**UNITED NATIONS DEVELOPMENT PROGRAMME**

**PROJECT DOCUMENT**

**Project Title**: Multi-country Western Pacific (MWP) Integrated HIV/TB Program

**Project Number:** 00116043

**Implementing Partners:** UNDP

**Start Date:** 01 January 2018 **End Date:** 31 December 2020

**PAC Meeting date:** 18 December 2018

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| **Brief Description** |
| The development challenge that the Western Pacific Integrated HIV/TB Program seeks to address is to support national and regional efforts to scale up and improve effective Human Immuno-Deficiency Virus (HIV) and Tuberculosis (TB) prevention, treatment and care services in 11 Pacific Islands with special attention to key and other vulnerable populations. This Project document is aligned with the grant submission and documents elaborated with all relevant national stakeholders and approved upon by the Global Fund Approval Committee.  |

Contributing Outcome (UNDAF/CPD, RPD or GPD):

**UNPS 2018-2020**

**Outcome 4: Equitable Basic Services**

By 2022, more people in the Pacific, particularly the most vulnerable, have increased equitable access to and utilization of inclusive, resilient, and quality basic services.

**Output**

1. Comprehensive prevention programmes for MSM, TG and SW (GEN 2)
2. Treatment, care and support for PLHIV (GEN 0)
3. TB care and prevention programme (GEN 0)
4. MDR-TB case detection and treatment (GEN 0)

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| --- | --- |
| **Total resources required:** |  |
| **Total resources allocated:** |  |
| **UNDP TRAC:** |  |
| **Donor:** | US$ 11,368,713 |
| **Government:** |  |
| **In-Kind:** |  |
| **Unfunded:** |  |

Agreed by (signatures)[[1]](#footnote-1):

|  |  |  |
| --- | --- | --- |
| Government | UNDP | Implementing Partner |
| Print Name: | Print Name: | Print Name: |
| Date:  | Date:  | Date: |

# Development Challenge (1/4 page – 2 pages recommended)

**Human Immunodeficiency Virus (HIV)**

HIV prevalencein the 11 Pacific Island Countries (Cook Islands, Federated States of Micronesia, Kiribati, Nauru, Niue, Marshall Islands, Palau, Samoa, Tonga, Tuvalu and Vanuatu) continues to be low with estimated prevalence amongst in the Western Pacific estimated at 0.1%[[2]](#footnote-2). The cumulative number of persons ever diagnosed, with HIV up until November 2017 in the 11 MWP supported countries is 234. [[3]](#footnote-3)

| Cumulative number ever diagnosed with HIV as Nov 2017 |  | PLHIV alive as at Nov 2017 | PLHIV on ART as at Nov 2017 |
| --- | --- | --- | --- |
|  |
| Country | Year first reported HIV case | Male | Female | Unknown | Total |  | Total | Total |
| Cook Islands | 1997 | 3 | 1 | 0 | 4 |  | 0 | 0 |
| FSM | 1989 | 30 | 20 |  | 50 |  | 12 | 5 |
| Kiribati | 1991 | 35 | 26 | 0 | 61 |  | 12 | 8 |
| Marshall Islands | 1984 | 14 | 13 | 5 | 32 |  | 7 | 7 |
| Nauru | 2013 | 4 | 0 | 0 | 4 |  | 0 | NA |
| Niue | N/A | 0 | 0 | 0 | 0 |  | 0 | NA |
| Palau | 1993 | 9 | 4 | 0 | 13 |  | 5 | 3 |
| Samoa | 1990 | 18 | 6 | 0 | 24 |  | 9 | 9 |
| Tonga | 1987 | 12 | 7 | 1 | 20 |  | 4 | 2 |
| Tuvalu | 1995 | 9 | 3 | 2 | 14 |  | 9 | 0 |
| Vanuatu | 2002 | 5 | 5 | 2 | 12 |  | 7 | 6 |
| **TOTAL** |  | **132** | **85** | **10** | **234** |  | **65** | **40** |
|   |   |   |   |   |   |   |   |   |

However, the above data needs to be interpreted with caution, as they are mainly based on testing among pregnant women and at voluntary confidential counselling and testing (VCCT) centres. All 11 countries now have the capacity to conduct in-country confirmatory tests and HIV testing has increased markedly. Most countries have adopted protocols for testing all pregnant women attending antenatal care (ANC) services. The coverage of pregnant women who were tested for HIV in the 11 MWP countries in 2016 was 15,029 of 20,222 ANC attendees i.e. 74%.

**Development Problem/Challenge** Despite the low rates and numbers, HIV vulnerability is still high due to factors such as widespread migration and mobility, dense sexual networks, a large caseload of untreated STIs, low knowledge about HIV and STIs, high levels of transactional sex and significant levels of intimate partner violence. Furthermore, there has been very little testing amongst the most vulnerable populations such as sex workers and their clients, men who have sex with men and transgender persons. Hence, it is likely that majority of HIV cases has not yet been identified and that the actual number is much higher that what is currently being reported. The second challenge is maintaining PLHIV on ART. Though the 11 supported MWP countries has a small number of confirmed HIV positive cases, only 62% are enrolled in treatment as of November 2017[[4]](#footnote-4).

**Supporting Evidence**

1. UNSW IBBS study on key populations conducted in 2015-2016, showed that the reach of HIV prevention programmes during this period to the three most vulnerable groups including female sex workers, men who have sex with men and transgender people were all below 1% in 9 of the 11 MWP supported countries (Nauru and Niue excluded). Similarly testing of all three groups for HIV was also below 1%.
2. The IBBS study also revealed high risks behaviours such as multiple sexual partners and unprotected sex. Forced sex amongst MSMs and TGs ranged from 7% in Palau to 47% in FSM.
3. The prevalence of STIs, particularly chlamydia, in PICT is among the highest in the world. Nearly 1 in 5 pregnant women, traditionally a low-risk population of women who are largely representative of the general population, were found to be infected with chlamydia, indicating a high prevalence of risk-taking behaviours and low use of condoms. Antenatal clinic data from several PICT in 2004-2005 found an overall prevalence of chlamydia of 18.0%, with prevalence highest among pregnant women aged 25 years and below (26.1%). Studies in the region support these findings, with positivity rates for chlamydia amongst pregnant women as high as 29.7% in Samoa and 22.4% Vanuatu.

**Causes of the Development Problem**

1. **Key human rights barriers and gender inequalities impeding access to HIV services**

While the HIV vulnerability of key populations (MSM, Transgender, Sex workers and their clients) is associated with specific risk behaviours, including unsafe sex with multiple partners, their vulnerability is often closely linked to underlying social, economic and psychological factors, which may also hamper their access to health and social services, including HIV-prevention and treatment services. Several factors contribute to disproportionately low access to prevention and treatment services for key and other vulnerable populations. The main reasons are:

* + The lack of specific services and interventions that are tailored to their needs and characteristics.
	+ The non-conducive social, cultural and legal environments hampering access to HIV-prevention and other health services for key populations. The nature of most PICTs with small to very small populations – e.g. Niue (1,600), Nauru (10,500), Tuvalu (10,800), Cook Islands (15,200) and Palau (17,800) – with most people living on small islands or in small communities, comes with very strong social control and limited possibilities to avoid societal expectations regarding traditional male and female gender roles.
	+ In addition, due to the small population sizes and the vast distances between islands in most of the 11 PICTs in this project, the availability of services is limited, and physical access to prevention and treatment services may be difficult, particularly among rural populations and on outer islands.
1. **Socio-cultural determinants of sexual health that contribute to high STI rates in PICTs include**
2. The predominantly young median age in the region (21 years in Melanesia, 23.1 years in Polynesia, and 23.4 years in Micronesia)
3. Low rate of condom use
4. Significant levels of gender inequality and gender-based violence, which may contribute to the spread of HIV and STI. Compounding these issues are the programmatic and logistical barriers to STI control in PICT, including the vast geographical spread of islands, limited health care budgets of governments, inconsistent and expensive supply of medical and testing equipment and lack of adequate laboratory facilities (MOH Vanuatu, 2007).
5. **Health System Constraints**

A recent mapping of health systems in selected Pacific countries found that the health system capacity is inadequate in most countries and health systems face many challenges.

These challenges include:

* Challenging geography and in some cases an inability to effectively absorb and utilise health funding;
* Complex health systems;
* Limited infrastructure;
* Lack of equipment and commodities, including in laboratory systems;
* Ineffective administration of the workforce (including pay);
* Shortages and inadequate distribution of skilled health-care staff; poor technical skills and the need to improve staff competency and performance; poor coordination between health stakeholders;
* Sub-optimal health information systems, with poor reporting and information management;
* Weak procurement and supply management systems.

The impact of these challenges includes:

• Varying levels of service quality, including in the field of HIV, TB and SRH;

• Staff burnout;

• Competition between services;

• The limiting of services to specific times (days of the week or hours during the day);

• Lack of confidentiality.

While the public health sector is the largest, there is an increasing private sector. Public health care is free or at very low cost for all persons in the 11 countries, and modest user fees are charged for some basic and selected services.

In terms of infrastructure, many buildings were built long ago, and upgrading has been inconsistent. Key medical and laboratory equipment is only available in capital cities, which seriously hampers service delivery in outer islands and rural areas.

In many PICTs there has been pressure to downsize the workforce to reduce costs, while at the same time the population and demand for services is growing. Insufficient numbers of health professionals, including specialists, worsened by emigration.

Ensuring availability and accessibility of sufficient accurate, timely and relevant health information to inform planning, policy development and monitoring of health sector performance is crucial for quality service delivery.

Government funding and support of HIV and TB programs is significantly constrained in many Pacific Island countries. This is due in part to the limitations on small economies for increasing spending on health and the high burden of NCDs.

1. **Community systems in the Western Pacific and constraints**

Community systems comprise traditional community structures, community-based organisations (CBOs), faith-based organisations (FBOs) and other civil society (non-governmental) organisations (CSOs). Traditional structures at the community level play an important role in most PICT countries. The influence of community leaders can be both an opportunity and a challenge. Traditional norms and values may hamper effective service delivery in the HIV and SRH field, especially for key populations such as sex workers, MSM and transgender people, who often face stigma and discrimination from society. However, community systems and leaders can be successfully involved in community-based programmes and initiatives to implement HIV/STI programmes and services. NGOs/civil society participation in general health services have been weak in the PICs.

Civil society organisations (CSOs) exist in all PICT, and some have been actively involved in HIV and SRH programmes. In 2017, the PR sub-contracted 9 CSOs working on HIV throughout the region as part of its efforts to improve prevention, treatment and care interventions to key populations. While the CSOs were expected to perform this function, they faced a range of capacity constraints and challenges including institutional and organisational capacity in terms of human resources development (limited staffing, weak technical capacity, low salaries), financial and programme management limitations, weak M&E systems and dependence on short-term, donor-funded projects, which hampers the implementation of their own activities in line with their mandates and mission and hampers continuity of services, which makes it difficult to build long-term, stable relationships with communities and individuals to whom they offer services.

**Relevance to Global Development Priorities**

**2016 – 2020 WHO Global Health Sector Strategies on HIV and STIs respectively**

In August 2016, the World Health Organization (WHO) disseminated the new WHO consolidated recommendations on ART, STI and HTS. ‘Test and treat’ is a major strategy and approach to be used as these guidelines are being adapted. In adapting this strategy and operationalization of these guidelines, the programme would be increasing the supply of rapid diagnostic tests to countries and would be engaging and training service providers on testing and treatment strategies, peer to peer education and counselling, stigma and discrimination and PSM capacity building. This strategy is envisioned to increase testing amongst communities and vulnerable groups.

**2017 – 2022 Global Fund Strategy**

1. **Objectives 2: Build Resilient and Sustainable Systems for Health**

As the adapted WHO Health Sector Strategies on HIV, STI and Hepatitis, treatment guidelines and recommendations are being rolled out in countries, the global UNAIDS (90-90-90) treatment targets which are linked to the SDGs, requires the strengthening of civil society networks and community systems. This includes technical support to strengthen community based routine surveillance systems that will contribute to national planning and programming. This approach is key as the engagement of communities will improve the programs reach to remote areas, to the most vulnerable populations and to overcome stigma and discrimination and other human rights abuses through their advocacy programs.

Moreover, part of the programmes regional M&E plan for 2018-2020 includes the review of national, and to the extent possible sub national level data management processes to identify gaps, inefficiencies and support systems strengthening. This is also key given that in majority of the PICs, there is an absence of proper systems and tools to capture information and data relating to key populations. Regional aggregation of reach is therefore very difficult due to the absence of a standard recording and reporting tools.

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| [UNAIDS 90-90-90: An ambitious treatment target to help end the AIDS epidemic](http://www.unaids.org/en/resources/documents/2017/90-90-90) *’90-90-90’ remains key strategy for ending AIDS by 2030. This equates to 90 % of PLHIV know their HIV status; 90% of PLHIV in are on ART; and 90% of PLHIV on ART are virally suppressed.*[WHO Global Health Sector Strategies on Sexually Transmitted Infections, 2016-2021](http://www.who.int/reproductivehealth/publications/rtis/ghss-stis/en/)*Reaching 70% of Key Affected Populations with a full range of STI & HIV services including condoms by 2020. (programme is targeting half the global target due to very low baselines)* |

1. **Objective 3: Promote and Protect Human Rights and Gender Equality**

Social discrimination is connected to HIV risk, vulnerability, and access to care and prevention. FSWs, TGs and MSMs often face stigma, discrimination, violation of human rights, sexual violence, homophobia, and heterosexism. There is a need to strengthen involvement of and strengthen organizations working with key affected populations. This includes strengthening capacity of the Pacific Sexual Diversity Network (PSDN) at the regional level to serve as mentors and trainers to individual country CSO or support groups. They will then be supported to expand capacity and strengthen national CSOs. PSDN is required to have human rights as their core function and will be working with regional technical partners to address legislative and social barriers to service access by vulnerable groups.

**Tuberculosis (TB)**

**Development Problem/Challenge:** Although the burden of TB in Pacific Island Countries and Territories (PICTs) is relatively small, in some of the PICTs, e.g. Kiribati, Marshall Islands, the Federated States of Micronesia and Solomon Islands, the case-notification rate is even higherthan the average notification rate of 75 per 100 000 population in the Western Pacific Region.[[5]](#footnote-5) In addition TB mortality is also high with death causes being linked to late diagnosis and co-morbidities like diabetes.

**Supporting Evidence**

1. In 2016, incidence rate across the 11 MWP supported PICTs was 112 per 100,000 population with total notified cases being 1019. The incidence rate per country were: HighTB incidence countries including Kiribati (469), Republic of Marshall Islands (327), Tuvalu (198), Federated States of Micronesia (141) and Palau (129). Medium TB incidence countries including Nauru (93) and Vanuatu (35). Low TB incidence countries including Cook Islands (13), Tonga (9), Samoa (7) and Niue (0).
2. Mortality rate in the 11 PICs remains high with 17 per 100,000 population.[[6]](#footnote-6)

**Causes of the Development Problem**

1. **Late case finding due to access/lack of awareness and diagnostic errors are possible causes of high TB mortality.**

While all high TB incidence countries are adopting Gene Xpert for testing all TB presumptive patients for improved microbiologic diagnosis and screening for rifampicin resistance (RR) as a surrogate marker for MDR-TB, not all countries have done so. Given the logistical issues with laboratory support to diagnosis of MDR-TB through traditional culture methods as well as the high burden of diabetes in the region (a condition associated with increased rates of smear negative TB), there is a need for countries to develop assessments regarding the use of WHO recommendations for Gene Xpert as the initial diagnostic test for all patients presenting with TB symptoms and, based on that assessment, move toward such adoption. It is recommended that all 11 Pacific Islands Countries develop an assessment and plan for the adoption of Gene Xpert as a first line diagnostic test (where appropriate, subject to financial considerations). Systems for specimen transportation and results transmission should be included in the analysis and plans.

1. **Human resource capacity**

The geographic isolation of the island states coupled with variable TB incidence. It is essential that all 11 Pacific Islands Countries develop a strategy to support human resource capacity for TB management and training using technologies such as internet-based linking, Project Echo for human capacity building, traditional telemedicine, social networking and/or eHealth. This strategy should be aligned and implemented with the same proposed by the HIV program for cost efficiency as well as improved service integration.

1. **Community systems in the Western Pacific and constraints**

Community and civil society are not involved enough in-service delivery in remote areas and among vulnerable populations. Involvement of community and civil society in awareness activities for early detection and adherence to treatment is likely to bring down any costs incurred in accessing services for diagnosis and treatment. This is line with the desired End TB Strategy target to have 0% of TB affected families facing catastrophic costs due to TB. PICs however have not conducted any assessment of direct or indirect costs to the TB patient and families hence it will be challenging to measure and achieve this target.

1. **Health System Constraints**

Same constraints listed under HIV above

1. **Key human rights barriers and gender inequalities impeding access to HIV services**

Among those population sub-groups identified with human right barriers to accessing TB services in the 11 PICs include prisoners, migrants, and PLHIV. Violation of confidentiality among PLHIV limiting access to TB services was a perceived challenge identified by few countries. Discrimination by the community often limited the access for TB services among TB patients within the PIC countries. While health seeking behaviour among women within the PICs was considered better than those among men, there is only anecdotal evidence that suggested men accessed health services lesser than women due to cultural and behavioural practices.

**Alignment to Development Priorities**

* The National TB Programmes will focus on achieving impact targets as recommended in the End TB strategy which is to reduce the 2015 TB death rates by at least 35% by 2020.
* Achieve a 90% treatment success rate by 2020 as per the End TB Strategy

# Strategy (1/2 page - 3 pages recommended)

In line with the UNPS outcomes and national priority concerns, this project primarily serves to strengthen the national capacity within the participating countries for improved and equitable service delivery for TB and HIV in the 11 countries concerned.

**Development Process:** The overall strategy adopted by this project to address HIV and TB in the region is focussed on key priorities identified through a rigorous and participatory process involving all key stakeholders including the Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM), whose members are representatives of the participating governments and civil societies groups from the 11 MWP supported countries. Technical guidance and support was also provided by the Regional Technical Working Group consisting of UNAIDS, WHO, UNDP (including country-based officers) and SPC.

**Strategic Approach**: The overall strategy adopted by this project takes a human right based approach dedicated to populations at most risk of infection and builds capacity of national entities.

For HIV, the programmes direction is largely influenced by the Global Funds approach in fast tracking the achievement of the Sustainable Development Goals and the UNAIDS Fast-Track targets which involves placing key affected populations (KAP) including sex workers, transgender persons and men who have sex with men, at the heart of the HIV response. The 2016 UNDP commissioned UNSW IBBS study on HIV and STI risk vulnerability among key populations was conducted to establish the population size estimates for these key groups. This was carried out for nine out of the eleven supported MWP countries and was basically the first time for many of these countries to have key pieces of evidence on which to base their HIV prevention programmes. In addition, the focus on providing proper care, treatment and support services to those living with HIV remains.

For TB, the approach is aligned with the Global End TB Strategy endorsed at the World Health Assembly in May 2014. The desired outcome of these strategy is to end the TB epidemic in the region, by promoting universal and equitable access to quality diagnosis and appropriate treatment of TB, drug-resistant TB, tuberculosis/diabetes mellitus (DM) and TB/HIV patients.

**Alignment to Development Results:** The programmes targets / desired results were aligned to the following global TB/HIV strategies

• WHO End TB Strategy

• UNAIDS 90-90-90: An ambitious treatment target to help end the AIDS epidemic

• WHO Global Health Sector Strategy on HIV 2016-2021

• WHO Global Health Sector Strategies on Sexually Transmitted Infections 2016- 2020

Under the United Nations Development Pacific Strategy (UNPS) 2018-22, the programme contributes to Outcome Area 4 - Equitable Basic Services: By 2022, more people in the Pacific, particularly the most vulnerable, have increased equitable access to and utilization of inclusive, resilient, and quality basic services.

**Integrating Gender**: Gender will be mainstreamed through the programmes social mobilization and advocacy interventions which includes working with communities, the media, health care providers, faith-based leaders, community leaders and LGBT groups to address GBV related issues and to advocate on breaking the barriers that promote ignorance, stigma and discrimination towards female sex workers and non-traditional gender identities including MSMs and TGs.

The proposed approach translates into five key programme deliverables including the

1. Provision of comprehensive prevention programmes for MSM, TG and SW for 9 of the 11 supported MWP PICTs (Niue and Nauru excluded)
2. Provision of treatment, care and support services for PLHIV
3. Provision of TB care and prevention programmes
4. Provision of MDR-TB consumables and commodities
5. Regional technical support from UNDP, PSDN, ASHM and OSSHHM, and the regional technical working group that is focussed on upskilling health care workers to improve service delivery and on the development of guidelines for reaching key populations.

**Key Results:** Through the interventions highlighted above, the following results are expected

1. **Results for civil society (inclusive of vulnerable and marginalized groups)**
* Increase in the uptake of key populations (MSM, TGs and FSWs) accessing HIVSTI prevention and testing services
* Improved awareness of the needs and issues important to key populations
* Increase in the number of PLHIV that are aware of their HIV status
* Increase in the number of KAP reporting condom use during last sex or with most recent client
* Improved capacity of civil society organizations representing marginalized communities including LGBTQI organizations and Women’s Councils. This includes the capacity to advocate for inclusive practices and to deliver program interventions that address drivers of HIV risk vulnerability including gender-based violence and stigma and discrimination.
* Strengthened community based routine surveillance systems that will inform national planning and programming
* Contextualized guidelines on HIV/STI prevention services for key populations will be available to support outreach programs by CSOs.
* Early identification of confirmed TB cases and less TB related deaths in communities
* TB patients receive quality care, support and treatment services
1. **Key results for government**
* HCW capacity strengthened to improve service delivery. This includes capacity building in HIV and TB prevention, treatment, care & support; stigma and confidentiality and grant management (including areas in PSM, M&E, Finance etc)
* National HIV strategic plans are inclusive of key populations
* HIV and TB National programmes have the resources (commodities, consumables) to support service delivery

**Assumptions:**

* According to the 2016 UNSW study, the UN categories (MSM, TG and FSW) do not easily translate into the realities of Pacific countries and networks due to the size and hidden nature of these key populations. Thus, the limitation of the study was the lumping together of the TG and MSM population tallying 27, 853. The assumption made is that two thirds of total size estimates is TG (18,569) and one third MSM (9,284). MSMs in the pacific are more hidden relative to TGs, thus size estimates and targets were set relatively lower.
* CSOs would gain sufficient capacity during the first year of program implementation to effectively reach the hidden populations most vulnerable to HIV including MSMs and FSW
* Prevention and awareness raising efforts by CSOs will be effective enough to persuade KAP to get tested and know their HIV status
* CSOs will effectively roll out the HIV prevention and testing register that collects data for most of the programme indicators relating to KAP
* PSDN will gain the sufficient capacity to provide TA support to national CSOs especially around human rights
* Health workers would have gained sufficient capacity through the TA support by OSSHHM to provide proper PLHIV patient management, care and support
* Stigma and discrimination against KAP would gradually decrease through increased advocacy and lobbying efforts by implementing partners
* National HIV programmes and policy makers receptive to the integration of key populations into national strategic plans and frameworks

**Wider Benefits**

* More accurate picture of the HIV epidemic in the pacific (i.e. HIV prevalence)
* Improvement in TB treatment outcomes would reduce TB related deaths (TB mortality rates) and improve overall health status

**Enabling Factors**

* Support from the regional technical working group including WHO, SPC, UNAIDS, FNU and UNICEF.
* Advisory support and program oversight by the governing body – The Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM)

**Risk Factors / Constraints**

* HIV criminalization bills existent in some countries such as Palau
* Absence of HIV laws & policies in majority of the MWP supported PICs
* Breach of patient confidentiality issues by HCW
* Stock expiry of TB/HIV medicines

**HIV Program Logic Model**

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**TB Program Logic Model**

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# Results and Partnerships

**Expected Results**

The programme will deliver on five main outputs (i.e. immediate results of the programme’s interventions)

**Output 1: Comprehensive Prevention Programmes for Key Affected Populations (FSW, MSM and TGs)**

* The minimum package of services includes the following 3 components
1. Behavioural change communication
2. Provision of consumables including condom and lubricants
3. Referral to other services such as STI diagnosis and treatment, testing and counselling etc

Civil society plays a critical role in HIV and AIDS advocacy and service delivery. Without civil society, fewer services would be available to key populations, people in remote areas would have to travel further for services and many of the gains made in treatment because of civil society advocacy would not exist. To deliver on this key result area, increased technical and financial support will be provided to community-based organisations to support HIV outreach and condom distribution activities. Technical support also includes strengthening advocacy capacity to address issues around stigma and discrimination and Gender based violence which are all connected to HIV risk, vulnerability, and the lack of access by to care and prevention. The program will also be procuring rapid diagnostic tests, diagnostic cartridges and lab consumables to support and increase rapid testing of STI and HIV in communities. The intended outcome of the above interventions is that civil society groups are equipped with the knowledge and resources to reach key populations with proper prevention programmes (including condoms) and that rapid tests are also available to facilitate rapid testing amongst these vulnerable groups so that they are aware of their HIV status and can reduce sexual risks behaviours.

**Output 2: Treatment, Care and Support for PLHIV**

Adherence is a major requirement for successful outcome of the HIV and AIDs care and treatment services. To ensure effective and efficient delivery of these services, the program will provide PLHIV regional treatment adherence support programs that will be led by the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) with support from the Oceania Society for Sexual Health and HIV Medicine (OSSHHM). The support entails capacity building of health care workers in the delivery of sexual health services with a focus on HIV, STIs, HIV/TB coinfections amongst key populations. In addition, the programme will support the procurement of ARV, lab reagents for CD4 monitoring and opportunistic infections treatment medicines. Intended outcome of such support is that the people living with HIV have access to proper care, support and treatment services and that the regional percentage of total PLHIV on treatment increases.

**Output 3: TB Care and Prevention Programmes**

Community outreach is a key activity under this thematic area. To support this, HCW will be trained in contact tracing, active case finding, lab refresher and stigma and discrimination. The programme will also support the procurement of TB medicines, cartridges and commodities.

In addition, national health programs would be supported to strengthen routine recording and reporting processes. This includes supporting data collection and reporting from other care providers and to facilitate timely submissions of reports from community clinics to the national TB programme.

**Output 4: MDR-TB**

This activity focusses on the procurement of MDR treatment drugs and commodities to support the treatment of the RR and/or MDR TB cases.

**Output 5: Regional Support**

Regional support earmarked for the 3-year grant period includes support to the development of guidelines for reaching key populations, support to health care workers in strengthening human rights interventions. This is intended to strengthen government and CSO capacity to deliver effective targeted prevention programmes (Output 1). The second regional TA is targeted at upskilling healthcare workers on ARV treatment adherence, PSM, M&E, a refresher training for TB clinicians, and other HIV/TB technical areas. This will contribute to outcome 2 and improve grant management capacity.

**Resources Required to Achieve the Expected Results**

Refer to [Section VII – Multi Year Workplan](#_Multi-Year_Work_Plan) for breakdown of resources required per activity line.

***Partnerships***

**Civil Society Organizations** – Responsible for reaching key affected populations with HIV prevention programmes (Output 1). For TB, civil society will support service delivery to remote areas and to vulnerable populations. (Output 3)

**Ministries of Health** – Responsible for reaching general and key populations with HIV prevention programmes as well These are especially true for countries that do not have CSOs to conduct prevention activities such as Palau and Marshall Islands. However, priority is the provision of proper HIV care, support and treatment adherence programs to people living with HIV (Output 1 and Output 2). Similarly, with TB, national TB programmes would be providing both prevention and treatment support to TB patients (Output 2 and 3)

**Regional Technical Working Group** – Includes regional partners such as WHO and UNAIDS who are responsible for providing regional technical advice to national implementing partners and to the PR (UNDP). Specific deliverables for the next 3 years include:

* Review of national HIV NSPs and supporting the integration of KAP into these HIV plans and frameworks
* Supporting the finalization and endorsement of newly updated HIV/STI and TB guidelines
* Develop the guidelines for key populations accessing HIV/STI prevention services
* Assessment of HIV testing in 11 PICTs (Output 1 and 3)
* TB regional capacity building support including refresher training for clinicians
* Development of country specific TB tests algorithm

**ASHM/OSSHHM** – Capacity building of HCW in the delivery of health services with a focus on ARV treatment adherence and stigma and confidentiality training. (Output 2 and 3)

**PSGDN** - Serve as mentors and trainers to individual country CSO. PSDN is required to have human rights as their core function and will be working with regional technical partners to address legislative and social barriers to service access by key populations. (Output 2 and 3)

**Risks and Assumptions**

Programme risks and assumptions are detailed in the [Strategy](#_Strategy_(1/2_page) section of this project document and in the [Annex](#_ANNEXES) – Risk Log

**Target Group Engagement**

**MSMs, TGs and FSW:** MSMs and the FSW groups are considered as hidden and hard to reach groups in the pacific. Programme strategy to identify and reach these hidden groups involves financial allocation towards CSOs for Human Rights interventions; financial allocation towards PSDN to mentor and guide advocacy efforts by CSOs and to work with regional technical agencies to address legislative barriers to service access.

**PLHIV:** One of the main barriers to accessing health services and maintaining these PLHIV on treatment as identified in the 2017 Stigma Index Report by FJN+ is personal stigma and stigma by HCW. Programme strategies to address this includes training and mentoring HCW by ASHM and OSSHHM to better manage those living with HIV.

For TB, this involves inclusion of communities and civil society in service delivery in remote areas and among vulnerable populations especially for awareness and early case detection activities

**South-South and Triangular Cooperation (SSC/TrC)**

The programme will use its regional programme activities as a platform to facilitate south-south learning. Spaces will be created for countries to share implementation experiences with sessions being moderated by either UNDP and/or regional technical partners. The sharing of success strategies from countries displaying good reach in their coverage of key populations will be prioritised. Experiences from regional implementing agencies such as ASHM, OSSHHM and PSDN is also key in identifying commonalities across PICTs with regards to the challenges and successes in reaching key populations and maintaining HIV positives on treatment.

**Knowledge**

The program anticipates having several information products highlighting the programs progress and achievements. These are detailed in Table 1. The programme will create visibility through preparing press releases about its public events and inviting local media. Information about the activities and achievements of the programme will be regularly updated on the programmes facebook page.

| **Table 1**: Programme Information Products  |  |
| --- | --- |
| Product | Description and/or Use | Submit to and/or display for |
| Programme Newsletter | Using MailChimp email tool, monthly update of progress and achievements by PR for grant supported interventions | * All key stakeholders
* UNDP Yammer
* Social media
 |
| Programme Brief/ Factsheet | Regularly updated programme brief, capturing key results | * UNDP Yammer
* Social media
* UNDP website
* Regional MWP Workshops
 |
| Results Infographic | Visual presentation of key results  | * UNDP Yammer
* Social media
* UNDP website
* Regional MWP Workshops
 |
| Facebook, Twitter | Regular, short updates on program progress, featuring photos, video and links to other related materials. Engage with partners and community. Accomplished via a program Facebook page as well as cross-posting on other UNDP country office and regional office pages and Twitter accounts. |  |
| Press releases, news articles, results stories, photo essays, videos | Program progress and results are presented in the form of press releases, news articles, results stories, photo essays, videos, etc. and published to the UNDP website (country office, regional, global) and other corporate platforms (for example: UNDP Stories, YouTube, Twitter, Medium, Flickr).  | * UNDP website
* UNDP Yammer
* Social media
* MailChimp (in the form of News Flash emails that highlight key developments)
 |
| Knowledge products | As per the program work plan, knowledge products are developed by the PR and SR and disseminated to target audiences. Types of products can include discussion papers, research reports, policy briefs, annual reports, etc. | * UNDP Yammer
* Social media
* UNDP website
* Regional MWP Workshops
 |

**Sustainability and Scaling Up**

Sustaining the HIV/TB response includes strengthening the technical and grant management capacities of local health care workers for both government and civil society organizations through training and mentoring programmes. This local knowledge and skill will remain beyond the lifetime of the grant. In addition, supporting the development of the national health information systems to improve recording and reporting processes amongst KAP and integrating key populations into the national HIV National Strategic Plans to foster national ownership of a focussed response to HIV programming.

# Project Management

***Cost Efficiency and Effectiveness***

Cost efficiency and effectiveness in the programme management will be achieved through adherence to the UNDP Programme and Operations Policies and Procedures (POPP) and reviewed regularly through the governance mechanism as well as annually by the project Board (PIRM CCM).

The strategy of this programme is to deliver maximum results with the available resources through ensuring the design is based on good practices and lessons learned, that activities are specific and clearly linked to the expected outputs, and that there is a sound results management and monitoring framework in place with indicators linked to the Theory of Change. The programme aims to balance cost efficient implementation and best value for money with quality delivery and effectiveness of activities. For its capacity building activities, the programme will utilise outside experts as well as in-house experts from within UNDP and UN sister organisations, and in-kind contributions from stakeholders.

The project has a very wide geographic spread and reduced resources compared to previous allocations. It is crucial therefore that strategies are adopted to ensure maximum results. There are five key strategies that are designed to assure cost effectiveness and efficiency. These are:

1. The project builds on global knowledge UNDP acquired through partnership with the Global Fund since 2003. Programmatic and operational guidelines are available to staff and ease implementation. UNDP Global Fund and Health Implementation Team based in New York, Geneva and Copenhagen provide guidance and advisory services on complex implementation issues as well as on health-related procurement
2. The project will make use of global procurement unit (GPU) based in Copenhagen for procurement of health products. GPU organises bulk procurement of goods which allows significant reduction of prices and economies of scale. The goods will be delivered to the MoH/UNDP warehouse in Fiji from which they will be distributed to other countries. Sound product use and forecasting strategies will be used to avoid health products and medicines expiry and wastage.
3. The project will make use of modern technology and support the use of tele-medicine activities whereby mentorship and coaching to the health staff will be provided through online media saving on cost of travel. Online courses and platforms will be used for sharing knowledge among countries.
4. In communicating results, UNDP will use Facebook, Twitter, electronic newsletters, email dissemination, annual reports and other electronic tools saving on production and paper while ensuring wider reach.
5. The project will utilise standardised programmatic and financial reporting and recording forms. This will ensure comparability of data and equal approach to all implementers.

***Project Management and Governance***

The project will be based in the UNDP Pacific Office in Fiji and implemented through the PMU set up for this purpose. The project will benefit from the institutional structure of the UNDP office as well as UNDP financial, operations, and procurement systems. The project will work closely in collaboration with WHO, UNAIDS, UNFPA and other partners and donors in the region to ensure complementarity and to avoid duplication of efforts. UNDP is directly implementing the action in partnership with 22 sub-recipients from 11 countries.

The geographical spread and complexity of this programme requires sizable team. UNDP has established a Programme Management Unit (PMU) to manage the operations of the Global Fund grants, provide general guidance on GF policies and procedures and ensure the responsibility for procurement of the health products and other commodities under this grant are met. The core PMU is based in Suva, Fiji, the Pacific hub. In addition, there are 2 out-posted positions. 1 in Vanuatu, given the size and complexity of the programme and 1 Samoa to cover Samoa, Niue, and Cook Islands.

The PMU presented in the organogram below comprises both internationally and locally recruited personnel that assist the Programme Manager (P4 International) with the delivery of project activities. The Project Manager coordinates with all the partners and ensures that project activities are efficiently and effectively carried out. She also oversees the implementation of all Global Fund grants in addition to providing support to the implementation of the Capacity Development Plan. Furthermore, the Project Manager ensures facilitation of knowledge building and sharing within the PMU as well as partnership strengthening and coordination.

The Pacific Centre’s regional adviser on HIV, Health and Development (P4) advises the programme on a part time basis (40%).

Reporting to the Global Fund Project Manager the following posts are in the UNDP PMU structure (see organogram hereafter):

**Suva, Fiji based staff**

* **Programme Manager - Suva Fiji (P4 International)**
* Responsible for the implementation of the Multi-Country Programmes
* Responsible for the day-to-day management of the Multi-Country Programmes,
* Establish and maintains strategic partnerships and supports the resource mobilization in cooperation with the Management Support and Business Development Team
* Ensure knowledge and capacity building, focusing on the achievement of the following results:
* **Programme Analysts (2) – Suva Fiji (SB4)**
* Support assigned portfolio of sub-recipients in several countries
* Focus on ensuring timely delivery of programme results and supporting sub-recipients in strategic planning, developing work plans and budgets, forecasting, reprogramming, innovations, communications, advocacy and capacity building.
* Monitor results and takes decisions on realignment of activities
* Liaise with ministries of health and other counterparts regarding the implementation
* Analyse programmatic and financial results
* **M&E Analyst – Suva Fiji (SB4)**
* Coordinates M&E activities within HIV/TB and Malaria Programmes
* Provides support to all sub-recipients in M&E area in eleven Programme Countries
* Collects, analyses and compiles programme reporting data.
* Drafts programmatic reports to the Global Fund.
* Contributes to the grant making process by developing programmatic targets, M&E plans and identifying gaps in national surveillance systems.
* Develops use-friendly reporting tools for sub-recipients.
* Contributes to enhancing national reporting systems in all programme countries.
* **Finance Specialist –Suva Fiji (IUNV)**
* Implements operational and financial management strategies
* Monitors and reports on management of GF Multi-Country Western Pacific programme budgets and functioning of the optimal cost-recovery system
* Controls of GF Multi-Country Western Pacific HIV, TB and malaria programme accounts
* Programme cash management and approves Funding Authorization and Certificate of Expenditures (FACE) Form for the SRs
* Facilitation of knowledge and capacity building of sub-recipients
* Acts as focal point for NIM audit
* **Procurement and Supply Chain Management Analyst –Suva Fiji (SB4)**
* Elaboration and implementation of operational strategies
* Efficient management of procurement and supply chain processes and oversight in line with GF/UNDP regulations
* Organization of procurement process
* Elaboration, introduction and implementation of sourcing strategy and e-procurement tools
* Development of procurement related reports and regular updates on the grants procurement process for the Global Fund, Global Fund LFA, UNDP Global Fund Programme Team, UNDP Procurement Support Office, UNDP Country Office, and others as required by UNDP management.
* Facilitation of knowledge and capacity building and knowledge sharing
* **Finance Associates (3) – Suva Fiji (SB3)**
* Support the implementation of operational and financial management strategies
* Provide support in budgeting and reporting function
* Sub-recipients report verification and forecast analysis
* Programme cash management and review/correct the submitted quarterly financial reports and Funding Authorization and Certificate of Expenditures (FACE) Form for the Sub Recipients (SRs)
* Handling payment process for the Multi-Country Western Pacific HIV, TB and malaria programmes
* Facilitation of knowledge and capacity building and knowledge sharing
* **Administrative and Finance Assistant (SB3)**
* Supports administration and implementation of programme/operations strategies
* Support to administration of budgets and functioning of the optimal cost-recovery system.
* Travel and visa support
* Organising regional events and trainings
* Leave monitor
* Learning focal point
* Facilitation of knowledge building and knowledge sharing

**Port Vila, Vanuatu Based staff**

* **Programme Analyst - Port Vila Vanuatu (SB4)**
* Supports assigned portfolio of sub-recipients in Vanuatu on all matters of programme implementation
* Focuses on ensuring timely delivery of programme results and supporting sub-recipients in strategic planning, developing work plans and budgets, forecasting, reprogramming, innovations, communications, advocacy and capacity building.
* Monitors activities and takes decisions on realignment if necessary
* Liaises with ministries of health and other counterparts regarding the implementation
* Analyses programmatic and financial results

**Apia, Samoa Based staff**

* **Programme Analyst –Apia Samoa (SB4)**
* Supports assigned portfolio of sub-recipients in Samoa, Cook Islands and Niue on all matters of programme implementation
* Focuses on ensuring timely delivery of programme results and supporting sub-recipients in strategic planning, developing work plans and budgets, forecasting, reprogramming, innovations, communications, advocacy and capacity building.
* Monitors activities and takes decisions on realignment if necessary
* Liaises with ministries of health and other counterparts regarding the implementation
* Analyses programmatic and financial result

Programme Management Unit Organigram for 2018 - 2020



# Results Framework[[7]](#footnote-7)

|  |
| --- |
| **Intended Outcome as stated in the UNDAF/Country [or Global/Regional] Programme Results and Resource Framework:** By 2022, more people in the Pacific, particularly the most vulnerable, have increased equitable access to and utilization of inclusive, resilient, and quality basic services. |
| **Outcome indicators as stated in the Country Programme [or Global/Regional] Results and Resources Framework, including baseline and targets:**HIV O-1: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (Baseline: TBD; Target: TBD)TB O-1a: Case notification rate of all forms of TB per 100,000 population - bacteriologically confirmed plus clinically diagnosed, new and relapse cases (Baseline: 101; Targets: 103 (2015)- 107 (2016)- 111(2017)TB O-1b: Case notification rate per 100,000 population- bacteriologically-confirmed TB, new and relapse (Baseline: 37; Targets: 39 (2015)- 42 (2016)- 46 (2017)TB O-2b: Treatment success rate - bacteriologically confirmed TB cases (Baseline: 85%; Targets: 86% (2015) – 88% (2016) – 90% (2016)TB O-4: Treatment success rate of MDR-TB: Percentage of bacteriologically confirmed drug resistant TB cases (RR-TB and/or MDR-TB) successfully treated (Baseline: 70%; targets: 72% (2015)- 74% (2016) – 75 (2017) |
| **Applicable Output(s) from the UNDP Strategic Plan: Accelerate structural transformations for sustainable development.** |
| **Project title:** Multi-Country Western Pacific**Atlas Project Number:** 00116043 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **EXPECTED OUTPUTS**  | **OUTPUT INDICATORS[[8]](#footnote-8)** | **DATA SOURCE** | **BASELINE** | TARGETS (by frequency of data collection) | DATA COLLECTION METHODS & RISKS |
| **Value** | **Year** | **Year1** | **Year2** | **Year3** | **Year4** | **Year…** | FINAL |
| **Output 1***Comprehensive prevention programmes for MSM, TG and SW* | ***1.1*** KP-1a(M): Percentage of men who have sex with men reached with HIV prevention programs - defined package of services | UNSW Pacific Multi-Country Mapping and Behavioural Study | 0.6% | 2016 | 7.2% | 11.1% | 17.1% | - | - | 17.1% | **Data Collection Methods**Reports and monitoring results will be provided from outreach activities.**Risks**Re-Testing of the same individuals and privacy must be respected for individuals who have not “officially” declared themselves as MSM to their community.  |
| ***1.2*** KP-3a(M): Percentage of men who have sex with men that have received an HIV test during the reporting period and know their results | UNSW Pacific Multi-Country Mapping and Behavioural Study | 0.2% | 2016 | 3.1% | 4.8% | 7.4% | - | - | 7.4% | **Data Collection Methods**Outreach reports will be verified against lab or on-site testing logs/registers**Risks**Re-Testing of the same individuals  |
| ***1.3*** KP-1b(M): Percentage of transgender people reached with HIV prevention programs - defined package of services | UNSW Pacific Multi-Country Mapping and Behavioural Study | 0.5% | 2016 | 7.2% | 11.1% | 17.2% | - | - | 17.2% | **Data Collection Methods**Reports and monitoring results will be provided from outreach activities.**Risks**Re-Testing of the same individuals and privacy must be respected for individuals who have not “officially” declared themselves as TG to their community. |
| ***1.4*** KP-3b(M): Percentage of transgender people that have received an HIV test during the reporting period and know their results | UNSW Pacific Multi-Country Mapping and Behavioural Study | 0.3% | 2016 | 5.4% | 8.2% | 12.7% | - | - | 12.7% | **Data Collection Methods**Outreach reports will be verified against lab or on-site testing logs/registers**Risks**Re-Testing of the same individuals |
| ***1.5*** KP-1c(M): Percentage of sex workers reached with HIV prevention programs - defined package of services | UNSW Pacific Multi-Country Mapping and Behavioural Study | 1% | 2016 | 7.2% | 11.1% | 17.2% | - | - | 17.2% | **Data Collection Methods**Reports and monitoring results will be provided from outreach activities.**Risks**Re-Testing of the same individuals and privacy must be respected for individuals who have not “officially” declared themselves as SW to their community. |
| ***1.6*** KP-3c(M): Percentage of sex workers that have received an HIV test during the reporting period and know their results | UNSW Pacific Multi-Country Mapping and Behavioural Study | 1% | 2016 | 6.9% | 10.6% | 16.3% | - | - | 16.3% | **Data Collection Methods**Outreach reports will be verified against lab or on-site testing logs/registers**Risks**Re-Testing of the same individuals |
| **Output 2***Treatment, Care and Support for PLHIV* | ***2.1*** TCS-1(M): Percentage of people living with HIV currently receiving antiretroviral therapy | Programme Records | 51% | 2016 | 79% | 84% | 90% | - | - | 90% | **Data Collection Methods**Reports received from the HIV focal point, dispensary/pharmacy reports verifying usage and total case load.**Risks**Lead time of ARVs drugs is currently 6 months so regular reporting should be provided by the HIV focal person so as not to face an out of stock situation. Regular CD4 monitoring must be conducted to verify that the current therapy is effective for the individual.  |
| **Output 3***TB care and prevention programme* | ***2.1*** TCP-1(M): Number of notified cases of all forms of TB- (i.e. bacteriologically confirmed + clinically diagnosed), includes new and relapse cases | R&R TB system, quarterly reports | 1,019 | 2016 | 1,253 | 1,254 | 1,266 | - | - | 1,266 | **Data Collection Methods**From SR reports which will be verified against the National TB register and National TB Lab register**Risks**Poor recording and data flow chain resulting in inaccurate data presented |
| ***2.2*** TCP-2(M): Treatment success rate- all forms: Percentage of TB cases, all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated (cured plus treatment completed) among all TB cases registered for treatment during a specified period, new and relapse cases | R&R TB system, quarterly reports | 84% | 2016 | 86% | 87% | 90% | - | - | 90% | **Data Collection Methods**From SR reports which will be verified against the National TB register and National TB Lab register**Risks**Poor recording and data flow chain resulting in inaccurate data presentedPoor patient adherence  |
| **Output 4***MDR-TB* | ***2.1*** MDR TB-3(M): Number of cases with RR-TB and/or MDR-TB that began second-line treatment | R&R TB system, quarterly reports | 1 | 2016 | 2 | 2 | 2 | - | - | 6 | **Data Collection Methods**From SR reports which will be verified against the National TB register and National TB Lab register**Risks**Poor recording and data flow chain resulting in inaccurate data presentedPoor patient adherenceSecond-line therapy availability Delayed diagnosis |

# Monitoring And Evaluation

**Monitoring Plan**

| **Monitoring Activity** | **Purpose** | **Frequency** | **Expected Action** | **Partners** **(if joint)** | **Cost** **(if any)** |
| --- | --- | --- | --- | --- | --- |
| **Track results progress** | Progress data against the results indicators in the RRF will be collected and analysed to assess the progress of the project in achieving the agreed outputs. | Quarterly, or in the frequency required for each indicator. | Slower than expected progress will be addressed by project management. |  |  |
| **Monitor and Manage Risk** | Identify specific risks that may threaten achievement of intended results. Identify and monitor risk management actions using a risk log. This includes monitoring measures and plans that may have been required as per UNDP’s Social and Environmental Standards. Audits will be conducted in accordance with UNDP’s audit policy to manage financial risk. | Quarterly | Risks are identified by project management and actions are taken to manage risk. The risk log is actively maintained to keep track of identified risks and actions taken. |  |  |
| **Learn**  | Knowledge, good practices and lessons will be captured regularly, as well as actively sourced from other projects and partners and integrated back into the project. | At least annually | Relevant lessons are captured by the project team and used to inform management decisions. |  |  |
| **Annual Project Quality Assurance** | The quality of the project will be assessed against UNDP’s quality standards to identify project strengths and weaknesses and to inform management decision making to improve the project. | Done after 2 years since start of Project  | Areas of strength and weakness will be reviewed by project management and used to inform decisions to improve project performance. |  |  |
| **Review and Make Course Corrections** | Internal review of data and evidence from all monitoring actions to inform decision making. | At least annually | Performance data, risks, lessons and quality will be discussed by the project board and used to make course corrections. |  |  |
| **Project Report** | A progress report will be presented to the Project Board and key stakeholders, consisting of progress data showing the results achieved against pre-defined annual targets at the output level, the annual project quality rating summary, an updated risk long with mitigation measures, and any evaluation or review reports prepared over the period.  | Annually, and at the end of the project (final report) |  |  |  |
| **Project Review (Project Board)** | The project’s governance mechanism (i.e., project board) will hold regular project reviews to assess the performance of the project and review the Multi-Year Work Plan to ensure realistic budgeting over the life of the project. In the project’s final year, the Project Board shall hold an end-of project review to capture lessons learned and discuss opportunities for scaling up and to socialize project results and lessons learned with relevant audiences. | Specify frequency (i.e., at least annually) | Any quality concerns or slower than expected progress should be discussed by the project board and management actions agreed to address the issues identified.  |  |  |

**Evaluation Plan[[9]](#footnote-9)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Evaluation Title** | **Partners (if joint)** | **Related Strategic Plan Output** | **UNDAF/CPD Outcome** | **Planned Completion Date** | **Key Evaluation Stakeholders** | **Cost and Source of Funding** |
| e.g., Mid-Term Evaluation |  |  |  |  |  |  |

# Multi-Year Work Plan [[10]](#footnote-10)[[11]](#footnote-11)

| **EXPECTED OUTPUTS** | **PLANNED ACTIVITIES** | **Planned Budget by Year** | **RESPONSIBLE PARTY** | **PLANNED BUDGET** |
| --- | --- | --- | --- | --- |
| Y1 | Y2 | Y3 | Y4 | Funding Source | Budget Description | Amount |
| **Output 1:** Comprehensive prevention programmes for MSM, TG and SW*Gender marker:* | * 1. Small grants for NGOs reaching key populations
 | 382,082 | 382,082 | 382,082 | - | SR – Country based NGOs | GF | Outreach and KAP workshop cost, staffing and operational cost | 1,146,246 |
| * 1. Condoms and lubricant procurement for prevention programmes
 | 140,659 | - | - | - | UNDP  | GF | Procurement, shipment and storage cost to Fiji, shipment cost to SR  | 140,659 |
| * 1. Rapid diagnostic Tests for MSM, TG, SW, ANC & vulnerable populations
 | 125,679 | 130,063 | 134,490 | - | UNDP | GF | Procurement, shipment and storage cost to Fiji, shipment cost to SR | 390,231 |
| * 1. Community Outreach Activities
 | 107,103 | 107,103 | 107,103 | - | SR – MHMS Only | GF | Travel, accommodation, DSA, workshop costs | 321,307 |
| * 1. Training of Health Care Workers as per country requirement can be as peer educators/counsellors, stigma and discrimination, testing and treatment strategies
 | 15,135 | 15,135 | 15,135 | - | SR – MHMS Only | GF | Workshop costs | 45,405 |
| * 1. Procurement of diagnostic cartridges and lab consumables for STI detection (CT/NG)
 | 25,030 | 25,636 | 26,640 | - | UNDP | GF | Procurement, shipment and storage cost to Fiji, shipment cost to SR | 77,306 |
| * 1. Advocacy: Gender Based Violence interventions; MSM and TG & rights and SOGI Workshop
 | 23,300 | 23,300 | 23,300 | - | SR – Vanuatu MHMS | GF | Travel, accommodation, DSA, workshop costs | 69,900 |
| MONITORING | Quarterly | Quarterly | Quarterly |  | Quarterly | Annually |  |  |
| **Sub-Total for Output 1** | **2,191,053** |
| **Output 2:***Treatment, Care and Support for PLHIV**Gender marker:* | 2.1 PLHIV Regional treatment adherence support programme | 20,000 | 20,000 | 20,000 | - | SR – Regional | GF | Operational Cost and Regional Intervention cost  | 60,000 |
| 2.2 ARV Procurement | 24,339 | 28,478 | 32,735 | - | UNDP | GF | Procurement, shipment and storage cost to Fiji, shipment cost to SR | 85,550 |
| 2.3 Lab reagents for CD4 monitoring | 7,754 | 7,754 | 7,754 | - | UNDP | GF | Procurement, shipment and storage cost to Fiji, shipment cost to SR | 23,262 |
| 2.4 Procurement of Opportunistic Infections Treatment medicines | 35,808 | 44,472 | 49,253 | - | UNDP | GF | Procurement, shipment and storage cost to Fiji, shipment cost to SR | 129,531 |
| 2.5 Salary payment  | 27,168 | 27,168 | 27,168 | - | SR – Kiribati MHMS | GF | Salary Payment | 81,504 |
| 21,538 | 21,538 | 21,538 | - | SR – Tonga MHMS | GF | Salary Payment | 64,613 |
| 13,521 | 13,521 | 13,521 | - | SR – Tuvalu MHMS | GF | Salary Payment | 40,561 |
| 19,940 | 19,940 | 19,940 | - | SR – Cook Islands MH | GF | Salary Payment | 59,819 |
| 22,389 | 17,911 | 11,195 | - | SR – Samoa MHMS | GF | Salary Payment | 51,494 |
| MONITORING | Quarterly | Quarterly | Quarterly |  | Quarterly | Annually |  |  |
| **Sub-Total for Output 2** | **596,329** |
| **Output 3:** *TB care and prevention programme**Gender marker:* | 3.1 Salary Payment | 101,193 | 101,193 | 101,193 | - | SR – FSM DOHSA  | GF | Salary Payment | 303,579 |
| 53,350 | 53,350 | 53,350 | - | SR – Kiribati MHMS | GF | Salary Payment | 160,048 |
| 151,525 | 151,525 | 151,525 | - | SR – RMI MHMS | GF | Salary Payment | 454,575 |
| 21,538 | 21,538 | 21,538 | - | SR – Tonga MHMS | GF | Salary Payment | 64,612 |
| 17,080 | 17,080 | 17,080 | - | SR – Tuvalu MHMS | GF | Salary Payment | 51,240 |
| 59,682 | 59,682 | 59,682 | - | SR – Vanuatu MHMS | GF | Salary Payment | 179,045 |
| 3.2 Procurement of TB Medicines, Cartridges and commodities | 143,754 | 95,316 | 96,811 | - | UNDP | GF | Procurement, shipment and storage cost to Fiji, shipment cost to SR | 335,880 |
| 3.3 SR M&E and Data collection | 104,603 | 104,603 | 101,596 | - | SR – MHMS Only | GF | Travel, accommodation, DSA, workshop costs | 310,802 |
| 3.4 Community Outreach Activities | 151,833 | 163,518 | 152,500 | - | SR – MHMS Only | GF | Travel, accommodation, DSA, workshop costs | 467,851 |
| 3.5 Training of Health Care Workers as per country requirement can be for Contact Tracing, Active case finding, Lab Refresher Training, Stigma and Discrimination | 19,480 | 36,680 | 19,480 | - | SR – MHMS Only | GF | Workshop Costs | 75,640 |
| MONITORING | Quarterly | Quarterly | Quarterly |  | Quarterly | Annually |  |  |
| **Sub-Total for Output 3** | **2,403,270** |
| **Output 4:** *MDR-TB**Gender marker:* | 4.1 MDR costs reimbursement to regional stock pile | 23,334 | 23,334 | 23,334 | - | UNDP | GF | Cost reimbursement for MDR medicines sourced from regional stockpile | 70,002 |
| 4.2 Green Light Committee (GLC) fees | - | 25,000 | - | - | UNDP | GF | 3-year fee for access to regional stockpile second line TB drugs in Manila | 25,000 |
| MONITORING | Quarterly | Quarterly | Quarterly |  | Quarterly | Annually |  |  |
| **Sub-Total for Output 3** | **95,002** |
| Other Interventions*Gender marker:* | Training Health Care workers on TB/HIV co-infection detection, management and treatment care guidelines | 36,737 | 38,837 | 36,737 | - | SR - MHMS Only | GF | Workshop costs | 112,311 |
| TB/HIV Community Outreach Activities  | 12,893 | 12,893 | 12,893 | - | SR - MHMS Only | GF | Travel, accommodation, DSA, workshop costs | 38,678 |
| PMTCT – training for better management for HIV/STIs | 15,000 | 15,000 | 15,000 | - | SR – MHMS Only | GF | Workshop Costs | 45,000 |
| MONITORING | Quarterly | Quarterly | Quarterly |  | Quarterly | Annually |  |  |
|  | **Sub-Total for Other Interventions** | **195,989** |
| **Evaluation** *(as relevant)* | EVALUATION |  |  |  |  |  |  |  |  |
| **General Management Support** | PR - HR Costs | 728,413 | 725,423 | 723,431 | - | UNDP | GF | Salary Payment | 2,177,268 |
| PR - Operational cost | 65,500 | 55,000 | 51,400 | - | UNDP | GF | Utility, Maintenance, rent etc.  | 171,900 |
| Regional Monitoring and supportive costs | 136,068 | 136,068 | 136,068 | - | UNDP | GF | Travel, accommodation, DSA.  | 408,202 |
| Audit Costs | 50,000 | 50,000 | 77,440 | - | UNDP | GF | PR and SR audit expenses | 177,440 |
| SR Operational Support Cost | 39,030 | 39,030 | 39,030 | - | SR – MHMS Only | GF | Utility, Maintenance, office related costs | 117,088 |
| GMS | 263,006 | 246,236 | 233,836 | - | UNDP | GF | Service and Administration fee | 743,078 |
| MONITORING | Quarterly | Quarterly | Quarterly |  | Quarterly | Annually |  |  |
| **Sub-Total for General Management Support** | **3,794,975** |
| **Regional Support** | Regional HIV/SRH Forum | - | 109,514 | - | - | UNDP | GF | Travel, accommodation, DSA, workshop costs | 109,514 |
| TB Regional Capacity Building Meeting | - | 89,489 | - | - | UNDP | GF | Travel, accommodation, DSA, workshop costs | 89,489 |
| Regional Refresher Training for Clinicians | - | - | 49,088 | - | UNDP | GF | Travel, accommodation, DSA, workshop costs | 49,088 |
| Regional PSM capacity development activities (systems and tools) | 40,000 | 40,000 | 40,000 | - | UNDP | GF | Travel, accommodation, DSA, workshop costs, software procurement | 120,000 |
| Technical Advisor -Health System Strengthening and/or sustainability | 120,000 | 120,000 | 120,000 | - | SR | GF | Salary, operational, and in-country support costs | 360,000 |
| TB/HIV Technical Advisor Costs | 192,600 | 192,600 | 192,600 | - | WHO | GF | Salary, operational, and in-country support costs | 577,800 |
| Regional - Telemedicine - Helpdesk and Supervision and Capacity Building Hub | 174,000 | 65,000 | 65,000 | - | ASHM | GF | Salary, operational, and in-country support costs | 304,000 |
| PATLAB technical support and PPTC initiative | 30,000 | 30,000 | 30,000 | - | PATLAB/PPTC | GF | Salary, operational, and in-country support costs | 90,000 |
| Digital campaign with the objective of increasing awareness, decreasing stigma & monitoring programme results -Continuation of the Public-Private partnership initiative | 61,894 | 61,894 | 61,894 | - | Digicel Pacific | GF | Webpage design and hosting payments, SMS and call survey | 185,682 |
| Gender Based Violence  | 102,053 | - | - | - | UNDP | GF | Travel, accommodation, DSA, workshop costs | 102,053 |
| Activities for Strengthening HIV surveillance | 94,238 | - | - | - | UNDP | GF | Travel, accommodation, DSA, workshop costs | 94,238 |
| MONITORING | Bi-Annually | Bi-Annually | Bi-Annually |  | Bi-Annually | Annually |  |  |
| **Sub-Total for Regional Support** | **2,081,864** |
| **TOTAL** |  |  |  |  |  |  |  |  | **11,358,482** |

# Governance and Management Arrangements

UNDP assumed its responsibilities as Principal Recipient of this Programme in 2015 following the decision of the PIRM CCM – the governance and advisory body of this Programme. This is a second three-year Programme cycle covering 2018-2020 in continuation of the first cycle of 2015-2017.

UNDP Pacific Office in Fiji directly implements this Multi-Country Programme covering 11 Pacific Island Countries. The implementation will be governed by the UNDP and the Global Fund rules and regulations. The Programme Management Unit has been set up in Suva which reports directly to UNDP Country Director in the Pacific Office in Fiji. UNDP Global Fund/Health Implementation Support Team in Geneva and New York will provide advisory services, guidance and technical assistance in Programme Implementation.

Except for matters specifically agreed to in a Grant Agreement, UNDP uses its standard operational framework for implementing Global Fund grants. Art. 2(a) of the UNDP–Global Fund Grant Regulations annexed to the [**Framework Agreement**](http://api.undphealthimplementation.org/api.svc/proxy/https%3A/intranet.undp.org/unit/bpps/hhd/GFpartnership/UNDPasPR/Legal%20Framework%20for%20Global%20Fund%20Grant%20Implementati/UNDP%20Global%20Fund%20Framework%20Agreement%20%28%20Searchable%20PDF%29.pdf) concluded between UNDP and the Global Fund on 13 October 2016 (Grant Regulations) recognizes that UNDP will “*implement or oversee the implementation of the Program in accordance with UNDP regulations, rules, policies and procedures and decisions of the UNDP Governing Bodies, as well as the terms of the relevant Grant Agreement.*”  The term “UNDP Governing Bodies” principally refers to the United Nations General Assembly, Executive Board and internal oversight bodies (such as the Chief Executive Board (CEB), High Level Committee on Management (HLCM) and the UNDP Executive Group) and such other organs of the United Nations that possess the authority to pass decisions of general applicability under the Charter of the United Nations or the legal framework of UNDP.

Project implementation must comply with the [**UNDP Programme and Operations Policies and Procedures (POPP)**](http://api.undphealthimplementation.org/api.svc/proxy/https%3A/popp.undp.org/SitePages/POPPRoot.aspx), and, particularly the section on [**Programmes and Projects**](http://api.undphealthimplementation.org/api.svc/proxy/https%3A/popp.undp.org/SitePages/POPPBSUnit.aspx?BSUID=1).   Effective 1 March 2016, UNDP launched programming reforms that include new quality standards, new monitoring policy, revised project document template and changes to the Country Programme Action Plan (CPAP) requirement. Further information on UNDP’s programming reforms and access to the revised guidance and templates are available [**here**](http://api.undphealthimplementation.org/api.svc/proxy/https%3A/popp.undp.org/SitePages/POPPSubject.aspx?SBJID=240).

As Principal Recipient (PR), UNDP is legally responsible and financially accountable for implementation results. The nature of these responsibilities, as well as the high level of legal and financial exposure involved, call for the use of the Direct Implementation Modality (DIM) as the optimal implementation modality. As defined in the [**UNDP POPP**](http://api.undphealthimplementation.org/api.svc/proxy/https%3A/popp.undp.org/SitePages/POPPSubject.aspx?SBJID=12), the requisite approvals need to be obtained for grants implemented under the DIM modality and Global Fund grants have, as a rule, been implemented under this modality.

As per UNDP rules, UNDP will engage with sub-recipients in 11 countries through sub-recipient agreement following appropriate selected process and sub-recipient’s capacity assessment. Funding to sub-recipients will be disbursed in line with the approved work plan and budget after submission and acceptance of quarterly programmatic and financial reports.

PIRM CCM is the Programme governance and advisory body. The Pacific Islands Regional Country Coordinating Mechanism (PIRM CCM), a country-level multi-stakeholder partnership, develops and submits grant proposals to the Global Fund based on priority needs at the national level. After grant approval, they oversee progress during implementation. The PIRM CCM is responsible for overseeing the performance of the grants and making strategic decisions at key opportunities during grant implementation, including endorsing requests for reprogramming or changing implementation arrangements. It is important for the Principal Recipient (PR) to maintain regular communication with the PIRM CCM at every stage of the grant cycle to ensure progress is actively monitored and any bottlenecks or challenges are addressed in a timely manner. The PIRM CCM has a wide representation from all 11 Pacific Island countries including representatives of the government, civil society and communities of people affected by HIV, TB and malaria. The PIRM CCM convenes once a year where UNDP is making its annual progress report. The PIRM CCM has Executive Committee and Oversight Working Group which convene twice a year.

UNDP interacts with PIRM CCM through several ways:

* PR regularly attends PIRM CCM meetings and provides updates on grant implementation progress and implementation issues;
* PR shares with the PIRM CCM progress updates and/or disbursement requests submitted to the Global Fund including the Global Fund feedback and decision;
* PR proactively shares with the PIRM CCM any Performance Letters or Notification Letters shared by the Global Fund, in case the PIRM CCM was not copied;
* PR involves the PIRM CCM in any reprogramming and extension requests that they may submit to the Global Fund and provides evidence of PIRM CCM’s endorsement of the requests; and
* At the time of grant closure, PR involves the PIRM CCM in the preparation of the closeout plan and budget that should be endorsed by the CCM prior to submission to the Global Fund for approval.

**Project Organisation Structure**


# Legal Context

This project document shall be the instrument referred to as such in Article 1 of the Standard Basic Assistance Agreement between the Government of Fiji and UNDP, signed on *which was signed by* ***both parties on 30 October 1970 and the Letter of Agreement dated 1 November 1975***.   All references in the SBAA to “Executing Agency” shall be deemed to refer to “Implementing Partner.”

This project will be implemented by UNDP Pacific Office in Fiji (“Implementing Partner”) in accordance with its financial regulations, rules, practices and procedures only to the extent that they do not contravene the principles of the Financial Regulations and Rules of UNDP. Where the financial governance of an Implementing Partner does not provide the required guidance to ensure best value for money, fairness, integrity, transparency, and effective international competition, the financial governance of UNDP shall apply.

# Risk Management

**Option b. UNDP (DIM)**

1. UNDP as the Implementing Partner will comply with the policies, procedures and practices of the United Nations Security Management System (UNSMS.)
2. UNDP as the Implementing Partner will undertake all reasonable efforts to ensure that none of the [project funds][[12]](#footnote-12) [UNDP funds received pursuant to the Project Document][[13]](#footnote-13) are used to provide support to individuals or entities associated with terrorism and that the recipients of any amounts provided by UNDP hereunder do not appear on the list maintained by the Security Council Committee established pursuant to resolution 1267 (1999). The list can be accessed via <http://www.un.org/sc/committees/1267/aq_sanctions_list.shtml>. This provision must be included in all sub-contracts or sub-agreements entered into under this Project Document.
3. Social and environmental sustainability will be enhanced through application of the UNDP Social and Environmental Standards (http://www.undp.org/ses) and related Accountability Mechanism (http://www.undp.org/secu-srm).
4. UNDP as the Implementing Partner will: (a) conduct project and programme-related activities in a manner consistent with the UNDP Social and Environmental Standards, (b) implement any management or mitigation plan prepared for the project or programme to comply with such standards, and (c) engage in a constructive and timely manner to address any concerns and complaints raised through the Accountability Mechanism. UNDP will seek to ensure that communities and other project stakeholders are informed of and have access to the Accountability Mechanism.
5. All signatories to the Project Document shall cooperate in good faith with any exercise to evaluate any programme or project-related commitments or compliance with the UNDP Social and Environmental Standards. This includes providing access to project sites, relevant personnel, information, and documentation.
6. UNDP as the Implementing Partner will ensure that the following obligations are binding on each responsible party, subcontractor and sub-recipient:
	1. Consistent with the Article III of the SBAA *[or the Supplemental Provisions to the Project Document]*, the responsibility for the safety and security of each responsible party, subcontractor and sub-recipient and its personnel and property, and of UNDP’s property in such responsible party’s, subcontractor’s and sub-recipient’s custody, rests with such responsible party, subcontractor and sub-recipient. To this end, each responsible party, subcontractor and sub-recipient shall:
		1. put in place an appropriate security plan and maintain the security plan, taking into account the security situation in the country where the project is being carried;
		2. assume all risks and liabilities related to such responsible party’s, subcontractor’s and sub-recipient’s security, and the full implementation of the security plan.
	2. UNDP reserves the right to verify whether such a plan is in place, and to suggest modifications to the plan when necessary. Failure to maintain and implement an appropriate security plan as required hereunder shall be deemed a breach of the responsible party’s, subcontractor’s and sub-recipient’s obligations under this Project Document.
	3. Each responsible party, subcontractor and sub-recipient will take appropriate steps to prevent misuse of funds, fraud or corruption, by its officials, consultants, subcontractors and sub-recipients in implementing the project or programme or using the UNDP funds. It will ensure that its financial management, anti-corruption and anti-fraud policies are in place and enforced for all funding received from or through UNDP.
	4. The requirements of the following documents, then in force at the time of signature of the Project Document, apply to each responsible party, subcontractor and sub-recipient: (a)UNDP Policy on Fraud and other Corrupt Practices and (b)UNDP Office of Audit and Investigations Investigation Guidelines. Each responsible party, subcontractor and sub-recipient agrees to the requirements of the above documents, which are an integral part of this Project Document and are available online at www.undp.org.
	5. In the event that an investigation is required, UNDP will conduct investigations relating to any aspect of UNDP programmes and projects. Each responsible party, subcontractor and sub-recipient will provide its full cooperation, including making available personnel, relevant documentation, and granting access to its (and its consultants’, subcontractors’ and sub-recipients’) premises, for such purposes at reasonable times and on reasonable conditions as may be required for the purpose of an investigation. Should there be a limitation in meeting this obligation, UNDP shall consult with it to find a solution.
	6. Each responsible party, subcontractor and sub-recipient will promptly inform UNDP as the Implementing Partner in case of any incidence of inappropriate use of funds, or credible allegation of fraud or corruption with due confidentiality.

Where it becomes aware that a UNDP project or activity, in whole or in part, is the focus of investigation for alleged fraud/corruption, each responsible party, subcontractor and sub-recipient will inform the UNDP Resident Representative/Head of Office, who will promptly inform UNDP’s Office of Audit and Investigations (OAI). It will provide regular updates to the head of UNDP in the country and OAI of the status of, and actions relating to, such investigation.

* 1. *Choose one of the three following options:*

*Option 1:*UNDP will be entitled to a refund from the responsible party, subcontractor or sub-recipient of any funds provided that have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of this Project Document. Such amount may be deducted by UNDP from any payment due to the responsible party, subcontractor or sub-recipient under this or any other agreement. Recovery of such amount by UNDP shall not diminish or curtail any responsible party’s, subcontractor’s or sub-recipient’s obligations under this Project Document.

*Option 2:*Eachresponsible party, subcontractor or sub-recipient agrees that, where applicable, donors to UNDP (including the Government) whose funding is the source, in whole or in part, of the funds for the activities which are the subject of the Project Document, may seek recourse to such responsible party, subcontractor or sub-recipient for the recovery of any funds determined by UNDP to have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of the Project Document.

*Option 3:* UNDP will be entitled to a refund from the responsible party, subcontractor or sub-recipient of any funds provided that have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of the Project Document. Such amount may be deducted by UNDP from any payment due to the responsible party, subcontractor or sub-recipient under this or any other agreement.

Where such funds have not been refunded to UNDP, the responsible party, subcontractor or sub-recipient agrees that donors to UNDP (including the Government) whose funding is the source, in whole or in part, of the funds for the activities under this Project Document, may seek recourse to such responsible party, subcontractor or sub-recipient for the recovery of any funds determined by UNDP to have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of the Project Document.

*Note:* The term “Project Document” as used in this clause shall be deemed to include any relevant subsidiary agreement further to the Project Document, including those with responsible parties, subcontractors and sub-recipients.

* 1. Each contract issued by the responsible party, subcontractor or sub-recipient in connection with this Project Document shall include a provision representing that no fees, gratuities, rebates, gifts, commissions or other payments, other than those shown in the proposal, have been given, received, or promised in connection with the selection process or in contract execution, and that the recipient of funds from it shall cooperate with any and all investigations and post-payment audits.
	2. Should UNDP refer to the relevant national authorities for appropriate legal action any alleged wrongdoing relating to the project or programme, the Government will ensure that the relevant national authorities shall actively investigate the same and take appropriate legal action against all individuals found to have participated in the wrongdoing, recover and return any recovered funds to UNDP.
	3. Each responsible party, subcontractor and sub-recipient shall ensure that all of its obligations set forth under this section entitled “Risk Management” are passed on to its subcontractors and sub-recipients and that all the clauses under this section entitled “Risk Management Standard Clauses” are adequately reflected, *mutatis mutandis*, in all its sub-contracts or sub-agreements entered into further to this Project Document.

# ANNEXES

1. **Project Quality Assurance Report**

| **Project QA Assessment: Design and Appraisal** |
| --- |
| **Overall Project**  |
| **Exemplary (5)****🞋🞋🞋🞋🞋** | **Highly Satisfactory (4)****🞋🞋🞋🞋⭘** | **Satisfactory (3)****🞋🞋🞋⭘⭘** | **Needs Improvement (2)****🞋🞋⭘⭘⭘** | **Inadequate (1)****🞋⭘⭘⭘⭘** |
| At least four criteria are rated Exemplary, and all criteria are rated High or Exemplary.  | All criteria are rated Satisfactory or higher, and at least four criteria are rated High or Exemplary.  | At least six criteria are rated Satisfactory or higher, and only one may be rated Needs Improvement. The Principled criterion must be rated Satisfactory or above.  | At least three criteria are rated Satisfactory or higher, and only four criteria may be rated Needs Improvement. | One or more criteria are rated Inadequate, or five or more criteria are rated Needs Improvement.  |
| **DECISION** |
| * **APPROVE** – the project is of sufficient quality to be approved in its current form**.** Any management actions must be addressed in a timely manner.
* **APPROVE WITH QUALIFICATIONS** – the project has issues that must be addressed before the project document can be approved. Any management actions must be addressed in a timely manner.
* **DISAPPROVE** – the project has significant issues that should prevent the project from being approved as drafted.
 |
| **RATING CRITERIA****For all questions, select the option that best reflects the project** |
| **Strategic** |  |
| 1. **Does the project specify how it will contribute to higher level change through linkage to the programme’s Theory of Change?**
* **3:** The project is clearly linked to the programme’s theory of change. It has an explicit change pathway that explains how the project will contribute to outcome level change and why the project’s strategy will likely lead to this change. This analysis is backed by credible evidence of what works effectively in this context and includes assumptions and risks. The prodoc clearly outlines the roadmap for action of the project throughout the narrative and contains a graph on the program logic with the ‘If-then’ causal relationship from interventions through to long term project impacts
* **2:** The project is clearly linked to the programme’s theory of change. It has a change pathway that explains how the project will contribute to outcome-level change and why the project strategy will likely lead to this change.
* **1:** The project document may describe in generic terms how the project will contribute to development results, without an explicit link to the programme’s theory of change.

*\*Note: Projects not contributing to a programme must have a project-specific Theory of Change. See alternative question under the lightbulb for these cases.* |
|
|
| 1. **Is the project aligned with the UNDP Strategic Plan?**
* **3:** The project responds to at least one of the development settings as specified in the Strategic Plan[[14]](#footnote-14) and adapts at least one Signature Solution[[15]](#footnote-15). The project’s RRF includes all the relevant SP output indicators. (all must be true)
* **2:** The project responds to at least one of the development settings as specified in the Strategic Plan4. The project’s RRF includes at least one SP output indicator, if relevant. *(both must be true)* Development setting: Accelerate structural transformations for sustainable development. Signature Solution: Strengthen effective, inclusive and accountable governance
* **1:** The project responds to a partner’s identified need, but this need falls outside of the UNDP Strategic Plan. Also select this option if none of the relevant SP indicators are included in the RRF.
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| 1. **Is the project linked to the programme outputs? (i.e., UNDAF Results Group Workplan/CPD, RPD or Strategic Plan IRRF for global projects/strategic interventions not part of a programme)** Yes
 |
| **Relevant** |  |
| 1. **Does the project target groups left furthest behind?**
* **3:** The target groups are clearly specified, prioritising discriminated, and marginalized groups left furthest behind, identified through a rigorous process based on evidence Project places key affected population at the heart of the HIV response. These include MSMs, FSW and PLHIV as highlighted in output 1. For TB this includes civil society, those affected by the disease, their contacts and also health care workers as highlighted in output 3
* **2:** The target groups are clearly specified, prioritizing groups left furthest behind.
* **1:** The target groups are not clearly specified.

\*Note: Management Action must be taken for a score of 1. *Projects that build institutional capacity should still identify targeted groups to justify support* |
|
|
| 1. **Have knowledge, good practices, and past lessons learned of UNDP and others informed the project design?**
* **3:** Knowledge and lessons learned backed by credible evidence from sources such as evaluation, corporate policies/strategies, and/or monitoring have been explicitly used, with appropriate referencing, to justify the approach used by the project. IBBS studies, Global TB reports and strategies; and monitoring data from progress reports (GF PUDR) have been used to inform the project design for the 2018-2020 period
* **2:** The project design mentions knowledge and lessons learned backed by evidence/sources but have not been used to justify the approach selected.
* **1:** There is little, or no mention of knowledge and lessons learned to inform the project design. Any references made are anecdotal and not backed by evidence.

\*Note: Management Action or strong management justification must be given for a score of 1 |
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|
| 1. **Does UNDP have a clear advantage to engage in the role envisioned by the project vis-à-vis national/regional/global partners and other actors?**
* **3:** An analysis has been conducted on the role of other partners in the area where the project intends to work, and credible evidence supports the proposed engagement of UNDP and partners through the project, including identification of potential funding partners. It is clear how results achieved by partners will complement the project’s intended results and a communication strategy is in place to communicate results and raise visibility vis-à-vis key partners. Options for south-south and triangular cooperation have been considered, as appropriate. *(all must be true)* According to 2018 Aid Transparency Index, UNDP has been rated second most transparent development aid organisation in the world. List of partners at national and regional level is clearly outlined in document including the South -South and triangular cooperation. Communication of programme results, including results of the work of partners is highlighted n table 1 under Programme Information Products
* **2:** Some analysis has been conducted on the role of other partners in the area where the project intends to work, and relatively limited evidence supports the proposed engagement of and division of labour between UNDP and partners through the project, with unclear funding and communications strategies or plans.
* **1:** No clear analysis has been conducted on the role of other partners in the area that the project intends to work. There is risk that the project overlaps and/or does not coordinate with partners’ interventions in this area. Options for south-south and triangular cooperation have not been considered, despite its potential relevance.

\*Note: Management Action or strong management justification must be given for a score of 1 |
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|
| **Principled** |
| 1. **Does the project apply a human rights-based approach?**
* **3:** The project is guided by human rights and incorporates the principles of accountability, meaningful participation, and non-discrimination in the project’s strategy. The project upholds the relevant international and national laws and standards. Any potential adverse impacts on enjoyment of human rights were rigorously identified and assessed as relevant, with appropriate mitigation and management measures incorporated into project design and budget.*(all must be true)* The project is guided by human rights and gender equality principles under objective 3 of the 2017-202022 Global Fund Strategy. Human rights barriers and gender inequalities assessment was identified and listed as part of the causes to the development problem identified on page 4 (HIV) and 7 (TB). Interventions to address these issues is integrated in the projects interventions under outputs 1 ,2, 3 and 5
* **2:** The project is guided by human rights by prioritizing accountability, meaningful participation and non-discrimination. Potential adverse impacts on enjoyment of human rights were identified and assessed as relevant, and appropriate mitigation and management measures incorporated into the project design and budget. *(both must be true)*
* **1:** No evidence that the project is guided by human rights. Limited or no evidence that potential adverse impacts on enjoyment of human rights were considered.

\*Note: Management action or strong management justification must be given for a score of 1  |
|
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| 1. **Does the project use gender analysis in the project design?**
* **3:** A participatory gender analysis has been conducted and results from this gender analysis inform the development challenge, strategy and expected results sections of the project document. Outputs and indicators of the results framework include explicit references to gender equality, and specific indicators measure and monitor results to ensure women are fully benefitting from the project. *(all must be true)* The project is guided by human rights and gender equality principles under objective 3 of the 2017-2020 Global Fund Strategy. Human rights barriers and gender inequalities assessment was identified and listed as part of the causes to the development problem identified on page 4 (HIV) and 7 (TB). Interventions to address these issues is integrated in the projects interventions under outputs 1 ,2, 3 and 5. Specific indicators relate to female sex workers reached with prevention and testing programmes under outputs 1
* **2:** A basic gender analysis has been carried out and results from this analysis are scattered (i.e., fragmented and not consistent) across the development challenge and strategy sections of the project document. The results framework may include some gender sensitive outputs and/or activities, but gender inequalities are not consistently integrated across each output. *(all must be true)*
* **1:** The project design may or may not mention information and/or data on the differential impact of the project’s development situation on gender relations, women and men, but the gender inequalities have not been clearly identified and reflected in the project document.

\*Note: Management Action or strong management justification must be given for a score of 1 |
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| **9. Did the project support the resilience and sustainability of societies and/or ecosystems?** * **3:** Credible evidence that the project addresses sustainability and resilience dimensions of development challenges, which are integrated in the project strategy and design. The project reflects the interconnections between the social, economic and environmental dimensions of sustainable development. Relevant shocks, hazards and adverse social and environmental impacts have been identified and rigorously assessed with appropriate management and mitigation measures incorporated into project design and budget. *(all must be true)*.
* **2:** The project design integrates sustainability and resilience dimensions of development challenges. Relevant shocks, hazards and adverse social and environmental impacts have been identified and assessed, and relevant management and mitigation measures incorporated into project design and budget. *(both must be true)* Socio-cultural determinants of health was analysed and integrated into the projects interventions
* **1:** Sustainability and resilience dimensions and impacts were not adequately considered. \*Note: Management action or strong management justification must be given for a score of 1
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| **10. Has the Social and Environmental Screening Procedure (SESP) been conducted to identify potential social and environmental impacts and risks?** The SESP is not required for projects in which UNDP is Administrative Agent only and/or projects comprised solely of reports, coordination of events, trainings, workshops, meetings, conferences and/or communication materials and information dissemination. [if yes, upload the completed checklist. If SESP is not required, provide the reason for the exemption in the evidence section.] SESP completed  |
|
| **Management & Monitoring** |
| 1. **Does the project have a strong results framework?**
* **3:** The project’s selection of outputs and activities are at an appropriate level. Outputs are accompanied by SMART, results-oriented indicators that measure the key expected development changes, each with credible data sources and populated baselines and targets, including gender sensitive, target group focused, sex-disaggregated indicators where appropriate. *(all must be true)* Outputs are measurable, contains credible data sources, baselines, targets, target grouped focused and sex disaggregation is a given. Ex Female Sex Workers, Transgender Men and Men Who Have Sex with Men
* **2:** The project’s selection of outputs and activities are at an appropriate level. Outputs are accompanied by SMART, results-oriented indicators, but baselines, targets and data sources may not yet be fully specified. Some use of target group focused, sex-disaggregated indicators, as appropriate. *(all must be true)*
* **1:** The project’s selection of outputs and activities are not at an appropriate level; outputs are not accompanied by SMART, results-oriented indicators that measure the expected change and have not been populated with baselines and targets; data sources are not specified, and/or no gender sensitive, sex-disaggregation of indicators. *(if any is true)*

\*Note: Management Action or strong management justification must be given for a score of 1 |
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|
| **12. Is the project’s governance mechanism clearly defined in the project document, including composition of the project board?** * **3:** The project’s governance mechanism is fully defined. Individuals have been specified for each position in the governance mechanism (especially all members of the project board.) Project Board members have agreed on their roles and responsibilities as specified in the terms of reference. The ToR of the project board has been attached to the project document. *(all must be true)*. PIRMCCM supporting docs are attached for reference
* **2:** The project’s governance mechanism is defined; specific institutions are noted as holding key governance roles, but individuals may not have been specified yet. The project document lists the most important responsibilities of the project board, project director/manager and quality assurance roles. *(all must be true)*
* **1:** The project’s governance mechanism is loosely defined in the project document, only mentioning key roles that will need to be filled at a later date. No information on the responsibilities of key positions in the governance mechanism is provided.

\*Note: Management Action or strong management justification must be given for a score of 1 |
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|
| **13.** **Have the project risks been identified with clear plans stated to manage and mitigate each risk?** * **3:** Project risks related to the achievement of results are fully described in the project risk log, based on comprehensive analysis drawing on the programme’s theory of change, Social and Environmental Standards and screening, situation analysis, capacity assessments and other analysis such as funding potential and reputational risk. Risks have been identified through a consultative process with key internal and external stakeholders, including consultation with the UNDP Security Office as required. Clear and complete plan in place to manage and mitigate each risk, including security risks, reflected in project budgeting and monitoring plans. *(both must be true)* See project risk log attached
* **2:** Project risks related to the achievement of results are identified in the initial project risk log based on a minimum level of analysis and consultation, with mitigation measures identified for each risk.
* **1:** Some risks may be identified in the initial project risk log, but no evidence of consultation or analysis and no clear risk mitigation measures identified. This option is also selected if risks are not clearly identified, no initial risk log is included with the project document and/or no security risk management process has taken place for the project.

\*Note: Management Action must be taken for a score of 1 |
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|
| **Efficient** |  |
| 1. **Have specific measures for ensuring cost-efficient use of resources been explicitly mentioned as part of the project design? This can include, for example: i) using the theory of change analysis to explore different options of achieving the maximum results with the resources available; ii) using a portfolio management approach to improve cost effectiveness through synergies with other interventions; iii) through joint operations (e.g., monitoring or procurement) with other partners; iv) sharing resources or coordinating delivery with other projects, v) using innovative approaches and technologies to reduce the cost of service delivery or other types of interventions.**

Yes. * Use of global UNDP and Global Fund guidelines, tools and templates for programmatic, financial and procurement operations. No need to start from scratch in the development of operational resources.
* Use of cost efficient channels for communicating results such as Facebook, twitter, e-newsletters etc for disseminating programme results whilst ensuring wide reach
* Use of global procurement unit based on Copenhagen for procurement of health products which allows for economies of scale and price reductions
* Use of tele-medicine activities in which health care workers receive remote online coaching and mentoring by health care professionals from regional partners such as ASSHHM / OSSHHM

*(Note: Evidence of at least one measure must be provided to answer yes for this question)* |
| **15. Is the budget justified and supported with valid estimates?*** **3:** The project’s budget is at the activity level with funding sources and is specified for the duration of the project period in a multi-year budget. Realistic resource mobilisation plans are in place to fill unfunded components. Costs are supported with valid estimates using benchmarks from similar projects or activities. Cost implications from inflation and foreign exchange exposure have been estimated and incorporated in the budget. Adequate costs for monitoring, evaluation, communications and security have been incorporated.
* **2:** The project’s budget is at the activity level with funding sources, when possible, and is specified for the duration of the project in a multi-year budget, but no funding plan is in place. Costs are supported with valid estimates based on prevailing rates. Refer to results framework. The project does not have a resource mobilisation plan. Completely reliant on GF funds.
* **1:** The project’s budget is not specified at the activity level, and/or may not be captured in a multi-year budget.
 |
|
|
| 1. **Is the Country Office/Regional Hub/Global Project fully recovering the costs involved with project implementation?**
* **3:** The budget fully covers all project costs that are attributable to the project, including programme management and development effectiveness services related to strategic country programme planning, quality assurance, pipeline development, policy advocacy services, finance, procurement, human resources, administration, issuance of contracts, security, travel, assets, general services, information and communications based on full costing in accordance with prevailing UNDP policies (i.e., UPL, LPL.) Refer to budget in Multi Year Workplan
* **2:** The budget covers significant project costs that are attributable to the project based on prevailing UNDP policies (i.e., UPL, LPL) as relevant.
* **1:** The budget does not adequately cover project costs that are attributable to the project, and UNDP is cross-subsidizing the project.

\*Note: Management Action must be given for a score of 1. The budget must be revised to fully reflect the costs of implementation before the project commences. |
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|
| **Effective** |  |
| **17. Have targeted groups been engaged in the design of the project?** * 3: Credible evidence that all targeted groups, prioritising discriminated and marginalized populations that will be involved in or affected by the project, have been actively engaged in the design of the project. The project has an explicit strategy to identify, engage and ensure the meaningful participation of target groups as stakeholders throughout the project, including through monitoring and decision-making (e.g., representation on the project board, inclusion in samples for evaluations, etc.) IBBS study
* 2: Some evidence that key targeted groups have been consulted in the design of the project.
* 1: No evidence of engagement with targeted groups during project design.
 |
|
|
| **18. Does the project plan for adaptation and course correction if regular monitoring activities, evaluation, and lesson learned demonstrate there are better approaches to achieve the intended results and/or circumstances change during implementation?** Yes. Monitoring of programme results is done on a quarterly basis. Corrective action taken on a needs basis. Annual performance assessment done annually. Project progress assessed annually by the Global Fund and planning decisions made in consultation with governing body  |
| **19. The gender marker for all project outputs are scored at GEN2 or GEN3, indicating that gender has been fully mainstreamed into all project outputs at a minimum.** GEN2 \*Note: Management Action or strong management justification must be given for a score of “no” |
|
| **Sustainability & National Ownership** |
| **20. Have national/regional/global partners led, or proactively engaged in, the design of the project?** * **3:** National partners (or regional/global partners for regional and global projects) have full ownership of the project and led the process of the development of the project jointly with UNDP.
* **2:** The project has been developed by UNDP in close consultation with national/regional/global partners.
* **1:** The project has been developed by UNDP with limited or no engagement with national partners.
 |
|
|
| **21. Are key institutions and systems identified, and is there a strategy for strengthening specific/ comprehensive capacities based on capacity assessments conducted?*** The project has a strategy for strengthening specific capacities of national institutions and/or actors based on a completed capacity assessment. This strategy includes an approach to regularly monitor national capacities using clear indicators and rigorous methods of data collection and adjust the strategy to strengthen national capacities accordingly. As per UNDP rules, UNDP engages with sub-recipients through sub-recipient agreement following appropriate selected process and sub-recipient’s capacity assessment.
* **2:** A capacity assessment has been completed. There are plans to develop a strategy to strengthen specific capacities of national institutions and/or actors based on the results of the capacity assessment.
* **1:** Capacity assessments have not been carried out.
 |
|
|
| **22. Is there is a clear strategy embedded in the project specifying how the project will use national systems (i.e., procurement, monitoring, evaluations, etc.,) to the extent possible?** Yes. Aligned to national HIV strategic plans and frameworks and National TB strategies and frameworks as these are all aligned to global HIV and TB goals |
| **23. Is there a clear transition arrangement/ phase-out plan developed with key stakeholders in order to sustain or scale up results (including resource mobilisation and communications strategy)?** Yes. Refer to page 15 Sustainability and Scale up Plan |

1. **Social and Environmental Screening Template**

**Project Information**

|  |  |
| --- | --- |
| ***Project Information***  |  |
| 1. Project Title
 | Multi-country Western Pacific (MWP) Integrated HIV/TB Program |
| 1. Project Number
 | 116043 |
| 1. Location (Global/Region/Country)
 | Regional |

**Part A. Integrating Overarching Principles to Strengthen Social and Environmental Sustainability**

|  |
| --- |
| **QUESTION 1: How Does the Project Integrate the Overarching Principles in order to Strengthen Social and Environmental Sustainability?** |
| ***Briefly describe in the space below how the Project mainstreams the human-rights based approach***  |
| The project is guided by human rights and gender equality principles under objective 3 of the 2017-2020 Global Fund Strategy. Human rights barriers and gender inequalities assessment was identified and listed as part of the causes to the development problem identified on page 4 (HIV) and 7 (TB). Interventions to address these issues is integrated in the projects interventions under outputs 1 ,2, 3 and 5.  |
| ***Briefly describe in the space below how the Project is likely to improve gender equality and women’s empowerment*** |
| The project is guided by human rights and gender equality principles under objective 3 of the 2017-2020 Global Fund Strategy. Human rights barriers and gender inequalities assessment was identified and listed as part of the causes to the development problem identified on page 4 (HIV) and 7 (TB). Interventions to address these issues is integrated in the projects interventions under outputs 1 ,2, 3 and 5. Specific indicators relate to female sex workers reached with prevention and testing programmes under outputs 1 |
| ***Briefly describe in the space below how the Project mainstreams environmental sustainability*** |
| The project does not mainstream environmental sustainability however it intends |

**Part B. Identifying and Managing Social and Environmental Risks**

|  |  |  |
| --- | --- | --- |
| **QUESTION 2: What are the Potential Social and Environmental Risks?** *Note: Describe briefly potential social and environmental risks identified in Attachment 1 – Risk Screening Checklist (based on any “Yes” responses). If no risks have been identified in Attachment 1 then note “No Risks Identified” and skip to Question 4 and Select “Low Risk”. Questions 5 and 6 not required for Low Risk Projects.* | **QUESTION 3: What is the level of significance of the potential social and environmental risks?***Note: Respond to Questions 4 and 5 below before proceeding to Question 6* | **QUESTION 6: What social and environmental assessment and management measures have been conducted and/or are required to address potential risks (for Risks with Moderate and High Significance)?** |
| ***Risk Description*** | ***Impact and Probability (1-5)*** | ***Significance******(Low, Moderate, High)*** | ***Comments*** | ***Description of assessment and management measures as reflected in the Project design. If ESIA or SESA is required note that the assessment should consider all potential impacts and risks.*** |
| Risk 1: …. Risk that duty bearers do not have the capacity to meet their obligations in the project | I = 3P= 3 | Moderate | Laws and policies to protect rights of PLHIV and Key affected populations not in place | Addressing human rights barriers to accessing health services.Increase awareness and advocacy activities around this |
| Risk 2 …. Risk that right holders do not have the capacity to claim their rights  | I = 3P = 3 | Moderate  | Not all PLHIV, key affected populations and contacts of TB patients are empowered to access the health services they need | Addressing human rights barriers to accessing health services.Increase awareness and advocacy activities around this |
| Risk 3: …. Risk of releasing pollutants to the environment due to routine or non-routine circumstances  | I = 2P =2 | Low  | Travel emissions and use of condoms for other purposes in the environment (eg fishing), IEC materials that are thrown into the environment | Project monitoring of consumables produced and staff travel  |
| [add additional rows as needed] |  |  |  |  |
|  | **QUESTION 4: What is the overall Project risk categorization?**  |
| **Select one (see** [**SESP**](http://www.undp.org/content/undp/en/home/librarypage/operations1/undp-social-and-environmental-screening-procedure.html) **for guidance)** | **Comments** |
| ***Low Risk*** | **x** |  |
| ***Moderate Risk*** | **☐** |  |
| ***High Risk*** | **☐** |  |
|  | **QUESTION 5: Based on the identified risks and risk categorization, what requirements of the SES are relevant?** |  |
| Check all that apply | **Comments** |
| ***Principle 1: Human Rights*** | **x** |  |
| ***Principle 2: Gender Equality and Women’s Empowerment*** | **☐** |  |
| ***1. Biodiversity Conservation and Natural Resource Management*** | **☐** |  |
| ***2. Climate Change Mitigation and Adaptation*** | **☐** |  |
| ***3. Community Health, Safety and Working Conditions*** | **☐** |  |
| ***4. Cultural Heritage*** | **☐** |  |
| ***5. Displacement and Resettlement*** | **☐** |  |
| ***6. Indigenous Peoples*** | **☐** |  |
| ***7. Pollution Prevention and Resource Efficiency*** | **x** |  |

|  |  |
| --- | --- |
| **Checklist Potential Social and Environmental Risks** |  |
| **Principles 1: Human Rights** | **Answer (Yes/No)** |
| 1. Could the Project lead to adverse impacts on enjoyment of the human rights (civil, political, economic, social or cultural) of the affected population and particularly of marginalized groups? | No |
| 2. Is there a likelihood that the Project would have inequitable or discriminatory adverse impacts on affected populations, particularly people living in poverty or marginalized or excluded individuals or groups? [[16]](#footnote-16)  | No |
| 3. Could the Project potentially restrict availability, quality of and access to resources or basic services, in particular to marginalized individuals or groups? | No |
| 4. Is there a likelihood that the Project would exclude any potentially affected stakeholders, in particular marginalized groups, from fully participating in decisions that may affect them? | No |
| 5. Is there a risk that duty-bearers do not have the capacity to meet their obligations in the Project? | Yes  |
| 6. Is there a risk that rights-holders do not have the capacity to claim their rights?  | Yes |
| 7. Have local communities or individuals, given the opportunity, raised human rights concerns regarding the Project during the stakeholder engagement process? | No |
| 8. Is there a risk that the Project would exacerbate conflicts among and/or the risk of violence to project-affected communities and individuals? | No |
| **Principle 2: Gender Equality and Women’s Empowerment** |  |
| 1. Is there a likelihood that the proposed Project would have adverse impacts on gender equality and/or the situation of women and girls?  | No |
| 2. Would the Project potentially reproduce discriminations against women based on gender, especially regarding participation in design and implementation or access to opportunities and benefits? | No |
| 3. Have women’s groups/leaders raised gender equality concerns regarding the Project during the stakeholder engagement process and has this been included in the overall Project proposal and in the risk assessment? | No |
| 4. Would the Project potentially limit women’s ability to use, develop and protect natural resources, taking into account different roles and positions of women and men in accessing environmental goods and services? *For example, activities that could lead to natural resources degradation or depletion in communities who depend on these resources for their livelihoods and well being* | No |
| **Principle 3: Environmental Sustainability:** Screeningquestions regarding environmental risks are encompassed by the specific Standard-related questions below |  |
|  |  |
| **Standard 1: Biodiversity Conservation and Sustainable** [**Natural**](#SustNatResManGlossary) **Resource Management** |  |
| 1.1 Would the Project potentially cause adverse impacts to habitats (e.g. modified, natural, and critical habitats) and/or ecosystems and ecosystem services?*For example, through habitat loss, conversion or degradation, fragmentation, hydrological changes* | No |
| 1.2 Are any Project activities proposed within or adjacent to critical habitats and/or environmentally sensitive areas, including legally protected areas (e.g. nature reserve, national park), areas proposed for protection, or recognized as such by authoritative sources and/or indigenous peoples or local communities? | No |
| 1.3 Does the Project involve changes to the use of lands and resources that may have adverse impacts on habitats, ecosystems, and/or livelihoods? (Note: if restrictions and/or limitations of access to lands would apply, refer to Standard 5) | No |
| 1.4 Would Project activities pose risks to endangered species? |  |
| 1.5 Would the Project pose a risk of introducing invasive alien species?  | No |
| 1.6 Does the Project involve harvesting of natural forests, plantation development, or reforestation? | No |
| 1.7 Does the Project involve the production and/or harvesting of fish populations or other aquatic species? | No |
| 1.8 Does the Project involve significant extraction, diversion or containment of surface or ground water? *For example, construction of dams, reservoirs, river basin developments, groundwater extraction* | No |
| 1.9 Does the Project involve utilization of genetic resources? (e.g. collection and/or harvesting, commercial development)  | No |
| 1.10 Would the Project generate potential adverse transboundary or global environmental concerns? | No |
| 1.11 Would the Project result in secondary or consequential development activities which could lead to adverse social and environmental effects, or would it generate cumulative impacts with other known existing or planned activities in the area? *For example, a new road through forested lands will generate direct environmental and social impacts (e.g. felling of trees, earthworks, potential relocation of inhabitants). The new road may also facilitate encroachment on lands by illegal settlers or generate unplanned commercial development along the route, potentially in sensitive areas. These are indirect, secondary, or induced impacts that need to be considered. Also, if similar developments in the same forested area are planned, then cumulative impacts of multiple activities (even if not part of the same Project) need to be considered.* | No |
| **Standard 2: Climate Change Mitigation and Adaptation** |  |
| 2.1 Will the proposed Project result in significant[[17]](#footnote-17) greenhouse gas emissions or may exacerbate climate change?  | No |
| 2.2 Would the potential outcomes of the Project be sensitive or vulnerable to potential impacts of climate change?  | No |
| 2.3 Is the proposed Project likely to directly or indirectly increase social and environmental [vulnerability to climate change](#CCVulnerabilityGlossary) now or in the future (also known as maladaptive practices)?*For example, changes to land use planning may encourage further development of floodplains, potentially increasing the population’s vulnerability to climate change, specifically flooding* | No |
| **Standard 3: Community Health, Safety and Working Conditions** |  |
| 3.1 Would elements of Project construction, operation, or decommissioning pose potential safety risks to local communities? | No |
| 3.2 Would the Project pose potential risks to community health and safety due to the transport, storage, and use and/or disposal of hazardous or dangerous materials (e.g. explosives, fuel and other chemicals during construction and operation)? | No |
| 3.3 Does the Project involve large-scale infrastructure development (e.g. dams, roads, buildings)? | No |
| 3.4 Would failure of structural elements of the Project pose risks to communities? (e.g. collapse of buildings or infrastructure) | No |
| 3.5 Would the proposed Project be susceptible to or lead to increased vulnerability to earthquakes, subsidence, landslides, erosion, flooding or extreme climatic conditions? | No |
| 3.6 Would the Project result in potential increased health risks (e.g. from water-borne or other vector-borne diseases or communicable infections such as HIV/AIDS)? | No |
| 3.7 Does the Project pose potential risks and vulnerabilities related to occupational health and safety due to physical, chemical, biological, and radiological hazards during Project construction, operation, or decommissioning? | No |
| 3.8 Does the Project involve support for employment or livelihoods that may fail to comply with national and international labor standards (i.e. principles and standards of ILO fundamental conventions)?  | No |
| 3.9 Does the Project engage security personnel that may pose a potential risk to health and safety of communities and/or individuals (e.g. due to a lack of adequate training or accountability)? | No |
| **Standard 4: Cultural Heritage** |  |
| 4.1 Will the proposed Project result in interventions that would potentially adversely impact sites, structures, or objects with historical, cultural, artistic, traditional or religious values or intangible forms of culture (e.g. knowledge, innovations, practices)? (Note: Projects intended to protect, and conserve Cultural Heritage may also have inadvertent adverse impacts) | No |
| 4.2 Does the Project propose utilizing tangible and/or intangible forms of cultural heritage for commercial or other purposes? | No |
| **Standard 5: Displacement and Resettlement** |  |
| 5.1 Would the Project potentially involve temporary or permanent and full or partial physical displacement? | No |
| 5.2 Would the Project possibly result in economic displacement (e.g. loss of assets or access to resources due to land acquisition or access restrictions – even in the absence of physical relocation)?  | No |
| 5.3 Is there a risk that the Project would lead to forced evictions?[[18]](#footnote-18) | No |
| 5.4 Would the proposed Project possibly affect land tenure arrangements and/or community-based property rights/customary rights to land, territories and/or resources?  | No |
| **Standard 6: Indigenous Peoples** |  |
| 6.1 Are indigenous peoples present in the Project area (including Project area of influence)? | No |
| 6.2 Is it likely that the Project or portions of the Project will be located on lands and territories claimed by indigenous peoples? | No |
| 6.3 Would the proposed Project potentially affect the human rights, lands, natural resources, territories, and traditional livelihoods of indigenous peoples (regardless of whether indigenous peoples possess the legal titles to such areas, whether the Project is located within or outside of the lands and territories inhabited by the affected peoples, or whether the indigenous peoples are recognized as indigenous peoples by the country in question)? *If the answer to the screening question 6.3 is “yes” the potential risk impacts are considered potentially severe and/or critical and the Project would be categorized as either Moderate or High Risk.* | No |
| 6.4 Has there been an absence of culturally appropriate consultations carried out with the objective of achieving FPIC on matters that may affect the rights and interests, lands, resources, territories and traditional livelihoods of the indigenous peoples concerned? | No |
| 6.5 Does the proposed Project involve the utilization and/or commercial development of natural resources on lands and territories claimed by indigenous peoples? | No |
| 6.6 Is there a potential for forced eviction or the whole or partial physical or economic displacement of indigenous peoples, including through access restrictions to lands, territories, and resources? | No |
| 6.7 Would the Project adversely affect the development priorities of indigenous peoples as defined by them? | No |
| 6.8 Would the Project potentially affect the physical and cultural survival of indigenous peoples? | No |
| 6.9 Would the Project potentially affect the Cultural Heritage of indigenous peoples, including through the commercialization or use of their traditional knowledge and practices? | No |
| **Standard 7: Pollution Prevention and Resource Efficiency** |  |
| 7.1 Would the Project potentially result in the release of pollutants to the environment due to routine or non-routine circumstances with the potential for adverse local, regional, and/or [transboundary impacts](#TransboundaryImpactsGlossary)?  | Yes |
| 7.2 Would the proposed Project potentially result in the generation of waste (both hazardous and non-hazardous)? | No  |
| 7.3 Will the proposed Project potentially involve the manufacture, trade, release, and/or use of hazardous chemicals and/or materials? Does the Project propose use of chemicals or materials subject to international bans or phase-outs?*For example, DDT, PCBs and other chemicals listed in international conventions such as the Stockholm Conventions on Persistent Organic Pollutants or the Montreal Protocol*  | No |
| 7.4 Will the proposed Project involve the application of pesticides that may have a negative effect on the environment or human health? | No |
| 7.5 Does the Project include activities that require significant consumption of raw materials, energy, and/or water?  | No |

1. **Risk Analysis**

| **#** | **Description** | **Risk Category** | **Impact &****Probability** | **Risk Treatment / Management Measures** | **Risk Owner** |
| --- | --- | --- | --- | --- | --- |
|  | Enter a brief description of the risk. Risk description should include future event and cause. | Social and EnvironmentalFinancialOperational OrganizationalPoliticalRegulatoryStrategicOther | Describe the potential **effect** on the project if the future event were to occur.Enter **probability** based on 1-5 scale (1 = Not likely; 5 = Expected)Enter **impact** based on 1-5 scale (1 = Low; 5 = Critical) | What actions have been taken/will be taken to manage this risk. | The person or entity with the responsibility to manage the risk. |
| 1. 1
 | Absence of HIV laws & policies in MWP supported PICs | OrganizationalRegulatory | Limits TGs, FSWs and MSMs accessing HIV STI prevention and testing services P = 3I = 5 | PSGDN - Serve as mentors and trainers to individual country CSO. PSDN is required to have human rights as their core function and will be working with regional technical partners to address legislative and social barriers to service access by key populations. (Output 2 and 3) | PSGDN |
| 1. 2
 | Breach of patient confidentiality issues by HCW  | Social and Environmental | Discourages KAP from accessing the health services they needP = 4I = 5 | Conduct training on proper PLHIV case management and patient confidentiality amongst HCW  | ASSHM and Health Care Workers |
| 1. 3
 | Stock expiry of TB/HIV medicines | Operational | Program inefficiencies occurP = 3I = 3 | PSM training on accurate stock reporting  | HIV / TB Coordinators and UNDP PSM Analyst |
| 1. 2
 | Lead time of ARVs drugs is currently 6 months so regular reporting should be provided by the HIV focal person so as not to face an out of stock situation.  | Operational  | Drugs unavailable to put patients on treatmentP = 3I = 5 | PSM training on timely stock reporting and replenishment Training of clinicians to conduct regular CD4 monitoring by HIV Coordinator must be conducted to verify that the current therapy is effective for the individual. | HIV Coordinators and UNDP PSM AnalystPLHIV consultant |
| 1. 3
 | Poor patient adherence to drug use | Operational | Increased risk of PLHIV health deteriorating at a faster pace and also increased risk of spreading HIVP = 3I = 3 | PLHIV workshopTraining of clinicians on PLHIV treatment and drug adherence  | PLHIV consultant, WHO  |
|  | Delayed diagnosis | Social and Environment | Late diagnosis leads to late initiation of treatmentP = 3I = 3 | More awareness on the importance of knowing your HIV status by getting testedMore TB community awareness | CSO and MOH Programme implementers |
|  | Lack of capacity of CSO implementers to reach program targets | Operational  | Less reach to target populationsP = 4I = 4 | Capacity building of CSOs | UNDP, PSGDN, WHO |
|  | Violence, stigma and discrimination of key affected populations | Social and Environment | Less KAP reached with health services they needP = 4I = 5 | Community awareness on addressing the barriers to human rights and gender equality  | CSOs, PSGDN, MOH, UNDP and regional partners |
|  | Violence, stigma and discrimination of PLHIV | Social and Environment | Less PLHIV accessing health services they needP = 4I = 5 | Community awareness on HIV education  | CSOs, MOH, UNDP and regional partners |

1. **Capacity Assessment:** Results of capacity assessments of Implementing Partner (including HACT Micro Assessment)
2. **Project Board Terms of Reference and TORs of key management positions**





1. Note: Adjust signatures as needed

2 Gender Marker measures how much a project invests in gender equality and women’s empowerment. Select one for each output: GEN3 (Gender equality as a principle objective); GEN2 (Gender equality as a significant objective); GEN1 (Limited contribution to gender equality); GEN0 (No contribution to gender quality) [↑](#footnote-ref-1)
2. WPRO, (2017). HIV/AIDS data and statistics: Prevalence and rates of infection remain low. <http://www.wpro.who.int/hiv/data/en/> [↑](#footnote-ref-2)
3. UNAIDS, (2015). GARP Country Reports

<http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2015countries/> [↑](#footnote-ref-3)
4. UNDP, (2017) 6 Monthly GF PUDR Reports [↑](#footnote-ref-4)
5. WPRO, (2017). Tuberculosis (TB) and Leprosy: South Pacific Situation Summary.

<http://www.wpro.who.int/southpacific/programmes/communicable_diseases/tuberculosis/page/en/> [↑](#footnote-ref-5)
6. UNDP, (2017). GF Reports [↑](#footnote-ref-6)
7. UNDP publishes its project information (indicators, baselines, targets and results) to meet the International Aid Transparency Initiative (IATI) standards. Make sure that indicators are S.M.A.R.T. (Specific, Measurable, Attainable, Relevant and Time-bound), provide accurate baselines and targets underpinned by reliable evidence and data, and avoid acronyms so that external audience clearly understand the results of the project. [↑](#footnote-ref-7)
8. It is recommended that projects use output indicators from the Strategic Plan IRRF, as relevant, in addition to project-specific results indicators. Indicators should be disaggregated by sex or for other targeted groups where relevant. [↑](#footnote-ref-8)
9. Optional, if needed [↑](#footnote-ref-9)
10. Cost definitions and classifications for programme and development effectiveness costs to be charged to the project are defined in the Executive Board decision DP/2010/32 [↑](#footnote-ref-10)
11. Changes to a project budget affecting the scope (outputs), completion date, or total estimated project costs require a formal budget revision that must be signed by the project board. In other cases, the UNDP programme manager alone may sign the revision provided the other signatories have no objection. This procedure may be applied for example when the purpose of the revision is only to re-phase activities among years. [↑](#footnote-ref-11)
12. To be used where UNDP is the Implementing Partner [↑](#footnote-ref-12)
13. To be used where the UN, a UN fund/programme or a specialized agency is the Implementing Partner [↑](#footnote-ref-13)
14. The three development settings in UNDP’s 2018-2021 Strategic Plan are: a) Eradicate poverty in all its forms and dimensions; b) Accelerate structural transformations for sustainable development; and c) Build resilience to shocks and crises [↑](#footnote-ref-14)
15. The six Signature Solutions of UNDP’s 2018-2021 Strategic Plan are: a) Keeping people out of poverty; b) Strengthen effective, inclusive and accountable governance; c) Enhance national prevention and recovery capacities for resilient societies; d) Promote nature-based solutions for a sustainable planet; e) Close the energy gap; and f) Strengthen gender equality and the empowerment of women and girls. [↑](#footnote-ref-15)
16. Prohibited grounds of discrimination include race, ethnicity, gender, age, language, disability, sexual orientation, religion, political or other opinion, national or social or geographical origin, property, birth or other status including as an indigenous person or as a member of a minority. References to “women and men” or similar is understood to include women and men, boys and girls, and other groups discriminated against based on their gender identities, such as transgender people and transsexuals. [↑](#footnote-ref-16)
17. In regard to CO2, ‘significant emissions’ corresponds generally to more than 25,000 tons per year (from both direct and indirect sources). [The Guidance Note on Climate Change Mitigation and Adaptation provides additional information on GHG emissions.] [↑](#footnote-ref-17)
18. Forced evictions include acts and/or omissions involving the coerced or involuntary displacement of individuals, groups, or communities from homes and/or lands and common property resources that were occupied or depended upon, thus eliminating the ability of an individual, group, or community to reside or work in a particular dwelling, residence, or location without the provision of, and access to, appropriate forms of legal or other protections. [↑](#footnote-ref-18)