic inequality emerge in all countries
- **Technological advances;** progress is allowing fast, innovative and affordable ways of creating social networks, and can make service delivery more efficient.

Values: Our fundamental beliefs, the guiding principles that dictate our behavior and actions at all levels of the Federation:

We believe:

- in **social inclusion** with a demonstrated commitment to enable the rights of the most under served to be realised
- in **diversity**, respecting all regardless of their age, gender, status, identity, sexual orientation or expression
- our **passion** and determination inspire others to have the courage to challenge and seek social justice for all
- In the significant contribution our **volunteerism** delivers across a range of roles and as activists inspiring the Federation to advance its mission
- in **accountability** as a cornerstone of trust which is demonstrated through high performance, ethical standards and transparency.

Our Vision: All people are free to make choices about their sexuality and wellbeing, in a world without discrimination



IPPF's Mission: To lead a locally-owned, globally connected civil society movement that provides and enables services, and champions sexual and reproductive health and rights for all, especially the underserved

Our Values: Social Inclusion Diversity Passion Volunteerism Accountability

OUTCOME 1 100 Governments respect, protect and fulfill sexual and reproductive rights and gender equality	
Priority One: Galvanize commitment and secure legislative, policy and practice improvements	
Why?	If governments, regional and international institutions, agree and implement, supportive legislation, policy and budgets for sexual and reproductive health and rights then it's a *'game changer'* for the lives of their citizens. Political commitment helps advance community support for SRHR and vice versa. National level political commitment can lead to more progressive regional and global agreements, and these in turn can encourage progress nationally.
What?	IPPF will further invest in political advocacy at all levels, including supporting Member Associations with capacity building, information, funding and monitoring. We need to target key institutions (e.g. Regional Economic Commissions), build supportive parliamentarians, community and religious networks and ensure country capitals are better connected with regional and international processes and representatives (e.g. UN Missions).
By 2022	IPPF will generate new political commitment and ensure implementation so governments deliver, and even exceed, their (new) sustainable development targets. As a political-change maker and catalyst, we shall lead the SRHR community's political advocacy and deliver on its own commitments to hold governments to account.
Priority Two: Engage women and youth leaders as advocates for change	
Why?	Promotion of women's and youth leadership remain an important priority of IPPF because of their right to participate and contribute to policy making and decision making processes that affect their lives. In addition, women and young people can be effective agents of change to challenge and transform social norms and policies that constitute a barrier to sexual and reproductive health and rights. Men also play a critical role with concepts of masculinity preventing gender equality and also hindering men from accessing the information and services they need.
What?	IPPF will implement a programme to attract, invest and provide pathways for young leaders within the Federation, with a focus on girls and young women. We will further strengthen and resource our youth networks and strengthen youth adult partnership. In our work it is crucial to recognize that young people are not a homogenous group, and hence our approaches should take into consideration the variety of factors that contribute to their needs. Male involvement and addressing issues related to sexuality, masculinity and gender will be promoted. We will also work with other CSOs to encourage them to adopt a youth centred approach and influence government services to be more client and youth centred.
By 2022	IPPF will have placed a high priority on youth leadership and have a distinct and strong global youth movement. We will have witnessed a future generation of female leaders championing and advocating for sexual and reproductive health and rights, both inside and outside of the Federation. These young leaders will function effectively and young people will have equal voice in decision making at all levels in the Federation. Governments and communities will be involving men so that they promote SRHR for themselves and their partners.

OUTCOME 2 1 billion people empowered to act freely on their sexual and reproductive health and rights	
Priority Three: Enable young people to access comprehensive sexuality education and realize their sexual rights	
Why?	Enabling young people to exercise their sexual rights is a vital priority as we address the expectations and potential of the largest youth generation ever. The majority of these young people live in developing countries. Overall, young people are a highly underserved group, both in accessing SRH services and information. We know that young people who are able to exercise their sexual rights have the potential to be effective agents of change and hence have the ability to transform social norms.
What?	IPPF will focus on establishing a right's based youth centred approach across the Federation including: • Prioritizing and investing in the scaling up of comprehensive sexuality education services and advocacy, both for those in and out of schools • Focusing on interventions for the most marginalized and underserved youth • Investing in rights awareness communications • Advocating for youth centered government policies including on access to contraception and ending early and forced marriage.
By 2022	Significantly more young people will demand and have accessed comprehensive sexuality education. IPPF will see more young people demand and access youth friendly SRH services. An increased number of young people will champion and advocate for young people's sexual rights. A significantly higher number of stakeholders will uphold and respect young people's rights.
Priority Four: Engage champions, opinion formers and the media to promote health, choice and rights	
Why?	Wider public and community opinion directly affects an individual's ability to realize their sexual and reproductive rights. In many countries achieving legislative, policy and practice improvements is only possible if there is a change in public opinion. Popular campaigns, with integrated communications supported by case studies and evidence, and amplified through champions, opinion formers and media providers can create the environment to promote health, choice and rights within the culture.
What?	IPPF will focus on having adaptable content featuring personal testimonies and evidence supporting SRHR. This content will be usable in a variety of media formats including digital channels such as social media and more traditional including TV programming and plotlines that sensitively raise SRHR issues. We will focus on how to embed this so that it becomes a regular and ongoing feature of IPPF's and other CSO's work.
By 2022	IPPF Member Associations will have on-going relationships with key opinion makers and a critical mass of influential champions. They will have adapted and shared powerful content through social media and other media to help shift attitudes and approaches to SRHR and gender equality at local and national levels. Member Associations, in an increasing number of cases will have become a national campaigning force to be reckoned with.

OUTCOME 3 2 billion quality integrated sexual and reproductive health services delivered	
Priority Five: Deliver rights-based services including for safe abortion and HIV	
Why?	There remains significant unmet need for a broad range of SRH services. We need to ensure at least a minimum integrated package of high quality essential services that are client-centred, rights-based, youth friendly and gender sensitive. It is important that services are rights-based because particular services (abortion), diseases (such as HIV) and issues (such as sexual and gender based violence) continue to carry a stigma. High quality of care is also critical as an individual right, to contribute to better health outcomes and to increase the utilisation of services.
What?	IPPF will focus to ensure: • Technical expertise to support systems strengthening (commodity supply chain/ infrastructure and equipment, management capacity / referral system) across the Federation to increase the number, range and quality of integrated services provided • Barriers to accessing SRH services including ability to pay, age, social or cultural stigma, HIV-status, gender, sexuality, lack of commodities or equipment, lack of skilled service providers or a lack of access to a service delivery point are being addressed • IPPF's systems for capturing service provision will need to move from being predominately service-orientated to being client-orientated.
By 2022	IPPF Member Associations will see an increased number of clients (particularly young people and those who are poor and underserved). The range of service delivery channels to take services to under-served communities will be expanded as will the range of integrated services on offer.
Priority Six: Enable services through public and private health providers	
Why?	IPPF Member Associations play an active role in strengthening national health systems. With more national governments now taking responsibility to provide SRH services it is critical that this is undertaken in a client centred and rights based manner. Private health providers are also looking for partnerships to expand their access to clients. Member Associations have the expertise, experience and role within communities to assist more services to be provided through public and private health providers.
What?	IPPF will focus on expanding the number of partnerships that deliver: • Pre-service and in-service training for medical personnel • Integrated SRH services in the facilities of private and public health providers • Reproductive health commodity security • Quality assurance and quality improvement through monitoring, training and evaluation • Life-saving responses to SRH needs in vulnerable settings before, during and after crisis hits.
By 2022	IPPF Member Associations will have a greater number of revenue agreements in place to provide training and other expertise to national government service providers. IPPF will have a range of global and regional partnerships with UN agencies and the private sector directly increasing the number of people able to access SRH services.

OUTCOME 4 A high performing, accountable and united Federation	
Priority Seven: Enhance operational effectiveness and double national and global income	
Why?	At the institutional level, we must adapt to constantly shifting political, financial and market conditions. Programmatically we are ethically obligated to sustain services and programs for which we have contributed to demand generation. At the financial level, IPPF must be able to innovate and adapt to an evolving business model.
What?	IPPF will apply diverse models that respond to a changing environment and ensure on-going demand and funding for our services by: • Providing a supporting environment to enable Member Associations to develop social enterprises including sharing knowledge and expertise across the Federation • Recruiting and retaining expert staff and volunteers that bring a broader skill set to the Federation including strategic and business planning, market feasibility and competitive trend analysis, performance management including using data for decision making, marketing and communications, and new partnership development • Strengthening financial management systems at all levels to support decision-making on cost efficiency and effectiveness.
By 2022	All parts of the Federation will be able to clearly define their model of sustainability. At the financial level, IPPF will have more diversified funding streams that generate more income. Social Enterprises will generate significant levels of resources for the Federation. At the institutional level, IPPF will have enhanced human resources that support effective resource mobilization, income generation and adaptation to new market and political conditions. At the programmatic level, IPPF will have a performance-driven culture with a focus on value for money that is supported by appropriate management information systems.
Priority Eight: Grow our volunteer and activist supporter base	
Why?	A critical mass of public support from the grass-roots up is needed to create the outcomes we seek e.g. political decision-makers need to hear demand for change from their constituents. Opposition to SRHR from a vocal minority threatens many of the significant improvements that have been realized.
What?	IPPF will invest in public communications, in skilled staff, systems and new technology (e.g. SMS and social media) with an initial focus on those countries with the greatest opportunity to grow the supporter base quickly.
By 2022	All IPPF volunteers will see themselves as activists (as many already do) and join with increasing numbers of SRHR supporters from diverse backgrounds, across all regions of the world, in boldly and courageously promoting SRHR and gender equality. We want a social movement which empowers people to claim their sexual rights and reproductive rights and hold their leaders to account.

DEED OF AMENDMENT

BETWEEN

COMMONWEALTH OF AUSTRALIA
represented by
The Department of Foreign Affairs and Trade (DFAT)
ABN 47 065 634 525 002

and

Marie Stopes International Australia

ABN 79 082 496 697

FOR

DFAT AGREEMENT NUMBER 37913/18

THIS DEED OF AMENDMENT is made this 2nd day of October 2014

BETWEEN:

The **COMMONWEALTH OF AUSTRALIA**, represented by the **Department of Foreign Affairs and Trade, ABN 47 065 634 525 002** ("the Commonwealth")

AND

Marie Stopes International Australia, ABN 79 082 496 697 of 620 St Kilda Road, Melbourne VIC (the "Organisation").

RECITALS

A. On 23 June 2014 the Commonwealth and the Organisation entered into **Funding Order 37913/18** in writing for the funding of the Activity described in the Agreement.

B. The parties have now agreed to alter the Funding Order as set out in this Deed.

OPERATIVE PROVISIONS:

1. In this Deed, unless the contrary intention appears, a reference to the "Agreement" is to the Agreement referred to in Recital A.

2. The Funding Order is amended as set out below:

Clause 7.1	Delete existing **Clause 7** and replace with new **Clause 7** as follows: INTELLECTUAL PROPERTY 7.1 Clause 14 of the Head Agreement is replaced by Clause 7.2. 7.2 The Intellectual Property in, or in relation to, Agreement Material vests in the Organisation upon its creation. The Organisation grants to DFAT an irrevocable, worldwide, royalty-free, non-exclusive licence (including a right of sub-licence) to use, reproduce, adapt and otherwise exploit the Agreement Material.
Clause 14.2	Delete existing **Clause 14.2** and replace with new **Clause 14.2** as follows: 14.2 The maximum amount payable by DFAT to the Organisation over the period 2014-15 under this Funding Order shall not exceed the sum of A$**1,849,148** ("the Funds") plus applicable GST if any up to a maximum amount of A$**184,914.80**. The annual allocation for 2014-15FY is set out in the table below and is subject to the achievement of the following milestones and **Clause 6.2**.

Financial Year (FY)	Tranche 1 (80% of financial year funding)	Tranche 2 (20% of financial year funding)	Total Amount
2014-15FY	A$**1,479,319** plus GST	A$**369,829** plus GST	A$**1,849,148** plus GST

The Funds are as follows:

a) Tranche 1 (80% of 2014-15 funding): A$**1,479,318** plus GST up to a maximum amount of A$**147,931.80** within 30 days of DFAT receipt and acceptance of 2014-15 Annual Development Plan (see Clause 4.2(a));

b) Tranche 2 (20% of 2014-15 funding): A$**369,830** plus GST up to a maximum amount of $A**36,983** within 30 days of DFAT receipt and acceptance of the 2014-15 annual performance report and financial report of expenditure against the Annual Development Plan (see Clause 4.2 (b));

3. The amendments set out in this Deed take effect on the date on which this Deed is signed by both parties.

4. In all other respects the parties confirm the Agreement.

EXECUTED AS A DEED by the Commonwealth, by an authorised officer, and by the Organisation by its authorised officer(s).

SIGNED for and on behalf of the
COMMONWEALTH OF AUSTRALIA
represented by the Department of Foreign Affairs and Trade by:

in the presence of:

Signature of Delegate

Signature of witness

MARY ELLEN MILLER
Name
(Print)

Name of witness
(Print)

AS NVB
Position, Section

SIGNED for and on behalf of

Marie Stopes International Australia by

.....
Signature

MATTHEW RALSTON
Name and position REGIONAL DIRECTOR - PACIFIC ASIA
(Print)

AMENDMENT SUMMARY SHEET

The Funding Order Agreement has been varied in accordance with the clause headed **Agreement Amendments** of Funding Order Agreement on the following dates relating to:

Amendment #	Date	Very Brief Summary of amendment	Increase/Decrease in financial limit	Adjusted Financial Limit
1	**September 2014**	**Amend Clause 7 to provide that Intellectual Property (IP) is vested with Organisation. The Commonwealth retains rights to use, reproduce, adapt and otherwise exploit the Agreement Material.** **Amend Clause 14 to rectify miscalculation of $1.00 in funding arrangement.**	**NIL**	**N/A**

Australian NGO Cooperation Program (ANCP) Full Annual Development Plan (ADPlan) Report 2014-15

Family Planning NSW

This report was drawn from the ANCP online database on 10 November 2015 and contains the ADPlan of Marie Stopes International Australia approved for implementation in the 2014-15 fiscal year. The ANCP is an annual grants program. Funding to NGOs is determined on an annual basis. Funding amounts proposed and approved for implementation of individual projects within ADPlans refers to annual project allocations. But, some projects planned by NGOs run over multiple years.

Project Overview

Project ID	Project Name	Country	ANCP Contribution	NGO Contribution	Sector
ANCP21--PRG0034--PRJ341	Increasing cervical cancer screening in Vanuatu	VANUATU	$50501.00	$0.00	Sexual Reproductive Health/Family Planning
ANCP21--PRG0034--PRJ342	Increasing cervical cancer screening in the Cook Islands	COOK ISLANDS	$65885.00	$0.00	Sexual Reproductive Health/Family Planning
ANCP21--PRG0035--PRJ293	Sexual and Reproductive Health and Rights Education Program	FIJI	$46744.00	$0.00	Sexual Reproductive Health/Family Planning
ANCP21--PRG0036--PRJ294	Strengthening of Sexually Transmitted Infections (STI) services in the Morobe Province	PAPUA NEW GUINEA	$55693.00	$0.00	Sexual Reproductive Health/Family Planning
ANCP21--PRG0037--PRJ295	Working with Men to Improve Sexual and Reproductive Health and Reduce Gender Violence	TIMOR-LESTE	$41435.00	$0.00	Sexual Reproductive Health/Family Planning
ANCP21--PRG0035--PRJ379	Increasing access to contraception in Vanuatu	VANUATU	$326.00	$66000.00	Sexual Reproductive Health/Family Planning
ANCP21--PRG0035--PRJ380	Post Basic Certificate Course in Sexual and Reproductive Health for Nurses and HEOs in Papua New Guinea	PAPUA NEW GUINEA	$9416.00	$123000.00	Sexual Reproductive Health/Family Planning

ANCP21 - Family Planning NSW (FPNSW)

Accreditation Type	Full
AAH2 Postal Address Full Address	328-336 Liverpool Road Ashfield NSW 2131
AAH2 Street Address Full Address	328-336 Liverpool Road Ashfield NSW 2131
Business Phone	(02) 8752 4311
Website	http://www.fpnsw.org.au

ABN	75000026335	**ABN Registered Organisation Name**	Family Planning Nsw
ABN Registered Charity		**ABN Registered Charity Type**	Health Promotion Charity
ABN Registered Organisation Type	Australian Public Company	**ABN Status**	Active
ABN Registered for GST	Yes	**Tax Concessions**	FBT Exemption, GST Concession, Income Tax Exemption
Registered as DGR		**Registered Postcode**	2131
DGR Funds		**Registered State**	NSW

Head NGO Full Name	Ms Ann Brassil
Position	Chief Executive Officer
Phone	
Email	annb@fpnsw.org.au

ANCP Contact 1 Full Name	
Position	Director Planning, Education and International Programme
Phone	
Email	@fpnsw.org.au

ANCP Contact 2 Full Name	
Position	
Phone	
Email	

ME Contact Full Name	
Position	
Phone	
Email	

DAR Contact Full Name	
Position	
Phone	
Email	

Financial Officer Full Name	
Position	Director Finance
Phone	
Email	@fpnsw.org.au

Overarching Development Approach
The Family Planning NSW projects are focussed on working to assist the poor and disadvantaged people in the Asia Pacific region to improve access to comprehensive family planning and reproductive health services. The DFAT Family Planning Guidelines recognise that access to family planning is one of the most cost effective approaches to reducing maternal and child mortality. Family Planning NSW's ANCP projects are focussed on increasing access to quality health and education services with an emphasis on achieving long term impact on marginalised groups and saving lives. We are committed to long term capacity building of NGOs and health systems to address areas of reproductive and sexual health need, such as high rates of cervical cancer mortality in the Pacific. Our projects are focussed on supporting the achievement of the Millenium Development Goals, in particular MDG5b, (increasing universal access to reproductive health) as this is key to reducing maternal mortality, preventing unwanted pregnancies, curbing the spread of sexually transmitted infections, including HIV, and AIDS, empowering women and girls to exercise their sexual and reproductive rights through greater decision-making powers, building a more sustainable world for all women, men and young people regardless of gender, sexual orientation, or social and economic status. Family Planning NSW achieve this through capacity building local NGOs to provide high quality family planning services including clinical services, community education, resource development and professional education. Emphasis is also placed on improving the monitoring and evaluation of all of our project work, implementing child protection training and supporting our NGO partners to improve financial management and governance.

Attachment	

Approach to Cross-cutting Issues
Family planning, sexual and reproductive health and gender are core to all ANCP activities. We support a human rights approach to family planning services and only support the development of voluntary, culturally appropriate, high quality services. Our approach ensures that all our clinicians, educators and service providers are well informed and support an informed choice approach. Our projects in Timor Leste and Papua New Guinea are an innovative strategy to gender equality. The aim is to address gender based issues by targeting men who are traditionally the dominant decision makers in these countries . Our education programs address negative values, practices and stereotypes held by health professionals and community members by guiding men through discussions on gender, sex, gender based violence and sexual consent. The aim is to change attitudes and behaviours that will then have a positive impact on the lives of women and children. Our education programs in PNG and Fiji for nurses and SRH educators are examples of how Family Planning NSW includes a focus on the SRH rights of people with disability. The programs have modules that advocate for accessible health services and promotes attitudinal changes that falsely and negatively stereotype people with disability. People are provided with tools and strategies for becoming -disability inclusive in their activities. Our long term partner in Fiji, RFHAF, has this year requested that Family Planning provides education on appropriate activities for people with disability to learn about SRH and their rights. This will enable them to do more targeted education on disability issues. This is an important expansion of their capacity. These programs also have both direct and indirect links to HIV/AIDS prevention through the aim of increasing knowledge in the community of safe sex practices and encouraging testing and treatment. Our NGO adheres to all DFAT requirements relating to child protection, anti-terrorism, environment, disability and gender.

Describe DME Program
As the FPNSW programming shifts to developing and implementing longer projects (of at least 3 years duration), many of the ANCP programs include an aspect of on-going design work including research and analysis. Specific support is provided to our partners in-country in program design and developing their capacity to implement the DFAT monitoring and evaluation framework.

We will continue to work with our project partners with an emphasis on improving their local monitoring and evaluation to clearly report on their beneficiaries in accordance with DFAT reporting guidelines.

Expected Beneficiaries

Baseline Direct	3175	**Baseline Indirect**	2706	**Baseline DAR**	
Expected Direct	10740	**Expected Indirect**	48607	**Expected DAR**	
Target Direct	18461	**Target Indirect**	82813	**Target DAR**	

Male Direct	3933	**Male Indirect**	17280	**Male DAR**	
Female Direct	4474	**Female Indirect**	21259	**Female DAR**	
Boy Direct	917	**Boy Indirect**	3838	**Boy DAR**	
Girl Direct	1105	**Girl Indirect**	4938	**Girl DAR**	
Male with Disability Direct	117	**Male with Disability Indirect**	442	**Male with Disability DAR**	
Female with Disability Direct	134	**Female with Disability Indirect**	615	**Female with Disability DAR**	
Boy with Disability Direct	26	**Boy with Disability Indirect**	100	**Boy with Disability DAR**	
Girl with Disability Direct	34	**Girl with Disability Indirect**	135	**Girl with Disability DAR**	

Urban Direct	6250	**Urban Indirect**	14525	**Urban DAR**	0
Rural Direct	4490	**Rural Indirect**	34082	**Rural DAR**	0

NGO Financial Year Period	July to June

Total NGO revenue - Previous	S734187.00
DFAT funding - Previous	S300000.00
Aus Gov Funding excl DFAT - Previous	$0.00
Revenue from Australian public - Previous	$60000.00

Total NGO revenue - current	S574107.00
Aus Gov funding excl DFAT - current	$
DFAT funding - current	$
Revenue from Australian public - current	S189000.00

Project Budget Summary	

Estimated DFAT ANCP Funding this ADPlan period

Rollover funds excluding interest	$30000.00

Rolled over interest	$3500.00
ANCP grant	$300000.00
Estimated interest ADPlan period	$5000.00
TOTAL funding	$338500.00

Estimated DFAT ANCP Expenditure this ADPlan period

Project activity costs	$302000.00
Design Monitoring and Evaluation expenditure	$6500.00
In-Australia Development Awareness Raising expenditure	$0.00
Administration Overheads expenditure	$30000.00
TOTAL Expenditure	$338500.00

NGO Contribution

NGO Contribution	$189000.00

Evaluation

Country	FJ;FIJI;Pacific Island Countries;500
Program Project Name	Sexual Reproductive Health and Rights Education Program
Program Project ANCP Online Identification	ANCP-21-PRG0035-PRJ293
Start Date	2014-09-01
End Date	2015-06-30
Sector Focus	Sexual Reproductive Health/Family Planning
Primary DAC Code	13030
Estimated total cost the evaluation	5000.00
Estimated DFAT subsidy towards cost evaluation	
Evaluation Outline	

Purpose

1. Assess the program effectiveness (extent to which the goal, objectives and outcomes have been achieved) and strengths and challenges of the process used
2. Report project outcomes to ANCP, Fiji Ministry of Health and other stakeholders and promote RFHAF work and the RFHAF – Family Planning NSW partnership
3. Report on a promising model of education with stakeholders
4. Build skills and experience of RFHAF and Family Planning NSW in conducting evaluations in Fiji and Pacific

Methodology:

The evaluation will use a participatory and capacity-building approach. FPNSW will facilitate a process of building evaluation skills of a core team (1-3 persons) within RFHAH to develop the methodology, undertake the data collection, analysis, report writing and dissemination.

Methods to collect data this year may include:

- Interviews/focus groups and written surveys of beneficiaries of the project including schools, students, community leaders and community members
- Interviews with stakeholders from relevant Ministries and other stakeholders
- Review of materials developed during the program including IEC materials, training resources and teaching manual
- Review of planning and strategic documents

Steps to implementation: 1. A substantial amount of data has already been collected and analysed during the first 2 years of this project including • Post and post training surveys for RFHAF staff • Follow-up evaluation surveys and interviews • Training plans for RFHAF staff • RFHAF training needs analysis report • RFHAF training plans • Training needs analysis for Fiji conducted by Family Planning NSW 2. FPNSW and RFHAF will work collaboratively to develop the main evaluation questions 3. An evaluation approach will be confirmed 4. The evaluation plan is documented 5. Review by ethics committee / update per review

Attach a copy material related to this evaluation	

Evaluation

Country	PG;PAPUA NEW GUINEA;Papua New Guinea;700
Program Project Name	Post basic certificate course in sexual and reproductive health for nurses and HEOs in PNG
Program Project ANCP Online Identification	ANCP21-PRG0035-PRJ380
Start Date	2014-07-01
End Date	2015-06-30
Sector Focus	Sexual Reproductive Health/Family Planning
Primary DAC Code	13081
Estimated total cost the evaluation	1500.00
Estimated DFAT subsidy towards cost evaluation	

Evaluation Outline
The aim of the evaluation will be to determine: 1. learning outcomes for participants have been achieved 2 teaching and learning materials were relevant to practice and user friendly 3. clinical placement was relevant to practice and placement objectives were achieved 4. participant satisfaction with learning methods and teaching styles The methodology will include: 1. written surveys completed after each module by each participant 2. written surveys completed after each module by course coordinator 3. structured interviews or focus groups conducted at completion of course with each participant Data from the surveys and interviews will be collated and analysed by Data and Evaluation Unit at Family Planning NSW. Results will be reported to DFAT, PNG Ministry of Health, Provincial Health Office and other stakeholders.

Attach a copy material related to this evaluation	

Indicators

Saving Lives	
Promoting Opportunities for all	
Sustainable Economic Development	

Effective Governance	
ANCP	6.101 - Number (x) of local in-country partners participating in ANCP funded projects/programs, 6.103 - Number (x) of local in-country partners reporting an increased capacity to deliver ANCP projects as a direct result of the Australian accredited NGO's mentoring and/or training
Involving Australian Community	

Baseline - 1101		**Expected - 1101**		**Target - 1101**	
Baseline - 1102		**Expected - 1102**		**Target - 1102**	
Baseline - 1201		**Expected - 1201**		**Target - 1201**	
Baseline - 1301		**Expected - 1301**		**Target - 1301**	
Baseline - 1307		**Expected - 1307**		**Target - 107**	
Baseline - 2101		**Expected - 2101**		**Target - 2101**	
Baseline - 2201		**Expected - 2201**		**Target - 2201**	
Baseline - 2202		**Expected - 2202**		**Target - 2202**	
Baseline - 2203		**Expected - 2203**		**Target - 2203**	
Baseline - 2204		**Expected - 2204**		**Target - 2204**	
Baseline - 2501		**Expected - 2501**		**Target - 2501**	
Total Number WASH Committee funded					
Baseline - 2705		**Expected - 2705**		**Target - 2705**	
Baseline - 2801		**Expected - 2801**		**Target - 2801**	
Baseline - 2807		**Expected - 2807**		**Target - 2807**	
Baseline - 3101		**Expected - 3101**		**Target - 3101**	
Baseline - 3102		**Expected - 3102**		**Target - 3102**	
Baseline - 3201		**Expected - 3201**		**Target - 3201**	
Baseline - 3202		**Expected - 3202**		**Target - 3202**	
Baseline - 4101		**Expected - 4101**		**Target - 4101**	
Baseline - 6000		**Expected - 6000**		**Target - 6000**	
Baseline - 6103		**Expected - 6103**	13	**Target - 6103**	13
Baseline - 7106		**Expected - 7106**		**Target - 7106**	

Copy signed approval attached	ANCP Annual Development Plan Certification.pdf
Authorised Officer Full Name	Ms Ann Brassil
Position	Chief Executive Officer
Date Approval	30/06/2013

Program - Cervical Cancer Screening Program, ANCP21--PRG0034

Program Approach	Yes
Program Name	Cervical Cancer Screening Program

Countries
COOK ISLANDS
VANUATU

Program Description
Cervical cancer is the second most common cancer in women worldwide. Every year, more than 270,000 women die from cervical cancer with more than 85% of deaths occurring in low and middle income countries. Effective methods of early detection of precancerous lesions such as Pap tests exist and have been shown to be successful in reducing deaths from cervical cancer. Reducing deaths through implementation of cervical cancer prevention and control programmes supports achievement of the Millennium Development Goals (universal access to sexual and reproductive health services to improve women's health). Cervical cancer screening saves women's lives, however screening is not routinely available in Pacific nations and women are dying up to nine times the rate of women in Australia (Australia 1.8; Fiji 17.9; Papua New Guinea 23.3; Solomon Islands 10.9 and Vanuatu 9.7 per 100,000 women). Over the past four years, Family Planning NSW (FPNSW) has worked in Fiji with the Ministry of Health, the Fiji Nursing Association and Reproductive and Family Health Association of Fiji to test the feasibility of using a low resource method of cervical screening, endorsed by the World Health Organisation, (VIA - visual inspection with acetic acid) followed by cryotherapy, an immediate "screen and treat" for a suspected cancer. The pilot proved that VIA and cryotherapy are an acceptable and effective method of cervical cancer screening and treatment in Fiji and is being implemented as part of the screening pathway for women 30-50 years across Fiji. Following the success of the program in Fiji, FPNSW is working in other Pacific countries to support effective cervical cancer screening and treatment. During 2013/14, we engaged with stakeholders in Vanuatu and Cook Islands to determine if the screen and treat method is acceptable to trial in each country. In the Cook Islands, we identified that the method of cervical cancer screening using Pap tests and Thin Prep was suitable, however, there was low community awareness of the need for screening, many community myths and fears to address and few trained clinicians to deliver screening, In 2014/15, Family Planning NSW will provide customised training and clinical supervision to up to 30 nurses to deliver quality screening, work with partners to develop key messages to address women's fear and shame and to develop and deliver quality community education sessions to women across Cook Islands. In Vanuatu, we identified that support was required for the implementation of HPV DNA testing to ensure that the donation received by the Ministry of Health can be implemented in a sustainable manner. By implementing this sustainable, low resource cervical cancer screening and treatment method, we can save many Pacific women's lives.

Expected Program Outcomes
The aim of the program is to work in partnership with local stakeholders in the Pacific to 1. Identify countries with high cervical cancer incidence and mortality rates. 2. Determine the adequacy of current cervical cancer prevention, screening and treatment services within the Pacific

country.

3. Consult with local Ministry of Health and NGOs to determine the most appropriate method of cervical cancer screening, including VIA and cryotherapy, HPV DNA testing and Pap tests.

4. Implement, as appropriately, a feasibility study within the country which include:
a.Defining the target population for the feasibility study;
b.Gaining ethics approval by approval from the Ministry of Health and appropriate bodies;
c.Engaging with the Nursing Board regarding the scope of practice of nurses;
d.Training local doctors and nurses to perform cervical cancer screening;
e.Perform an audit of clinical facilities to determine equipment requirements and purchase medical consumables and equipment;
f.Ensure appropriate clinical policies are documented to manage clinical risk factors such as infection control;
g.Defining the pathway of care for women from screening, diagnosis and treatment;
h.Implementing client information and recruitment strategies for women in the target population;
i.Implementing data collection, monitoring and evaluation processes;
j.Defining and implement quality assurance processes;
k.Implement screen and treat to defined target population.

5.Document the outcomes of the feasibility study.

6.Consult with local stakeholders to develop recommendations for future cervical prevention, screening and treatment programs.

7.Support local implementation to ensure sustainability of the program within the current health system.

By implementing this sustainable method, we will increase access for women to routine screening, ensuring early detection and treatment of precancerous lesions and help fight the unacceptably numbers of women dying from cervical cancer in Pacific countries.

Project - Increasing cervical cancer screening in Vanuatu, ANCP21--PRG0034--PRJ341

Project Name	Increasing cervical cancer screening in Vanuatu
Project Start Date	01/07/2013
Project End Date	30/06/2016
project funded in last financial year	Yes
Primary Country Region	VANUATU
Primary Provinces Regions	Port Vila

Secondary Countries	**Provinces Regions**
SOLOMON ISLANDS	Honiara

Implementing In-Country Partners
Vanuatu Family Health Association
Vanuatu Ministry of Health
Solomon Islands Ministry of Health and Medical Services

Private Sector Partnerships

Does this project involve working or partnering with the private sector	

Gender Equality

How the activity addressing gender equality	
Gender equality Specify focus the activity	

Disability Inclusion

How the activity addressing accessibility	
Disability Inclusion Specify focus the activity	

GPS Coordinates

Latitude	**Longitude**	**Location Name**
17° 45′ 0″ S	168° 18′ 0″ E	Port Vila, Vanuatu
-9.426055	160.0534	Honiara, Solomon Islands

Project Information

Project Description
Cervical cancer is the second most common cancer in women worldwide. Every year, more than 270,000 women die from cervical cancer with more than 85% of deaths occurring in low and middle income countries. Cervical cancer screening saves women's lives, however screening is not routinely available in Pacific nations and women in Vanuatu are dying up to five times the rate of women in Australia (Australia 1.8; Vanuatu 9.7 per 100,000 women). During 2013/14, Family Planning NSW engaged in stakeholder consultation with key stakeholders in Vanuatu including

the Ministry of Health, World Health Organisation, Vanuatu Family Health Association and DFAT regarding current capacity to deliver cervical cancer screening and treatment and the acceptability of introduction of the model used in Fiji, visual inspection with acetic acid followed by cryotherapy, an immediate "screen and treat" for a suspected cancer. All key stakeholders supported the need to implement population based screening program for cervical cancer screening and treatment.

In May and June 2014, Family Planning NSW consulted with the Australian Cervical Cancer Foundation who have signed recently an agreement with the Vanuatu Ministry of Health to provide careHPV DNA test for a five year period. The careHPV test provides primary, stand-alone screening for high-risk human papillomavirus (HPV) in women 30 years and older, to detect high-risk HPV infection, which is a risk factor for developing cervical intraepithelial neoplasia (CIN) 2 or higher. The careHPV Test is for use in limited resource settings. The careHPV DNA test has a shorter testing time of 2.5 hours, can be done by technical support staff, has a lower cost, is user friendly hence has a great appeal in developing countries.

Initial discussions with the Australian Cervical Cancer Foundation highlighted that while the donation of the careHPV test is for a five year period, there are no resources to support the integration of the test into a population screening pathway, such as providing training to clinicians, development of key messages for the community, defining referral pathways and defining and implementing data collection systems.

In 2014/15, Family Planning NSW will work with the Australian Cervical Cancer Foundation to develop a partnership to ensure that careHPV DNA testing is implemented as part of a population based screening pathway.

Based on the outcomes of the meeting, it is proposed that Family Planning NSW will engage with Vanuatu Family Health Association and the Vanuatu Ministry of Health to develop key promotional materials for women, develop and deliver training for nurses and midwives to deliver cervical cancer screening and develop an evaluation plan documented to determine effectiveness of the project, including data collection methods, monitoring and evaluation and risk management processes.

Our aim is to work with the Vanuatu Ministry of Health, Vanuatu Family Health Association and the Australian Cervical Cancer Foundation to ensure that the investment of careHPV testing is implemented in a way to ensure a sustainable, low resource cervical cancer screening and treatment program and save women's lives.

Family Planning NSW is committed to taking the learnings from our cervical cancer prevention programs in Fiji, Cook Islands and Vanuatu and implementing appropriate programs to address high rates of cervical cancer across the Pacific. In 2014/15, we will engage with government and non-government organisations is the Solomon Islands to seek stakeholder feedback regarding the opportunity to implement a pilot cervical cancer screening program in the Solomon Islands. This program will leverage off the two year GAVI funded immunisation program and cervical cancer prevention policy currently being implemented by the Solomon Islands Ministry of Health and Medical Services.

Project Outputs

1. Engage with the Australian Cervical Cancer Foundation, Ministry of Health, local NGOs and stakeholders to define the partnership roles and responsibility, scope and document the cervical cancer screening pathway for women using careHPV DNA testing.

2. Develop an evaluation plan documented to determine effectiveness of the project, including development of data collection methods, monitoring and evaluation and risk management processes.

3. Workforce and training plan developed to support clinicans to deliver cervical cancer screening including customisation of training materials and confirmation of schedule of training.

4. Develop a plan to encourage women to attend screening, incorporating community education sessions, resource development and media.

5. Engage with the Ministry of Health and Medical Services, local NGOs and stakeholders to use the learnings from this project and scope a cervical cancer screening program for the Solomon Islands, including identification of pilot sites and confirmation of implementing partners.

Sectoral Focus at Project Level	Sexual Reproductive Health/Family Planning
Primary DAC Code	13020
Secondary DAC Code	13081
Tertiary DAC Code	

DFAT ANCP Grant Excluding Interest	$50501.00
Total Funds Rolled Over From Previous Ye	$22739.00
NGO ANCP Contribution	$0.00
DME expenditure from ANCP funding	$0.00
Prior Funding	$30000.00

Project Risk Information
From the stakeholder consultation in Vanuatu it is clear that the restructuring of the Ministry of Health has resulted in many changes in key personnel and as a result a loss of corporate knowledge. There have been many cervical cancer screening projects implemented in Vanuatu, including VIA and cryotherapy and HPV DNA testing, that have not been planned to be integrated into the health system and as such, once the donor has left the country, have not been sustainable. Despite this significant investment, the cervical cancer mortality rates remain high. From initial discussions with the donor, Family Planning NSW plan to support to ensure the implementation of the project to ensure that it is done as part of the screening pathway and that it is implemented in a sustainable manner. However, this does require the support of the Australian Cervical Cancer Foundation to support the program to be implemented in this way.

Other Information
All activities will be implemented in accordance with the DFAT family planning guidelines. All staff engaged in the project will be employees of MoH or local NGO and must have appropriate registration and medical liability coverage to be involved. FPNSW Nurses working in country will seek registration from the local Nursing Board and will provide clinical supervision and support to registered nurses in country, but not provide direct clinical services, however if this is not granted, it will not impact on project delivery as the FPNSW Nurses are working in a supervisory capacity with local nurses. FPNSW will ensure that nurses trained have current skills and experience in family planning or midwifery, working within the MoH or NGOs providing reproductive and sexual health services; thus enhancing their clinical skills and ensuring sustainability of the program. The monitoring and evaluation component involves review of epidemiological data, current data collection systems, proposing data collection and monitoring and evaluation systems for the project and development of ethics proposals for Vanuatu and Australian ethics committees as appropriate.

Expected Beneficiaries

Baseline Direct		**Baseline Indirect**	
Expected Direct	30	**Expected Indirect**	7050
Target Direct	30	**Target Indirect**	7050

Male Direct	0	Male Indirect	3000
Female Direct	30	Female Indirect	3000
Boy Direct	0	Boy Indirect	500
Girl Direct	0	Girl Indirect	500
Male with Disability Direct	0	Male with Disability Indirect	0
Female with Disability Direct	0	Female with Disability Indirect	50
Boy with Disability Direct	0	Boy with Disability Indirect	0
Girl with Disability Direct	0	Girl with Disability Indirect	0

Urban Direct	25	Urban Indirect	4050
Rural Direct	5	Rural Indirect	3000

Family Planning

Family Planning Project	Yes
Expected Women family planning only	30
Expected Men family planning only	0

Project - Increasing cervical cancer screening in the Cook Islands, ANCP21--PRG0034--PRJ342

Project Name	Increasing cervical cancer screening in the Cook Islands
Project Start Date	01/07/2013
Project End Date	30/06/2015
project funded in last financial year	Yes
Primary Country Region	COOK ISLANDS
Primary Provinces Regions	Rarotonga

Secondary Countries	**Provinces Regions**

Implementing In-Country Partners
Cook Islands Family Welfare Association
Cook Islands Ministry of Health

Private Sector Partnerships

Does this project involve working or partnering with the private sector	

Gender Equality

How the activity addressing gender equality	
Gender equality Specify focus the activity	

Disability Inclusion

How the activity addressing accessibility	
Disability Inclusion Specify focus the activity	

GPS Coordinates

Latitude	**Longitude**	**Location Name**
21°14'S	159°47'W	Rarotonga, Cook Islands

Project Information

Project Description
The Ministry of Health (MoH) in the Cook Islands advocates the use of Pap tests for cervical cancer screening. There is however a very low screening rate with many eligible women never having received a Pap test in their life, missing the opportunity to identify pre-cancerous lesions that can be treated to prevent cervical cancer developing. All Pap tests in Rarotonga are performed by either the Cook Islands Family Welfare Association (CIFWA) or the Outpatients Department of the General Hospital. Both CIFWA and the Ministry of Health have identified the key issues impacting on screening rates which include; lack of adequate training for nurses and the need to train more nurses across the Cook Islands, resistance by women due to low level of reproductive and sexual health literacy, poor community based

promotion of cervical cancer screening and poor quality of data collection.

To address these issues Family Planning NSW will support the implementation of a joint clinical and community education project aimed at increasing cervical cancer screening in the Cook Islands. The project will include

1. Provision of training/updates to relevant nurses in the Cook Islands on cervical cancer screening (Pap Test and Thin Prep) by Family Planning NSW and CIFWA in collaboration with the MOH

The Clinical training program will be offered to up to 15 nurses at a time with an anticipated 30 nurses to be trained. It will consist of 2 days in-class education and 1 day clinical instruction. During the clinical component nurses will be instructed and assessed in performing cervical cancer screening on women. This will be conducted immediately after the in-class training and could take up to 2 weeks for all nurses to complete.

The in-class training and clinical components will be conducted in Rarotonga with nurses from 6 outer islands brought in to attend.

Eligibility for participation in the training program will be determined by Dr May Aung, Ministry of Health and will be based on nurses being able to perform cervical cancer screening in their own clinics i.e. having equipment required. These nurses will be drawn from the main island and the outer islands from both private and public clinics. Two clinical instructors from the Ministry of Health and a third from CIFWA will receive coaching from the Family Planning NSW nurse educators so they can work alongside them in delivering the training and undertaking the clinical instruction.

2. Provision of community education training programs

Staff from CIFWA, MoH Health Promotion and Community Health Services and relevant NGOs and volunteers will be invited to attend training to develop and strengthen an integrated stakeholder approach. The training will equip them to conduct community education sessions to raise awareness of the need for cervical cancer screening and to motivate women to have regular Pap tests.

In addition staff and volunteers will be coached by Family Planning NSW educators to write session plans, promote and organise the sessions and effectively deliver key messages. This will include classroom or community based observations of the delivery of information sessions.

3. Development of key messages and Information Education and Communication (IEC) materials and strategies to support the community education program and health promotion activities

Family Planning NSW will work with CIFWA and the Ministry of Health to identify key messages, review/develop IEC materials and test new materials to be used by nurses and community educators in awareness sessions. IEC methods will include distribution of printed materials, radio messaging and possible TV spots.

Project Outputs

1. Development of teaching materials for clinical and community education training.

2. Provision of clinical training up to 30 nurses drawn from across the Cook Islands on cervical cancer screening.

3. Provision of on the job mentoring to up to 30 nurses as part of the clinical component over a 2 week period following immediately after in- class training.

4. Delivery 2 community education outreach training sessions to CIFWA, MOH and NGO partner organisations on awareness raising strategies, community engagement techniques, IEC development and use of IEC materials.

5. Develop customised education session plans on cervical cancer screening in Cook Islands for use in all community awareness sessions.

6. Review, adaptation and/or development of cervical screening information and education materials for community level use i.e. flipcharts, pamphlets, radio scripts etc.

Sectoral Focus at Project Level	Sexual Reproductive Health/Family Planning
Primary DAC Code	13020
Secondary DAC Code	
Tertiary DAC Code	

DFAT ANCP Grant Excluding Interest	$65885.00
Total Funds Rolled Over From Previous Ye	$0.00
NGO ANCP Contribution	$0.00
DME expenditure from ANCP funding	$
Prior Funding	$30000.00

Project Risk Information
It is costly and time consuming for nurses to travel from outer islands and difficult to find people to back-fill their positions. These issues may result in some nurses not prioritising attendance at this training. However due to low numbers of nurses it is not feasible for the training to be conducted on each island. This risk is being mitigated by having the support of the Chief Obstetrician in selecting and supporting nurses to attend. Not all clinics have the equipment to enable nurses to perform cervical cancer screening. There is little point in providing training if the nurse can then not practise the skills. To address this, a clinic audit has been conducted and equipment needs identified. Nurses who have adequately equipped clinics will be selected by the Chief Obstetrician to attend the training. Family Planning NSW will also negotiate with the Ministry of Health to determine if equipment can be purchased for any of the clinics. Some women are resistant to having a Pap test and even though nurses are trained, women may not attend the service. This will be addressed by building the capacity of nurses and community educators to have clear positive messages about cervical cancer screening and strategies and activities to deliver those messages, including IEC materials, to community members. Community education activities will be conducted at the same time as clinical services can be provided.

Other Information
All staff engaged in the project will be employees of the Ministry of Health or Cook Islands Family Welfare Association and must have appropriate registration and medical liability coverage to be involved. Family Planning NSW Nurses working in country will seek registration from the local Nursing Board and will provide clinical supervision and support to registered nurses in country, but not provide direct clinical services. All activities will be implemented in accordance with the DFAT family planning guidelines.

Expected Beneficiaries

Baseline Direct		**Baseline Indirect**	
Expected Direct	4732	**Expected Indirect**	4687
Target Direct	4732	**Target Indirect**	4687

Male Direct	1653	**Male Indirect**	1638
Female Direct	2485	**Female Indirect**	2455
Boy Direct	182	**Boy Indirect**	182
Girl Direct	274	**Girl Indirect**	274
Male with Disability Direct	50	**Male with Disability Indirect**	50

Female with Disability Direct	75	**Female with Disability Indirect**	75
Boy with Disability Direct	5	**Boy with Disability Indirect**	5
Girl with Disability Direct	8	**Girl with Disability Indirect**	8

Urban Direct	3545	**Urban Indirect**	3515
Rural Direct	1187	**Rural Indirect**	1172

Family Planning

Family Planning Project	No
Expected Women family planning only	
Expected Men family planning only	

Program - Family Planning Program - FPNSW, ANCP21--PRG0035

Program Approach	Yes
Program Name	Family Planning Program - FPNSW

Countries
PHILIPPINES
FIJI
PAPUA NEW GUINEA
VANUATU

Program Description

Family Planning NSW projects are focussed on working to assist the poor and disadvantaged people in the Asia Pacific region to improve access to comprehensive family planning and reproductive health services. The DFAT Family Planning Guidelines recognise that access to family planning is one of the most cost effective approaches to reducing maternal and child mortality.

In 2014/15, we will focus on increasing access to quality health and education services with an emphasis on achieving long term impact on marginalised groups and saving lives. We will achieve this through capacity building local NGOs to provide high quality family planning services including clinical services, community education, resource development and professional education.

In Fiji, we will support a local NGO to promote and expand a sexual and reproductive health education program in Central, Western and Northern Fiji, developing customised family planning fact sheets and supporting the update and implementation of training for professionals such as teachers and nurses.
This capacity building approach will result in more people being able to provide accurate information to young people and members of the community about family planning and prevention from, and treatment of, STIs including HIV.

In the Morobe Province of Papua New Guinea, we will focus on building capacity building supporting nurses and health extension officers to complete a post basic certificate course in Sexual and Reproductive Health.

In Timor Leste and Papua New Guinea we are working with in-country partners, including Ministries of Health and local NGOs, to address gender inequality and the high rates of domestic and sexual violence against women, through a Men's Health program. These programs seek to enable men to become agents for improving reproductive and sexual health in their family and community. Voluntary peer educators are trained in a structured health education program that is flexible and can be delivered to communities and individuals.

In Vanuatu and the Philippines we will work with young people to increase access to family planning and contraception, including long acting contraception (LARC).

Expected Program Outcomes

1. Increasing awareness of family planning, contraception and safe sex, including use of condoms, among young people.

2. Providing to young people a range of family planning clinical services through fixed clinics and outreach services.

3. Building the capacity of teachers, nurses and health extension officers to deliver high quality family planning community education and clinical services.

Project - Sexual and Reproductive Health and Rights Education Program, ANCP21--PRG0035--PRJ293

Project Name	Sexual and Reproductive Health and Rights Education Program
Project Start Date	01/07/2012
Project End Date	30/06/2015
project funded in last financial year	Yes
Primary Country Region	FIJI
Primary Provinces Regions	Suva, Labasa and Lautoka

Secondary Countries	Provinces Regions

Implementing In-Country Partners
Reproductive and Family Health Association of Fiji (RFHAF)

Private Sector Partnerships

Does this project involve working or partnering with the private sector	

Gender Equality

How the activity addressing gender equality	
Gender equality Specify focus the activity	

Disability Inclusion

How the activity addressing accessibility	
Disability Inclusion Specify focus the activity	

GPS Coordinates

Latitude	Longitude	Location Name
S 18° 8' 29.76"	E 178° 26' 30.84"	Suva, Fiji
17° 37' S	177° 27' E	Lautoka, Fiji
16° 25' 0" S	179° 22' 58" E	Labasa, Fiji

Project Information

Project Description
This project builds on outcomes from activities implemented from 2012 to 2014 by Family Planning NSW in partnership with the Reproductive and Family Health Association of Fiji (RFHAF), the only provider of sexual health education and advocacy in Fiji. The rates of sexually transmissible infections (STIs) and teenage pregnancies in Fiji are indicators that not all young people are receiving information and education that can assist them to make informed decisions which will keep them healthy and safe. There are also a number of under-served groups that miss out on information and education including

people with disability and young people who are same sex attracted. In a needs assessment conducted by RFHAF of stakeholders in Central, Western and Northern Divisions, there was strong support for more sexual and reproductive health (SRH) education of young people as well as identifying the need for professionals such as nurses and teachers to also be more informed.

In 2012/13 all staff and volunteers of RFHAF successfully underwent an education program delivered by Family Planning NSW that aimed to build their capacity to plan, deliver and evaluate sexual and reproductive health and rights education.

In 2013/14 RFHAF staff and volunteers delivered training to young people both in and out of school as well as under-served groups such as young people with disability. Parents, communities and churches were all included as a way of promoting people's rights to access family planning services and to have good sexual and reproductive health.

Staff and volunteers have also worked together to write and test session plans to be made into a training manual that will ensure standardised approaches to training.

RFHAF staff were also trained to gain skills in conducting assessments as this is an important skill set that will increase their capacity to provide an education program for health workers. RFHAF has now started to design information, education and communication (IEC) materials on contraception, STIs and puberty. These give accurate information about family planning, contraceptive methods and condom use in easy to understand, culturally relevant ways.

In 2014/15 the focus will be on promoting expansion of the education program. RFHAF works closely with the Ministries of Health, Youth and Education and will take the next step to develop an education program for professionals such as teachers and nurses. This capacity building approach will result in more people being able to provide accurate information to young people and members of the community about family planning and prevention from, and treatment of, STIs including HIV. An important step will be to gain accreditation as a tertiary education provider with the national organisation in Fiji which RFHAF will continue to progress.

RFHAF staff will also be supported to build their skills to better reach and educate underserved groups, specifically people with disability, men who have sex with men and prisoners. They will be supported to develop teaching activities aimed at the needs of these groups.

An evaluation of the 3 year project will be implemented this year by Family Planning NSW. A significant amount of information and data has been collected over the past 2 years and this year a participatory approach will be used with the RFHAF staff and volunteers to collect more data. This will include Family Planning NSW providing training in evaluation methods, data analysis and reporting. These skills and knowledge will be applied to the evaluation of this project creating an opportunity to build capacity.

Project Outputs

1. Development of Information, Education and Communication (IEC) materials on contraception including long acting reversible contraceptives (LARC), STIs and safe sex including condom use, puberty and healthy relationships including child safety.

2. Distribution of IEC materials to schools and health services in Central, Western and Northern Divisions of Fiji.

3. Delivery of education sessions on sexual and reproductive health topics to 3 schools and 3 communities in each of the 3 Divisions.

4. Delivery of sexual and reproductive health education to 30 teachers and nurses.

5. Delivery of sexual and reproductive health community education to underserved groups.

6. Publication of the sexual and reproductive health training manual and distribution to key stakeholders.

7. Increased skills of RFHAF staff in implementing evaluation methods, analysing data and writing reports.

8. Development and update of policies, procedures and systems to assist RFHAFs work as an sexual and reproductive health education provider.

Sectoral Focus at Project Level	Sexual Reproductive Health/Family Planning
Primary DAC Code	13030
Secondary DAC Code	13040
Tertiary DAC Code	11230

DFAT ANCP Grant Excluding Interest	$46744.00
Total Funds Rolled Over From Previous Ye	$13500.00
NGO ANCP Contribution	$0.00
DME expenditure from ANCP funding	$5000.00
Prior Funding	S110467.00

Project Risk Information
In 2014/15 Fiji will have its first general election since a military coup in 2006. It is unknown what impact the lead up to and results of the election will have on civil stability. It could be a period of unrest and the safety and security of the population and also project staff will need to be assessed. It may also be a period of time when there are delays in normal operation of activities for staff of our in-country partner, Reproductive and Family Health Association of Fiji. The Executive Director is an experienced educator who provides strong leadership in building the capacity of RFHAF. She has recently accepted a secondment at IPPF regional office in Kuala Lumpur. It is possible that further opportunities will be offered to her. Her possible absence from RFHAF may impact on the progress of activities being implemented especially in relation to becoming accredited, providing nurse education and completing the education manual. This risk will be mitigated by Family Planning NSW continuing to provide regular coaching by distance to the education coordinator to keep activities on track. Family Planning NSW will also discuss this risk with the Executive Director and make a contingency plan for the possibility of her leaving. This would include building the capacity of the relevant staff member who would act in her position in relation to leading programs and reporting.

Other Information
All project activities will be implemented in accordance with the DFAT family planning guidelines. Any promotion of safe sex and condom use will be reported in relation to HIV prevention aspects of this proposal.

Expected Beneficiaries

Baseline Direct	3100	**Baseline Indirect**	1200
Expected Direct	1032	**Expected Indirect**	2970
Target Direct	4132	**Target Indirect**	4170

Male Direct	254	**Male Indirect**	720
Female Direct	268	**Female Indirect**	720
Boy Direct	240	**Boy Indirect**	720
Girl Direct	240	**Girl Indirect**	720
Male with Disability Direct	8	**Male with Disability Indirect**	24
Female with Disability Direct	8	**Female with Disability Indirect**	24
Boy with Disability Direct	7	**Boy with Disability Indirect**	21
Girl with Disability Direct	7	**Girl with Disability Indirect**	21

Urban Direct	351	**Urban Indirect**	990
Rural Direct	681	**Rural Indirect**	1980

Family Planning

Family Planning Project	Yes
Expected Women family planning only	268
Expected Men family planning only	254

Project - Strengthening of Sexually Transmitted Infections (STI) services in the Morobe Province, ANCP21--PRG0036--PRJ294

Project Name	Strengthening of Sexually Transmitted Infections (STI) services in the Morobe Province
Project Start Date	01/01/2013
Project End Date	30/06/2016
project funded in last financial year	Yes
Primary Country Region	PAPUA NEW GUINEA
Primary Provinces Regions	Morobe, Lae

Secondary Countries	**Provinces Regions**

Implementing In-Country Partners
Papua New Guinea Family Health Association
Morobe Provincial Health Office

Private Sector Partnerships

Does this project involve working or partnering with the private sector	

Gender Equality

How the activity addressing gender equality	
Gender equality Specify focus the activity	

Disability Inclusion

How the activity addressing accessibility	
Disability Inclusion Specify focus the activity	

GPS Coordinates

Latitude	**Longitude**	**Location Name**
6°44'S	147°0'E	Lae, Morobe Province

Project Information

Project Description
Since 2007 Family Planning NSW (FPNSW) has worked in the Morobe Province to support delivery of programs aimed at improving the HIV status, firstly through the Clinical Outreach, Men's Programs, Advocacy and Sexual Health Services Strengthening Project (COMPASS), under the PNG Sexual Health Improvement Program, funded by AusAID from 2007 to 2012 and then, since January 2013, in a reduced form through the ANCP Program. The Men and Boys Project was the first of its kind in Papua New Guinea (PNG) and has made inroads in challenging old ways of thinking and acting have been documented in the COMPASS program external evaluation.

The Men and Boys Program seeks to raise awareness and support positive change among men and boys regarding sexual health, gender equality, especially challenging the accepted norms of gender violence. It is also designed to address the key role of men in the prevention of transmission of sexually transmitted infections (STIs). The role of men in the prevention of STIs and improvement of sexual health for themselves and their partners is critical however men's involvement had been identified as largely ignored in previous aid programs even though men hold most of the power and decision making within PNG culture. The program aims to focus on positive role modelling for men as fathers, partners and community leaders. The focus of activities provides opportunities through a peer education model to discuss issues to help bring about desired attitudinal and behavioural change. Volunteer Community-Based Advocates (CBAs) are trained to conduct community, workplace education and one-to-one sessions to encourage men to discuss issues related to sexual health, domestic violence, family dynamics and conflict resolution. CBAs also refer the target group to STI services. The target group is all men and boys though specifically unemployed men in settlements and rural areas across the Morobe Province and out-of-school youth.

The Men and Boy's Program Officer has worked across Morobe Province with caretaker agencies, such as church groups, who in turn work with their CBAs. His role is to strengthen their capacity to work with men and boys through a series of trainings and support visits. The training sessions are based on the COMPASS developed and nationally accredited Men and Boys Manual, Working with Men and Boys to improve Sexual and Reproductive Health in PNG.

In 2014/15 this coordinating role will continue and be strengthened with Family Planning NSW providing technical advice to support the development and refinement of community participation resources and curricula relating to men's sexual and reproductive health needs in line with the recommendations from the evaluation of the program in 2012. This will include refinement of the Men's health manual to include more directed behaviour change strategies to support greater outcomes and increased institutional support; refinement of the Facilitators Guide to complement the men's manual and support smooth handover to other organisations in PNG. A Tool Kit which is user friendly will be developed and translated for use by peer educators working with community members.

The Men and Boys program will also work with the Morobe Provincial Health Office's Family Health Services to integrate Men and Boys Health issues into their clinical programs. To demonstrate the viability of the program a pre intervention survey will be implemented in a new District in the first year of the funding. The post survey, analysis and report will be executed late in the 2nd phase funding. A workshop for Family Health Services Nurses and HEO staff on sexual and reproductive health clinical issues and community education in partnership with the Provincial Health Office will be conducted by the Program Officer.

Project Outputs

1. Conduct pre and post knowledge, attitude and practice surveys to the target population in a new District to provide empirical data for impact over time.

2. Revision of Men's Health Manual to include more directed behaviour change strategies and to be more focused for community level to support greater outcomes and increased institutional support.

3. Refinement of the Facilitators Guide to complement the Men's Manual and support the smooth handover to other caretaker agencies.

4. Translation of all community level materials into Tok Pisin.

5. Printing and distribution of community level materials to caretaker agencies and Community-Based Advocates.

6. Quarterly meetings held with stakeholders including relevant, provincial and District Government departments, church groups.

7. Development and delivery of a workshop to Family Health Services Nurses and HEO staff on sexual and reproductive health clinical issues and and community education in partnership with the Provincial Health Office.

8. Men and Boys caretaker agencies capacity built and services supported through regular training and support visits by the Men's Project Officer.

Sectoral Focus at Project Level	Sexual Reproductive Health/Family Planning
Primary DAC Code	13040
Secondary DAC Code	13081
Tertiary DAC Code	

DFAT ANCP Grant Excluding Interest	$55693.00
Total Funds Rolled Over From Previous Ye	$43104.00
NGO ANCP Contribution	$0.00
DME expenditure from ANCP funding	$
Prior Funding	S144513.00

Project Risk Information
There are ongoing security risks in working in Papua New Guinea and particularly in Morobe Province. The risks of tribal unrest and rascol activity are ever present and can disrupt activities as can issues to do with poor roads, inclement weather, power outages. It is not always possible to minimise these risks but all safety precautions are in place to safeguard staff as much as possible. Currently our long term partner agency PNG Family Health Association (PNGFHA) in Lae is experiencing structural and financial difficulties which has disrupted their work. PNGFHA receive core funding from IPPF and have had continued issues with extensive delays in tranche payments. This impacts on service delivery as the office has been regularly closed due to non payment of rent and staff do not receive salaries. A meeting will be held at the IPPF Regional Council meeting on 28-29 June between the Regional Executive of IPPF and Board Chair of PNGFHA and it is hoped that the ongoing issues can be resolved and a clear agreement on ongoing funding for PNGFHA. However, there is a significant level of risk that they may be unable to resume the delivery of their services and we will be unable to continue our partnership with them. Having worked consistently in Lae for 8 years Family Planning NSW has developed strong associations with other sexual and reproductive health NGOs working in Lae. We have been in discussion with Susu Mamas a major non-government provider of reproductive health services, who are enthusiastic for us to join them in partnership and regard this as a way of strengthening their own services. Once the outcomes of discussions with IPPF are known, Family Planning NSW will progress discussions with the relevant partners to ensure that the project is delivered through the most appropriate NGO. .

Other Information
All project activities will be implemented in accordance with the DFAT family planning guidelines. The employment of a project coordinator to support the project officer strengthens the quality of the project. For example, peer educators will have increased support to deliver community education sessions by having monitoring and supervision visit. There will also be increased capacity for advocacy with government and community to integrate the program into activity plans to enable sustainability of the project.

Expected Beneficiaries

Baseline Direct		**Baseline Indirect**	
Expected Direct	1000	**Expected Indirect**	2400
Target Direct	1000	**Target Indirect**	2400

Male Direct	650	Male Indirect	1397
Female Direct	210	Female Indirect	582
Boy Direct	117	Boy Indirect	350
Girl Direct	0	Girl Indirect	0
Male with Disability Direct	14	Male with Disability Indirect	43
Female with Disability Direct	6	Female with Disability Indirect	18
Boy with Disability Direct	3	Boy with Disability Indirect	10
Girl with Disability Direct	0	Girl with Disability Indirect	0

Urban Direct	280	Urban Indirect	720
Rural Direct	720	Rural Indirect	1680

Family Planning

Family Planning Project	Yes
Expected Women family planning only	210
Expected Men family planning only	530

Project - Working with Men to Improve Sexual and Reproductive Health and Reduce Gender Violence, ANCP21--PRG0037--PRJ295

Project Name	Working with Men to Improve Sexual and Reproductive Health and Reduce Gender Violence
Project Start Date	01/07/2009
Project End Date	30/06/2016
project funded in last financial year	Yes
Primary Country Region	TIMOR-LESTE
Primary Provinces Regions	Ermera District

Secondary Countries	**Provinces Regions**

Implementing In-Country Partners
Cooperativa Café Timor

Private Sector Partnerships

Does this project involve working or partnering with the private sector	

Gender Equality

How the activity addressing gender equality	
Gender equality Specify focus the activity	

Disability Inclusion

How the activity addressing accessibility	
Disability Inclusion Specify focus the activity	

GPS Coordinates

Latitude	**Longitude**	**Location Name**
8°50'S	125°23'E	Ermera District, Timor Leste
8° 55' 30" S	125° 23' 53" E	Atsabe Timor Leste
8° 50' 4S	125° 25' 35E	Letefoho Timor Leste

Project Information

Project Description
With the success of the pilot project the Men's Health program was extended in 2013-14 to two new Sub Districts, Lesefoto and Atsabe with the aim to fully demonstrate a sustainable men's health program for rural Timor Leste. The program goals are fourfold: 1. To have men self-improve their personal health

2. For men to assume a lead role to improve their family's health by understanding the benefits of and facilitating access to local Maternal and Child Health and Family Planning services.
3. To reduce the level of gender violence
4. To demonstrate the transferability of the operating model and program resources for consideration by other primary care health services in Timor Leste.

The project utilises a peer education model using self-selected men's groups within each target community. The peer educators employ a specifically designed Men's Health Manual which presents targeted topics utilising participatory activities. This manual is a dynamic document which has been evaluated after the end of the First Phase in 2012 and revised accordingly to achieve maximum impact. The peer educators are supported by Cooperativa Clinic Timor (CCT) staff through a structured program of training and community support.

Achievements in 2013/14 include:
- Employment of Men's Health Program Manager and a District Men's Health Coordinator based in Ermera
- Refinement of the Men's Health Manual to include more directed behaviour change strategies to support greater outcomes and increased institutional support
- Development of a Facilitators Guide to complement the Men's Manual and support the smooth handover to other organisations
- Printing of the revised Men's Health manual for Timor Leste in both Tetun and English
- Selection of 20 peer educators in the Subdistricts of Atsabe and Letefoho
- Two, 2 week training sessions for the Peer Educators, utilising the Men's Manual and other tools for use in community based trainings
- Baseline survey of 400 men and boys in the 2 new Subdistricts of Atsabe and Letefoho. Developed, printed and executed. Baseline analysis and report completed
- Delivery of two 3 day workshops to train CCT clinic staff on sexual and reproductive health clinical and community education modules
- 22 CCT community health workers trained in the practical application of men's health concepts to integrate into their MCH and Family Planning community extension duties in Ermera and Ainaro Districts
- 92 individual men's health groups established in all but 1 of the 93 Aldeia of the 14 target Sucu covering a population of close to 30,000 up until March 2014.

To consolidate and improve on the expected gains in community knowledge and behaviour change an extension of the program is sought to June 2016.

The 2nd year of the 2nd Phase will include:
- consolidation of the Men's Program activities in the same suck's (villages), building on the existing program structures, systems, staffing and resources established in order to maximise the impact and demonstrate the strength of the model.

- a concerted and strategic effort to demonstrate the benefits of a sustainable and integrated Men's health program by influencing key stakeholders particularly the Ministry of Health and the Gender Directorate of the Prime Ministers Department of the merit of sustaining and expanding the program into the future

- continued integration of Men's health activities into local Health services by ongoing work with CCT clinics to modify and create family and men friendly local health facilities that are inviting, confidential and accepting.

- provision of empirical evidence of program benefits for Government decision makers and potential funders in Timor Leste. The mid-term project evaluation is an important objective of the second 12 months of the men's health program.

Project Outputs

1. Delivery of two 5 day refresher training courses for 20 peer educators with monthly support by the program manager and district coordinator.

2. The CCT Men's Health Manager and the Ermera based Men's District Health Coordinator to liaise on a monthly basis with local community Councils and local health providers and support the peer educators to ensure that community men's groups are operating regularly and effectively.

3. Key personnel from the Ministry of Health and Gender Directorate of the Prime Ministers Department invited and supported to participate in program activities in order to engender ownership and leadership for the program.

4. Provision of training to 52 clinical and community health CCT staff in three separate training sessions. Follow-up support sessions by CCT's quality team will occur during regular CCT in-services and on-site support visits.

5. Bimonthly meetings with communities to provide feedback and share information with community leaders and members.

6. Regular meetings for project updates with key policy persons in the Ministry of Health and Gender Directorate of the Prime Ministers Department.

7. Ongoing liaison with relevant key rural non-government health service providers for updating and information sharing.

8. Mid-term project evaluation based on the pre-intervention survey to be completed in October/ November 2014. As all the target communities have had no men's heath interventions prior to CCT's men's health program commencing, the analysis and comparison of the pre and post intervention survey results will offer a precise measure of the program impact to date.

Sectoral Focus at Project Level	Sexual Reproductive Health/Family Planning
Primary DAC Code	13081
Secondary DAC Code	13030
Tertiary DAC Code	

DFAT ANCP Grant Excluding Interest	$41435.00
Total Funds Rolled Over From Previous Ye	$0.00
NGO ANCP Contribution	$0.00
DME expenditure from ANCP funding	$
Prior Funding	$221151.00

Project Risk Information
In all development projects there is a risk that key personnel who are the drivers of the project may leave. By building capacity within the project and increasing to institutionalise the program into the core activities of the organisation it is hoped that this risk may be lessened.

Other Information
From 2010 Cooperativa Café Timor (CCT) has partnered with Family Planning NSW to develop and implement the first Men's Health program for Timor Leste. This pilot program introduced men's health concepts across a number of sub districts in the Ermera province and was highly successful. This project provides theoretical training to clinical staff and supports the provision of community based education. Family Planning NSW does not support the provision of any clinical services in Timor Leste. CCT provide clinical services funded from a variety of sources and have their own provisions for medical indemnity in place. All project activities will be implemented in accordance with the DFAT family planning guidelines .

Expected Beneficiaries

Baseline Direct	75	**Baseline Indirect**	1506
Expected Direct	1052	**Expected Indirect**	15000
Target Direct	1127	**Target Indirect**	16506

Male Direct	812	**Male Indirect**	6548
Female Direct	113	**Female Indirect**	6548
Boy Direct	87	**Boy Indirect**	728
Girl Direct	9	**Girl Indirect**	728
Male with Disability Direct	24	**Male with Disability Indirect**	202
Female with Disability Direct	3	**Female with Disability Indirect**	202
Boy with Disability Direct	3	**Boy with Disability Indirect**	22
Girl with Disability Direct	1	**Girl with Disability Indirect**	22

Urban Direct	0	**Urban Indirect**	0
Rural Direct	1052	**Rural Indirect**	15000

Family Planning

Family Planning Project	Yes
Expected Women family planning only	113
Expected Men family planning only	812

Project - Increasing access to contraception in Vanuatu, ANCP21--PRG0035--PRJ379

Project Name	Increasing access to contraception in Vanuatu
Project Start Date	01/08/2014
Project End Date	30/06/2016
project funded in last financial year	No
Primary Country Region	VANUATU
Primary Provinces Regions	Tafea, Sanma and Shefa Provinces

Secondary Countries	Provinces Regions

Implementing In-Country Partners
Vanuatu Family Health Association

Private Sector Partnerships

Does this project involve working or partnering with the private sector	

Gender Equality

How the activity addressing gender equality	
Gender equality Specify focus the activity	

Disability Inclusion

How the activity addressing accessibility	
Disability Inclusion Specify focus the activity	

GPS Coordinates

Latitude	Longitude	Location Name
16° 0' S	167° 0' E	Port Vila Vanuatu
15°30'21"S	167°13'17"E	Espiritu Santo island
20.2000° S	169.8167° E	Aneityum island

Project Information

Project Description
The goal of this project is to promote access to family planning, contraception and information for people aged 14 to 25 years on four islands in Vanuatu by 1. Increasing awareness of family planning and safe sex, including use of condoms, among young people aged 14-25 years

2. Providing to young people a range of family planning contraceptives and clinical services through fixed and mobile clinics.

This is a new partnership between Family Planning NSW and the Vanuatu Family Health Association (VFHA), which is a sexual and reproductive health (SRH) service accredited by International Planned Parenthood Federation (IPPF) providing clinical services, community and peer education and advocacy. This is the first year of a proposed 2 year project.

Young people in Vanuatu are often making decisions affecting their SRH without accurate information or support from service providers. Family planning, which is a means of improving sexual and reproductive health as well as reducing infant and maternal deaths, is often ignored particularly on grounds of religion, distance, ignorance, cost and culture.

Over 40% of the population in Vanuatu is younger than 15 years and 58% are under 25 years (UNFPA). The World Development Indicators (WDI) show poor SRH for young people living in Vanuatu especially those who are outside urban areas and have lower educational levels. There is a high teenage fertility rate estimated at 52 per 1,000 births (UNICEF 2012). The contraceptive prevalence rates is 38% and the maternal mortality rate is 86 (WDI). VFHA states that unsafe abortion and infanticide cases are regularly reported in the press and consequences of unsafe abortions seen by clinical staff. There is limited education about, and awareness of, sexual and reproductive health including family planning, contraception and sexually transmissible infections. (UNFPA)

Improving access to, and uptake of, family planning services requires the availability of adequate commodity supplies, human resources, facilities and awareness campaigns. This project would promote increased access to family planning services by providing quality contraceptives, counselling and accurate information to the underserved young people particularly those living in rural areas.

Activities in the first year of the project include:
1. developing key messages about family planning and contraception and design information, education and communication (IEC) materials with key stakeholders in Port Vila.

2. production and distribution of booklets in Bislama language about family planning and contraception.

3. awareness campaign sessions about family planning, safe sex and contraception in schools and in communities.

4. promotion of contraceptive services and safe sex messaging using local radio.

5. provision of contraception information and clinical services to young people, men and women through fixed and mobile clinics program in 4 islands.

The project will target rural areas of the two most populated islands, Efate and Espiritu Santo. The smaller rural islands of Aneityum and Tanna will be included in the project as young people on the island have limited access to services.

This project will add value to a new outreach clinical service being implemented by the Vanuatu Family Health Association. This project will also align with another new project to train 4 VFHA nurses over 2 years to be able to insert contraceptive implants. This will assist with the uptake of long acting reversible contraceptives (LARC).

Sustainability beyond this project will be planned from the start. Data about barriers and enablers to contraceptive use and the needs of rural young people will be collected and an evidence base will be created to identify contraceptive need in rural areas. This will assist in advocacy activities with Government, policy making and decision making.

Project Outputs

1. Delivery of community education on contraceptive choices and family planning to 3,000 people.

2. Increased knowledge of young people of contraceptive choices and importance of family planning.

3. Development and distribution of IEC materials on contraception and family planning in Bislama language.

4. Provide family planning clinical services to 3,000 people aged 14–24, living in rural areas, including people with disability and new adopters. 5. Increased uptake of long acting reversible contraction (LARC) by young people.

Sectoral Focus at Project Level	Sexual Reproductive Health/Family Planning
Primary DAC Code	13030
Secondary DAC Code	11230
Tertiary DAC Code	

DFAT ANCP Grant Excluding Interest	$326.00
Total Funds Rolled Over From Previous Ye	$20693.00
NGO ANCP Contribution	$66000.00
DME expenditure from ANCP funding	$
Prior Funding	$0.00

Project Risk Information
Data collection systems are being upgraded in VFHA. Poor data collection will impact on reporting on the project and also in creating the evidence base for future advocacy. The organisation is currently working on creating a comprehensive data collection system with the help of an international volunteer. However it may not be ready for implementation in Santo or Aneityum during the life of this project. The risk is being mitigated by identifying strategies with VFHA to collect data as an interim measure at the start of the project. One of the project sites – Aneityum – is a remote island with limited infrastructure and a more conservative culture than Efate and Espritu Santo. VFHA has only a limited presence on the island currently. It may take the community time to trust the VFHA staff and volunteers and be willing to accept the family planning services. This may delay implementation of the project. The risk is being mitigated by working with the volunteer peer educator that lives on the island, and working with communities to ensure that services are provided in culturally acceptable ways. Also this project will be aligned with another new clinical outreach project that is being introduced by VFHA which will provide an integrated and substantial service to the communities. The provision of long acting reversible contraceptives will be partly reliant on 2 nurses from the VFHA being trained on inserting implants. This training has been planned and funded through a separate project. If this training does not happen, there will be no capacity for implants to be provided. Other LARC ie injectibles and IUDs will be among the choices available however.

Other Information
In March 2015 Vanuatu was significantly impacted by a cyclone. During recovery Vanuatu Family Health Association requested support to meet the sexual and reproductive health needs that they felt were not being prioritised in the Government Recovery Program. VFHA was invited by the chiefs on Tanna Island, the worst hit island, to provide integrated health services including sexual and reproductive health. Family Planning provided additional funding for the purchase of additional contraceptive supplies to support this outreach and to replace lost supplies in Port Vila. The project will be implemented in accordance to the DFAT family planning guidelines. All clinical services will be delivered by Vanuatu Family Planning Association (VFHA) staff by registered nurses and midwifes and will have appropriate medical liability coverage.

Expected Beneficiaries

Baseline Direct	0	**Baseline Indirect**	0

Expected Direct	4250	**Expected Indirect**	9000
Target Direct	7500	**Target Indirect**	22500

Male Direct	729	**Male Indirect**	2037
Female Direct	1550	**Female Indirect**	4074
Boy Direct	550	**Boy Indirect**	873
Girl Direct	1311	**Girl Indirect**	1746
Male with Disability Direct	30	**Male with Disability Indirect**	63
Female with Disability Direct	50	**Female with Disability Indirect**	126
Boy with Disability Direct	10	**Boy with Disability Indirect**	27
Girl with Disability Direct	20	**Girl with Disability Indirect**	54

Urban Direct	1000	**Urban Indirect**	3000
Rural Direct	3250	**Rural Indirect**	6000

Family Planning

Family Planning Project	Yes
Expected Women family planning only	1800
Expected Men family planning only	879

Project - Post Basic Certificate Course in Sexual and Reproductive Health for Nurses and HEOs in Papua New Guinea, ANCP21--PRG0035--PRJ380

Project Name	Post Basic Certificate Course in Sexual and Reproductive Health for Nurses and HEOs in Papua New Guinea
Project Start Date	01/07/2014
Project End Date	30/06/2016
project funded in last financial year	No
Primary Country Region	PAPUA NEW GUINEA
Primary Provinces Regions	Lae, Morobe Province

Secondary Countries	**Provinces Regions**

Implementing In-Country Partners
Morobe Provincial Health Office
Susu Mamas

Private Sector Partnerships

Does this project involve working or partnering with the private sector	

Gender Equality

How the activity addressing gender equality	
Gender equality Specify focus the activity	

Disability Inclusion

How the activity addressing accessibility	
Disability Inclusion Specify focus the activity	

GPS Coordinates

Latitude	**Longitude**	**Location Name**
6°44'S	147°0'E	Lae, Morobe Province

Project Information

Project Description
In November 2012 nine nurses graduated from the first post graduate course in sexual and reproductive health ever delivered in Papua New Guinea (PNG). The pilot course was coordinated through the Clinical Outreach, Men's Programs, Advocacy and Sexual Health Services Strengthening Project (COMPASS)in Lae in Morobe Province in partnership with the PNG Family Health Association. It was managed by Family Planning NSW with funding for the pilot provided by AusAID.

The course was designed by Family Planning NSW in response to a request from PNG's National Department of Health (NDoH) that registered nurses and health extension officers have the opportunity to develop knowledge, skills and the desired attitudes for promoting the sexual and reproductive health of people of PNG.

This was in direct response to the fact that PNG has some of the poorest sexual and reproductive health indicators in the Asia Pacific. There are 31,000 adults and more than 3,000 children living with HIV in PNG. There are 3,200 new infections diagnosed each year with women and adolescents most affected. The number of women dying due to complications of pregnancy or birth is one of the highest in the region. Contraceptive use remains low, fertility rates high and antenatal care, beyond a single visit, is only accessed by the minority of women.

The independent evaluation of the pilot in 2012 found that "the course was highly relevant to the current and future health strategies of PNG. It was also very positively regarded by all the students and their managers. It recommended that the course should continue into the future and that to make a difference it needs to increase its reach to a high percentage of nursing and Health Extension Officers."

Family Planning NSW is advocating for the course to be taken up by PNG educational institutions but recognises that this will take time to engage a local provider. In the meantime we have secured funding through a private donor to repeat the pilot course over a 12 month period. However supplementary funding is required to implement and maximise the efficacy of the recommendations made in the 2012 external evaluation.

These recommendations included "re-running the course pilot over 18 months and refining the course in light of internal and external evaluation of the pilot in anticipation of expected integration in to training programs offered by a suitable health training institute in PNG."

The activities for this project will include:
• working with the National reproductive health curriculum expert on the recommended changes and contextualisation of the Training Manual
• surveying the graduating students from 2012 to document the impact of the course
• gathering further empirical evidence as to its merit as a National training tool through a second evaluation to be implemented in 2016
• consulting with relevant stakeholders on sustainability strategies into the future

The course will then be implemented once the recommended changes to the Training Manual have been made. Fifteen health staff from both private and public health services will be enrolled with the aim of building and strengthening the pool of SRH experts in the Morobe Province. The Morobe Provincial Health Adviser is firmly committed to supporting the project to make this happen.

Project Outputs

1. Revise and update the Post Basic Certificate course in Sexual and Reproductive Health for PNGs Health Extension and Nursing Officers in line with recommendations made in the 2012 external review.

2. Recruitment of a National Sexual Health Course Coordinator to coordinate all aspects of the program with support from Family Planning NSW.

3. Selection and enrolment of 15 students, nurses and HEOs from government and non-government organisations in Lae through a rigorous selection procedure by a panel of Provincial and District Health professionals to participate in the course.

4. Implementation of a pilot distance mode Certificate course completed over an 11 month period from January 2015 – December 2015 based in Lae Morobe Province.

5. Weekly tutorials and study sessions that include peer based learning, guest speakers and support from the course coordinator who will facilitate discussions, clarify learning activities, coordinate work assessment and assist individual students with planning the study workload.

6. Printing and dissemination of training support tools and resources to students.

7. Surveying and reporting on the progress of the 9 graduates of the 2012 course to establish sustained learning and empowerment to implement their new knowledge, attitudes and skills.

8. Regular meetings with key PNG stakeholders from NDoH, PDOH and other Government departments, relevant training institutions, representatives from the PNG Sexual Health and O&G Societies and potential funders, i.e. extractive industries to promote the course and demonstrate its impact.

Sectoral Focus at Project Level	Sexual Reproductive Health/Family Planning
Primary DAC Code	13081
Secondary DAC Code	13030
Tertiary DAC Code	13040

DFAT ANCP Grant Excluding Interest	$9416.00
Total Funds Rolled Over From Previous Ye	$0.00
NGO ANCP Contribution	S123000.00
DME expenditure from ANCP funding	$1500.00
Prior Funding	$0.00

Project Risk Information

There are ongoing security risks in working in Papua New Guinea and particularly in Morobe Province. The risks of tribal unrest and rascol activity are ever present and can disrupt activities as can issues to do with poor roads, inclement weather, power outages. It is not always possible to minimise these risks but all safety precautions are in place to safeguard staff as much as possible.

Partnerships with NGOs can be put at risk due to in-country instability, funding issues, environment challenges such as affordable office space, reliable staff etc. This risk is mitigated by assessing partner capacity in relation to financial and organisational stability and reputation and alliance with ANCP and Family Planning NSW principles and values. Family Planning NSW has identified a partner that has long term stability and a strong reputation for quality service deliver and good governance.

Other Information

Grant funding for this project has been received for 12 months commencing in July 2014. Ideally the project needs a full 18 months to demonstrate its potential. The initial 3-4 months would include; revision, updating and further development of existing materials in accordance with the external evaluation, preparation for course implementation such as selection and recruitment of Nurse and HEO students, reformation of the Morobe S&RH expert panel to support the course as guest tutors and advisers and liaison meetings with all stakeholders, including MOH, NDOH and private and public clinic managements to ensure effective partnerships to strengthen the subsequent input and output of the course.

It would be planned to start the course proper in early November and run it for at least 12-14 months. The previous course in 2012 ran for 10 months and placed a substantial burden on the students (80% women) and their families, most of whom live in urban settlements without reliable power supply, have multiple commitments to their family and community as well as having full time clinic jobs with varying levels of family support. From the external evaluation many reported studying at 3am using kerosene lanterns as it was the only free time they could study. We would like to avoid placing any undue hardship on students where possible in this course. The course would be due for completion and Graduation in December 2015.

An internal evaluation would take place in early 2016 and the findings would be distributed to MOH and the PHO and all key relevant educational institutions and to the Reproductive Health training Unit in Port Moresby.

All project activities will be implemented in accordance with the DFAT family planning guidelines.

Expected Beneficiaries

Baseline Direct		**Baseline Indirect**	
Expected Direct	15	**Expected Indirect**	7500
Target Direct	15	**Target Indirect**	25500

Male Direct	5	**Male Indirect**	1940
Female Direct	10	**Female Indirect**	3880
Boy Direct	0	**Boy Indirect**	485
Girl Direct	0	**Girl Indirect**	970
Male with Disability Direct	0	**Male with Disability Indirect**	60
Female with Disability Direct	0	**Female with Disability Indirect**	120
Boy with Disability Direct	0	**Boy with Disability Indirect**	15
Girl with Disability Direct	0	**Girl with Disability Indirect**	30

Urban Direct	5	**Urban Indirect**	2250
Rural Direct	10	**Rural Indirect**	5250

Family Planning

Family Planning Project	Yes
Expected Women family planning only	10
Expected Men family planning only	5

Australian NGO Cooperation Program (ANCP) Full Annual Development Plan (ADPlan) Report 2014-15

Marie Stopes International Australia

This report was drawn from the ANCP online database on 10 November 2015 and contains the ADPlan of Marie Stopes International Australia approved for implementation in the 2014-15 fiscal year. The ANCP is an annual grants program. Funding to NGOs is determined on an annual basis. Funding amounts proposed and approved for implementation of individual projects within ADPlans refers to annual project allocations. But, some projects planned by NGOs run over multiple years.

Table of Contents

Project Overview

Project ID	Project Name	Country	ANCP Contribution	NGO Contribution	Sector
ANCP29--PRG9929--PRJ430	The Business of Development: Private Partnerships to Deliver on Vietnam's Maternal and Child Health Goals	VIET NAM	$681395.00	$107270.00	Sexual Reproductive Health/Family Planning
ANCP29--PRG9929--PRJ431	The Chance to Choose: Mobile family planning services for underserved communities in rural Nepal	NEPAL	$485663.00	$148019.00	Sexual Reproductive Health/Family Planning
ANCP29--PRG9929--PRJ432	Guff2Y ("Chat to youth)" project for providing interactive information and services on a wide range of sexual health matters to urban and rural youth in Nepal	NEPAL	$394881.00	$128234.00	Sexual Reproductive Health/Family Planning
ANCP29--PRG9929--PRJ468	Bringing quality to quantity: Strengthening the delivery of family planning products and services through the private health sector in Cambodia.	CAMBODIA	$119104.00	$0.00	Sexual Reproductive Health/Family Planning

ANCP29 - Marie Stopes International Australia (MSIA)

Accreditation Type	Full
AAH2 Postal Address Full Address	GPO Box 3308 Melbourne VIC 3001
AAH2 Street Address Full Address	
Business Phone	(03) 9658 7537
Website	http://www.mariestopes.org.au

ABN	79082496697	**ABN Registered Organisation Name**	Marie Stopes International Australia
ABN Registered Charity		**ABN Registered Charity Type**	Public Benevolent Institution
ABN Registered Organisation Type	Australian Public Company	**ABN Status**	Active
ABN Registered for GST	Yes	**Tax Concessions**	FBT Rebate, GST Concession, Income Tax Exemption
Registered as DGR		**Registered Postcode**	3001
DGR Funds		**Registered State**	VIC

Head NGO Full Name	Ms Maria Deveson Crabbe
Position	Chief Executive Officer
Phone	
Email	Maria.DevesonCrabbe@mariestopes.org.au

ANCP Contact 1 Full Name	
Position	Grants Officer
Phone	
Email	@mariestopes.org.au

ANCP Contact 2 Full Name	
Position	Grants Manager
Phone	
Email	@mariestopes.org.au

ME Contact Full Name	
Position	Manager, Policy, Research and Design
Phone	
Email	@mariestopes.org.au

DAR Contact Full Name	
Position	
Phone	
Email	

Financial Officer Full Name	
Position	International Finance Advisor
Phone	
Email	@mariestopes.org.au

Overarching Development Approach
Marie Stopes International Australia (MSIA) is a member of Marie Stopes International (MSI) global partnership providing contraception, safe abortion and maternal and child healthcare services to women and men around the world. MSI is focused on reaching underserved communities; working in remote areas with the young, the poor and the displaced using innovative methods designed to achieve the greatest impact. A social business philosophy underpins our development approach. We deliver on social objectives using commercial principles and strategies. We're committed to providing choice in family planning so the people we work with can control their own future by managing their own fertility. We offer short term and long term methods of family planning allowing clients to make informed choices about the most suitable contraception for them. We offer integrated services providing maternal and child health care, HIV and STI prevention, counselling and testing and safe abortion options where we legally can. We work with governments, communities and local organisations to expand access to family planning and maternal health services and strengthen local health systems. We use a variety of different delivery channels in order to reach the people who need our services most. As well as expanding choice in contraceptive methods through static clinics, we undertake social marketing which increases family planning choices in outlets where people access health products. Mobile outreach teams travel from our clinics to take family planning services to hard-to-reach communities. We also work with existing private and government healthcare providers through a social franchise model. This works by grouping providers under a shared brand to form a network of practitioners offering standardised services. These social franchise providers receive extensive and ongoing training and we provide them with affordable high quality family planning commodities and other products. We closely monitor the quality of their services to make sure they meet our international standards. MSI consistently works to build the clinical and management capacity of country programs so they are better able to respond to unmet need for family planning. We continuously improve upon clinical quality under our clinical Quality Assurance Framework. Remaining innovative and responsive to the needs of our clients by evolving our centres, expanding choice, increasing the reach of our services and improving clinical quality enables us to transform access to the services we provide, improve efficiency and catalyse other public and private health providers who deliver family planning and safe abortion services.

Attachment	

Approach to Cross-cutting Issues
Gender - While the majority of our clients globally are female, male involvement in family planning and sexual reproductive health (SRH) is recognised as an essential strategy to improving health outcomes. We target men both as prospective service users and for their role in family planning decision-making. Through Information, Education and Communication (IEC) and Behaviour Change Communication (BCC) activities MSI promotes the role of men and women in SRH. Environment Sustainability - MSI has considered mechanisms for reducing environmental transaction costs by focusing on low cost, client-focused services delivered as close to clients as possible using existing community structures and government systems. MSI maintains the highest standards in medical waste management regardless of location or service modality. HIV/AIDS - Operationally MSI integrates family planning and HIV services through the provision of voluntary, confidential testing and counselling at many of our static centres and mobile outreach. Referral linkages are in place for HIV treatment including the Prevention of Mother to Child Transmission for those testing positive. HIV awareness and prevention are also key elements of our IEC and BCC strategies. Recognising the specialised FP needs of people living with HIV/AIDS and most at risk populations, we promote a "condom plus" approach to FP with dual method messages. Disability inclusion - MSIA considers issues of disability inclusion in its strategic approach to program design and implementation across all its programs. While not implementing any disability specific projects through ANCP, MSIA recognises the importance of considering disability while planning and implementing programs targeting both the supply and demand of SRH services. Such considerations take into account the capacity of service providers to deliver

disability friendly services as well as the accessibility of service delivery points for people with disabilities. Demand side considerations include the provision of SRH information and education tailored to the needs of people with disabilities as well as provision of information regarding accessible service delivery points.

Describe DME Program
Design: MSI project designs are led by country teams and facilitated by technical design experts with skills in participatory program design. The design process involves consultation with country program staff and technical units, partners and community groups. Designs often utilise theory of change approaches and usually contain detailed considerations of value for money within M&E frameworks. All projects proposed in our ADPlans stem from priorities identified through country programme strategic planning processes. Monitoring: Monitoring against project targets and project expenditure is the responsibility of project teams in each country with MSIA providing oversight and technical support. MSIA provides technical support to ensure projects remain on track. All MSI programs also collect data daily and conduct monthly analysis of data to identify learning to feed into the project cycle. Evaluations: Evaluation is undertaken for projects and their components for internal and external learning. MSI has a number of resources, tools and processes in place for the evaluation of the impact and effectiveness of our services and program activities. Large scale and long term projects are evaluated for outcomes and impacts.

Expected Beneficiaries

Baseline Direct	1086750	**Baseline Indirect**	768815	**Baseline DAR**	
Expected Direct	1128048	**Expected Indirect**	1149600	**Expected DAR**	
Target Direct	2972256	**Target Indirect**	2922015	**Target DAR**	

Male Direct	2592	**Male Indirect**	5678	**Male DAR**	
Female Direct	1084656	**Female Indirect**	975922	**Female DAR**	
Boy Direct	12240	**Boy Indirect**	53000	**Boy DAR**	
Girl Direct	28560	**Girl Indirect**	115000	**Girl DAR**	
Male with Disability Direct	0	**Male with Disability Indirect**	0	**Male with Disability DAR**	
Female with Disability Direct	0	**Female with Disability Indirect**	0	**Female with Disability DAR**	
Boy with Disability Direct	0	**Boy with Disability Indirect**	0	**Boy with Disability DAR**	
Girl with Disability Direct	0	**Girl with Disability Indirect**	0	**Girl with Disability DAR**	

Urban Direct	344837	**Urban Indirect**	300160	**Urban DAR**	0
Rural Direct	783211	**Rural Indirect**	849440	**Rural DAR**	0

NGO Financial Year Period	January - December

Total NGO revenue - Previous	S12211929.00
DFAT funding - Previous	S8049426.00
Aus Gov Funding excl DFAT - Previous	$0.00

Revenue from Australian public - Previous	S2836138.00

Total NGO revenue - current	S12849758.00
Aus Gov funding excl DFAT - current	$
DFAT funding - current	$
Revenue from Australian public - current	S3835000.00

Project Budget Summary	

Estimated DFAT ANCP Funding this ADPlan period

Rollover funds excluding interest	$52664.00
Rolled over interest	$7902.00
ANCP grant	S1849148.00
Estimated interest ADPlan period	$7902.00
TOTAL funding	S1917616.00

Estimated DFAT ANCP Expenditure this ADPlan period

Project activity costs	S1634841.00
Design Monitoring and Evaluation expenditure	S114670.00
In-Australia Development Awareness Raising expenditure	$0.00
Administration Overheads expenditure	S168105.00
TOTAL Expenditure	S1917616.00

NGO Contribution

NGO Contribution	S383523.00

Evaluation

Country	
Program Project Name	
Program Project ANCP Online Identification	
Start Date	
End Date	
Sector Focus	
Primary DAC Code	
Estimated total cost the evaluation	
Estimated DFAT subsidy towards cost evaluation	
Evaluation Outline	
Attach a copy material related to this evaluation	

Indicators

Saving Lives	
Promoting Opportunities for all	
Sustainable Economic Development	
Effective Governance	
ANCP	
Involving Australian Community	

Baseline - 1101		Expected - 1101		Target - 1101	
Baseline - 1102		Expected - 1102		Target - 1102	
Baseline - 1201		Expected - 1201		Target - 1201	
Baseline - 1301		Expected - 1301		Target - 1301	
Baseline - 1307		Expected - 1307		Target - 107	
Baseline - 2101		Expected - 2101		Target - 2101	
Baseline - 2201		Expected - 2201		Target - 2201	
Baseline - 2202		Expected - 2202		Target - 2202	
Baseline - 2203		Expected - 2203		Target - 2203	
Baseline - 2204		Expected - 2204		Target - 2204	
Baseline - 2501		Expected - 2501		Target - 2501	
Total Number WASH Committee funded					
Baseline - 2705		Expected - 2705		Target - 2705	
Baseline - 2801		Expected - 2801		Target - 2801	
Baseline - 2807		Expected - 2807		Target - 2807	
Baseline - 3101		Expected - 3101		Target - 3101	
Baseline - 3102		Expected - 3102		Target - 3102	
Baseline - 3201		Expected - 3201		Target - 3201	
Baseline - 3202		Expected - 3202		Target - 3202	
Baseline - 4101		Expected - 4101		Target - 4101	
Baseline - 6000		Expected - 6000		Target - 6000	
Baseline - 6103		Expected - 6103		Target - 6103	
Baseline - 7106		Expected - 7106		Target - 7106	

Copy signed approval attached	2014 - 15 ADPlan Cerification_signed.pdf
Authorised Officer Full Name	Ms Elizabeth Sime
Position	Regional Director - Asia Pacific Region
Date Approval	28/06/2013

Program - , ANCP29--PRG9929

Program Approach	No
Program Name	

Countries

Program Description

Expected Program Outcomes

Project - The Business of Development: Private Partnerships to Deliver on Vietnam's Maternal and Child Health Goals, ANCP29--PRG9929--PRJ430

Project Name	The Business of Development: Private Partnerships to Deliver on Vietnam's Maternal and Child Health Goals
Project Start Date	01/01/2013
Project End Date	31/12/2015
project funded in last financial year	Yes
Primary Country Region	VIET NAM
Primary Provinces Regions	Ha noi city, Hai Phong City, Khanh Hoa province, Ho Chi Minh city, Binh Duong province, Dong Nai province and An Giang province

Secondary Countries	**Provinces Regions**

Implementing In-Country Partners
Marie Stopes International Viet Nam (MSIVN)

Private Sector Partnerships

Does this project involve working or partnering with the private sector	

Gender Equality

How the activity addressing gender equality	
Gender equality Specify focus the activity	

Disability Inclusion

How the activity addressing accessibility	
Disability Inclusion Specify focus the activity	

GPS Coordinates

Latitude	**Longitude**	**Location Name**
21.033333	105.85	Ha noi, Vietnam
20.844912	106.688084	Hai Phong, Vietnam
12.25851	109.052608	Khanh Hoa, Vienam
10.823099	106.629664	Ho Chi Minh, Vietnam
11.325402	106.477017	Binh Duong, Vietnam
10.957413	106.842687	Dong Nai, Vietnam
10.521584	105,125896	An Giang, Vietnam

Project Information

Project Description
There is a great need for Family Planning (FP) and Sexual and Reproductive Health (SRH) services in Vietnam as its

population of 90 million is predominately young (58% under 25) and includes many women of reproductive age (28.9%).

Although FP is prioritised within national health strategies, the overloaded public health system struggles to provide comprehensive quality care to all those in need.
To address this issue Marie Stopes International Vietnam (MSIVN) has established two SRH social franchise clinic networks. In partnership with the government and using a local brand, Tinh Chi Em (TCE), and MSI's international brand, BlueStar, and working across seven provinces, both networks have become strong and effective service delivery channels integrated into the national health system delivering family planning and safe abortion services.

The aim of this project is to strengthen the capacity and sustainability of the social franchise networks so that MSIVN can increase access to FP for underserved populations. This will be achieved through:

1. Increasing access to family planning and safe abortion services for women and couples by:
• identifying unmet need among underserved populations such as low income women living in peri-urban areas, employed in factories and industrialised labour, and improving service delivery to them by mobilising social franchisees to provide outreach services
• utilising social marketing and education materials to increase awareness of FP services provided by social franchises targeting priority underserved clients (migrant factory workers, ethnic minorities in isolated communities, low income women and youth) to continue aiming for equity in access to family planning.
• supporting franchisees with a supply of high quality, branded and competitively priced, socially marketed commodities
• strengthening internal referral systems from midwives to obstetricians and/or general health practitioners

2. Improving quality and efficiency of sexual and reproductive health services by
• strengthening quality of services through monitoring and trainings across the network including both clinical and non-clinical capacity building in infection prevention, family planning and reproductive health counselling, service quality in FP provision (including IUD insertion and removal), safe abortion provision, , and needs-based in depth trainings.
• developing a cost analysis model for BlueStar social franchise

3. Increasing accountability of the franchise network by
• educating clients on their rights and the quality of service they can expect from the social franchise network and soliciting client feedback through various channels to constantly improve quality.

4. Increasing the operation management synergy between TCE and BlueStar by
• joint development and rollout of Information, Education and Communication (IEC) materials across the network
• collaborating on opportunities to conduct joint training activities, clinical quality assessments, technical assistance visits, and advocacy for health system integration and public financing.

This project is the core part of a three-year Sustainability Strategy for MSIVN's social franchises, where continuous quality improvement is identified as a core component for achieving these aims. MSIVN currently implements the full quality assurance system of MSI Global, but will additionally seek to champion innovative approaches to ensuring clinical quality. Within this project MSIVN seeks to pioneer initiatives to maximise client access including introducing a voucher redeemable for family planning services for underserved clients and leveraging the already established MSIVN Call Centre to support connection between clinics and clients. BlueStar will continue to expand the coverage and availability of safe abortion, including medical abortion.

MSIVN has built strong relationships between private providers, local health authorities and the Ministry of Health at national and local levels, and today these social franchise networks represent a platform to further develop the sustainability, quality and diversity of family planning and sexual and reproductive health services available across Viet Nam.

Project Outputs
Planned outputs to be delivered by the end of project, December 2015 are: Output 1.1 MSIVN will increase access to FP and safe abortion services for men and women by: - Providing a total of 700,000 family planning services

- Achieving a total of 1,700,000 Couple Years of Protection (CYPs)
- Increase the % of family planning clients under the age of 24 from 15.9% to 20%
- Increase the % of first time users (adopters) of FP services from 20% to 30%
- Increase coverage of MSIVN medical abortion available at BlueStar from 70% to 80%

Output 1.2 Improved quality and efficiency of SRH services

- Strengthened quality through monitoring and training across the network. A total of five trainings reaching over 400 providers including midwives will be conducted. Training will include clinical and non-clinical capacity building on FP and reproductive health counselling, FP service provision, and safe abortion (both medical and surgical)
- Improve efficiency through the development of a cost analysis model for BlueStar franchise

Output 1.3 Increased Accountability of the franchise network

- Educate clients on their rights and the quality of service they can expect from the social franchise network and solicit client feedback through 11 information sessions in target areas/with target populations annually

Output 1.4 Increase the operational management synergy between TCE and BlueStar

- Joint development and roll-out of Information, Education and Communication (IEC) materials across both the TCE and Blue Star network
- Conduct joint training activities in quality assurance, technical assistance and advocacy for health system integration and public financing
- Conduct one meeting with key stakeholders at provincial level to promote the model and share information on quality improvements of the network
- Produce a case study on effectiveness of collaboration to share lessons learnt and successes

Sectoral Focus at Project Level	Sexual Reproductive Health/Family Planning
Primary DAC Code	13030
Secondary DAC Code	13020
Tertiary DAC Code	13040

DFAT ANCP Grant Excluding Interest	$681395.00
Total Funds Rolled Over From Previous Ye	$0.00
NGO ANCP Contribution	$107270.00
DME expenditure from ANCP funding	$23207.00
Prior Funding	$835030.00

Project Risk Information

Some project activities outlined are dependent on interest and investment at both the public and private (clinics, corporations) level. MSIVN will minimise lack of engagement/interest by carefully considering and effectively communicating the benefits and opportunities of membership for social franchisees within the network. Research has been conducted to gauge provider willingness for investment and collect information on their preferences for support. MSIVN will utilise the findings to develop service packages tailored to the needs and wants of the providers. If providers are unwilling to continue, or are unable to commit, they could be supported to 'Graduate' to an 'associate network' rather than leave the franchise altogether. They would continue to receive information from BlueStar and have the option to access trainings or commodities, but would not actively participate in the network or require BlueStar resources/support.

An additional risk is the lengthy bureaucratic processes required to seek approval to transition the nature and activities of BlueStar within this project. For example, signing MoUs with local Department of Health has been the greatest challenge experienced to date due to long administrative procedures. However, if delays occur, workplans can be amended so that operations focus on unrestricted activities until others have been approved.

Further risks include an unforeseen incident at a clinic; high staff turnover; and maintaining consistent quality of care. There are existing protocols and procedures to address such risks and these will be continued to be updated, strengthened and communicated with staff to reduce the risk of occurrence and improve management of incidences.

New MoH regulations require renewal of medical practice licences across the private health sector. Completing these administrative procedures could impact on availability of services. MSIVN is conducting training and certification to providers to support their applications.

Other Information

- MSIVN fully complies with government regulations for medical liability. All private providers in the BlueStar network will have secured it by medical liability insurance will be compulsory by the end of 2015.
- This project is supporting the provision of safe abortion (though not by directly funding service providers). All BlueStar clinics must follow the Vietnam government regulations for private clinic service provision and the Vietnamese government conducts regular annual audits to monitor their compliance. Services through BlueStar are provided by independent private practitioners while MSIVN staff support the providers to deliver quality services consistent with government policies through training and monitoring (with checklists developed according to government guidelines and regulations).
- MSIA and MSI Vietnam confirm that this project adheres to the DFAT family planning guidelines.
- Vouchers are distributed to targeted clients by project team and community based distributors who then redeem them at BlueStar clinics to receive family planning services at a subsidised price. The scheme is already operational; this project will focus on IEC material development and demand generation activities for the scheme.
- The call centre was established in 2007. It is funded across a number of projects that leverage the system at any given time. Through this project the centre will be utilised for assisting BlueStar clients (with SRH information, referrals to clinics, appointment bookings, follow up, complaints/feedback mechanism) and the voucher program.

Changes since previous ADPlan 2013 - 14: The 'development and rollout of a national professional code of ethics framework in partnership with the provincial Departments of Health has been removed from the project activities as this was deemed too difficult within the timeframe for our current resources and BlueStar priorities.

Expected Beneficiaries

Baseline Direct	1086750	**Baseline Indirect**	768815
Expected Direct	1050000	**Expected Indirect**	900000
Target Direct	2800000	**Target Indirect**	2318815

Male Direct	0	**Male Indirect**	0
Female Direct	1050000	**Female Indirect**	900000
Boy Direct	0	**Boy Indirect**	0
Girl Direct	0	**Girl Indirect**	0
Male with Disability Direct	0	**Male with Disability Indirect**	0
Female with Disability Direct	0	**Female with Disability Indirect**	0
Boy with Disability Direct	0	**Boy with Disability Indirect**	0
Girl with Disability Direct	0	**Girl with Disability Indirect**	0

Urban Direct	315000	**Urban Indirect**	180000
Rural Direct	735000	**Rural Indirect**	720000

Family Planning

Family Planning Project	Yes
Expected Women family planning only	230000
Expected Men family planning only	0

Project - The Chance to Choose: Mobile family planning services for underserved communities in rural Nepal, ANCP29--PRG9929--PRJ431

Project Name	The Chance to Choose: Mobile family planning services for underserved communities in rural Nepal
Project Start Date	01/08/2013
Project End Date	30/06/2016
project funded in last financial year	Yes
Primary Country Region	NEPAL
Primary Provinces Regions	Seti, Lumbini, Dhaulagiri, Mahakali, Bheri, Narayani, Bagamati, Koshi, Rapti, Janakpur, Gandaki, Mechi, Sagarmatha

Secondary Countries	Provinces Regions

Implementing In-Country Partners
Marie Stopes International Nepal (MSIN)

Private Sector Partnerships

Does this project involve working or partnering with the private sector	

Gender Equality

How the activity addressing gender equality	
Gender equality Specify focus the activity	

Disability Inclusion

How the activity addressing accessibility	
Disability Inclusion Specify focus the activity	

GPS Coordinates

Latitude	Longitude	Location Name
29.690543	81.339941	Seti, Nepal
27.4872	83,277384	Lumbini, Nepal
28.611176	83.50702	Dhaulagiri, Nepal
29.39	80.3	Mahakali, Nepal
28.517456	81.778702	Bheri, Nepal
27.361177	84.856793	Narayani, Nepal
27.651752	85.28817	Bagamati, Nepal
27.053652	87.301613	Koshi, Nepal
28.274347	82,388578	Rapti, Nepal
26.712222	85.921667	Janakpur, Nepal
28.373204	84.438272	Gandaki, Nepal

26.876001	87.93348	Mechi, Nepal
27.323826	86.741637	Sagarmatha, Nepal

Project Information

Project Description

This project will contribute to a decrease in maternal mortality through reducing unmet need for FP in hard to reach areas of Nepal. Specific project objectives include strengthening supply of quality modern FP services and increasing demand for these services. The Nepal Demographic and Health Survey 2011 highlights little progress in the Contraceptive Prevalence Rate (CPR). Slipping from 44% in 2006 to 43% in 2011, the CPR remains behind Nepal's Millennium Development Goal of 67%. Supply side barriers to greater contraceptive uptake include lack of choice of FP methods, inaccessible terrain and low human resource capacity among government service providers. Demand side barriers include myths and misinformation relating to FP as well as financial and opportunity cost barriers. Marie Stopes International Nepal (MSIN) will coordinate with Ministry of Public Health (MOPH) and district health offices (DHOs) to strengthen the long term availability of FP services.

To address supply side barriers MSI Nepal will deploy a new model of outreach service delivery comprising:
• Mini Mobile Clinic teams: consisting of two nurses trained in delivering long acting reversible contraception (LARCs), these teams will visit rural and hard to reach areas providing a comprehensive choice of modern FP methods. The teams are small, flexible and highly mobile
• Independent Permanent Methods seasonal teams: These teams focus on provision of tubal ligations and vasectomy and comprise up to 6 people including a senior doctor
• Joint Government of Nepal (GoN) Permanent Method teams: The government run permanent method services during the dry season and MSIN provides key skilled team members to provide technical assistance to GoN.

Demand side barriers will be addressed by utilising strategies which go beyond the traditional health delivery systems to gain interest from a wider audience for FP services, including:
• Leverage existing nationwide call centre with a toll free number to provide FP counselling and information, facilitate referrals to outreach teams or FP clinics
• Information, Education and Communication (IEC) and Behaviour Change Communication (BCC) campaigns to increase awareness of FP services which will link into public service announcements on dates of individual outreach site visits
• Strengthening relationships with key non-health related networks and community groups such as district level civil society organisations, milk collection groups and micro financing groups to assist in promoting key messages in the community
• SMS and direct call client follow up to ensure continuity of care and to assist in lowering discontinuation rates
Other critical project stakeholders include local health post staff, Female Community Health Volunteers, community leaders and clients. Ongoing partnerships with international non-government organisations and village development community (VDC's) will help to embed knowledge of FP at a community level. MSIN will contribute to health force skills development by providing on the job technical assistance and clinical mentoring to health post staff. Through the project the role of the MSI Nepal teams will evolve from direct/joint government service provision to an ongoing role in quality technical assurance and clinical excellence. This will be maintained beyond the project through on the job supervisions and support and mentoring. In addition MSI Nepal will participate in the national outreach planning workshops with MOH and other relevant I/NGO's to ensure ongoing government capacity building. To assist GoN to assess models of service delivery MSIN will complete a 'Cost of Delivery of Family Planning' study to estimate both the cost and the impacts of the three service delivery models employed by the project. We will work with the MOH and DHOs on budget allocation for the continued service delivery support and for building capacity of government health workers to deliver FP across Nepal.

Project Outputs

Planned outputs to be delivered by the end of project, June 2016 are:
Output 1.1 MSIN will respond to supply side barriers by:
- Delivering an estimated 1,540 LARC Mini Mobile Clinics to provide 48,480 FP services
- Delivering an estimated 240 independent permanent method outreach sessions to provide up to of 21,120 permanent and long acting FP services
- Partnering with the GoN to deliver 240 joint permanent method outreach sessions to provide up to 20,521

permanent FP methods
- Introducing an SMS system to the existing MSIN call centre and providing over 110,976 follow up SMS/ direct calls to clients to ensure robust post procedure care

Output 1.2 MSIN will address resource and capacity barriers by:
- Training 28 outreach staff in IUD and Implant insertion and removal
- Mentoring 4 district government teams through joint permanent method delivery each year

Output 1.3 MSIN will address demand side barriers by:
- Reaching over 100,000 people with FP information and education communications

Output 2.1 MSIN will monitor and improve the program by:
- Undertaking a cost of delivery of FP Services Report
- Conducting two Client exit surveys and one Mystery Client Survey
- Conducting a discontinuation study to obtain information on post procedure barriers

Output 2.2 MSIM will ensure joint coordination, planning and learning with the GoN through participation in:
- Detailed midterm and end of term project evaluations produced independently by GoN
- Up to 6 Central Project Advisory Committee meetings with key government representatives
- Up to 48 District Project Advisory Committee (DPAC) meetings with key district government representatives
- Up to 48 Reproductive Health Committee (RHC) meetings with wider cross section of district health stakeholders.

Sectoral Focus at Project Level	Sexual Reproductive Health/Family Planning
Primary DAC Code	13030
Secondary DAC Code	13020
Tertiary DAC Code	

DFAT ANCP Grant Excluding Interest	$485663.00
Total Funds Rolled Over From Previous Ye	$0.00
NGO ANCP Contribution	$148019.00
DME expenditure from ANCP funding	$41369.00
Prior Funding	$177656.00

Project Risk Information
1. Supplies of FP commodities interrupted - MSIN will work closely with MOPH and DHO to limit commodity shortages, and where possible seek commodities from alternate sources. 2. Political instability could affect ability to implement programme activities (i.e. protests) - MSIN will engage closely with MOPH, DHO's and key community representatives on regular basis to support stability for activities. 3. A natural disaster/ unusual weather pattern that affects target areas and delays program implementation - Annual contingency plans will be developed to support continued service delivery to affected population (where possible). 4. Due to outward migration insufficient availability of qualified staff in all service provision activities – MSIN will work closely with MOPH and DHO to attract and retain qualified staff. 5. The lack of elected local government representatives whereby the existing appointed District Development Committees (DDC) may have no interest in supporting in key health priorities. - MSIN will work closely with DHO and the DDC's to gain support for key health outcomes and improved service delivery to enable both planning and monitoring at a local government level. 6. New demand generation strategies may not successfully motivate clients - MSIN will consult with BBC MA, who has proven success in Nepal and reviewed and adjusted activities on a timely basis. 7. Due to conservative attitudes towards women in remote areas, mobile LARC nurses are at risk of harassment. The support office team has a detailed plan in place for all nurses which includes regular location checks and close

coordination with DHO's and local government security.
8. Lack of quality infrastructure for Government health posts in remote areas.MSI has global experience of delivering quality services that conform to global standards of infection prevention, even in the most remote areas. Training and regular quality assurance supervision will ensure no lapses in quality.

Other Information

- MSIN fully complies with government regulations pertaining to medical liability. Nepal's insurance provides coverage for staff and for the client in the event of complications and accidents. In addition, appropriate clinical governance structures and medical liability insurance is in place for any clinical services/training provided as part of this project.
- MSIA and MSIN confirm that this project adheres to the DFAT family planning guidelines.
- Sustainability of outreach teams: The immediate goal of the project is to provide access for hard to reach groups, filling the gap in service provision. In the medium future will evolve from service provision to providing quality technical assurance for government providers through on the job supervision, peer to peer support and education. The long term goal is for government to provide this unaided by MSI. By the end of this project we aim to be in transition from the short term, gap filling role into the quality assurance role.
- Nurses wages: At present MSIN pays the nurses as they are a part of the wider technical network. MSIN will look to transition nurses into the government health networks, in particular in remote settings with health staffing gaps. MSIN will work with both MOH and DHO to enable budget allocation for these staff.
- Call centre sustainability: MSIN has utilised internal funds to establish the call centre. Other MSIN projects will also leverage the call centre for various purposes. At present MSIN pays for calls (these will not be charged to the ANCP project)
- Links with VDCs and INGOs: these groups will receive professional development for family planning awareness raising - skills which can be utilised beyond the project. Working with VDC's, DHO's and INGO's makes it possible to coordinate with existing health systems and non-health programs, to create partnerships which will increase sustainability of the project.

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Expected Beneficiaries

Baseline Direct	0	**Baseline Indirect**	0
Expected Direct	37248	**Expected Indirect**	81600
Target Direct	62976	**Target Indirect**	134400

Male Direct	2592	**Male Indirect**	5678
Female Direct	34656	**Female Indirect**	75922
Boy Direct	0	**Boy Indirect**	0
Girl Direct	0	**Girl Indirect**	0
Male with Disability Direct	0	**Male with Disability Indirect**	0
Female with Disability Direct	0	**Female with Disability Indirect**	0
Boy with Disability Direct	0	**Boy with Disability Indirect**	0
Girl with Disability Direct	0	**Girl with Disability Indirect**	0

Urban Direct	3725	**Urban Indirect**	8160
Rural Direct	33523	**Rural Indirect**	73440

Family Planning

Family Planning Project	Yes
Expected Women family planning only	34656
Expected Men family planning only	2592

Project - Guff2Y ("Chat to youth)" project for providing interactive information and services on a wide range of sexual health matters to urban and rural youth in Nepal, ANCP29--PRG9929--PRJ432

Project Name	Guff2Y ("Chat to youth)" project for providing interactive information and services on a wide range of sexual health matters to urban and rural youth in Nepal
Project Start Date	01/07/2013
Project End Date	31/12/2016
project funded in last financial year	Yes
Primary Country Region	NEPAL
Primary Provinces Regions	Kathmandu Valley, Parsa, Morang, Kaski

Secondary Countries	**Provinces Regions**

Implementing In-Country Partners
Marie Stopes International Nepal (MSIN)

Private Sector Partnerships

Does this project involve working or partnering with the private sector	

Gender Equality

How the activity addressing gender equality	
Gender equality Specify focus the activity	

Disability Inclusion

How the activity addressing accessibility	
Disability Inclusion Specify focus the activity	

GPS Coordinates

Latitude	Longitude	Location Name
27.666667	85.35	Kathmandu, Nepal
26.6799	87.460397	Morang, Nepal
28.262215	84.016742	Kaski, Nepal

Project Information

Project Description
The goal of the project is to improve the sexual and reproductive health (SRH) status of urban and rural youth in Kathmandu, Morang and Kaski, Nepal through increased availability and uptake of SRH services. The specific objectives of the project are: • Increased SRH awareness among rural and urban youth

• Increased capacity of service providers to provide youth friendly SRH services and information
• To document and share best practice models for increasing youth friendly SRH service delivery and uptake

To address demand side challenges Marie Stopes International Nepal (MSIN) will implement three key strategies:
• Urban Youth Sexual Health Gathering Points – these will be linked directly to services. In order to overcome the stigma of open discussion of sexuality and attract youth, Gathering Points incorporate wider themes (e.g. environment, careers, personal development). Information is disseminated by centre teams into the community and through linkages with youth community groups to promote the take up of youth health services.
• Youth friendly interactive social communication platform – An interactive social communication platform to provide a safe and confidential environment for youth to talk about all their sexual health needs. The platform will be an entry point for referrals to both MSIN and non-MSI clinics where youth friendly services will be available.
• Urban and Rural Youth Pop Ups – Three pop up teams will be deployed in 3 target program districts to host approximately 15 pop up events each month at key locations in urban areas such as shopping malls universities and local football games and on significant days such as International Youth Day. These events focus on empowering urban youth to take control of their sexual health and provide information on SRH, details on the youth friendly communication platform and referral for direct service delivery.
Supply side strategies include:
• Sensitization and training of service providers in youth friendly approaches to SRH service delivery
• On-going support to service providers in developing youth specific client focus
• The possibility of supporting accreditation of existing networks of youth friendly SRH providers will be explored
• Assisting service providers to create suitable youth friendly spaces within their facilities

Project learning and dissemination strategies include:
• Assessment of barriers and enablers to greater access to and uptake of SRH services
• Conducting operational research on youth engagement with SRH and associated health outcomes
• Sharing project learning with stakeholders through participation on technical working groups, NGO forums and presentations at local and regional conferences

The project is working with key stakeholders both at government and community level including Government of Nepal (GoN), Ministry of Public Health (MoPH), District Health Offices, local health post staff, private and public sector SRH service providers, community based youth groups and their leadership and community leaders. Local research partners and ethics approval boards are also be critical stakeholders in the development and implementation of research protocols. Audiences for shared learnings include central and local government, local and international NGOs, United Nation agencies, technical and thematic working groups and professional associations.

Considerations of sustainability have been incorporated into the project planning. Information, Education and Communication and Behaviour Change Communication (BCC) materials developed for youth audiences through the project will be shared with stakeholders. Sustainability of skills development among SRH service providers will be ensured through ongoing follow up and support in youth SRH service delivery. Policy level sustainability of project outcomes will be strengthened through the inclusion of operational research and dissemination of lessons learned to a wide group of health stakeholders.

Project Outputs

Planned outputs to be delivered by the end of project, December 2016 are:
Output 1.1 Increase SRH awareness among rural and urban youth by:
- Provide over 450,000 people information on youth SRH
- Reach 105,000 youth with personalised information based on current and reliable youth SRH information
- Deliver over 65,000 SRH services to youth, including FP services
- Respond to over 200,000 calls, SMS, instant messages via social communication platform

Output 2.1 Increase capacity of service providers to provide youth friendly SRH services and information by:
- Training a minimum of 30 SRH service providers on youth friendly services

Output 3.1 To document and share best practice models for increasing youth friendly SRH service delivery and uptake in partnership with the GoN through:
- Publication of a minimum of one technical report on best practices for scaling up youth friendly SRH service

delivery in Nepal - Complete two youth surveys and one Mystery Client Survey - Participation in a detailed midterm and end of term project evaluation produced independently by GoN - Up to 6 Central Project Advisory Committee meetings with key central government representatives - Up to 15 District Project Advisory Committee (DPAC) meetings with key district government representatives - Up to 15 Reproductive Health Committee meetings with wider cross section of district health stakeholders

Sectoral Focus at Project Level	Sexual Reproductive Health/Family Planning
Primary DAC Code	13020
Secondary DAC Code	13030
Tertiary DAC Code	

DFAT ANCP Grant Excluding Interest	$394881.00
Total Funds Rolled Over From Previous Ye	$48275.00
NGO ANCP Contribution	$128234.00
DME expenditure from ANCP funding	$50094.00
Prior Funding	$127030.00

Project Risk Information
The below are the key risks to the project and our mitigation strategy: 1. Year one of this project was impacted by nationwide post-election delays in government approval for new development projects. This led to delayed start-up of project activities which DFAT at post were informed and keep up to date. Project activities have since begun and MSIN is confident that planned activities and outputs can still be achieved over the life of the project. 2. New youth marketing and social communication platform may not be able to change cultural perceptions and youth aren't able to access the information freely. To address this MSIN will consult with successful youth community networks, which have proven success in Nepal. All youth strategies will be reviewed and adjusted on a timely basis. 3. Regular supplies of FP commodities interrupted or unavailable. To address this MSIN will work closely with MOPH and DHO to limit commodity shortages, and where possible seek commodities from alternate sources. 4. Political instability at a national and local level could interrupt ability to implement programme activities (i.e. pre-election voting/ bandhas/ federalism). To address this MSIN will engage closely with MOPH, DHO's and key community representatives on regular basis to support stability for programme activities from inception. 5. A natural disaster/ unusual weather pattern that affects target areas and delays program implementation (i.e. earthquake). To address this annual contingency plans will be developed to support continued delivery to affected population (where possible). 6. The lack of elected local government representatives whereby the existing appointed District Development Committees (DDC) may have no interest in supporting in key youth sexual health priorities or have conflicting heath interests. To address this MSIN will work closely with DHO and the DDC's to gain support for key youth health outcomes

Other Information
MSIN is a member of the Government of Nepal's (GoN) Adolescent Sexual and Reproductive Health (ASRH) sub-committee which is actively working on the issue of adolescent friendly sexual and reproductive health information and services. MSIN is working in alignment with GoN policy and training manuals on ASRH. Delays in government approvals, required for all development programs, delayed program start-up as discussed above in Risk section. MSIN fully complies with government regulations pertaining to medical liability. Nepal's insurance provides coverage for staff and for the client in the event of complications and accidents. In addition, appropriate clinical governance structures and medical liability insurance is in place for any clinical services/training provided as part of this project.

MSIA and MSIN confirm that this project adheres to the DFAT family planning guidelines.

Changes since previous ADPlan 2013 - 14:
Chitwan province was included in the original ADPlan for this project. The District Commissioner of Chitwan did not provide approval to carry out the project in the district and so the project will now focus on the 4 remaining districts.

Expected Beneficiaries

Baseline Direct	0	**Baseline Indirect**	0
Expected Direct	40800	**Expected Indirect**	168000
Target Direct	109280	**Target Indirect**	468800

Male Direct	0	**Male Indirect**	0
Female Direct	0	**Female Indirect**	0
Boy Direct	12240	**Boy Indirect**	53000
Girl Direct	28560	**Girl Indirect**	115000
Male with Disability Direct	0	**Male with Disability Indirect**	0
Female with Disability Direct	0	**Female with Disability Indirect**	0
Boy with Disability Direct	0	**Boy with Disability Indirect**	0
Girl with Disability Direct	0	**Girl with Disability Indirect**	0

Urban Direct	26112	**Urban Indirect**	112000
Rural Direct	14688	**Rural Indirect**	56000

Family Planning

Family Planning Project	Yes
Expected Women family planning only	6144
Expected Men family planning only	9216

Project - Bringing quality to quantity: Strengthening the delivery of family planning products and services through the private health sector in Cambodia., ANCP29--PRG9929--PRJ468

Project Name	Bringing quality to quantity: Strengthening the delivery of family planning products and services through the private health sector in Cambodia.
Project Start Date	01/07/2014
Project End Date	30/06/2015
project funded in last financial year	No
Primary Country Region	CAMBODIA
Primary Provinces Regions	Kandal province

Secondary Countries	**Provinces Regions**

Implementing In-Country Partners
Marie Stopes International Cambodia (MSIC)

Private Sector Partnerships

Does this project involve working or partnering with the private sector	

Gender Equality

How the activity addressing gender equality	
Gender equality Specify focus the activity	

Disability Inclusion

How the activity addressing accessibility	
Disability Inclusion Specify focus the activity	

GPS Coordinates

Latitude	**Longitude**	**Location Name**
11.457332	104.693403	Kandal, Cambodia

Project Information

Project Description
The goal of this project is to strengthen the capacity of private sector health providers and pharmacists (referred to as “private providers”) in Cambodia to provide high quality family planning (FP) services to underserved women. To achieve this Marie Stopes International Cambodia (MSIC) will focus on three key objectives: building the capacity of private providers to provide comprehensive information about FP options to clients; supplying providers with high quality FP products; providing on-going quality assurance and coaching visits.

The Cambodian Demographic and Health Survey in 2010 reported that 56% of men and women of reproductive age preferred to access health services through the private sector. Private providers are commonly accessed for a range of health services, including FP, but they are currently unregulated by government agencies and are of variable quality. This project will ensure that private providers in up to five operational districts will receive high quality training, FP products and on-going support, providing their communities with high quality FP options.

Building capacity of private health providers: MSIC will carefully select approximately 100private providers to attend a comprehensive FP counselling and service delivery training in Kandal Province in 2014. The training will present best practices in interpersonal client-centred FP counselling and emphasise provision of a wide choice of FP methods to potential clients. Participants will be provided with a range of tools and best practice approaches to ensure clients receive comprehensive information on available FP methods, potential side effects, clinical protocols for dealing with complications and procedures for method switching. The training will also include a module on demand creation, to ensure the providers know how to raise awareness about their high quality FP products and services available in the community. MSIC will draw upon its expertise in providing friendly, confidential, non-judgemental service delivery to ensure selected providers have the capacity to offer a comprehensive, quality client experience. MSIC will also invite members from its partner distribution company to the trainings, to improve their awareness on the range of FP products and the importance of quality.
MSIC will also offer a three-day two-rod contraceptive implant training at a location agreed with the Government, to highly-motivated private providers who have not yet received the training.

High quality FP products: MSIC will ensure that the selected private providers have access to high quality FP products. MSIC will leverage its procurement and logistic expertise to ensure a functional supply chain and providers will be trained in stock management and forecasting. In order to address the largely unregulated market of low quality FP products available through private providers in Cambodia, training will also emphasise the importance of quality FP products at all price points and equip providers with the knowledge and resources to ensure that they best meet their clients' needs.

Quality assurance support: Selected providers will receive at least three follow-up visits at their locations from the clinically qualified MSIC team, in 2015, to ensure they are applying the content of the training. These visits will provide an opportunity for quality assurance and project monitoring. MSIC will build the capacity of providers to conduct stock-checks and forecasting processes as well as supporting them to streamline quality assured stock management systems. Providers will have access to technical support through MSIC's Hotline service to ensure individual or contextual factors do not inhibit the supply of quality products and the delivery of quality services. MSIC will also conduct a minimum of two mystery shopper visits per provider over the life of the project to assess the client friendliness of the service and identify areas for further capacity development.

Project Outputs
Planned outputs to be delivered by the end of project, June 2015 are: Output 1.1 MSIC will develop the capacity of private providers and pharmacists by: - Developing a comprehensive modular training curriculum for private providers and pharmacists to deliver high quality FP services; - Delivering a comprehensive FP quality service delivery and product training to approximately 100 private providers, pharmacists and distributors; - Delivering a three-day two-rod contraceptive implant training to 12 private providers; - Conducting regular quality assurance, coaching and FP stock forecasting visits to all trained private providers and pharmacists; - Offering on-going information and support through the existing MSIC Hotline. Output 1.2 MSIC will monitor and evaluate quality in service and products by: - Conducting mystery shopper visits, with improved scores over time; - Conducting regular quality assurance visits, resulting in improved quality technical assurance scores over time; - Reported increase in client flow from private providers / pharmacists

Sectoral Focus at Project Level	Sexual Reproductive Health/Family Planning
Primary DAC Code	13030

Secondary DAC Code	13020
Tertiary DAC Code	

DFAT ANCP Grant Excluding Interest	$119104.00
Total Funds Rolled Over From Previous Ye	$20193.00
NGO ANCP Contribution	$0.00
DME expenditure from ANCP funding	$0.00
Prior Funding	$0.00

Project Risk Information

1) Insufficient private provider interest

Private providers and pharmacists may not be willing to take time off from their practice to attend MSIC's comprehensive FP counselling and service delivery training. Private providers may also not be willing to be assessed by MSIC through the quality assurance follow-up visits.

Providers will be carefully selected using stringent criteria to ensure they are committed and motivated to improving the quality of their FP products and services. Referrals will be sought from selected providers to other like-minded individuals. The number of operational districts may be increased to meet the target.

2) Two-rod implant training approved by Provincial Health Department (PHD)

MSIC will work closely with the relevant PHD(s) to ensure they fully understand and support the importance of being able to offer comprehensive FP services, including two-rod contraceptive implants. MSIC has a strong advocacy team who have experience in this field.

3) Client complication management

MSIC will support the private providers through the comprehensive FP counselling and service delivery training to develop client complication management systems, which includes referral options such as MSIC's Hotline, MSIC clinics and the public health sector.

Other Information

MSIA and MSIC confirm that this project adheres to the DFAT family planning guidelines.

Sustainability of MSIC team. MSIC clinically experienced staff will be trained to take on the role of trainers, quality assurance, and stock forecasting activities for and with private providers.

Expected Beneficiaries

Baseline Direct	0	**Baseline Indirect**	28500
Expected Direct	100	**Expected Indirect**	28500
Target Direct	100	**Target Indirect**	28500

Male Direct	80	**Male Indirect**	13700
Female Direct	20	**Female Indirect**	14800
Boy Direct	0	**Boy Indirect**	0
Girl Direct	0	**Girl Indirect**	0
Male with Disability Direct	0	**Male with Disability Indirect**	0
Female with Disability Direct	0	**Female with Disability Indirect**	0
Boy with Disability Direct	0	**Boy with Disability Indirect**	0
Girl with Disability Direct	0	**Girl with Disability Indirect**	0

Urban Direct	100	**Urban Indirect**	28500
Rural Direct	0	**Rural Indirect**	0

Family Planning

Family Planning Project	Yes
Expected Women family planning only	20
Expected Men family planning only	80

Department of Foreign Affairs and Trade

Complex Grant Agreement number 71002

Commonwealth of Australia represented by the Department of Foreign Affairs and Trade (**DFAT**)

International Planned Parenthood Federation (**Recipient**)

Details

Parties

Name	The Commonwealth of Australia represented by the Department of Foreign Affairs and Trade ABN 47 065 634 525
Short form name	**DFAT**
Name	International Planned Parenthood Federation, East & South East Asia and Oceania Region, No. 246 Jalan Ampang, Kuala Lumpur, 50450, Malaysia (Registration No: 919156)
Short form name	**IPPF (Recipient)**

Background

A DFAT provides grant funding to support activities for overseas development assistance.

B The Recipient applied for grant funding to perform the Activity.

C DFAT is required by law to ensure accountability for the grant funding and accordingly the Recipient is required to be accountable for all grant funding received.

D DFAT has agreed to provide an amount of grant funding to the Recipient for the purposes of the Activity, subject to the terms and conditions of this Agreement.

E The Recipient accepts the grant funding for the purposes of the Activity, and subject to the terms and conditions of this Agreement.

DFAT Complex Grant Agreement

General Conditions

Interpretation

1. Definitions and interpretation

1.1 Defined terms

In this Agreement, except where the contrary intention is expressed, the following definitions are used:

Abandoned	not having carried on any work or activities on the Activity for sixty (**60**) consecutive days, except where relieved of the obligation to do so under this Agreement. **Abandon** has a corresponding meaning.
Activity	the Activity described in Item 1 of the Activity Proposal.
Activity End Date	the date specified in Item 7 of **Schedule 1**.
Activity Event	any promotional event conducted by the Recipient relating to the Activity, including the award of grant funding, the attainment of a Milestone or launch of the completed Activity.
Activity Proposal	as described in **Schedule 2**.
Activity Start Date	the date specified in Item 6 of **Schedule 1**.
Administered Grant Arrangement	the Agreement between the Recipient and an Administered Grant Recipient.
Administered Grant Recipient	the recipient of a grant under an Administered Grant Scheme.
Administered Grant Scheme	a grant scheme specified in Item 9 of **Schedule 1**.
Agreement	this Agreement which is a Deed between DFAT and the Recipient, as varied from time to time in accordance with **Clause 38.4**, including the Schedules and any attachments.
Agreement Material	any Material created by, for or on behalf of the Recipient on or following the Commencement Date, for the purpose of or as a result of performing its obligations under this Agreement including any modifications that may be required under **Clause 21.6**(b).
Agreement Period	the period from the Commencement Date to the date DFAT accepts the final report provided in accordance with **Item 4** of **Schedule 4**.
Applicable Auditing Procedures	the internal and external auditing procedures in the rules and regulations applicable to the Recipient.
Application	the application submitted by, for or on behalf of the Recipient for grant funding in relation to the Activity.

Assets	(a) items described in Item 5.1 of the Activity Proposal; and (b) any items of tangible property which are purchased, leased, created or otherwise brought into existence by, for or on behalf of the Recipient either wholly or in part with use of the Funds, not including Agreement Material.
Asset Register	the register of Assets set out in Item 5 of the Activity Proposal.
Asset Threshold	means the amount set out in Item 5.2 of the Activity Proposal.
Australian Privacy Principles	the Australian Privacy Principles (APPs) as defined in the *Privacy Act 1988* (Cth).
Authority	any Commonwealth, State, Territory, local or foreign government or semi-governmental authority, court, administrative or other judicial body or tribunal, department, commission, public authority, agency, minister, statutory corporation or instrumentality, including the Partner Government.
Budget	the Budget (if any) set out in Item 4 of the Activity Proposal, as varied from time to time in accordance with this Agreement.
Business Day	a day that is a working day in the place where the act is to be performed or where the Notice is received.
Change in Control	in relation to an entity, a change in the direct or indirect power or capacity of a person to: (a) determine the outcome of decisions about the financial and operating policies of the entity; or (b) control the membership of the board of directors of the entity, whether or not the power has statutory, legal or equitable force or is based on statutory, legal or equitable rights and whether or not it arises by means of trusts, agreements, arrangements, understandings, practices, the ownership of any interest in shares or stock of the entity or otherwise, not including a change in control resulting from ordinary course trading on a stock exchange in the shares of the entity.
Commencement Date	the date specified in Item 5 of **Schedule 1**.
Commonwealth	the Commonwealth of Australia.
Confidential Information	information that is by its nature confidential and: (a) is designated by a Party as confidential; or (b) a Party knows or ought to know is confidential, but does not include information which is or becomes public knowledge other than by breach of this Agreement or any other confidentiality obligation.

DFAT	the Party specified in Item 1 of **Schedule 1**.
DFAT Material	any Material provided to the Recipient by DFAT, including the Material (if any) specified in Item 13 of **Schedule 1**.
DFAT Representative	the person identified in Item 3 of **Schedule 1**.
Depreciation	depreciation calculated for income tax purposes under, and in accordance with, the *Income Tax Assessment Act 1997* (Cth).
Force Majeure Event	has the meaning given in Clause 33.1.
Fraudulent Activity, Fraud or **Fraudulent**	dishonestly obtaining a benefit, or causing a loss, by deception or other means, and includes incidents of attempted, alleged, suspected or detected fraud.
Funds	the grant funding paid by DFAT to the Recipient under this Agreement and any interest earned by, for or on behalf of the Recipient on that grant funding, proceeds from the disposal or write-off of any Asset and any exchange rate gains made on that grant funding by the Recipient.
General Conditions	Clauses 1 to 38 of this Agreement.
GST Law	has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999* (Cth).
Independent Auditor	a person who is: (a) a certified financial professional is; (b) registered under the *Corporations Act 2001* (Cth) or an appropriately qualified member of: (i) the Institute of Chartered Accountants in Australia; (ii) of CPA Australia or of the National Institute of Accountants; or (iii) a recognised foreign or international institution for accountants of equivalent status; and (c) in no way linked or associated with the Activity or the Parties
Insolvency Event	in relation to an entity: (a) the entity disposes of the whole or any part of its assets, operations or business other than in the ordinary course of business; (b) the entity ceases to carry on business; (c) the entity ceases to be able to pay its debts as they become due; (d) proceedings are initiated with a view to obtaining an order for the winding up of the entity, or any person convenes a meeting for the purpose of considering or passing any resolution for the winding up of the entity;

	(e) the entity applies to come under, the entity receives a notice requiring it to show cause why it should not come under, an order has been made for the purpose of placing the entity under, or the entity otherwise comes under one of the forms of external administration referred to in Chapter 5 of the *Corporations Act 2001* (Cth) or Chapter 11 of the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (Cth) or equivalent provisions in State or Territory legislation or the laws of the Partner Country in relation to incorporated entities; (f) where the entity is a natural person, the entity is declared bankrupt or assigns his or her estate for the benefit of creditors; (g) where the entity is a partnership, any step is taken to dissolve that partnership; or (h) anything analogous to an event referred to in paragraph (d), (e), (f) or (g) occurs in relation to the entity.
Intellectual Property Rights	all intellectual property rights, including: (a) copyright, patents, trade marks (including goodwill in those marks), designs, trade secrets, know how, rights in circuit layouts, domain names and any right to have confidential information kept confidential; (b) any application or right to apply for registration of any of the rights referred to in paragraph (a); and (c) all rights of a similar nature to any of the rights in paragraphs (a) and (b) which may subsist in Australia or elsewhere, whether or not such rights are registered or capable of being registered.
Law	any applicable statute, regulation, by-law, ordinance or subordinate legislation in force from time to time in: (a) Australia, whether made by a State, Territory, the Commonwealth, or a local government; and (b) the Partner Country.
Material	includes property, equipment, information, data, documentation or other material in whatever form, including any software, reports, specifications, business rules or requirements, user manuals, user guides, operations manuals, training materials and instructions, and the subject matter of any category of Intellectual Property Rights.
Milestone	a milestone set out in Item 3 of the Activity Proposal in **Schedule 2**.

Modify	to add to, enhance, reduce, change, replace, vary or improve. **Modification** and **Modified** have corresponding meanings.
Moral Rights	the right of integrity of authorship (that is, not to have a work subjected to derogatory treatment), the right of attribution of authorship of a work, and the right not to have authorship of a work falsely attributed, as defined in the *Copyright Act 1968* (Cth).
Notice	a notice, demand, consent, approval or communication issued under this Agreement.
Outcomes	the outcomes for the Activity, as set out in Item 2 of the Activity Proposal.
Partner Country	the country or countries in which the Activity is to be undertaken in whole or in part.
Partner Government	the government of the Partner Country.
Party	DFAT and the Recipient who are listed in the Details section of this Agreement. **Parties** have a corresponding meaning.
Payment Claim	has the meaning given in Clause 8(a).
Payment Criteria	the payment criteria specified in Item 3 of **Schedule 3**.
Performance Improvement Plan	has the meaning given in Clause 15(b).
Performance Issue	has the meaning given in Clause 15(a).
Personal Information	has the same meaning as in the *Privacy Act 1988* (Cth).
Personnel	in relation to a Party, any employee, officer, agent, volunteer, subcontractor or professional adviser of that Party.
Pre-existing Recipient Material	Material developed by the Recipient that: (a) is in existence at the Commencement Date or is subsequently brought into existence other than as a result of the performance of the Agreement; and (b) is embodied in or attached to the Agreement Material, or otherwise necessarily related to the performance of the Activity.
Recipient	the Party specified in Item 2 of **Schedule 1**.
Recipient Representative	the person identified in Item 4 of **Schedule 1**.
Related Agreement	any other agreement between the Parties under which DFAT provides grant funding to the Recipient, whether entered into before or after this Agreement.

Relevant List	the lists of terrorist organisations made under Division 102 of the *Criminal Code Act 1995* (Cth) and the *Charter of the United Nations Act 1945* (Cth) posted at: http://www.nationalsecurity.gov.au/agd/www/nationalsecurity.nsf/AllDocs/95FB057CA3DECF30CA256FAB001F7FBD?OpenDocument and http://www.dfat.gov.au/icat/UNSC_financial_sanctions.html#3
Reports	the reports to be provided under Clause 14.2(a) and any Performance Improvement Plan.
Schedules	the schedules to this Agreement.
Similar List	any similar list to the World Bank List maintained by any other donor of development funding.
Special Conditions	the terms and conditions (if any) set out in Item 17 of **Schedule 1.**
Third Party Material	any Material made available by the Recipient for the purpose of the Agreement Material or the Activity in which a third party holds Intellectual Property Rights.
Total Funds	the amount specified in Item 1 of **Schedule 3**, as reduced in accordance with this Agreement.
Warranted Materials	(a) Pre-existing Recipient Material; (b) Third Party Material; and (c) Agreement Material.
World Bank List	a list of organisations maintained by the World Bank in its 'Listing of Ineligible Firms' or 'Listings of Firms, Letters of Reprimand' posted at: http://web.worldbank.org/external/default/main?theSitePK=84266&contentMDK=64069844&menuPK=116730&pagePK=64148989&piPK=64148984.

1.2 **Interpretation**

In this Agreement, except where the contrary intention is expressed:

(a) the singular includes the plural and vice versa, and a gender includes other genders;

(b) another grammatical form of a defined word or expression has a corresponding meaning;

(c) a reference to a clause, paragraph or schedule is to a clause or paragraph of, or schedule to, this Agreement;

(d) a reference to a document or instrument includes the document or instrument as novated, altered, supplemented or replaced from time to time;

(e) a reference to **AUD**, **A$**, **$A**, **dollar** or **$** is to Australian currency;

(f) a reference to time is to Canberra, Australia time;

(g) a reference to a Party is to a Party to this Agreement, and a reference to a party to a document includes the party's executors, administrators, successors and permitted assignees and substitutes;

(h) a reference to a person includes a natural person, partnership, body corporate, association, governmental or local authority or agency or other entity;

(i) a reference to a statute, ordinance, code or other law includes regulations and other instruments under it and consolidations, amendments, re-enactments or replacements of any of them;

(j) the meaning of general words is not limited by specific examples introduced by **including, for example** or similar expressions;

(k) a rule of construction does not apply to the disadvantage of a Party because the Party was responsible for the preparation of this Agreement or any part of it;

(l) if the last day on or by which an obligation must be performed or an event must occur is not a Business Day, the obligation must be performed or the event must occur on or by the next Business Day; and

(m) headings are for ease of reference only and do not affect interpretation.

2. Priority of documents

2.1 If there is any inconsistency between any of the documents forming part of this Agreement, those documents will be interpreted in the following order of priority to the extent of the inconsistency:

(a) Special Conditions;

(b) General Conditions;

(c) Schedules;

(d) any attachments to the Schedules; and

(e) documents incorporated by reference in this Agreement.

3. Duration of Agreement

3.1 This Agreement begins on the Commencement Date and continues until the end of the Agreement Period unless terminated in accordance with **Clause 33** or **Clause 35**.

Activity

4. Activity

4.1 **Undertaking the Activity**

(a) The Recipient must:

(i) undertake the Activity to achieve the Outcomes;

(ii) undertake the Activity diligently, effectively, safely and to a professional standard;

(iii) comply with all applicable Laws, guidelines and policies, including as set out in **Clause 16**;

(iv) ensure that in its performance of the Activity, all of the Recipient's subcontractors and Personnel, while in the Partner Country, respect and comply with the Laws and regulations in force in the Partner Country;

(v) meet the completion dates for the Milestones, as specified in the Activity Proposal;

(vi) start the Activity by the Activity Start Date and complete the Activity by the Activity End Date;

(vii) ensure that any statement or information given or made to DFAT by the Recipient from time to time under this Agreement (including information or statements contained in any Report) is true and correct (except where the information is provided to the Recipient by another person in which case the Recipient must ensure that it has made reasonable endeavours to verify the accuracy of the information);

(viii) take responsibility for the security of all of its Personnel and for taking-out and maintaining all appropriate insurances; and

(ix) not, by act or omission, place DFAT in breach of its obligations under the *Work Health and Safety Act 2011* (Cth).

(b) The Recipient must advise DFAT immediately in writing of any difficulties or delays in implementation of the Activity.

4.2 Warranties

The Recipient represents and warrants that:

(a) it has the legal right and power to enter into, perform and observe its obligations under this Agreement;

(b) the execution, delivery and performance of this Agreement has been duly and validly authorised by the Recipient;

(c) the statements and information in its Application are accurate and complete;

(d) it and its subcontractors and Personnel have the necessary experience, skill, knowledge, expertise and competence to undertake the Activity and (where appropriate) will hold such licences, permits or registrations as are required under any Law to undertake the Activity, and are fit and proper people to be involved in an activity, which is funded by the Australian Government;

(e) it is not subject to any judicial decision against it relating to employee entitlements (not including decisions under appeal) where it has not paid the claim;

(f) it is not named as not complying with the *Workplace Gender Equality Act 2012* (Cth); and

(g) if the Recipient is a trustee, it enters this Agreement personally and in its capacity as trustee and has the power to perform its obligations under this Agreement.

5. Variation to the Activity

(a) If the Recipient wants to seek a variation to the Activity, including postponement of the completion date for a Milestone or change in an intended Outcome as specified in the Activity Proposal, the Recipient must submit a notice to DFAT in writing setting out:

(i) details of the proposed variation to the Activity or relevant Milestone completion date or change in an intended Outcome and reasons for the request;

(ii) in relation to requests to postpone a Milestone completion date, reasons why the Activity cannot be performed in such a way as to meet the given date; and

(iii) the impact the proposed variations will have on:

(A) effective delivery of the Activity;

(B) the Budget; and

(C) the Milestones.

(b) DFAT will give the Recipient a written notice accepting or rejecting the Recipient's request.

(c) Notwithstanding DFAT's acceptance of a proposed variation, it will not vary this Agreement or be binding unless and until a variation to this Agreement is made in accordance with **Clause 38.4** (Variation).

Funds

6. Use of Funds by Recipient

6.1 What Funds can be used for

(a) The Recipient must spend the Funds only for the purposes of undertaking the Activity and purposes that are incidental to the Activity, including for the independent audit of acquittal reports as set out in **Schedule 4**.

(b) The Recipient must spend the Funds only in accordance with the Budget.

(c) Any increase or decrease in the amount allocated to an item of expenditure in the Budget cannot be made without DFAT's prior written approval.

6.2 When Funds cannot be used

(a) Without limiting any other right or remedy of DFAT, DFAT may by written notice direct the Recipient not to spend Funds if the Recipient has not achieved a Milestone that was due to be achieved before the date of notification, or the Recipient is otherwise in breach of this Agreement.

(b) The Recipient must not spend any Funds that it has not already legally committed for expenditure after it receives notice from DFAT under **Clause 6.2**(a) unless and until DFAT notifies the Recipient otherwise.

6.3 Bank account

The Recipient must:

(a) ensure that Funds are held in an account:

(i) in the Recipient's name;

(ii) held at an institution regulated by the *Banking Act 1959* (Cth) or a reputable banking institution approved or regulated by the relevant banking authority or regulator in the jurisdiction in which the Activity is performed; and

(iii) which the Recipient solely controls;

(b) ensure that the account referred to in **Clause 6.3**(a) is:

(i) established solely for the purposes of accounting for, and administering, any Funds;

(ii) an account that bears a rate of interest consistent with the interest rate of Australia as issued by the Reserve Bank of Australia or the equivalent rate set by the Reserve Bank of the Partner Country; and

(iii) separate from the Recipient's other operational accounts;

(c) unless the Recipient is a sole director company, ensure that two signatories, who have the Recipient's authority to do so, are required to operate the account;

(d) notify DFAT, prior to the receipt of any Funds, of details sufficient to identify the account;

(e) on notification from DFAT, provide DFAT and the institution that provides the account with an authority for DFAT to obtain any details relating to the use of the account;

(f) if the account changes, notify DFAT within **14 days** after the change occurring, providing DFAT with details of the new account, and comply with **Clause 6.3**(a) to **6.3**(e) in respect of the new account; and

(g) identify the receipt and expenditure of the Funds separately within the Recipient's accounting records so that at all times the Funds are identifiable, traceable and ascertainable.

7. Payment of Funds by DFAT

7.1 Payment

(a) Subject to this Agreement (including satisfaction of the Payment Criteria in Schedule 3) and sufficient grant funding being available to DFAT, DFAT will provide grant funding to the Recipient as set out in **Schedule 3**.

(b) DFAT's liability under this Agreement is limited to:

(i) the Total Funds; or

(ii) the amount of grant funding paid under this Agreement (and any amount of grant funding for which DFAT is liable under **Clause 33.5**(a) or **Clause 35.1**(c)(i) and (ii)),

whichever is the lesser.

7.2 Suspension

(a) Without limiting any other right or remedy of DFAT, DFAT may suspend payment of grant funding under this Agreement in whole or in part:

(i) if the Recipient has not provided a Report due to be provided before the date for payment, until the Report is provided;

(ii) if a Report provided by the Recipient is not acceptable to DFAT, until a replacement Report that is acceptable to DFAT is provided;

(iii) if the Recipient has not achieved a Milestone that was due to be achieved before the date for payment, until the Milestone is achieved;

(iv) if the Recipient has not otherwise undertaken a Milestone or the Activity to the satisfaction of DFAT, until the Recipient remedies its performance;

(v) if the Recipient has not spent Funds in accordance with the Agreement, until the Recipient has done so;

(vi) if the Recipient has not satisfied the Payment Criteria in **Schedule 3**; or

(vii) if the Recipient is in breach of this Agreement or a Related Agreement, until that breach is remedied.

(b) Despite any suspension, the Recipient must continue to perform its obligations under this Agreement, unless otherwise agreed to in writing by the Parties.

7.3 Reduction

Without limiting any other right or remedy of DFAT, DFAT may reduce the amount of any instalment of grant funding under this Agreement:

(a) if by the date for payment of the instalment the Recipient has not spent Funds in accordance with the Payment Criteria, by the amount that has not been spent; or

(b) if Funds have been spent other than in accordance with this Agreement, by the amount that was spent other than in accordance with this Agreement.

7.4 Due date for payment

Subject to this **Clause 7** and DFAT being satisfied with:

(a) the Recipient's performance of the Activity; and

(b) the achievement of the Payment Criteria,

DFAT must make payment within **30 days** of receiving a correctly rendered invoice.

7.5 Incorrect invoices, under/over payment

If an invoice is found to have been rendered incorrectly after payment, any underpayment or overpayment will be recoverable by or from the Recipient, as the case may be.

7.6 Taxes

The Recipient must pay:

(a) all stamp duty (including penalties and interest) assessed or payable in respect of this Agreement and the Activity; and

(b) subject to **Clause 9** (GST and PAYG tax), all taxes, duties and government charges imposed or levied in Australia or overseas in connection with the performance of this Agreement.

8. Claims for payment

(a) If the Recipient has achieved the Payment Criteria in respect of the applicable instalment, then not earlier than the due date specified in item 3 of **Schedule 3,** the Recipient must submit to DFAT a claim for payment of the relevant instalment of the grant funding (**Payment Claim**).

(b) A Payment Claim submitted under clause 8(a) must include a correctly rendered invoice to DFAT in accordance with the requirements specified in clause 9.4 and item 4 of **Schedule 3**.

9. GST and PAYG tax

9.1 Interpretation

Unless specifically defined otherwise in this Agreement, words and expressions used in this **Clause 9** which have a defined meaning in the GST Law have the same meaning as in the GST Law.

9.2 Consideration GST exclusive

Unless otherwise expressly stated, all prices or other sums payable or consideration to be provided under this Agreement are exclusive of GST.

9.3 GST gross up

Subject to this **Clause 9**, if GST is payable by a Party ('GST Supplier') on any supply made under this Agreement, the recipient of the supply ('GST Recipient') will pay to the GST Supplier an amount equal to the GST payable on the supply ('GST Amount'), in addition to and at the same time that the consideration for the supply is to be provided under this Agreement.

9.4 Tax invoice

(a) The GST Supplier must deliver a tax invoice or an adjustment note to the GST Recipient before the GST Supplier is entitled to payment of a GST Amount under **Clause 9.3**.

(b) The GST Recipient can withhold payment of the GST Amount payable under **Clause 9.3** until the GST Supplier provides a tax invoice or an adjustment note as appropriate.

9.5 Payment of GST Amount

(a) DFAT will only pay a GST Amount in respect of any taxable supply made to it under this Agreement if:

(i) the Recipient has, in this Agreement or otherwise, provided its ABN and confirmed it is GST registered; and

(ii) DFAT has received a valid tax invoice from the Recipient for the taxable supply in accordance with **Clause 9.4**.

(b) To avoid doubt, if the Recipient indicates at Item 8 of **Schedule 1** that it is not registered or required to be registered for GST, DFAT will not pay any GST Amount to the Recipient.

9.6 GST adjustment event

If an adjustment event arises in respect of a taxable supply made by a GST Supplier under this Agreement the amount payable by the GST Recipient under **Clause 9.3** will be recalculated to reflect the adjustment event and a payment will be made by the GST Recipient to the GST Supplier or by the GST Supplier to the GST Recipient as the case requires.

9.7 Reimbursements

If a payment to a Party under this Agreement is a reimbursement or indemnification, calculated by reference to a loss, cost or expense incurred by that Party, then the payment will be reduced by the amount of any input tax credit to which that Party is entitled on the acquisition of the supply to which that loss, cost or expense relates.

9.8 PAYG withholding tax

(a) If the Recipient's ABN is not stated in this Agreement, the Recipient must, on or before any payments are required to be made to it under this Agreement, either:

(i) advise DFAT in writing of its ABN; or

(ii) provide evidence to the reasonable satisfaction of DFAT as to why it is not required to obtain an ABN, which obligation may be discharged by providing a signed statement in the form approved by the Commissioner of Taxation from time to time and available at: http://www.ato.gov.au/Business/Australian-business-number/In-detail/Statement-by-a-supplier/Statement-by-a-supplier--not-quoting-ABN-to-an-enterprise/.

(b) If the Recipient does not satisfy its obligations under **Clause 9.8**(a), the Recipient acknowledges that DFAT may be required to deduct PAYG withholding tax in accordance with **Part 2-5** of the *Taxation Administration Act 1953* (Cth) from the relevant payments to the Recipient at the prescribed rate and remit that to the Australian Taxation Office.

10. Repayment

10.1 Misspent Funds

At any time, DFAT is entitled to recover from the Recipient the amount of any Funds which have been spent or used other than in accordance with this Agreement.

10.2 Unspent Funds

On the earlier of the Activity End Date, expiry or termination of this Agreement, DFAT is entitled to recover from the Recipient any Funds which have not been spent, or legally committed for expenditure by the Recipient in accordance with this Agreement and payable by the Recipient as a current liability (written evidence of which will be required).

10.3 Repayment notice

(a) DFAT may give the Recipient a notice requiring the Recipient to pay to DFAT (or deal with as specified by DFAT) an amount which DFAT is entitled to recover under this **Clause 10** or **Clause 12** (Assets).

(b) If DFAT gives a notice under **Clause 10.3**(a), the Recipient must pay the amount specified in the notice in full (or deal with it as specified by DFAT) within 14 days after the date of the notice.

10.4 Interest

If the Recipient fails to make payment as required by **Clause 10.3**, the Recipient must pay DFAT interest:

(a) at the rate set out in Item 2 of **Schedule 3** on a daily compounding basis upon the amount specified in the notice as payable to DFAT; and

(b) from the date the payment was due, for the period it remains unpaid.

10.5 DFAT's rights

This **Clause 10** does not limit any other right or remedy of DFAT.

11. Procurement

11.1 If the Funds are being used to procure goods or services, the Recipient must implement procedures so that procurement is undertaken in a manner consistent with the principles of the Australian Commonwealth Procurement Rules (**http://www.finance.gov.au/procurement/procurement-policy-and-guidance/commonwealth-procurement-rules/index.html**), in particular the core principle of achieving value for money and the supporting principles of:

(i) encouraging competition by ensuring non-discrimination in procurement and using competitive procurement methods;

(ii) promoting use of resources in an efficient, effective, economical and ethical manner; and

(iii) making decisions in an accountable and transparent manner.

(b) If the Funds are being used to procure goods, the Recipient must ensure in its procurement of goods that the goods to be procured:

(i) are of a merchantable quality;

(ii) are free from defects in design, materials and workmanship;

(iii) are fit for purpose;

(iv) have good and marketable title and are free from encumbrances; and

(v) are delivered in good order and condition and in accordance with the Milestones.

(c) If the Funds are being used to procure services, the Recipient must ensure in its procurement of services that the services to be procured are performed:

(i) diligently, effectively, safely and to a professional standard; and

(ii) with the skill and care normally exercised by similarly qualified and competent persons in the performance of comparable work.

12. Assets

12.1 Ownership

(a) The Recipient must not use the Funds to acquire any Assets, apart from those Assets specified in Item 5.1 of the Activity Proposal.

(b) Subject to the requirements of this Clause 12 and the terms of any lease, the Recipient will own the Assets unless otherwise specified in Item 5.3 of the Activity Proposal.

12.2 Use and dealings

(a) During the Agreement Period, the Recipient must use any Asset only for the purposes of the Activity, or other purposes consistent with the Outcomes approved by DFAT.

(b) During the Agreement Period, the Recipient must:

(i) obtain good title to all Assets (other than Assets which the Recipient leases);

(ii) hold all Assets securely and safeguard them against Fraud, theft, loss, damage, or unauthorised use;

(iii) maintain all Assets in good working order;

(iv) maintain all appropriate insurances in respect of any Assets;

(v) if required by Law, maintain registration and licensing of all Assets;

(vi) be fully responsible for, and bear all risks relating to, the use or disposal of all Assets; and

(vii) maintain an Asset Register containing the details as described in item 5.4 of the Activity Proposal and provide a copy of the Assets Register to DFAT on request.

(c) The Recipient must reconcile, the Asset Register with the Assets at least on each anniversary of the Activity Start Date and include the results of that reconciliation in the annual report to be provided to DFAT set out in Item 2 of **Schedule 4**.

(d) The Asset Register and other relevant documents such as import papers and manufacturers' warranties relating to the Assets must be available for audit or review as required by DFAT.

12.3 Sale or disposal

(a) The Recipient must not:

(i) dispose (including any write-offs) of Assets unless:

(A) the disposal is conducted on an arms-length basis; and

(B) any conflicts of interest relevant to the disposal are disclosed to DFAT pursuant to **Clause 30** (Conflict of Interest).

(b) If the Recipient sells or otherwise disposes of an Asset during the Agreement Period, the proceeds of any sale or disposal of the Assets forms part of the Funds.

(c) If the Recipient sells or otherwise disposes of an Asset during the Agreement Period, DFAT is entitled, at its discretion, to recover from the Recipient:

(i) the value of the Asset obtained from the sale or disposal of the Asset; or

(ii) the market value of the Asset.

12.4 Termination

On termination or expiry of this Agreement, DFAT may require the Recipient to use, deal with or transfer any Asset as DFAT directs in writing.

12.5 Lost or damaged Assets

If any Asset is stolen, lost, damaged or destroyed, the Recipient must:

(a) reinstate the Asset (including using the proceeds of insurance) without using any Funds (unless DFAT's prior written consent is obtained to do otherwise);

(b) notify DFAT in writing if the Asset is valued above the Asset Threshold at the time of purchase; and

(c) this **Clause 12** continues to apply to the reinstated Asset.

Grant administration

13. Grant administration

13.1 Application of this clause

(a) This **Clause 13** applies if Item 9 of **Schedule 1** specifies that the Recipient will administer an Administered Grant Scheme.

13.2 Grant administration

(a) In administering an Administered Grant Scheme, the Recipient must:

(i) implement procedures so that grant administration is undertaken in a manner that is consistent with the Commonwealth Grants Rules and Guidelines, in particular the Key Principles for Grants Administration;

(ii) implement systems and processes to manage the risks of the Administered Grant Scheme;

(iii) maintain complete and accurate records documenting the procedures followed in selecting Administered Grant Recipients;

(iv) ensure that all Administered Grant Arrangements satisfy the requirements of **Clause 13.3** and allow the Recipient to comply with its obligations under this **Clause 12** and this Agreement;

(v) ensure that Administered Grant Recipients are financially viable and have the necessary relevant expertise and the appropriate types and amounts of insurance to perform their obligations under the Administered Grant Arrangements; and

(vi) not enter into an Administered Grant Arrangement with an organisation that has been named as not complying with the *Workplace Gender Equality Act 2012* (Cth). [**Note to Recipients:** The Workplace Gender Equality Act 2012 (Cth) applies to employers who employ 100 or more employees in Australia and provides for certain reporting obligations by those employers. Failure to comply with this Act may mean that the Director of Workplace Gender Equality may name a person as non-compliant with this Act.]

(b) The Commonwealth Grants Rules and Guidelines are available at: http://www.finance.gov.au/publications/fmg-series/3-commonwealth-grant-guidelines.html

(c) The Recipient must promptly provide copies of Administered Grant Arrangements, if requested by DFAT at any time.

(d) The Recipient must manage and administer each Administered Grant Arrangement in accordance with this Agreement, including by monitoring each Administered Grant Recipient's performance of, and compliance with, its contractual obligations.

(e) The Recipient must, to the extent it is legally able to do so, comply with any written direction of DFAT concerning an Administered Grant Arrangement.

(f) The Recipient must not terminate an Administered Grant Arrangement unless it gives DFAT notice of the proposed termination and has consulted with DFAT in relation to the proposed termination.

(g) Where an Administered Grant Recipient is unable to perform the work, the Recipient agrees to notify DFAT immediately.

13.3 Administered Grant Arrangements

The Recipient must ensure that each Administered Grant Arrangement:

(a) facilitates compliance by the Recipient with its obligations under this Agreement;

(b) is consistent with this Agreement and will not conflict with or detract from the rights and entitlements of the Recipient under this Agreement;

(c) contains all the relevant terms of this Agreement including those relating to compliance with laws, guidelines and policies, subcontracting, intellectual property, audit and access, privacy, confidentiality, warranties and indemnities, disclosure, repayment of funds, Fraud, child protection, counter-terrorism and termination and in particular that the Recipient has a right to terminate each Administered Grant Arrangement on terms no less favourable than those accorded to DFAT by **Clause 35.1**(Termination for Convenience), in the event of this Agreement being terminated;

(d) contains obligations requiring the Administered Grant Recipient to:

(i) manage the Funds paid by the Recipient to the Administered Grant Recipient and maintain a bank account, in accordance with the requirements in **Clause 6.3** (Bank Account);

(ii) maintain records, books and accounts to meet the same requirements the Recipient must meet under **Clause 25** (Records, Books and Accounts);

(iii) during the term of the Administered Grant Arrangement provide reports (including ad-hoc reports as requested) containing the same information as the Recipient is required to provide to DFAT under **Schedule 4**; and

(e) specifies that the Administered Grant Recipient acknowledges that:

(i) it may be considered a 'Commonwealth service provider' for the purposes of the *Ombudsman Act 1976* (Cth);

(ii) it may be subject to investigation by the Ombudsman under that Act; and

(iii) DFAT will not be liable for the cost of any such investigation by the Ombudsman in connection with the Administered Grant Arrangement or this Agreement;

(f) specifies that the Administered Grant Recipient is prohibited from subcontracting the entirety of its obligations under the Administered Grant Arrangement without the prior written approval of DFAT;

(g) specifies the purposes for which the Funds are being paid ('Specified Purposes');

(h) requires the Administered Grant Recipient to repay to the Recipient any Funds which are not properly acquitted, or which remain unspent (as if **Clause 10.2** (Unspent Funds) referred to the Administered Grant Recipient instead of the Recipient) promptly on the earlier of the end date or the termination or expiry of the Administered Grant Arrangement with that Administered Grant Recipient; and

(i) requires the Administered Grant Recipient to repay to the Recipient any Funds or property which have been spent for purposes other than the Specified Purposes, or lost as a result of Fraud or misappropriation, without delay.

13.4 Repayment of administered grant funds

(a) The Recipient must immediately notify DFAT of any administered grant funds it recovers under **Clause 13.3**(h) and 13.3(i) above. Any such administered grant funds will constitute Funds under the terms of this Agreement and the Recipient must deal with those Funds accordingly, or as otherwise directed in writing by DFAT.

(b) On receipt of notice under **Clause 13.4**(a), DFAT may by written notice to the Recipient require the Recipient to repay to DFAT any or all of the recovered administered grant funds, and the Recipient must repay to DFAT the amounts specified in the notice within **30 days** of the date of the notice.

Performance and compliance

14. Monitoring progress

14.1 Progress meetings

The Parties will meet at the times and in the manner reasonably required by DFAT to discuss any issues in relation to this Agreement or the Activity. The Recipient must ensure that the Recipient Representative, and DFAT must ensure the DFAT Representative, is reasonably available to attend such meetings and answer any queries relating to the Activity raised by either Party.

14.2 Reporting

(a) The Recipient must provide DFAT with Reports in accordance with **Schedule 4**.

(b) When the Recipient provides DFAT with a Report, DFAT will notify the Recipient in writing within 30 days after receiving the Report that it has either:

(i) accepted the Report; or

(ii) rejected the Report, providing reasons for its rejection.

(c) If DFAT rejects a Report, excluding a Performance Improvement Plan in accordance with **Clause 15** (Performance Improvement Plan), the Recipient must reissue the Report in a form that addresses the reasons for the earlier rejection and DFAT will comply with **Clause 14.2**(b) in relation to any reissued Report. Deadline for resubmission of the Report will be mutually agreed in writing by the Parties.

(d) Acceptance of a Report by DFAT does not constitute a release of the Recipient in respect of any matter, an admission or acceptance that the Recipient's performance complies with this Agreement, or acceptance of the accuracy of the Report.

14.3 Evaluation

(a) DFAT may at any time undertake, or engage an expert to undertake a review or evaluation of the Activity or DFAT's grant programs.

(b) In relation to any review or evaluation of the Activity or DFAT's grant programs, the Recipient must within 14 days after a request by DFAT (or any expert):

(i) provide all reasonable assistance to DFAT (and any expert);

(ii) respond to all reasonable requests from DFAT (and any expert); and

(iii) provide any information reasonably required by DFAT (and any expert).

15. Performance Improvement Plan

(a) If there is a potential failure or failure to meet a Milestone, perform the Activity or achieve the Outcomes in accordance with this Agreement, other than due to a Force Majeure Event (in this **Clause 15** a 'Performance Issue'), the Recipient must immediately notify DFAT of the Performance Issue.

(b) If the Recipient notifies DFAT of a Performance Issue in accordance with **Clause 15** (a), or if DFAT notifies the Recipient of a Performance Issue, then without limitation to any of DFAT's rights or the Recipient's obligations under this Agreement, the Recipient must, if requested by DFAT, within **7 days** (or such longer period as determined by DFAT) prepare and submit to DFAT a report ('Performance Improvement Plan') identifying:

(i) the nature and extent of the Performance Issue;

(ii) the consequences of the Performance Issue and in particular the Milestones and Outcomes that are likely to be affected; and

(iii) steps the Recipient will take to rectify the Performance Issue,

Performance Improvement Plan

(c) After receiving the Recipient's Performance Improvement Plan in accordance with **Clause 15**(b), DFAT will within **30 days** review the Performance Improvement Plan and give the Recipient notice that:

(i) DFAT approves the Performance Improvement Plan; or

(ii) DFAT does not approve the Performance Improvement Plan.

(d) If DFAT rejects the Performance Improvement Plan, the Recipient must amend and resubmit its proposed Performance Improvement Plan (again within the timeframe determined in accordance with **Clause 15**(b)), to take account of any concerns that DFAT may have with it, including in relation to matters such as the steps proposed to be taken by the Recipient, and the timeframe in which any steps are proposed to occur.

(e) If a Performance Improvement Plan is rejected and resubmitted, the process described in **Clauses 15**(c) and (d) will apply to the resubmitted Performance Improvement Plan.

(f) Once a Performance Improvement Plan is approved by DFAT, the Recipient must complete all of the steps and activities in the approved Performance Improvement Plan within the timeframes specified in the approved Performance Improvement Plan.

(g) If the Recipient:

(i) does not submit a Performance Improvement Plan that DFAT is prepared to approve; or

(ii) does not comply with the requirements of any approved Performance Improvement Plan,

then DFAT may immediately suspend payment in accordance with **Clause 7.2**(a)(ii) (Suspension) or terminate this Agreement in accordance with **Clause 35.2** (Termination for default).

(h) The exercise of DFAT's rights under this **Clause 15**, including the approval of a Performance Improvement Plan, will:

(i) not operate as a waiver of the obligations (or any breach thereof) that the Recipient may have under this Agreement; and

(ii) not limit DFAT's rights or remedies it may have against the Recipient in connection with the Performance Issue (for example, to claim damages for breach or terminate this Agreement).

16. Compliance with Laws

(a) The Recipient must, and must ensure that its subcontractors and Personnel, have regard to and comply with, relevant and applicable Laws, guidelines and policies, including those in Australia and in the Partner Country.

(b) The Recipient must ensure:

(i) that individuals or organisations involved in implementing the Activity are in no way linked, directly or indirectly, to organisations and individuals associated with terrorism, including 'terrorist organisations' as defined in **Division 102** of the *Criminal Code Act 1995* (Cth) and listed in regulations made under that Act and regulations made under the *Charter of the United Nations Act 1945* (Cth); and

(ii) that the Funds are not used in any way to provide direct or indirect support or resources to organisations and individuals associated with terrorism.

(c) The Recipient must in carrying out its obligations under this Agreement:

(i) comply with Laws in relation to sanctions, including the *Charter of the United Nations Act* 1945 (Cth) and regulations made under the Act and the *Autonomous Sanctions Act 2011* (Cth) and regulations made under that Act; and

(ii) ensure that Funds provided under this Agreement do not provide direct or indirect support or resources to organisation and individuals for whom Australia has imposed sanctions under the *Charter of the United Nations Act* 1945 (Cth) and regulations made under that Act or the *Autonomous Sanctions Act 2011* (Cth) and regulations made under that Act.

(d) If during the Agreement Period, the Recipient discovers any link whatsoever with any organisation or individual listed in **sub-clauses 16**(b) and **16**(c) above, it must inform DFAT immediately.

(e) The Recipient must have regard to the Australian Government guidance "*Safeguarding your organisation against terrorism financing: a guidance for non-profit organisations*", available at http://www.nationalsecurity.gov.au/agd/WWW/nationalsecurity.nsf/Page/What_Governments_are_doing_Risk_of_Misuse_-_Terrorism_Financing.

(f) If, during the Agreement Period, the Recipient discovers that it or its subcontractors or Personnel have any link whatsoever with any organisation or individual associated with terrorism it must inform DFAT immediately.

(g) If, during the Agreement Period, the Recipient or any of its subcontractors or Personnel are:

(i) listed on a World Bank List or Similar List or subject to any proceedings or an informal process which could lead to them becoming so listed;

(ii) temporarily suspended from tendering for World Bank grants by the World Bank pending the outcome of a sanctions process or from tendering by a donor of development funding other than the World Bank; and/or

(iii) the subject of an investigation (whether formal or informal) by the World Bank or another donor of development funding,

the Recipient must inform DFAT immediately.

(h) The Recipient warrants that the Recipient and its subcontractors and Personnel have not made or caused to be made, or received or sought to receive, any offer, gift or payment, consideration or benefit of any kind, which would or could be construed as an illegal or corrupt practice, either directly or indirectly to any Party, as an inducement or reward in relation to the execution of this Agreement.

(i) The Recipient must not, and must ensure that its subcontractors and Personnel do not:

(i) make or cause to be made, or receive or seek to receive, any offer, gift or payment, consideration or benefit of any kind, which would or could be construed as an illegal or corrupt practice, either directly or indirectly to any party, as an inducement or reward in relation to this Agreement; or

(ii) bribe public officials.

17. Child protection

(a) The Recipient must, and must ensure that its subcontractors and Personnel comply with the Child Protection Policy for the DFAT – Australian Aid Program, accessible at http://www.dfat.gov.au.

(b) DFAT may conduct a review of the Recipient's compliance with DFAT's Child Protection Policy referred to in **sub-clause 17**(a). DFAT will give reasonable notice to the Recipient and the Recipient must participate co-operatively in any such review.

18. Compliance with DFAT policies

(a) The Recipient must, and must ensure that its subcontractors and Personnel comply with all DFAT policies as listed on DFAT's website http://aid.dfat.gov.au.

(b) A list, as amended from time to time, of Australian laws and guidelines that may apply to the delivery of developmental aid to foreign countries can be found on the DFAT website: http://aid.dfat.gov.au. This list is not exhaustive and is provided for information only.

(c) The provision of the list referenced at **sub-clause 18**(b) above does not relieve the Recipient from complying with the obligations contained in this **Clause 18**.

(d) The Recipient must have regard to and comply with the Statement of International Development Practice Principles in **Schedule 5**.

19. Acknowledgement and publicity

19.1 Acknowledgment by Recipient

The Recipient must, in all publications, promotional and advertising materials, public announcements, events and activities in relation to the Activity, or any products, processes or inventions developed as a result of it, acknowledge the financial and other support received from DFAT, in the manner specified in the DFAT publication 'Visibility and Recognition: Guidelines for NGOs' (available on DFAT's website) or otherwise approved by DFAT prior to its use.

19.2 DFAT rights

(a) DFAT reserves the right to publicise and report on the awarding of the grant funding under this Agreement, and may do this by, amongst other means, including the Recipient's name, any subcontractor's name, the amount of the Total Funds and a brief description of the Activity on websites and in media releases, general announcements about the DFAT's grant programs and annual reports.

(b) Without limiting any other right of DFAT, DFAT may disclose information about this Agreement, the Recipient or the Activity to any State or Territory government of Australia or a Partner Government.

19.3 Announcements

(a) The Recipient must, before making a public announcement in connection with this Agreement or any transaction contemplated by it, provide DFAT with **21 days** prior written notice, except if required by Law or a regulatory body (including a relevant stock exchange).

(b) If the Recipient is required by Law or a regulatory body to make a public announcement in connection with this Agreement or any transaction contemplated by this Agreement, the Recipient must, to the extent practicable, first consult with and take into account the reasonable requirements of DFAT.

19.4 Activity Events

(a) The Recipient must not undertake, or participate in any way in, any Activity Event, without providing DFAT with 21 days prior written notice.

(b) The Recipient must:

(i) notify DFAT of a proposed Activity Event at least **21 days** before the proposed date for the Activity Event and submit all details of the Activity Event to DFAT in the format required by DFAT;

(ii) invite a representative of DFAT to the Activity Event; and

(iii) if required by DFAT, provide the DFAT representative an opportunity to speak at the Activity Event.

(c) The Recipient must notify DFAT of any change to Activity Event details as soon as possible.

Subcontracting

20. Subcontractors

(a) The Recipient must notify DFAT of the details of its subcontractors on request from DFAT.

(b) The Recipient must obtain any subcontractor's express consent for the disclosure to DFAT of the subcontractor's identity (and their Personal Information, if the subcontractor is an individual). The consent obtained must extend to allowing DFAT to disclose for reporting purposes the subcontractor's identity and the existence and nature of the subcontract.

(c) The Recipient must not enter into a subcontract with a subcontractor named as an organisation that has not complied with the *Workplace Gender Equality Act 2012* (Cth). [***Note to Recipients**: The Workplace Gender Equality Act 2012 (Cth) applies to employers who employ 100 or more employees in Australia and provides for certain reporting obligations by those employers. Failure to comply with this Act may mean that the Director of Workplace Gender Equality may name a person as non-compliant with this Act.*]

(d) The Recipient must ensure that any subcontractor complies with all Laws and:

(i) **Clause 16** (Compliance with Laws);

(ii) **Clause 17** (Child protection);

(iii) **Clause 18** (Compliance with DFAT policies);

(iv) **Clause 23** (Confidentiality);

(v) **Clause 29** (Insurance);

(vi) **Clause 24** (Protection of Personal Information);

(vii) **Clause 30** (Conflict of interest);

(viii) **Clause 25** (Records, books and accounts);

(ix) **Clause 26** (Audit and access); and

(x) **Clause 31** (Fraud).

(e) The Recipient is fully responsible for:

(i) undertaking the Activity and performing this Agreement even if the Recipient subcontracts any aspect of the Activity; and

(ii) the performance of all of the Recipient's obligations under this Agreement.

and will not be relieved of that responsibility because of any:

(iii) involvement by DFAT or any third party in the performance of the Activity; or

(iv) payment of any Funds.

Information management

21. Intellectual Property Rights

21.1 Pre-existing Recipient Material and Third Party Material

(a) This **Clause 21** does not affect the ownership of the Intellectual Property Rights in any DFAT Material, Pre-existing Recipient Material or Third Party Material.

(b) The Recipient must obtain all necessary copyright and other Intellectual Property Right permissions before making any Pre-Existing Recipient Material or Third Party Material available as a part of the Agreement Material or Activity.

21.2 Selecting an ownership model for Intellectual Property Rights in Agreement Material

(a) If no ownership model is selected in Item 10 of **Schedule 1**, **Clause 21.3** applies and **Clause 21.4** in its entirety, does not apply to this Agreement.

(b) Each Party must, at its own cost, do all things and execute all documents necessary or convenient to give effect to the ownership model.

21.3 Recipient ownership of Intellectual Property Rights in Agreement Material

(a) All Intellectual Property Rights in the Agreement Material vest in the Recipient on creation.

(b) Unless otherwise specified in Item 11 of **Schedule 1**:

(i) the Recipient grants to, or must obtain for, DFAT, a perpetual, irrevocable, world-wide, royalty free, non-exclusive licence (including the right to sublicense) to use, reproduce, adapt, Modify, distribute and communicate:

(A) the Agreement Material; and

(B) any Third Party Material and Pre-Existing Recipient Material,

required to receive the full benefit of the Agreement Material and the Activity, and for any other DFAT or Commonwealth purpose; and

(ii) to the extent that the Recipient needs to use any of the DFAT Material for the purpose of performing its obligations under this Agreement, DFAT grants to the Recipient for the Agreement Period, subject to any conditions or restrictions specified in item 13 of Schedule 1 and any direction by DFAT, a revocable, world-wide, royalty-free, non-exclusive, non-transferable licence (including the right to sublicense) to use, reproduce, adapt, Modify and communicate such Material solely for the purpose of performing the Activity.

21.4 DFAT ownership of Intellectual Property Rights in Agreement Material

(a) All Intellectual Property Rights in the Agreement Material vest in DFAT on creation.

(b) Unless otherwise specified in Item 12 of **Schedule 1**, to the extent that:

(i) DFAT needs to use any of the Pre-Existing Recipient Material or Third Party Material to receive the full benefit of the Activity, and for any other DFAT or Commonwealth purpose, the Recipient grants to, or must obtain for, DFAT, a perpetual, irrevocable, world-wide, royalty free, non-exclusive licence (including the right to sublicense) to use, reproduce,

adapt, Modify and communicate that Pre-Existing Recipient Material or Third Party Material; or

(ii) the Recipient needs to use any of the:

(A) DFAT Material; or

(B) Agreement Material,

for the purpose of performing its obligations under this Agreement, DFAT grants to the Recipient for the term of this Agreement, subject to any conditions or restrictions specified in Item 13 of **Schedule 1** and any direction by DFAT, a revocable, world-wide, royalty-free, non-exclusive, non-transferable licence (including the right to sublicense) to use, reproduce, adapt, Modify, distribute and communicate such Material solely for the purpose of performing the Activity.

21.5 Warranty

The Recipient warrants that:

(a) the Warranted Materials and DFAT's use of the Warranted Materials will not infringe the Intellectual Property Rights of any person; and

(b) it has the necessary rights to vest the Intellectual Property Rights and grant the licences as provided for in this **Clause 21**.

21.6 Remedy for breach of warranty

If someone claims, or DFAT reasonably believes that someone is likely to claim, that all or part of the Warranted Materials infringe their Intellectual Property Rights, the Recipient must, in addition to the indemnity under clause 28 and to any other rights that DFAT may have against it, promptly, at the Recipient's expense:

(a) use its best efforts to secure the rights for DFAT to continue to use the affected Warranted Materials free of any claim or liability for infringement; or

(b) replace or modify the affected Warranted Materials so that the Warranted Materials or the use of them does not infringe the Intellectual Property Rights of any other person without any degradation of the performance or quality of the affected Warranted Materials.

22. Moral Rights

22.1 Obtaining consents

To the extent permitted by applicable Laws and for the benefit of DFAT, the Recipient must use its best endeavours to ensure that:

(a) each of the Personnel used by the Recipient in the production or creation of the Agreement Material gives, in a form acceptable to DFAT; and

(b) any holder of Moral Rights in Third Party Material included in the Agreement Material gives,

genuine consent in writing, to the use of the Agreement Material for the Specified Acts, even if such use would otherwise be an infringement of their Moral Rights.

22.2 Specified Acts

(a) In this **Clause 22**, unless otherwise specified in Item 14 of **Schedule 1**, **Specified Acts** means:

(i) failing to attribute or falsely attributing the authorship of any Agreement Material, or any content in the Agreement Material (including literary, dramatic, artistic works and cinematograph films within the meaning of the *Copyright Act 1968* (Cth));

(ii) materially altering the style, format, colours, content or layout of the Agreement Material and dealing in any way with the altered Agreement Material;

(iii) reproducing, communicating, adapting, publishing or exhibiting any Agreement Material; and

(iv) adding any additional content or information to the Agreement Material.

(b) For the purposes of this **Clause 22**, Agreement Material includes any Pre-existing Recipient Material and Third Party Material to the extent that it is included in, forms part of or is attached to the Agreement Material.

23. Confidentiality

23.1 Prohibition on disclosure

(a) Subject to **sub-clause 23.2** below, a Party must not, without the prior written consent of the other Party, disclose any Confidential Information of the other Party to a third party.

(b) In giving written consent to the disclosure of Confidential Information, a Party may impose such conditions as it thinks fit, and the other Party agrees to comply with these conditions.

23.2 Exceptions to obligations

The obligations on the Parties under **sub-clause 23.1** above will not be taken to have been breached to the extent that Recipient Confidential Information:

(a) is disclosed by a Party to its Personnel or advisers solely in order to comply with obligations, or to exercise rights, under this Agreement;

(b) is disclosed to a Party's internal management personnel, solely to enable effective management or auditing of activities related to this Agreement;

(c) is disclosed by DFAT, to the responsible Minister, a House or a Committee of the Parliament of the Commonwealth of Australia;

(d) is shared by DFAT within DFAT, or with another Commonwealth agency, State or Territory Government or Partner Government, where this serves the Commonwealth's legitimate interests, the State's or Territory's legitimate interests or the Partner Government's legitimate interests;

(e) is authorised or required by Law to be disclosed or required in connection with legal proceedings; or

(f) is in the public domain otherwise than due to a breach of this Agreement.

23.3 Transfer of data

The Recipient must not transfer, transmit or disclose Confidential Information of DFAT and Personal Information or allow Confidential Information of DFAT and Personal Information to be taken, transferred, transmitted, accessed or disclosed outside Australia, except to the Partner Country, or allow parties outside Australia to have access to it, without the prior approval of DFAT.

23.4 Return of information

The Recipient must use any Confidential Information of DFAT held, acquired or which the Recipient may have had access to in connection with this Agreement only for the purposes of fulfilling its obligations under this Agreement. Upon expiry or earlier termination of this Agreement the Recipient must either destroy or deliver to DFAT all Confidential Information of DFAT, as required by DFAT.

24. Protection of Personal Information

24.1 Privacy

The Recipient must:

(a) use and disclose Personal Information provided by DFAT or collected by the Recipient under this Agreement only for the purposes of performing its obligations under this Agreement;

(b) not do any act or engage in any practice that would breach an Australian Privacy Principle if done or engaged in by DFAT and must not do or omit to do anything that causes DFAT to be in breach of an Australian Privacy Principle (see http://www.oaic.gov.au/);

(c) comply with any directions, guidelines, determinations or recommendations of the Information Commissioner, Privacy Commissioner or Freedom of Information Commissioner, to the extent that they are not inconsistent with the requirements of this Agreement and promptly notify DFAT in writing of any such occurrence; and

(d) ensure that any subcontract entered into for the purpose of fulfilling the Recipient's obligations under this Agreement contains provisions to ensure that the subcontractor has the same awareness and obligations as the Recipient has under this **Clause 24**, including this requirement in relation to subcontracts.

24.2 Disclosure

Subject to **Clause 23** (Confidentiality) and this **Clause 24**, the Recipient acknowledges that the Commonwealth of Australia may disclose or publish details about this Agreement or Activity. The details may include (but are not limited to) organisation name, the value of the Activity's Funding, and the location where the Activity is being delivered or performed.

25. Records, books and accounts

25.1 Recipient to keep records, books and accounts

The Recipient must:

(a) at all times maintain, and must ensure that its subcontractors maintain, full, true, separate and up-to-date records, books and accounts in relation to the Activity, Funds and this Agreement, including operational records, financial records and records in relation to the Funds. Such records, books and accounts must, without limitation:

(i) record all operational activities in relation to the Activity, including to enable the prevention, detection and investigation of Fraud as required by **Clause 31**(Fraud and Anti-Corruption);

(ii) record all receipts and expenses related to the Activity, including those involving foreign exchange transactions;

(iii) enable all receipts and expenses related to the Activity to be identified and reported in accordance with this Agreement;

(iv) enable the amounts payable by DFAT under this Agreement to be determined;

(v) be kept in a manner that permits them to be conveniently and properly audited or reviewed;

(vi) enable the extraction of all information relevant to this Agreement; and

(b) retain and require its subcontractors to retain for a period of seven years after the expiry or termination of this Agreement, all records, books and accounts relating to the Activity, the Funds and this Agreement.

25.2 Costs

The Recipient must bear its own costs of complying with this **Clause 25**.

25.3 Survival

This **Clause 25** applies for the Agreement Period and for a period of seven years from the expiry or termination of this Agreement.

26. Audit and access

26.1 Right to conduct audits or reviews

(a) DFAT or a representative may conduct audits or reviews relevant to the performance of the Recipient's obligations under this Agreement. Audits or reviews may be conducted of:

(i) the use of the Funds;

(ii) the Assets;

(iii) the Recipient's operational practices and procedures as they relate to this Agreement;

(iv) the accuracy of the Recipient's invoices and Reports;

(v) the Recipient's compliance with its confidentiality and privacy obligations under this Agreement;

(vi) the Recipient's compliance with Laws, guidelines and policies including the policies listed at **Clause 16** (Compliance with Laws) and **18** (Compliance with DFAT Policies);

(vii) the Recipient's compliance with its child protection policy obligations under **Clause 17** (Child Protection);

(viii) the Recipient's compliance with its Fraud control strategy and policies including Fraud prevention, reporting and investigation obligations under this Agreement;

(ix) Material (including records, books and accounts) in the possession of the Recipient relevant to the Activity or this Agreement; and

(x) any other matters determined by DFAT to be relevant to the Activity or this Agreement.

(b) If DFAT decides to conduct or commission audits or reviews, it will give reasonable notice to the Recipient. The Recipient must participate co-operatively in any audit or review conducted by DFAT or a representative.

26.2 Access by DFAT

(a) DFAT may, at reasonable times and on giving reasonable notice to the Recipient:

(i) access the premises of the Recipient and premises where the Activity is being undertaken to the extent relevant to the performance of this Agreement;

(ii) require the provision by the Recipient, its Personnel or subcontractors of records and information in a data format and storage medium accessible by DFAT by use of DFAT's existing computer hardware and software;

(iii) inspect and copy documentation, records, books and accounts, however stored, in the custody or under the control of the Recipient, its Personnel or subcontractors; and

(iv) require assistance in respect of any inquiry into or concerning the Activity or this Agreement. For these purposes an inquiry includes any administrative or statutory review, audit or inquiry (whether within or external to DFAT), any request for information directed to DFAT, and any inquiry conducted by Parliament or any Parliamentary committee.

(b) The Recipient must provide access to its computer hardware and software to the extent necessary for DFAT to exercise its rights under this **Clause 26**, and provide DFAT with any reasonable assistance requested by DFAT to use that hardware and software.

26.3 Conduct of audit and access

DFAT must use reasonable endeavours to ensure that:

(a) audits or reviews performed pursuant to **sub-clause 26.1** above; and

(b) the exercise of the general rights granted by **sub-clause 26.2** by DFAT,

do not unreasonably delay or disrupt in any material respect the Recipient's performance of its obligations under this Agreement or its business.

26.4 Costs

Unless otherwise agreed in writing, each Party must bear its own costs of any reviews and/or audits.

26.5 DFAT officers and experts

The rights of DFAT under **sub-clause 26.2**(a)(i) to 26.2(a)(iii) apply equally to:

(a) the Auditor-General, Information Commissioner, Privacy Commissioner and Freedom of Information Commissioner and their delegates, for the purpose of performing their statutory functions or powers; and

(b) any expert engaged for the purposes of **Clause 14.3** (Evaluation).

26.6 Recipient to comply with DFAT officers' requirements

The Recipient must do all things necessary to comply with the Auditor-General's, Information Commissioner's, Privacy Commissioner's or Freedom of Information Commissioner's or his or her delegate's requirements, notified under **sub-clause 26.2** above, provided such requirements are legally enforceable and within the power of the

Auditor-General, Information Commissioner, Privacy Commissioner or Freedom of Information Commissioner, or his or her respective delegate.

26.7 **No reduction in responsibility**

The requirement for, and participation in, audits or reviews does not in any way reduce the Recipient's responsibility to perform its obligations in accordance with this Agreement.

26.8 **Subcontractor requirements**

The Recipient must ensure that any subcontract entered into for the purpose of this Agreement contains an equivalent clause granting the rights specified in this **Clause 26**.

26.9 **No restriction**

Nothing in this Agreement reduces, limits or restricts in any way any function, power, right or entitlement of the Auditor-General, Information Commissioner, Privacy Commissioner or Freedom of Information Commissioner, other Commonwealth Commissioner or their delegates. The rights of DFAT under this Agreement are in addition to any other power, right or entitlement of the Auditor-General, Information Commissioner, Privacy Commissioner or Freedom of Information Commissioner or their delegates.

26.10 **Survival**

This **Clause 26** applies for the Agreement Period and for a period of seven years from the expiry or termination of this Agreement.

Risk management

27. Risk management

(a) The Recipient is responsible for, accepts must manage all the risks of and associated with the Activity.

(b) The Recipient must maintain appropriate risk mitigation measures which may include preparing, maintaining and using risk registers.

28. Indemnity

(a) The Recipient at all times indemnifies and holds harmless DFAT, its officers and employees (referred to in this **Clause 28** as "**those indemnified**") from and against any loss or liability, including:

(i) loss of, or damage to, property of DFAT;

(ii) claims by any person in respect of personal injury or death;

(iii) claims by any person in respect of loss of, or damage to, any property; and

(iv) costs and expenses, including the costs of defending or settling any claim referred to in **Clause 28** (a)(ii) or clause 28(a)(iii),

arising out of or as a consequence of:

(v) the unlawful, negligent or wilfully wrongful, act or omission of the Recipient, its subcontractors or Personnel in the conduct of the Activity;

(vi) the Warranted Materials (including the use of the Warranted Materials by DFAT or its Personnel) infringing or allegedly infringing the Intellectual Property Rights of any person;

(vii) a breach of **Clause 23** (Confidentiality) or **Clause 24** (Protection of Personal Information); or

(viii) without limiting the preceding paragraphs, any breach of this Agreement by the Recipient, its Personnel or subcontractors.

(b) The Recipient's liability to indemnify those indemnified under **Clause 28** (a) will be reduced proportionally to the extent that any negligent act or omission of those indemnified contributed to the loss.

29. Insurance

29.1 Obligation to maintain insurance

(a) In connection with the Activity, the Recipient must have and maintain for the Agreement Period, valid and enforceable appropriate insurance policies relevant to the performance of the Activity including where appropriate, the amount of any professional indemnity insurance specified in Item 15 of **Schedule 1**.

(b) If it is specified in Item 15 of **Schedule 1** that the Recipient is required to have and maintain professional indemnity insurance, the Recipient must continue to maintain such insurance for a period of seven years following the expiry or termination of the Agreement.

29.2 Confirmation of insurance

The Recipient must, on request by DFAT, provide current relevant confirmation of insurance documentation for example, a certificate of currency from its insurers or insurance brokers certifying that it has insurance as required by **Clause 29.1**.

30. Conflict of interest

30.1 Warranty

The Recipient warrants that, to the best of its knowledge after making diligent inquiry, at the date of signing this Agreement, no conflict of interest exists or is likely to arise in the performance of its obligations under this Agreement.

30.2 Notification of a conflict of interest

If, during the Activity a conflict of interest arises, or appears likely to arise, the Recipient must:

(a) notify DFAT immediately in writing;

(b) make full disclosure of all relevant information relating to the conflict; and

(c) take such steps as DFAT requires to resolve or otherwise deal with the conflict.

31. Fraud and anti-corruption

31.1 Bribery of Foreign Officials and Facilitation Payment

For the purposes of this **Clause 31**, the definition of 'Fraud' includes:

(a) **bribery of foreign officials** which includes providing or offering a benefit to a foreign public official, or causing a benefit to be provided or offered to a foreign public official, where the benefit is not legitimately due. The benefit must be intended to influence a foreign public official in the exercise of their official duties for the purpose of obtaining or retaining business or a business advantage or other benefit which is not legitimately due; and

(b) **facilitation payment** which means making or receiving any payments outside the terms of agreements, contracts or established procedures paid in order to expedite or secure the performance of a routine action which is legitimately required without payment.

31.2 Warranty

(a) The Recipient warrants that, to the best of its knowledge, at the date of signing this Agreement it has disclosed all current allegations or investigations in relation to Fraudulent Activity to DFAT.

(b) The Recipient warrants that it did not make or cause to be made, receive or seek to receive, any offer, gift or payment, consideration or benefit of any kind, which would or could be construed as an illegal or corrupt act, either directly or indirectly to any party, as an inducement or reward in relation to the execution of this Agreement.

(c) The Recipient must not bribe public officials, including foreign officials, and must ensure that all Recipient Personnel do not bribe public officials including foreign officials.

31.3 Prevention of Fraud and anti-corruption

(a) The Recipient must not, and must ensure that its subcontractors and Personnel do not, engage in any Fraudulent Activity.

(b) The Recipient is responsible for preventing and detecting Fraud.

(c) Within one month following the Commencement Date, the Recipient must prepare a fraud risk assessment and zero tolerance fraud control strategy for the Activity. The risk assessment and strategy must contain appropriate fraud prevention, detection, investigation and reporting processes and procedures that comply with the Commonwealth Fraud Control Framework (http://www.ag.gov.au). The Recipient's strategies must include:

(i) preparation and implementation of a Fraud control strategy, policy and relevant procedures applicable to the Recipient, its subcontractors and Personnel;

(ii) development of guidance on anti-corruption and bribery and delivery of materials and training to the Recipient's subcontractors and Personnel;

(iii) provision of mandatory fraud control awareness training to all of the Recipient's subcontractors and Personnel and implementation of procedures to track attendance; and

(iv) development and implementation of procedures to record and maintain books, accounts and records relating to the Activity that are required to be kept in accordance with **Clause 25** (Records, books and accounts).

31.4 Investigation of Fraud and anti-corruption

(a) The Recipient must report in writing within **five Business Days** to DFAT any suspicion or detection of Fraudulent Activity involving the Activity including any Fraudulent Activity involving or relating to the Recipient's subcontractors and Personnel.

(b) In the event of a Fraud and in consultation with DFAT, the Recipient must develop and implement a strategy to investigate the Fraud, based on the principles set out in the Australian Government Investigations Standards (http://www.ag.gov.au/RightsAndProtections/FOI/Pages/Freedomofinformationdisclosurelog/AustralianGovernmentInvestigationStandards2011andAustralianGovernmentInvestigationsStandards2003.aspx). The Recipient must undertake the investigation at the Recipient's cost.

(c) In addition to the investigation carried out by the Recipient under **sub-clause 31.4** (b) above, DFAT or its nominee may conduct its own investigation. If DFAT exercises its rights under this clause, the Recipient must provide all reasonable assistance that may be required at the Recipient's sole expense.

(d) Following the conclusion of an investigation (whether by the Recipient or by DFAT) if the investigation finds that:

(i) the Recipient, its subcontractors or Personnel have acted in a Fraudulent manner, the Recipient must:

(A) where money has been misappropriated, pay to DFAT the full value of the Funds that have been misappropriated or reinstate such amount to the use of the Activity;

(B) where an Asset has been misappropriated, either return the item to DFAT or for use in the Activity or if the Asset cannot be recovered or has been damaged so that it is no longer usable, replace the Asset with one of equal value at the time of original purchase and of at least equal quality to the Asset at the time of original purchase;

(C) refer the matter to the relevant Partner Country police or other authorities responsible for prosecution of Fraudulent Activity, unless an exemption has been sought and granted by the relevant DFAT delegate; and

(D) keep DFAT informed, in writing, on a monthly basis, of the progress of the investigation and recovery action; or

(ii) a Party other than the Recipient, its subcontractors or Personnel have acted in a Fraudulent manner, the Recipient must, at the Recipient's cost make every effort to recover any Funds or Assets acquired or distributed through Fraudulent Activity, including the following:

(A) take recovery action in accordance with recovery procedures, including civil litigation, available in the Partner Country;

(B) refer the matter to the relevant Partner Country police or other authorities responsible for prosecution of fraudulent activity, unless an exemption has been sought and granted by the relevant DFAT delegate; and

(C) keep DFAT informed, in writing, on a monthly basis, of the progress of the recovery action.

(e) If the Recipient considers that after all reasonable action has been taken to recover the Funds or Assets and full recovery has not been achieved or recovery has only been achieved in part, the Recipient may seek approval from DFAT that no further recovery action be taken.

(f) The Recipient must provide to DFAT all information, records and documents required by DFAT to enable DFAT to make a decision on whether or not to approve non-recovery of losses arising from Fraudulent Activity or misappropriated Funds or Assets.

31.5 Subcontractor and Personnel requirements

The Recipient must ensure that any subcontract entered into for the purpose of this Agreement contains an equivalent clause granting the rights specified in this **Clause 31**.

31.6 Survival

This **Clause 31** survives termination or expiration of this Agreement in relation to:

(a) any Fraudulent Activity which was not detected by the Recipient before the date of termination or expiry of this Agreement;

(b) any Fraudulent Activity detected by the Recipient before the date of termination or expiry of this Agreement but which the Recipient had not begun to investigate under **sub-clause 31.4** above;

(c) any investigation commenced by the Recipient under clause 31.4, but not completed, before the date of termination or expiry of this Agreement;

(d) any investigation commenced by DFAT under **sub-clause 31.4** above, but not completed, before the date of termination or expiry of this Agreement; and

(e) any investigation completed by the Recipient under **sub-clause 31.4** above, or by DFAT under **sub-clause 31.4**, but where:

(i) Funds have been lost to Fraudulent Activity or misappropriated and the full value of misappropriated funds have not been paid to DFAT or the account of the Activity;

(ii) Assets or other DFAT-funded property has been lost to Fraudulent Activity or misappropriated but the property has not been returned to DFAT or the account of the Activity; or

(iii) Assets or other DFAT-funded property cannot be recovered or has been damaged so that it is no longer usable and has not been replaced by property of equal value at the time of original purchase and of at least equal quality to the property at the time of original purchase.

32. Transparency

DFAT and the Recipient are committed to principles of transparency consistent with the Transparency Charter for the DFAT-Australian Aid Program, accessible on the DFAT website: http://aid.dfat.gov.au. DFAT and the Recipient will apply these principles of transparency to information relating to Australian funding for the Activity. DFAT will periodically publish detailed information about work under the Agreement on the DFAT website. This will include information about the Recipient's policies, plans, processes, the

results of Recipient's aid activities and DFAT's evaluations of the Recipient's performance. DFAT and the Recipient will consult prior to publication or release of information regarded as sensitive (for example, Fraud or corruption matters).

Dispute resolution and termination

33. Force Majeure Events

33.1 Occurrence of Force Majeure Event

A Party (**Affected Party**) is excused from performing its obligations under this Agreement to the extent it is prevented by circumstances which:

(a) are beyond its reasonable control (other than, in respect of the Recipient only, lack of funds for any reason or any strike, lockout or labour dispute) including acts of God, natural disasters, acts of war, riots and strikes outside the Affected Party's organisation; and

(b) could not have been prevented or overcome by the Affected Party (or, where the Affected Party is the Recipient) exercising a standard of care and diligence consistent with that of a prudent and competent person operating within the relevant industry ((a 'Force Majeure Event').

33.2 Notice of Force Majeure Event

When a Force Majeure Event arises or is reasonably perceived by the Affected Party as an imminent possibility, the Affected Party must give notice of those circumstances to the other Party as soon as possible, identifying the effect they will have on its performance. The Affected Party must make all reasonable efforts to minimise the effects of such circumstances on the performance of this Agreement.

33.3 Payment

DFAT is not obliged to pay the Recipient any grant funding for so long as a Force Majeure Event prevents the Recipient from performing its obligations under this Agreement.

33.4 Termination

If non-performance or diminished performance by the Recipient due to a Force Majeure Event continues for a period of more than **60 days**, DFAT may, at any time after the period, terminate this Agreement immediately by giving the Recipient written notice.

33.5 Consequences of termination

If this Agreement is terminated under **sub-clause 33.4** above:

(a) DFAT is liable only for:

(i) payments under **Clause 7** (Payment of Funds by DFAT) in accordance with this Agreement before the effective date of termination, but only to the extent that those monies have been spent, or legally committed for expenditure by the Recipient in accordance with this Agreement and are payable by the Recipient as a current liability, by the date the Recipient receives the notice of termination (written evidence of which will be required); and

(ii) where the Recipient has undertaken work on but not completed a Milestone by the date the Recipient receives the notice of termination, grant funding in accordance with this Agreement to the extent that those monies have

been spent, or legally committed for expenditure by the Recipient in accordance with this Agreement and payable by the Recipient as a current liability, on that Milestone by the date the Recipient receives the notice of termination (written evidence of which will be required); and

(b) each Party will bear its own costs and neither Party will incur further liability to the other.

34. Dispute resolution

34.1 No arbitration or court proceedings

If a dispute arises in relation to this Agreement ('Dispute'), a Party must comply with this **Clause 34** before starting arbitration or court proceedings, except proceedings for urgent interlocutory relief. After a Party has sought or obtained any urgent interlocutory relief, that Party must follow this **Clause 34**.

34.2 Notification

A Party claiming a Dispute has arisen must give the other Party notice setting out details of the Dispute.

34.3 Parties to resolve Dispute

During the **60 days** after a notice is given under **sub-clause 34.2** (or longer period if the Parties agree in writing), each Party must use its reasonable efforts through a meeting of senior management representatives (or their nominees) to resolve the Dispute.

34.4 Breach of this clause

If a Party breaches **sub-clauses 34.1** to **34.3** above, the other Party does not have to comply with those clauses in relation to the Dispute.

34.5 Exception

For the purpose of this **Clause 34**, a Dispute does not include a dispute arising in relation to DFAT:

(a) suspending payment of grant funding under **Clause 7.2** (Suspension);

(b) reducing the amount of an instalment of grant funding under **Clause 7.3** (Reduction) ;

(c) requiring payment under **Clause 10** (Repayment); or

(d) terminating this Agreement or reducing the scope of the Activity under **Clause 35** (Termination).

35. Termination

35.1 Termination for convenience

(a) Without limiting any other rights or remedies DFAT may have arising out of or in connection with this Agreement, DFAT may, by notice, terminate this Agreement or reduce the scope of the Activity for any reason.

(b) On receipt of a notice of termination or reduction the Recipient must:

(i) take all available steps to minimise loss resulting from that termination or reduction and to protect Agreement Material; and

(ii) in the case of a reduction in scope, continue to undertake any part of the Activity not affected by the notice (unless the Recipient, acting reasonably, notifies DFAT that it is not commercially viable to do so).

(c) If this Agreement is terminated under this **sub-clause 35.1**, DFAT is liable only for:

(i) payments under **Clause 7** (Payment of funds by DFAT) in accordance with this Agreement before the effective date of termination, but only to the extent that those monies have been spent, or legally committed for expenditure by the Recipient in accordance with this Agreement and are payable by the Recipient as a current liability, by the date the Recipient receives the notice of termination (written evidence of which will be required);

(ii) where the Recipient has undertaken work on but not completed a Milestone by the date the Recipient receives the notice of termination, grant funding in accordance with this Agreement to the extent that those monies have been spent, or legally committed for expenditure by the Recipient in accordance with this Agreement and payable by the Recipient as a current liability, on that Milestone by the date the Recipient receives the notice of termination (written evidence of which will be required); and

(iii) subject to **sub-clause 35.1**(e), reasonable costs actually incurred by the Recipient and directly attributable to the termination.

(d) If the scope of the Activity is reduced, DFAT's liability to pay the grant funding under this Agreement abates in accordance with the reduction in the Activity.

(e) DFAT is not liable to pay compensation under **sub-clause 35.1**(c)(iii) that exceeds an amount equal to the Total Funds less any amounts paid or due, or becoming due, to the Recipient under this Agreement.

(f) The Recipient is not entitled to compensation for loss of prospective profits.

35.2 Termination for default

(a) Without limiting any other rights or remedies DFAT may have arising out of or in connection with this Agreement, DFAT may terminate this Agreement or reduce the scope of the Activity effective immediately by giving notice to the Recipient if:

(i) the Recipient breaches a material provision of this Agreement where that breach is not capable of remedy;

(ii) the Recipient breaches any provision of this Agreement and fails to remedy the breach within 14 days after receiving notice requiring it to do so;

(iii) in the opinion of DFAT, a conflict of interest exists which would prevent the Recipient from performing its obligations under this Agreement;

(iv) in DFAT's reasonable opinion, one or more of the circumstances described in **Clause 15**(g)(Performance Improvement Plan) apply;

(v) the Recipient:

(A) Abandons the Activity;

(B) notifies DFAT of an intention to Abandon the Activity; or

(C) states an intention to Abandon the Activity,

and does not, when requested by DFAT, demonstrate to DFAT's satisfaction within **14 days** that the Recipient will proceed with the Activity;

(vi) in DFAT's reasonable opinion, it is unlikely that the Recipient will be able to achieve a Milestone to DFAT's satisfaction;

(vii) DFAT is satisfied that any statement made in the Application is incorrect, incomplete, false or misleading in a way which would have affected the original decision to approve the provision of the grant funding under this Agreement;

(viii) the organisation is listed in the World Bank list or Similar List;

(ix) the organisation is listed on a Relevant List;

(x) a Related Agreement is terminated by DFAT for default by the Recipient;

(xi) there is a Change in Control of the Recipient; or

(xii) an Insolvency Event occurs in relation to the Recipient.

(b) Without limitation, for the purposes of **Clause 35.2**(a)(i), each of the following constitutes a breach of a material provision:

(i) breach of warranty under **Clause 4.2** (Warranties);

(ii) a failure to comply with **Clause 6.1** (What Funds can be used for);

(iii) a failure to comply with **Clause 16** (Compliance with Laws) including a failure to notify DFAT **under sub-clause 16**(g);

(iv) a failure to comply with **Clause 17** (Child protection);

(v) a failure to comply with **Clause 18** (Compliance with DFAT policies);

(vi) a failure to comply with **Clause 20** (Subcontractors);

(vii) a failure to comply with **Clause 21** (Intellectual Property Rights);

(viii) a failure to comply with **Clause 24** (Protection of Personal Information);

(ix) a failure to comply with **Clause 29** (Insurance);

(x) a failure to notify DFAT of a conflict of interest under **Clause 30** (Conflict of interest); and

(xi) a breach of warranty or a failure to comply with **Clause 31** (Fraud and anti-corruption).

(c) If the scope of the Activity is reduced under this **sub-clause 35.2**:

(i) DFAT's liability to pay the grant funding under this Agreement abates in accordance with the reduction in the Activity; and

(ii) the Recipient must continue to undertake any part of the Activity not affected by the notice (unless the Recipient, acting reasonably, notifies DFAT that it is not commercially viable to do so).

35.3 DFAT rights

Without limiting any of DFAT's other rights or remedies, on termination of this Agreement:

(a) subject to **sub-clauses 33.5** and **35.1**(c), DFAT is not obliged to pay to the Recipient any outstanding amount of grant funding under this Agreement; and

(b) DFAT is entitled to exercise any right to recover from the Recipient, including under **Clause 10** (Repayment) and **Clause 12** (Assets).

35.4 Termination does not affect accrued rights

Termination of this Agreement does not affect any accrued rights or remedies of a Party.

General obligations

36. Survival

The following clauses survive the expiry or termination of this Agreement:

(a) **Clause 6** (Use of Funds by Recipient);

(b) **Clause 9** (GST);

(c) **Clause 10** (Repayment);

(d) **Clause 12** (Assets);

(e) **Clause 13.4** (Repayment of administered grant funds);

(f) **Clause 14.2** (Reporting);

(g) **Clause 14.3** (Evaluation);

(h) **Clause 19** (Acknowledgment and publicity);

(i) **Clause 21** (Intellectual Property Rights);

(j) **Clause 22** (Moral Rights);

(k) **Clause 23** (Confidentiality);

(l) **Clause 24** (Protection of Personal Information);

(m) **Clause 25** (Records, books and accounts);

(n) **Clause 26** (Audit and access);

(o) **Clause 28** (Indemnity);

(p) **Clause 29** (Insurance);

(q) **Clause 31** (Fraud and anti-corruption);

(r) **Clause 35.3** (DFAT rights); and

(s) **Clause 38.2** (Amounts due to DFAT),

together with any provision of this Agreement which expressly or by implication from its nature is intended to survive the expiry or termination of this Agreement.

37. Notices and other communications

37.1 Service of Notices

A Notice must be:

(a) in writing, in English and signed by a person duly authorised by the sending Party; and

(b) hand delivered or sent by prepaid post, facsimile or email to the recipient's address for Notices specified in Item 16 of **Schedule 1**, as varied by any Notice given by the recipient to the sender.

37.2 Effective on receipt

A Notice given in accordance with **Clause 37.1** delivered by hand, prepaid post or facsimile takes effect when it is taken to be received (or at a later time specified in it), and is taken to be received:

(a) if hand delivered, on delivery;

(b) if sent by prepaid post, on the third Business Day after the date of posting (or on the seventh Business Day after the date of posting if posted to or from a place outside Australia); or

(c) if sent by facsimile, when the sender's facsimile system generates a message confirming successful transmission of the entire Notice unless, within one Business Day after the transmission, the recipient informs the sender that it has not received the entire Notice,

but if the delivery, receipt or transmission is not on a Business Day or is after **5.00pm** (AEST) on a Business Day in the place where the Notice is taken to be received, the Notice is taken to be received at **9.00am** (AEST) on the next Business Day in the place where the Notice is taken to be received.

37.3 Notices by email

(a) A Notice relating to a matter under **Clause 33.4** (Termination), **Clause 34** (Dispute Resolution) or **Clause 35** (Termination) must not be sent by email.

(b) Subject to **sub-clause 37.3**(c) below, a Notice given in accordance with **sub-clause 37.1** above delivered by email is taken to be received on the first to occur of:

(i) receipt by the sender of an email acknowledgement from the recipient's information system showing that the notice has been delivered to the email address specified in the recipient's address for Notices specified in Item 16 of **Schedule 1** as varied by any Notice given by the recipient to the sender;

(ii) the time that the notice enters an information system which is under the control of the recipient; and

(iii) the time that the notice is first opened or read by the intended addressee.

(c) If the sender receives an out of office reply that states the recipient is out of the office until a later date, the Notice will only be taken to be given on that later date. If the result is that a Notice would be taken to be given or made on a day that is not a Business Day in the place to which the Notice is sent or is after **5.00pm** (AEST) on a Business Day in the place where the Notice is sent, it will be taken to have been duly given or made at the start of business on the next Business Day in that place.

38. Miscellaneous

38.1 No security

The Recipient must not without the prior written consent of DFAT use any of the following as any form of security for the purpose of obtaining or complying with any

form of loan, credit, payment or other interest, or for the preparation of, or in the course of any litigation:

(a) the Funds;

(b) this Agreement or any of DFAT's obligations under this Agreement; or

(c) any Assets or Intellectual Property Rights in Agreement Material.

38.2 Amounts due to DFAT

(a) Without limiting any other of DFAT's rights or remedies, any amount owed or payable to DFAT (including by way of refund), or which DFAT is entitled to recover from the Recipient, under this Agreement will be recoverable by DFAT as a debt due and payable to DFAT by the Recipient.

(b) DFAT may set-off any money due for payment by DFAT to the Recipient under this Agreement against any money due for payment by the Recipient to DFAT under this Agreement or a Related Agreement.

38.3 Notice of certain events

The Recipient must notify DFAT immediately if an Insolvency Event or a Change in Control occurs in relation to the Recipient.

38.4 Variation

No agreement or understanding varying or extending this Agreement is legally binding upon either Party unless the agreement or understanding is in writing in the form of a deed of amendment and signed by both Parties.

38.5 Approvals and consents

Except where this Agreement expressly states otherwise, a Party may, in its discretion, give conditionally or unconditionally or withhold any acceptance, approval or consent under this Agreement.

38.6 Assignment and novation

The Recipient may only assign its rights or novate its rights and obligations under this Agreement with the prior written consent of DFAT.

38.7 Costs

Each Party must pay its own costs of negotiating, preparing and executing this Agreement.

38.8 Counterparts

This Agreement may be executed in counterparts. All executed counterparts constitute one document.

38.9 No merger

The rights and obligations of the Parties under this Agreement do not merge on completion of any transaction contemplated by this Agreement.

38.10 Entire agreement

This Agreement constitutes the entire agreement between the Parties in connection with its subject matter and supersedes all previous agreements or understandings between the Parties in connection with its subject matter.

38.11 Further action

The Recipient must do, at its own expense, everything reasonably necessary (including executing documents) to give full effect to this Agreement and any transaction contemplated by it.

38.12 Severability

A term or part of a term of this Agreement that is illegal or unenforceable may be severed from this Agreement and the remaining terms or parts of the terms of this Agreement continue in force.

38.13 Waiver

Waiver of any provision of or right under this Agreement:

(a) must be in writing signed by the Party entitled to the benefit of that provision or right; and

(b) is effective only to the extent set out in any written waiver.

38.14 Relationship

(a) The Parties must not represent themselves, and must ensure that their officers, employees, agents and subcontractors do not represent themselves, as being an officer, employee, partner or agent of the other Party, or as otherwise able to bind or represent the other Party.

(b) This Agreement does not create a relationship of employment, agency or partnership between the Parties.

38.15 Governing law and jurisdiction

This Agreement is governed by the law of the Australian Capital Territory and each Party irrevocably and unconditionally submits to the non-exclusive jurisdiction of the courts of the Australian Capital Territory.

38.16 False or misleading information

The Recipient acknowledges that giving false or misleading information is a serious offence.

38.17 No reliance

The Recipient:

(a) acknowledges that DFAT is not liable for any advice, comments, consultation, assistance, information or material made available by DFAT before the Commencement Date in connection with the Recipient applying for grant funding (**Information**);

(b) acknowledges that the Information may not be accurate or complete and that the Recipient is responsible for making its own enquiries;

(c) warrants that it has not, in deciding whether or not to enter into this Agreement, relied on any Information or representation (whether oral or in writing), other than as expressly set out in this Agreement, or any other conduct of DFAT or any of its Personnel; and

(d) waives any right to make any claims in relation to any loss or damage suffered or incurred, whether directly or indirectly, arising out of or in connection with any use of or reliance on the Information.

38.18 **No further grant funding**

The Recipient acknowledges that the provision of grant funding under this Agreement for the Activity does not entitle the Recipient to any other or further grants.

Schedule 1 – Agreement details

Item number	Description	Clause reference	Details
1.	**DFAT**	**1.1**	Commonwealth of Australia as represented by the Department of Foreign Affairs and Trade ABN 47 065 634 525 Department of Foreign Affairs and Trade – Australian Aid Program GPO Box 887 CANBERRA ACT 2601 AUSTRALIA
2.	**Recipient**	**1.1**	International Planned Parenthood Federation East & South East Asia and Oceania Region, No. 246 Jalan Ampang, Kuala Lumpur, 50450, Malaysia (Registration No: 919156)
3.	**DFAT Representative**	**1.1 and 14.1**	1) Program Director, Regional Health, Education & Leadership, Australian High Commission, Suva. 2) Senior Program Manager, Regional Health, Australian High Commission, Suva. 3). Program Manager, Regional Health, Australian High Commission, Suva.
4.	**Recipient Representative**	**1.1 and 14.1**	1) Regional Director, International

[illegible]	[illegible]	[illegible]	[illegible]
			Planned Parenthood Federation, East/South East Asia Oceania Region, Kuala Lumpur, Malaysia 2) Manager, International Planned Parenthood Federation, Sub-Regional Office for the Pacific, Suva.
5.	**Commencement Date**	**1.1 and 3**	The date this Agreement is signed by the last Party.
6.	**Activity Start Date**	**1.1 and 3**	15th December 2014
7.	**Activity End Date**	**1.1 and 3**	31st December 2017
8.	**GST registration status**	**9.5(b)**	☐ the Recipient is not registered for GST
9.	**Administered Grant Scheme**	**13**	The Recipient will administer the 'Partnerships for Reproductive Health & Rights Incentive Grant Scheme', to its 8 member organisations in the Pacific. This incentive grant will be performance based, using the Guidelines in Schedule 2 Annex 2.
10.	**Ownership of Intellectual Property Rights**	**21.2**	☐**Clause 21.4** (DFAT ownership of Intellectual Property Rights in Agreement Material) is to apply.
11.	**Recipient ownership of Intellectual Property in Agreement Material**	**21.3**	*Not Applicable*
12.	**DFAT ownership of Intellectual Property Rights in Agreement Material**	**21.4**	*In addition to the licences granted in **Clause 21.4**(b)(i) and (ii), DFAT grants the Recipient a revocable, world-wide, royalty-free, non-exclusive licence to use, reproduce, adapt and otherwise exploit the Agreement Material for development assistance purposes (teaching and research) only and not for commercial profit.* *The following must appear in all*

Item Number	Description	Clause reference	Details
			material which reproduces the Agreement Material. DFAT does not guarantee the accuracy, reliability, currency, completeness of any information contained in the material. Furthermore, DFAT accepts no liability whatsoever arising from any use of the material. Users should exercise their own skill and care with respect to their use of the material. *For advice on any amended wording please contact Procurement and Commercial Law Section.*
13.	**DFAT Material**	**1.1**	Nil
14.	**Moral Rights – Specified Acts**	**22**	Nil
15.	**Insurance**	**29**	NA
16.	**Address for Notices**	**37**	**DFAT:** Program Director, Regional Health, Education & Leadership, Australian High Commission, Suva. **Postal address:** Department of Foreign Affairs and Trade – Australian Aid Program PO Box 214 SUVA FIJI **Physical address:** Australian High Commission, 37 Princes Road, Suva, FIJI. **Facsimile:** +679 3382 695 **Email:** @dfat.gov.au **Recipient:** Director IPPF ESEAOR Office, Kuala Lumpur, Malaysia

[redacted]	[redacted]	[redacted]	[redacted]
			Postal address: 246 Jalan Ampang Kuala Lumpur 50450 Malaysia **Physical address:** 246 Jalan Ampang Kuala Lumpur 50450 Malaysia **Facsimile:** +60342 566 386 **Email:** @ippfeseaor.org
17.	**Special Conditions**	**1.1 and** 2	a) DFAT will liaise with the Recipient's Pacific Sub-Regional Office in Suva as its primary point of contact in relation to the implementation of this Agreement. Governance b) The Pacific Reproductive Health & Rights Program will be governed by a Committee established by IPPF in collaboration with DFAT. Members of this Committee will consist of IPPF, DFAT and representatives from all the 8 Family Health Associations participating in this program. DFAT reserves the right to co-opt other development partners, such as NZMFAT and UNFPA into the Committee as observers, when appropriate. The Committee will be co-chaired by IPPF and DFAT. (i) The Governance Committee will meet annually, around September or October of each year. At its annual meetings, the Committee will: a) review implementation progress against yearly workplans and financial expenditure reports (both at FHA and regional level), and make recommendations on improvements and adjustments to be included in the preparation of the

[illegible]	[illegible]	[illegible]	[illegible]
			following year's plans; b) review and endorse yearly workplans and budgets for the program for submission to DFAT; c) review and endorse the draft annual reports prior to submission to DFAT; and d) address emerging risks to the program, including maintenance of a Risk Register. The Governance committee shall have its first meeting during the inception phase of the program. Program Implementation c) IPPF and the FHAs will produce yearly workplan and budgets for the Program. The yearly workplan must have a clear implementation timeframe and budget for the various indicative activities outlined for each program component as indicated in the Program Design Document in Schedule 2 Annex 1. Positions that are funded from the Program must be included in the yearly workplans and budget. Monitoring and Evaluation d) IPPF and DFAT will jointly commission an independent evaluation of the Program in 2017. IPPF must ensure that its reports meet the DFAT monitoring and evaluation standards. Sustainability e) IPPF commits to work closely with its 8 Pacific member associations to transition full implementation and management of their activities to these organisations upon completion of this program.

Schedule 2 – Activity Proposal

1. Activity description (clause 1.1)

1.0 BACKGROUND

1.1 Australia has a strong interest in promoting health outcomes in the Pacific region. This *'Partnerships for Reproductive Health & Rights Program'* will help contribute to the Australian Government's objectives to promote sexual and reproductive health and rights in the Pacific.

1.2 Australia will work with International Planned Parenthood Federation (IPPF) to support its eight member associations in the Pacific, which includes: the Reproductive and Family Health Association of Fiji, Cook Islands Family Welfare Association, Kiribati Family Health Association, Vanuatu Family Health Association, Samoa Family Health Association, Solomon Islands Planned Parenthood Association, Tuvalu Family Health Association and Tonga Family Health Association.

1.3 IPPF will support its eight member associations in the Pacific to deliver quality assured, integrated and innovative sexual and reproductive health and rights services which address the rights of clients from poor, marginalise, socially exclusive and underserved communities. IPPF will also provide targeted support to women and girls sexual and reproductive health and rights.

2. Outcomes (clauses 1.1 and 4.1(a)(i))

2.1 The *'Partnerships for Reproductive Health & Rights'* Program aims to advance equity for all through improving life-saving sexual and reproductive health and rights in eight Pacific Island countries, including Cook Islands, Fiji, Kiribati, Samoa, Tonga, Vanuatu, Solomon Islands and Tuvalu. The Program is expected to achieve the following outcomes:

a) to unite partnerships with government, faith-based organisations, civil society organisations and community village groups to tackle sexual and reproductive health and rights (SRHR) and other health inequalities; and

b) to deliver scaled-up integrated health services that reach the most marginalised and vulnerable communities.

3. Milestones (clauses 1.1 and 4.1(a)(v))

	Milestone	Completion date
1.	**Description** Reports to be provided by the Recipient as part of this Milestone: • Inception workplan for each of the 8 member associations of IPPF received and accepted in writing by DFAT	Milestone 1 to be completed by 10th December 2014
2.	**Description** Reports to be provided by the Recipient as part of this Milestone: • Inception Report (December 2014 – April 2015) received and accepted in writing by DFAT • Acquittal report for the period December 2014 – April 2015	Milestone 2 to be completed by 5th May 2015
3.	**Description** Reports to be provided by the Recipient as part of this Milestone: • Progress Report (May – October 2015) received and accepted in writing by DFAT • Acquittal report for the period May – October 2015	Milestone 3 to be completed by 1st November 2015
4.	**Description** Reports to be provided by the Recipient as part of this Milestone: • Annual Report for 2015 (January – December 2015) received and accepted in writing by DFAT • Acquittal report for the period (January - December 2015	Milestone 4 to be completed by 30th January 2016
5.	**Description** Reports to be provided by the Recipient as part of this Milestone: • Progress Report (January – June 2016) received and accepted in writing by DFAT • Acquittal report for the period January – June 2016	Milestone 5 to be completed by 15th July 2016

	[illegible]	[illegible]
6.	**Description** Reports to be provided by the Recipient as part of this Milestone: • Annual Report for the period (January – December 2016) • Terms of Reference for Mid Term Review accepted by DFAT in writing, including IPPF and DFAT joint selection of Review team • Acquittal report for the period January - December 2016	Milestone 6 to be completed by 30th January 2017
7.	**Description** Reports to be provided by the Recipient as part of this Milestone: • Mid Term Review Report received and accepted by DFAT in writing • Progress Report (January – June 2017) received and accepted by DFAT in writing • Acquittal report for the period January – June 2017 **Final Report**	Milestone 7 to be completed by 30th July 2017
8.	**Description** Reports to be provided by the Recipient as part of this Milestone: • Final Activity Completion Report • Final Financial Acquittals covering Program Period	Milestone 8 to be completed by 30th December 2017

4. Budget (clauses 1.1 and 6.1)

Item	Description	Price (ex GST) in AUD
Training	The training of clinic staff in a broad range of contraceptive methods, especially long-acting reproductive commodities (LARCs), and other SRHR services (including those that link to NCDs) to support IPPF's	858,500

[redacted]	[redacted]	[redacted] AUD
	Integrated Package of Essential Services (IPES) compliance. This would also include supervision and support during the implementation of the new methods post-training.	
Service Delivery	Preparation for the new services to progress to IPES compliance, including outreach services/ costs and strengthening of services including passage/ transportation for areas that are geographically hard to reach.	1,100,025
Infrastructure – renovations and construction	All Family Health Association clinics will need some renovation and additional equipment for the new services. This includes refurbishment and renovations and the building of a new clinic/ youth centre in Solomon Islands; as well as establishment costs of new clinic.	276,500
Procurement	For procurement of commodities (medical). For procurement of commodities (non-medical)	69,500 606,000
Advocacy	Framing the key messages is crucial to achieve this output. Support will be provided for all FHAs to develop the most appropriate and effective messages and deliver them in their proper channels. While the more practical issues will entail a lot of face to face advocacy activities between the FHAs and the gatekeepers (Ministry of Health, National Drug Formulary/ Essential Drugs List, Contraceptive Supply Chains, etc) the advocacy for comprehensive SRHR policies may entail other channels of communication such as the use of media and the development of advocacy	409,500

[illegible]	[illegible]	[illegible] AUD
	materials (eg policy briefs).	
Monitoring and Evaluation	This will involve costs for the regional team to provide in-country support visits and also for national monitoring activities	512,313
Incentive grant scheme	To find new and innovative ways of working (eg with the private sector, etc) to improve women and girls' (including women and girls with disabilities, and those in hard to reach places) access to sexual reproductive health and rights services	258,000
		409,662
Total costs		**4,500,000**

5. Assets (clauses 1.1 and 12)

5.1 Assets to be acquired with the Funds

Description	**Yr 1 (AUD)**	**Yr2 (AUD)**	**Yr3 (AUD)**
Infrastructure – new SRHR clinic in Solomon Islands, Clinic set up in Samoa, Tonga and upgrades to associate clinics in all 8 countries	140500	81000	55000
Medical commodities – purchase of contraceptives	63500	5000	1000
Non-medical commodities – clinical equipment	21500	147000	153000
Motor-vehicles, motor bikes and motor-boats to improve transportation needs/ meet service delivery targets	249500		35000
TOTAL	475,000	233000	244000

5.2 Asset Threshold

AUD500 (inclusive of GST) (or equivalent)

5.3 Ownership of Assets

Ownership of the assets to be handed over to the Family Health Associations and the IPPF Pacific Sub-Regional Office upon termination of the agreement or completion of the Program.

5.4 Asset Register

The Recipient must maintain the Asset Register which must record:

(a) non-consumable items of a portable nature with a value below the Asset Threshold;

(b) all Assets with a value at or above the Asset Threshold;

(c) Asset description;

(d) purchase price or total lease cost;

(e) date of purchase or lease and date of payment;

(f) reason for acquisition;

(g) type and term of lease (if applicable);

(h) date of receipt of the Asset at the Activity site;

(i) identification number for the Asset;

(j) location of Asset;

(k) disposal date;

(l) disposal method; and

(m) reason for disposal.

6. Personnel positions

Personnel	**Role**	**Directly working with /contact with children**
Manager – IPPF Pacific Sub-Regional Office (SROP)	Will manage the Program overall, including communicating with DFAT Suva; serving as the primary spokesperson for the project; creating a cohesive vision among the Program team; and ensuring that staff are accountable for delivering agreed project outputs. He will lead the project's capacity building efforts, drawing on a wide range of skills available through IPPF staff and potential partners. Reporting directly to IPPF's East & South East Asia and Oceania Regional Director will ensure improved integration of the newly accredited FHAs within IPPF's global movement.	No
Senior Program Officer	Will lead technical oversight and timely implementation of Outcomes 1, 2, 3 and 4. He will lead technical responsibilities	No

	outlined in the Program to ensure that by the end of the Program period, fragmented health systems can demonstrate clearly a more integrated response to the sexual and reproductive health and rights of the poor and most marginalized populations in the eight Pacific Island countries. He will lead needs assessments and develop implementation plans for the Program working together with FHAs and, where present, DFAT offices. He will lead the preparation of regular and ad hoc reports to DFAT and work closely with the Program Officers to identify performance issues and provide support to FHAs to ensure successful delivery of key outputs.	
Finance & Administration Officer	Will, in consultation with the **Pacific Sub Regional Manager**, oversee project budgeting and financial management, including negotiation and development of sub-grants to implementing partners. She will ensure compliance with DFAT regulations and will provide guidance and capacity development to FHAs.	No
Monitoring & Evaluation Program officer	Will engage with the different service channels through the FHAs and will establish effective M&E systems across partners and outreach sites, including mechanisms for ensuring and strengthening data quality.	No
Program Officer for Quality Improvement	Will work with Pacific FHAs to attain high quality services and serve clients better following the IPPF's Quality Improvement framework which builds on the Quality of Care Strategy. Build on the QoC undertaken in the Capacity Building Program, and the IPES Quality Improvement tool used by all Pacific FHAs. Conduct training to develop Quality Improvement plans and	No

	to conduct in-country visits will monitor progress of each country plan.	
Program Officer for National Change	Creating and working with multi-stakeholder network(s) for advocacy. Network Building and Working with Parliamentarians to achieve both regional and national advocacy strategies. Engaging parliamentarians to ensure that any legislative advocacy measures will be given attention	No

Schedule 3 – Funds

1. Total Funds (clause 1.1)

Subject to this Agreement, the maximum amount of grant funding payable by DFAT under this Agreement is AUD4,500,000 (excluding GST). No other amount of grant funding is payable by DFAT.

2. Interest rate (clause 10.4)

The general interest charge rate as defined in section 8AAD of the *Taxation Administration Act 1953* (Cth).

3. Payment (clauses 1.1, 7 and 8)

Subject to this Agreement, DFAT will pay the grant funding to the Recipient in instalments as set out in the table below.

No.	Payment Criteria	Payment Claim Due Date	Instalment (GST exclusive) AUD
1.	Achievement of Milestone No. 1, including DFAT receipt and acceptance of the Inception workplans for each of the 8 IPPF member associations in the Pacific. Note: No instalments will be paid if the Payment Criteria is not satisfied.	*Recipient must submit its Payment claim by 19 December 2014, or within 30 days of achievement of Milestone 1, whichever is earlier.* *Note: this is the invoice date, not the date the Milestone is due – see Schedule 2)]*	1,000,000
2.	• Achievement of Milestone No. 2, including DFAT receipt and acceptance of the Inception Phase Report; and • Financial statement indicating that at least 80% of payment No. 1 has been committed for program activities; Note: No instalments will be	*Recipient must submit its Payment claim by 30th May 2015, or within 30 days of achievement of Milestone 2, whichever is earlier.*	500,000

No.	Payment Criteria	Payment Due Date	Instalment (GST exclusive) AUD
	paid if the Payment Criteria is not satisfied.	*Note: this is the invoice date, not the date the Milestone is due – see Schedule 2)]*	
3.	• Achievement of Milestone No. 3, including DFAT receipt and acceptance of the Progress Report (May-October 2015); and • Financial statement indicating that at least 80% of payment No. 2 has been committed for program activities; Note: No instalments will be paid if the Payment Criteria is not satisfied.	*Recipient must submit its Payment claim by 5th November 2015, or within 30 days of achievement of Milestone 3, whichever is earlier.* *Note: this is the invoice date, not the date the Milestone is due – see Schedule 2)]*	750,000
4.	• Achievement of Milestone No. 4, including DFAT receipt and acceptance of the Annual Report for 2015 (Jan – December 2015); and • Acquittal report for the period (Jan- December 2015) • Financial statement indicating that at least 80% of payment No. 3 has been committed for program activities; Note: No instalments will be paid if the Payment Criteria is not satisfied.	*Recipient must submit its Payment claim by 5th February 2016 or within 30 days of achievement of Milestone 4, whichever is earlier.* *Note: this is the invoice date, not the date the Milestone is due – see Schedule 2)]*	750,000

No.	Payment Criteria	Payment Criteria Due	Instalment (GST exclusive) AUD
5.	• Achievement of Milestone No. 3, including DFAT receipt and acceptance of the Progress Report (January – June 2016) ; and • Financial statement indicating that at least 80% of payment No. 4 has been committed for program activities; Note: No instalments will be paid if the Payment Criteria is not satisfied.	*Recipient must submit its Payment claim by 30th July 2016 or within 30 days of achievement of Milestone 5, whichever is earlier.* *Note: this is the invoice date, not the date the Milestone is due – see Schedule 2)]*	750,000
6.	• Achievement of Milestone No. 3, including DFAT receipt and acceptance of: i) the Annual Report for the period (January – December 2016) ii) Terms of Reference for Mid Term Review including IPPF and DFAT joint selection of Review team; and • Financial statement indicating that at least 80% of payment No. 5 has been committed for program activities; Note: No instalments will be paid if the Payment Criteria is not satisfied.	*Recipient must submit its Payment claim by 5th February 2017 or within 30 days of achievement of Milestone 6, whichever is earlier.* *Note: this is the invoice date, not the date the Milestone is due – see Schedule 2)]*	400,000
7.	• Achievement of Milestone No. 3, including DFAT receipt and acceptance of: i) Mid Term Review Report ii) Progress Report (January – June 2017) and	*Recipient must submit its Payment claim by 5th August 2017 or within 30 days of achievement of*	350,000

No.	Payment Criteria	Payment Date	Instalment (GST exclusive) AUD
	• Financial statement indicating that at least 80% of payment No. 1 has been committed for program activities; Note: No instalments will be paid if the Payment Criteria is not satisfied.	*Milestone 7, whichever is earlier.* *Note: this is the invoice date, not the date the Milestone is due – see Schedule 2)]*	
		Total	4,500,000

4. Invoicing requirements (clause 8)

(a) To be a correctly rendered invoice the invoice must include:

(i) the agreement number and Activity title;

(ii) the payment event number(s) notified by DFAT;

(iii) the amount of grant funding to be paid by DFAT together with any substantiating material required;

(iv) the name of the DFAT Representative;

(v) be accompanied by any supporting documentation and other evidence specified in item 3 of Schedule 3 for that instalment; and

(vi) such other information as DFAT requires.

(b) Where Australian GST applies to this Agreement all invoices must be in the form of a valid tax invoice. Invalid tax invoices will be returned to the Recipient. Information on what constitutes a valid tax invoice can be found at:
http://www.ato.gov.au/businesses/content.asp?doc=/content/50913.htm

(c) Invoices must be submitted to:

Department of Foreign Affairs and Trade – Australian Aid Program
GPO Box 887
Canberra ACT 2601 Australia
or
accountsprocessing@dfat.gov.au and a copy sent to the DFAT Representative.

Schedule 4 – Reporting

1. Milestone reports

(a) The Recipient must provide a Milestone report as required by the item 3 of Schedule 2.

(b) Each Milestone report must include:

(i) the name of the Recipient and all subcontractors;

(ii) a contact name, telephone number and email address;

(iii) the Activity title and number;

(iv) the Milestone and period to which the report relates;

(v) a Budget update (including cost to completion);

(vi) a statement of the Funds provided or spent ;

(vii) the amount remaining in the account referred to in clause 6.3;

(viii) a technical report of the Milestone activities, including:

(A) a description and analysis of the technical progress of the Activity;

(B) evidence that the activities within the Milestone have been achieved;

(C) any major issues or risks which have arisen in the course of achieving the Milestone and the effect they will have on the Activity and what will be done to address any ongoing issues or risks; and

(D) any proposed changes to the Activity; and

(ix) copies of any published reports, promotional material, media publicity, pamphlets or other documentation relevant to the Activity.

2. Annual reports

(a) The Recipient must provide an annual progress report as required by item 3 of Schedule 2 and if not specified at item 3 of Schedule 2, within [60 days] of each anniversary of the Commencement Date.

(b) Each annual progress report must include:

(i) the name of the Recipient and all subcontractors;

(ii) the Activity title and number;

(iii) the period to which the report relates;

(iv) a Budget update (including cost to completion);

(v) a statement of the Funds provided or spent;

(vi) the amount remaining in the account referred to in clause 6.3;

(vii) the reconciliation of Assets required under clause 12.2(c) and a copy of the Assets Register; and

(viii) a description and analysis of the progress of the Activity, including:

(A) whether the Activity is proceeding in accordance with the Budget and, if it is not, an explanation of why the Budget is not being met, the effect this will have on the Activity and the action the Recipient proposes to take to address this;

(B) progress on achieving the Outcomes;

(C) any major issues or developments which have arisen and the effect they will have on the Activity; and

(D) any proposed changes to the Activity.

(c) If the Recipient administers an Administered Grant Scheme, the annual report must include a summary of all new Administered Grant Arrangements the Recipient will enter into, or has entered into, in relation to the upcoming calendar year, including details of:

(i) the identity of the Administered Grant Recipient;

(ii) the value of the Administered Grant Arrangement;

(iii) the subject matter of the Administered Grant Arrangement; and

(iv) the expected completion date for the Administered Grant Arrangement.

3. Acquittal reports

(a) The Recipient must provide acquittal reports:

(i) as required by item 3 of Schedule 2; and

(ii) within 40 days after the earlier of the Activity End Date, expiry or termination of this Agreement .

(b) Each acquittal report must include the following:

	Content	Prepared by
(i)	audited financial statements in accordance with the Applicable Auditing Procedures in respect of the Funds (separately and in the context of the Recipient's overall financial position), which must include a definitive statement as to whether the financial information for the Activity represents the financial transactions fairly and is based on proper accounts and records.	an Independent Auditor
(ii)	where there are any qualifications or limitations on the audit, a letter to the Recipient, or a report providing an outline of the reasons for the qualifications or limitations and the remedial action recommended.	an Independent Auditor
(iii)	a certificate: (A) that all Funds were spent for the purpose of the Activity and in accordance with this Agreement and that the Recipient has complied with this Agreement; and (B) the amount remaining in the account referred to in	the CEO or CFO of the Recipient

	clause 6.3.	

4. Final report

(a) Unless stated otherwise in item 3 of Schedule 2, the Recipient must within 60 days of the completion of the Activity provide a report which includes:

(i) the name of the Recipient and all subcontractors;

(ii) the Activity title and number;

(iii) a statement of the Funds provided and spent;

(iv) the amount (if any) remaining in the account referred to in clause 6.3;

(v) a description and analysis of the progress of the Activity, including:

(A) evidence that the Activity has been completed, and the Milestones have been achieved;

(B) details of the extent to which the Activity achieved the Outcomes;

(C) any highlights, breakthroughs or difficulties encountered; and

(D) conclusions or recommendations (if any) arising from the Activity;

(vi) copies of any published reports, promotional material, media publicity, pamphlets or other documentation relevant to the Activity; and

(vii) reconciliation of Assets and a copy of the Asset Register.

5. Ad hoc reports

The Recipient must provide ad-hoc reports as requested by DFAT from time to time at the time and in the manner reasonably required by DFAT in relation to any significant developments concerning the Activity or any significant delays or difficulties encountered in undertaking the Activity.

Schedule 5 – Statement of International Development Practice Principles

This Statement of International Development Practice Principles (**The Principles**) promotes the active commitment of all non-accredited, not-for-profit organisations funded by DFAT to the fundamentals of good development practice, and to conducting their activities with integrity, transparency and accountability.

The Principles are founded on a premise of 'do no harm' and drawn from good practice principles in the international development not-for-profit sector and international development community more broadly. In line with Aid Effectiveness principles, when planning interventions, not-for-profit organisations are encouraged to consider: what other agencies are doing in the chosen area of focus; where their organisation can add value; and how they can join with others to increase the impact and sustainability of their activities.

Where relevant, DFAT encourages eligible Australian organisations to work towards becoming Australian Council for International Development (ACFID) Code of Conduct signatories.

International Development Principles

Lessons drawn from best practice NGO and civil society programs recognise the importance of working in partnerships, building creative and trusting relationships with people of developing countries and supporting basic program standards which:

- give priority to the needs and interests of the people they serve and involve beneficiary groups to the maximum extent possible in the design, implementation and evaluation;
- promote an approach that includes all people in a community and ensures the most vulnerable, including people with disability, women and children, are able to access, and benefit equally, from, international development assistance;
- encourage self help and self-reliance among beneficiaries;
- avoid creating dependency through the facilitation of active participation and contributions (as appropriate) by the most vulnerable;
- respect and foster all universally agreed international human rights, including social, economic, cultural, civil and political rights;
- are culturally appropriate and accessible;
- seek to enhance gender equality;
- recognise and put in place processes to mitigate against the vulnerability of not for profit organisations to potential exploitation by organised crime and terrorist organisations;
- have appropriate mechanisms in place to actively prevent, and protect children from harm and abuse;
- integrate environmental considerations and mitigate against adverse environmental impacts; and
- promote collaborative approaches to development challenges including through working in partnerships and avoiding duplication of effort.

All non-accredited, not for profit organisations receiving grant funding from DFAT commit to apply these principles of good development practice, and adhere to the organisational integrity and accountability standards set out on the following page.

Organisational Integrity and Accountability for Development

DFAT grant funds and resources are designated for the purposes of international aid and development (including development awareness). They can not be used to promote a particular religious adherence, missionary activity or evangelism, or to support partisan political objectives, or an individual candidate or organisation affiliated to a particular political movement. DFAT reserves the right to undertake an independent audit of an organisation's accounts, records and assets related to a funded activity, at all reasonable times.

In all of its activities and particularly in its communications to the public, DFAT expects not-for-profit organisations it works with to accord due respect to the dignity, values, history, religion, and culture of the people it supports and serves, consistent with principles of basic human rights.

Not-for-profit organisations working with DFAT should:

- not be a willing party to wrongdoing, corruption, bribery, or other financial impropriety in any way in any of its activities;
- take prompt and firm corrective action whenever and wherever wrongdoing is found among its Governing Body, paid staff, contractors, volunteers and partner organisations;
- have internal control procedures which minimise the risk of misuse of grant funds and processes and systems that ensure grant funds are used effectively to maximise development results;
- establish reporting mechanisms that facilitate accountability to members, donors and the public;
- have adequate procedures for the review and monitoring of income and expenditure and for assessing and reporting on the effectiveness of their aid;
- have a policy to enable staff confidentially to bring to the attention of the Governing Body evidence of misconduct on the part of anyone associated with the Recipient, including misconduct related to the harm and abuse of children;
- be aware of terrorism-related issues and use their best endeavours to ensure that grant funds do not provide direct or indirect support or resources to organisations and individuals associated with terrorism and/or organised crime; and
- ensure that individuals or organisations involved in implementing activities on behalf of the Recipient are in no way linked, directly or indirectly, to organisations and individuals associated with terrorism and/or organised crime.

DFAT Grant Agreement Requirements

Each DFAT grant agreement also comes with obligations for both DFAT and the Recipient being funded. These are spelt out in detail in the grant agreement. The Principles will not affect or diminish the obligations or liabilities of the Recipient under the grant agreement as outlined in the grant agreement conditions.

Broadly speaking, any Recipient funded by the Australian Government, through DFAT, is required to comply with relevant and applicable laws, regulations and policies, including those in Australia and in the country/ countries in which they are operating. In particular, the Recipient needs to observe the contractual requirements regarding Child Protection and Counter Terrorism.

Additional Information and Related Links

Further information on DFAT's Child Protection Policy, Counter Terrorism and other applicable laws and policies can be found on DFAT's website at:

http://aid.dfat.gov.au

Further information on terrorist organisations listed under Division 102 of the Criminal Code Act 1995 (Cth) and the DFAT Consolidated List of persons and entities subject to UN sanctions regimes maintained in accordance with the Charter of the United Nations Act 1945 (Cth) can be found at:

http://www.dfat.gov.au/icat/UNSC_financial_sanctions.html#3
http://www.nationalsecurity.gov.au/agd/www/nationalsecurity.nsf/AllDocs/95FB057CA3DECF30CA256FAB001F7FBD?OpenDocument

Further information on DFAT Accreditation and the ACFID Code of Conduct can also be found at:

http://aid.dfat.gov.au
http://www.acfid.asn.au/code-of-conduct

Further information on Aid Effectiveness can be found at:

http://www.oecd.org/department/0,3355,en_2649_3236398_1_1_1_1_1,00.html
http://www.oecd.org/document/18/0,3343,en_2649_3236398_35401554_1_1_1_1,00.html

Performance Based Funding Model for ESEAOR – 2014

Performance indicators

The 10 performance indicators together with the criteria for measures are as follows:

Indicator	Means of verification
1. Number of services provided to youth*	Service statistics
2. Provision of essential components in sexuality education programme	Global indicators survey
3. Number of young people who have completed a comprehensive sexuality education programme	Global indicators survey
4. Number of HIV-related services*	Service statistics
5. Number of abortion-related services*	Service statistics
6. Number of SRH services*	Service statistics
7. Number of clients who are poor, marginalized, socially-excluded & underserved (PMSEU)	Global indicators survey
8. Number of couple year protection (CYP)*	Service statistics
9. Provision of an integrated package of essential services (IPES)	Service statistics
10. Demonstrated contribution to advancing the SRHR agenda	Global indicators survey

Criteria for Measure

Improvement Score

Indicators 1, 3 and 4 – 8

For these indicators, the criteria for measure will be based on the percentage increase/decrease of the most current data (2012) as compared to the previous year (2011). The percentage increase/decrease for each indicator is capped at 40%.

Indicator 2

Provision of essential components in sexuality education programme – the 7 essential components are as follows:

1. Gender
2. Sexual & reproductive rights
3. Sexual citizenship
4. Pleasure
5. Violence
6. Diversity
7. Relationships

MAs will receive an improvement score ranging from 0% to 15% depending on the number of essential components that they incorporated in their sexuality education manual/ curriculum. An MA that incorporates all seven will receive a score of 15% in improvement scoring, with each component worth 2.143%.

Indicator 9

Provision of an integrated package of essential services (IPES) – the eight (8) SRH services under the IPES (latest updates with changes highlighted in red font) with the essential components for each of these services are listed below:

SRH services	Essential components
1. [redacted]	[redacted]
2. Contraceptives	a. Counselling, **AND** b. Oral contraceptive pills, **AND** c. Condoms [also provided under RTIs/STIs & HIV], **AND** d. Injectables, **AND** e. At least one long-acting and reversible contraceptive (LARC): intra-uterine device/system (IUD/IUS) **OR** implants, **AND** f. At least one emergency contraceptive (EC) method: tablet-based **OR** IUD
3. [redacted]	[redacted]
4. RTIs/STIs	a. At least one RTI/STI treatment method **OR** b. At least one RTI/STI lab test
5. [redacted]	[redacted]
6. Gynaecology	a. Manual pelvic examination (auto-qualify if provides pap smear) **AND** b. Manual breast examination, **AND** c. Pap smear **OR** other cervical cancer screening method
7. [redacted]	[redacted]
8. Gender-based violence (GBV)	a. Screening for GBV **AND** b. Referral mechanisms for clinical*, psycho-social, and protection services [*Note: *EC provided under contraceptives. Other life-saving clinical services include STI presumptive treatment and HIV post-exposure prophylaxis (PEP)*]

MAs will receive an improvement score ranging from 0% to 15% depending on the number of essential services provided. An MA that provides all eight will receive a score of 15% in improvement scoring, with each component worth 1.875%.

Only MAs with static clinics will be included for calculation of Indicator 9. Thus for CFPA (China); RFHAF (Fiji); and LPFHA (Lao PDR), Indicator 9 will not be included in the calculation of the overall improvement score.

Indicator 10

Demonstrated contribution to advancing the SRHR agenda – under the PBF, this indicator was supposed to be scored from 0% to 40% based on demonstrated success in change policy and the 3 key elements of advocacy i.e. demonstrated progress toward expected results; strategic planning; and implementation. However, we are still unable to collect data based on the 3 elements mentioned – in the 2012 Evaluation Focal Points Meeting, it was highlighted that we should focus on two elements instead i.e. results (maximum score) and progress (score to vary). Even though data on progress (whether Excellent; Good; or No/little progress) was collected in the 2012 GIS, we are still unable to verify as well as

putting a score to this, thus the Region decided to adopt a different measure for the said indicator as follows:

1. 40% for at least one successful advocacy initiative

If there was no successful advocacy initiative, then measure will be based on the efforts put in by MAs on advocacy as follows:

2. 10% for conducting advocacy to advance national policy and legislation on SRHR
3. 10% for conducting advocacy for national governments to commit more financial resources to SRHR

MAs will receive an improvement score ranging from 0% to 40% based on the measure highlighted above. The scoring will be based on "positive" responses to the following questions from the 2012 GIS:

1. Question 41: *Did your Member Association contribute to any successful policy initiatives and/or positive legislative changes in support of SRHR or defend against any negative changes between January-December last year*?
   Question 42: *How many such policy or legislative changes have been achieved*?
   Response: Yes to Q41 and at least one successful policy initiative/legislative change in Q42. **However the final decision will be based on CO and RO's verification as to whether the data provided are successful policy initiatives and/or positive legislative changes**.
2. Question 40: *Does your Member Association conduct advocacy activities to advance national policy and legislation on sexual and reproductive health and rights?*
   Response: Yes to question.
3. Question 45: *On which campaign issue(s) does your Member Association advocate for national governments to commit more financial resources to sexual and reproductive health and rights (SRHR)?*
   Response: Yes to either "Specific financial commitment in government budget lines for sexual and reproductive health and rights services" or "Government to meet its financial commitments under international agreements such as Cairo and Beijing".

Overall Improvement Score

An overall improvement score will then be calculated based on the average of the 10 indicators. There is a cap of 25% to the overall improvement score.

Contribution Score

Contribution score will be calculated for indicators 1, 3 and 4 – 8 which will be used for the measure of the contribution bonus to be allocated to the MA. The calculation of MA's contribution to regional performance is based on an MA's increase in performance for each indicator (in absolute numbers) divided by the total **gross increase** by all MAs in the region.

Signing page

EXECUTED as a deed.

Signed, sealed and delivered for and on behalf of the **Commonwealth of Australia represented by the Department of Foreign Affairs and Trade** by its duly authorised delegate in the presence of

Signature of witness

Name of witness (print)

10.12.14

Date

Signature of delegate

John Davidson

Name of delegate (print)

Minister Counsellor Pacific

Position of delegate and section (print)

The common seal of International Planned Parenthood Federation, East & South East Asia and Oceania Region, No. 246 Jalan Ampang, Kuala Lumpur, 50450, Malaysia (Registration No: 919156)

is fixed to this document in accordance with its constitution in the presence of

INTERNATIONAL PLANNED PARENTHOOD FEDERATION, FFO ★ THE COMMON SEAL OF

Signature of director

NORA MURAT

Name of director (print)

9.12.14

Date

in the presence of:

Name of witness (Print)

Signature of witness

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
PROJECT TITLE
PROJECT PERIOD

Cost Elements	Y1 AUD	Y2 AUD	Y3 AUD	TOTAL AUD
I. TRAINING	379,000	249,000	230,500	**858,500**
II. SERVICE DELIVERY	515,734	718,011	748,780	**1,982,525**
III. PROCUREMENT	63,500	5,000	1,000	**69,500**
IV. ADVOCACY	138,500	116,000	155,000	**409,500**
V. M&E	267,000	275,350	227,963	**770,313**
X. TOTAL DIRECT COSTS	**1,363,734**	**1,363,361**	**1,363,243**	**4,090,338**
	136,373	136,336	136,324	**409,034**
X. TOTAL PROPOSED BUDGET	**1,500,107**	**1,499,697**	**1,499,567**	**4,499,372**

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
PROJECT TITLE
PROJECT PERIOD

Cost Elements	Y1 AUD	Y2 AUD	Y3 AUD	TOTAL AUD
I. TRAINING	**379,000**	**249,000**	**230,500**	**858,500**
COOK ISLANDS	17,000	23,000	17,000	**57,000**
FIJI	18,000	3,000	9,000	**30,000**
KIRIBATI	16,000	21,000	16,000	**53,000**
SAMOA	8,000	23,000	27,000	**58,000**
SOLOMON ISLANDS	30,000	41,000	37,500	**108,500**
TONGA	19,000	25,000	18,000	**62,000**
TUVALU	14,000	20,000	19,000	**53,000**
VANUATU	17,000	23,000	17,000	**57,000**
COUNTRY-LEVEL	240,000	70,000	70,000	**380,000**
REGIONAL OFFICE	0	0	0	**0**
II. SERVICE DELIVERY	**515,734**	**718,011**	**748,780**	**1,982,525**
COOK ISLANDS	67,400	85,900	132,400	**285,700**
FIJI	30,500	52,331	60,700	**143,531**
KIRIBATI	45,900	69,900	51,400	**167,200**
SAMOA	58,900	121,900	92,900	**273,700**
SOLOMON ISLANDS	148,700	149,200	159,200	**457,100**
TONGA	38,400	92,400	88,200	**219,000**
TUVALU	30,380	42,480	36,280	**109,140**
VANUATU	75,554	103,900	107,700	**287,154**
COUNTRY-LEVEL	20,000	0	20,000	**40,000**
REGIONAL OFFICE	0	0	0	**0**
III. PROCUREMENT	**63,500**	**5,000**	**1,000**	**69,500**
COOK ISLANDS	6,000	0	0	**6,000**
FIJI	5,000	0	0	**5,000**
KIRIBATI	6,000	0	0	**6,000**
SAMOA	6,000	0	1,000	**7,000**
SOLOMON ISLANDS	17,500	0	0	**17,500**
TONGA	11,000	0	0	**11,000**
TUVALU	6,000	0	0	**6,000**
VANUATU	6,000	5,000	0	**11,000**
COUNTRY-LEVEL	0	0	0	**0**
REGIONAL OFFICE	0	0	0	**0**
IV. ADVOCACY	**138,500**	**116,000**	**155,000**	**409,500**
COOK ISLANDS	14,000	9,500	16,000	**39,500**
FIJI	14,000	9,500	16,000	**39,500**

KIRIBATI	14,000	19,500	16,000	**49,500**
SAMOA	14,000	9,500	16,000	**39,500**
SOLOMON ISLANDS	14,000	9,500	16,000	**39,500**
TONGA	14,000	9,500	16,000	**39,500**
TUVALU	10,500	9,500	13,000	**33,000**
VANUATU	14,000	9,500	16,000	**39,500**
COUNTRY-LEVEL	30,000	30,000	30,000	**90,000**
REGIONAL OFFICE	0	0	0	**0**
V. M&E	**267,000**	**275,350**	**227,963**	**770,313**
COOK ISLANDS	3,500	1,000	3,000	**7,500**
FIJI	3,000	0	1,700	**4,700**
KIRIBATI	3,500	1,000	2,500	**7,000**
SAMOA	3,500	750	2,500	**6,750**
SOLOMON ISLANDS	4,000	2,000	4,000	**10,000**
TONGA	3,500	500	2,000	**6,000**
TUVALU	3,000	1,000	2,500	**6,500**
VANUATU	4,000	1,000	2,500	**7,500**
COUNTRY-LEVEL	84,000	156,000	18,000	**258,000**
REGIONAL OFFICE	155,000	112,100	189,263	**456,363**
X. TOTAL DIRECT COSTS	**1,363,734**	**1,363,361**	**1,363,243**	**4,090,338**
	136,373	**136,336**	**136,324**	**409,034**
X. TOTAL PROPOSED BUDGET	**1,500,107**	**1,499,697**	**1,499,567**	**4,499,372**

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
PROJECT TITLE
PROJECT PERIOD

Cost Elements	Y1 AUD	Y2 AUD	Y3 AUD	TOTAL AUD
I. TRAINING				
	0	0	0	0
Total Training	**0**	**0**	**0**	**0**
II. SERVICE DELIVERY				
	0	0	0	0
Total Service Delivery	**0**	**0**	**0**	**0**
III. PROCUREMENT				
	0	0	0	0
Total Procurement	**0**	**0**	**0**	**0**
IV. ADVOCACY				
	0	0	0	0
Total Advocacy	**0**	**0**	**0**	**0**
V. M&E				
Support & Monitoring Visits	40,000	40,000	40,000	120,000
Inception, MTR, EPE	45,000		75,000	120,000
	70,000	72,100	74,263	216,363
VI. Incentive Based Funding				0
				0
Total M&E	**155,000**	**112,100**	**189,263**	**456,363**
X. TOTAL PROPOSED BUDGET	**155,000**	**112,100**	**189,263**	**456,363**
	15,500	11,210	18,926	45,636
TOTAL	**170,500**	**123,310**	**208,189**	**501,999**

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
PROJECT TITLE
PROJECT PERIOD

Cost Elements	Y1 AUD	Y2 AUD	Y3 AUD	TOTAL AUD
I. TRAINING				
Clinical Training (IPES compliant)	35,000		35,000	70,000
Thematic Non-Clinical Training	35,000		35,000	70,000
Introduce Quality Assurance	110,000	0	0	110,000
Introduce Clinic MIS	60,000	0	0	60,000
ToT on Disability	0	70,000	0	70,000
	0	0	0	0
Total Training	**240,000**	**70,000**	**70,000**	**380,000**
II. SERVICE DELIVERY				
IEC and training materials (design & Printing)	20,000	0	20,000	40,000
	0	0	0	0
Total Service Delivery	**20,000**	**0**	**20,000**	**40,000**
III. PROCUREMENT				
	0	0	0	0
Total Procurement	**0**	**0**	**0**	**0**
IV. ADVOCACY				
Regional & International Advocacy	30,000	30,000	30,000	90,000
	0	0	0	0
Total Advocacy	**30,000**	**30,000**	**30,000**	**90,000**
V. M&E				
Incentive Based Funding	84,000	156,000	18,000	258,000
Total M&E	**84,000**	**156,000**	**18,000**	**258,000**
X. TOTAL PROPOSED BUDGET	**374,000**	**256,000**	**138,000**	**768,000**
	37,400	25,600	13,800	76,800
GRAND TOTAL	**411,400**	**281,600**	**151,800**	**844,800**

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
PROJECT TITLE
PROJECT PERIOD

Cost Elements	Y1 AUD	Y2 AUD	Y3 AUD	TOTAL AUD
I. TRAINING				
Relevant clinic staff trained to support IPPF IPES compliance	2,000	3,000	2,000	7,000
people with a disability	5,000	10,000	10,000	25,000
IPPF's Quality Improvement framework (QI) implemented	10,000	10,000	5,000	25,000
	-	-	-	-
Total Training	**17,000**	**23,000**	**17,000**	**57,000**
II. SERVICE DELIVERY				
SRH services and service mix promoted, and their utilization increased	4,000	-	4,000	8,000
Capacity built to deliver services for the most marginalized, especially for people with a disability	4,000	2,000	-	6,000
Static service delivery points improved and/or expanded	5,000	-	5,000	10,000
Demand created for SRH services among the most marginalized, especially people with a disability	200	20,200	20,200	40,600
Outreach and mobile service sites mapped, approved and resourced in partnership with governments and communities	9,500	7,500	40,000	57,000
Networks of trained volunteers, PPA partnerships and community stakeholders developed and engaged	11,000	16,000	10,500	37,500
Capacity at outreach sites improved facilitating use of IPPF's Quality Improvement Tool	30,200	20,200	20,200	70,600
Implementation of outreach activities in partnership	2,500	20,000	32,500	55,000
Links with non-communicable diseases (NCD) integrated into SRHR	1,000	-	-	1,000
	-	-	-	-
Total Service Delivery	**67,400**	**85,900**	**132,400**	**285,700**
III. PROCUREMENT				
Commodity security and management improved	6,000	-	-	6,000
	-	-	-	-
Total Procurement	**6,000**	**-**	**-**	**6,000**
IV. ADVOCACY				
Evidence for advocacy collated and documented – including IPPF's cost effective, sustainable model for the Pacific	3,500	-	2,500	6,000
allocated	3,000	3,000	3,000	9,000
Creating/working with multi-stakeholder network/s for advocacy	5,500	4,500	5,500	15,500
and implemented	2,000	2,000	5,000	9,000
	-	-	-	-
Total Advocacy	**14,000**	**9,500**	**16,000**	**39,500**
V. M&E				
Implementation of outreach activities in partnership	500	1,000	1,500	3,000
Systems to capture and analyze qualitative and quantitative data strengthened	3,000	-	1,500	4,500
	-	-	-	-
Total M&E	**3,500**	**1,000**	**3,000**	**7,500**
X. TOTAL PROPOSED BUDGET	**107,900**	**119,400**	**168,400**	**395,700**

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
PROJECT TITLE
PROJECT PERIOD

Cost Elements	Y1 AUD	Y2 AUD	Y3 AUD	TOTAL AUD
I. TRAINING				
Relevant clinic staff trained to support IPPF IPES compliance	3,000	-	3,000	6,000
Capacity built to deliver services for the most marginalized, especially for people with a disability	3,000	3,000	6,000	12,000
IPPF's Quality Improvement framework (QI) implemented	12,000	-	-	12,000
	-	-	-	-
Total Training	**18,000**	**3,000**	**9,000**	**30,000**
II. SERVICE DELIVERY				
SRH services and service mix promoted, and their utilization increased	1,500	500	3,500	5,500
Capacity built to deliver services for the most marginalized, especially for people with a disability	2,000	2,000	2,000	6,000
Static service delivery points improved and/or expanded	18,500	37,000	17,000	72,500
Demand created for SRH services among the most marginalized, especially people with a disability	7,500	7,500	7,000	22,000
Outreach and mobile service sites mapped, approved and resourced in partnership with governments and communities	-	-	2,500	2,500
Networks of trained volunteers, FHA partnerships and community stakeholders developed and engaged	-	5,331	10,000	15,331
Capacity at outreach sites improved facilitating use of IPPF's Quality Improvement Tool	-	-	10,200	10,200
Implementation of outreach activities in partnership	-	-	8,500	8,500
Links with non-communicable diseases (NCD) integrated into SRHR	1,000	-	-	1,000
	-	-	-	-
Total Service Delivery	**30,500**	**52,331**	**60,700**	**143,531**
III. PROCUREMENT				
Commodity security and management improved	5,000	-	-	5,000
	-	-	-	-
Total Procurement	**5,000**	**-**	**-**	**5,000**
IV. ADVOCACY				
Evidence for advocacy collated and documented – including IPPF's cost effective, sustainable model for the Pacific	3,500	-	2,500	6,000
Government SRHR policies and regulations changed and resources allocated	3,000	3,000	3,000	9,000
Creating/working with multi-stakeholder network/s for advocacy	5,500	4,500	5,500	15,500
Plans for scaling-up of SRH service developed, endorsed by government and implemented	2,000	2,000	5,000	9,000
	-	-	-	-
Total Advocacy	**14,000**	**9,500**	**16,000**	**39,500**
V. M&E				
Implementation of outreach activities in partnership	-	-	200	200
Systems to capture and analyze qualitative and quantitative data strengthened	3,000	-	1,500	4,500
	-	-	-	-
Total M&E	**3,000**	**-**	**1,700**	**4,700**
X. TOTAL PROPOSED BUDGET	**70,500**	**64,831**	**87,400**	**222,731**
	7,050	6,483	8,740	22,273

GRAND TOTAL	77,550	71,314	96,140	245,004

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
PROJECT TITLE
PROJECT PERIOD

Cost Elements	Y1 AUD	Y2 AUD	Y3 AUD	TOTAL AUD
I. TRAINING				
Relevant clinic staff trained to support IPPF IPES compliance	1,000	1,000	1,000	3,000
Capacity built to deliver services for the most marginalized, especially for people with a disability	5,000	10,000	10,000	25,000
IPPF's Quality Improvement framework (QI) implemented	10,000	10,000	5,000	25,000
	-	-	-	-
Total Training	**16,000**	**21,000**	**16,000**	**53,000**
II. SERVICE DELIVERY				
SRH services and service mix promoted, and their utilization increased	4,000	-	3,500	7,500
Capacity built to deliver services for the most marginalized, especially for people with a disability	4,000	2,000	-	6,000
Static service delivery points improved and/or expanded	-	5,000	-	5,000
Demand created for SRH services among the most marginalized, especially people with a disability	7,200	10,200	7,200	24,600
Outreach and mobile service sites mapped, approved and resourced in partnership with governments and communities	7,500	5,500	5,000	18,000
Networks of trained volunteers, FHA partnerships and community stakeholders developed and engaged	6,000	16,000	5,500	27,500
Capacity at outreach sites improved facilitating use of IPPF's Quality Improvement Tool	10,200	15,200	10,200	35,600
Implementation of outreach activities in partnership	7,000	15,000	20,000	42,000
Links with non-communicable diseases (NCD) integrated into SRHR	-	1,000	-	1,000
	-	-	-	-
Total Service Delivery	**45,900**	**69,900**	**51,400**	**167,200**
III. PROCUREMENT				
Commodity security and management improved	6,000	-	-	6,000
	-	-	-	-
Total Procurement	**6,000**	**-**	**-**	**6,000**
IV. ADVOCACY				
Evidence for advocacy collated and documented – including IPPF's cost effective, sustainable model for the Pacific	3,500	10,000	2,500	16,000
Government SRHR policies and regulations changed and resources allocated	3,000	3,000	3,000	9,000
Creating/working with multi-stakeholder network/s for advocacy	5,500	4,500	5,500	15,500
Plans for scaling-up of SRH service developed, endorsed by government and implemented	2,000	2,000	5,000	9,000
	-	-	-	-
Total Advocacy	**14,000**	**19,500**	**16,000**	**49,500**
V. M&E				
Implementation of outreach activities in partnership	500	1,000	1,000	2,500
Systems to capture and analyze qualitative and quantitative data strengthened	3,000	-	1,500	4,500
	-	-	-	-
Total M&E	**3,500**	**1,000**	**2,500**	**7,000**
X. TOTAL PROPOSED BUDGET	**85,400**	**111,400**	**85,900**	**282,700**
	8,540	11,140	8,590	28,270
GRAND TOTAL	**93,940**	**122,540**	**94,490**	**310,970**

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
PROJECT TITLE
PROJECT PERIOD

Cost Elements	Y1 AUD	Y2 AUD	Y3 AUD	TOTAL AUD
I. TRAINING				
Relevant clinic staff trained to support IPPF IPES compliance	3,000	3,000	2,000	8,000
Capacity built to deliver services for the most marginalized, especially for people with a disability	-	10,000	10,000	20,000
IPPF's Quality Improvement framework (QI) implemented	5,000	10,000	15,000	30,000
	-	-	-	-
Total Training	**8,000**	**23,000**	**27,000**	**58,000**
II. SERVICE DELIVERY				
SRH services and service mix promoted, and their utilization increased	4,500	-	4,000	8,500
Capacity built to deliver services for the most marginalized, especially for people with a disability	4,000	2,000	-	6,000
Static service delivery points improved and/or expanded	11,000	40,000	39,000	90,000
Demand created for SRH services among the most marginalized, especially people with a disability	5,200	20,200	5,200	30,600
Outreach and mobile service sites mapped, approved and resourced in partnership with governments and communities	10,000	10,500	10,500	31,000
Networks of trained volunteers, FHA partnerships and community stakeholders developed and engaged	6,000	16,000	5,500	27,500
Capacity at outreach sites improved facilitating use of IPPF's Quality Improvement Tool	10,200	20,200	10,200	40,600
Implementation of outreach activities in partnership	7,000	13,000	18,500	38,500
Links with non-communicable diseases (NCD) integrated into SRHR	1,000	-	-	1,000
	-	-	-	-
Total Service Delivery	**58,900**	**121,900**	**92,900**	**273,700**
III. PROCUREMENT				
Commodity security and management improved	6,000	-	1,000	7,000
	-	-	-	-
Total Procurement	**6,000**	**-**	**1,000**	**7,000**
IV. ADVOCACY				
Evidence for advocacy collated and documented – including IPPF's cost effective, sustainable model for the Pacific	3,500	-	2,500	6,000
Government SRHR policies and regulations changed and resources allocated	3,000	3,000	3,000	9,000
Creating/working with multi-stakeholder network/s for advocacy	5,500	4,500	5,500	15,500
Plans for scaling-up of SRH service developed, endorsed by government and implemented	2,000	2,000	5,000	9,000
	-	-	-	-
Total Advocacy	**14,000**	**9,500**	**16,000**	**39,500**
V. M&E				
Implementation of outreach activities in partnership	500	750	1,000	2,250
Systems to capture and analyze qualitative and quantitative data strengthened	3,000	-	1,500	4,500
	-	-	-	-
Total M&E	**3,500**	**750**	**2,500**	**6,750**
VI BUDGET AREA 6				
	-	-	-	-
	-	-	-	-
Total budget area 6	**-**	**-**	**-**	**-**
X. TOTAL PROPOSED BUDGET	**90,400**	**155,150**	**139,400**	**384,950**
	9,040	15,515	13,940	**38,495**
GRAND TOTAL	**99,440**	**170,665**	**153,340**	**423,445**

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
PROJECT TITLE
PROJECT PERIOD

Cost Elements	Y1 AUD	Y2 AUD	Y3 AUD	TOTAL AUD
I. TRAINING				
Relevant clinic staff trained to support IPPF IPES compliance	3,000	4,000	2,500	9,500
Capacity built to deliver services for the most marginalized, especially for people with a disability	7,000	12,000	10,000	29,000
IPPF's Quality Improvement framework (QI) implemented	20,000	25,000	25,000	70,000
	-	-	-	-
Total Training	**30,000**	**41,000**	**37,500**	**108,500**
II. SERVICE DELIVERY				
SRH services and service mix promoted, and their utilization increased	4,000	-	5,500	9,500
Capacity built to deliver services for the most marginalized, especially for people with a disability	2,000	-	-	2,000
Static service delivery points improved and/or expanded	85,000	25,000	5,000	115,000
Demand created for SRH services among the most marginalized, especially people with a disability	11,000	11,000	11,000	33,000
Outreach and mobile service sites mapped, approved and resourced in partnership with governments and communities	5,000	36,500	34,000	75,500
Networks of trained volunteers, FHA partnerships and community stakeholders developed and engaged	11,500	16,500	16,000	44,000
Capacity at outreach sites improved facilitating use of IPPF's Quality Improvement Tool	10,200	20,200	20,200	50,600
Implementation of outreach activities in partnership	16,000	40,000	67,500	123,500
Links with non-communicable diseases (NCD) integrated into SRHR	4,000	-	-	4,000
	-	-	-	-
Total Service Delivery	**148,700**	**149,200**	**159,200**	**457,100**
III. PROCUREMENT				
Commodity security and management improved	17,500	-	-	17,500
	-	-	-	-
Total Procurement	**17,500**	**-**	**-**	**17,500**
IV. ADVOCACY				
Evidence for advocacy collated and documented – including IPPF's cost effective, sustainable model for the Pacific	3,500	-	2,500	6,000
Government SRHR policies and regulations changed and resources allocated	3,000	3,000	3,000	9,000
Creating/working with multi-stakeholder network/s for advocacy	5,500	4,500	5,500	15,500
Plans for scaling-up of SRH service developed, endorsed by government and implemented	2,000	2,000	5,000	9,000
	-	-	-	-
Total Advocacy	**14,000**	**9,500**	**16,000**	**39,500**
V. M&E				
Implementation of outreach activities in partnership	1,000	2,000	2,500	5,500
Systems to capture and analyze qualitative and quantitative data strengthened	3,000	-	1,500	4,500
	-	-	-	-
Total M&E	**4,000**	**2,000**	**4,000**	**10,000**
VI BUDGET AREA 6				
	-	-	-	-
	-	-	-	-
Total budget area 6	**-**	**-**	**-**	**-**
X. TOTAL PROPOSED BUDGET	**214,200**	**201,700**	**216,700**	**632,600**
	21,420	20,170	21,670	**63,260**
GRAND TOTAL	**235,620**	**221,870**	**238,370**	**695,860**

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
PROJECT TITLE
PROJECT PERIOD

Cost Elements	Y1 AUD	Y2 AUD	Y3 AUD	TOTAL AUD
I. TRAINING				
Relevant clinic staff trained to support IPPF IPES compliance	2,000	3,000	3,000	8,000
Capacity built to deliver services for the most marginalized, especially for people with a disability	7,000	12,000	10,000	29,000
IPPF's Quality Improvement framework (QI) implemented	10,000	10,000	5,000	25,000
	-	-	-	-
Total Training	**19,000**	**25,000**	**18,000**	**62,000**
II. SERVICE DELIVERY				
SRH services and service mix promoted, and their utilization increased	4,000	1,000	3,500	8,500
Capacity built to deliver services for the most marginalized, especially for people with a disability	2,000	-	-	2,000
Static service delivery points improved and/or expanded	10,000	17,000	10,000	37,000
Demand created for SRH services among the most marginalized, especially people with a disability	200	20,200	10,000	30,400
Outreach and mobile service sites mapped, approved and resourced in partnership with governments and communities	5,000	11,000	15,500	31,500
Networks of trained volunteers, FHA partnerships and community stakeholders developed and engaged	6,000	17,000	15,500	38,500
Capacity at outreach sites improved facilitating use of IPPF's Quality Improvement Tool	5,200	13,200	20,200	38,600
Implementation of outreach activities in partnership	5,000	13,000	13,500	31,500
Links with non-communicable diseases (NCD) integrated into SRHR	1,000	-	-	1,000
	-	-	-	-
Total Service Delivery	**38,400**	**92,400**	**88,200**	**219,000**
III. PROCUREMENT				
Commodity security and management improved	11,000	-	-	11,000
	-	-	-	-
Total Procurement	**11,000**	**-**	**-**	**11,000**
IV. ADVOCACY				
Evidence for advocacy collated and documented – including IPPF's cost effective, sustainable model for the Pacific	3,500	-	2,500	6,000
Government SRHR policies and regulations changed and resources allocated	3,000	3,000	3,000	9,000
Creating/working with multi-stakeholder network/s for advocacy	5,500	4,500	5,500	15,500
Plans for scaling-up of SRH service developed, endorsed by government and implemented	2,000	2,000	5,000	9,000
	-	-	-	-
Total Advocacy	**14,000**	**9,500**	**16,000**	**39,500**
V. M&E				
Implementation of outreach activities in partnership	500	500	500	1,500
Systems to capture and analyze qualitative and quantitative data strengthened	3,000	-	1,500	4,500
Total M&E	**3,500**	**500**	**2,000**	**6,000**
VI BUDGET AREA 6				
	-	-	-	-
Total budget area 6	**-**	**-**	**-**	**-**
X. TOTAL PROPOSED BUDGET	**85,900**	**127,400**	**124,200**	**337,500**
	8,590	12,740	12,420	**33,750**
GRAND TOTAL	**94,490**	**140,140**	**136,620**	**371,250**

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
PROJECT TITLE
PROJECT PERIOD

Cost Elements	Y1 AUD	Y2 AUD	Y3 AUD	TOTAL AUD
I. TRAINING				
Relevant clinic staff trained to support IPPF IPES compliance	2,000	3,000	2,000	7,000
Capacity built to deliver services for the most marginalized, especially for people with a disability	5,000	10,000	10,000	25,000
IPPF's Quality Improvement framework (QI) implemented	7,000	7,000	7,000	21,000
	-	-	-	-
Total Training	**14,000**	**20,000**	**19,000**	**53,000**
II. SERVICE DELIVERY				
SRH services and service mix promoted, and their utilization increased	4,000	-	4,000	8,000
Capacity built to deliver services for the most marginalized, especially for people with a disability	4,000	2,000	-	6,000
Static service delivery points improved and/or expanded	5,000	-	5,000	10,000
Demand created for SRH services among the most marginalized, especially people with a disability	5,200	15,200	5,200	25,600
Outreach and mobile service sites mapped, approved and resourced in partnership with governments and communities	5,000	8,000	5,000	18,000
Networks of trained volunteers, FHA partnerships and community stakeholders developed and engaged	5,980	5,980	5,980	17,940
Capacity at outreach sites improved facilitating use of IPPF's Quality Improvement Tool	200	4,200	4,000	8,400
Implementation of outreach activities in partnership	-	7,100	7,100	14,200
Links with non-communicable diseases (NCD) integrated into SRHR	1,000	-	-	1,000
	-	-	-	-
Total Service Delivery	**30,380**	**42,480**	**36,280**	**109,140**
III. PROCUREMENT				
Commodity security and management improved	6,000	-	-	6,000
	-	-	-	-
Total Procurement	**6,000**	**-**	**-**	**6,000**
IV. ADVOCACY				
Evidence for advocacy collated and documented – including IPPF's cost effective, sustainable model for the Pacific	500	500	-	1,000
Government SRHR policies and regulations changed and resources allocated	3,000	3,000	3,000	9,000
Creating/working with multi-stakeholder network/s for advocacy	5,000	4,000	5,000	14,000
Plans for scaling-up of SRH service developed, endorsed by government and implemented	2,000	2,000	5,000	9,000
	-	-	-	-
Total Advocacy	**10,500**	**9,500**	**13,000**	**33,000**
V. M&E				
Implementation of outreach activities in partnership	-	1,000	1,000	2,000
Systems to capture and analyze qualitative and quantitative data strengthened	3,000	-	1,500	4,500
	-	-	-	-
Total M&E	**3,000**	**1,000**	**2,500**	**6,500**
VI BUDGET AREA 6				
	-	-	-	-
	-	-	-	-
Total budget area 6	**-**	**-**	**-**	**-**
X. TOTAL PROPOSED BUDGET	**63,880**	**72,980**	**70,780**	**207,640**
	6,388	7,298	7,078	**20,764**
GRAND TOTAL	**70,268**	**80,278**	**77,858**	**228,404**

INTERNATIONAL PLANNED PARENTHOOD FEDERATION
PROJECT TITLE
PROJECT PERIOD

Cost Elements	Y1 AUD	Y2 AUD	Y3 AUD	TOTAL AUD
I. TRAINING				
Relevant clinic staff trained to support IPPF IPES compliance	2,000	3,000	2,000	7,000
Capacity built to deliver services for the most marginalized, especially for people with a disability	5,000	10,000	10,000	25,000
IPPF's Quality Improvement framework (QI) implemented	10,000	10,000	5,000	25,000
	-	-	-	-
Total Training	**17,000**	**23,000**	**17,000**	**57,000**
II. SERVICE DELIVERY				
SRH services and service mix promoted, and their utilization increased	5,000	-	5,000	10,000
Capacity built to deliver services for the most marginalized, especially for people with a disability	4,000	2,000	-	6,000
Static service delivery points improved and/or expanded	5,000	-	5,000	10,000
Demand created for SRH services among the most marginalized, especially people with a disability	10,200	15,200	15,200	40,600
Outreach and mobile service sites mapped, approved and resourced in partnership with governments and communities	10,000	11,000	10,000	31,000
Networks of trained volunteers, FHA partnerships and community stakeholders developed and engaged	9,000	15,000	22,000	46,000
Capacity at outreach sites improved facilitating use of IPPF's Quality Improvement Tool	13,854	30,200	5,000	49,054
Implementation of outreach activities in partnership	17,500	30,500	45,500	93,500
Links with non-communicable diseases (NCD) integrated into SRHR	1,000	-	-	1,000
	-	-	-	-
Total Service Delivery	**75,554**	**103,900**	**107,700**	**287,154**
III. PROCUREMENT				
Commodity security and management improved	6,000	5,000	-	11,000
	-	-	-	-
Total Procurement	**6,000**	**5,000**	**-**	**11,000**
IV. ADVOCACY				
Evidence for advocacy collated and documented – including IPPF's cost effective, sustainable model for the Pacific	3,500	-	2,500	6,000
Government SRHR policies and regulations changed and resources allocated	3,000	3,000	3,000	9,000
Creating/working with multi-stakeholder network/s for advocacy	5,500	4,500	5,500	15,500
Plans for scaling-up of SRH service developed, endorsed by government and implemented	2,000	2,000	5,000	9,000
	-	-	-	-
Total Advocacy	**14,000**	**9,500**	**16,000**	**39,500**
V. M&E				
Implementation of outreach activities in partnership	1,000	1,000	1,000	3,000
Systems to capture and analyze qualitative and quantitative data strengthened	3,000	-	1,500	4,500
	-	-	-	-
Total M&E	**4,000**	**1,000**	**2,500**	**7,500**
VI BUDGET AREA 6				
	-	-	-	-

	-	-	-	-
Total budget area 6	-	-	-	-
X. TOTAL PROPOSED BUDGET	116,554	142,400	143,200	402,154
	11,655	14,240	14,320	**40,215**
GRAND TOTAL	128,209	156,640	157,520	442,369

37909/9

FUNDING ORDER

This Funding Order is issued by the Department of Foreign Affairs and Trade (DFAT) in accordance with the clause headed **Formation of Funding Agreements** of the Head Agreement No. **37909** between DFAT and Family Planning NSW ("**Organisation**") **75000026335** and brings into existence a contract (**"Cooperation Agreement"**) between DFAT and the Organisation for the provision of the Services detailed below subject to the terms and conditions set out in the Head Agreement.

BACKGROUND

A. NGOs which have demonstrated systems, capacity and accountability in managing a program through the DFAT accreditation process are eligible to receive accountable funds under Full or Base Accreditation procedures as specified in the Australian NGO Accreditation Manual on the DFAT Internet site at www.dfat.gov.au.

B. This Funding Order concerns the Organisation's membership of and obligations under Full Level Accreditation of the Australian NGO Cooperation Program (ANCP).

C. ANCP is a flexible mechanism that supports NGOs' programs and strategic directions in line with the goal of the Australian aid program and is consistent with the Millennium Development Goals (MDGs).

D. The Organisation must continue to meet DFAT accreditation and effectiveness standards and meet the following eligibility criteria:

   i. have a strong corporate governance structure, be DFAT Full Level accredited NGOs and be signatories to the ACFID Code of Conduct;

   ii. have proven capacity to contribute to the development of an effective aid program at significant scale and with lasting impact;

   iii. have demonstrated ability to use ANCP funds for programs which align with the priorities of the Australian aid program, and make a significant contribution to the Monitoring, Evaluation and Learning Framework (MELF);

   iv. play an active role in strengthening the Australian NGO sector and civil society organisations in partner countries including through the dissemination of learning, analysis and evidence-based good practice; and

   v. proactively engage with DFAT and the broader development sector on policy and practice issues with sound evidence and knowledge gained from program and developing country experience which help to enhance development effectiveness.

E. The provision of funds through this funding order under the ANCP operates in accordance with the NGO Periodic Funding Head Agreement, and additional conditions as contained in this funding order, and is implemented in accordance with the ANCP Manual.

F. It should be noted that **Clauses 7** and **10** below provide additional strength in these priority cross-cutting issue areas for DFAT, and if they duplicate clauses in the existing specific NGO Head Agreement, the clauses in this funding order take precedence.

1. **INTERPRETATION**

1.1 All terms used in this Funding Order have the same meaning as is given to them in the Head Agreement, unless the context otherwise requires.

2. **TERM OF FUNDING ORDER**

2.1 The term of this Funding Order will commence on the date that both parties sign this Funding Order and continues until all obligations have been fulfilled under the Funding Order, unless terminated earlier in accordance with the Head Agreement.

2.2 The Organisation must commence the Activity on **1 July 2014** and must complete the Activity by **30 June 2015**.

2.3 If an Organisation does not comply with the minimum eligibility criteria (defined in the Recitals and at Clause 6.2a), DFAT will refer the matter to the Committee for Development Cooperation for guidance. DFAT may elect to amend, this Funding Order in the case of non-compliance with these critiera, which would be actioned through a deed of amendment.

3. **THE ACTIVITY**

3.1 DFAT offers to provide the Organisation with annual accountable funds for the implementation of the Activity "**Australian NGO Cooperation Program Funding 2014-15 (Global)**" as specified in the Organisation's ANCP Annual Development Plan to be accepted by DFAT.

3.2 The parties agree that the title of the Activity to be used in all documentation, correspondence and publicity is **- Australian NGO Cooperation Program Funding 2014-15 (Global).**

3.3 The Organisation is required to submit the Annual Development Plan via ANCP Online by 30 June 2014.

3.4 Once accepted by DFAT, DFAT must be advised in writing prior to any changes to the Activity. Proposed changes must be made to the Organisation's Annual Development Plan, through ANCP Online. DFAT approval must then be issued prior to any changes formally accepted and made to the Activity.

4. **REPORTING REQUIREMENTS**

4.1 All reports must:

(a) conform to ANCP's Monitoring, Evaluation and Learning Framework (MELF)

(b) be comprehensive, accurate and not misleading in any respect;

(c) be prepared as directed in writing by DFAT;

(d) be provided via ANCP Online;

(e) not incorporate the Australian aid logo or Australian Government crest;

(f) be provided at the time specified in this Funding Order; and

(g) incorporate sufficient information which allows DFAT to monitor and assess the success of the Activity in achieving Government benchmarks.

4.2 Before DFAT makes payments for the relevant financial year, in addition to meeting the requirements of Clause 6.2 below, the Organisation must provide to DFAT a copy of the following reports by the due date via ANCP Online:

(a) by **30 June each year**, an Annual Development Plan that outlines the Organisation's planned activities for the following financial year;

(b) by **30 September each year**, an Annual Performance Report and financial report for the previous financial year;

(c) by **31 March each year**, its Recognised Development Expenditure (RDE) calculations and submission of audited financial statements for the NGO's most recent completed financial year.

(d) promptly when requested by DFAT from time to time, additional information regarding the Activity.

5. MONITORING AND EVALUATION

5.1 The Organisation is responsible for ensuring that quality reporting of results achieved with DFAT funding is provided through the Monitoring, Evaluation and Learning Framework (MELF).

5.2 The Organisation is responsible for monitoring and evaluation of the performance of ANCP activities and the performance of the Delivery Organisation against the MELF and the Organisation's Annual Development Plan. The Organisation shall report to DFAT on the results in the Annual Performance Report, and in exception reports as requested by DFAT. NGOs may also be expected to contribute to biennial ANCP meta-evaluations and thematic reviews.

5.3 DFAT may also undertake monitoring, review and evaluation of activities at any time. The Organisation must, and must request its Delivery Organisation staff to, facilitate any monitoring visits, provide reasonable assistance to and cooperate fully with other service providers as DFAT may reasonably request. DFAT undertakes to provide reasonable notice (where possible at least 4 weeks) to the Organisation prior to commencing a review or evaluation.

5.4 DFAT will advise the Organisation of the results of any monitoring or evaluation report by letter in hard or electronic copy. DFAT may use the information generated in the report to provide the Organisation with recommendations concerning implementation.

6. FUNDS PAYABLE TO THE ORGANISATION

6.1 The financial limitation for this Activity is A$***300,000*** plus GST as specified in ***Annex C, Basis of Funding.***

6.2 The provision of Funds to the Organisation is subject to:

(a) Compliance with all of the requirements set down within this Funding Order, the Head Agreement and the DFAT NGO Accreditation Guidance Manual contained as part of the DFAT Internet site at www.dfat.gov.au, as amended from time to time;

(b) annual budget processes and availability of funds;

(c) NGOs meeting performance benchmarks as defined in at Annex D; and

(d) Issuing of an appropriate tax invoice as required by **Clause 12** below.

6.3 The Organisation must ensure that the Funds are spent in accordance with the following requirements, or as otherwise agreed in writing with DFAT:

(a) The percentage of the Funds spent on administration must not exceed 10% per financial year;

(b) The percentage of the Funds spent on Design Monitoring and Evaluation (DME) must not exceed 10% per financial year; and

(c) Where the Annual Development Plan contains new or potentially higher risk projects (as advised by DFAT when the Annual Development Plan is accepted), the Organisation must not spend the Funds on these projects until DFAT has approved these projects in writing.

All other funds must be expended on activities as agreed in the Annual Development Plan in line with the ANCP Guidelines.

6.4 Over the period 2014-15, the Organisation must contribute a minimum of ***A$60,000*** of their own funds to the activities funded by DFAT under the ANCP and accurately record this in their Annual Development Plan. This contribution is calculated as a matching ratio of 5:1 against the total funds provided by DFAT under this Funding Order.

6.5 The Organisation must only spend the Funds on the Activity, as approved in each Annual Development Plan. The Organisation will be responsible to DFAT for the expenditure of the Funds in accordance with all programming and reporting requirements of the Head Agreement and this Funding Order.

6.6 If the Organisation does not spend all of the Funds by the end of the financial year in which the Funds were received (30 June), the Organisation may roll-over up to ten per cent of the Funds to the next financial year after consultation and obtaining the written agreement of DFAT. Unless otherwise agreed in writing with DFAT:

(a) any funds rolled-over from previous funding orders to the first financial year of this Funding Order cannot be rolled-over again to the next financial year; and

(b) any funds rolled over from one financial year of this Funding Order to the following financial year, cannot be rolled over again to the next financial year,

then DFAT may reduce the next tranche payment of the Funds to the Organisation by the amount of unexpended Funds which DFAT has declined approval to roll-over.

6.7 The Organisation may roll-over to the next financial year an amount greater than ten per cent of the Funds if the Organisation obtains DFAT's prior written approval to do so. If, at the end of a financial year, more than ten per cent of the Funds (including Funds rolled over from previous financial years, if any) remain unexpended, DFAT will consult with the Organisation regarding its future planned expenditure. Following this consultation, if DFAT determines that:

(a) it will not approve a roll-over of an amount greater than 10 per cent of the Funds; or

(b) it will approve a roll-over of an amount greater than 10 per cent of the Funds but it will not approve the roll-over of all of the unexpended Funds,

then DFAT may reduce the next tranche payment of the Funds to the Organisation by the amount of unexpended Funds which DFAT has declined approval to roll-over.

6.8 The Organisation must repay to DFAT within 28 days of DFAT's final acceptance of the final annual Performance Report and Financial Report any unexpended Funds if the Organisation will not be receiving further ANCP funds.

6.9 The Organisation must maintain its current status of Accreditation and its eligibility for ANCP funding for the term of this Funding Order to be eligible to receive the level of funding as set out in this Funding Order. If the Organisation ceases to hold the level of accreditation that applies on the date of signing this Funding Order or ceases to be eligible for ANCP Funding, DFAT may, by notice in writing, require the Organisation to repay to DFAT all or part of the Funds which the Organisation has not committed for expenditure.

6.10 DFAT may undertake Recognised Development Expenditure (RDE) spot checks, at any time. The Organisation must provide reasonable assistance to and cooperate fully with other service providers as DFAT may reasonably request. DFAT undertakes to provide reasonable notice (where possible at least 10 days) to the Organisation prior to commencing an RDE spot-check.

7. INTELLECTUAL PROPERTY

7.1 Clause 14 of the Head Agreement is replaced by Clause 7.2.

7.2 The Organisation hereby assigns to DFAT any intellectual property rights in materials developed or created by the Organisation in the course of performing the Activity.

8. SECURITY

8.1 The Organisation must liaise and cooperate with DFAT, the Project stakeholders and the Australian Diplomatic Mission in or having responsibility for the Partner Country, especially in relation to project security, personal safety and welfare matters.

8.2 The Organisation must use its best endeavours to ensure that all international Organisation personnel working in the Partner Country:

(a) are certified as fit and health by a legally qualified medical practitioner to work in the Partner Country and have received the necessary medical advice, including that on vaccinations and other preventive medical assistance allowing them to undertake work in-country in a safe manner; and

(b) are adequately briefed and understand the environment and culture of the Partner Country.

9. FRAUD

9.1 For the purpose of this clause, 'fraudulent activity', 'fraudulent' or 'fraud' means: Dishonestly obtaining a benefit, or causing a loss, by deception or other means.

9.2 The Organisation, its Delivery Organisations and its subcontractors must not engage in any fraudulent activity. The Organisation is responsible for preventing and detecting fraud.

9.3 The Organisation must report in writing within 5 working days to DFAT any detected, suspected, or attempted fraudulent activity involving an Initiative.

9.4 In the event of detected, suspected or attempted fraud and in consultation with DFAT, the Organisation must develop and implement a strategy to investigate, based on the principles set out in the *Australian Government Investigations Standards*. The Organisation must undertake the investigation at the Organisation's cost.

9.5 Following the conclusion of an investigation, where the investigation finds the Organisation, an employee or a subcontractor of the Organisation, the Delivery Organisation, an employee or a subcontractor of the Delivery Organisation has acted in a fraudulent manner, the Organisation shall:

(a) where money has been misappropriated, pay to DFAT or the Project the full value of the Grant funds that have been misappropriated; or

(b) where an item of property has been misappropriated, either return the item to DFAT or the project or if the item cannot be recovered or has been damaged so that it is no longer usable, replace the item with one of equal quality;

(c) refer the matter to the relevant Partner Country police or other authorities responsible for prosecution of fraudulent activity; and

(d) keep DFAT informed, in writing, on a monthly basis, of the progress of the recovery action.

9.6 Following the conclusion of an investigation, where the investigation finds that a party other than the Organisation, an employee or subcontractor of the Organisation, the Delivery Organisation, an employee or a subcontractor of the Delivery Organisation, have acted in a fraudulent manner, the Contractor shall, at the Organisation's cost:

(a) make every effort to recover any Grant funds or funded property acquired or distributed through fraudulent activity, including without limitation, the following:

(i) take recovery action in accordance with recovery procedures, including civil litigation, available in the Partner Country;

(ii) refer the matter to the relevant Partner Country police or other authorities responsible for prosecution of fraudulent activity; and

(iii) keep DFAT informed, in writing, on a monthly basis, of the progress of the recovery action.

9.7 If the Organisation considers that after all reasonable action has been taken to recover the Grant funds or funded property and full recovery has not been achieved or recovery has only been achieved in part, the Organisation may seek approval from DFAT that no further recovery action be taken. The Organisation must provide to DFAT all information, records and documents required by DFAT to enable the DFAT delegate to make a decision on whether to approve non-recovery of Grant funds or funded property.

10. INTERNAL AUDIT

10.1 DFAT may undertake audits of the Organisation against any of the contractual requirements set out in the Head Agreement of this Funding Order.

10.2 Consistent with the Transparency Charter for the Australian Aid Program and the DFAT Internal Audit Publishing Approach, DFAT publishes audit reports on the DFAT website. All draft audit reports will be provided to the Organisation for consultation. DFAT will notify the Organisation prior to publication or release of information about a sensitive mater (e.g. fraud, corruption, counter-terrorism and child protection).

11. WORK HEALTH AND SAFETY

11.1 The Organisation must ensure that the Activity is performed in a safe manner.

11.2 The Organisation agrees, when using DFAT's premises or facilities, to comply with all reasonable directions and procedures relating to work health and safety and security in effect at those premises or in regard to those facilities, as notified by DFAT or as might reasonably be inferred from the use to which the premises or facilities are being put.

11.3 The Organisation agrees to, on request, give all reasonable assistance to DFAT, by way of provision of information and documents, to assist DFAT and its officers (as defined in the *Work Health and Safety Act 2011* (**"WHS Act"**)) to comply with the duties imposed on them under the WHS Act.

11.4 The Organisation acknowledges that DFAT may direct the Organisation to take specified measures in connection with the Organisation's work under this Agreement or otherwise in connection with the Activity that DFAT considers reasonably necessary to deal with an event or circumstance that has, or is likely to have, an adverse effect on the health or safety of persons. The Organisation must comply with the direction. The Organisation agrees that it is not entitled to an adjustment to the Funds merely because of compliance with the direction.

12. CLAIMS FOR PAYMENT

12.1 Tax invoices must be submitted when due in accordance with this Funding Order, in a form identifying the Activity title and the Funding Order number **37909/9**.

12.2 All tax invoices must be made to:

Chief Finance Officer – Australian Aid Program
Department of Foreign Affairs and Trade
GPO Box 887
CANBERRA ACT 2601

12.3 Tax invoices should be sent to the above address with a copy sent to:

ANCP Manager
NGO Programs Section
DFAT
GPO Box 887
CANBERRA ACT 2601

12.4 Tax invoices should be sent to the above address. Alternatively DFAT will accept electronic tax invoices. These can be sent to accountsprocessing@dfat.gov.au with a copy sent to the ANCP Manager at ancpau@dfat.gov.au.

12.5 Invalid invoices will be returned to Organisations. Information on what constitutes a valid tax invoice can be found at http://www.ato.gov.au/businesses/content.asp?doc=/content/50913.htm

13. ACCEPTANCE OFFER

13.1 Please indicate your acceptance of this Funding Order on the Acceptance of Offer of Funds attached and return it to DFAT. This Funding Order will not take effect until it is signed by DFAT (see **Clause 2.1**).

37909/9

Issued for and on behalf of the **Commonwealth of Australia** represented by the Department of Foreign Affairs and Trade by:

In the presence of:

Signature of witness

Name of witness
(Print)

Signature of FMA Act s32B/44 Delegate

Name CHRISTINA MUNRO

Name

Position, Section DIRECTOR, NGO PROGRAMS

Position, Section

Annexures:

A ***Acceptance of Offer of Funds***

B ***Annual Development Plan (updated annually)***

C ***Basis of Funding***

D ***Benchmarks***

37909/9

Annex A

Agreement Title

FUNDING ORDER

ACCEPTANCE OF OFFER OF FUNDS

Family Planning NSW, 75000026335, accepts the offer of Funds as set out above and agrees to undertake the Activity in accordance with the requirements contained in this Funding Order No. 37909/9 and the DFAT NGO Accreditation Manual, as amended from time to time.

Dated this 24th day of June 2014

Signed for and on behalf of **Family Planning NSW, 75000026335** by:

ANN BRASSIL

CEO

Name and Position
(Print)

Signature

By executing this Funding Order the signatory warrants that the signatory is duly authorised to execute this Funding Order on behalf of the Organisation.

Annex B

FAMILY PLANNING NSW ANNUAL DEVELOPMENT PLAN

(as submitted on 30 June via ANCP Online)

Annex C

BASIS OF FUNDING

AUSTRALIAN NGO COOPERATION PROGRAM 2014-15 (GLOBAL)

FAMILY PLANNING NSW

14. TOTAL AMOUNT PAYABLE

14.1 The funding outlined in this Funding Order is subject to annual budget processes and availability of funding and is not guaranteed. DFAT will inform the Organisation as soon as possible of any changes to the funding outlined in **Clause 6.1** but such changes will not require the Organisation's prior agreement. If the funding outlined in **Clause 6.1** changes, the Funding Order will be amended through a deed of amendment.

14.2 The maximum amount payable by DFAT to the Organisation over the period 2014-15 under this Funding Order shall not exceed the sum of A$**300,000** ("the Funds") plus applicable GST if any up to a maximum amount of A$**30,000**. The annual allocation for 2014-15FY is set out in the table below and is subject to the achievement of the following milestones and **Clause 6.2**.

Financial Year (FY)	**Tranche 1 (80% of financial year funding)**	**Tranche 2 (20% of financial year funding)**	**Total Amount**
2014-15FY	A$**240,000** plus GST	A$**60,000** plus GST	A$**300,000** plus GST

The Funds are as follows:

(a) Tranche 1 (80% of 2014-15 funding): A$**240,000** plus GST up to a maximum amount of $**24,000** within 30 days of DFAT receipt and acceptance of 2014-15 Annual Development Plan (see Clause 4.2(a));

(b) Tranche 2 (20% of 2014-15 funding): A$**60,000** plus GST up to a maximum amount of $**6,000** within 30 days of DFAT receipt and acceptance of the 2014-15 annual performance report and financial report of expenditure against the Annual Development Plan (see Clause 4.2 (b));

Annex D

BENCHMARKS

FAMILY PLANNING NSW- AUSTRALIAN NGO COOPERATION PROGRAM 2014-15

Benchmarks will be agreed between DFAT and the NGOs in late 2014/early 2015 and this will require an amendment to the contract related to this **Annex D**.

GRANT AGREEMENT DEED

BETWEEN

COMMONWEALTH OF AUSTRALIA

represented by the Australian Agency for International Development (AusAID)

ABN 62 921 558 838

and

INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF)

FOR

SPRINT Stage 2

AUSAID AGREEMENT 63191

DEED made 31st day of May [2012]

BETWEEN:

COMMONWEALTH OF AUSTRALIA represented by the Australian Agency for International Development ("**AusAID**") **ABN 62 921 558 838**

AND

INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF), of **4 Newhams Row LONDON SE1 3UZ UNITED KINGDOM** (the "**Organisation**").

RECITALS:

A. AusAID wishes to provide the Organisation with a Grant to undertake an Activity.

B. The Organisation wishes to accept the Grant subject to the terms and conditions in this Deed.

OPERATIVE:

AusAID and the Organisation promise to carry out and complete their respective obligations in accordance with this Deed including the Deed conditions, schedules and any annexes contained herein.

EXECUTED AS A DEED by the Commonwealth, by an authorised officer, and by the Organisation, by its authorised officer.

SIGNED for and on behalf of the
COMMONWEALTH OF AUSTRALIA
represented by the Australian Agency
for International Development by:

in the presence of:

Signature of FMA Act s44 Delegate

Signature of witness

Catherine Walker

Name

Name of witness
(Print)

FADG H/S O

Position, Section

SIGNED for and on behalf of
INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF) by:

TEWODROS MELESSE

DIRECTOR GENERAL

Name and Position
(Print)

Signature

By executing this Deed the signatory warrants that he/she is duly authorised to execute this Grant Agreement Deed on behalf of the Organisation.

in the presence of:

Name of witness
(Print)

Signature of witness

AGREEMENT CONDITIONS

1. INTERPRETATION

Definition

1.1 In this Agreement, including the recitals, unless the context otherwise requires:

"**Acquittal Statement**" means a statement acquitting the Grant against the budget in the Activity Proposal.

"**Activity**" means the activity **SPRINT Stage 2** described in the Activity Proposal for which the Grant is provided.

"**Activity Proposal**" means the specific tasks and budget associated with the Activity included as **Schedule 1** to this Agreement.

"**Agreement**" means this Deed and includes the Agreement Conditions and any schedules and annexes.

"**Agreement Material**" means all material created or required to be developed or created as part of, or for the purpose of undertaking the Activity, including documents, equipment, information data, sounds and images stored by any means.

"**Business Day**" means a day on which AusAID is open for business.

"**Commonwealth**" means Commonwealth of Australia or AusAID, as appropriate.

"**Fraudulent Activity**", "**Fraud**" or "**Fraudulent**" means dishonestly obtaining a benefit, or causing a loss, by deception or other means, and includes suspected, alleged or attempted fraud.

"**Grant**" means the amount of money as specified in the clause titled "Grants and Payment" of this Agreement that has been approved by AusAID and paid to the Organisation subject to the conditions outlined in this Agreement for the Activity.

"**Independently Audited**" means financial records audited by a certified financial professional that is in no way linked or associated with the Activity or the Parties.

"**Intellectual Property**" means all copyright and all rights in relation to inventions (including patent rights), trade marks, designs and confidential information, and any other rights resulting from intellectual activity in the industrial, scientific, literary, and artistic fields recognised in domestic law anywhere in the world.

"**Partner Government**" means the Government of the Partner Country.

"**Partner Country**" means the country or countries in which the Activity is to be undertaken in whole or in part.

"**Party**" means AusAID or the Organisation.

"**Personnel**" means the personnel of the Organisation who are engaged in the performance of the Activity, including the Organisation's employees, subcontractors, agents and volunteers.

"**Prior Material**" means all material developed by the Organisation or a third party independently from the Activity whether before or after commencement of the Activity.

"**Relevant List**" means the lists of terrorist organisations made under Division 102 of the *Criminal Code Act 1995* (Cth) and the *Charter of the United Nations Act 1945* (Cth) posted at:http://www.nationalsecurity.gov.au/agd/www/nationalsecurity.nsf/AllDocs/95FB057CA3DECF30CA256FAB001F7FBD?OpenDocument and http://www.dfat.gov.au/icat/UNSC_financial_sanctions.html#3

"**Similar List**" means any similar list to the World Bank List maintained by any other donor of development funding.

"**World Bank List**" means a list of organisations maintained by the World Bank in its "Listing of Ineligible Firms" or "Listings of Firms, Letters of Reprimand" posted at: http://web.worldbank.org/external/default/main?theSitePK=84266&contentMDK=64069844&menuPK=116730&pagePK=64148989&piPK=64148984

Agreement prevails

1.2 If there is any inconsistency (whether expressly referred to or to be implied from this Agreement or otherwise) between the provisions of this Agreement ("Agreement Conditions") and those in the schedules and any annexes, the schedules and any annexes are to be read subject to the Agreement Conditions and the Agreement Conditions prevail to the extent of the inconsistency.

2. TERM OF THE AGREEMENT

2.1 The term of this Agreement commences upon execution by both parties being the date indicated at the front of this Agreement and continues until all obligations have been fulfilled under this Agreement, unless terminated earlier in accordance with this Agreement.

2.2 The Organisation must commence the Activity no later than 5 June 2012 and must complete the Activity by 30 June 2016.

2.3 The AusAID funding may only be used to support the implementation of the Activity.

2.4 Should circumstances arise that call the feasibility or validity of the Activity into question or cause IPPF to make major changes in its objectives, or if IPPF decides to make any substantial deviation from the relationship with SPRINT, IPPF must obtain AusAID's prior written approval before any change is made.

2.5 The Organisation and its Personnel must comply with: Family Planning and the Aid Program: Guiding Principles (August 2009), accessible on the AusAID's website (http://www.ausaid.gov.au/keyaid/health.cfm) and must immediately report any real of potential incidences of non-compliance.

3. NOTICES

3.1 For the purpose of serving notices to either Party, a notice must be in writing and will be treated as having been duly given and received:

(a) when delivered (if left at that Party's address);

(b) on the third Business Day after posting (if sent by pre-paid mail); or

(c) on the Business Day of transmission (if given by facsimile and sent to the facsimile receiver number of that Party and no intimation having been received that the notice had not been received, whether that intimation comes from that Party or from the operation of facsimile machinery or otherwise).

3.2 For the purposes of this Agreement, the address of a Party is the address set out below or another address of which that Party may give notice in writing to the other Party:

AusAID:

To: Emergencies Officer, Humanitarian Emergency Response

Postal Address: Australian Agency for International Development
GPO Box 887
CANBERRA ACT 2601 AUSTRALIA

Street Address: 255 London Circuit
CANBERRA ACT 2601 AUSTRALIA

Facsimile: +61 2 61784191

Organisation

To: Mr Tewodros Melesse
Director General IPPF

Postal Address: 4 Newhams Row

LONDON SE1 3UZ UNITED KINGDOM

Street Address: 4 Newhams Row

LONDON SE1 3UZ UNITED KINGDOM

Facsimile: +44 20 7939 8307

4. GENERAL CONDITIONS

4.1 The Organisation must carry out the Activity in accordance with the Activity Proposal and the terms and conditions of this Agreement.

4.2 The Organisation must advise AusAID immediately of any difficulties or delays in implementation of the Activity.

4.3 The Organisation must acknowledge in writing to AusAID receipt of the Grant immediately on its receipt.

4.4 The Grant and any interest earned or exchange rate gains must be used diligently and for the sole purpose of the Activity outlined in **Schedule 1** of this Agreement. Any interest earned or exchange rate gains made on the Grant must only be expended on the Activity.

4.5 The Organisation acknowledges that the Grant provided by AusAID to the Organisation for this Activity does not entitle the Organisation to any other or further grants.

4.6 The Organisation must acknowledge AusAID Grant funding assistance provided under this Agreement in accordance with the AusAID *Guidelines for NGOs on the use of AusAID logos and other forms of acknowledgement* (available from AusAID's website) and discuss any matters relating to publicity or media relations before any publication or media release

4.7 The Organisation must not represent itself and must ensure that its Personnel participating in the Activity do not represent themselves as being employees, partners or agents of the Commonwealth of Australia.

4.8 The Organisation must use its best endeavours to ensure that in its performance of the Activity all Personnel and their dependents, while in the Partner Country, respect the laws and regulations in force in the Partner Country.

4.9 The Organisation is responsible for the security of all of its Personnel and for taking-out and maintaining all appropriate insurances.

4.10 The Organisation must not assign its interest in this Agreement without first obtaining the consent in writing of AusAID.

4.11 No delay, neglect or forbearance by either Party in enforcing against the other any term or condition of this Agreement will be deemed to be a waiver or in any way prejudice any right of that Party.

4.12 This Agreement is governed by, and is to be construed in accordance with, the law of the Australian Capital Territory and the Parties submit to the exclusive jurisdiction of the courts of the Australian Capital Territory and any court hearing appeals from those courts.

5. AGREEMENT AMENDMENTS

5.1 AusAID or the Organisation may propose amendments to this Agreement at any time for the purpose of improving the delivery of the Activity, the efficiency, cost-effectiveness and development impact of the Activity.

5.2 Changes to this Agreement (including to **Schedule 1** and any annexes) will only be effected if agreed in writing and signed by both Parties in the form of a Deed of Amendment.

6. PROCUREMENT

6.1 The Organisation must not use the Grant to acquire any asset, apart from those detailed in the Activity Proposal without obtaining AusAID's prior written approval. Subject to the requirements of this clause, the Organisation will own the assets acquired with the Grant unless specified otherwise in the Activity Proposal.

6.2 If the Grant is being used to procure goods or services, the Organisation must implement procedures so that procurement is undertaken in a manner consistent with the Australian Commonwealth Procurement Guidelines (http://www.finance.gov.au/publications/fmg-series/procurement-guidelines/index.html), in particular the core principle of achieving value for money and the supporting principles of:

(a) encouraging competition by ensuring non-discrimination in procurement and using competitive procurement methods;

(b) promoting use of resources in an efficient, effective and ethical manner; and

(c) making decisions in an accountable and transparent manner.

6.3 If the Grant is being used to procure goods, the Organisation must also ensure in its procurement of goods that:

(a) the goods to be procured are of a satisfactory quality; and

(b) the goods are delivered in good order and condition and in accordance with the Activity timetable.

6.4 If the Grant is being used to procure goods, the Organisation must maintain a Register of Activity Assets ("**Register**"). The Register must:

(a) record non-consumable items purchased with the Grant or supplied by AusAID for the Activity which have a value of AUD1,000 (or equivalent) or more;

(b) record non-consumable items of a portable and attractive nature with a value of less than AUD1,000 (or equivalent); and

(c) record the date of receipt of the asset at the Activity site, the cost, the purchase/payment document date and reference number, a description and identification number, and the location of the asset.

6.5 The Organisation must not dispose of or write-off AusAID funded or provided assets except as agreed in writing by AusAID. The Register and other relevant documents such as import papers and manufacturers' warranties relating to the assets must be available for audit as required by AusAID. The Register must be reconciled with Activity assets at least every twelve months and the results of that reconciliation included in the Annual Reports required in clause titled "Reports".

7. MONITORING AND EVALUATION

7.1 The Organisation must, if required by AusAID, permit AusAID to monitor and/or evaluate the Activity and/or use of the Grant. AusAID will give the Organisation at least two (2) weeks notice of its intentions prior to commencing such a review. In that event, the Organisation must cooperate fully with any request for assistance pursuant to any such study.

8. INDEMNITY

8.1 The Organisation must at all times indemnify AusAID, its employees, agents and contractors (except the Organisation) ("**those indemnified**") from and against any loss or

liability whatsoever suffered by those indemnified or arising from any claim, suit, demand, action or proceeding by any person against any of those indemnified where such loss or liability was caused or contributed to in any way by any wilfully wrongful, unlawful or negligent act or omission of the Organisation, or any of the Organisation's Personnel in connection with this Agreement.

8.2 The Organisation agrees that AusAID may enforce the indemnity in favour of the persons specified in **Clause 8.1** above for the benefit of each of such persons in the name of AusAID or of such persons.

8.3 The indemnity in this **Clause 8** is reduced to the extent that the loss or liability is directly caused by AusAID, its employees, agents or contractors (except the Organisation), as substantiated by the Organisation.

8.4 This indemnity survives the termination or expiration of this Agreement.

9. INTELLECTUAL PROPERTY RIGHTS

9.1 The Intellectual Property in or in relation to Agreement Material vests in AusAID upon its creation. AusAID grants to the Organisation a revocable, non-exclusive, world-wide, royalty-free licence to use the Agreement Material.

9.2 **Clause 9.1** does not affect the ownership of Intellectual Property in any Prior Material incorporated into the Agreement Material, but the Organisation grants to AusAID a permanent, irrevocable, non-exclusive, world-wide, royalty-free licence to use, reproduce, adapt and otherwise exploit such Prior Material in conjunction with the Agreement Material. The licence granted under this **Clause 9.2** includes the right of AusAID to sub-license any of its employees, agents or contractors to use, communicate, reproduce, adapt and otherwise exploit the Prior Material incorporated into the Agreement Material for the purposes of performing functions, responsibilities, activities or services for, or on behalf of, AusAID.

10. COMPLIANCE WITH LAWS, GUIDELINES AND POLICIES

10.1 The Organisation and its Personnel must have regard to and comply with, relevant and applicable laws, guidelines, regulations and policies, including those in Australia and in the Partner Country. A list, as amended from time to time, of Australian laws and guidelines that may apply to the delivery of developmental aid to foreign countries can be found on the AusAID website: http://www.ausaid.gov.au/business/Pages/contracting.aspx. This list is not exhaustive and is provided for information only. The provision of this list does not relieve the Organisation from complying with the obligations contained in this clause titled "Compliance with Laws, Guidelines and Policies".

10.2 The Organisation must have regard to and comply with the Statement of International Development Practice Principles located at **Schedule 2** to this Agreement.

10.3 The Organisation and its Personnel must comply with:

(a) AusAID's *Child Protection Policy* (http://www.ausaid.gov.au/Publications/Pages/7954_7703_6074_4255_4227.aspx) and particularly the child protection compliance standards at Attachment 1 to the policy. AusAID may audit the Organisation's compliance with AusAID's *Child*

Protection Policy and child protection compliance standards. The Organisation must participate cooperatively in any reviews conducted by AusAID;

(b) The Thematic Strategy 'Promoting Opportunities for All: Gender Equality and Women's Empowerment' (November 2011) accessible at: http://www.ausaid.gov.au/publications/pages/7174_3886_222_8237_2915.aspx

(c) The strategy "Development for All": Towards a Disability-Inclusive Australian Aid Program 2009-2014' (http://www.ausaid.gov.au/publications/documents/dev-for-all.doc), and in particular the strategy's six (6) guiding principles; and

(d) *Family Planning and the Aid Program: Guiding Principles* (August 2009), accessible on AusAID's website (http://www.ausaid.gov.au/publications/pages/5045_1822_5780_5045_6070.aspx).

10.4 The Organisation must use its best endeavours to ensure:

(a) that individuals or organisations involved in implementing the Activity are in no way linked, directly or indirectly, to organisations and individuals associated with terrorism; and

(b) that the Grant is not used in any way to provide direct or indirect support or resources to organisations and individuals associated with terrorism.

10.5 The Organisation must have regard to the Australian Government guidance "Safeguarding your organisation against terrorism financing: a guidance for non-profit organisations", available at http://www.nationalsecurity.gov.au/npo.

10.6 If, during the course of this Agreement, the Organisation discovers any link whatsoever with any organisation or individual listed on a Relevant List it must inform AusAID immediately.

10.7 If, during the course of this Agreement, the Organisation is listed on a World Bank List or Similar List it must inform AusAID immediately.

10.8 The Organisation agrees that:

(a) The Organisation and its employees, agents, representatives or its subcontractors must not engage in any Fraudulent Activity. The Organisation is responsible for preventing and detecting Fraud;

(b) If the Organisation becomes aware of any suspected, alleged or attempted Fraudulent Activity which relates to the Activity, it must report the matter to AusAID in writing within five (5) Business Days. AusAID may direct the Organisation to investigate the Fraud and the Organisation must undertake an investigation at the Organisation's cost and in accordance with any directions or standards required by AusAID;

(c) Following the conclusion of any investigation which identifies Fraudulent Activity, the Organisation must;

(i) take all reasonable action to recover any Grant funds, the subject of Fraudulent Activity;

(ii) refer the matter to the relevant police or other authorities responsible for prosecution of Fraudulent Activity; and

(iii) be liable for the repayment of any Grant funds misappropriated by the Organisation, its agents, representatives or subcontractors.

(d) The Organisation's obligations under paragraphs 10.8(b) and 10.8(c) above survive the termination or expiration of this Agreement;

(e) The Organisation warrants that the Organisation will not make or cause to be made, nor will the Organisation receive or seek to receive, any offer, gift or payment, consideration or benefit of any kind, which would or could be construed as an illegal or corrupt practice, either directly or indirectly to any party, as an inducement or reward in relation to the execution of this Agreement. In addition, the Organisation will not bribe public officials and will ensure that its delivery organisations comply with this provision. Any breach of this clause shall be grounds for immediate termination of this Agreement by notice from AusAID.

11. TERMINATION

11.1 If the Organisation:

(a) becomes, or AusAID considers there is a reasonable prospect of the Organisation becoming bankrupt, insolvent, deregistered or no longer able to undertake the Activity to a standard acceptable to AusAID;

(b) makes an assignment of its estate for the benefit of creditors or enters into any arrangement or composition with its creditors;

(c) fails to commence, or in the opinion of AusAID, fails to make satisfactory progress in carrying out the Activity and such failure has not been remedied within the time specified in a written request from AusAID to remedy the failure;

(d) assigns its interest in this Agreement without the consent in writing of AusAID;

(e) is, during the term of this Agreement, listed on a World Bank List, Relevant List or Similar List;

(f) breaches any of its obligations under the clause titled "Compliance with Laws, Policies and Guidelines"; or

(g) breaches any other term of this Agreement and such breach has not been remedied within the time stipulated in a written request notice from AusAID to remedy the breach;

then in every such case AusAID may immediately terminate this Agreement by giving the Organisation notice in writing, without prejudice to any of AusAID's other rights.

11.2 In addition, either Party may terminate this Agreement by giving to the other a notice to terminate in writing stating the reasons for termination.

11.3 In the event of any termination, the Organisation must provide an Independently Audited statement of expenditure of the Grant within thirty (30) days of the date of the notice to

terminate, signed by the head of the Organisation, and return any uncommitted Grant funds to AusAID.

11.4 In the event that a notice to terminate is given by either Party, the Organisation must:

(a) immediately do everything possible to prevent and mitigate all losses, costs and expenses arising in consequence of the termination of this Agreement;

(b) in a prompt and orderly manner cease expenditure of any uncommitted Grant funds; and

(c) refund any uncommitted part of the Grant already paid by AusAID, together with any uncommitted or unspent interest, within thirty (30) days of the date of the notice to terminate.

11.5 In the event that a notice to terminate is given by either Party, AusAID will not be liable to pay compensation in an amount which, in addition to any amounts paid or due or becoming due to the Organisation under this Agreement, together would exceed the amount of the total financial limitation of this Agreement, as specified in clause titled "Grants and Payment".

12. ACCOUNTS AND RECORDS

12.1 The bank account used by the Organisation must be in the name of the Organisation and must not be a personal bank account.

12.2 The Organisation must:

(a) maintain a sound administrative and financial system capable of verifying all Acquittal Statements;

(b) keep proper and detailed accounts, records and assets registers along with adequate Activity management records providing clear audit trails in relation to expenditure under this Agreement;

(c) afford adequate facilities for audit and inspection of the financial records referred to in this Agreement by AusAID and its authorised representatives at all reasonable times and allow copies and extracts to be taken;

(d) ensure that its accounts and records are held by the Organisation for the term of this Agreement and for a period of seven (7) years from the date of expiry or termination of this Agreement;

(e) if requested by AusAID, provide an Acquittal Statement, certified by the senior financial officer or the head of the Organisation; and

(f) in addition to its obligation under the clause titled "Reports", if reasonably requested by AusAID in order to verify the expenditure of the Grant, provide an Acquittal Statement Independently Audited by an auditor nominated by AusAID at no cost to AusAID.

13. AusAID USE OF AGREEMENT INFORMATION

13.1 AusAID may disclose matters relating to this Agreement, including this Agreement, and other relevant information, except where such information may breach the *Privacy Act 1988* (Cth), to Commonwealth governmental departments and agencies, Commonwealth Ministers and Parliamentary Secretaries, and to the Commonwealth Parliament, including responding to requests for information from Parliamentary committees or inquiries. In addition, AusAID may publicly report information regarding this Agreement. This clause survives the termination or expiration of this Agreement.

14. GRANT ADMINISTRATION

14.1 In administering **the Activity** the Organisation must:

(a) implement procedures so that grant administration is undertaken in a manner that is consistent with the Commonwealth Grant Guidelines, in particular the seven Key Principles for Grants Administration; and

(b) maintain complete and accurate records documenting the procedures followed in selecting grant recipients.

14.2 The Commonwealth Grant Guidelines are available at:
http://www.finance.gov.au/publications/fmg-series/docs/FMG23_web.pdf

15. REPORTS

15.1 AusAID shall receive the Organisation's Annual Performance Report, and the Organisation;s Annual Financial Report. Reports are in addition to SPRINT reports listed below.

15.2 The Organisation must submit to AusAID one (1) Interim Inception Plan, by 30 June 2012, one (1) Inception Plan, within 30 days of the Hub Directors recruitment, and three (3) Annual Plans, by 15 February 2013, 2014 and 2015. These plans may be adjusted following recommendations made by meetings of the Steering Committee.

(a) Each plan must include an implementation strategy and work program for the coming period that:

(i) outlines the inputs, activities, expected outputs and outcomes of the proposed program of work;

(ii) details the expected and required inputs from the Organisation and other key stakeholders;

(iii) provides a updated risk management strategy to identify and mitigate any relevant risks.

(iv) where appropriate, include proposals and justifications for budgetary or programmatic variations.

15.3 The Organisation must submit one (1) Inception Report, to AusAID by 15 February 2013, and three Annual Reports on 15 February 2014, 2015 and 2016.

15.4 Reporting will be to an agreed standard and format. Reporting should not exceed eight (8) pages and should cover;

(a) An assessment of progress against the Plans for the respective period and project-to-date. This is to cover both normal development activities and emergency response activities over the period. The reports are to cover, at a minimum, deliverables provided, outcomes achieved, as well as problems encountered and solutions employed;

(i) Attached to the Reports will be a Statement of Acquittal of Funds. The statement must be signed by the senior financial officer or the head of the organisation, indicating that the grant has been spent in accordance with the terms of this Agreement. The grant acquittal must include details of any unspent funds, exchange rate gains or losses, and interest earned on the Grant.

15.5 The Organisation must submit an interim financial and variance report on 15 February 2013 and every year on 15 August (2013, 2014 and 2015) and a full financial report on 15 February 2014, 2015 and 2016. The Organisation will report in Australian Dollars, based on the exchange rate of the specific day the grant remittances were received in the Organisation's bank account.

15.6 Within sixty (60) days prior to completion of the Activity, the Organisation must submit to AusAID, a report against unexpensed and projected unexpensed funds for consideration of reallocation. The report must;

(a) include details of any unexpensed funds;

(b) include details of any interest earned on the Grant;

(c) include details of any exchange rate gains or losses on the Grant;

(d) include options for reallocation of the Grant funds.

15.7 Within thirty (30) days of completion of the Activity, the Organisation must submit to AusAID:

(a) a final report which provides a brief outline of the Activity and in more detail covers key outcomes compared with objectives, development impact, sustainability and lessons learned; and

(b) a final Acquittal Statement.

15.8 The final Acquittal Statement must:

(a) include details of any interest earned on the Grant;

(b) include details of any exchange rate gains or losses on the Grant;

(c) be prepared in accordance with the internal and external auditing procedures laid down in the rules and regulations applicable to the Organisation;

(d) be Independently Audited and certified;

(e) be signed by the senior financial officer or the head of the Organisation, indicating that the Grant has been spent in accordance with the terms of this Agreement;

(f) be in Australian Dollars.

15.9 These Reports are to be submitted to AusAID in accordance with the schedule at Attachment A or as otherwise agreed in writing.

15.10 AusAID will provide written feedback on reporting within 30 days of receiving the report.

15.11 The Organisation must repay to AusAID any unspent Grant funds or interest with the final report and Acquittal Statement.

15.12 The annual report, final report and Acquittal Statement must be sent to:

Emergencies Officer, Humanitarian Emergency Response
Australian Agency for International Development
GPO Box 887
CANBERRA ACT 2601 AUSTRALIA
@ausaid.gov.au

in the following format:

(a) one bound hard copy; and

(b) one electronic version in PDF (Portable Document Format).

16. GRANTS AND PAYMENT

16.1 AusAID will pay the Organisation an acquittable Grant up to a maximum of **AUD10,000,000**, in tranches divided as follows:

Indicative Date	Tranche Number	Amount of Grant Funds
June 2012 Refer to **Clause 16.2** below	1	AUD3,500,000
February 2014 (Refer to **Clause 16.3**	2	AUD3,000,000

below)		
February 2015 (Refer to **Clause 16.3** below)	3	AUD3,500,000

16.2 AusAID will pay Tranche 1 within thirty (30) days of the date of this Agreement and subject to receipt of a valid invoice.

16.3 AusAID will pay subsequent tranches at the date indicated above subject to the Organisation:

(a) providing an Acquittal Statement of **85** % of the previous tranche, or as agreed by AusAID, signed by the senior financial officer or the head of the Organisation indicating that the Grant funds being acquitted have been expended in accordance with the terms of this Agreement;

(b) submitting a valid invoice; and

(c) making satisfactory progress with the Activity as determined by AusAID.

17. CLAIMS FOR PAYMENT

17.1 Invoices must be submitted when due in accordance with this Agreement, in a form identifying this Agreement title and Agreement number **63191**. Invoices must also contain the Payment Event number(s) notified by AusAID.

17.2 All invoices must be **made** to:

Chief Finance Officer
Australian Agency for International Development
GPO Box 887
CANBERRA ACT 2601 AUSTRALIA

17.3 Invoices should be sent to the above address. Alternatively AusAID will accept electronic invoices. These can be sent to accountsprocessing@ausaid.gov.au and a copy sent to the AusAID Activity Manager.

17.4 Where Australian GST applies to this Agreement all invoices must be in the form of a valid tax invoice. Invalid tax invoices will be returned to organisations. Information on what constitutes a valid tax invoice can be found at:
http://www.ato.gov.au/businesses/content.asp?doc=/content/50913.htm

SCHEDULE 1 – ACTIVITY PROPOSAL
TO GRANT AGREEMENT DEED NUMBER 63191

SCHEDULE 2 –
STATEMENT OF INTERNATIONAL DEVELOPMENT PRACTICE PRINCIPLES

A Basic Standard for Engagement with Not-For-Profit Organisations

The Statement of International Development Practice Principles (Attached) has been developed in consultation with the Australian Council for International Development (ACFID). It is **founded on the good development practice and experience of accredited Australian Non-Government Organisations** (NGOs) and other international development agencies over the last three decades.

The Statement takes account of the Accra Action Agenda on Aid Effectiveness, and in particular, encourages a participatory approach to development. 'Not for profit' organisations are strongly encouraged to work in partnership with others thereby reducing the burden on communities and governments with whom they work. The Statement seeks to articulate the minimum standards and commitment that AusAID expects from all 'not- for- profit' organisations that it funds. It will form an annex to grant agreements with not-for-profit organisations that are not accredited with AusAID.

The Principles are **not aimed at accredited Australian NGOs** which have already undergone a rigorous accreditation process.

Statement of International Development Practice Principles

This Statement of International Development Practice Principles (The Principles) promotes the active commitment of **all non-accredited, not-for-profit organisations funded by AusAID** to the fundamentals of good development practice, and to conducting their activities with integrity, transparency and accountability.

The Principles are founded on a premise of '**do no harm**' and drawn from good practice principles in the international development not-for-profit sector and international development community more broadly. In line with Aid Effectiveness principles, when planning interventions, not-for-profit organisations are encouraged to consider: what other agencies are doing in the chosen area of focus; where their organisation can add value; and how they can join with others to increase the impact and sustainability of their activities.

Where relevant, AusAID encourages eligible Australian organisations to work towards becoming Australian Council for International Development (ACFID) Code of Conduct signatories.

International Development Principles

Lessons drawn from best practice NGO and civil society programs recognise the importance of working in partnerships, building creative and trusting relationships with people of developing countries and supporting basic program standards which:

- give priority to the needs and interests of the people they serve and involve beneficiary groups to the maximum extent possible in the design, implementation and evaluation;
- promote an approach that includes all people in a community and ensures the most vulnerable, including people with disability, women and children, are able to access, and benefit equally, from, international development assistance;
- encourage self help and self-reliance among beneficiaries;
- avoid creating dependency through the facilitation of active participation and contributions (as appropriate) by the most vulnerable;
- respect and foster all universally agreed international human rights, including social, economic, cultural, civil and political rights;
- are culturally appropriate and accessible;
- seek to enhance gender equality;
- recognise and put in place processes to mitigate against the vulnerability of not for profit organisations to potential exploitation by organised crime and terrorist organisations;
- have appropriate mechanisms in place to actively prevent, and protect children from harm and abuse;
- integrate environmental considerations and mitigate against adverse environmental impacts; and
- promote collaborative approaches to development challenges including through working in partnerships and avoiding duplication of effort.

All non-accredited, not for profit organisations receiving grant funding from AusAID commit to apply these principles of good development practice, and adhere to the organisational integrity and accountability standards set out on the following page.

Organisational Integrity and Accountability for Development

AusAID grant funds and resources are designated for the purposes of international aid and development (including development awareness). They can not be used to promote a particular religious adherence, missionary activity or evangelism, or to support partisan political objectives, or an individual candidate or organisation affiliated to a particular political movement. AusAID reserves the right to undertake an independent audit of an organisation's accounts, records and assets related to a funded activity, at all reasonable times.

In all of its activities and particularly in its communications to the public, AusAID expects not-for-profit organisations it works with to accord due respect to the dignity, values, history, religion, and culture of the people it supports and serves, consistent with principles of basic human rights.

Not-for-profit organisations working with AusAID should:

- not be a willing party to wrongdoing, corruption, bribery, or other financial impropriety in any way in any of its activities;
- take prompt and firm corrective action whenever and wherever wrongdoing is found among its Governing Body, paid staff, contractors, volunteers and partner organisations;
- have internal control procedures which minimise the risk of misuse of grant funds and processes and systems that ensure grant funds are used effectively to maximise development results;
- establish reporting mechanisms that facilitate accountability to members, donors and the public;
- have adequate procedures for the review and monitoring of income and expenditure and for assessing and reporting on the effectiveness of their aid;
- have a policy to enable staff confidentially to bring to the attention of the Governing Body evidence of misconduct on the part of anyone associated with the Organisation, including misconduct related to the harm and abuse of children;
- be aware of terrorism-related issues and use their best endeavours to ensure that grant funds do not provide direct or indirect support or resources to organisations and individuals associated with terrorism and/or organised crime; and
- ensure that individuals or organisations involved in implementing activities on behalf of the Organisation are in no way linked, directly or indirectly, to organisations and individuals associated with terrorism and/or organised crime.

AusAID Grant Agreement Requirements

Each AusAID grant agreement also comes with obligations for both AusAID and the Organisation being funded. These are spelt out in detail in the grant agreement. The Principles will not affect or diminish the obligations or liabilities of the Organisation under the grant agreement as outlined in the grant agreement conditions.

Broadly speaking, any Organisation funded by the Australian Government, through AusAID, is required to comply with relevant and applicable laws, regulations and policies, including those in Australia and in the country/ countries in which they are operating. In particular, the Organisation needs to observe the contractual requirements regarding Child Protection and Counter Terrorism.

Additional Information and Related Links

Further information on AusAID's Child Protection Policy, Counter Terrorism and other applicable laws and policies can be found on AusAID's website at:

http://www.ausaid.gov.au/Publications/Pages/1429_8356_2982_8415_9415.aspx
http://www.ausaid.gov.au/Publications/Pages/7954_7703_6074_4255_4227.aspx

Further information on terrorist organisations listed under Division 102 of the Criminal Code Act 1995 (Cth) and the DFAT Consolidated List of persons and entities subject to UN sanctions regimes maintained in accordance with the Charter of the United Nations Act 1945 (Cth) can be found at:

http://www.dfat.gov.au/icat/UNSC_financial_sanctions.html#3
http://www.nationalsecurity.gov.au/agd/www/nationalsecurity.nsf/AllDocs/95FB057CA3DECF30CA256FAB001F7FBD?OpenDocument

Further information on AusAID Accreditation and the ACFID Code of Conduct can also be found at:

http://www.ausaid.gov.au/ngos/pages/accreditation.aspx
http://www.acfid.asn.au/code-of-conduct

Further information on Aid Effectiveness can be found at:

http://www.oecd.org/department/0,3355,en_2649_3236398_1_1_1_1_1,00.html
http://www.oecd.org/document/18/0,3343,en_2649_3236398_35401554_1_1_1_1,00.html

DEED OF AMENDMENT

BETWEEN

COMMONWEALTH OF AUSTRALIA
represented by
The Department of Foreign Affairs and Trade (DFAT)
ABN 47 065 634 525 002

and

INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF)

FOR

SPRINT STAGE 2

DFAT AGREEMENT No. 63191

THIS DEED OF AMENDMENT is made this 14th day of February 2014

BETWEEN:

The **COMMONWEALTH OF AUSTRALIA**, represented by the **Department of Foreign Affairs and Trade**, ABN 47 065 634 525 002
("the Commonwealth")

AND

INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF), of 4 Newhams Row LONDON SE1 3UZ UNITED KINGDOM (the "Organisation").

RECITALS:

A. On 31 May 2012 the Commonwealth and the Organisation entered into **Grant Agreement Deed 63191** in writing for the funding of the Activity described in the Agreement.

B. The parties have now agreed to alter the Grant Agreement Deed set out in this Deed.

OPERATIVE PROVISIONS:

1. In this Deed, unless the contrary intention appears, a reference to the "Agreement" is to the Agreement referred to in Recital A.
2. The Parties to this Deed agree that all references to the Australian Agency for International Development (AusAID) or related entities are to be read as references to the Department of Foreign Affairs and Trade (DFAT) ABN 47 065 634 525 002.
3. The Parties to this Deed agree that all references to the AusAID Australian Aid Program are to be read as references to the DFAT- Australian Aid Program.
4. The Organisation and Organisation Personnel must comply with all policies relevant to the DFAT- Australian Aid Program which are available at http://aid.dfat.gov.au. Where there are policies in place within DFAT which are not in use for the Australian Aid Program but which relate to the same or a similar subject matter to a DFAT - Australian Aid Program Policy, the parties will use the DFAT - Australian Aid Program policy unless it is agreed in writing between the parties that the DFAT policy will be used.
5. The Grant Agreement is amended as set out below:

Clause 2.2	**Delete existing 2.2 and replace with new Clause 2.2 as follows:** The Organisation must commence the Activity no later than 5 June 2012 and must complete the Activity by 30 June 2017.
Clause 3.2	Delete existing 3.2 and replace with new Clause 3.2 as follows: Department of Foreign Affairs and Trade To: Senior Emergencies Officer, Humanitarian Emergency Response Postal Address: Department of Foreign Affairs and Trade GPO Box 887 CANBERRA ACT 2601 AUSTRALIA Street Address: 255 London Circuit CANBERRA ACT 2601 AUSTRALIA Facsimile: +61 2 61784191 **Organisation** To: Mr Tewodros Melesse Director General IPPF Postal Address: 4 Newhams Row LONDON SE1 3UZ UNITED KINGDOM Street Address: 4 Newhams Row LONDON SE1 3UZ UNITED KINGDOM Facsimile: +44 20 7939 8307
Clause 15.12	Delete existing Clause 15.12 and replace with new Clause 15.12 as follows: The annual report, final report and Acquittal Statement must be sent to: Senior Emergencies Officer, Humanitarian Emergency Response Department of Foreign Affairs and Trade GPO Box 887 CANBERRA ACT 2601 AUSTRALIA @dfat.gov.au in the following format: (a) one bound hard copy; and (b) one electronic version in PDF (Portable Document Format).

<table>
<tr><td>Clause 16.1</td><td>Delete existing Clause 16.1 and replace with new Clause 16.1 as follows:

DFAT will pay the Organisation an acquittable Grant up to a maximum of AUD10,000,000, in tranches divided as follows:

<table>
<tr><th>Indicative Date</th><th>Tranche Number</th><th>Amount of Grant Funds</th></tr>
<tr><td>June 2012
Refer to Clause Error! Reference source not found. below</td><td>1</td><td>AUD3,500,000</td></tr>
<tr><td>February 2014
Refer to Clause 16.3 below</td><td>2</td><td>AUD1,000,000</td></tr>
<tr><td>August 2014
(Refer to Clause 16.3 below)</td><td>3</td><td>AUD2,000,000</td></tr>
<tr><td>August 2015
Refer to Clause 16.3 below</td><td>4</td><td>AUD3,500,000</td></tr>
</table>
</td></tr>
<tr><td>Clause 17.2</td><td>Delete existing Clause 17.2 and replace with new Clause 17.2 as follows:

Invoices

a) All claims for payment must be made to:

Chief Finance Officer
Department of Foreign Affairs and Trade – Australian Aid Program
GPO Box 887
CANBERRA ACT 2601 AUSTRALIA

b) Tax invoices should be sent to the above address. Alternatively DFAT will accept electronic invoices. These can be sent to accountsprocessing@dfat.gov.au.</td></tr>
</table>

6. The amendments set out in this Deed take effect on the date on which this Deed is signed by both parties.

7. In all other respects the parties confirm the Agreement.

EXECUTED AS A DEED by the Commonwealth, by an authorised officer, and by the Organisation by its authorised officer(s).

SIGNED for and on behalf of the
COMMONWEALTH OF AUSTRALIA
represented by the Department of Foreign Affairs and Trade by:

in the presence of:

Signature of FMA Act ~~s44~~ 32b Delegate

Signature of witness

Catherine Walker
Name

Name of witness
(Print)

FAS HMO
Position, Section

SIGNED for and on behalf of
INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF) by

John Good Finance Director
Name and Position
(Print)

Signature

By executing this Deed of Amendment the signatory warrants that the signatory is duly authorised to execute this Deed of Amendment on behalf of the Organisation.

in the presence of:

Name of Witness
(Print)

Signature of Witness

AMENDMENT SUMMARY SHEET

The Grant Agreement has been varied in accordance with the clause headed **Agreement Amendments** of the Grant Agreement on the following dates relating to:

Amendment #	Date	Very Brief Summary of amendment	Increase/ Decrease in financial limit	Adjusted Financial Limit
1	14/02/2014	**Reduction in tranche 2 amount, with the remainder to be paid in the new financial year (August 2014)**	**Nil**	**AUD 10,000,0000**