

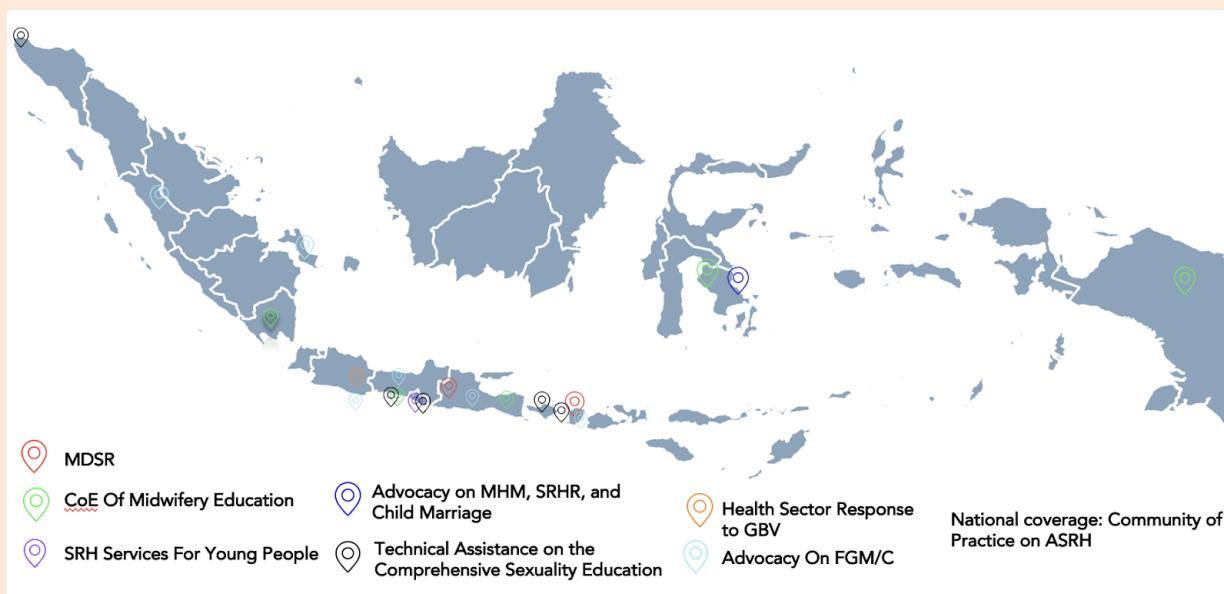


# **FINAL EVALUATION OF THE BETTER SEXUAL REPRODUCTIVE HEALTH AND RIGHTS FOR ALL IN INDONESIA (BERANI) PROGRAMME (2018-2022)**

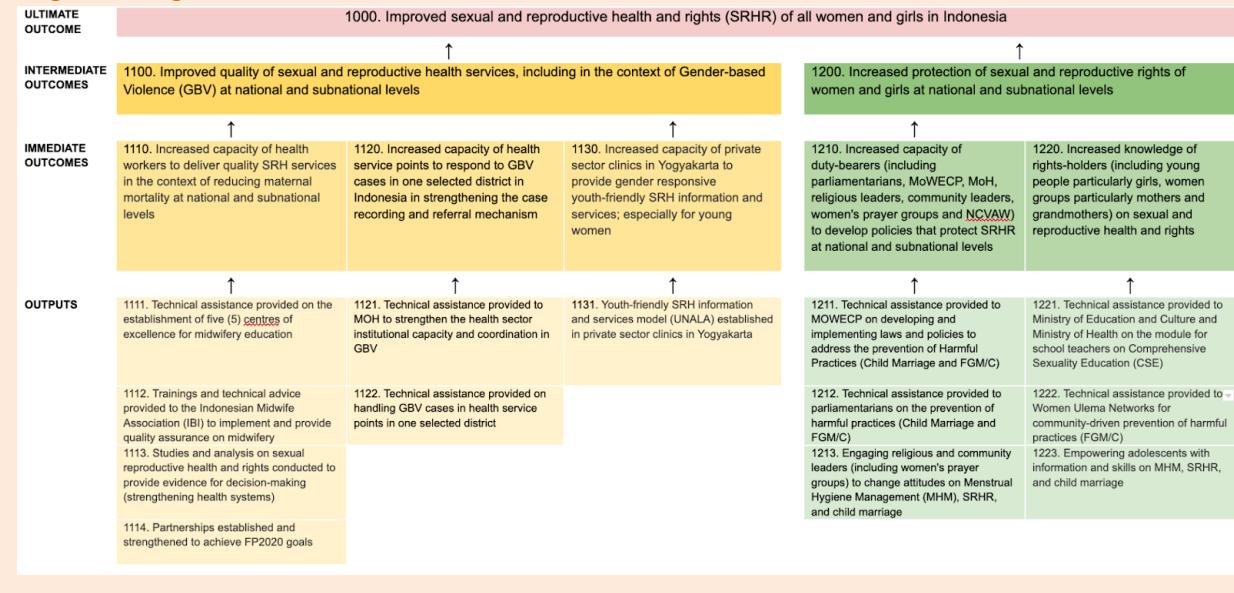
DRAFT OF FINAL REPORT

***February 2023-March 2023***

## Programme Geographic Coverage



## Programme Logic Model



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Disclaimer: This is a product of the independent review by the above team and the content, analysis and recommendations of this report do not necessarily reflect the views of the United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and their Executive Committees or Member States. The report is not professionally edited.

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## Abbreviations and Acronyms

ARM	Annual Review Meetings
ASRH	Adolescent sexual and reproductive health
AWP	Annual Work Plan
Bappenas	National Development Planning Agency
Bappeda	Regional Development Planning Agency
BKKBN	National Population and Family Planning Board
BPS	BPS Statistics - Indonesia
CCA	Country Common Assessment
CEDAW	Convention on the Elimination of Discrimination against Women
CO	Country office
COAR	Country office annual report
CoC	Continuum of Care
CoP	Community of Practice
COVID-19	CoronaVirus Disease 2019
CP	Country programme
CPAP	Country programme action plan
CPD	Country programme document
CPE	Country programme evaluation
CSE	Comprehensive Sexuality Education
CPR	Contraceptive prevalence rate
CoE	Center of Excellence
CSO	Civil Society Organization
DAC	Development Assistance Committee of the OECD
DHS	Demographic and health survey
DIS	District Information System
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting <sup>1</sup>
FP	Family Planning
GAC	Global Affairs of Canada
GBB	<i>Guru Belajar dan Berbagi</i> (Teacher Learning and Sharing)

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<sup>1</sup> The term ‘female genital mutilation/cutting’ (FGM/C) is used in this document instead of ‘female genital mutilation’ (FGM) based on the agreed term to be used by the Government of Indonesia.

GBV	Gender-based violence
GEDSI	Gender Equality, Disability and Social Inclusion
GSHS	Global School Health Survey
HMIS	Health management information system
IANYD	Interagency Network for Youth Development
ICPD	International Conference on Population and Development
ICT	Information and communication technology
IDHS	Indonesian Demographic and Health Survey
INGO	International non-governmental organization
Kemdikbudristek	Kementerian Pendidikan, Kebudayaan, Riset dan Teknologi (Ministry of Education, Culture, Research and Technology - MoECRT)
Kemenkes	Kementerian Kesehatan (Ministry of Health - MoH)
Kemenpora	Kementerian Pemuda dan Olahraga (Ministry of Youth and Sport - MoYS)
LPA	<i>Lembaga Perlindungan Anak</i> (Child Protection Institute)
LPP Bone	<i>Lembaga Pemberdayaan Perempuan</i> in Bone (Centre for Women's Empowerment)
LPSDM	Lembaga Pengembangan Sumber Daya Mitra
M&E	Monitoring and evaluation
MIC	Middle-income Country
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MoECRT	Ministry of Education, Culture, Research and Technology
MoHA	Ministry of Home Affairs
MoWECP	Ministry of Women's Empowerment and Child Protection
MNH	Maternal and neonatal health
MSS- SPM	Minimum Service Standard
MSS VAWC	Minimum Service Standards for Integrated Services to Victims of Violence against Women and Children
MTR	Mid-term review
NAB	National Advisory Board
NAP	National Action Plan
NCVAW	National Commission on Violence against Women
NGO	Non-governmental organization
OECD	Organization for Economic Co-operation and Development
PEDUM	<i>Pedoman Umum</i> /programme Management Implementation Guideline
PoA	Plan of Action (for ICPD)

PKBI	Indonesia Planned Parenthood Association
PMME	Planning Matrix for Monitoring and Evaluation
P2TP2A	Pusat Pelayanan Terpadu Pemberdayaan Perempuan dan Anak, Integrated Services for Women Empowerment and Child Protection
Puskesmas	Primary Health Center (managed by Government – MoH)
PUSPAGA	Pusat Pembelajaran Keluarga, Family based Learning Center
RRF	Results and resources framework
RBM	Results-based management
RH	Reproductive health
RPJMN	National Mid Term Development Plan
RPJPN	National Long Term Development Plan
SCM	Supply Chain Management
SISN	National Social Security System
SGBV	Sexual and gender-based violence
SKPD	Local government task force
SP	Strategy Plan
SPR	Standard Progress Report
SRHR	Sexual and Reproductive Health and Rights
STRADA	Strategi Daerah, Regional Strategy
STRANAS	Strategi Nasional, the National Strategy
SWAP	Sector-wide assistance programme
TA	Technical assistance
TOR	Terms of reference
TWG	Technical Working Group
UNALA	The name of a youth-friendly SRH information and services model
UNCT	United Nations Country Team
UNDCAF	United Nations Development Assistance Framework
UNDP	United Nations Development programme
UNPDF	United Nations Partnership for Development Framework 2016-2020 Indonesia
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNSCDF	United Nations Sustainable Development Cooperation Framework Guidance
UNWomen	United Nations on Women

UPT/D	Unit Pelaksana Teknis (Daerah), Technical Unit at the Regional Government Level
VAW	Violence against Women
WHO	World Health Organization
LPSDM	Lembaga Pengembangan Sumber Daya Mitra
YDI	Youth Development Index
YFS	Youth Friendly Services
YSSI	Yayasan Siklus Sehat Indonesia

# **Executive Summary**

## **Background**

UNFPA and UNICEF Indonesia jointly commissioned an independent final evaluation of “Better Reproductive Health and Rights for All in Indonesia” (BERANI) programme (2018-2022). Managed jointly by UNFPA and UNICEF, this evaluation is an external, independent exercise conducted by a team of evaluators based on UNFPA guidelines on programme Evaluations, ethical norms, and The United Nations Evaluation Group (UNEG) standards.

The BERANI joint programme focuses on enhancing quality of care of Skilled Birth Attendants (SBA) through midwifery education and practices and its regulation; improving the maternal death surveillance and response system; providing youth-friendly services (YFS) and information; working together with as many youth groups as possible as a means of creating a large “youth community” and reflecting the needs of youth; strengthening CSE; and advocacy and community-based programming for the prevention of GBV, child marriage, and FGM/C across development and humanitarian continuum.

## **The Purpose and objectives of the Evaluation**

The final evaluation aims at assessing the results of the BERANI programme in achieving its intended goals and overall achievements hence it could be utilized for the basis to improve the implementation of future programming. The final evaluation examines the implementation approaches, progress made, and challenges encountered, identify, and document the lessons learnt and good practices as specified below under specific objectives, and make specific recommendations for future courses of action.

## **Scope and Methodology**

The evaluation covered the period March 2018-December 2022; and included all activities planned and/or implemented under the programme at a national level and in selected target districts during this period within each project component (sexual and reproductive health and rights, Adolescent Sexual and Reproductive Health (ASRH), and gender equality and women’s empowerment). As the previous mid-term review (MTR) has been conducted to cover the period of March 2018-December 2021, this evaluation is built upon that to avoid duplication. It includes its recommendations where applicable, and how the project has responded to the recommendations post-MTR. Further, sustainability aspects are also emphasized in this evaluation.

Evaluation applied qualitative study, by performing document review and primary data collection through interviews and FGDs. The primary data collection conducted only when the literatures reviewed are not sufficient to provide information sought in this evaluation. The Theory of Change is reviewed and compared with project implementers’ understanding on how the interventions are in line and can contribute to the intended outcomes. Structured around seven evaluation criteria: Relevance, Effectiveness, Efficiency, Sustainability, Coherence/Coordination, and specific to humanitarian sector, Coverage and Connectedness. Triangulation mechanism was done through method triangulation (document review – primary qualitative survey), and evaluator triangulation (2 team members).

## **Main Conclusions**

Based on the findings from the MTR and additional data analysis, the evaluation draw the following conclusions:

1. UNFPA and UNICEF have followed up most of the recommendations made in the MTR report. One of the crucial aspects being simplification/streamlining of the logic model in accordance with the

GAC monitoring framework. By doing so, the logic pathway is becoming clearer than the initial developed one.

2. *Relevance*: The overall BERANI programme (and each component) is relevant with the current GoI priorities. The programme has supported government and related stakeholders (national and subnational) in generating evidence, facilitating policy dialogue, contributing to policy/programme design, including establishing a governing body, and critical capacity building.
3. *Effectiveness*: BERANI has achieved the intended targets at the output level. Meanwhile contributions of output to the outcome level can solely be qualitatively justified, as the programme's scope is fairly small compared to the national-joint or GoI effort.
4. *Efficiency*: UNFPA and UNICEF have effectively utilized their established international and national networks in implementing the BERANI programme. This is a key success factor leading to the programme's acceptability by stakeholders, hence contributing largely to its achievements. In addition, this has also enabled BERANI to provide the required technical expertise, international and nationally.
5. *Coherence*: While BERANI is designed as a joint-programme, the coherence across thematic components, and between overlapping issues addressed by UNFPA and UNICEF, are still lacking. Each component of the BERANI programme has different pilot sites and partners despite having similar target groups (e.g. health service providers).
6. *Sustainability*: Numbers of pilot project innovations have been replicated (fully or partially) by subnational and national governments, hence increasing its odds of sustainability. Among others, it includes MoH funding commitment to Poltekkes as Midwifery CoEs, adaptation of UNALA module for posyandu remaja, translation of STRANAS to Prevent Child Marriage into STRADA and replication of Bone's child marriage Model into Wajoo and Luwu Utara District by the local government.
7. *Coverage and Connectedness*: During the COVID-19 pandemic, BERANI has managed to act in an adaptive manner, putting notable effort in alternating the approach (to online or hybrid models) and responding to the national agenda on pandemic response (series of COVID-19 webinars, PPE provisions). Regardless of the pandemic's impact on the programme, the era has also brought an opportunity for the programme to be innovative, being one is the use of digital technology for GBV services, and CoP initiation for COVID-19, later expanded for ASRH.
8. The Joint programme's design and implementation has identified and incorporated the needs of women and girls, including vulnerable, marginalized ones, and those with disabilities in ASR, GBV and harmful practices' preventions. GEDSI transformative approach in SRH components is identified as male's involvement in FP, and improvements are still needed in SRH capacity building, including disability friendly SRH services.

#### **General Recommendations for Future Joint programming**

The following general recommendations are proposed based on the lessons learned from BERANI programme implementation. These recommendations are not made specifically for the continuation of the BERANI programme rather for multi-thematic programming. In principle, it is recommended that future joint-programming to:

1. Maximize the use of each agency's expertise, and extend collaboration beyond proposal stage development.
2. Strengthen the high-level engagement in the future joint-programming to achieve a greater policy impact and potential for sustainability
3. Promote gender transformative approaches in the future joint-programme to achieve gender equality and sexual reproductive health and rights by explicitly addressing the underlying causes of

- gender inequality in policies, legislations, institutions, norms, and stereotypes through engagements with the non-traditional groups, including males, and youth.
4. Ensure programme adaptability in a humanitarian context to cover both responding to the needs and alteration in project approach/method of delivery.

### **Programmatic Recommendations**

The following programmatic recommendations are proposed in a spirit of continuing what have been achieved by BERANI, by thematic component.

1. Sexual and Reproductive Health. It is proposed for UNFPA to:
  - a. Ensure the endorsement of the National Standard and Curriculum for Midwifery Education by the Ministry of Education.
  - b. Identify and provide the support needed to continue the midwifery CoEs and its plan for knowledge hub and “institution-mentoring” mechanism..
  - c. Assist IBI in replicating the supervision and coaching mechanism.
  - d. In consultation and collaboration with the key stakeholders, develop a grand design for midwifery pre-service quality improvement with a strengthened GEDSI component.
  - e. Develop a strategic approach for FP2030 in addressing key challenges of FP programme with a strong involvement of relevant MoH units.
2. Adolescent Sexual and Reproductive Health. It is proposed for UNFPA to:
  - a. Expanding the target beneficiaries and programme coverage of ASRH information through existing youth networks.
  - b. Involving youth in ASRH programme, not only as a target, but also promoting their active engagement in programme design, and throughout the programme cycle (implementation, monitoring and evaluation). For instance, initiatives that support a bottom-up approach, like those in the CoP when selecting the themes and speakers for the webinars.
  - c. Better coordinate and strategize the established Community of Practice (CoP).
  - d. Document lesson learned, and evaluate the effectiveness of CSE in the pilot project, and provide evidence for replication/scale up.
3. GEWE
  - a. **Prevention of GBV**
    - UNFPA to facilitate the MoWECP to monitor and advocate the MOH’s work to adopt the BERANI’s capacity development model on HSR to GBV in its regular capacity development programme, based on the BERANI’s lessons learnt
    - UNFPA to facilitate the MoWECP to continue promoting the use of digital technology and online reporting of GBV cases in wider P2TP2A/UPT PPA in Indonesia.
  - b. **Prevention of Child Marriage.**
    - UNFPA and UNICEF to disseminate the good practice on the approaches and implementation of the BERANI’s programme to prevent child marriage at the national level and the local level, including the pilot project in South Sulawesi to wider stakeholders (relevant government units, donor organizations, universities, and NGOs/CSIs), for further adoption and replication of the workable approaches and models and do necessary follow up.

- UNFPA and UNICEF to improve evidence generation and data utilization on the prevention of child marriage at the sub-national level
  - UNFPA and UNICEF to promote stronger multisectoral approach for related government institutions and sectors to address child marriage in Indonesia
- c. **Prevention of FGM/C.**
- UNFPA and the MoWECP to facilitate KUPI to disseminate the KUPI's Fatwa on FGM/C to wider stakeholders, including female and male ulemas in Indonesia
  - UNFPA and the MoWECP to continue engagements with MoH, IBI, and IDI as well as with women movements, including PUSPAGA, youth forums, and cultural based organizations to prevent FGM/C

## Key Facts Table (Indonesia and the current indicators related to SRHR)

Table 1. Key Facts

Geographical location	South East Asia; An enormous archipelago, Indonesia has 16,056 <sup>2</sup> islands straddling the equator and is the most southerly of all of the countries of South-East Asia.
Land area	1,916862.20 km <sup>23</sup>
Terrain	Diverse terrain with masses of coastline, mountainous regions mostly made of active and dormant volcanoes and very large forested areas.
<b>People</b>	
Population	266.9 million <sup>4</sup>
Urban/ rural ratio	0.181 <sup>5</sup>
Total Fertility Rate	2.4 <sup>6</sup>
<b>Government</b>	
Type of government	Parliamentary Democratic Republic with lower and upper houses and regional parliaments at national, province and district levels. Since 2000, Indonesia implements a wide range of decentralization initiatives to reform its centralized government and development planning. Bypassing the provinces, the reforms granted greater authority, political power, and financial resources to regencies and municipalities.
% of seats held by women in national parliament	17.32% <sup>7</sup>
<b>Economy</b>	
GDP per capita	USD 4,332 <sup>8</sup>
GDP Growth rate	3 <sup>9</sup>
Main industries	Oil, Gas, Forestry, Palm Oil, Coal, manufacturing, tourism inter alia <sup>10</sup>
<b>Social indicators</b>	
Human Development Index Rank	114 <sup>11</sup>
Gender Inequality Index Rank	104 <sup>12</sup>
Gender parity in tertiary education (GPI)	85 <sup>13</sup>
Adult literacy rate (15+ years)	96% <sup>14</sup>
Unemployment. rate	5.86 <sup>15</sup>

<sup>2</sup>Indonesian Statistical year book 2018.

<sup>3</sup>*Ibid.*

<sup>4</sup>BPS, BAPPENAS & UNFPA, 2018, 2015-2045 Indonesia Population Projection.

<sup>5</sup>*Ibid.*, Urban Rural Growth Difference Rates (URGD) for 2015-2020.

<sup>6</sup>2017, IDHS.

<sup>7</sup> BPS-Statistics Indonesia, 2015, Percentage of Women House of Representatives (*Dewan Perwakilan Rakyat/DPR*) Members in 2014 General Election

<sup>8</sup>World Bank, 2021, Capita of GDP at Current Price in 2021

<sup>9</sup>*Ibid.*

<sup>10</sup>Indonesian Statistical yearbook 2018

<sup>11</sup>[http://hdr.undp.org/sites/all/themes/hdr\\_theme/country-notes/IDN.pdf](http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/IDN.pdf), accessed March 24, 2023

<sup>12</sup>*Ibid.*

<sup>13</sup>2018, The Global Gender Gap Report 2018: [http://www3.weforum.org/docs/WEF\\_GGGR\\_2018.pdf](http://www3.weforum.org/docs/WEF_GGGR_2018.pdf)accessed August 26, 2019

<sup>14</sup>World Bank, 2021,

<sup>15</sup>BPS-Statistics Indonesia, August 2022.

Youth not in education, employment or training (NEET)	22.5% <sup>16</sup>
Life expectancy at birth	73.0 <sup>17</sup>
Under-5 mortality (per 1000 live births)	32 <sup>18</sup>
MMR	305 <sup>19</sup>
Health expenditure (% of GDP)	3.6% (2015) <sup>20</sup>
% of births attended by skilled health personnel..	91% <sup>21</sup>
Antenatal care coverage by at least 4 visits	77% <sup>22</sup>
Percent of births delivered by C-section	17.0% <sup>23</sup>
Adolescent birth rate	36 <sup>24</sup>
The proportion of women age 15–19 who have begun childbearing	7% <sup>25</sup>
Contraceptive Prevalence Rate	64% (any method) and 57% (any modern method) <sup>26</sup>
Unmet need for family planning	16.8% <sup>27</sup>
Percent of women aged 20–24 who were married before age 18	11.2% <sup>28</sup>
Median age at first marriage	21.0 <sup>29</sup>
% of people living with HIV, 15-49 years old	0.4% <sup>30</sup>
The proportion of deliveries attended by SBAs (%)	95.2% <sup>31</sup>
The proportion of institutional deliveries (%)	87.9% <sup>32</sup>
Adolescent birth rate (aged 15-19 years) per 1,000 women	36 <sup>33</sup>

<sup>16</sup> Statistic Indonesia, cited in Voluntary National Review (VNR) ‘Empowering People and Ensuring Inclusiveness and Equality’, Republic of Indonesia, 2019.

<sup>17</sup>BPS, BAPPENAS & UNFPA, 2018, 2015-2045 Indonesia Population Projection.

<sup>18</sup>2017, IDHS.

<sup>19</sup>2015 Intercensal Population Survey (SUPAS)

<sup>20</sup>2018, Ministry of Health, Indonesia Health Profile 2017

<sup>21</sup>2017, IDHS.

<sup>22</sup>*Ibid.*

<sup>23</sup>*Ibid.*

<sup>24</sup>*Ibid.*

<sup>25</sup>*Ibid.*

<sup>26</sup>*Ibid.*

<sup>27</sup>Update PK2022

<sup>28</sup> BPS-Statistics Indonesia, 2018 the National Socio-Economic Survey (SUSENAS)

<sup>29</sup>Update PK2022

<sup>30</sup>2018, UNAIDS at <https://www.unaids.org/en/regionscountries/countries/indonesia> accessed August 26, 2019

<sup>31</sup> National Social-Economic Survey, Statistics Indonesia, cited in Voluntary National Review, 2021

<sup>32</sup> *Ibid*

<sup>33</sup> 2017, IDHS

## Structure of report

This Report comprises an Executive Summary, six chapters, and Annexes, and follows the structure recommended in the Evaluation Handbook by the UNFPA Independent Evaluation Office.

**Chapter 1**, the Introduction, provides the background to the review, objectives and scope, the methodology used. **Chapter 2** describes the Indonesia country context, development challenges it faces in the UNFPA and UNICEF mandated areas, national strategies, and the role of BERANI. **Chapter 3** refers to the BERANI strategic response and programme in the areas of sexual and reproductive health and rights, adolescent and youth, gender equality and women's empowerment. **Chapter 4** presents the findings for each of the review questions specified in the Review Matrix (which is annexed). In doing so, we classify sub-bab by areas of intervention (i.e., SRH, ASRH, and GEWE). **Chapter 5** discusses conclusions, and **Chapter 6** concludes with strategic and programmatic level recommendations based on the conclusions.

# Chapter 1: Introduction

## 1.1 Purpose and Objective of the Evaluation

The final evaluation aims at assessing the results of the BERANI programme in achieving its intended goals and overall achievements hence it could be utilized for the basis to improve the implementation of future programming. The final evaluation assesses the implementation approaches, progress made, and challenges encountered, identifies, and documents the lessons learnt and good practices as specified below under specific objectives, and makes specific recommendations for future courses of action.

With the above stated purpose, the objectives of the final evaluation are:

1. To assess the relevance, effectiveness, efficiency, coherence, sustainability, coverage, and connectedness of the programme from its inception to its completion
2. To document important lessons learned, good practices and innovations of the BERANI programme
3. To provide strategic and operational recommendations for potential continuation or scaling-up of the programme
4. To assess the integration of gender equality and women's empowerment into the programme activities aimed at improving sexual and reproductive health and rights of women and young people in Indonesia.

## 1.2 Scope of Evaluation

The Final Evaluation covers the entire programme cycle (February 2018 - December 2022), but the analysis builds upon the results of the Mid-Term Review (which covered the period of February 2018 - June 2021). The evaluation covers all programme activities planned and/or implemented at the national and district level within each programme component (sexual reproductive health and rights, adolescents and youth, and gender equality and women's empowerment).

## 1.3 Evaluation Criteria

The final evaluation applied four OECD/DAC evaluation criteria, complemented with additional evaluation criteria - Connectedness and Coverage

- Relevance: Assessing the extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, partners', governments' and donor priorities
- Effectiveness: Assessing the extent to which the development intervention's objectives were achieved, considering their importance to both achieving the programme goals and addressing the beneficiaries and country needs
- Efficiency: Assessing the suitability and contribution of resources allocated to achieve the programme objectives

- Sustainability: Assessing the potential continuation of benefits/established mechanism established beyond the programme lifetime
- Coverage and Connectedness: Measuring (1) the extent to which major population groups facing life-threatening suffering were reached by the programme intervention, with a specific case of those who are at higher risks of COVID-19. (2) the extent to which activities of a short-term COVID-19 response are carried out in a context that takes longer-term and interconnected problems into account.
- Coherence: Assessing the extent of programme intervention has an added value to country and UN current efforts in addressing the issue, including the collective efforts and communication across UN partners, and with key stakeholders

Evaluation questions and matrix against each criterion is attached in Annex 2.

## 1.4 Methodology and Process

Evaluation applied qualitative design by performing document review and primary data collection through interviews, group discussions, and focus group discussions. The primary data collection was conducted only when the literature reviews were not sufficient to provide information sought in this evaluation. The Theory of Change was reviewed and compared with project implementers' understanding on how the interventions are in line and can contribute to the intended outcomes. The evaluation was built on the mid-term review (MTR), including its recommendations, and how the project has responded to the recommendations post-MTR. Further, sustainability aspects are also emphasized in this evaluation.

The evaluation paid special attention to ensure gender equality and human rights-based approaches are embedded into the data collection and analysis. Gender was treated as a cross cutting theme and the review was guided by the United Nations Evaluation Group (UNEG) ethical guidelines for evaluation, as well as UNEG Norms and Standards.<sup>34</sup> Making the process transparent, inclusive, and participatory as well as gender and human rights responsive. It utilizes data disaggregated by age, gender, vulnerable groups, etc. to ensure findings are gender reflective and targeted.

The evaluation is done in stages shown in Figure 1.

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<sup>34</sup><http://www.unevaluation.org/document/detail/102>.

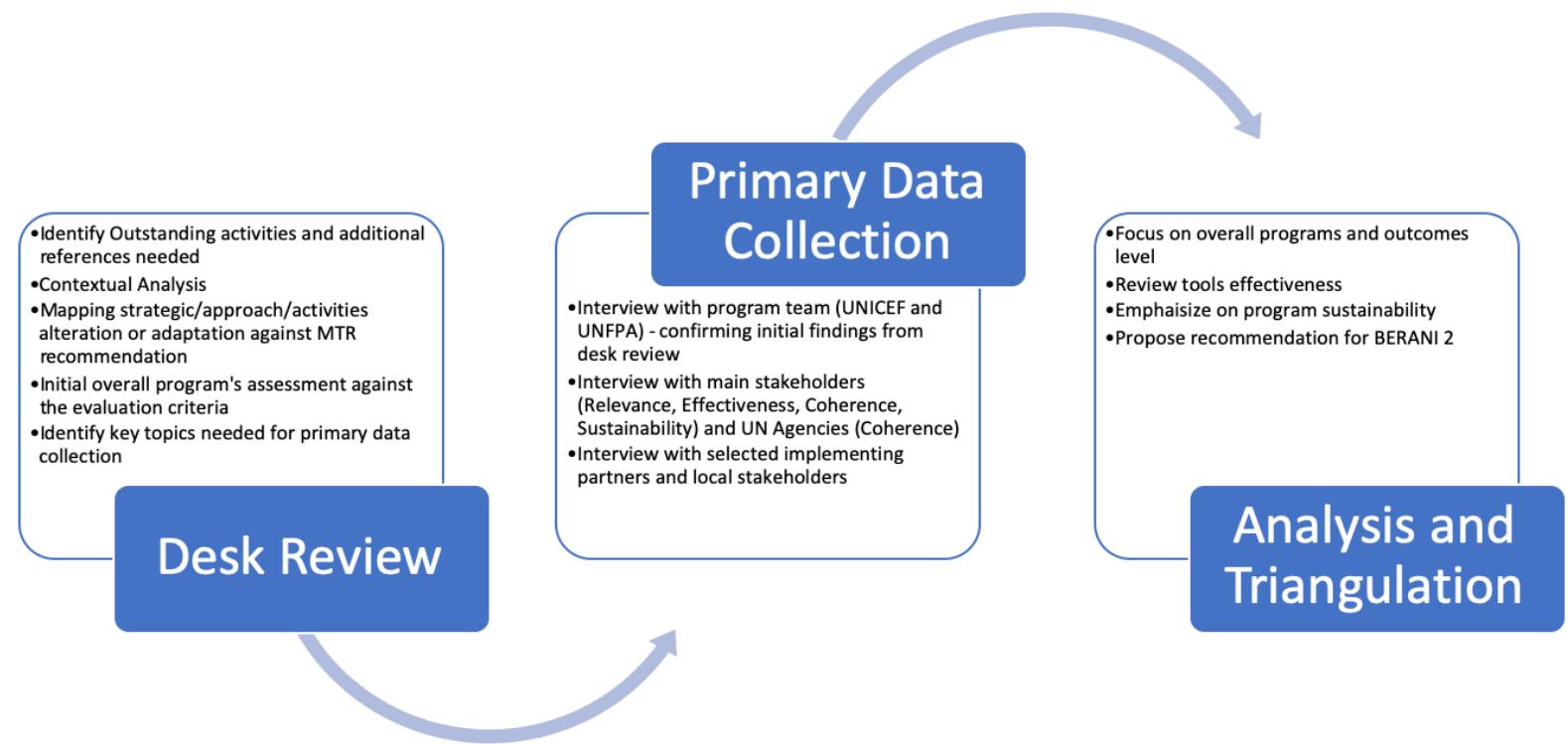


Figure 1 Evaluation Process

#### 1.4.1 Desk Review

As the evaluation is aimed to fill in the MTR gaps, firstly the initial review was conducted to map the outstanding activities, and identified additional references needed from the programme team. Documents included in the desk review stage include those related to the current context's development and programme's report post MTR, BERANI knowledge products and best practices document. A contextual analysis of the current's situation related to Sexual Reproductive Health Service (related to Midwifery Curriculum, health service transformation), Adolescents and Youth, and GBV was conducted to allow a deeper evaluation of the BERANI programme's relevance to the current context.

In addition, to provide understanding of the current context, the desk review aims to:

1. Map the strategic/approach/activities alteration or adaptation against MTR recommendation
2. Review the overall programme's assessment against the evaluation criteria based on the programme's documentation
3. Identify key topics needed for primary data collection

## 1.4.2 Primary Data Collection

Primary data collection was done through Key Informant Interviews (KII) either through online platforms or face-to-face interviews. The interview is digitally recorded for analysis purposes. Interviews are conducted using the interview guidelines developed based on the document reviews.

In addition, we conducted field visits to further look into selected interventions or initiatives, either through observation or discussion with local implementers. The selection criteria for the interventions to be observed are:

- Initial replication is indicated; OR
- Intervention that is potentially affected by current development changes; OR
- Intervention that is highly linked with current government's priority

A purposive sampling strategy was applied to select the participants for the interview and FGDs. Participants invited to the interview and/or Focus Group Discussion are those fulfilling the inclusion criteria below:

- Involved in BERANI programme implementation (either as UN agencies, or implementing partners)
- Managing SRHR and GBV programme at national/sub national level, including ASRH education
- Beneficiaries (direct or indirect) beneficiaries of BERANI programme

In the initial stage, UNFPA and UNICEF RH, youth, gender and child protection team acted as gatekeeper to identify key partners that were required to be interviewed. Next, during the step 2 interview with partners, selected beneficiaries were invited to participate in group discussions or FGDs. Participants invited to the interview and group discussion reflected the full range of interventions under BERANI post the MTR. The local level implementing partners and the project level staff assistance sought in identifying the feasibility of reaching the stakeholders for interviews. Data collection was done either online or onsite, depending on the participants availability and time of data collection. Other than with the programme team, no primary data collected for SRH components. Briefly, the data collection includes:

- Online: BERANI programme team, UNRCO, UN Women, National stakeholders, Puskesmas and P2TP2A in Tangerang, Bogor, Palu and Sigi (for GBV service)
- Onsite: Yogyakarta (for ASRH), Wajo (for child marriage prevention and MHM)
- Secondary data using documentation video: SRH implementing partners (IBI, DG human resource for health MoH), MoECRT (for CSE), end beneficiaries (midwifery students and midwives supervision and coaching), and CoP.

The list of participants and detailed field visits are available in the Annex 3.

## 1.4.3 Analysis and Triangulation

This step encompassed data analysis, results interpretation, and justifying them against the project logical model/ToC and GAC gender transformative approach. Content analysis was performed on the data obtained in the KII and Focus Group Discussions, applying a deductive approach, using the evaluation matrix as analysis guidance. Each interview was firstly analyzed independently, similar codes and themes across the interview were collated and used for triangulation with the document review. Additional literature review was performed to confirm the pathway of assumption in the logical framework, and the evaluation criteria.

Summary against questions, assumptions, and indicators reflecting the evaluation matrix as well as specific details such as demographic characteristics (gender, age, institution represented, geography), and their level of engagement in the project is developed to guide the narrative reporting. The analysis was also guided by the GAC Gender Equality Coding Framework<sup>35</sup> to examine the impacts of the BERANI Joint programme on gender.

Triangulation mechanism was done through method (document review - qualitative), evaluator (2 team members). Further details on the evaluation design can be seen in Annex 1.

#### 1.4.4 Limitations

We acknowledge that the evaluation has several limitations. First, a strategy to recruit gatekeeper participants may lead to potential participant bias. Participants selected for the primary data collection were those referred by the programme team, and implementing partners. Addressing this potential bias, we triangulate the data with data obtained from document review. Second, there was no quantitative assessment conducted, including for assessing cost efficiency. The evaluator team did not have access to financial actual data and relies on information obtained from interviews and MTR reports for this matter. Third, no interview or focus group discussion was participated by end beneficiaries (including children and GBV survivors), due to time limitation to proceed with ethical clearances. Moreover, the planned observation of LSE's student activities was not able to be carried out as participating students of LSE in Wajo were on holiday. Only an activity of women's preachers on MHM and child marriage prevention in Wajo can be observed. During the final evaluation's field visit Hence, information on programme impact for end beneficiaries were based on perception of implementing partners as well as other relevant beneficiaries, such as teachers and schools' facilitators in the case of LSE. Despite the limitation, the evaluation was done independently, maximizing the use of document review and series of discussion with the programme team.

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<sup>35</sup> GAC, *How Projects Are Coded for Gender Equality*, [nd].

## Chapter 2: Country and programme Context

Along with shifts in the size, composition and distribution of Indonesia's population, the country is getting wealthier and education levels are increasing (see Key Facts Table). Indonesia has shown significant progress in both social and economic development in the past decade, although there continues to be regional disparities and inequalities in the level of benefit sharing of development gains.

As an emerging middle-income country, Indonesia has made enormous gains in poverty reduction, cutting the poverty rate to more than half since 1999, to 9.8% in 2018.<sup>33</sup> However, out of a population of around 270 million, more than 25.9 million Indonesians still live below the poverty line. Based on March 2017 data, the incomes of approximately 21% of the population hover marginally above the national poverty line.<sup>34</sup> Given the context of COVID-19 pandemic, this situation may have worsened as the impacts of the pandemic are complex and have created a health crisis. Affecting the economics and the social fabric of the country, the pandemic had a severe drain on the health services. Addressing these problems, local governments play a key role in Indonesia's decentralization governance system. Indonesia's decentralization has brought various positive impacts in the key areas of development including local democracy, women's participation in economic and political activities, public service quality, and health services.<sup>35</sup> Further, decentralization has promoted innovative approaches to emerge, allowing the local government to design, adapt and implement programmes contextualized to their people's needs. However, not all local governments have adequate capacity and resources to do so, underlining the needs for assistance at the sub-national level.

The changes in demographic parameters in the past two decades have caused rapid changes in the current population age structure and distribution by sex, including a rapid decline of fertility and mortality and more dynamics of migration direction and patterns. As the implications, Indonesia has entered the era of demographic dividend/bonus in which the working-age population is increasing and becoming more than the non-working age population. In addition, the proportion of people aged 60 and over, has also substantially gone up. Finally, currently, one out of two Indonesians lives in urban areas, and projected to become 3 out of 4 Indonesians will live in urban areas. However, the effects of the pandemic on population dynamics are not yet measured. A recent projection, taking different scenarios into consideration, have shown several important implications for planning. For example, i) numbers of primary and secondary school-aged children will continue to increase. As Indonesia aims to reach 9, and then 12 years universal education, the challenge of raising enrolment ratios at the more expensive middle and upper secondary levels of education will be great; ii) numbers in the younger working ages will continue to increase, but the increase will be much greater in the mature working ages (30-64 years), with implications for employment, labour productivity, economic and labour force planning; iii) increasing numbers of elderly will require attention to the needs of this most rapidly growing segment of the population (pensions, health care, etc.)<sup>35</sup>.

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<sup>36</sup>Baidhowah, A. R. (2022). Explaining Decentralization Performance in Indonesia: Member of Parliament Decision, Political Networks, and Constitution Amendment. *Jurnal Bina Praja*, 14(1), 97–109.

## Humanitarian context

COVID-19 Pandemics have occurred across the globe, including in Indonesia. A rapid assessment on COVID-19 impact on FP and maternal health services was initiated in 2020 in nine locations that covers three epidemic zones: a) red zone (Jakarta, Surabaya, Makassar); b) yellow zone (Lombok Tengah, Balikpapan, Lahat); and c) green zone (West Aceh, Minahasa, Manokwari districts). The rapid assessment was conducted in three phases of a six-month cycle. The first two phases of data collection have been conducted. The third phase is currently ongoing and will be finalized by the end of 2021. It showed a decreasing tendency of service coverage during the early stage of the pandemic, but then it was back to normal in the third phase. A study on unmet need for FP services is currently ongoing.

Social restriction policy during the COVID-19 Pandemics increased risk of termination from work for women. Transition to online mechanisms also presented a barrier for women who have limited access to the internet. Multiple burdens and violence had been an issue even before the pandemic, yet they became more prominent during the pandemic, despite the difficulties to document violence cases, during the Pandemics, making it more difficult for women to obtain support (reproductive health services such as antenatal care, childbirth, and services on mental/emotional disorders, as well as routine check of non-communicable diseases), as the health system was prioritized on COVID-19.

Children, particularly girls, were among the most vulnerable groups impacted by the COVID-19 Pandemics. While children lost their opportunity to learn, due to the social restriction, as schools went online and access to the internet was not evenly distributed among Indonesians, girls were on higher risks to experience child marriage during the pandemics<sup>37</sup>. It was reported that from January to June 2020 only, the Indonesian Religious Courts received around 34,000 applications for marriage dispensation for children younger than 19 years old<sup>38</sup>.

Hence, the focus of this section is to briefly discuss the challenges the country faces in the key areas that are related to the BERANI programme and the national strategies and policies that are in place to address some of these.

## 2.1 Development Challenges and National Strategies

### Sexual and Reproductive Health (SRH)

Maternal health continues to be a significant public health issue in Indonesia. Despite a high reported percentage of deliveries attended by skilled birth attendants (SBA, 91.5%) and institutional deliveries (77.6%), the country has a paradoxical phenomenon with a maternal mortality ratio (MMR) as high as 305

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<sup>37</sup> UNFPA, Desk Review on Impacts of COVID-19 Pandemics to Child Marriage, 2020.

<sup>38</sup> NCAW, Looking at the Impacts of the COVID-19 Pandemic and Social Restriction Policy Through Indonesian Women's Perspective, a Policy Brief, 2020

maternal deaths per 100,000 live births<sup>39</sup>. Latest figure in 2021, there were 7389 maternal deaths in Indonesia throughout the year. It is thought that poor quality of care is a major contributor to the high number of MMR. A recent study conducted in East Java noted that inadequate maternal quality of care in referral health service include poor application of protocols, poor patient flow, delay in emergency care, and delays in treating deteriorating mothers.<sup>40</sup> This underlines the importance of an integrative quality improvement, including health professionals and health service management.

The Government of Indonesia has committed to improving maternal health, reducing MMR and promoting Family Planning (FP) by putting maternal health as central in its national development plan and as part of its SDGs, especially SDG 3. The maternal and perinatal issue has been prioritized as a development issue; therefore, it is expanded to health system interventions with a commitment to universal health coverage. Significant technical support from relevant partners is required to meet SDG 3 target of reducing maternal mortality below 70 per 100,000 live births by 2030<sup>41</sup>. Meanwhile, the GoI has set up an MMR target of 183 per 100,000 live births by 2024 (i.e. the mortality rate needs to be reduced by 5.5% per year).

According to the National Action Plan for Maternal and Neonatal Health 2016-2030, Indonesia will still rely on the midwifery workforce to provide reproductive, maternal, neonatal and child health care to its population. The estimate suggests an addition of around 13,000 more midwives are required by 2025. This will be met through pre-service education provided by over 700 midwifery schools around the country, of which only 43% are accredited. Among other interventions, the MoH plans to address the issues around competencies and quality of care of the midwifery workforce through improving the existing pre-service education and regulatory mechanisms.

However, the COVID-19 pandemic has been disrupting the health system. As the COVID-19 pandemic restricts health workers from providing health services and hinders the supply chain for the availability of pharmaceuticals and medical equipment, it disrupts the achievement of health development targets in improving maternal and neonatal health, family planning, and other reproductive health services, and the fulfillment of health workers, pharmaceuticals, and medical equipment<sup>42</sup>. In response to the pandemic, the Government, through the Task Force for the Acceleration of the Response to COVID-19, has developed a National Response and Mitigation Plan for COVID-19. The plan has the following objectives<sup>43</sup>: i) to limit transmission of the COVID-19 outbreak, reduce subsequent infections in vulnerable communities and health workers, including preventing the wider impact due to comorbidities; ii) Early detection, isolation and early treatment, including carrying out optimal services for COVID-19 patients; iii) implementation of pharmaceutical and non-pharmaceutical measures for the COVID-19 outbreak; iv) identification of all resource requirements related to COVID-19 response; and, v) maintaining public order and security as well as social and economic stability during the COVID-19 response.

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<sup>39</sup> National Social-Economic Survey, Statistics Indonesia, as cited in Indonesia's Voluntary National Review, 2021.

<sup>40</sup> Mahmood MA, Hendarto H, Laksana MAC, Damayanti HE, Suhargono MH, Pranadyan R, et al. (2021) Health system and quality of care factors contributing to maternal deaths in East Java, Indonesia. PLoS ONE 16(2): e0247911. <https://doi.org/10.1371/journal.pone.0247911>

<sup>41</sup> Ministry of Health. Strategic Plan 2020-2024. Jakarta, 2020

<sup>42</sup> BERANI Project document, 2020.

<sup>43</sup> UNOCHA and UNRCO. Indonesia Multi-sectoral Response Plan to COVID-19. Jakarta, 2020

In relation to the family planning programme, Indonesia is still lacking behind the set target of unmet needs in 2015-2019 Strategic Plan of 9.9%. The 2022 national figure of unmet needs was 16.8% (doubled the target of 8%), with modern contraceptive prevalence rate (mCPR) was 59.4% (target for 2022 was 62.5%)<sup>44</sup>. The COVID-19 pandemic was an additional constraint for the family planning programme. The health service disruption has affected the FP services, including counseling, leading to reduced contraceptive coverage, changes in type of contraception, methods, counseling behavior, and reduced visit to health facilities.<sup>45,46</sup> The situation has clearly affected the FP service, and in a larger context, effort to achieve the target set in FP2020. Despite this, health system has adapted to provide FP services, emphasizing on health education and telecounseling.<sup>41</sup>

#### Adolescent Sexual and Reproductive Health (ASRH)

Around 17% or 46 million of Indonesia's productive age population are adolescents (age 10-19). The wellbeing and optimal development of adolescents hold significant importance for Indonesia to excel as a nation. Nevertheless, a considerable percentage of the adolescent population still faces challenges accessing services, especially reproductive health services. Knowledge and services on sexual and reproductive health are still considered taboo that access to information remains limited.

The IDHS shows that almost all young men and women are familiar with modern contraceptives (female: 96%; male: 93%); yet, a significant proportion of adolescents have not been able to apply their knowledge in the contexts of mitigating the risk of pregnancy or preventable sexually transmitted infections (STIs). The same report demonstrates that only 50.5% of adolescent girls and 48.6% of adolescent boys understand the risk of teenage pregnancy. In addition to this, the proportion of adolescents who possess comprehensive knowledge is even lower, only 15% among adolescent girls and 11% among adolescent boys. One of the methods of increasing adolescents' knowledge and skills in SRH is through the education curriculum. Although the discourse of integrating SRH into Indonesia's school curriculum has been discussed for more than a decade, the delivery of SRH content to students is still unsystematic, mainly due to social and religious concerns. Lack of knowledge has the potential to make adolescents exposed to health myths and increase the risk of unwanted pregnancies, sexually transmitted infections and being trapped in violence in relationships with partners.

During the Pandemic COVID-19, many health services must focus on cases of COVID-19 infections, which also affect the deployment of their health workers. The re-orientation has reduced the adolescent sexual and reproductive health (ASRH) services. In the beginning of the pandemic crisis, some community health centers had to stop their reproductive health services for adolescents due to the high viral infection cases in their areas<sup>47</sup>. School closures have increased the chance of dropping out, especially for adolescents, which reduced their exposure to reproductive health education and services, increasing their SRH-related risks.

<sup>44</sup> BKKBN, Update data Pendataan Keluarga 2022

<sup>45</sup> Larasati, A., et al. 2021. Determinants of Family Planning Unmet Needs in West Java and Policy Recommendations during the Covid-19 Pandemic (Based on Advanced Analysis of 2019 SKAP Data). Journal of Indonesian Health Policy and Administration;6(2): <http://dx.doi.org/10.7454/ihpa.v6i2.4672>

<sup>46</sup> Mediastuti, F. et.al. 2022. Pola Pelayanan Keluarga Berencana pada Masa Pandemi COVID-19 dan Strategi Menghadapi New Normal di Yogyakarta. Jurnal Kependudukan Indonesia;17(01): <https://doi.org/10.14203/jki.v17i1.648>

<sup>47</sup> Aliansi Satu Visi, Survei Terbatas Dampak Pandemi COVID-19 pada Layanan Kesehatan Reproduksi Remaja, 2020

Adolescent girls were affected significantly. The national commission on violence against women recorded 954 cases of violence against female children in 2021<sup>48</sup>.

The Government of Indonesia (GoI) has included adolescents in their national mid-term development plan 2020-2024 (RPJMN) as part of their targets in human resource development through improving access to improved health services, including reproductive health services, education and vocational profession, gender equality and inclusion, and quality youth development<sup>49</sup>.

The GoI has prioritized programmes targeted at adolescents, as illustrated by the coordinating ministry for Human Development and Culture which endorses the National Action Plan on Adolescent Wellbeing in order to build up the coordination mechanism among ministries to prioritize adolescent programmes. One of the central government's programmes that prioritize adolescents' needs and sensitive delivery methods is the Adolescent-Friendly Health Service, Pelayanan Kesehatan Peduli Remaja (PKPR). PKPR aims to ensure access to adolescent-friendly promotion, prevention, treatment, care, and referral services. As of 2019, 65.62% or 6,650 community health centres in Indonesia have had adolescent care services. Currently, provinces are requested to provide adolescent-friendly services in at least 40% of their community health centres. Most of the provinces (27 out of 34 provinces) have met this service requirement. Apart from providing services at health centres, PKPR in Indonesia also provides outreach services through the adolescent health post (Posyandu Remaja), with a total service of 2,794 units available nationwide. In addition, PKPR has provided the government with the strategic engagement of adolescents that it attracts interests from other programmes to synergize their activities with the PKPR activities, for example, the programme to integrate Counseling and Testing activities for Human Immunodeficiency Virus (KTHIV), infectious infections, and COVID 19 services into the programme.

These provisions of adolescent friendly services, however, still need to be strengthened with quality assurance services to ensure indiscriminative ARH services for unmarried adolescents and adolescents from marginal backgrounds. Opportunity for broader integration of ARH to school level activities also emerges through the efforts to revitalize Usaha Kesehatan Sekolah (UKS, a school-health interventions). With the support of its partners, the MOECRT has refined the four strata of UKS, from minimal to paripurna (complete), by including relevant issues such as provision and adequate practices of water and sanitation. These initiatives can be used to optimize and sustain the ARH practices in school.

Responding to the pandemic COVID-19, the government has issued policies to ensure SRH education and services even during the crisis. In 2020, the MOECRT integrated ARH into school-health policy and teacher development modules on life-skills education, which had some materials on SRH, into the online platform of Guru Bersama Berbagi (GBB). The online mode of teacher learning would enable more extensive coverage of teachers equipped with life-skill education teachings and materials. Meanwhile, the MoH has deployed a telemedicine method to provide SRH services during the Pandemic COVID-19, including adolescents. In

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<sup>48</sup> KOMNAS Perempuan, "Perempuan dalam himpitan pandemi: Lonjakan kekerasan seksual, kekerasan siber, perkawinan anak, dan keterbatasan penanganan di tengah COVID-19", *Catatan Tahunan Kekerasan Terhadap Perempuan Tahun 2020*, Jakarta: Komnas Perempuan, 2021.

<sup>49</sup> GOI, RPJMN 2020-2024.

addition, many communications, information, and education-related ASRH materials have also been conducted online through various media.

### Gender-based Violence (GBV)

Reported cases of gender-based violence experienced on-going fluctuations, from years to years. For example, there was a decrease of reported cases in 2019, as the COVID-19 Pandemic hindered survivors from reporting their cases. In addition, there has been an indication of stagnation with regard to the capacities of service providers to report on cases of GBVs, although the National Commission Against Women (NCAW) or the Catahu 2023 reported the complexities of handling the different cases of violence occurred in 2022, not only that in the personal level, but also in public and in state level. The Catahu report elaborated the different cases of violence to include cases of human rights violations, sexual violence, violence against women with disabilities, violence against minority women, and violence against marginalized women, for example, women HIV/AIDS. It was highlighted that cases of violence have been more massive and complex in natures, and targeted to different groups of girls and women, including those who experienced physical violence and/or cyber based violence.



Figure 2 Number of Reported Cases of Violence Against Women and Children from 2008 to 2020

Source: National Commission of Anti Violence Against Women , Catahu 2023

Reported cases of violence were 457,895 in 2022 or a slight decrease from the reported cases in 2021, 459,094, which captured the decrease of reported cases done by the Badilag, although the reported cases carried out by the NCAW increased in 2022. The NCAW reported that 339,782 out of total reported cases came from GBV, comprising 336,804 (or 99%) of violence cases at the personal level, 2,978 violence cases

at the public sphere, meanwhile 68 cases at the state level in 2022. In total, 38.8% of the reported cases were from physical violence, 38.21% of them considered as sexual violence, and 35.72% of psychological violence. It can be said that violence in the public sphere has been the highest reported case, which showed different phenomena as compared to the report in the previous year. The latest NCVAW report has included data of reported cases from the Badan Peradilan Umum (Badilum) and Badan Pembinaan Hukum (BABINKUM) of the Arm Force, although the data has not been consolidated into the Annual Report yet, due to the different format that has been used by the arm force<sup>50</sup>.

Reported cases of violence against women with disabilities had been problematic. There were 42 cases of sexual violence against persons with disabilities reported in 2021, which had three dimensions of severity. **First**, many cases of violence against women with hearing and speech disabilities and violence against women with mental disabilities had usually been done by perpetrators who were known to the victims. However, many cases had not been able to be put on court as investigators did not understand the variety of disabilities and there were no survivors' companions, such as translators were not available, so that the evidence became insufficient. Moreover, many times, the violence cases being reported about had been going on for a long time and there were neither witnesses nor lead witnesses so that law enforcement officers who do not have a disability perspective neglected the case. **Second**, many times, sexual violence against women with disabilities happen repeatedly and are not immediately known to both the victims (due to their disabilities) and their families. The sexual violence was discovered only after the victim's physical changes were quite prominent. In addition, sexual violence, including those that experienced by women with disabilities are still considered a private matter. **Third**, difficulties in proving and suspecting sexual violence against women with disabilities, where the perpetrators denied and stated that the act was consensual and had been carried out often. Unfortunately, investigators concluded that they had no evidence because there were absolutely no witnesses or lead witnesses who saw or could explain the rape incident. Specifically, the Catahu Report 2022 indicated that issues of violence against women with disabilities become more severe in the context such as Papua. The report shared that 50% of women with psychosocial disabilities (people with mental disorders) at the Abepura Mental Hospital of Papua Province have been victims of domestic violence, violence from intimate partners, and experienced multiple layers of violence. Apart from experiencing mental disorders due to domestic violence and violence from intimate partners, the NCVAW also found many cases of wives being infected with sexually transmitted diseases, including hepatitis, HIV, STIs and drug use. Perpetrators of violence range from spouses, in-laws, uncles to biological fathers, as well as police officials.

Sexual violence in the world of work were also highlighted by the NCVAW, namely obscenity, sexual harassment and rape, which occurred in private companies, government agencies, banking sector, non-governmental organizations (NGOs), the world of entertainment and online public transportation. The impact of sexual violence experienced by victims is unsafe working conditions, obstruction of work processes, psychological pressure and decreased work productivity. Perpetrators of sexual violence are men who have a higher position than the victim, meaning layered power that places superiority as both superior and male.

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<sup>50</sup> National Commission on Anti Violence Against Women, Annual Report CATAHU, March 2023

On the backward side of the legal framework, the Parliament and the Government agreed to the revision of the Criminal Code. The Indonesian women activists and NCVAW indicated that the new Law has the potentials for overcriminalizing women, including raising concerns on the lack of protections of survivors of sexual violence, the right to be free from gender-based discrimination, and the basic rights of civilians. There were several aspects of the Law need to be monitored, among others :

1. vulnerabilities that leads to the crime of 'sexual immorality', including crimes against the women's bodies,
2. reduces of legal protections for women against sexual exploitation as it does not correct the term sexual exploitation related to pornography, in accordance with the Sexual Violence Law<sup>51</sup>;
3. neglects the rights of victims of sexual violence due to the absence of a criminal formula for forced prostitution and forced abortion; d) reduces of legal certainties and encouragement to the the existence of discriminatory policies against women, due to the provisions of the application of law that live in society<sup>52</sup>;
4. reduces the rights to privacy in marriage and overcriminalization related to the crime of adultery;
5. doesn't have protections for competent volunteers who socialize the contraceptives for pregnancy and abortion for children<sup>53</sup>,
6. doesn't contain aggravating penalties for killings based on gender hatred or femicide,
7. denies the guarantee of the right to life and freedom from torture as a result of the death penalty provisions, although it is intended as a last alternative by imposing a probationary period of 10 (ten) years and then switching to life imprisonment<sup>54</sup>, and
8. leads to the risk of diminishing basic rights guarantees due to multiple interpretations of the formulation, among others on freedom of religion/belief with articles that still adopt protectionist perspectives for the majority and dominant groups in certain religious groups, on freedom of opinion and on the right to defend rights related to the crime of insulting government or state agencies.

### Child Marriage

Harmful practices cover several matters, including cases of child marriage and '*female genital mutilation*' (FGM/C ). Child marriages have kept going and need to get attention. Indonesia has been one among 10 countries with the highest prevalence of child marriage in the world<sup>55</sup>. Regardless the revision of the Marriage Law No 1 the year 1974 to Law Number 16 of 2019, which changed the provisions of Article 7 regarding the age limit for marriage to put the requirement that both girls and boys must be 19 years of age, there were 59,709 applications for child marriage dispensation to the Religious Courts in 2021. While the figure showed a little decrease to 50,673 applications in 2022,<sup>56</sup> there was a high concern in the public as 15,337 cases of them came from the province of East Java only. Data from Susenas mentions that the number of child marriages in 2018 was 11.2%, decreased to 10.35% in 2020, 9.23 % in 2021, and further

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<sup>51</sup> article 172

<sup>52</sup> article 2, article 66, article 96, article 97, article 116, article 120, article 597

<sup>53</sup> article 416 paragraph (3), the Law

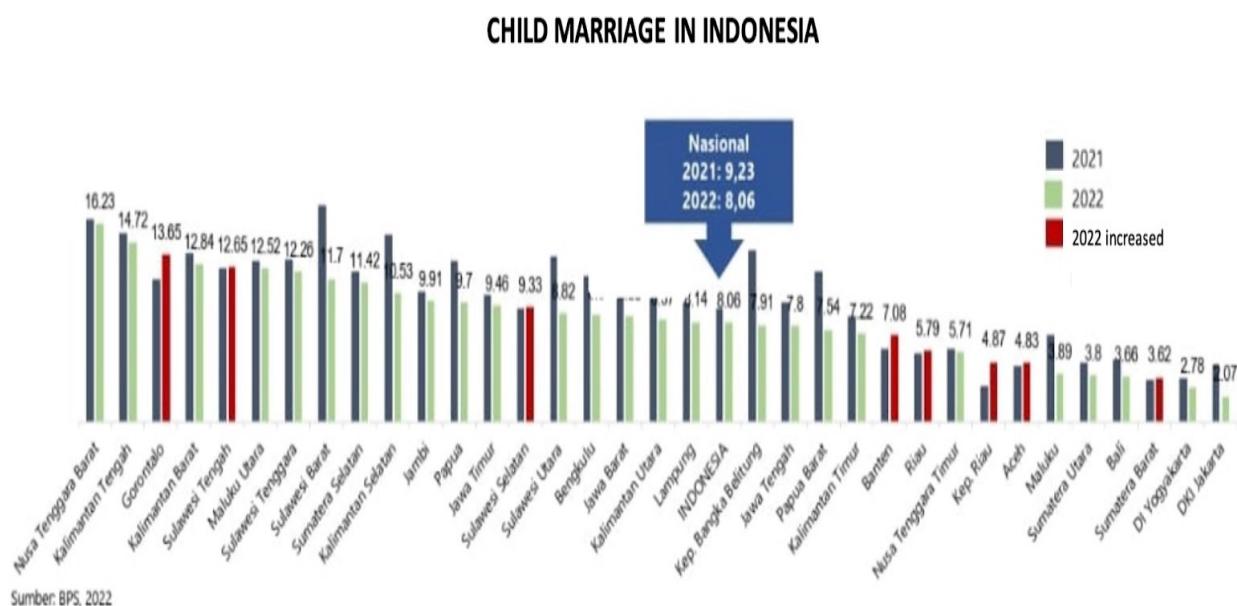
<sup>54</sup> articles 98-102

<sup>55</sup> UNICEF, Girls Not Bride, 2019

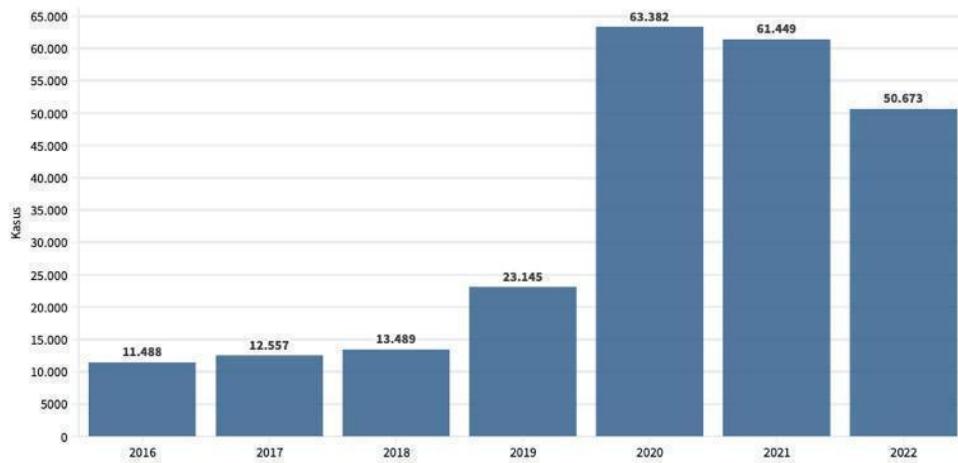
<sup>56</sup> <https://dataindonesia.id/ragam/detail/dispensasi-pernikahan-anak-menreach-50673-kases-pada-2022>

down to 8.06% in 2022, which was over the target of the RPJMN 2023 of 8.74%. Most of provinces have declined in child marriage prevalence, except Gorontalo and South Sulawesi with slight increase in 2022, where NTB becomes the highest with 16.23%. Such fluctuations have indicated that while the Act 16 of 2019 concerning Amendment on Marriage Law number 1 in 1974 set the age limit of marriage for 19 years, many other things on the Marriage Law Number 1 the year 1974 regarding unregistered marriage and child rights and gender-responsive and non-discriminatory marriage law are urgent to be discussed and passed by the parliament. The high number of reported application for getting dispensation of child marriage to Badilag indicated efforts of parents (and children as well as families) to get around the Marriage Law has still been high.

*Figure 3 Child Marriage in Indonesia*



The figure showed tremendous increase from 2019 to 2020, decreased slightly in 2021, and further decreased to 8.06 % in 2022, which was over the RPJMN 2024 target of 8.74% (SUSENAS 2022). Most of provinces have declined in child marriage prevalence except Gorontalo and South Sulawesi with slightly increased in 2022, and NTB became the highest rate with 16.23%. Strong collective actions may help decreasing the number of dispensation of child marriage, but such high, and yet fluctuated number of request for dispensation indicating serious and volatile issues of child marriage in Indonesia. Factors such as social culture, education background, as well as economy have been behind such numbers.



*Figure 4 Number of Reported Application for Getting Dispensation of Child Marriage to BADILAG*

Source: DataIndonesia.com

#### Female Genital Mutilation/Cutting (FGM/C)

A joint Study, carried out by the NCVAW and the University of Gadjah Mada in 17 districts of 10 provinces in 2017 discovered that FGM/C was mostly found in Type 1 (clitoridectomy) and type 4 (pricking, piercing, incising, scraping and cauterizing the genital area) of World Health Organization (WHO) categories, while 1.6% of cases of FGM/C was for symbolic reasons done by traditional healers<sup>57</sup>. Impacts of the wound, unfortunately, were more serious when health staff doing the FGM/C (43% of 60 midwives) compared to traditional healers (34% of 26 traditional healers), and clitoris cut (23% of 60 midwives) as compared to those made by traditional healers (11,5% of 26 traditional healers). The changes or transition of FGM/C practices from symbolic or minor injuries to medicalization in the form of genital surgery/severance cannot be separated from the strengthening of global conservatism,<sup>58</sup> assuming that medical staffs, i.e. midwives can do the FGM/C in more hygienic way. This problem has been exacerbated by the emergence of commercialization of health services that utilize regulations that require circumcision to be carried out by health service providers. This can be seen, for example, from the emergence of female circumcision services that are publicly advertised by health service institutions, from general hospitals, maternity hospitals, to vaccine clinics. Nevertheless, the increased awareness of midwives on the prohibition of FGM/C practiced had put some tentions, due to the pressures made by parents for having FGM/C for their girls<sup>59</sup>.

While more organizations, including religious women ulemas and media raised their awareness about the harmful consequences of the FGM/C, there have been more indications that the FGM/C practices remain, due to the strong intentions, on behalf of tradition, follow the world of the old, religious belief, and, due to the limited knowledge among the community and members of the families. Because the hospital refused to

<sup>57</sup> National Commission on Violence Against Women and the University of Gajah Mada, Female Genital Mutilation and Cutting : In the Crossroad between Traditions and Modernity. A Mixed method Study on Medicalization of FGM/C in 17 districts in 20 provinces in Indonesia (2017).

<sup>58</sup> Rumah Kitab, Fiqh of Working Women, 2021

<sup>59</sup> Lies Marcoes, for UNFA : Photo Story of a Decade of UNFPA's Partners to Prevent FGM/C, March 2023

facilitate FGM/C, there were several indications that some community groups, including Islamic groups, organized free FGM/C in the form of ‘Sunat Massal’. In Bandung. For example, there has been a Mass Female Circumcision activity, organized by an Islamic foundation during the Birthday of the Prophet Muhammad in the month of Rabiul Awal in the Hijriyah calendar, in which medical staff, female medical doctors and midwives affiliated with the Foundation were involved. It was reported that in one of mass female circumcision activities, about 150 little girls were circumcised. Many families sent their girls to take part in the activity because, in addition to free of charge, the families receive an envelope of money<sup>60</sup>. In Tuban (East Java) and in Sidikalang, a tradition of FGM/C has been done in Islamic boarding schools, while another activity has been organized by the local government and the women movement organization (PKK)<sup>61</sup>. Supported by UNFPA, Indonesia’s Women Ulema Network or KUPI has organized various efforts to stop FGM/C by adopting progressive interventions using gender transformative approaches to involve male ulema to talk about the harmful practices of the FGM/C. The UNFPA’s Gender Transformative programming (GTP) addresses institutional, social, and cultural dynamics that influence the behaviours and vulnerabilities of women and men in Indonesia’s society<sup>62</sup>. A critical part of this approach, which has been adopted in the programme for preventing FGM/C was engaging men and boys as well as making ulemas and traditional leaders as ***partners and agents of change in support of gender equality*** and addressing negative forms of masculinities that prevent FGM/C in Indonesia.

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<sup>60</sup>

<https://www.vice.com/en/article/akwdb5/ritual-sunatan-massal-perempuan-terbesar-di-indonesia-bandung-sunat-perempuan-dilarang-kemenkes>

<sup>61</sup> <http://eprints.walisongo.ac.id/id/eprint/10354/>

<sup>62</sup> UNFPA Indonesia, men’s engagement in UNFPA Indonesia programming: Strengthening understanding, capacity, and policy to transform inequitable and unhealthy gender attitudes and norms, 2018

# Chapter 3: Strategic Response and programme

## 3.1 BERANI Strategic Response

Guided by the global corporate strategy set out in the UNFPA and UNICEF strategic plans (2018–2021) contributing to the 2030 development agenda, both agencies are committed to fulfilling goals that are common in the BERANI programme. UNFPA Strategic Plan while covering the first of three UNFPA strategic plans leading to 2030, it describes the transformative results that will contribute to the achievement of the SDGs. By aligning the strategic plan to the SDGs, most directly to Goal 3 (Ensure healthy lives and promote well-being for all at all ages); Goal 5 (Achieve gender equality and empower all women and girls); Goal 10 (Reduce income inequality within and among countries); Goal 16 (Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels); and Goal 17 (Strengthen the means of implementation and revitalize the global partnership for sustainable development), UNFPA has advanced the work of the programme of Action of International Conference on Population and Development, contribute to achieving the goals of its strategic plan and, ultimately, to reducing maternal mortality, overarching goal. Similarly, UNICEF strategic plan, anchored in the Convention on the Rights of the Child, is specifically keyed to drive progress towards the achievement of the 2030 Sustainable Development Goals – and thus, to help realize the SDGs' vision of a world in which no one is left behind. Primary health (SDG 3) and education (SDG 4) indicators since the early 1990's continue to trend in the right direction. However, these projections may need to be re-visited in light of the impacts of the COVID-19 pandemic. UNSDCF 2021-2025, to which both UNFPA and UNICEF contribute, mentions that the pandemic, in addition to negatively impacting SDG 3 will also likely halt the progress made on achieving other SDGs. The response to the virus is also having a differentiated impact on segments of the population. The direct impact of COVID-19 on human development will be on health services, nutrition, education, social protection among others. Resources reallocation for responding to the pandemic will impact overall development, making it difficult to achieve many of development targets.

UNSDCF (2021-2025) identified four strategic priorities around which the UN system should mobilize its combined expertise to support Indonesia for dynamic economic transformation based on human rights and development for all. BERANI programme is in line with most of the the first strategic priority that is of 'Inclusive Human Development', encompassing human capital and social development, fostering equality and social cohesion, as well as addressing gaps in health, food security and nutrition, water- sanitation and hygiene, education, skills development and social protection.

Due to its global and country programming experience and technical expertise, the centrality of its mandate - increasing universal access to SRHR- and its close partnership with GoI, UNFPA is positioned to deliver this programme. Furthermore, not only has UNFPA advocated addressing SRHR issues with a broad array of stakeholders, UNFPA co-leads the Family Planning 2020 country coordination, working to ensure that a rights-based approach is central to national and subnational family planning. Similarly, UNICEF Indonesia has been supporting a multi-sectoral programme which aims to increase knowledge and skills of girls in areas related to menstrual hygiene management (MHM), adolescent health, child marriage,

competency-based life skills, and adolescent participation. Strategically, the two UN agencies' mandates fit well to serve the areas covered under BERANI programme, in turn supporting the two country programmes and the first strategic outcome of UNSDCF.

## 3.2 BERANI Response

### BERANI programme of Support to the Government of Indonesia

UNFPA and UNICEF support the government and other national partners in reaching Indonesia's development objectives to better the lives of women and girls. The interventions can be grouped into three main components as below.

#### **SRH service quality improvement**

To significantly improve the quality of integrated SRH services, UNFPA contributes to increasing the capacity of health workers in order to provide the best possible care for all. To promote integrated maternal health care and safe childbirth, UNFPA works to strengthen and enforce the standards and regulations pertaining to midwifery education together with the Ministry of Health and the Indonesian Midwives Association. Midwives are at the frontline of healthcare, often they are the first point of engagement for maternal and reproductive health prior to referrals to state health care. Making sure that the midwives deployed to communities have the highest standards of skills in their practice will lead to positive results in SRH. Through BERANI, UNFPA has been supporting the establishment of five centers of excellence (COE) for midwifery education by adopting the International Confederation of Midwives (ICM) and WHO gold standards for midwifery education. The midwives curriculum does include topics on responding to the needs of people with disabilities and will adopt standards for waste management. However, a recent report on Environment Assessment of BERANI (2021) showed that there was not much additional knowledge and skills from the BERANI programme on medical waste management and this topic was only briefly mentioned and had not provided a specific module on it. There has not been a structured effort by the BERANI programme in waste management to improve midwives and midwifery clinics' knowledge and practices.

Centers were selected to represent variations of the schools (public, private, diploma, profession), and geographical/regional spread. To promote evidence-based policymaking, UNFPA has been carrying out studies on SRHR, covering the areas of midwifery, family planning, and maternal health, including within the context of Indonesia's Health Insurance Scheme – providing the basis for policy dialogue with national stakeholders. Together with BKKBN, partnerships fostered through the FP 2020 Country Committee involving government, donors, CSOs, faith-based organizations, and the private sector, will provide results in reaching data consensus, ensuring rights-based family planning, and overcoming challenges in the implementation/ operationalization of the national family planning programme. There are 4 outputs to achieve this immediate outcome, namely:

- Technical assistance provided on the establishment of 5 centers of excellence for midwifery education;

- Training and technical advice provided to the Indonesian Midwife Association to implement and provide quality assurance on midwifery;
- Studies and analysis on SRHR conducted to provide evidence for decision-making (strengthening health systems); and
- Partnerships established and strengthened to achieve FP2020 goals.

In further promoting integrated and rights-based SRH care, UNFPA has been working together with Ministry of Health (MoH) and Ministry of Women's Empowerment and Child Protection (MoWECP) to better respond to GBV cases at health service points, ensuring the protection of rights of survivors of violence including women and girls with disabilities through the health sector, psychosocial counselors and law enforcement. UNFPA will ensure the inclusion of the most vulnerable group including women and girls with disabilities will be integrated as part of beneficiaries of the programme on the piloting area and will be reflected through the baseline, monitoring, and evaluation exercises. There are two planned outputs to achieve this outcome, namely:

- Technical assistance to Ministry of Health to strengthen the health sector institutional capacity and coordination in GBV; and
- Technical assistance provided on handling GBV cases in health service points in one selected district.

#### **Adolescents Sexual and Reproductive Health**

UNFPA, through BERANI, actively supported the promotion of universal and equitable SRH services through an innovative model called UNALA. The model generated the demand from young people for accurate information on SRH and improved SRH services that are high quality, youth-friendly, stigma-free and that caters to the specific needs of young people. With a space to safely get information on SRH, young people were better equipped to make informed decisions on their well-being, preventing unwanted pregnancies, sexual violence, HIV and STIs, and in increasing their knowledge on their SRH. High-quality services and the establishment of referral networks with state health service points ensured that young people receive the SRH care they need.

It is equally important that the initiative reaches out to vulnerable young people who are most in need, including young people with disabilities. Therefore, UNFPA and our implementing partners have been working together with institutions that work/have networks with marginalized young people, particularly young people with disabilities. The initiative used an approach where youth could assist their peers with disabilities in accessing information, by making short information videos and voice recording if IEC materials through YouTube that have been uploaded in the UNALA website and mobile application (young people with hearing impairments can watch, and those with vision impairments will be able to listen). Through the UNALA model, the YSSI worked with institutions that have expertise in dealing with youth with disabilities to strengthen the capacity of health care providers in delivering services for youth with specific needs.

The results of this model have been used to continue the advocacy for policies that support universal access to SRH services and information. The output to achieve this outcome is, Youth-friendly SRH information and services model (UNALA) established in private sector clinics in Yogyakarta.

### **Gender-based Violence**

From the rights point of view, UNFPA and UNICEF have been working together to increase the capacity of duty-bearers to protect sexual and reproductive rights at both national and sub-national levels as well as increase the knowledge of rights-holders regarding their sexual and reproductive rights to increase the demand for better protection and services from the state. From the duty-bearers perspective, UNFPA has been supporting MOWECP to advance issues of GBV and harmful practices as a priority state-funded agenda of the Ministry. Continued technical expertise to the Ministry will enable them to develop, implement and coordinate multi-sector advocacy strategies and national action plans to prevent and respond to GBV and prevent FGMC and child marriage by integrating approaches to engagement with men and boys in the prevention of GBV and harmful practice within the pilot districts. On the legislative side, exposing parliamentarians with the evidence on harmful practices will complement advocacy efforts from the executive side, pushing forward necessary policies for prevention as well as reaching out to parliamentarian constituents. UNFPA and UNICEF have been engaging religious and community leaders , including Women Ulema Network (KUPI) as well as women's prayer groups on adolescent girls' rights including MHM and child marriage. Two planned outputs to achieve this outcome are:

- Technical assistance provided to MOWECP on developing and implementing laws and policies to address the prevention of harmful practices (child marriage and FGM/C); and
- Technical assistance provided to parliamentarians on the prevention of harmful practices (child marriage and FGM/C)

From the perspective of rights-holders, UNFPA and UNICEF aim to increase the knowledge and skills of young people (girls and boys) in and out of schools, as well as the communities –who are not only right-holders but who also make up the enabling environment where young people thrive. In the absence of a clear curriculum on CSE, UNFPA and UNICEF have been actively continuing the advocacy to incorporate ARH as a manifestation of CSE in Indonesia and the adolescent health post (Posyandu Remaja) as an outreach mechanism (UNFPA) and specific topics such as menstrual hygiene management and child marriage through co- curricular activities such as life skills and literacy sessions (UNICEF) through the entry point of teachers. Outside the classroom, UNICEF has been engaging girls and boys through community-based informal learning centers using life skills methodology as well as through digital-based adolescent-friendly health education. UNICEF has close working relationships with the provincial governments as well as with local religious groups and they have requested further support in the area of child marriage. As such, it is hoped that through this programme UNICEF can refine the most appropriate tools for reaching in school and out of school girls as well as document an evidence-based approach to promote girls' protection and wellbeing that will serve as a scalable model for government and civil society to utilize in other provinces in Indonesia. Through innovative partnerships, such as through the Islamic Women's Prayer Groups, UNICEF has been testing an integrated package using MHM as an entry point for wider SRH communication, including the development and testing of digital adolescent health education materials through human- centered design in partnership with the Indonesia Adolescent Girls Network (AKSI). To reach out to communities on harmful

practices, particularly women, UNFPA has been engaging female ulama to open dialogue on the evidence against child marriage and FGM/C, so that they can advocate their followers to change mindsets and behaviors to stop these harmful practices. The outputs that will achieve this outcome are:

- Technical assistance provided to MoEC and MoH on the module for school teachers on CSE;
- Technical assistance provided to Women Ulema Networks for community-driven prevention of harmful practices (FGM/C); and
- Empowering adolescents with information, knowledge, and skills on MHM, SRHR, and child marriage.

### **Partners**

Background documents state that UNFPA and UNICEF have been working closely to ensure that programme results do not overlap and are complementary to reach a common development objective. In the cases where thematic areas coincide, UNFPA and UNICEF have applied different approaches and target different communities in their work with the collective objective of changing mindsets and behaviors that lead to improved services and protection of rights and filling the persistent gaps in the issues of SRHR.

Government of Indonesia (GoI) ministries, departments and agencies, and CSOs with which UNFPA and UNICEF primarily work on BERANI programme include:

- Ministry of National Development Planning/ National Development Planning Agency (BAPPENAS);
- National Family Planning Coordinating Board (BKKBN);
- Ministry of Health (MOH);
- Ministry of Women's Empowerment and Child Protection (MOWECP);
- National Commission on Violence Against Women (Komnas Perempuan);
- Lembaga Perlindungan Anak (LPA), North Lombok;
- Lembaga Pengembangan Sumber Daya Mitran (LPSDM);
- Yayasan Siklus Sehat Indonesia (YSSI);
- Indonesian Midwives Association (IBI);
- Yayasan Kesehatan Perempuan;
- Women Ulema Network (KUPI);
- Jaringan AKSI;
- Lembaga Pemberdayaan Perempuan (LPP) in Bone;
- Yayasan Indonesia Mengabdi (YIM); and
- TULODO Indonesia

The programme is also implemented through UNFPA-UNICEF partnerships with several strategic partners, active partnerships with parliamentarians, faith-based organizations, the private sector, philanthropists, and youth and women's networks.

## BERANI Intervention Geographical Coverage and the programme Structure

As shown in the map below, BERANI interventions are spread throughout the islands. The GOI's priorities and the economic, social, and cultural context in Indonesia, UNFPA and UNICEF mandate continue to be the main influencing factors in determining the BERANI programme.

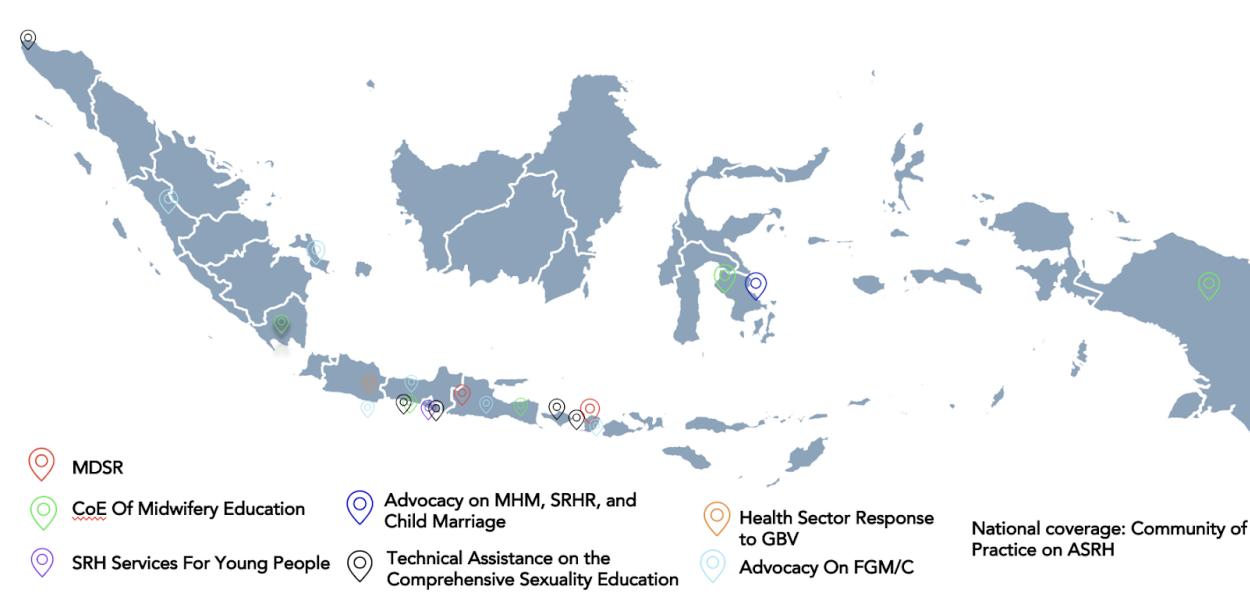


Figure 5 Maps Illustrating BERANI Intervention Sites including COVID-19 Response

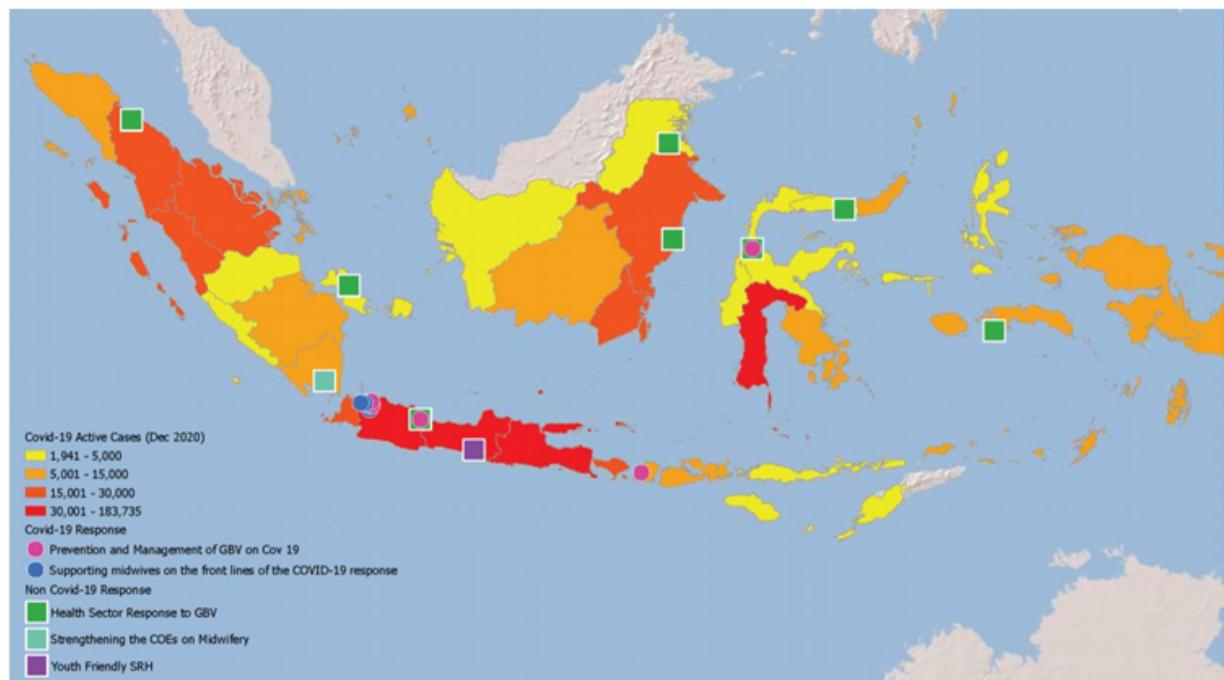


Figure 6 Maps Illustrating COVID-19 cases in Indonesia

The **overall structure of the BERANI programme interventions** is illustrated in the BERANI Logical Model, as can be seen in Figure 5, with more detailed information in Annex 5. The programme has a general goal, specific goal, ultimate outcome (coded as 1000), and two intermediate outcomes (coded as 1100 and 1200). The intermediate outcome 1100 has three immediate outcomes (coded as 1110, 1120, and 1130). The intermediate outcome 1200 has two immediate outcomes (coded as 1210, and 1220).

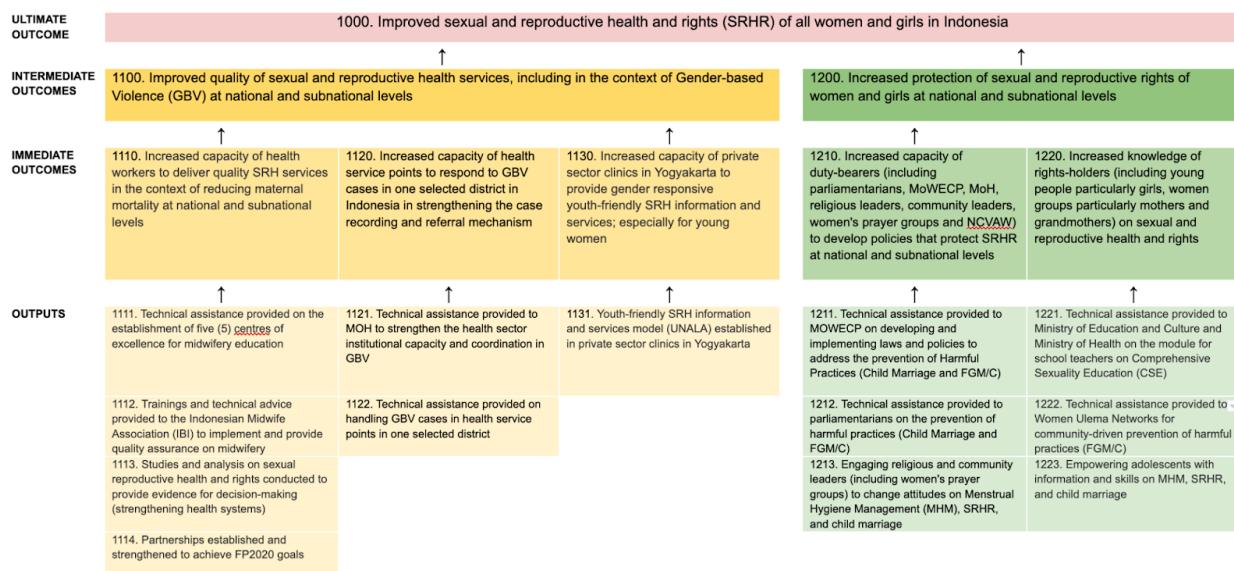


Figure 7 programme Structure of BERANI

Of the five immediate outcomes cover the following outputs:

- the immediate outcome 1110 with four outputs related to SRHR interventions (1111-1114);
- the immediate outcome 1120 with two outputs related to GBV interventions (1121 and 1122);
- the immediate outcome 1130 with two outputs related to ASRH interventions (1131 and 1132);
- the immediate outcome 1210 with three outputs related to FGM/C-MHM and child marriage interventions (1211-1213);
- the immediate outcome 1220 has three outputs related to increased knowledge on MHM, SRHR and child marriage interventions (1221-1223).

UNICEF contributes to the implementation of Output 1213 and 1223, while the rest is delivered by UNFPA.

#### BERANI Financial Structure

The financial structure of the BERANI programme can be seen in Table 6. The total estimated budget at the start of the programme is USD 8,018,975 that includes UNFPA core funding of USD 1,143,985 and UNICEF core funding of USD 678,243. The programme immediately responded to the COVID-19 pandemic situation by providing additional funding of USD 1,109,413 that includes funding delivered through UNFPA (USD

782,997) and UNICEF (USD 315,322). No financial data is accessed for the final evaluation. Efficiency criteria is assessed based on the MTR report and the perspective of programme teams and partners.

<p>Total estimated budget*: USD 8,018,975 (CAD 10,352,497)</p> <p>Out of which:</p> <ol style="list-style-type: none"> <li>1. Funded Budget: USD 8,018,975 (CAD 10,352,497)</li> <li>2. Unfunded Budget: USD 0</li> </ol> <p>* Total estimated budget includes both programme costs and indirect support costs</p> <p>Sources of funded budget:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>USD<sup>†</sup></th> <th>CAD</th> </tr> </thead> <tbody> <tr> <td>UNFPA Core Funding</td> <td>1,143,985</td> <td>1,476,885</td> </tr> <tr> <td>UNICEF Core Funding</td> <td>678,243</td> <td>875,612</td> </tr> <tr> <td>GAC for UNFPA (incl. IC 7%)<sup>†</sup></td> <td>4,907,824</td> <td>6,336,000</td> </tr> <tr> <td>GAC for UNICEF (incl. IC 7%)<sup>†</sup></td> <td>1,226,956</td> <td>1,584,000</td> </tr> <tr> <td>AA 1% of GAC<sup>†</sup></td> <td>61,967</td> <td>80,000</td> </tr> <tr> <td><b>Total</b></td> <td><b>8,018,975</b></td> <td><b>10,352,497</b></td> </tr> </tbody> </table> <p><sup>†</sup> The amount is based on the CAD amount (1 USD = 1.291 CAD by UNORE April 2018), and so may fluctuate depending on exchange rate.</p>		USD <sup>†</sup>	CAD	UNFPA Core Funding	1,143,985	1,476,885	UNICEF Core Funding	678,243	875,612	GAC for UNFPA (incl. IC 7%) <sup>†</sup>	4,907,824	6,336,000	GAC for UNICEF (incl. IC 7%) <sup>†</sup>	1,226,956	1,584,000	AA 1% of GAC <sup>†</sup>	61,967	80,000	<b>Total</b>	<b>8,018,975</b>	<b>10,352,497</b>	<p>Total estimated budget*: CAD 1,498,817; USD 1,109,413</p> <p>Out of which:</p> <ol style="list-style-type: none"> <li>1. Funded Budget: CAD 1,498,817; USD 1,109,413</li> <li>2. Unfunded Budget: USD 0</li> </ol> <p>* Total estimated budget includes both programme costs and indirect support costs</p> <p>Sources of funded budget:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>CAD</th> <th>USD<sup>†</sup></th> </tr> </thead> <tbody> <tr> <td>GAC for UNFPA (incl. IC 7%)<sup>†</sup></td> <td>1,057,829</td> <td>782,997</td> </tr> <tr> <td>GAC for UNICEF (incl. IC 7%)<sup>†</sup></td> <td>426,000</td> <td>315,322</td> </tr> <tr> <td>AA 1% of total GAC<sup>†</sup></td> <td>14,988</td> <td>11,094</td> </tr> <tr> <td><b>Total</b></td> <td><b>1,498,817</b></td> <td><b>1,109,413</b></td> </tr> </tbody> </table> <p><sup>†</sup>) The amount is based on the CAD amount (1 USD = 1.351 CAD by UNORE June 2020), and so may fluctuate depending on exchange rate</p>		CAD	USD <sup>†</sup>	GAC for UNFPA (incl. IC 7%) <sup>†</sup>	1,057,829	782,997	GAC for UNICEF (incl. IC 7%) <sup>†</sup>	426,000	315,322	AA 1% of total GAC <sup>†</sup>	14,988	11,094	<b>Total</b>	<b>1,498,817</b>	<b>1,109,413</b>
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Figure 8 Overview of the budget (for BERANI Components) including COVID-19 response budget, in USD

# CHAPTER 4: Findings

This chapter primarily addresses the evaluation questions by thematic areas, to which BERANI has contributed since 2018. By separating programmes and activities into the three areas (SRHR, adolescent, and GEWE, including child marriage and FGM/C), we aim to supplement the mid-term review (MTR), which has discussed the project in detail from its relevance to connectedness, covering the period between February 2018 and June 2021.

Prior to the description of each theme, the logical framework of the BERANI programme is discussed. BERANI set an ultimate goal of improving SRHR for all women and girls in Indonesia. Thirteen outputs, five immediate and two intermediate outcomes are expected to contribute to the programme's achievement towards its ultimate goal. Based on the discussion with the programme team, the BERANI logical model was planned in such a way to fill in the gaps of the 2018-2022 collaborative programme between UNFPA and GoI. The MTR has already noted the limitation for integrating GAC monitoring framework template into the larger Country joint programme. Furthermore, the MTR team also suggested the difficulties in understanding the logical linkages and the pathways between indicators, outputs and outcomes, and a suggestion to develop a new result framework is proposed. This is followed up by a slight adjustment of the logic model, streamlining it to the GAC monitoring framework by adjusting the terminology and simplifying the pathways/linkage between immediate and ultimate outcomes. programme's efforts post MTR were heavily focused on completing the remaining activities and strategy for sustainability.

In the next sections, findings from the evaluation are presented in three sections - SRH, ASRH and GEWE. Each section starts by reviewing focal programmes/activities in each area which build upon annual reports, mid-term review and other related knowledge products. Subsequently, it is followed by additional analysis from data collection focusing on the period of July 2021 to December 2022. Finally, it summarizes and examines good practices and lessons learned in order to help future planning.

## 4.1 Sexual and Reproductive Health

Indonesia is still among countries with high Maternal Mortality Ratio and Newborn Mortality Ratio. Among others, the root causes of the issues is the quality of maternal and newborn care, which is worsened by the disparities across regions in the country. In Indonesia, the vast majority of maternal care, especially AnteNatal Care service are provided by midwives - being 82.4% of ANC were performed by midwives. Despite this, concern arose as studies and observations showed a lack of essential midwives' competencies, with only 50% of midwives in Indonesia passing the

national competency test.<sup>63</sup> Acknowledging the importance of this issue, midwifery quality improvement has become one of the key interventions within the BERANI SRHR thematic programme. Further, BERANI also plays a coordination role of FP2020 (later FP2030) as an effort to strengthen the Family Planning programme in Indonesia.

Based on the assessment in the mid-term review, this area interventions from BERANI, are thought to be relevant and progressing reasonably well. The programmes and activities in these areas are closely related to the immediate outcome 1110 which is to increase the capacity of health workers to deliver quality SRH services in the context of reducing maternal mortality at national and subnational levels. Up to the period of the MTR, the outstanding achievement was the endorsement of the midwifery education curriculum by MoECRT.

Figure 9 summarizes the key interventions within the SRHR theme of BERANI. Briefly these include, knowledge generation and evidence based advocacy; strengthening IBI's capacity in performing advocacy, supervision and mentoring; quality improvement of midwifery education through curriculum and CoE establishment; and coordination role of FP2020 (later FP2030).

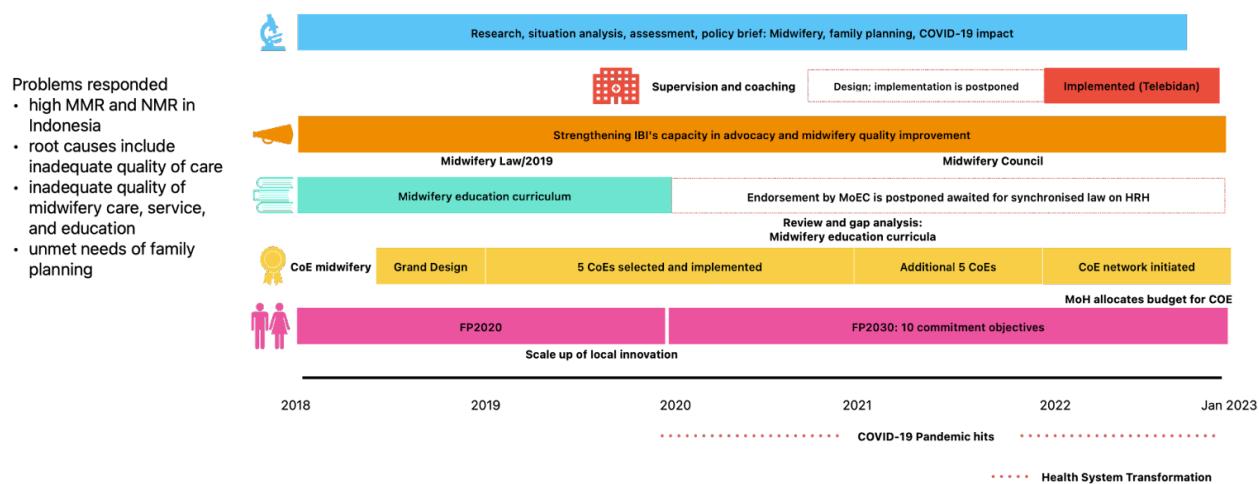


Figure 9 Key intervention within SRH theme

### Knowledge generation and Evidence based advocacy: Research, Situation Analysis and Policy Brief (Outcome 1110, Output 1113)

Despite growing evidence in maternal and newborn care service, gaps existed in the area of midwifery education, and contextual understanding on family planning in Indonesia. In addition, gaps between evidence and policy are also existing. Filling in the gaps, BERANI initiated its

<sup>63</sup> Sherrat, DR., Sailah, I. 2018. Grand Design for Piloting Development of Centres of Excellence in Midwifery Education. Jakarta: Ministry of Health and UNFPA

programme implementation in SRHR theme through knowledge generation to support advocacy. The knowledge generated was also translated into policy briefs to overcome “barriers” between production of evidence by academics and its use by policy makers.

*Table 1.* Summary of knowledge products on SRH

Topic	Research/ Review/ Situation Analysis	Products developed based on the evidence
Maternal Mortality	MDSR: Report of Pilot Activities in Lombok Tengah and Sampang District	Policy Brief: Maternal Death Surveillance and Response (MDSR)
Midwifery Care	Situation analysis of Midwifery in Indonesia Midwives Supply Scheme in the Era of Referral Health System	
Organization and Advocacy	Organization Capacity Index Assessment of IBI Technical Implementation Review: Midwifery Council Policy Review: Midwifery Council within Indonesia Human Resource for Health Council Recommendation for Midwifery Supervision and Coaching Mechanism	Law no 4/2019 on Midwifery Midwifery Council established Midwifery Supervision and Coaching Mechanism Policy Brief: Ensuring Consistent Quality of Midwifery Care
Midwifery Education	Review and gap analysis of Midwifery Education Curricula	Best practice guidance for a blended-learning approach for midwifery education in Indonesia Grand design for Midwifery Centre of Excellence
Family Planning and Reproductive Health	Study on Standardization of Family Planning and Services 2018  FP2020: Family Planning and Reproductive Health Data Book  Family Planning 2020 in Indonesia: Progress review 2012-2018 The Role of Indonesia Health Insurance in Family Planning Service How Well Indonesia's Urban Poor being Provided Acess to Quality Reproductive Health Service?  How Well are Indonesia's Urban Poor being Provided Access to Quality Reproductive Health Services?  Report on Progress FP2020 Working Group Rights and Empowerment  Lessons Learned and Key Achievements of SRH BERANI programme	Policy Brief: Strengthened Family Planning is Critical to Help Accelerating Reduction of Maternal Mortality Policy Brief: After 2020 - The Integral Role of Family Planning in Advancing SDGs in Indonesia Policy Brief: Strengthening Rights-based Family Planning in Indonesia Policy Brief: Increasing Male Involvement in Family Planning in Indonesia Policy Brief: Harnessing the Demographic Dividend and Window of Opportunity through Human Capital Development Using a Life Cycle Approach  Policy Brief: Addressing Unmet Need for Family Planning in Indonesia Policy Brief (CSO): Roadmap of transforming advocacy into sustainable legacy for family planning and reproductive health in Indonesia Policy Brief: Standing for ASRH Fulfilment: Recommendation for Adolescents Sexual Reproductive Health and Rights Policies and Programmes in Indonesia (FP2030 CSO and Youth Group) The Role of Indonesia Health Insurance in Family Planning Service Scale-up of local FP innovation

During BERANI programme implementation, over 10 researches (including programme review, situation analysis) and 11 policy briefs have been produced and published in the area of SRHR, including family planning. The research is focused both in understanding the issue to inform programme implementation (such as for midwifery curriculum improvement, advocating midwifery council), and responding to the updated country’s situation (for example, assessment on COVID-19 impact on SRH services). Selected research produced by topic are presented in Figure 10.

The evidence-informed programming and advocacy in the BERANI programme is one of the good practices identified in this programme. The programme has managed to not only provide important evidence for midwifery, reproductive health and family planning issues, but more importantly, utilize the evidence to advocate the government and other relevant stakeholders to take action. A long-standing barrier in evidence generation is a communication gap between

scientists and policy makers. Study suggested that it is often that evidence is often framed in a way to generate attention.<sup>64</sup> BERANI programme addressed this problem by actively involving stakeholders and policy makers throughout the process of each study. By doing so, the evidence is triangulated and informed as early as possible to the policy makers, and has the potential to be utilized and translated into policy in an optimal way. As shown in Figure 9 and 10, the evidence generated by BERANI programme has been followed up by advocacy activities (using the policy brief as advocacy materials), contributed to midwifery education and in-service quality improvement through the followed-up pilot project (CoE, supervision and coaching mechanism), and establishment of governance body (midwifery council). This is worth continuing in the future.

## Midwifery Association (IBI) Capacity Strengthening (Outcome 1110, Output 1112)

The BERANI joint programme focuses on enhancing the quality of care of SBA through midwifery education, practices, and regulation. UNFPA contributes to increasing the capacity of health workers to provide the best possible care for all to improve the quality of integrated SRH services.

In 2020, IBI has established a midwifery collegium to support the future establishment of a midwifery council. The Collegium developed six modules for those who have not graduated from midwifery schools since 2013 (UKOM Retaker), as tools for assisting the retakers in preparing the competency exams in 2021. With about 9,000 retakers, 98% of them passed the first batch of the competency examination. Later in 2022, a midwifery council was established. BERANI supported the initiation by conducting a policy review on midwifery council and technical review of midwifery councils across the globe as a basis for the council establishment (see section outcome 1110, output 1113 above). In the future, the council is expected to play a governance role for midwifery in Indonesia, including on competencies and midwives registration system (*Surat Tanda Registrasi - STR*). Meanwhile, IBI can play an important role in maintaining the competencies of their members as well as the quality of services provided, including through supervision and coaching mechanisms.

### Supervision and Coaching What do They Say?

#### Benefits

- Assisting IBI in maintaining the quality of midwives
- Provide updated knowledge and skills for private midwives
- Wide coverage of the program

#### Challenges

- Schedule arrangement between supervisors and supervises
- For some, online coaching is seen as less effective than onsite coaching

#### Expectations

- Being embedded into bidan delima to further expand the program coverage
- Continue the program

With the enactment of the Midwifery Act in 2019, IBI has updated the supervision and coaching guideline and mechanism to include respectful midwifery care, with a special attention to the vulnerable, marginalized groups and those with disabilities. It was designed to be

not like evidence-based medicine, so how far should you go to bridge *Systems*, 15:35 DOI 10.1186/s12961-017-0192-x

piloted in five CoEs locations/cities. There were 75 midwives supervised that demonstrated increased knowledge and skills on midwifery practices. IBI has expanded its targets to not only midwives in private practice, but also those who work in other health facilities (health centers and hospitals).

During the first batch in 2019, a total 25 supervisors are trained. In 2021, supervisors are re-recruited, consisting of first-batch supervisors, and new supervisors that had been supervised in 2019 if fulfilling the recruitment criteria. There were 45 supervisors recruited; each of them will be given the task to supervise three midwives, so there will be 225 midwives supervised. To speed up achieving the target of 350 midwives supervised by the end of the programme, the utilization of digital platforms was introduced in 2021. A hybrid model, a combination of online platforms and offline contacts was developed. and can be used as a model to maintain the quality of skills improvement and carry out core activities. Despite the COVID-19 pandemics, significant achievements have been made, with IBI highly appreciating the BERANI support. Furthermore, the supervisees also see that the supervision and mentoring programme is also benefiting them to get updated knowledge and skills.

### Midwifery Education Quality Improvement (Outcome 1110, Output 1111)

Through the BERANI programme, UNFPA works to strengthen and enforce the standards and regulations pertaining to midwifery education together with the MoH and the Indonesian Midwives Association (IBI) to promote integrated maternal health care and safe childbirth. BERANI has been supporting the establishment of the Center of Excellence (CoE) for midwifery education by adopting the International Confederation of Midwives (ICM) and WHO's global standard for midwifery education.

#### National Midwifery Education Standard

Acknowledging the importance of education in improving the quality of midwives, BERANI programme put a great emphasis on midwifery education. Currently, a 2016 midwifery education standard is in place. While the core topic has met the ICM standards, gaps remain in responding to the needs of people with disabilities and standards for waste management. While it is a national standard, midwifery education institutions have flexibility to adapt and contextualize it.

BERANI programme has supported the MoH, IBI and AIPKIND in drafting the National Midwifery Education Guidelines. As of March 2023, the standard has not been endorsed by the MoECRT, due to the GoI vision to develop Health Omnibus Law, including to regulate human resource for health, that might affect both competencies and authority of health professionals. Nevertheless, BERANI programme has maintained to support IBI and AIPKIND in preparing the standard, draft

competencies and other documents that should be prepared by the professional association for the law drafting purpose.

### Center of Excellence (CoE)

In 2019, the Grand Design for Piloting the CoE in Midwifery Education was finalized, and by the end of the year, five midwifery CoEs had been established, located in five cities/regencies, Jakarta, Surabaya, Jayapura, Tanjungkarang, and Makassar. The five CoEs were chosen to represent the western, middle, and eastern Indonesian midwifery schools and evaluated based on a set of 16 technical criteria that were detailed in the guideline. According to the MTR, the Board for Development and Empowerment Human Health Resources (BPPSDMK) - now Directorate General of Human Resource for Health, MoH, fully supports the COEs initiative. They also suggest that the initiative should ensure the quality and effectiveness of the CoEs in improving the performance of midwifery graduates and in ensuring the quality of focus of interest of each CoE.

Centre of Excellence What do They Say?	
<b>Strengths</b>	<ul style="list-style-type: none"><li>• A ground breaking approach to improve quality of midwifery education to meet the international midwifery curriculum standard</li><li>• Recognition of the quality of the selected education institutions</li><li>• Reflects a strong joined commitment among government, professional association and education institution to improve quality of midwifery education</li><li>• Open opportunity for collaborating with international institution</li></ul>
<b>Challenges</b>	<ul style="list-style-type: none"><li>• COVID-19 pandemic has resulted in postponing of numbers of CoE's activities</li><li>• Availability of health facilities for skills education/internships</li></ul>
<b>Expectations</b>	<ul style="list-style-type: none"><li>• Being continued with a knowledge hub established as a learning platform across CoEs</li><li>• Mentoring system for other education institution</li><li>• Support from local government for student's internship program</li></ul>

MoH has a strategic and governance role in facilitating the expansion of the CoEs' initiative across the country. Resulting from the initiative, MoH plans to provide additional financial support of IDR 250 million to each CoE, particularly Poltekkes. Post-BERANI programme, UNFPA and MoH will continue to support the expansion of CoE. A "sister-institution" method is planned in which the established CoE will act as mentor to the other midwifery education institutions in their region. By doing so, it is expected that the internationally standard met curriculum can be applied in more institutions, hence the overall number and quality of midwifery graduates will be improved.

### Family Planning (FP) 2020 (Outcome 1110, Output 1114)

FP2020 works with governments, civil society, multilateral organizations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020. Although the majority of the FP services are provided by MoH-affiliated hospitals and providers, the FP programme is managed by BKKBN. The MoH was not included in the FP Country Committee, which develops the policies and strategies for

accomplishing the FP2020 objectives, even though a CSO is a member of the FP2020 Country Committee. The FP2020 Country Committee was directed by BKKBN, with co-chairs UNFPA and GAC as well as a CSO. In order to ensure that the national FP strategy and programme are founded in rights-based methods, four working groups were established: the FP Strategy Working Group, the Rights and Empowerment Working Group, the Data, Monitoring, and Evaluation Working Group, and the Youth Working Group. In 2019, the partnerships were established with five groups: i) women's groups; ii) youth groups; iii) Muslim religious leaders; iv) private sector, and v) professional/academia. These partnerships facilitated a greater involvement of CSOs to strengthen FP programmes. In 2020, the partnerships in FP have made FP2020 commitments to improve and expand the national FP programme by reducing disparities and increasing funding. The four FP2020 working groups ended their tasks by the end of 2020.

The FP2020 Country Committee prepared FP2030 with the goals to achieve the SDGs targets. BKKBN, UNFPA, GAC, and the CSO have initiated focus group discussions on FP2030 involving a wide range of stakeholders in 2021. At present, ten objective commitments have been determined to direct the FP2030 partnerships programme. The commitments are formulated beyond expanding family planning coverage to improve women's health, including gender transformative,<sup>65</sup> COVID-19 risk and mitigation, health financing, and integration of FP programmes into HIV/AIDS and community nutrition programmes. This reflects a recognition of multiple factors contributing to access to and quality of family planning services, and coordination becoming critical in achieving the FP2030's goals.

While the decided targets for outputs related to FP2020 for BERANI are fully achieved, the MTR raised an issue of difficulties in linking the output to the consecutive immediate and intermediate outcomes. Hence, proxy to FP2020 goals were used in the MTR instead. The MTR reported a failure or doubt in achieving FP2020 goals, and demanded overall FP2020 review and programme management. Despite this, it is worth noting that FP2020 has laid a strong foundation for the grand design of FP2030. Among others, it has resulted in various knowledge generated to further understand the underlying reasons of unmet needs FP, situation analysis of FP services and potential strategies to strengthen FP programmes. By the end of FP2020 era, various local solutions implemented by numerous NGOs and CSOs were uptake and scaled up by the national government, including promoting male involvement in Family Planning.

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## Pathways to Outcomes

### Sexual and Reproductive Health

Evidence has shown a crucial role of midwives in delivering SRH services. Strengthening midwifery care would mean improving women and girls' quality of life through various outcomes. According to the ICM, there are three pillars for midwifery practice and development – education, regulation, and association – with midwifery education strengthening aims to provide a competent, qualified workforce.<sup>66</sup> Further, Midwifery education contributes to the health workforce transformation and expansion to accelerate inclusive economic growth and progress towards health equity, hence women quality of life.<sup>67</sup> Despite this, the evidence indicates a lack of investment in midwifery skills education and training in low- and middle-income countries (LMICs) with few educating providers to international standards, even where health workers are being given the professional title "midwife". This is despite the outcomes that can be improved and the cost savings that can be made when midwives are educated to international standards. In SRH components, BERANI addressed all the components as summarized in the figure below. These interventions are expected to improve the quality of SRH services, and in the long term will improve the quality of women and girls in Indonesia.

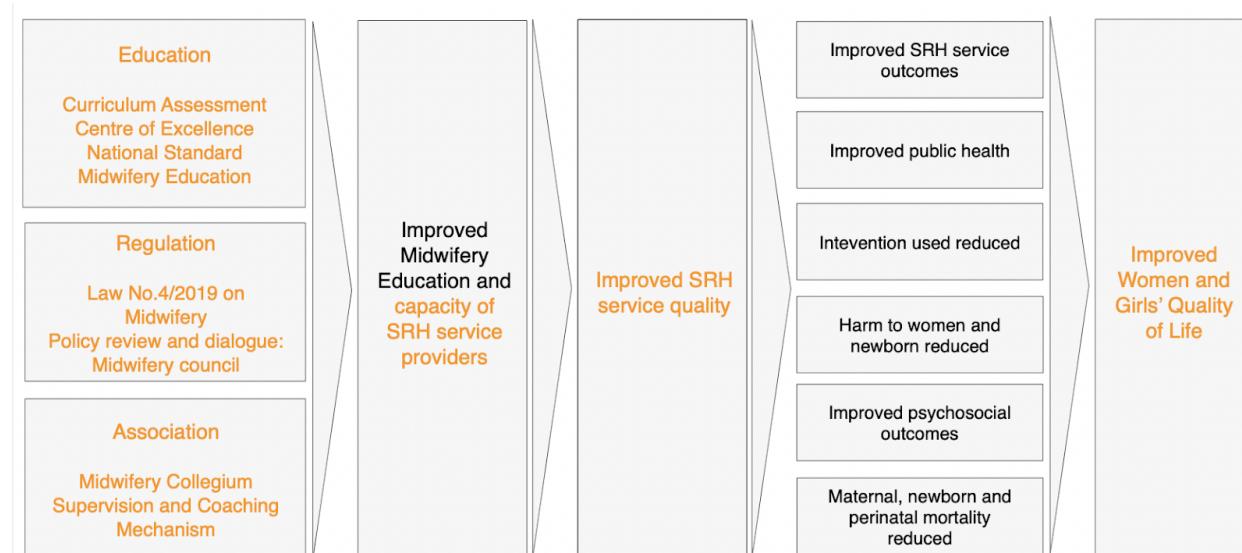


Figure 10 Pathway of BERANI SRH intervention to programme immediate, intermediate, and ultimate outcomes (printed in orange: BERANI's interventions, immediate, intermediate and ultimate outcomes). Developed based on references 65 and 66

<sup>66</sup> International Confederation of Midwives. Global standards for midwifery education (2010): amended 2013 [Internet]. The Hague, Netherlands; 2013

<sup>67</sup> Strengthening quality midwifery education for Universal Health Coverage 2030: framework for action. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.

Pathway of assumption from the SRH component intervention to BERANI intermediate and ultimate goals is presented in Figure 10. As seen, the interventions within the SRH components have addressed the three critical pillars of midwifery education strengthening - education, regulation, and association. These interventions contribute to the improved quality of midwifery education leading to a strengthened capacity of SRH workers (immediate outcome). The improved capacity of health workers is one of the critical elements to improved quality of SRH services (intermediate outcomes) which in turn could lead to improved services outcomes including reduced maternal mortality<sup>68</sup> and women and girls' quality of life (ultimate goal).

### Family Planning

The unmet needs of family planning has become a major problem in family planning services globally. It is often that Global and national pronouncements and policies assume that the cause of unmet need is women's inability to access family planning services, when in fact numerous evidences show that there are multiple factors contributing to the unmet need of contraceptive services. Despite the global evidence, contextual evidence on root causes of unmet needs of family planning is also lacking in Indonesia. BERANI programme's intervention in family planning are done through two main activities: evidence generation, and coordination role in FP2020.

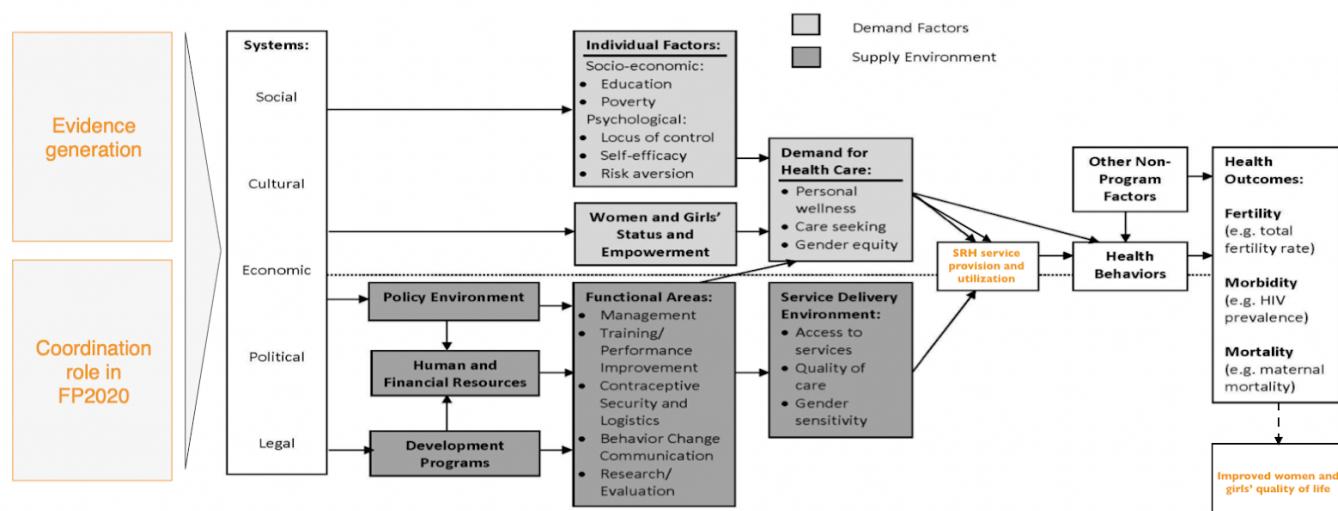


Figure 11 Pathway of assumption from two BERANI's interventions in family planning to intermediate and ultimate outcomes. Interventions and outcomes are printed in orange. Developed based on reference 66<sup>69</sup>.

The vision is for FP2020 to serve as an inclusive and results-oriented partnership that is working with a diverse group of stakeholders and experts to accelerate action and to address the most significant global and country-level barriers to progress against FP2020 goals. UNFPA, supported by the BERANI programme, plays a coordinated role to fulfill the commitment. Strong coordination is

<sup>68</sup> Strengthening quality midwifery education for Universal Health Coverage 2030: framework for action. Geneva: World Health Organization; 2019

<sup>69</sup> Data for Impact, University of North Carolina. Family Planning and Reproductive Health Conceptual Framework. USAID. <https://www.data4impactproject.org/prh/overview/conceptual-framework/>

expected to provide a positive economic, political and legal environment for SRH service quality improvement, leading to improved access to family planning services (Figure xx). As seen, through the coordination role in FP2020, BERANI programme has contributed to the family planning's supply system environment. Meanwhile, the evidence generated to understand the root causes of unmet needs of family planning, inform the programme design for demand creation. These two axes (demand and supply) would then be expected to improve FP service and provision (as part of the SRH services), leading to the improved women and girls' quality of life.

## SRH programme Evaluation against the Evaluation Criteria

### Relevance (Evaluation Question 1)

SRH components of BERANI programme are in alignment with the government priorities and respond to changes in the national development, including health system transformation, plan to synchronize health law, and programme adaptation during the COVID-19 pandemic. The research conducted has also been relevant to the updated situation and was delivered in a timely manner. As such, BERANI SRH components have contributed to GoI efforts in reducing maternal mortality and improving reproductive health service, mainly through midwifery quality improvement (pre and in-service), coordinating roles in FP2020 (and later FP2030), and evidence generation to fill in knowledge gaps in policy and programme design. The programme has also put an effort to reach all geographic areas in its CoEs pilot project by selecting the representative from each region. Further, the midwifery curriculum of the CoEs and IBI's supervision and coaching guidelines have put a special attention to the vulnerable and marginalized groups, including people with disabilities.

#### Sexual and Reproductive Health

*Outcome 1110, Output 1111 – 1114*

##### Good Practices (contributed to the achievements)

- Strong streamlining with GoI's agendas and priorities, has resulted in high GoI's buy-in and potential for program sustainability (scale up and replication)
- Built on a strong established network with governments and partners, and able to utilize UNFPA's national and international networks to achieve the targets in an optimal way
- Using an evidence-informed programming, BERANI initiated the intervention with evidence generation to direct advocacy, program's design and implementation; and put notable efforts in communicating the evidence to related stakeholders
- Expanding the focus of midwifery quality improvement to pre-service setting. While the impact might have seen in later than in-service intervention, this might potentially be more cost-effective in a longer term
- Adaptive to the country's recent development and situation, including during the COVID-19 pandemic

##### Gaps

- Program synergies with the related components, such as Adolescent Reproductive Health and gender
- Lack of clarity on gender transformative SRH program, beyond the male involvement in family planning

##### Challenges

- COVID-19 pandemic has resulted in delayed of several activities that potentially affected the success rate
- In-country's policy development to a certain extent, has affected the achievement. For example, health system transformation agenda and synchronization of health law are potentially resulted in the needs to revisit the developed curriculum. It also has resulted in the delayed of the curriculum endorsement by the MoECRT

### Effectiveness (Evaluation Questions 2, 3, 4)

Targets determined under SRH components are achieved, with an exception of the MoECRT's endorsement to the National Midwifery Education Standard due to changes in policy direction. Despite the great challenges during the COVID-19

pandemic, while it took more time to achieve the expected results, the programme has effectively done its best to implement activities that potentially contribute to the intended outcomes. At the end of BERANI, activities implemented in SRH components have a clear contribution to its immediate and intermediate outcomes of improving the capacity of SRH health workers, hence quality of SRH services. This in particular is highly acknowledged by the GoI and professional association on how pre-service midwifery strengthening, as well as supervision and coaching, are positively contributed to the midwifery education and service quality improvement. Further, partnerships between BERANI, MoH and other related stakeholders have resulted in several key documents critical for improving the quality of midwifery care - both at policy and programmatic level. These include a worth noted achievement are BERANI's contribution in Midwifery Law enactment, support given to midwifery council establishment and national midwifery standard.

In specific for FP2020, while the outputs determined are not clearly linked with the intended and intermediate outcomes, the programme has managed to lay a critical foundation of knowledge generation and strengthening the public private partnerships in family planning. This will act as a strong basis for the FP2030, and has been incorporated into the 10 objective commitments of FP2030.

#### **Efficiency (Evaluation Question 5)**

This evaluation did not quantitatively assess the efficiency aspect of the BERANI programme, rather depending on MTR report, availability of knowledge products generated, and interview with programme team. Overall, the programme has made good use of its human, financial and administrative resources in a timely manner. The MTR report noted that an appropriate combination of tools was used by the programme to demonstrate accountability to stakeholders and to pursue the achievement of the outcomes. These include mechanisms that show transparency in managing resources, quarterly and annual reporting on progress of the programme, sharing and utilization of products, conducting a mid-term review of the programme, and regular coordination meetings with stakeholders. For the SRH component, resource allocation to generate evidence has been proven to positively impact programme and policy - both at a pilot scale project, and nationally.

Services of both international and national consultants were provided timely. International consultants were recruited timely for the development of the "Grand Design of the CoE" in 2018-2019, and for the review of the national midwifery curriculum in 2020-2021. This is found to be useful by Indonesia's national and local governments in guiding them with specific analysis and assistance to help them achieve desired outputs. National consultants were also provided to carry out an important environment analysis on the programme that included medical waste management in 2019-2020. This has been useful in supporting government efforts to improve medical waste management, especially in the context of COVID-19 pandemic. The national

research institution, such as the Knowledge Hub FKM UI is involved in carrying out studies on family planning services, and study on the impact of COVID-19 pandemic on SRH services. Both are translated into policy briefs informing the FP programme improvement, and SRH programme adaptation during the COVID-19 pandemic. The use of financial resources for supporting webinar related to COVID-19 targeting the SRH service providers was also seen to be useful and inline with the programme's aim to strengthen the HRH capacity.

### **Coherence (Evaluation Questions 6, 7)**

*Comparative advantages.* The main comparative advantages of the SRH component of BERANI mainly stem from UNFPA's mandate, experiences, reputation and networks in the areas of SRH – particularly midwifery and family planning. Support from Global Affairs Canada is an added value to UNFPA CP9 implementation, not solely related to its use for filling the funding gaps but also strengthening the gender transformative aspect<sup>70</sup> of the programme. BERANI programme comparative advantages lie in its capacity to converge critical stakeholders and various programmes to focus on long-standing key challenges related to SRH – access to and quality of SRH and family planning services. While most programmes are heavily relied on in-service setting, BERANI has added to the effort in focusing on pre-service setting, potentially achieving a longer-term impact. Further, in a collective manner, the programmes have supported GoI's effort to address the SRH issues synergizing with GoI priority agenda. Within the UN system, BERANI contributes to outcomes 1 of UNSCDF 2021 – 2025, with a specific contribution in improving maternal health outcomes according to its expertise and mandate.

Further, as it has been already noted in MTR, discussion with stakeholders and partners also underlined BERANI comparative advantages in tackling SRH issues in Indonesia through strong national and international networking, including the ability to facilitate policy dialogue across levels. On a technical aspect, UNFPA's initiative in bringing expertise within the BERANI programme is appreciated. This includes bringing international and national expertise who were needed in policy and programme design and implementation.

*Coordination.* Within the SRH components, stakeholders and implementing partners recognized BERANI has done its best to establish and maintain a good coordination among the related actors. Appreciation is particularly given for UNFPA's effort in its coordinating role of FP2020, bringing together CSO and development partners in one forum with the government, under the leaderships of BKKBN. Further, IBI appreciated UNFPA's facilitative role with MoH, MoECRT and education institution in national midwifery curriculum, and CoEs grand design and pilot project. The existence of NPCU in BAPPENAS has strengthened coordination between BERANI and BAPPENAS,

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<sup>70</sup>Gender transformative programming refers to programmes addressing gender-based inequalities and works to transform harmful gender roles, norms and power relations. In the BERANI programme, gender transformative aspect is guided by GAC gender transformative tools (please refer to section 4.3)

ensuring all the programme interventions are aligned with the government's priorities. Further, special administrative support provided to strategic partners has streamlined the administrative burden, with the programme provided support to all IPs.

On the contrary, coordination gaps are identified within the thematic of the BERANI programme. There is an indication that coordination (and collaboration) across thematic programme within UNFPA (i.e. Maternal, Reproductive Health, ASRH, Gender), and between UNFPA and UNICEF, was solely on proposal development, MTR and evaluation stage – with UNFPA acting as the coordinator. Meanwhile, during the programme implementation, each component had its sole intervention, with specified target groups. Within outcome 1110, the target groups for components SRH, gender, and youth were implemented independently by UNFPA and UNICEF, with unclear connections among the components. Within the UN system, coordination between agencies are perceived to be good by the UNRCO, recognizing both agencies have equal expertise and mandate within SRH issues.

### **Sustainability (Evaluation Question 8)**

BERANI has made an important contribution to set a strong foundation for a quality midwifery education and service delivery, and family planning. Selection of interventions were made and designed accordingly to fill in the gaps of the current efforts in strengthening SRH programmes in Indonesia. In midwifery services and education quality improvement, programme's streamlining with GoI's priority and policies have made BERANI contribute to the national agenda, rather than a stand-alone, project based intervention. This includes its contribution to national law and curriculum, as well as IBI's capacity in governing its members.

Pilot projects such as Midwifery CoEs, and IBI's supervision and coaching mechanism are seen to be conveniently replicable by stakeholders, and have gained the required support. The Ministry of Health, for example, has agreed to provide funding to each Poltekkes established as CoEs in 2022. Initiative to establish SRH knowledge hub is also seen as a good sustainability strategy to improve the quality of midwifery education, by providing a learning platform for midwifery education institutions, facilitating and energizing the modalities for empowering young professionals in the SRH area, which would contribute to the sustainability of producing meaningful SRH products in the future.

### **Coverage and Connectedness (Evaluation Question 9)**

Evaluation question 9 is in relation to the programme response to COVID-19 pandemic. During this evaluation, BERANI programme response to COVID-19 is non-existing, hence this question has been fully answered in the MTR report. In short, for the SRH component, the MTR noted that the SRHR, ASRH, GBV and harmful practices interventions and approaches in COVID-19 settings are

in line with the principles of coverage and connectedness. All the support provided by the BERANI's SRH component relates to COVID-19 settings are logical and consistent in addressing key issues that arise during the pandemic. Switching to online method delivery for CoE and IBI's supervision and coaching has made the IPs manage to continue their activities, with a slight delay. Beyond the initial design, support through a series of IBI webinars have reached and supported midwives across the country. Rapid assessment on COVID-19 impact on SRH situation in Indonesia has also provided useful information for decision making during the earlier time of pandemic.

Further, beyond COVID-19 response, BERANI has supported ten CoE midwifery receiving support to conduct learning and assessment in accordance with the midwifery standard curriculum. Although there are over 700 midwifery schools in Indonesia, this is a critical initial step for midwifery education quality improvement. Expanding its impact through "sister institutions" and knowledge sharing platform (knowledge hub) is also potential to extend the impact beyond the BERANI programme. Further, for CoEs, the target set for reaching 1000 students has been exceeded and it received positive response from the student participants.

For supervision and coaching mechanism, the BERANI programme has provided capacity building to 70 supervisors who provided supervision and coaching to over 350 midwives. More importantly, the BERANI programme has managed to establish commitment at the national level to adapt this initiative as part of the enactment of Midwifery Law. The Telebidan application is also seen as a promising platform for reaching more midwives beyond the project, and potential for being embedded into other platform managed by IBI.

## 4.2 Adolescent Sexual and Reproductive Health (ASRH)

In ASRH, based on the MTR, BERANI has generated positive results by engaging adolescents and young people through UNALA programme (outcome 1130, output 1131), an innovative model that engages the private sector in the delivery of health information and services for young people. The programme proliferates and includes the youth content creators' community of practices (CoP) for ASRH issues which provides a youth-led space for open discussions and creativity. Another contribution in the ASRH area is the technical assistance to the Ministry of Education, Culture, Research and Technology (MoECRT) and Ministry of Health (MoH) on the module for school teachers on Comprehensive Sexuality Education (CSE) (output 1221). Together with UNICEF, UNFPA has been constantly supporting the inclusion of ARH as a manifestation of CSE. In doing so, while UNFPA collaborates with the adolescent health post (Posyandu Remaja) as an outreach mechanism, UNICEF work closely with teachers as the entry point to incorporate specific topics such as menstrual hygiene management and child marriage through co-curricular activities (e.g., life skills and literacy sessions).

## UNALA: Youth-friendly SRH Information and Service Model (Outcome 1130, Output 1131)

UNALA has been implemented since 2014 or four years before the BERANI programme. The objective of UNALA is to generate a mechanism for quality youth-friendly services under private clinic providers. The innovative character of UNALA has been acknowledged by key stakeholders and especially adolescents as the main beneficiaries. UNALA is implemented in Yogyakarta through Yayasan Siklus Sehat Indonesia (YSSI), while UNFPA handles the coordination at the national level supporting MoH and BAPPENAS. UNALA increased access to ASRH service by giving consultation vouchers to adolescents which were distributed and promoted by YSSI through their networks. According to the MTR, the information provided was quite eye-opening yet remains less systematic compared to the general adolescent population. Youth and adolescent engagement through UNALA currently provides one of the most important project references in improving access to improved services, meeting their needs, and encouraging positive participation.

Having a partnership with 47 health providers, UNALA also initiated a telemedicine facility and training on gender and mental health awareness. The latest available quarterly information on the number of adolescents using this facility is from July to September (Quarter 3) 2021, which consisted of 1,742 consultations (M:62, F: 680). The number of consultations increased by about 694% from April to June (Q2) to 251 consultations (M: 53, F: 198). There were 16 doctors and 11 midwives involved in the Q3 2021 consultation, with the most topics being discussed are reproductive health and menstrual problems. According to the latest annual report, the UNALA model has reached and provided SRH information to 28,779 young people (M: 9,296, F: 19,483). Furthermore, 24% of the above number or 6,870 young people (M: 1,683, F: 5,187) utilized services for their SRH needs through UNALA.

During the implementation, the YSSI team established another project that still targets young people in accessing SRH information and services, which is a community of practice (CoP) for youth SRH content creators. The COP is one of the exit strategies of the UNALA model, which is based on the good practices and lessons learned of the UNALA model in promoting young people's participation to access ASRH information. There are two main approaches to this project. First, it initially worked with 25 social media content creators, before it grew to 59 members, who are interested in adolescents and ASRH issues and shared information on their social media platforms. YSSI coordinated the network as well as provided them with a knowledge hub filled with scientific resources regarding the issues. Second, as a result of this collaboration, various online discussions, classes, and webinars were held, inviting important speakers to deepen and enrich their perspectives on ASRH. These speakers included experienced academics, activists, religious leaders, and adat leaders. The network is entirely youth-led and emphasizes on bottom-up and

participatory approaches of the members, as exemplified by the selection of speakers for their activities.

With the high total reach of the sexuality education content produced by the content creator and high-level participation in each webinar or online class, it is suggested that the CoP be institutionalized as a youth-led forum. Hence, specific support such as mentoring programmes should be given to COP to develop a sustainability framework to continue beyond the coverage of the BERANI programme. It has also been suggested that the experience in Bone (and West Papua) could be followed as an example, where the LSE training has been expanded with national coverage through the Guru Belajar dan Guru Berbagi teacher digital learning platform under MoECRT (see output 1223 below). Further, while it requires efforts and financial commitment, CoP as a network, founded on shared interests, already possesses human and social capital as well as a youth-friendly brand that could be leveraged into a more expansive and long-lasting programme.

Additional data collection reiterates findings from the MTR regarding the challenges of UNALA. For services under private clinic providers, issues that emerge are regarding replicability and sustainability. The programme's model which relied upon voucher-based was contested, as it is difficult to replicate in government-led programmes. While the system is thought to be efficient by the users, it is difficult to be institutionalized by the government, considering its nature, structural capabilities, and other public system procedures. The issue with replicability relates to sustainability issues. While it is difficult to replicate the programme as a whole, many argue that it can sustain through integration with the existing government-led programme, such as the adolescent health post (Posyandu Remaja). Answering this, advocacy through the BERANI programme has resulted in a partial replication of the UNALA programme. The MoH has adapted UNALA's module and conducted online capacity building for coordinator of posyandu remaja in selected provinces.

Testimonial from one of the capacity building participants, UNALA adaptation into posyandu remaja is believed to make Posyandu Remaja a more appealing, fun, and youthful platform for non-facility based ASRH initiatives. The integration will work to alter government officials' social norms about ASRH and increase their support for providing comprehensive SRH services to all populations, including adolescents. Follow-up data collection with Posyandu Remaja's cadres suggests that the main obstacle to enhancing adolescent interest in ASRH issues is the absence of a platform for those who want to learn about the issues casually and in a non-formal forum. Thus, there is an opportunity to partially integrate UNALA's demand generation into Posyandu Remaja (e.g., adaptation of its module to Posyandu Remaja cadre's training). Considering the high utilization of the programme, UNALA's experience could also help Posyandu Remaja in re-branding the images of "posyandu" and mobilizing youth-initiated activities.

For CoP, The primary concern is the safety of the content creators because the contents can be occasionally regarded as sensitive and taboo. Additionally, there is always a risk with the 2016

Electronic Information and Transactions (ITE) Law. Hence, numerous internal discussions have been held to ensure that the network's group members are aware of the risks. These discussions have included webinars with experts in the fields of online safety, community standards, hoaxes and misinformation, content algorithms, and others. These discussions have also given CoP members the chance to learn about the best practices for creating content directly from social media platforms.

### Technical assistance on the Comprehensive Sexuality Education (CSE) (Output 1221)

While UNICEF focuses on LSE as part of the child marriage programme in Bone (output 1223), UNFPA works on the comprehensive sexual education (CSE). The programme involves teachers from special and inclusive education backgrounds. The inclusion of teachers of students with intellectual disabilities is done by adding some technical orientation to the existing CSE modules. The issues of adolescents with disabilities, especially on intellectual disabilities, were covered through CSE modules' revision.

Based on the programme document, the achievement targets related to CSE are as follows: (1) policy brief on incorporating CSE into the national curriculum available; (2) 160 teachers in selected provinces (DKI Jakarta, Yogyakarta, and NTB) have the skills to teach age appropriate SRH education in school. In order to achieve the first goal, UNFPA set the stage for a policy brief on integrating CSE into the national education curriculum in 2021. Both the policy mapping and the curriculum mapping that UNFPA has completed will be important data points for the brief. Results from studies testing Indonesian CSE modules on 5000 students as part of the Global Early Adolescent Survey will be used as specific evidence in the brief. The second goal has been achieved since 2019, where 212 teachers (140 female and 72 male) trained in the insertion of gender transformative comprehensive sexuality education into the curriculum.

Additionally, according to the 2021 annual report, it is argued that the commitment of MOH and MOECRT has increased regarding the CSE. It is demonstrated by the following three activities that were established in 2021 and serve as examples of the success of BERANI's CSE advocacy: a) The MOECRT's Directorate of Teachers for Special Needs Education supported adapting CSE modules to serve students with intellectual disabilities. They tested these modules with 512 students with intellectual disabilities in 54 schools using domestic funding; b) UNFPA facilitated the development of a memorandum of understanding (MOU) between MOH and MOECRT for a joint teacher capacity building programme on CSE that will train 5000 teachers in three years and use modules created by BERANI; c) UNFPA provided technical assistance to MOECRT for the creation of national guidelines for managing CSE programmes in secondary schools. These policies have been distributed to 2450 teachers and 345 district education offices.

While the technical support for CSE interventions is highly valued by key stakeholders, several MOH and MoECRT officials highlighted the issue related to the subject matter because CSE is still seen as a non-essential element of teacher training. The majority of education stakeholders consider Indonesia's educational curriculum to be overly crowded. As a result, they place a higher priority on reducing curriculum load and preserving learning quality than on introducing new subjects. In addition, an evaluation study done by UNICEF (UNICEF and Indonesia, 2018) reveals that teachers still feel uncomfortable in delivering ASRH-related learning materials to students. Further, collaboration with related stakeholders needs to be enhanced in tackling this socio-emotional teaching barrier. One of the strategies to choose could be by advocating MoECRT as one joint initiative and presenting CSE and LSE to MoECRT and MoH as inter-connected capacity building programmes for school teachers. BERANI could be used as an opportunity to join forces in terms of resource mobilization, creating linkages between CSE and LSE as a strategy to strengthen relevance and address identified gaps.

Further, it is argued that the experience of CSE shows that working through government systems and policies may not be the quickest route to results; nonetheless, interactions with government partners have opened opportunities for advocacy and familiarization, learning from one another (indirect capacity building), and developing creative and innovative programmatic approaches, which are crucial elements that can lead to institutionalization and increase the likelihood of sustainability.

## Pathway to Outcomes

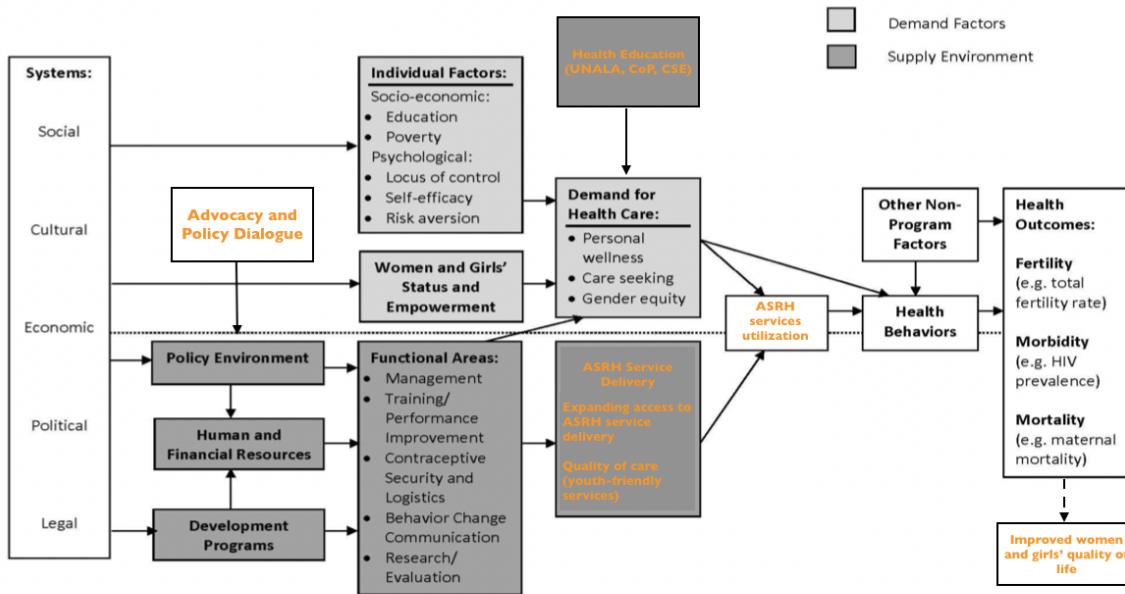


Figure 12 Pathway of assumption from two BERANI's programmes in ASRH to intermediate outcomes (SRH service) and ultimate outcome. Interventions, outcomes and ultimate goals are printed in orange. Developed based on reference 66.

Intervention at ASRH programmes (i.e., UNALA, CoP, and CSE) concentrated on increasing demand for health care and raising awareness of it. The intervention is crucial in raising health awareness because sexual and reproductive health are still taboo topics. According to UNALA's annual report, this eventually led to a rise in the utilization of ASRH services at affiliated private clinics. Further, UNALA assisted in the improvement of the quality of SRH services by offering training to their counterparts. Numerous health outcomes, including fertility, morbidity, and mortality, are improved as a result of rising healthcare demand as well as enhancing supply conditions. Even though the intervention was small in its scope, it nonetheless improved the quality of life for women and girls.

## ASRH programme Evaluation against the Evaluation Criteria

### Relevance (EQ1)

Additional data collection strengthens the results from the MTR regarding the relevance of BERANI in ASRH aspect. Both UNALA and CSE programmes are aligned with the national priority in improving the participation of adolescent and youth development. In accordance with Peraturan Pemerintah (PP) Number 61/2014 on Reproductive Health, CSE is intended to strengthen education's important role in fostering communication, information sharing, and adolescent empowerment (Article 12). UNALA, which uses a more youth-friendly approach, contributes to the

implementation of RPJMN agenda in improving young people's productivity and competitiveness and the achievements of SDG Target 3.7 (especially Indicator 3.7.2 on adolescent birth rate).

UNALA team has also engaged adolescents with disabilities individually and institutionally, which indicated by its partnership with Sentra Advokasi Perempuan Difabel dan Anak (SAPDA), a community-based organization in Yogyakarta whose work also covers ASRH issues. The CSE programme currently involves teachers from special and inclusive education backgrounds. The inclusion of teachers of students with intellectual disabilities is done by adding some technical orientation to the existing CSE modules. The programme responded to the COVID-19 pandemic challenge by rapidly transforming and shifting ASRH activities into virtual forms by relying on national radio broadcasts (Radio Republik Indonesia [RRI]) and common online platforms (e.g., Zoom, WhatsApp).

### Effectiveness (EQ2-4)

#### **Adolescent Sexual and Reproductive Health**

*Outcome 1130, Output 1131; Outcome 1220, Output 1221*

##### Good Practices (contributed to the achievements)

- Innovative and adaptive to the adolescent's needs and interest. This include extending ASRH service to private sector (UNALA), the use of IT and digital technology to reach wider coverage for ASRH education
- Has a GEDSI transformative approach in ASRH, aiming to target the vulnerable adolescent (including those who have no access to education through rebranding of posyandu remaja), and initiated CSE adaptation for children with disabilities
- Establish a strong adolescents forum and network potential for future adolescents' program beyond ASRH

##### Gaps

- UNALA and CoP applied a project-based approach with a lack of clarity in its sustainability plan. Despite this, the two have components that can be conveniently replicated/adapted for another adolescent program
- Connectedness between CSE and LSE

##### Challenges

- Gaining private sector interest in ASRH service provision
- Financing for ASRH program
- Institutional and social norms and values towards ASRH and CSE

Since there have been no longitudinal studies conducted on the programme during the period, the effectiveness of the intervention can only be evaluated using observational data and desk review. According to the latest report available, UNALA has created a partnership with 47 private health providers. The partnership has increased the capacity of the private clinics in providing accurate information, non-discriminative and convenient services for adolescents. The use of customer lines and social media in this programme has improved the number of adolescents who want to do a consultation. For some of the teenagers, the programme has become their first experience in accessing such services. It is thought to be one of the important contributions of this programme because the first step in accessing SRH services are

seen to be a major obstacle.

Besides private clinics, UNALA has built partnerships with the local district health office in Sleman. During the FGD with the officers, the programme is thought to be effective in increasing occupancy of Puskesmas services, primarily on mental health services. They claimed that the programmes better connect the supply of health workers in Puskesmas—who were facing a decline in visitation during the pandemic—with the demand among adolescents for information on topics such as

mental health. Further, the flexibility of programmes in meeting local needs and working with them, benefits other stakeholders involved.

In terms of reach beyond those who access the health providers, the UNALA team has also regularly disseminated information through CoP. Among others, it addresses gender equality issues, including the root causes of gender inequalities through the contents delivered, i.e. child rights, youth empowerment, and others. This intervention effectively targets those who seek a deeper understanding of SRH but are unable or unwilling to have a formal one-on-one consultation.

For the CSE, The effectiveness of its advocacies is shown by the government's subsequent decision to financially support the ASRH practices. Several government-issued policies regarding CSE are as follows: (1) The inclusion of CSE in the general school-health programme; (2) Guidelines for CSE in Primary and Secondary Schools; (3) Teacher Training Modules on Age-Appropriate CSE, Including Special Education Teachers and CSE in Time of Pandemic COVID-19; in-house trainers (widyaiswara) from the education quality assurance and teachers and education personnel empowerment and training unit; (4) technical cooperation between MoECRT and MOH on pool of trainers for CSE.

### **Efficiency (EQ5)**

*Financial resources.* Due to the COVID-19 pandemic and the alteration to the BERANI output structure (i.e., the cancellation of Output 1132 on UNALA in NTB), the implementation of Outputs 1131 (UNALA) and 1221 (CSE) for the ASRH component is impacted. The cancellation resulted in an extra budget of USD 575,657 under Output 1131. For both Output 1131 and 1221 in 2020, an additional budget of USD 94,019 for the COVID-19 response was added, which decreased the financial disbursement rate. The government partners did not consider the lower rates to be significant because they also needed to concentrate on the government's response to COVID-19. But the team reported no programmatic alterations or goals.

*Administrative resources.* The programme delivered through the UNFPA structure and system has been providing administrative support in such a way that satisfies the IPs. All the IPs expressed their satisfaction and appreciation for the administrative support provided by the programme. The special administrative support that is provided to strategic partners has been very much appreciated.

### **Coherence (EQ6-7)**

The main comparative and collective advantages of the programme in the ASRH aspect lie in its specific targets and reach where it focuses on adolescents in accessing the SRH services and

information. The programme's adaptability, which allows it to transform and take into account local needs based on ongoing findings from stakeholders, is also valued and nurtures closer and stronger partnerships with them. Additionally, it is recognized The UNFPA and UNICEF organizations have a strong and extensive network including the international pool of talent, which enables the programme to gather them in achieving its goals.

On coordination, based on MTR, in ASRH there was no clear separation based on comparative advantage, expertise, or level (policy or field presence). The division of labour between UNFPA and UNICEF is more based on the projects that they run as individual organizations. UNFPA works on UNALA and CSE, which is focused on the adolescent sexual and reproductive health and based on the International Technical Guidance on Sexuality Education (ITGSE). On the other hand, UNICEF focuses on LSE as part of the child marriage programme in Bone (output 1223). However, close coordination is unavoidable with or without the BERANI programme due to the similarity of the population target (i.e., adolescents and young people), particularly at the national level where the two organizations are collaborating with the same ministries.

### **Sustainability (EQ8)**

Most of the parties involved in UNALA recognize the value of UNALA as a role model for involving the private health sector in enhancing ASRH services and empowering youth. However, the majority of government stakeholders are unsure of the initiative's long-term viability. UNALA is less likely to be completely replicated or integrated into government-led programmes due to its complexity and its approach that is private-based. According to a key informant from MoH, private services ideally be included in the Puskesmas programme, but private clinics occasionally have their own methods, while Puskesmas have other priorities and tasks. As a result, the idea of running ASRH through the private sector is still questionable from the financing perspective, and is thought to be too complicated for the MoH to handle.

From the private clinic provider perspective, according to a private health professional, one of the difficulties in continuing the UNALA concept into a sustainable and independent programme at their clinics is that some of the current members are only workers who are not in a position that is able to accomplish it. Thus, it is suggested that future programmes involve private health provider management or health workers who have influential positions in their clinics when targeting a sustained and transformed intervention at private clinic providers. Nonetheless, the interventions at the private clinics are thought to be effective in increasing the capacity of their health professionals.

Further, there are still areas in which ASRH programmes could be sustained, which relates to capacity development. These can include training, advocacy work, networking, collaboration that increases awareness, and the development of the fundamental knowledge and abilities related to adolescent issues. The continuation of the practices will probably be supported by (1) networks

that can link practitioners, such as UNALA clinic partners, CoP, and teachers trained in CSE; (2) adaptation of LSE curriculum in schools through local content in religious and public schools; (3) training modules, guidelines for CSE at MoECRT.

#### Coverage and Connectedness (EQ9)

Issues with coverage and connectedness has been fully answers in MTR, which stated that the SRHR, ASRH, GBV and harmful practices interventions and approaches in COVID-19 settings are in line with the principles of coverage and connectedness. All the support provided by the BERANI's ASRH component relates to COVID-19 settings are logical and consistent in addressing key issues that arise during the pandemic. The support of adolescent and youth programmes managed to enrich the existing structure and utilized opportunities coming from the pandemic crisis, especially in fostering digital transformation among the youth (51 content creators have joined CoP). By the end of the BERANI programme, 47 private health service providers were strengthened and provided ASRH services. Further, over 28 thousands of adolescents have received ASRH information delivered through UNALA, with nearly 7000 accessed and utilized the ASRH services.

CSE modules have been tested and the pilot reached 5000 teachers (join funding with MoH and MoECRT) and CSE guidelines have been distributed to all district education officers, and over 2400 teachers. MoECRT has also adapted the module for youth with disabilities, where it is tested in 54 schools reaching 212 students with disabilities.

### 4.3 Gender Equality and Women's Empowerment (GEWE)

#### Prevention of GBV (Outcome 1120, Output 1121, Output 1122)

To respond to the seriousness of gender based violence (GBV) cases in Indonesia, the Ministry of Health (MoH) has committed to addressing and responding to GBVs. A mutual agreement was made in 2002 between the Ministry of Women Empowerment and Child Protection (MoWECP), MoH, Ministry of Social Affairs (MoSA) and the Police Department to strengthen their commitments to provide victim or survivors-friendly services to address GBV. The Minimum Service Standard for Responding Survivors of GBV was developed in 2010, stimulating the MoH to provide a minimum of two Primary Health Centers with GBV response competencies in each district and a minimum of 1-2 hospitals providing an integrated service center<sup>71</sup>.

The BERANI programme on GBV had an objective to increase capacity of health service points to respond to GBV cases in Indonesia, which were contributed by two Outputs (1121 and 1122), implemented through some initiatives.

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<sup>71</sup> UNFPA/UNICEF, Design Document of BERANI, 2018.

## **Technical Assistance to MoH for HSR to GBV**

The provision of technical assistance to increase MOH's capacities in many ways, including in skills and knowledge development of health workers from 34 provinces on GBV case handling, development of a TOT manual, revision of a Guideline, and development of an algorithm of sexual violence, where 6 provinces organized the training with the support of BERANI, while other 28 provinces organized the training with MOH's budget commitment.

The MTR reported that participating health staff were able to do early detection on cases of GBV, including cases of trafficking in persons, to do networks and to use the existing referral mechanisms, and to record cases of GBV through the SIMFONI system. The BERANI programme's initiatives also included the development of an Algorithm of Sexual Violence (Clinical management of Sexual Violence Cases) guide. Participating health staffs of capacity building involving 34 provinces increased, however, the MTR reported that the new skills and knowledge had not been able to be utilized effectively and in a sustainable way as HSR to GBV had not been considered as the MoH's priority mandate.

### **Pilot Project of HSR to GBV in Cirebon District.**

A capacity development initiative through the development of a pilot project for health staff to respond to the needs of survivors of GBV at the local hospitals was organized in Cirebon District. The MTR indicated that the Pilot Project on HSR to GBV in Cirebon District was considered appropriate. An independent evaluation report on the Cirebon district's Pilot Project indicated that Cirebon was chosen by the MoH to be part of a BERANI's Pilot Project as it met some criteria, including being carried out in an urban area in the north coastal line of Java with hospitals and 60 PUSKESMAS and had high incidence of GBV.<sup>72</sup> The Pilot Project provided a model for building services for survivors of GBV from the HSR's One Stop Service Center, which integrated protocols for COVID-19 Pandemics' setting and with the emergency preparedness support for marginalized women and girls. The programme increased capacities of 30 health staff from 2 hospitals and 11 health centers and 30 psycho-social counselors, law enforcement officers on knowledge and skills on early detection and data recording to handle GBV cases. Some works to strengthen networking with non-health staffs, including the P2TP2A were carried out from 2018 to 2021 through the organization of coordinating meetings of P2TP2A, capacity development of Satgas PPA, development of *Perlindungan Anak Terpadu Berbasis Masyarakat* (PATBM) or integrated child protection using community based, training on SIMFONI, training of sub-district's motivators, training on SOP of GBV case's management, as well as development of MOUs between targeted hospitals and stakeholders, including Lembaga Psikolog Ordinat, and a legal aid foundation, LBH Universitas Muhammadiyah Cirebon (UMC). It was reported that a useful module for assessing standardized services was produced and used. Nevertheless, it was reported that effectiveness of the Pilot Project was challenged by the lack of funding from the national and regional state budget (APBN/APBD) for HSR to GBV, the lack of health service chains for GBV, and the lack of governance arrangements within the health service points, which led to the limited numbers of health staffs

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<sup>72</sup> An Independent Consultant's Report for UNFPA, Evaluation and Learning Report "Strengthening of the Health Sector in Providing Comprehensive Services for Victims of Violence Against Women and Children : Case Study of a Pilot Project on HSR to GBV in Cirebon District", 2022

implementing the new knowledge and skills<sup>73</sup>. Final evaluation of the Pilot Project raised issues on the need to have a better design on the Pilot Project, in terms of Project's structure and the need of an appropriate risk assessment. For better results, it was expected that training on HSR to GBV was not only provided to health staff but also to the Directors and/or Management of the participating hospitals and Puskesmas, as the HSR to GBV requires decision making and adaptations, for the services to be internalized and integrated into the structure and health service chains of the hospitals/Puskesmas. Moreover, stronger coordination between the Pilot Project and the local BAPPEDA with regard to funding of the HSR to GBV has been identified as necessary.

Replication of the pilot project was done through a training for health staff of Puskesmas and Hospitals of Bogor district, Bogor City, Tangerang District, Tangerang City, Palu City and Sigi District, carried out in November 2022. While the new knowledge and skills were reported by the alumni as being useful, assessment on the effectiveness had not able to be measured, and the new skills and knowledge were reported not to be effectively utilized, due to the lack of readiness of the service chains within the health service points<sup>74</sup>.

With regard to services for survivors of sexual violence, it was reported 88 cases (25 female, 44 girls, 19 boys) were handled by 41 trained community health centers (government-owned centers) and 2 trained district hospitals in Cirebon District. Nevertheless, due to the COVID-19 related temporary closure of several primary health centers in Cirebon district, the number of reported sexual violence cases decreased in 2020 as compared to the case in 2019<sup>75</sup>.

#### **Adaptation of Standard of Operating Procedures (SOPs) for P2TP2A/UPTD.**

Based on a Rapid Assessment and Policy Brief on COVID-19 Impact to GBV document, a series of capacity development for P2TP2A of DKI Jakarta was carried out through the adoption of a Revised Protocol on GBV Case Management for COVID-19 response, which included the organization of training for P2TP2A Staffs, and the provision of psychosocial support. The Protocol also allows survivors to report through an online system. The programme, through UNFPA, introduced a Guideline on Health Sector Response to GBV for Hospitals and PHC, and Algorithm of Sexual Violence (Clinical management of Sexual Violence Cases) to the P2TP2A/UPTD of the DKI Jakarta Province. Capacities of the P2TP2A DKI Jakarta to deliver services for survivors/victims of GBVs, by adopting the revised protocol on GBV Case Management and capacity development of P2TP2A Staffs in response to Covid 19. Due to the usefulness of the Protocol to close the gaps on survivors' accessibility to services, the Protocol has been replicated in other BERANI's target districts in Bogor and Tangerang District, Palu City and Sigi District. Replications also occurred in 4 provinces (North Sumatera, Central Java, North Sulawesi, and Maluku ) as well as in other 12 districts (North Aceh,

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<sup>73</sup> UNFPA, Independent Final Evaluation Evaluation and Learning, Strengthening Of The Health Sector In Providing Comprehensive Services For Victims Of Violence Against Women And Children (Case Study Of A Pilot Area Management of KTP/A Handling in Cirebon District), 2021

<sup>74</sup> Group discussions with 18 medical doctors, midwives, and management of hospitals and Puskesmas as well as with P2TP2A and officials from the Health Units

<sup>75</sup> UNFPA/UNICEF's BERANI Annual Report 2020

Padang, Bandung, Sleman, Jombang, North Central Timor, South Central Timor, Muna, Maros, Pare-pare, Tana Toraja, Nias, and Central Lombok District, which are under MAMPU/DFAT programme. Such an initiative, which was carried out within COVID-19 Pandemics's context, was considered as a good practice. Moreover, this initiative also inspired the MOH to develop a revised Protocol for HSR to GBV in health service points to suit within COVID-19 Pandemics' context. The shift to digital technology indeed was recognized as opening up new opportunities in terms of GBV survivor's accessibility to services, although reliance on online platforms has also generated a digital divide that has marginalized some adolescent groups, especially those without access to ICT technologies, infrastructure, and capacity.

To respond to Covid-19 Pandemics, 2,400 Dignity Kits (400 from the BERANI programme's funding and 2,000 from the MoWECP and Sapa Foundation)'s funding were procured and distributed for the most marginalized women (GBV Survivor, Women with Disability, Women living with HIV, women-headed households and Elderly) in the BERANI's project areas (Bekasi City, Bogor District, Tangerang District Tangerang city, Cirebon district, North Lombok district, DKI Jakarta,) for responding appropriate services during the Covid-19 Pandemic. In addition, survivors of Semeru's eruption in Lumajang received the Dignity kits as well. Interviewed staff of the P2TP2A/UPTD PPA of DKI Jakarta and the MoWECP's officials reported that the dignity kits were appropriate and useful within the covid-19 pandemics' context, although planning on the distribution of the Dignity Kits required better assessments. The activity concluded in 2021.

### **Pilot Project in North Lombok**

A pilot project in 2 villages of Tenige and Tanjung of North Lombok (NTB), was implemented by LPSDM and LPA Lombok promoted efforts to prevent GBV and harmful practices at the community level, involving youth groups, families' community, including fathers and male members of the families, traditional leaders, religious leaders, and village governments. Two village regulations were produced. LPSDM and LPA Lombok carried out advocacy in the development of North Lombok's District Regulation on the Protection of Women and Children as well as increased capacities of P2TP2A/UPTD PPA of the North Lombok to develop its UPTD PPA's new structure and to increase capacitate of its staffs. The advocacy has created awareness about the importance of understanding about GBV in general and building recognition among youth and families that women and girls face more vulnerabilities, due to their unequal status and discrimination. Unfortunately, no ASHR material was integrated in the community dialogues. It was noted that the pilot project also supported P2TP2A/UPTD PPA to report and manage GBV cases and to collaborate with hospitals, but no initiatives were done to include HSR to GBV in this pilot project. It was reported also that implementation of the 2 village regulations were hindered by the lack of budget availability at the village level as most budgets were absorbed for COVID-19 Pandemics, making the trained village facilitators have not continued working at the village.

A summary of strengths, gaps, and challenges of the key interventions can be seen below.

#### **Box 4.3.1 Key Interventions, Strengths, Gaps, and Challenges in the Prevention of GBV's Theme**

### **Key Interventions , Strengths, Gaps, and Challenges in the Prevention of GBV's Theme**

#### **Interventions**

- Capacity development on HSR to GBV for health staffs of MOH In 34 provinces
- Pilot Project on HESR to GBV at health service points in Cirebon District
- A Rapid Assessment to the impacts of COVID-19 Pandemics to GBV services
  - Pilot Project Adoption of COVID-19 Pandemics' Protocols in P2TP2A/UPTD PPA in DKI Jakarta
  - Procurement and distribution of 2,400 Dignity Kits
- Advocacy to prevent GBV implemented by LPSDM and LPA Lombok in 2 villages in North Lombok and supported to the P2TP2A/UPTD PPA in North Lombok, advocacy to the development of District Regulation on the Protection of Women and Children

#### **Strengths**

- MoH's funding of the capacity development on HSR to GBV in 28 provinces
- Curriculum development (TOT, PTGS, Facilitators' Guide, Referral System Guide - PTGS)
- Algorithm of Sexual Violence (Clinical Management of Violence Cases)
- Integration of COVID-19 Pandemics' Protocols, its replication in 7 targeted districts/cities, and replication in DFAT's funded MAMPU's targeted areas in 4 provinces and 12 districts/cities
- Gender transformative approach in the implementation of Pilot Villages in North Lombok and modules (youth, parents, religious/traditional leaders)

**Gaps :** a) Commitment building for reconfirming the HSR to GBV and relevant capacity development initiatives to be integrated into the MOH's system; b) Design of the Pilots and no ASHR's materials in the community dialogues; c) Assessment on the distribution of the Dignity's Kits.

**Challenges :** COVID-19 Pandemics and its implications to time schedule and local budget, sustainability of village facilitators

## Pathway to Outcome

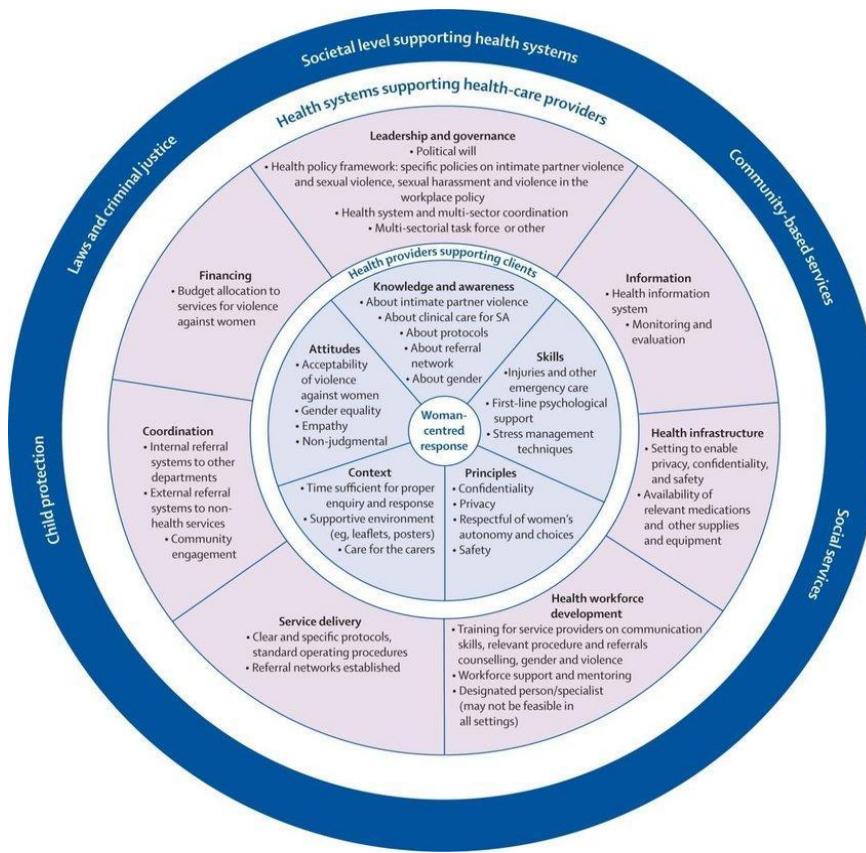
Addressing GBV through UNFPA-supported SRH programmes is the minimum standard to which all UNFPA operations should be held accountable, and UNFPA plays a leadership role in ensuring that GBV is addressed as an integral part of the essential SRH package<sup>76</sup>. An assessment and review of existing approaches to and models of health sector responses to GBV was carried out by the UNFPA Asia Pacific Regional Office (APRO) indicated various countries in the region have implemented different approaches to addressing GBV through the health sector,<sup>77</sup> where a combined hospital-based *One Stop Service Center* (OSSC), and with NGO support has become popular. The combined OSSC with NGO support model was offered to recognize that not all hospital staff have been sensitized to detect and refer cases, which happened in many countries, including Indonesia. Such government-led models with NGO support can often be successful, as they draw on the strengths of each institution, requiring strong diplomacy and effective communication and collaboration among partners, with agreed clear roles and responsibilities. The UNFPA/APRO's assessment recommended the HSR to GBV were compatible to a Colombini Model, adapted by Claudia García-Moreno,<sup>78</sup> as follows.

*Figure 13 Elements of Health System and Healthcare Response to address GBV, adapted from a Colombini and Claudia García-Moreno et ALL's Model*

<sup>76</sup> UNFPA's Asia Pacific Regional Office (APRO), Health Sector Response to Gender Based Violence, An Assessment on the Asia Pacific Region, 2010

<sup>77</sup> UNFPA's Asia Pacific Regional Office (APRO), 2010 ibid

<sup>78</sup> Claudia Garcia-Moreno, et ALL. The Health-Systems Response to Violence Against Women, www.thelancet.com Vol 385 April 18, 2015



The Model underlines the importance of a)leaderships and governance, which include health policy framework, b) evidence based response, information system, documentation, and M&E, c) health infrastructure, including GBV service point d) health workforce development, including training and mentoring, e) service delivery, including screening, examination, protocols and referral networks, f) coordination (internal and external, multi-sector responses, legal aid, community engagements), g ) financing, and h) prevention strategy.

From the perspective of the Colombini model<sup>79</sup> and the model of primary health service (Puskesmas) in Indonesia, as outlined in the MoWECP's Guidelines,<sup>80</sup> it can be analyzed that the BERANI's programme delivered some interventions, which can be summarized below, where the BERANI's interventions were highlighted in orange fonts.

<sup>79</sup> Claudia Garcia-Moreno, et ALL., *ibid*

<sup>80</sup> Purwaningtyas, et ALL. The role of primary healthcare physicians in violence against Women intervention programme in Indonesia, 2019

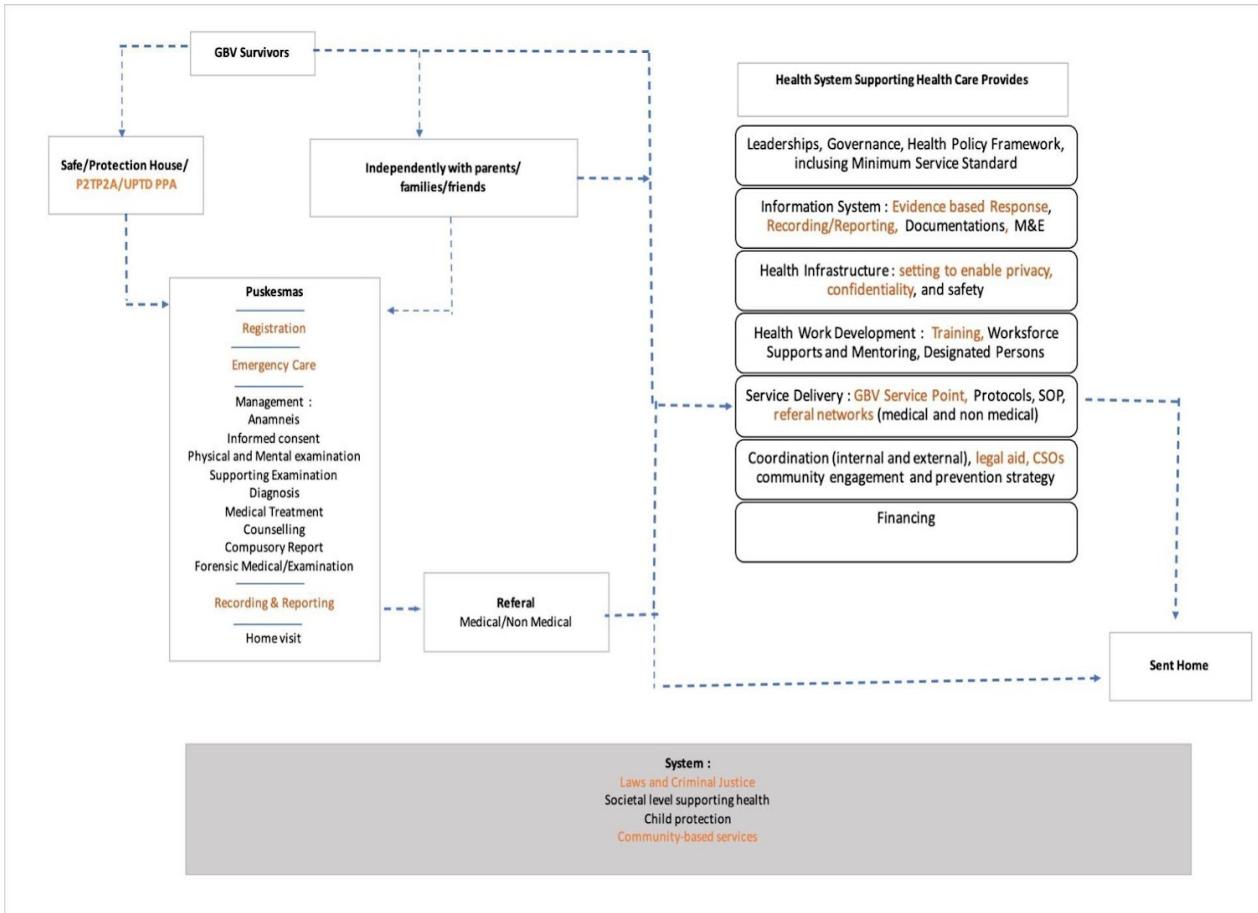


Figure 14 The BERANI programme's interventions on HSR to GBV using the above reference

For the Pilot Project in Cirebon District, GBV's survivors would go to either P2TP2A, or directly to the health service points in Puskesmas or local hospital, for accessing HSR to GBV. Depending on the services provided by trained health staff at the health service points, survivors would either get referral services, or go home, as the internal structures within the Puskesmas and hospital have not integrated the HSR GBV's protocols.

The pathway of the BERANI programme's interventions to prevent GBV through HSR to GBV to contribute to outputs, immediate outcomes, outcomes, and ultimate outcomes, based on the above Colombini's model<sup>81</sup> and the MoWECP's model<sup>82</sup> can be summarized below. Orange fonts indicated what the BERANI programme intervened.

<sup>81</sup> Claudia Garcia-Moreno, et ALL. The Health-Systems Response to Violence Against Women, www.thelancet.com Vol 385 April 18, 2015

<sup>82</sup> Purwaningtyas, et ALL. The role of primary healthcare physicians in violence against Women intervention programme in Indonesia, 2019

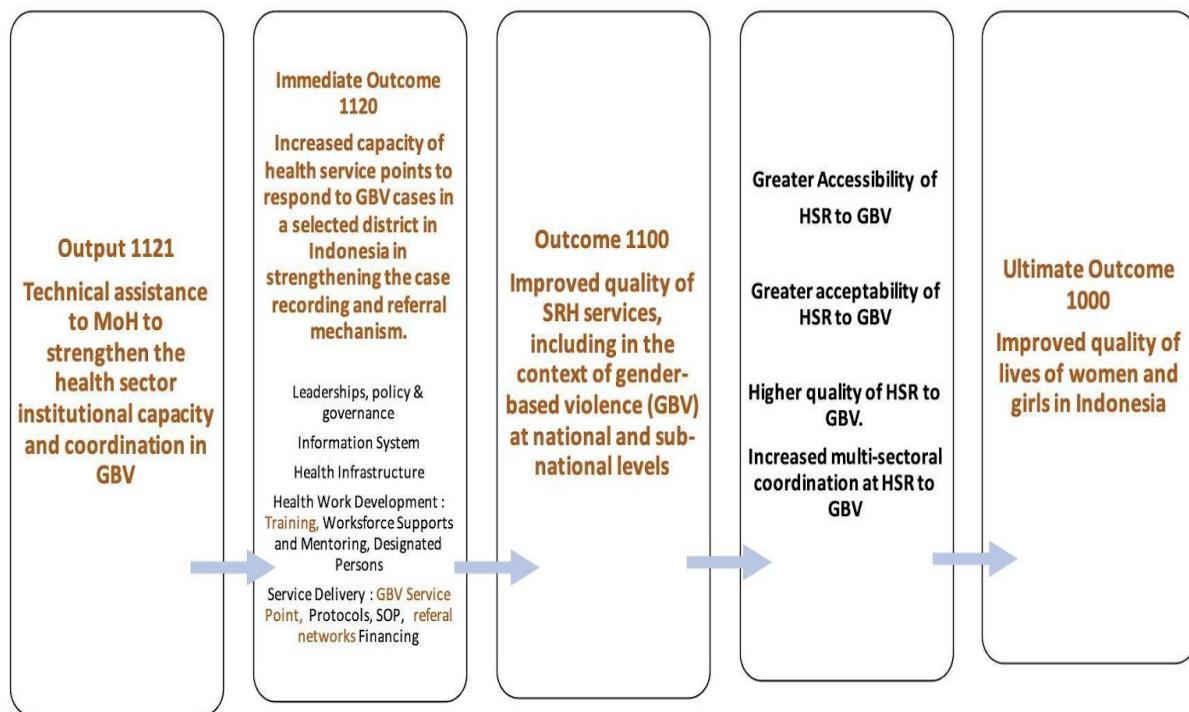


Figure 4.3.3 Pathway of assumption from the BERANI's programmes in HSR to GBV to intermediate outcomes (capacity of health service points to GBV), outcomes (improved quality of HSR to GBV) and ultimate outcomes.

Contribution of the programme's outputs to the immediate outcomes occurred. Nevertheless, the programme's interventions to increase capacity of health staff on HSR to GBV from 34 provinces and a pilot project to increase capacity of health service points to respond to GBV cases in Cirebon district in Indonesia in strengthening the case recording and referral mechanism for contributing to HSR to GBV for contributing to outcome 1100 of improved quality of SRH services, including in the context of gender-based violence (GBV) at national and sub-national levels were unlike to happen. To respond of Health care providers to the need of GBV's survivors requires diagnose and registration of the GBV cases, full physical (and psychological) examination, and expectation to minimize the prevalence and impact of GBV through improved primary, secondary and tertiary preventions, and referral to social, economic, and legal supports<sup>83</sup>. The provided capacity development to the health staffs, carried out through training was insufficient to provide comprehensive HSR to GBV, due to the lack of leadership commitment, the lack of service chains, the absence of SOP and guidelines, the lack of resources (staff's time and financing), lack of internal and external coordination, lack of access to data system<sup>84</sup> and with limited direct communication to the community to encourage survivors to have willingness to use HSR to GBV (the demand side), making the large majority of survivors either turn to informal networks of friends and community members for help or with no support.

<sup>83</sup> [http://web.worldbank.org/archive/website01213/WEB/0\\_CO-56.HTM](http://web.worldbank.org/archive/website01213/WEB/0_CO-56.HTM)

<sup>84</sup> Access to SIMFONI and to survivor's data have also been a challenge, due to the confidentiality issue as stipulated by Law on Health. r

## Prevention of GBV Against Evaluation Criteria

### Relevance ( Evaluation Question 1)

The programme's initiatives were considered relevant, overall. The capacity development for health workers on HSR to GBV contributed to the increasing the capacity of health workers and health service systems both at the national and local level, and specifically in hospitals and health centers in the pilot project in Cirebon District. The capacity development on HSR to GBV were considered to be useful and realistic and have been aligned with the GoI's priorities in the prevention of gender-based violence (GBV), in order to meet the target of 5.3 of the SDGs and aligned with the CEDAW. The Pilot Project increased capacities of health services in health service points in Cirebon District was considered appropriate, in terms of the completeness of the health service's ecosystem of availability of hospitals in an urban area, and the capacity development offered in the initiative. However, the capacity development of health staff that include a national coverage and the pilot project in Cirebon District survivors of GBV has not fulfilled the requirements to the development of comprehensive HSR to GBV as expected, as the financing for the services only covered post-mortem services, which were funded by both Cirebon District's APBD funds and DAK 2021 from the MoWECP, and did not have an SOP of health service chains for GBV in place.

The programme supported LPDSM and LPA Lombok to design and implement a Pilot Project to prevent GBV and harmful practices in North Lombok by providing advocacy to the youth, families, traditional leaders and religious leaders and village government as well as provided capacity development of P2TP2A/UPTD PPA, including to increase the P2TP2A/UPTD PPA's capacities to link with the referral system, including hospitals. The choice of the BERANI programme to select two different areas (Cirebon District in West Java and North Lombok in NTB) for the Pilot Project has missed the opportunity for the programme to have a complete picture of model to link relevant HSR to GBV's interventions under the supply side to meet the demand side, which has been done through interventions in North Lombok. Unfortunately, interventions on HSR to GBV have not responded the need of survivors of GBV for fulfilling their mental health services (psychological services and clinical psychologist services), as part of the comprehensive services on HSR to GBV and the mandate of the health sector<sup>85</sup> In such, the interventions have not closed the gaps for the needed HSR to GBV services.

The Rapid Assessment and Policy Brief on COVID-19 Impact to GBV document and a series of capacity development for P2TP2A of DKI Jakarta was carried out through the introduction of a Revised Protocol on GBV Case Management for COVID-19 response, which included the organization of training for P2TP2A Staffs, and the provision of psychosocial support were considered relevant and appropriate. The usefulness of the revised Protocols, which allow survivors to report through an online system has been considered as a good practice. Replication on the adoption of the revised Protocols in other BERANI's target districts in Bogor and Tangerang District, Palu City and Sigi District as well as in 4 provinces (North Sumatera, Central Java, North Sulawesi, and Maluku ) and 12 districts (North Aceh, Padang, Bandung, Sleman, Jombang, North Central Timor, South Central Timor, Muna, Maros, Pare-pare, Tana Toraja, Nias, and Central Lombok District under MAMPU/DFAT programme were well recognized.. Moreover, this initiative inspired the MoH

<sup>85</sup> MENPANRB, Regulation of the Minister for Empowerment of State Apparatuses and Bureaucratic Reform (PAN and RB) No Per/11/M.PAN/5/2008 concerning functional positions of clinical psychologists and their credit scores, where the clinical psychologist advisor is the Ministry of Health.

to also develop a revised Protocol for HSR to GBV in health service points to suit within COVID-19 Pandemics' Context. The shift to digital technology indeed has opened new opportunities in terms of GBV survivor's accessibility to services, although reliance on online platforms has also generated a digital divide that has marginalized some adolescent groups, especially those without access to ICT technologies, infrastructure, and capacity.

#### **Effectiveness (Evaluation Questions no 2, 3 and 4)**

The BERANI programme's initiatives for providing capacity development to health staff on HSR to GBV in 34 provinces and the Pilot Project in Cirebon District were delivered. Most outputs completed during the Mid-term Review processes in 2021.

The programme's interventions on the Technical assistance to MoH and the Technical assistance provided on handling GBV cases in health service points, which also included in the COVID-19 Pandemics' setting and with the emergency preparedness support for marginalized women and girls were recognized by the capacity development's beneficiaries as successful in increasing capacities of the health system to respond to GBV. Nevertheless, most of the trained health workers have not effectively exercised their new skills and knowledge at the local level as it has not been considered as MoH's key mandates.

The Pilot Project of HSR to GBV in health service points in Cirebon District was implemented and completed in 2021. In November 2022, a replication of the capacity development interventions in the Pilot Project of Cirebon was replicated in Bogor District, Bogor Cities, Palu City and Sigi District, where internalization of the initiatives was impossible to happen within a month before the BERANI programme's completion in December 2022. Project Effectiveness of the interventions were challenged by the lack of funding allocation from both the national and local government's budget (APBN/APBD) and the lack of readiness of the HSR to GBV's system in the health sector, as indicated by the absence of health service' chains for GBV as well as SOPs of the services. Training alone was insufficient to develop a comprehensive HSR system to GBV. A better design of the Pilot Project's Structure to include a systematic model of HSR to GBV with components of commitment building and cross-sectoral coordination, as well as HSR to GBV's SOP development and testing, mentoring and coaching, inclusions of directors and/or management of the health service points into the capacity development, and stronger linkages with the referral system was necessary. Interviewed alumni of the capacity development initiatives from Bogor District and Palu City, as part of replication of the capacity development through the Cirebon's Pilot Project have done possible efforts within their individual capacity and control. For example, the alumni reported having shared the information about HSR to GBV to their colleagues in emergency units and poly clinic units. Some others have started to develop data systems, to provide referrals, to forward the case to get *visum et repertum* and/or to forward the case to the P2TP2A/ UPTD PPA. At the minimum, alumni started to provide counseling services and to identify available networks for referral.<sup>86</sup> The alumni reported that the absence of health service's chains and SOP has challenged the implementation of the new knowledge and skills. Accessibility to training material, which were limitedly done through online basis is also one among the challenges as budget availability for printing references was limited.

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<sup>86</sup> FGD with 18 health staffs and non health staffs from health service points in District of Bogor and Palu City, carried out in early March 2023

The capacity development to adopt protocols within COVID-19 Pandemics' context in P2TP2A/UPT PPA in DKI Jakarta and other areas of replications in Bogor District and Bogor City, Tangerang District and Tangerang City, and in Palu City as well as in Sigi District was considered effective. Approximately, about 49% out of 2,371 survivors of GBV were able to access at least one type of service at UPTD/P2TP2A/Satker in Bogor district and Bogor City. More replications also happened in 4 provinces and 12 districts of MAMPU (DFAT Funded) programme.

A summary of changes in capacities of the MoH's staffs at the national and local level as well as capacity of district unit of health and women empowerment and child protection increased on HSR to GBV can be seen in the box, below.

**Box 4.3.1 Changes have been recorded on the Prevention of GBV**

**Output 1121 and 1122's Contribution to Outcomes 1120 and Good Practices**

- Available capacity development (CD) model was exercised on a national scale (34 provinces). MoH's capacity to mainstream gender through HSR to GBV increased. The MoH plans to integrate the cD model into its programme.
- Available capacity development model, including a Training of Trainers (TOT) Manual for GBV in HSR, e-protocols for HSR to GBV to strengthen case management and referral mechanisms to be applied in the health service points in Cirebon district, and replicated in Bogor and Tangerang District as well as Palu City. Capacity of MoH at the national level and Health units and Women Empowerment and Child Protection in Cirebon district as well as in the BERANI's targeted areas of replication on the promotion of survivors-friendly services increased.
- Made available a model for adopting Standard of Operating Procedures (SOPs) for P2TP2A/UPTD of DKI Jakarta, introduced quality assurance, TOT manuals of One Stop Service for GBV survivors, and GBV case management, as well as the use of online media for reporting GBV cases and adoption of SOP for GBV with the COVID-19 protocol. The model was replicated in UNFPA's targeted area (Bogor District, Bogor city, Tangerang District, Tangerang City, Palu City, and Sigi District. Replications also occurred in 4 provinces (North Sumatera, Central Java, North Sulawesi, and Maluku ) as well as in other 12 districts (North Aceh, Padang, Bandung, Sleman, Jombang, North Central Timor, South Central Timor, Muna, Maros, Pare-pare, Tana Toraja, Nias, and Central Lombok District, which are under MAMPU/DFAT programme.
- Made available a model on One Stop Service for GBV Survivor in health points in Cirebon District, which was replicated in Bogor and Tangerang district and Palu City. The Cirebon's pilot was considered meeting technical aspects, environmental requirements, and applying systematic planning and M&E. Capacity of both health staff and non health staff increased and survivors were reported being satisfied with the services and the excellent infrastructures. Some medical staffs increased capabilities to coordinate with relevant units of HSR get medical report (*visum et repertum*) and/or to forward to gynecologists/obstetric<sup>87</sup>.
- Increased confidence of local women NGOs, LPSDM and LPA in advocating sensitive issues, such as GBV and harmful practices to the community, using gender transformative approach in the community, advocating the North Lombok District's Regulation (PERDA) on the protection of women and children from violence , and increasing capacities of TPP2A/UPTD PPA

**Challenges:** a) COVID-19 Pandemics limited accessibility of GBV survivors to get services, b) the new capacity of HSR to GBV has not exercised at the local level as it has not been considered as the MoH's key mandates, c) The Pilot Project reported lacking of HSR's Chains to GBV and SOP in the Pilot Health Service Points

<sup>87</sup> An FGD with 18 health workers from Bogor District and Palu City organized for the final evaluation in May 2023

### **Efficiency (Evaluation Question 5)**

For the prevention of GBV and harmful practices as well as for the provision and standardization of key services for survivors of violence against women and children (VAW/C), it was reported in the MTR that the BERANI programme has efficiently mobilized resources in a timely manner and triggered resources from the national government, i.e. MoH to cover capacity development activities to enable coverage on the national scale, building strong partnerships among government agencies, women organizations, and civil society organizations (CSOs). It can be said that stakeholders and beneficiaries of the BERANI joint programme received the human, financial and administrative resources as planned and accountable, in economical, quality, and timely manner, including to respond to the context of COVID-19 pandemics<sup>88</sup>. The programme has made good use of its human, financial and administrative resources in a timely manner and provided good quality of assistance.

### **Coherence (Evaluation Question 6 and 7)**

UNFPA has been recognized as a UN Agency that carries out initiatives on SRHR, ASRH, and prevention of GBV and harmful practices. Meanwhile, UNICEF has been recognized as a UN agency that focuses its works on Child Health, Child Protection, prevention of child violence. The programme has both UNFPA and UNICEF systems, strengths, and networks as its comparative advantage<sup>89</sup>. In the capacity development, including training of HSR to GBV, for example, commitment building and high level coordination with the MoH can be improved so that the new knowledge and skills can be internalized in the MoH's regular capacity development activities. Moreover, the Pilot Project of HSR to GBV in Cirebon District can improve its coordination with the district's BAPPEDA so that funding of HSR to GBV can be facilitated. Some levels of coordination and synergy between UNFPA and UNICEF in facilitating capacity development's interventions to the MoWECP in the area of data and case management of GBV could be improved.

### **Sustainability (Evaluation Question 8)**

The programme's Implementing Partners have established sustainability strategies and plans to continue implementing the new knowledge and skills introduced by the BERANI joint programme support, among others in the form of :

- Availability of written Service Standards and SOPs for handling victims of VAW/A at P2TP2A of DKI Jakarta and availability of service standard and SOPs for implementation in two hospitals (Waled Hospital, Arjawanangun Hospital), Beber Health Centre, Arsana Japura Health Centre, and Plumpon Health Centre as well as in other hospitals and Puskesmas in Bogor and tangerang Districts and in Palu City.
- Availability of a training model and TOT manuals for health services to provide services for survivors of GBV in some hospitals and Puskesmas in Cirebon District, Bogor District, Tangerang District, Palu City and Sigi District. The local government of Cirebon has not only increased awareness among

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<sup>88</sup> UNFPA/UNICEF, Mid-term Review Report, february 2022

<sup>89</sup> The programme was delivered through UNFPA (12 outputs), and UNICEF (2 outputs): i) prevention of child marriage (under the Child Protection's programme); and ii) menstrual hygiene management (MHM, under the WASH programme).

non-targeted hospitals and health centers to consider establishing GBV's services but also proactively invited the Provincial Government of West Java and the MoWECP to facilitate cross learning. It was reported that the Ministry of Health has planned to integrate the capacity building model into the Ministry's regular capacity building plan.

Nevertheless, sustainability of the pilot training for health system's response to the needs of survivors of GBV confronted some challenges, with regard to a) the absence of service chains and SOP for HSR in facilitating survivors of GBV, b) the absence of insurance coverage (BPJS) for financing services for survivors of GBV, particularly from the marginalized groups and the poor c) the lack of para-legal services to accompany survivors of GBV to pursue services and receiving further supports, including investigation to pursue the court processes, d) the lack of safe house for survivors of GBV during the process of examinations, hospitalization, and treatment, e) the lack of mental health services, i.e. clinical psychologist services. Lastly, the participating health staff were concerned they could not exercise their new skills and knowledge as HSR to GBV may have not been recognized as a priority mandate.

#### **Coverage and Connectedness (Evaluation Question 9)**

As indicated by the Mid-term Review Report, the BERANI's interventions on GBV and harmful practices interventions and approaches in COVID-19 settings are in line with the principles of coverage, coherence, and connectedness. All the support provided by the programme related to COVID-19 settings were logical and consistent in addressing key issues that arise during the pandemics. programme's intervention to prevent GBV have laid out linkages to a new normal to the partners and beneficiaries and contributed to building resilience in reliable and timely data. The programme supported BAPPENAS with technical and strategic support to assess the impact of the COVID-19 pandemic situation and its possible medium-term impact on GBV. It shows that women and children are the most at-risk population, due to the Pandemics, through two channels: (i) reduced abilities to prevent, to protect, and to provide services, particularly during social restrictions, and ii) increased incidence of violence. Based on the results of the rapid assessment, BERANI has provided additional fund to addressed GBV, child marriage, and FGM/C. Furthermore, new ways to deliver activities, including capacity development activities through the use of online media in the reporting system of GBV cases among IPs from BERANI, including P2TP2A DKI Jakarta were recognized. Reporting cases of gender-based violence through online media allows survivors' accessibility to report cases and get survivors' services. The introduction of the application programmes, such as Zoom, which has been simple, yet had positive impacts to P2TP2A DKI Jakarta to operate during the Pandemics. Wide adoption of the protocol contributed to increased access of survivors of GBV to the services. *In terms of connectedness*, the social inclusion and attention to the marginalized groups was emphasized in the delivery of services for survivors of VAW/C in DKI Jakarta and in the pilot activity in Cirebon District. Introduction of learning sessions and materials on Protection from Sexual Exploitation and Abuse (PSEA), trafficking, disability, medical certificate (medico-legal), and psychosocial support through online media provided options for delivering learning activities.

Prevention of Child Marriage - (Outcome 1200, Immediate Outcome 1210, Output 1211, Output 1212, Output 1213) and (Immediate Outcome 1220, Output 1222, Output 1223)

Indonesia has been one among 10 countries in the world with the highest child marriage prevalence, thus, prevention of child marriage in Indonesia is a priority. In 2014, NGO networks carried out a judicial review on the Marriage Law No 1/1974 on increasing the marriage age of women from 16-18 years old was rejected by the Constitutional Court. The second attempt of the Judicial Review to delay the age of marriage to 19 years for women was organized in 2017. In 2018, the BERANI programme was mobilized to address the above development challenges.

Modeling of the BERANI programme's interventions on the prevention of child marriage was developed based on the 2017 UNFPA and MoWECP's documentation of best practices and lesson learned<sup>90</sup>. These included taking the lesson learned from the UNFPA's 2011-2015 Country programme Evaluation (CPE) underlining the importance of improving the national and inter-sectoral coordination to increase linkages actors across outputs and better utilize data in policy making, UNFPA's support in the development of stakeholders' mapping, while recognizing the UNICEF's collaboration in the development of the National Plan of Action and the Child Friendly City pilots in 18 sites and on Menstrual Hygiene and Management (MHM) since 2014.<sup>91</sup> Such model was compatible with the UNFPA-UNICEF Global programme To Accelerate Action to End Child Marriage (2018)<sup>92</sup> summarized 4 key actions, including :

1. Turning Commitment into Tangible Action Through ***Five Proven Strategies*** a) Empower adolescent girls at risk of child marriage, or who are already married, to express their views, exercise their choices, and facilitate their participation in education, b) Educate and mobilize families, communities and leaders to invest in adolescent girls, c) Strengthen the accessibility, quality and responsiveness of services for adolescent girls in key sectors., d) Foster national laws and policies that protect and promote the rights of adolescent girls, e) Generate and use robust *data and evidence* to inform programmes and policies relating to adolescent girls.
2. Leveraging Government Investments through ***strengthening girls as agents of change*** through awareness sessions and outreach activities on child marriage and other adolescent-related topics.
3. ***Engaging youth*** through the facilitation on share information and voice their opinions and discuss issues that affect them through various modalities;
4. ***Involving religious leaders*** to discuss issues on sexual and reproductive health issues, child marriage preventions, and deliver messages to end child marriage during religious preaching.

Under this theme, the BERANI programme, initiatives were implemented to produce outputs to contribute to immediate outcomes 1210 and 1220, and to the Outcome 1200. The Immediate Outcomes 1210 "Increased capacity of duty-bearers (including parliamentarians, MOWECP, MOH, religious leaders, community leaders, women's prayer groups and NCVAW to develop policies that protect SRHR at national and subnational levels", and the Immediate Outcome 1220 "Increased knowledge of rights-holders

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<sup>90</sup> UNFPA/UNICEF, BERANI, Better Reproductive Health and Rights for All in Indonesia, Annual Report, 2018

<sup>91</sup> UNFPA/UNICEF, BERANI, Better Reproductive Health and Rights for All in Indonesia's programme Document, 2018

<sup>92</sup> UNFPA-UNICEF Global programme To Accelerate Action to End Child Marriage, 2018

(including young people particularly girls, women groups particularly mothers and grandmothers) on sexual and reproductive health and rights".

### National Strategy for Preventing Child Marriage

The BERANI programme provided technical assistance to the MoWECP and Bappenas in the revision of Marriage Law No 1 the year 1974 to Law Number 16 of 2019, and the provisions of Article 7 regarding the age limit for marriage, where both girls and boys must be 19 years of age. Under this Law, there is an application for child marriage dispensation to be requested to the Religious Courts, when child marriage shall urgently happen, which, unfortunately open up possibilities for child marriage to go up and down, in trend. The child marriage prevalence in Indonesia was 10.82% in 2019, decreased to 10.35 in 2020, and further decreased to 9.23% in 2021. The prevalence of child marriage in 2022 was 8.06%<sup>93</sup> indicating that the Country met the RPJMN 2024 targets to 8.74%.<sup>94</sup> However, the child marriage prevalence has in general decreased at the provincial level, the prevalence increased in West Sulawesi, Maluku, DI Yogyakarta and DKI Jakarta in 2021 and slightly increased in South Sulawesi, Banten, Central Sulawesi, Gorontalo in 2022<sup>95</sup>.

As reported by the Mid-term review, UNFPA and UNICEF interventions shared common approaches in their programme's implementation, by focusing on the delivery methods to include policy engagements, expert technical advice and support, coalition and network building, and provision of supports to provincial, district, and village governments and communities as well as the development of TOT and piloting locally-developed solutions to key challenges. Meanwhile, greater attention to scale out and institutionalization of the most promising solutions were done in the last 2 - 3 years of the programme's implementation. The programme's initiatives and resources have leveraged and developed a more integrated approach of expertise in preventing child marriages, by focusing on strengthening social norm change work and gender-transformative approaches to deliver significant and long-term changes.

The programme facilitated the MoWECP and BAPPENAS to develop a cross-sectoral National Strategy for Preventing Child Marriage (STRANAS), which has provided a strong working mechanism for preventing child marriage in Indonesia, as it has been translated into government policies at the national and sub-national level. The programme, through UNICEF, supported the development of guidelines and toolkits to facilitate STRANAS's implementation as well. Adoption of Guideline on the Development of Sub-National (provincial, city/district, village) Regulation on the Prevention of Child Marriage, including costing has been produced with high appreciation.

The MoWECP has cooperated with local governments, through the Women's Empowerment Office in the Province and at the District to facilitate cross-sectoral units in the provincial government and in the district government to implement the STRANAS. Through the BERANI programme, results had been well produced by the South Sulawesi Province, where several policies were developed to prevent child marriage, including: (1) Instruction of the Governor of South Sulawesi No. 1 of 2018 concerning Stipulation on Child

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<sup>93</sup> BPS, SUSENAS 2022

<sup>94</sup> UNICEF, Child Marriage Prevention - BERANI May 2019 - October 2021

<sup>95</sup> BPS, SUSENAS, Child Prevalence in Indonesia by Province, 2021

Marriage in South Sulawesi; (2) Road Map for Prevention of Child Marriage in South Sulawesi 2019-2023; (3) Governor of South Sulawesi Regulation No. 31 of 2021 concerning the Regional Strategy for the Prevention of Child Marriage; (4) Regulation of the Governor of South Sulawesi No.177/I/2022 concerning the Establishment of a Communication Forum on the Prevention of Child Marriage; (5) Joint Movement Activities (*GeBer* or Gerakan Bersama) for the Prevention of Child Marriage; (6) Joint Movement for Marriage Education for Child Welfare in South Sulawesi in 2021; (7) Integrity Pact on the Prevention of Child Marriage by the Regional Secretary, South Sulawesi DPRD, relevant OPD Leaders, and Provincial level Structural Institutions, 12 Regents/Mayors, and Development Partners/Community Organizations in South Sulawesi in 2021, and (8) Joint preparation of the Regional Action Plan (RAD) for the Prevention of Child Marriage in South Sulawesi Province which involves cross-sectors, both government, private, and Non-Government Organizations (NGOs). The above results were only examples of how the STRANAS has led to movements to prevent child marriage at the national and sub-national level (Output 1213 and 1223). A full list of BERANI programme's support to the development of local policies and regulations can be seen in Annex 6 of this report.

### **Pilot Project in Bone District**

The Pilot Project in Bone District was implemented (1213 and 1223). The local government of Bone district and the government of South Sulawesi province found the development of regional strategy (Strada) on the Prevention of Child Marriage have been critical to respond issues of child marriage in their area. The Strada has been used by government units of the South Sulawesi Province and the Bone District as an important reference for preventing child marriage. One pilot project to prevent child marriage, to introduce LSE in Bone Districts, and to disseminate MHM and child marriage's prevention through women's ulemas, for example, have used the Strada as a key reference to implement concrete interventions at the local level. In Bone, 4 circular letters at the district level, 7 MOU at the sub-district level, 6 village regulations, and other documents at the district and provincial level were produced, released, disseminated, used as references to prevent child marriage. The success of the Pilot in Bone was replicated in Wajo and Luwu Utara District.

Training series for master trainers and teachers were organized to include facilitation of a working group leveraging a school-based health platform (UKS-the School Health Programme /*Usaha Kesehatan Sekolah*), which was reported to open up more opportunities for adopting LSE in more sustainable ways.

A Pilot Project in Bone District was implemented using the STRANAS and STRADA of the Provincial Government of South Sulawesi as references to respond issues of child marriage in the district. The programme delivered some interventions, including Life Skills Education programme (LSE) in schools targeting teenagers, intervention for parents through community groups that include religious, social and economic groups, and support the development of public declarations and Village Regulations as well as Action Plans and Village Funding and Dialogue. Specifically for LSE, some changes were reported to include increased confidence of the schools and teachers to educate students about menstrual hygiene management, improved schools' toilets through the improved provision and cleanliness of water, and sanitary napkins' disposal, readiness of teachers to access schools' operational cost fund (BOS), promotion of LSE as local content's material ('Mulok') for school children in December 2020 as instructed by the district head (Bupati), and increased experience of various modes of information dissemination, including

through local radio for students and public, and compact discs for teachers. Such production and dissemination supported the ‘Learning from Home’ series, reaching more adolescents in the area.

At the beginning of the Programme’s interventions, a baseline study was carried out and found that around one out of four parents or adolescents had perceptions that support determinants of child marriage. In addition, a total of 25.8% of parents and 26.0% of adolescents agreed that a girl is ready for marriage once she starts menstruation and 25.6% of parents and 32.6% of adolescents agreed that girls aged over 18 who are not married are a burden to their families<sup>96</sup>. The Study provided key information regarding the prevalence of positive perceptions of the benefits of child marriage towards family honour and reputation was stronger among adolescents than parents. In addition to economic benefits of having child marriage to resolve poverty, the shame around unwanted pregnancy contributes to the additional push to convince parents to seek marriage, based on perceptions girls’ readiness based on signs of puberty provide the behaviour trigger for action.

An end-line study, which was carried out in 2021 reported that assessed households’ and adolescents’ knowledge, attitudes, and perceptions towards child marriage and menstrual health management (MHM) in Bone, South Sulawesi, particularly after the BERANI program implemented in Bone, South Sulawesi. The end-line study found that the BERANI program has improved adolescents’ knowledge of SRH through Life Skills Education (LSE), which was integrated into the curriculum in schools, which was supported by the local district government’s decision to include LSE as a local content subject in school). SRH related knowledge and unwanted pregnancy issues were found to be needed as unwanted pregnancy was the most cited contributing factor to child marriage <sup>97</sup>as marriage has been considered the only solution for unwanted pregnancy as it cannot be negotiated as it has been considered siri’ (bring shame to the family, failure to protect purity), and thus, it has been one among factors where the religious court will dispense the marriage<sup>98</sup>. It was recommended that the LSE needs to be continued as it was identified as a medium to deliver the SRH knowledge to adolescents. Nevertheless, it was reported that LSE, which was carried out using distance learning during the social restriction in the COVID 19 Pandemic’s was not effectively delivered. Such finding was consistent with the results of FGDs with adolescents during the MTR, indicating that social restriction had limited interactions among teachers, facilitators and participating students in the LSE processes. The endline study also highlighted the importance of continuing improving the relationships between parents and their children to support positive and nurturing parenting. It was expected that BERANI needs to ensure that parents continue to deliver the campaign messages obtained from the community mobilization activities and initiate the communication with their children using the BERANI communication materials.

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<sup>96</sup> Heribertus Rinto Wibowo, et All, One household, two worlds: Differences of perception towards child marriage among adolescent children and adults in Indonesia, *The Lancet Regional Health, Western Pacific* 8, 2021,

<sup>97</sup>An endline study carried out by Tolodo for UNICEF’s reported that adolescent knowledge related to pregnancy was low as only 60.2% of girls answered correctly, while 33.9% of boys responded correctly about menstruation and indication of a woman is biologically able to conceive and have children

<sup>98</sup> Tulodo for UNICEF, Endline and Formative research on Child Marriage and Menstrual Health Management in Bone, South Sulawesi, 2021, page 86

Interviewed with teachers, schools' supervisors, schools' facilitators during the MTR of BERANI recorded some changes to include increased confidence of the schools and teachers to educate students about menstrual hygiene and management, improved schools' toilets through the improved provision and cleanliness of water, and sanitary napkins' disposal, readiness of teachers to access the school's operational cost' fund (BOS fund), promotion LSE as local contents' material for the school children in December 2020 as instructed by the district head (Bupati), and increased experiences of various modes of information dissemination, including through local radio for students and public, and compact disks for teachers. Such findings were also expressed by interviewed teachers and schools' supervisors in Wajo district. Nevertheless, it was reported by Tulodo that services for those who experienced child marriage and seeking help and supports for addressing child marriage, or the negative impact of child marriage had not been adequately established<sup>99</sup>.

To support the campaign activities for parents, TULODO and LPP Bone have developed a printed communication material to be placed in the house (e.g., one page-calendar, hand held fan/kipas, stickers,) and also strategic areas conveying the campaign messages. There were also some other documents, including a Replication Guidelines to provide lessons learned of the child marriage prevention and menstrual health management project in Bone, to provide information on the activities on the project and how the activities can be replicated and scaled up, to provide replication tools and information on how to use the tools, and to guide encourage the development of other local good practices from other areas in Indonesia as child marriage prevention and MHM efforts. Meanwhile, Costing Analysis Documentation, which was developed by YIM used for providing analyses on the costs incurred during the implementation, identification of roles of different parties in the child marriage implementation, and identification of potential cooperation with relevant stakeholders. The STRANAS and STRADA have led Bone District to produce 4 circular letters, 7 MOUs, 6 village regulations, and other relevant policy documents.

The success of the Pilot in Bone was replicated in Wajo District, where its child marriage was the highest in South Sulawesi province, and in Luwu Utara District, where some innovations to promote gender equality by utilizing village grants happened. The series of initiatives, which were implemented in South Sulawesi Province, in Bone, Wajo and Luwu Utara District reached a total beneficiaries of 35,102 (3,819 women, 1,365 men and 19,675 girls, 10,243 boys), surpassed the target set forth in the programme<sup>100</sup>. Furthermore, the LSE modules had been used to facilitate dialogues with adolescents in key cities Papua and West Papua province.

### **Pilot Project in North Lombok**

A Pilot Project in North Lombok was implemented by LPSCM and LPA Lombok for preventing GBV and harmful practices (child marriage and FGM/C) to increase capacities of community members, adolescents, and care givers as well as village government of Tanjung and Tenige Village of North Lombok (Output 1211). The pilot project aimed at encouraging girls and boys between 12 and 18 years of age to develop values and behaviours that promote gender equality, eliminate GBVs, and harmful practices was

<sup>99</sup> Tulodo for UNICEF, Endline and Formative research on Child Marriage and Menstrual Health Management in Bone, South Sulawesi, 2021, page 84

<sup>100</sup> UNPA/UNICEF BERANI's Annual Report 2022

implemented. An independent evaluation of the pilot project using Gender Equitable Men Scales (GEMS), which was standardized to look at gender norms in the relation between women and men reported that on some levels, indicated that there has been an increase of GEMs among participants, although it was also found that there were many male adolescents in one area that still accepted some forms of violence against women. From this Pilot Project, two village regulations were released. Youth forum was used as a platform for facilitating youth, males and females, to discuss gender issues and the vulnerability of women and girls from discrimination. The overall works concluded in 2021, where implementation of the movements at the village level were dependent fully on the availability of village budget, which was considered as a challenge as most village's budgets were used for responding COVID-19 Pandemics. LPSDM and LPA Lombok continue their advocacy through the development of Regional Regulation (PERDA) on Women and Child Protection of the North Lombok District to help assure results of their works at the 2 villages continue and the good works at the two villages can be used as model for replications by other villages and efforts to prevent GBV and harmful practices commence.

A summary of the BERANI's Pilot Project can be seen in Box.4.3, below.

#### Box 4.3 BERANI's Pilot Projects

UNFPA's Facilitated Pilot Project in North Lombok, NTB	UNICEF's Facilitated Pilot Project in Bone of South Sulawesi
<p><b>Interventions</b> Prevent GBV and harmful practices (child marriage and FGM/C) through gender transformative approach (Output 1221) via :</p> <ul style="list-style-type: none"> <li>• Village Children's Communication Forum/ Youth Forum</li> <li>• Community activities and discussions in families' communities involving female and male members of the households, traditional leaders who are males, religious leaders (Tuan Guru), who are male</li> <li>• Village regulation development and advocacy</li> </ul> <p>In addition, there are some other activities in the Pilot Project. They were :</p> <ul style="list-style-type: none"> <li>- Advocacy to the development of North Lombok District's Regulation on the Protection of Women and Children</li> <li>- Advocacy and capacity development of P2TP2A/UPTD PPA in the process of developing the new structure of the UPTD PPA and its staffs</li> </ul> <p><b>Challenges :</b> COVID-19 Pandemics delayed activities and limited the Pilot Project's outreach</p> <p>-</p>	<p><b>Interventions</b> Strengthen Life Skills Education (LSE) in schools , targeting teenagers (Output 1223), involving 12 targeted schools and 14 replication schools</p> <p>Engage Religious and community leaders, including women's prayers groups to change attitudes on Menstrual Hygiene Management (MHM) and child marriage prevention (Output 1213)</p> <p>Develop Pilot and support for replication and scale up of Child Marriage Prevention Model. Engagements with the Provincial Government of South Sulawesi, producing local regulations. Replications were started in 2021 in Wajo and Luwu Utara District (Output 1211)</p> <p><b>Challenges</b> CCOVID-19 Pandemics limited interactions with beneficiaries (students, youth, community) and used online media as alternatives</p> <p>-</p>

In early 2023, the MoWECP reactivated the Joint Movement for the Prevention of Child Marriage (Geber PPA) which began in 2018 to invite all parties to take efforts to prevent child marriage. There are several ministries that have started this effort, including but not limited to the Coordinating Ministry for Human and Cultural Development, the Ministry of Religion, BKKBN, the Ministry of Education and Culture.

#### Technical Assistance to the Parliamentarians

Other activities done to prevent child marriage in West Nusa Tenggara (East Lombok) and in East Java indicated that there were huge number of age marriage dispensations issued by the District Religious Courts. There were indications that some parties such parents, village apparatus, and other stakeholders might change the demographic and individual data of the prospective couple in order to get the dispensation of age of marriage. It has been suggested therefore to conduct legal, social and cultural sanctions to those who provide false data and information of the prospective couple. The results of the review might be used as tools to advocate the government and local government to reduce the number of age marriage dispensations.

## Pathway to Outcomes

The programme's initiatives to prevent child marriage contributed to the expected output and immediate outcomes 1200 increased protection of sexual and reproductive rights of women and girls at national and sub-national levels. Adolescent pregnancy is one among drivers of child marriage has a hugely detrimental impact on the health and well-being of girls and young women, as well as on that of their children. Preventing child marriage will improve married and unmarried adolescent girls' access to sexual and reproductive health services, which can dramatically improve health outcomes for millions of girls and children worldwide.<sup>101</sup>

The programme's initiatives to prevent child marriage have been delivered, considering a Model, which took the lessons from the previous UNFPA and UNICEF supports to MoWEC and BAPPENAS and followed the National Strategy in the Prevention of Child Marriage, which was developed based on the latest research and consultation with stakeholders and used a holistic and systematic approach.

Specifically, the Pilot Project to prevent child marriage in South Sulawesi and some districts (Bone, Wajo and Luwu Utara) has been implemented by delivering some of the 5 (five) strategies in the STRANAS, including optimizing children's capacity through LSE, improving enabling environment to prevent child marriage through the promotion of LSE and facilitation of dialogues to promote MHM and child marriage's prevention through women's ulema's advocacy to women's prayers groups, strengthening and developing regulations and facilitating stakeholder coordination.

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<sup>101</sup> Girls not Bride, Child Marriage and Sexual and Reproductive Health and Rights, November 2019

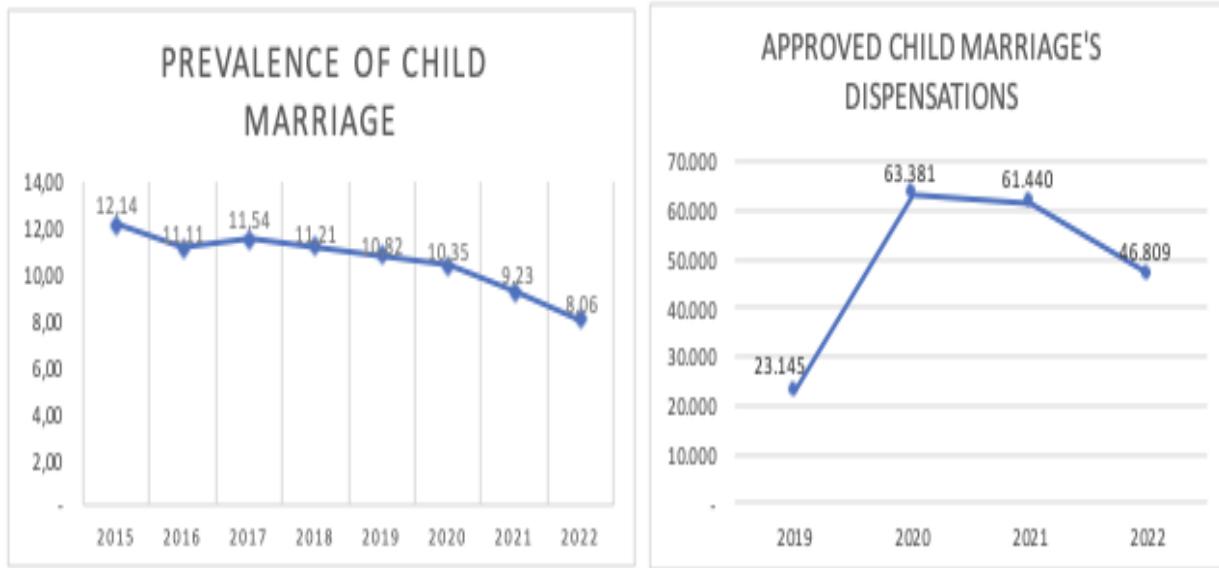


Figure 15 Prevalence of Child Marriage and Approved Child Marriages in Indonesia

The reported cases of child marriage, as indicated by the number of approved child marriage's dispensation in Bone was 222 (2020), decreased to 62 (2021) and 45 (2022), in Wajo was 61 (2020), 780 (2021) and 336 (2023), while in Luwu Utara was 83 (2021) and 72 (2022). The national prevalence of child marriage decreased from 10.35 % in 2020, to 9.23% in 2021 and to 8.06 in 2022, which was lower than that of the RPJMN 2019-2024's target of 8.4% by 2024. Approved child marriage's dispensation also decreased, from 23,345 in 2019, 63,381 in 2020, 61,400 in 2021 and 46,809 in 2022. Such success was reported to be contributed by the BERANI programme's to prevent child marriage, including through the development of the STRANAS and its guidelines for implementing it.

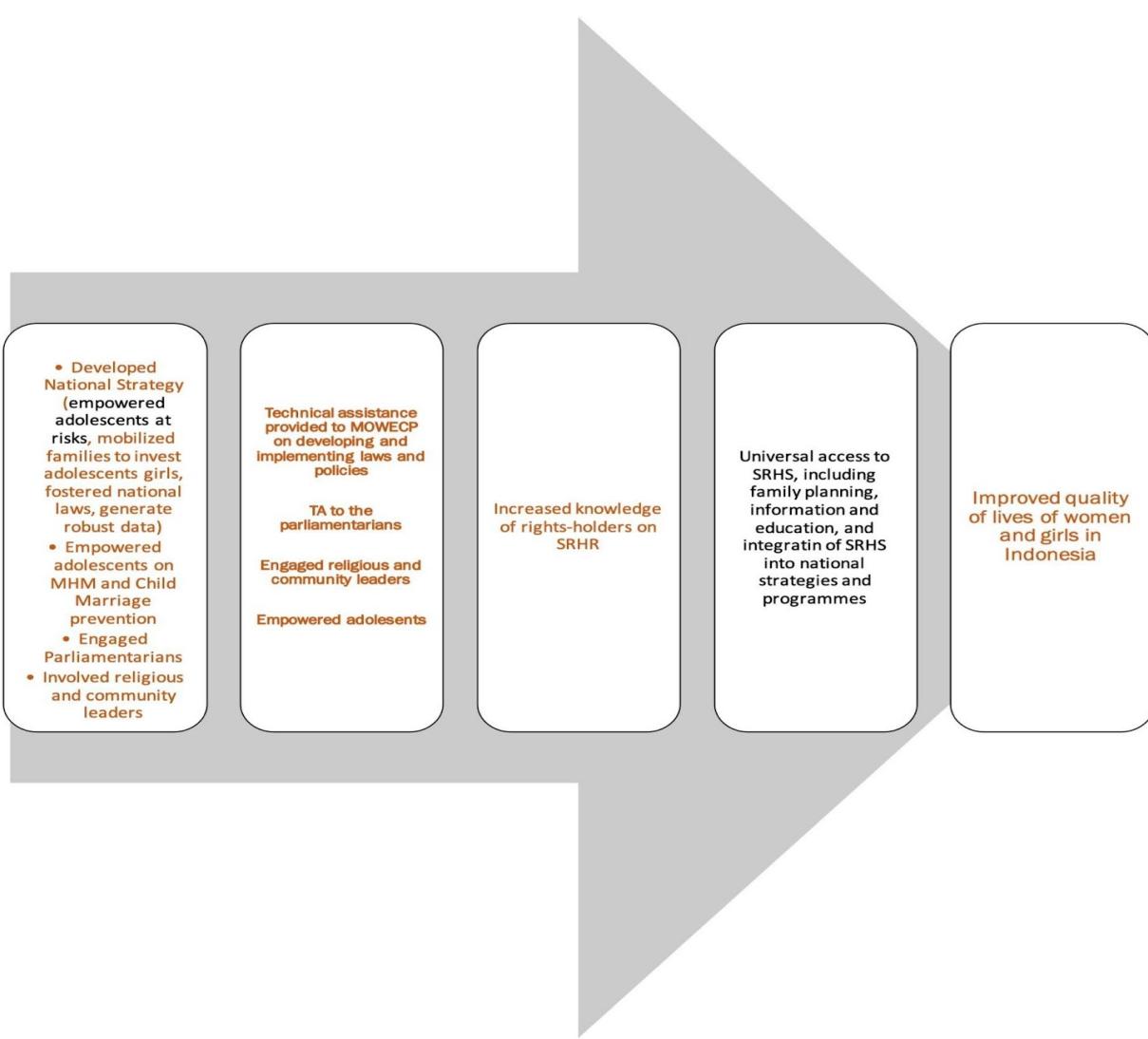


Figure 16 Pathway to Outcomes on the Child Marriage's Prevention

Evidence showed that programme's interventions (the National Strategy, the empowerment of adolescents on MHM and child marriage's prevention, involvements of religious and traditional leaders), contributed to the immediate outcomes of 'increased knowledge of rights holders on SRHR'. Although the programme's interventions to empower adolescents at risk or those who have married had not been carried out, the programme's interventions contributed to the decreased of child marriage prevalence at the national level and at the targeted provinces and districts, as indicated by the progress of the prevalence of child marriage in the country, which surpassed the RPJMN's target. Nevertheless, there had been insufficient information can be unfolded whether the programme contributed to the ultimate outcomes for improving quality of lives of women and girls in Indonesia, particularly as promoting *Universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes* could be an issue. Please see also findings under SRH and ASRH's themes. Too, at the local level, for example, interviewed educators involved in the

MHM and child marriage preventions in the targeted pilot project in Wajo district South Sulawesi indicated that accessing sexual and reproductive health care services for adolescents might still be considered taboo.

## Prevention of Child Marriage -Against Evaluation Criteria

### **Relevance (Evaluation Question 1)**

The BERANI programme, through UNFPA and UNICEF, then facilitated the development of a National Strategy on the Prevention of Child Marriage (STRANAS) to address the high prevalence of child marriage in Indonesia, where it was considered relevant and appropriate. The programme considered relevance in helping the development of models for translating the National Strategy into local context, where the child marriage prevalence was high, even higher than that the national level, such as South Sulawesi Province and its district, including Bone, Wajo, and Luwu Utara district. The LSE training module, the women ulema's toolkit, and the cross-sectoral coordination was needed and appropriated. The Pilot Project was in Bone district, however, the programme's engagement with the Provincial government of South Sulawesi to develop policies, including STRADA and guidelines for replicating the Pilot Project were very appropriate as the role of the Provincial government has been critical for supporting with guidelines for replication on the work at the district level. South Sulawesi was ranked at the 13 for having high prevalence of child marriage in 2019. Data showed that the child marriage's prevalence in the South Sulawesi province has been fluctuated, was 11.25 in 2020, 9.25% in 2021, and slightly increased to 9.33% in 2022. Meanwhile, there were some districts with the highest child marriage prevalence in South Sulawesi, such as Pangkep (26.8%), Wajo (24.04%), Barru (21.11%), and Tana Toraja (14.49%) in 2022. After the programme implementation, child marriage cases in Bone, which were 61 in 2019, increased to 746 in 2019, and finally decreased to 222 in 2020, further decreased to 62 in 2021 and to 45 in 2022. There has to be more work in Wajo District as it had the highest cases of child marriage of 760 in 2021. Although the child marriage cases went down to half to 336 in 2022, after the programme's intervention, Wajo's district government still need to push the case down, considering the social and cultural as well as economic context of the district.<sup>102</sup> The model for building the government units and wider stakeholders's awareness and commitment to stop child marriage, to educate students through LSE, and to develop dialogues and disseminate information through women's ulema to the broader communities was considered relevant and necessary.

### **Effectiveness ( Evaluation Question 2, 3 and 4)**

The programme effectively implemented some initiatives on the prevention of child marriage at the national level, through the development of a National Strategy on the Prevention of Child Marriage in 2021 as well as the development action plan, which have facilitated to the implementation at the national and sub-national level. Not only national government agencies, such as the Ministry of Education and Culture, the Ministry of Religious Affairs, and the Coordinating Ministry of Human Development but also donor agencies, such as DFAT through Australia Indonesia Partnership for Justice (AIPJ) implemented the National Strategy.

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<sup>102</sup> Report of the Ministry of Religious Affairs of Wajo District, 2022

The programme's intervention of Bone Pilot Project has been successful, creating significant changes in the prevention of child marriage in the pilot districts. More specifically, the good practice in Bone has led the government of Bone District achieving a **Public Service Innovation Award** given by the Ministry of Empowerment of State Apparatus and Bureaucratic Reform (PANRB)<sup>103</sup>. The District government submitted the child marriage prevention strategy adopted from BERANI model and was **awarded Top 30 Public Service Innovations at provincial level and Top 45 at national level** among 3,478 innovations submitted from all over Indonesia<sup>104</sup>. The good practice of Bone District (the LSE, the MHM, and the prevention of child marriage) was well replicated in Wajo and Luwu Utara district as well as in the neighbouring districts, where high prevalence of child marriage occurred. Specifically, LSE interventions have been well recognized as introducing new norms and values with regard to healthy gender relations among students in the targeted school, while the women's ulema booklet and modules have changed norms of selected women's prayer groups in the three districts. Together, these have critically changed the norms and values on MHM promotion and child marriage prevention among the youth, schools teachers, students, families and women in the targetted communities.

There were some changes identified. They can be seen in box 432, below.

**Box 4.3.2. Changes of Output 1211, 1212, 1213, 1223 to Contribute to the Immediate Outcomes 1210/1220 and Outcome 1200**

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<sup>103</sup> BERANI's Annual Report, 2022

<sup>104</sup> BERANI's Annual Report for 2022

## **Changes of Output 1211, 1212, 1213, 1223 to Contribute to the Immediate Outcomes 1210/1220 and Outcome 1200**

### **Changes and Good Practices**

- Law No. 16 Year 2019 on the legal age of marriage for both women and men at the minimum age of 19 was enforced. Changes occurred at the national and sub-national level, due to the development and implementation of a National Strategy (STRANAS) on the Prevention of Child Marriage;
- Built joint leadership capacities of the MoWE and Bappenas during the development and implementation of the STRANAS, as a systematic cross sectoral working mechanism for facilitating government organizations and stakeholders at the national and sub-national level as well for triggering donor organizations, NGOs, and others
- Facilitated opportunities for different agencies to work together to prevent child marriage, to link child marriage with cross sectoral issues, such as sexual and reproductive health and rights of women and girls, and to build synergy among different toolkits, including many toolkits that facilitate capacity development of BADILAG
- Built new norms among government departments at different levels (province, district, sub-district, and village) in the Programme's target area and few non-target area to commit concrete actions to tackle child marriage, including developing regional policies and regulations at the province, district and village level. Areas : Province (South Sulawesi, East Java, Central Java), Districts (Bone, Wajo, Luwu Utara of South Sulawesi and Jayapura City of Papua) and Villages in the 3 districts in South Sulawesi and 2 villages in North Lombok
- Developed institutional capacities of Dinas WECP of Bone District (South Sulawesi), to bring together relevant local government units to work in synergy for mainstreaming gender, by using the amendment of the Marriage Law, the Supreme Court Decree, and the STRANAS as key references, where replications were done in Wajo and Luwu Utara
- Built public awareness on the importance of preventing GBV and harmful practices in targeted villages of Bone, Wajo and Luwu Utara district and also in Tenige and Tanjung villages of North Lombok district. Developed models for working through Tim Penggerak PKK, the PUSPAGA, and the local communities, including religious and traditional leaders, families, youth to prevent child marriage and for working with women's ulema groups and schools (teachers and students) to change attitudes on Menstrual Hygiene Management (MHM), SRHR, and child marriage

**Gaps :** Synergy of different modules (for CD of the Badilag and those in the different Pilot Projects of UNFPA/UNICEF

**Challenges :** a) social, cultural and economic reasons for having child marriage, b) 'Nikah Siri', which is unseen, c) TA provided to parliamentarians on the prevention of harmful practices (Child Marriage and FGM/C) was partially completed, due to the change in the parliamentarian structure, not contributing to the immediate outcomes,

Initiatives on the ground have built concrete results in child marriage cases, as shown by a decrease in the approval for dispensation of child marriages, which were 760 cases in 2021 and decreased to 345 cases in 2022, after the programme's interventions<sup>105</sup>. The replication of the Bone's model for preventing child marriage in Wajo District is worth learning, as being effective in reducing child marriage cases in the district.

### **Box. 4.3.3 A Good Practice in the Prevention of Child Marriage in Wajo District**

#### **Collective Action to Stop Child Marriage in Wajo District<sup>106</sup>**

The success of the prevention of child marriage in Bone District called some attentions of the Dinas of Women Empowerment and Child Protection of the South Sulawesi Province, for replicating the Model in Wajo District, which was ranked as the number 1 of district with child marriage case in 2021<sup>107</sup> as well as in Luwu Utara, which

<sup>105</sup> High religious Court of Makassar, Dispensation for Child marriage in South Sulawesi 2021-2022

<sup>106</sup> From the field visit to Wajo District, South Sulawesi, 13 - 15 March 2023

<sup>107</sup> Data of Unit Pelaksana Teknis Daerah Perlindungan Perempuan dan Anak (UPTD PPPA) Dinas Sosial Pengendalian Penduduk Kabupaten Wajo, there were 506 cases of child marriage in 2020, which increased to 746 in 2021. By December 2022, there were 336 child marriage in Wajo District.

was appointed, due to its local innovations in the allocation of village grants to promote gender equality. A series of awareness raising, which was carried out by the UNICEF using appropriate data and analysis, organized in September 2021 was considered an effective eye opener for the government, i.e. the District's Dinas for Population Control and Women Empowerment and Child Protection and Social Welfare (DP5AKS) that has a mandate to facilitate and coordinate gender mainstreaming and women empowerment in Wajo District. The DP5AKS, advocated the Bupati of Wajo to bring together all relevant government units, stakeholders and MUSPIDA to commit to child marriage's prevention in Wajo. The BERANI programme, then, mobilized the MHM promotion and LSE activities in 10 targeted schools, meanwhile the facilitation of women's ulema to dialogue about MHM and child marriage in Majelis Taklim introduced the new norms at the community levels.

*The Village Head of Tempe, who is a woman, Ibu Hani, instructed the Village Imam 'Imam Desa' to stop providing recommendations to the dispensation for child marriages. Such initiatives, surely, create some mixed responses. "From that time, I have had many haters, coming from parents as the village religious leader Imam Desa no longer provides dispensations. My community protested against me and asked why the village policy is different to the policies in other villages. People asked me about the legal framework of my policy. Surely, I showed the Marriage Law and the STRANAS. Nevertheless, people kept asking me. I kept going with that policy. In fact my village, Dau Tempe village had Zero Child Marriage after implementing the policy. I understand parents tried to find loopholes from the policy. I received reports that many parents arranged marriage to their daughter/sons through the Nikah Siri, which surely put girls and women at higher risks".*

It was the State Minister of Women Empowerment and Child Protection who visited Wajo on the 26 of July 2022, and advised the DP4AKS to work with the Bupati to bring all senior government officials, the District Parliamentarians, the Head of the Religious Court, The Chief Representative of the Ministry of Religious, Majelis Ulama Indonesia (MUI), all Village Heads, all Camat (Head of Sub-districts Head) and relevant stakeholders to sign a Declaration to Stop Child Marriage. Forum Anak Tomaradeka Wajo facilitated the process of establishing the Declaration. Social sanctions was agreed to be given to those who still do child marriage practices. They are not allowed to attend any wedding invitations, where they involve under-aged children. More importantly, all village heads were committed to develop and release a village regulation for preventing child marriage.

In parallel, there have been massive interventions at the district level. **KESATRIA**, Komunitas Stop Perkawinan Anak, or Community to Stop Child Marriage was established, along with **SatGas Kelurahan and Desa** for preventing child marriage, a Coordinating Meeting among Government Units and stakeholders to do concrete movement. Collective initiatives have been mobilized to include awareness raising and child marriage preventions' messages into **Puskesmas conselling, Friday Prayers' Speech, PUSPAGA and PKK activities**, as well as through the university's community service (**KKN**), through the office of Family Planing via **programme Pendewasaan Usia Nikah** (the increasing of marriage's age limit ), through **Forum Anak Sebaya** among the youth, and through a SAKINA programme for preventing child marriage within the Ministry of Religious Affairs, which also links to the prevention of stunting. Finally, In November 2020, a Bupati Regulation was released, providing another legal umbrella for village heads to act with more confidence in the efforts to prevent child marriage.

As a consequence of the collective actions in Wajo district, there were 14 out of 17 sub-districts, including 54 villages/kelurahan that had **Zero of Child marriage** where the DP5AKS provided a certificate to the Head of Villages who have successfully achieved the Zero Cases of Child Marriage. The child marriage cases, which were reported to be 506 in 2020, and increased to 746 in 2021, was able to be cut drastically to 336 in 2022. The role of the BERANI programme has been critical as a facilitator in providing eye opener data on child marriage, in the facilitating training of facilitators and school facilitators, and in building strong networks among the government units and relevant stakeholders in the District, which has not only been effective but also promoted sustainability. Strong commitments and real collective actions have proven to be ways for preventing child marriage in Wajo District.

More specifically, the BERANI programme provided useful learning experience on how to design Pilot Project in an issue where long term engagement and cross sectoral interventions needed, such as preventing child marriage. A pilot Project that has focused more interventions at the village level and targeted only few villages, without sufficient cross-sectoral coordination and political pressures at the district level may not be effective. Village level is a critical point where child marriage is started to happen through the proposal letter for child marriage dispensation sent by parents to the village government, i.e. Imam Desa; however as the proposal of child marriage dispensation will go to the Religious Court, for approval, interventions focusing at the village are insufficient. The programme has offered lessons learnt that to be successful, massive interventions shall be done in as many villages as possible as parents tended to try arranging marriages of their children to the nearby villages when a child marriage dispersion was not provided by one village government. Moreover, child marriage is a complex phenomenon, due to various social, cultural and economic factors, which shall be solved by cross-sectoral agencies, minimally at the district level.

Although the programme's interventions to empower adolescents at risk or those who have married had not been carried out and the promotion of *Universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes* might be a long way to go and there was no assessment on how the programme contributed to the ultimate outcome of improving quality of lives of women and girls in Indonesia, the BERANI programme's interventions significantly contributed to the decreased of child marriage prevalence at the national level and at the targeted provinces and districts, as indicated by the progress of the prevalence of child marriage in the country, which surpassed the RPJMN's target, and made the efforts to prevent child marriage on going.

#### **Efficiency (Evaluation Question 5)**

The programme has facilitated not only funding on the development of the National Strategy and Action Plan, but also triggered other donor agencies and international NGOs ( MAMPU/DFAT, AIPJ/DFAT, Yayasan Plan International Indonesia, Save the Children) to fund initiatives for implementing the STRANAS and Action Plan. Two activities under Output 1212 were carried out in North Lombok District and East Java Province in a little delay, due to COVID-19 Pandemics. It was reported that only sessions with the Provincial Parliaments of East Java were well attended in November 2022. No report has been able to be made on the results of the meeting yet. The Inter-Parliamentary forum's legal framework, which included the prevention of GBV and harmful practices, was only formally organized in March 2023. Implementation of a series of virtual workshops on GBV, FGM/C and Child Marriage and for building capacity to strengthen advocacy on the draft of sexual violence law with parliamentarians through the Indonesia Forum of Parliamentarians on Population and Development (IFPPD) were not implemented, making activities under output 1212 were only partially completed

#### **Coherence (Evaluation Questions 6 and 7)**

Under comparative advantages, the programme has successfully facilitated technical expertise and assistance to the implementation of the STRANAS at the national and sub-national level as well as promoted strong networks among partners and stakeholders. Both UNFPA and UNICEF have proven to be successful in raising

issues and facilitating dialogues on sensitive issues, such as child marriage through the programme's intervention at the bureaucratic and community level using various vehicles and forums, and filled resource gaps. Specifically, the longer time of work of UNICEF in South Sulawesi, including in Bone, Wajo, and Luwu Utara in child protection, even before the BERANI programme is active, is a comparative advantage as this has built UNICEF's understanding and familiarity to child related issues as well as the government's ecosystem in the targeted areas, which contributed to the good work in the prevention of child marriage.

#### **Box 4.3.2.B Coherence**

<b>Coherence : Comparative Advantage and Coordination</b>	
<b>Strengths:</b>	<ul style="list-style-type: none"> <li>• Facilitated expertise, technical assistance's back up (national and international);</li> <li>• Promoted strong networks,</li> <li>• Facilitated and moderated sensitive issues</li> <li>• Have had good understanding on the division labour, based on the project run as individual organizations and at the output level,</li> <li>• Filled the gap among other major sources of funding to carry out interventions on national priority issues, whilst maintaining flexibility on the use of funds.</li> <li>• Facilitated dialogues on the importance of preventing of child marriage in the political and programmatic agenda at all levels</li> </ul>
<b>Gaps :</b>	No joint assessment made during the design of the joint programme and alignment of the pilot projects]
<b>Challenges :</b>	Both the GoI and the UN System have tended to depend on the coordination based on Project

There are some areas for improving coherence among the duty bearers and the UNFPA/UNICEF. They are, among others :

- The joint leadership arrangement between BAPPENAS and the MoWECP in the prevention of child marriage can be optimized by UNFPA and UNICEF to work more in synergy so that they can align their facilitation to the capacity development for different government partners and IPs
- Coordination and alignment between UNFPA and UNICEF in the design and implementation of Pilot Projects for preventing child marriage could be improved. While UNFPA and UNICEF could divide their labour using project-based, which helped minimizing overlap between them with small scale duplications, yet there was limited cross-pollications and inter-connection between the projects

they managed. A paradigm for designing individual pilot projects of the UN agencies to be located in different localities in the Joint programme may need to be retested. Cross-sectoral approaches for having UN bodies in the Joint programme to work in the common co-location may provide rooms for exercising the Theory of Changes and for enriching results at the expanded scale.

To follow up the MTR's findings and recommendations, UNFPA and UNICEF facilitated a sharing of lessons and joint monitoring visit, participated by the national government agencies, including the Ministry of Home Affairs (MOHA), Bappenas, MoWECP MoECRT, and the State Secretariate (Setneg) on the implementation of Pilot Project to Prevent Child Marriage in Bone, South Sulawesi, which was highly appreciated. The exposure on the Bone's success story had led to the stronger commitment of the MoWECP, where the State Minister of Women Empowerment and Child Protection herself visited Wajo District, and brought all the local government leaderships at the district, sub-district (Camat) and village

level as well as local parliamentarian leadership, women organizations, and as well universities and NGOs at the district level to sign a **Declaration to Stop Child Marriage** in Wajo District. Such a high level initiative provided solid commitments among key actors in Wajo District to make changes, producing solid results, indicated by the High Religious Court of Makassar that child marriage cases decreased significantly.<sup>108</sup> Yet, sharing the experience of UNFPA's facilitated Pilot Project in North Lombok may need to be explored.

### Sustainability (Evaluation Questions 8 )

The MTR Report indicated that Implementing Partners of BERANI's interventions to prevent child marriage have sustainability strategies and plans in place to continue the BERANI programme's works without the BERANI joint programme support. UNICEF continues to prevent child marriage through Safe Environment through Awareness and Response Approach (SETARA), which respond GBV and child marriage as well as through Online Child Sexual Exploitation and Abuse (OCSEA), which prevent and respond online based sexual violence as continuation of the BERANI's interventions through LSE. These are some examples of the sustainability plans, among others

- Continuation of the joint leaderships of BAPPENAS and the MoWECP in facilitating the implementation of the STRANAS at the national and targeted areas at the local level;
- Development and monitoring of regional regulations at different levels, including some drafts of action plans that are in place;
- UNFPA's implementing partners, LPSDM and LPA continue advocating the implementation of the regional government's regulation (PERDA) to promote gender equality and to protect women from GBV and harmful practices. The LPSDM continues working on the themes, focusing on women and girls with disabilities through the INKLUSI Project (DFAT);
- Exploration of integration of teachers of programme's target areas in Bone, Wajo, and Luwu Utara into different subjects and activities, including Character Education within the Kurikulum Merdeka, Counseling Teachers (Guru BP), and boyescott's camping programmes<sup>109</sup>;
- Exploration of funding opportunities for PUSPAGA activities as PUSPAGA has been an effective forum for preventing child marriage at the family level. A model of using village grants for promoting gender equality and women empowerment in Luwu Utara District, can be presented as an innovative initiative.
- UNICEF has two new projects for responding GBV and child marriage. They are the Online Child Sexual Exploitation and Abuse (OCSEA) and Safe Environment through Awareness and Response Approach (SETARA) project. The two projects

There were some issues, however, which may hinder the sustainability of the good results, including **a) Issues of social, culture, and economy** and perceptions on parents on the solutions, which may increase child marriage, including the increasing number of Nikah Siri, where not only penghulu (Muslim

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<sup>108</sup> Child marriage's dispensations in South Sulawesi was 4,126 in 2021 and decreased to 2,669 in 2022, meanwhile the total number of proposals for child marriage's dispensations in Wajo District was 692 in 2021 and 345 in 2022

<sup>109</sup> Exploration on potential integration into relevant schools' subjects and activities continues. Schools' Supervisors expected interventions shall include all schools in the district to create significant changes. Involvement of the District's Education Unit in the coordination meetings with the District's WECP is needed to explore sufficient budget, beyond BOSS

wedding officiant) but also father can do the marriage ceremony. *Nikah siri* is married religiously but not registered by the state. As no official marriage registration is available under Nikah Siri, many negative implications and multi-layered suffering for women and children can happen. Children resulting from unregistered marriages lose the legal relationship with their father, and lose their rights to inheritance and distribution of poverty, for example. While UNICEF supported Pusat Studi Gender dan Anak (PSGA) LP2M UIN Alauddin Makassar to develop a pocket book for parents, entitled “The Prevention of Child Marriage: A Steep Cliff on the Nikah Siri” in 2022,<sup>110</sup> academicians recommended that an action-research on *Nikah Siri* shall be supported by the future programmes . **b) Governance.** It is critical to propose Key Performance Indicator (Indikator Kinerja Utama/IKU) of the Religious Courts and the Office of the Ministry of Religious Affairs that providing incentives for decreasing of child marriage<sup>111</sup>, **c) programmatic issues**, on the limited synergy between intervention on LSE (Output 1221), which was coordinated by the District’s Education Unit with the cross sectoral coordination facilitated by the District’s WECP (Output 1211) has led to the limited exposure of the District’s Education units on the issue discussed under the cross sectoral coordination of the WECP unit. Linkage and synergy between the 2 outputs may lead to sustainability; **d) The COVID-19 Pandemics** and changes of the parliamentarian structure have, together, had implications to the organization of initiatives (workshops) for parliamentarians on the importance of preventing GBV and harmful practices. While BERANI facilitated cross learning from an international parliamentarians conference, which included prevention of GBV in March 2023, some initiatives for parliamentarians on the prevention of GBV and harmful practices were not completed.

#### Prevention of Female Genital Mutilation/Cutting (FGM/C) - (Outcome 1220, Output 1211, Output 1222)

BERANI programme’s initiatives were carried out to respond to the high prevalence of female genital mutilation and cutting (FGM/C) in Indonesia. While there was an MoH’s Decree 6/2014 in effect, there was an ambiguous Article 2 within the Decree stating that the Advisory Council of Health and Islamic teaching must publish guidelines on FGM/C to ensure the safety and health of girls and prevent FGM/C, legitimizing the medicalization of FGM/C.

The term FGM/C or in Bahasa Indonesia, *Pemotongan dan Pelukaan Genitalia Perempuan* (P2GP) officially came into use in 2018 to replace female circumcision, when the BERANI programme was initiated in collaboration between UNFPA, UNICEF, which was funded by the Canadian Government. This definition of FGM/C has been used to avoid the notion that attempts to abolish the practice of circumcision are "anti-sunnah" in the definition of religion. Because of this, the term FGM/C was agreed

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<sup>110</sup> Pusat Studi Gender dan Anak (PSGA) LP2M UIN Alauddin Makassar, in collaboration with UNICEF Indonesia released i “The Prevention of Child Marriage : A Steep Cliff on the Nikah Siri” in 2022.

<sup>111</sup> The Office of the Ministry of Religious Affairs, confirmed by other Dinases, raised concerns over performance indicators of the Religious Court and the Ministry of Religious Affairs, which use an indicator of ‘total number of marriage cases served’ as one among success indicators. As this indicator does not separate the number of child marriage cases, efforts to eliminate child marriage may be seen as not useful for the two offices’ performance indicators, as this may decrease the budget allocations

upon and used in general to refer to all forms of practice of injuring or cutting a female's clitoris without medical reasons, either in the name of tradition or based on beliefs.

More specifically, there were 45 different initiatives under 2 outputs, i.e. 1211 technical assistance to the MoWECP to develop and implement regulations and policies on harmful practices and 1222 technical assistance to the Indonesia's Women Ulema Networks (KUPI), were delivered, to collectively contribute to the immediate outcomes 1220. The support to the MoWECP was enabled the Ministry facilitating and carrying out a series of initiatives, which provided not only strong commitments and foundational working mechanisms, but also produced guidelines, tools, communication material for leveraging efforts to prevent FGM/C to line ministries at the national level and sub-national levels and to wider stakeholders. The Ministry also facilitated KUPI to carry out dialogues with key stakeholders, including male ulemas, to prevent FGM/C through discussions 'hallaqah'. The BERANI programme's interventions followed recommendations of various studies, to end FGM/C by a) highlighting the importance of a) building understanding on the social dynamics of decision making related to FGM/C, b) working with – not against – cultural and community practices and beliefs, c) targeting local, national and international levels of influence, and d) using a comprehensive and rights-based approach. The programme's interventions have built social and gender norms in the area of preventing FGM/C among the government institutions at the national level and stakeholder, which have previously considered as taboo. Interventions were, among others:

***Facilitated in the development of the Risalah Bogor and awareness raising of it***

- a National Meeting of Islamic Boarding Schools (Pesantren) and Islamic Organizations in Bogor, which produced the *Risalah Bogor* or Bogor Treatise. This treatise states that FGM/C is a *makrumah*, means that the action can be permissible and/or can even become unlawful if it's dangerous.
- added with the national government's fund, The programme supported the MoWECP to work with religious leaders at the national and local level to conduct a series of awareness raising on the *Bogor Risalah* in six Islamic boarding schools (Pesantren) in six regions (Pati, Payakumbuh, Bogor, Pamekasan-Madura, West Lombok, North Lombok)
- conducted socialization of the Risalah Bogor at two Islamic boarding schools in two regions (Pamekasan-Madura and Bogor Regency) with the initiative of religious leader

***Developed national policies, advocacy modules, and reference group mechanism to FGM/C's Prevention***

- Developed a 2030 Road Map for Prevention of FGM/C and an Action Plan. Along the line with the 2030 Roadmap on the Prevention of FGM/C, an Advocacy Strategy Guideline on the Prevention of FGM/C was developed and endorsed by the MoH to be disseminated to 1) Religious Leaders and Religious Organizations 2) Health Service Providers 3) Young People and 4) CSO using Family Approach. The Advocacy Guideline and Information Education Communication (IEC) materials on FGM/C prevention for IBI member midwives were disseminated to 34 provinces and 449 districts. Virtual workshops for the youth include male involvement, where 34 girls and 23 boys attended the workshop.

- Implemented a Gender-Based Violence and Harmful Practices Prevention Pilot using a transformative gender approach (involvement of men) and an ecological approach in North Lombok (2019 – 2021)
- Developed an FGM/C Prevention Advocacy Training Module for Young People.
- Organized a National Reference Group Meeting for the Prevention of FGM/C in Indonesia involving religious leaders.

#### ***Worked with Youth***

- organized training for youth facilitators related to FGM/C prevention advocacy.
- developed guidelines on advocacy strategies for communicating the prevention of FGM/C for community organizations using a family approach via PUSPAGA
- conducted FGM/C prevention sessions at several high-level educational institutions and children's forums.

#### ***Worked with the Ministry of Health (MoH) :***

- with IBI to create awareness raising on the availability and use Guidelines for Preventing the Practice of FGM/C for health workers at the IBI Congress.
- included information regarding the harmful practices of FGM/C in the Maternal and Child Health (MCH) or KIA book and distributed it to community health center
- developed advocacy guidelines and information sheets with pictorial information (backsheets) on IEC regarding prevention of FGM/C for health workers, carrying out outreach at the national level, involved health workers from 10 provinces and 12 districts, and disseminated the advocacy guidelines and sheets on KIE regarding the prevention of FGM/C for health workers in four areas (Bogor City, East Belitung, Pandeglang-Banten, and Banjar-South Kalimantan).
- developed an advocacy guide and KIE on preventing FGM/C for health workers (midwives, Health Office, and others)

#### ***Worked with the National Commission on Violence Against Women (NCVAW)***

- developed a Policy Paper on Prevention of FGM/C in the education environment, in collaboration with the Ministry of Education and Culture and the Ministry of Religion.
- disseminated information on the prevention of FGM/C at Islamic boarding schools
- in collaboration with PSGA UIN Jakarta conducted a socialization on Prevention of FGM/C for young people through Parallel Sessions at the International Conference on Gender and Social Movement (UIN Jakarta).

#### ***Worked on Research and Data***

- with BAPPENAS to propose the recommendation of the 2030 Roadmap on the Preventon of FGM/C to integrate FGM/C into the questionnaire of the 2<sup>nd</sup> *Survai Nasional Pengalaman Hidup Perempuan Nasional* (SPHN) as meta data for SDG reporting 's purposes;
- with Kalyanamita to conduct a research on FGM/C practices during COVID-19 in Greater Jakarta
- UNFPA conducted research for the preparation of photo stories on FGM/C interventions

#### ***Facilitated the 2<sup>nd</sup> Congress of KUPI***

- Organized a KUPI pre-congress FGD at the residence of Mrs. Sinta Nuriyah, attended by prominent male ulema who involve in the efforts to prevent violence against women, such as Kiai Husein Muhammad, Kiai Lukman Hakim Saifuddin, Gus Jamaluddin Muhammad, and Kiai Wahid Maryanto.
- Organized a Parallel session on Preventing FGM/C in the KUPI's congress

While there were only limited high quality and systematic evaluation on the effectiveness of FGM Prevention, a review done by UNFPA on the effectiveness of FGM/C's interventions<sup>112</sup>suggested an interrelated system approach, as follows.

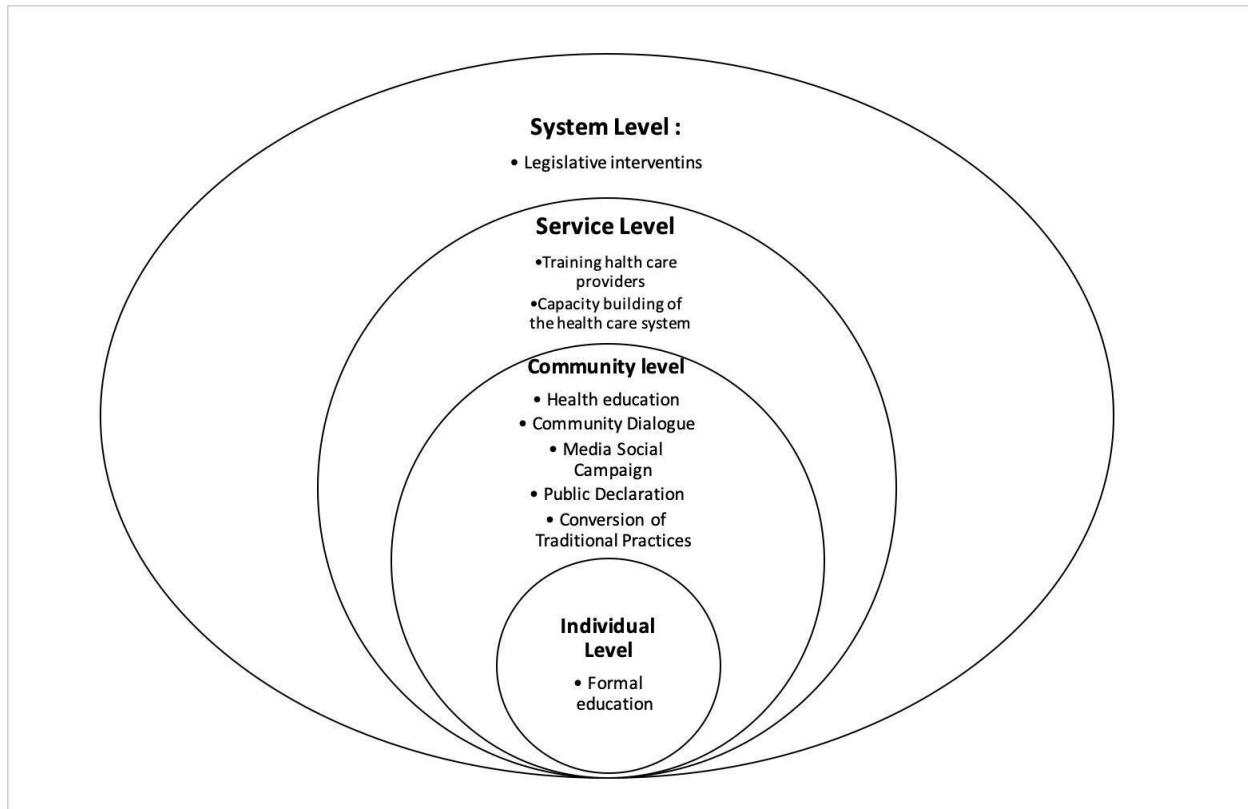


Figure 17 Model for Effective Interventions Designed to Prevent or Respond to FGM/C

The review suggested a model for having a system level approach, through multi-faceted legislation-related interventions. Such system level interventions shall also be followed by interventions at the community level, which can be done through health education via community dialogues, multiple media approaches, public declaration, and conversion of traditional practices, and service level through training of health practitioners for preventing FGM/C. Innovative community-level interventions have been suggested for not only changing attitudes towards FGM, but also creating behaviour change. although they shall be done but more must be done to innovate with these interventions so that they move beyond affecting attitudes alone to creating behaviour change. At the individual level, as formal

<sup>112</sup> UNFPA, Effectiveness of Interventions Designed to Prevent or Respond to Female Genital Mutilation : A Review of Evidence, June 2021

education can take long time to bring effects, informal education through dialogue and awareness raising individuals or groups of the community who influence the FGM/C practices, such as mothers, grand mothers and traditional practitioners are recommended. Work with health practitioners, i.e. midwives at the service level, especially into how the health system can effectively prevent and respond to FGM/C are recommended.

The programme worked at different levels (System, individual, service, and community level) and led to the production of changes, as summarized in the box below.

#### **Box 4.4.3. Gender Transformative Approach being used to Prevent FGM/C in Indonesia**

##### **Gender Transformative Approach to Eliminate and Prevent FGM/C in Indonesia**

**The long process of efforts in preventing FGM/C has build good practices on how systematic strategies for introducing gender transformative approach and collective works can realize changes, particularly through the engagements with the non-traditional groups, such as ulema, males, youth, and the cross sectoral government agencies. There are some factors contributing factors in producing such results, among others :**

- **First**, a joint leadership between the MoWECP and the Ministry of Health (MoH) facilitated the implementation of the 2030 Roadmap and Action Plan for Eliminating FGM/C, helped assure the implementation of a cross-sectoral advocacy strategy, which were carried out by the MoWECP, the MoH, the Ministry of Education and Culture (MoEC), and the Ministry of Religious Affairs. The MoWCP and MoH worked with KUPI networks, midwives, the *Pusat Pembelajaran Keluarga* (PUSPAGA), CSOs/NGOs, religious leaders, and youth. As part of the 2030 Roadmap to Prevent FGM/C, a recommendation to integrate FGM/C into the questionnaire of a National Survey on the Life Experience of Women (*Survei Pengalaman Hidup Perempuan Nasional* or SPHPN) was carried out, so that enabled producing metadata for reporting FGM/C for the national SDGs, indicator 5.3.2. The Proportion of Women Age of 15-49 had FGM/C. It was reported that 5% of women aged 14-49 years had FGM/C for their girls.
- **Second**, the potential for Law Number 4 of 209 on Midwifery, including articles on the functions and ethics of midwifery, which can optimize the role of midwives to prevent FGM/C. MoWECP and BKBN conducted a series of dialogues involving 3,040 midwives in July/August 2020, and during the 2021-2022 period, opening up dialogue among midwives about the health risks of FGM/C to convince parents for not doing FGM/C
- **Third**, the work of KUPI and its members Alimat, Fahmina, Rahima, PEKKA and PSGA (Center for the Study of Gender and Children) are progressive clerics, Muhammadiyah and Nahdatul Ulama, who have strong influence. They advocated female and male clerics, youth as well as universities and the media from 12 cities in Indonesia through the 'hallaqah', which has produced good results. Hallaqah alumni continue advocating wider range of clerics, including male clerics and through social media as well as at universities so that FGM/C elimination becomes a growing discourse.
- **Fourth**, the BERANI initiative implemented by LPSDM and LPA in North Lombok advocated for the prevention of GBV and harmful practices in a series of training and dialogues in youth forums, family communities, and the village government, leading to new behaviors and norms

**Working with cross-sectoral government ministries, midwives, Indonesia's Women Ulemas, including men ulemas, families, including men and youth, medias and universities considered transformative to tackle the very sensitive issues such as FGM/C.**

Source : Lies Marcoes for UNFPA, "One Decade of Indonesia's Efforts to Abolish FGM/C Practices : Experiences of UNFPA's Partners", March 2023

## Pathway to Outcome

The BERANI programme's interventions worked at the system level, through the development of 2030 Roadmap for FGM/C Prevention, at the individual level through the integration through Youth Groups and at school level, at the community level through community dialogues at the Islamic Boarding School, and with female and male ulemas, which were facilitated through KUPI, and at the service level though dialogues and trainings of midwives through midwives' association and picked up the opportunities of using the Midwifery Law to integrate FGM/C's prevention as part of the midwives' ethique.

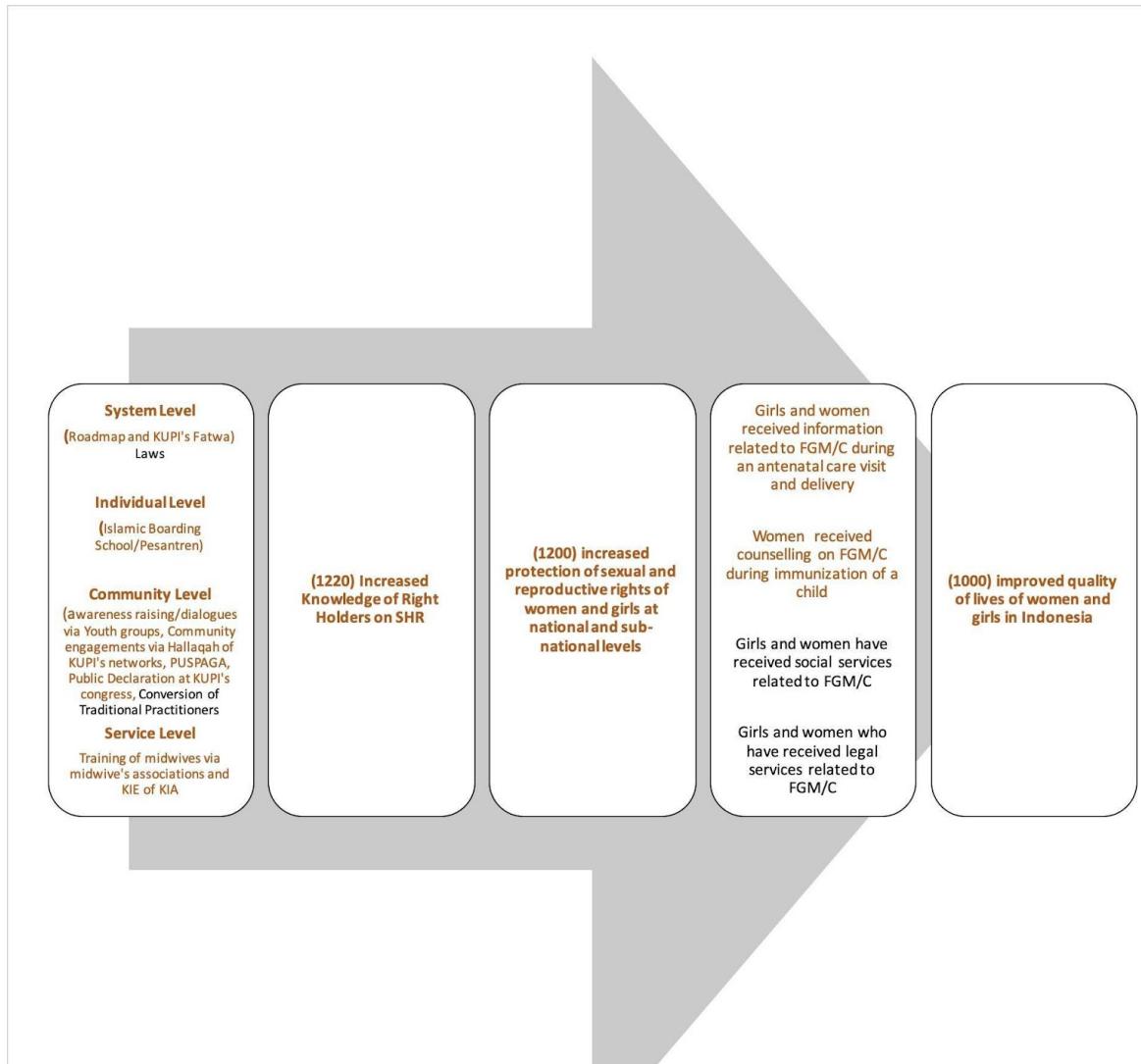


Figure 18 Pathway to Outcomes for Preventing FGM/C

## The Prevention of Female Genital Mutilation/Cutting Againts Evaluation Criteria

### **Relevance (Evaluation Question 1)**

The programme has provided Technical Assistance to the MoWECP (Output 1211) and KUPI (Output 1222). The work to facilitate the MoWECP has systematically produced a model for preventing FGM/C through interventions with cross-sectoral ministries and key stakeholders.

The facilitation of a National Meeting of Islamic Boarding Schools ‘ Pesantren’ and Islamic Organizations in Bogor, which produced *the Risalah Bogor* and the dissemination activities of the Risalah Boogor was considered relevant and strategic as most FGM/C practices were linked to cultural and religious’ believes.

The development of 2030 Roadmap and Action Plan on the Elimination of FGM/C, which uses cross-sectoral approach facilitated various organizations to address FGM/C in Indonesia. This has been refelected by the programme’s initiatives to facilitate the MoWECP to engage with the MoH, IBI, Islamic boarding schools ‘*Pesantren*’, *ulemas*, youth groups, and schools through its works with the NCVAW, the Ministry of Education and Culture, the Ministry of Religious Affairs, universities as well as with national and local NGOs, considered critically important in addressing the FGM/C issues.

The MoWECP’s works with the MoH and BKKBN to advocate midwives through the Midwife Associations (IBI) have not only created awareness on the prevention of FGM/C to the health staffs, but also disseminated the efforts to wide audiences. The development of Guidelines for Preventing FGM/C for health practitioners, the development of advocacy guide and KIE on the prevention ot FGM/C for health practitioners, and the integration of FGM/C into the KIA Book for dissemination to Puskesmas were all critically important for building arguments for midwifes to refuse parents’ request for doing FGM/C and for preventing FGM/C’s practices to happen at the hospitals, Puskesmas, and other private health services.

The programme’s initiatives were very relevant and beneficial, recognizing that the prevalence of FGM/C in Indonesia was significant, so that BAPPENAS and the MoWECP agreed that FGM/C was included in the GOI’s RPJMN 2019-2024. Through its work with Bappenas, the MoWECP proposed a recommendation of the 2030 Roadmap to integrate FGM/C into the questionaire of the 2nd Survai Nasional Pengalaman Hidup Perempuan (SNPHP) or National Survey on the Experience of Women’s Life so that the Survey can provide meta data for reporting FGM/C in the SDG’s national reporting. In specific, the programme’s initiatives that were implemented through the cooperation with key government ministries and the Indonesia’s Women Ulema Networks (KUPI) have been consistent with recommendations of a series of research done by the NCVAW, pointing out that religious leaders and governments are among the groups expected to change the FGM/C practice.

### **Effectiveness (Evaluation Questions 2, 3 and 4)**

The programme's interventions to facilitate the MoWECP to organize events to develop and disseminate the Risalah Bogor, the development of 2030 Roadmap, the development of advocacy training module for Pesantren, ulema and Youth group, with the MoH, with KUPI and worked on research works considered effective in contributing to the expected outcomes.

The BERANI programme has supported the State Ministry of Women and Empowerment and Child Protection, the Ministry of Health, and Indonesia's Women Ulema Network (KUPI) to abolish and prevent FGM/C in many ways, including promoting the use of Female Genital Mutation/Cut (FGM/C) or *Pemotongan dan/atau Pelukaan Genitalia Perempuan* (P2GP) as a **formal term** to replace '*Sunat Perempuan*', which was perceived as a practice advised by religious values. A 2030 Roadmap and Action Plan on the Prevention of FGM/C was released. The work of the Indonesia's Women Ulema Networks (KUPI) on advocating critical groups of ulemas, including male ulemas, and broader community, as well as the release of KUPI's Fatwa to forbid FGM/C transformed how people perceive FGM/C. COVID-19 pandemics had significant implications not only for delaying some activities, but also changing modalities for implementing and delivering activities. The use of digital technology provided opportunities for the programme to reach wider audiences, and involved different experts from different parts of the world.

The work of MoWECP with the youth groups and adolescents was considered effective for introducing the new norms. Interventions to develop and disseminate a Module for Advocacy Training for Preventing FGM/C for youth, which was followed up with a series of advocacy works to youth groups, involvements of youth and traditional leaders in North Lombok and West Lombok, and tested advocacy training module in DKI Jakarta and Bogor District highlighted how importance the roles of youth in changing the norms.

PUSPAGA has been considered as a potential and critical mechanism for changing norms and behavior within families, particularly female and male members of the family., and the programme followed the advice of a study on the FGM/C in Indonesia to work with female members in the family (mothers and grand mothers) as the Study found that the largest decision makers for FGM/C have been done by senior female members by the families, and later by traditional and religious leaders.

There were some changes reported in the efforts to prevent FGM/C. They were

### **Changes to Contribute to the Outcomes 1220 (Output 1222)**

- The terms of FGM/C or *Pelukaan dan Pemotongan Genitalia Perempuan* (P2GP) has been formally used among the government people, CSOs/NGOs, professional health workers (medical doctors and midwives), and targeted ulemas since 2018, to replace the word of 'Sunat Perempuan' (female circumcision), which has a clear objective for advocating FGM/C prevention and abolition without perceiving it as traditional practices, for abolishing FGM/C, both the physical and symbolic acts. This has disseminated a new norm among the government people and women's ulema, as well as targeted community groups, such as progressive male ulemas and youth
- FGM/C has been integrated into 2019-2024's RPJMN. A model of a cross-sectoral strategy to prevent FGM/C, in the form of a Roadmap has built new values and norms among key government ministries and agencies as well as CSOs and NGOs on the health risks of FGM/C, which shall be ended in order to promote gender equality.
- Advocacy and capacity building models to prevent FGM/C, which disseminated to wider networks through moderate '*Hallaqah*' with gender equality promotion have built new norms among 239 women ulema and their networks, including male and female as well as young ulemas in Yogyakarta, Banten, Pandeglang, Bandung, Pekalongan, Semarang, Situbondo, Tasikmalaya, Ambarawa, Pati, Salatiga, dan Majalengka was further disseminated through '*hallaqah*'. KUPI members who come from major progressive ulema, Muhammadiyah and Nahdhatul Ulama have strong influence on Islamic society in Indonesia. Collective works, participated by Bappenas, the State Ministry of Women Empowerment and Child Protection (MoWECP), the Ministry of Health, the Ministry of Religious Affairs, the Ministry of Education and Culture, the National Commission on Violence Against Women (NCVAW), the Indonesian Midwives Association (IBI), research institutes within some universities (PSKK UGM, PSGA IAIN Metro Lampung), the Indonesia Women Ulema Networks (KUPI), as well as Forum Anak and Pesantren.
- Participated by 1,200 Indonesia's women ulema, the 2<sup>nd</sup> congress of KUPI, which was organized in Jepara, Central Java in November 2022, produced 5 fatwa (results of the religious 'Musywarah'), including one on the prevention of FGM/C, highlighted that without medical reasons, FGM/C is *haram* or prohibited, as it introduces health related risks rather than usefulness, and thus shall be abolished<sup>1</sup>.
- PSDM and LPA's worked with traditional and religious leaders as well as youth and families, including male members, to prevent child marriage and FGM/C and the series of training with the village governments to develop village regulation in the village of Tenige and Tanjung in North Lombok have collectively changed behaviours and norms among village government's officials, traditional and religious leaders, as well as males, husbands and boys to practice the new norms for gender equality and to recognize that women and girls more vulnerabilities on the potential of violence and the discrimination against them.

**Dynamics :** COVID-19 Pandemics had significant implications non only in delaying some activities, but also expanding outreach of the activities' delivery

### **Efficiency (Evaluation Question 5)**

**Financial resources.** This BERANI's programme was added with UNFPA-UNICEF Global Joint programme on the Abandonment of FGM/C for funding for the FGM/C prevention for youth training to be used for Child Forum and meeting with other youth groups. The BERANI's funding from the GAC provided UNFPA and UNICEF with flexibility to use resources for delivering critical interventions. UNFPA's Implementing Partners in abolishing FGM/C reported that all funding, which has been channeled through the UNFPA's key partner, the MoWECP has been well implemented. Nevertheless, the IPs found the fund channeling through the MoWECP has not been the most efficient way.

### **Coherence (Evaluation Question 6 and 7)**

While issues of prevalence of FGM/C raised in the Indonesia Basic Health Research (Riset Kesehatan Dasar/Riskesda) in 2013, UNFPA has worked long before with the State Ministry of Women Empowerment, BAPPENAS, the Ministry of Health, the Ministry of Religious Affairs, the Ministry of National Education, and the National Commission on Anti Violence Against Women to prevent FGM/C.

*" From the very beginning, the abolishment of FGM/C is challenging and controversial. However, there has to be one who is brave doing it. UNFPA has stood up base on evidence that FGM/C is a form of violence against women. It is impossible to stop violence against women without abolishing FGM/C" (Martha Ismali Santosa, former Assistant to the Representative of UNFPA Indonesia )*

UNFPA's critical roles to start preventing and abolishing FGM/C in Indonesia has put this UN Agency with key comparative advantages, and through the BERANI programme, such roles have been more prominent.

Coordination in abolishing FGM/C under the BERANI programme has been good. The UNFPA's key partner, the MoWECP and the UNFPA's implementing partner, the Indonesia Women Ulema Networks (KUPI) has established good coordination. Coordination of the MoWECP with the MoH, the NCVAW, with Bappenas, relevant NGOs as well as KUPI were commented as being very good and well managed. The engagements with KUPI, in collaboration with Alimat, Fahmina, Rahima, dan PEKKA) and PSGA (Pusat Studi Gender dan Anak) to advocate efforts to abolish FGM/C through a series of *halaqah* webinar were commented to be productive and strengthened workable networking, including with *Mubadallah* Media, which is a progressive Islamic media with male ulemas members as well as with the Women Study Centre of Metro Lampung brought productive coalitions for preventing FGM/C.

### **Sustainability (Evaluation Question 8)**

There were some areas on sustainability, which were worth reporting.

- 1) KUPI's key networks comprise of women's religious based organizations, which work toward Islamic teaching, and thus fatwa on the abolishing of FGM/C will be brought into their discourses and dialogues, which at the end promote sustainability. With or without BERANI, this network will remain working on the Fatwa. Exploration on future funding for KUPI to carry out awareness raising 'socialization' of the Fatwa will be useful.
- 2) While there has been a Fatwa to confirm that without medical reasons it is unlawful to do FGM/C as FGM/C causes more harm/bad than benefits., some recommendations for sustainability are raised, among others ;
  - a) Develop and release firm and clear GoI's regulations on the prohibition of FGM/C , which will be a critical basis for promoting action to eliminate FGM/C, especially for the health service providers so that they have a legal basis in rejecting parents and prohibiting FGM/C.
  - b) Expand the Indonesian government's and any future programmes to orient towards cultural strategies to change gender norms so that they are more just and equal. Therefore, the FGM/C prevention programme must always be in line with political and cultural strategies that seek to eliminate negative prejudice/gender bias that has been instigated for a long time.
  - c) Orient FGM/C campaign messages towards eliminating traditional practices that perpetuate labelling/prejudice, subordination, and GBV or discrimination against women through FGM/C practices

- d) Develop traditions that contain good values in honoring women, teaching the norms of equality, justice, and respect for women's bodies, sexuality, and existence.

## Gender Considerations in the Overall BERANI programme : Adoption of Feminist International Assistance Policy (FIAP) and the GAC's Gender Coding Framework

The BERANI's MTR Report indicated that the programme continued to employ the UN SWAP<sup>113</sup> for assessing gender equality, and not using the Feminist International Assistance Policy (FIAP) and the GAC's Gender Coding Framework. Nevertheless, the MTR Report indicated that BERANI's initiatives enhanced the protection and promotion of the human rights of women and girls and increased the access and participation of women and girls to resources. GAC Gender Coding requires a systematic gender analysis to be carried out and sex disaggregated data to be collected, but unfortunately, no joint gender assessment was done during the design of the BERANI programme and on the pilot projects, recommending GAC to provide awareness about the GAC Gender Coding and the Feminist International Policy to UNFPA and UNICEF. To follow up the MTR's recommendations, it was reported that GAC sat a few times with UNFPA and UNICEF and carried out gender sessions to discuss the Feminist International Assistance Policy (FIAP) and the GAC's Gender Coding Framework. Such efforts clarified what shall be done for any future joint programmes funded by GAC.

Adoption of gender transformative approaches in the BERANI programme were implemented through some of the programme's initiatives in SRH, SARH, Pilot Project of child marriage prevention in North Lombok and in South Sulawesi, and in the engagements with the women ulema network (KUPI). Specifically, for the engagement with KUPI, the approach was adopted through the effective involvement of religious and community leaders (including women's prayer groups) to change attitudes about Menstrual Hygiene Management (MHM), SRHR, child marriage, and FGM/C facilitated by UNFPA and UNICEF. Specifically, UNFPA adopted its strategy of men's engagement for strengthening understanding, capacity, and policy to transform inequitable and unhealthy gender attitudes and norms. This strategy aims at addressing pervasive gender stereotypes, promoting shared power, control of resources and decision-making, and support women's empowerment. It was noted that information on equal decision making and promotion of equitable control over resources was found limited<sup>114</sup>. The BERANI programme did not recruit any gender specialist to help the adoption of the gender transformative approach so that the approach was implemented rather unevenly in the programme. There were initiatives, which used significant gender transformative approach, such as in the SARH, child marriage prevention ( both at the 2 pilot projects) and FGM/C's prevention, but there were initiatives

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<sup>113</sup> The UN System-Wide Action Plan on Gender Equality and the Empowerment of Women (UN-SWAP) ensures greater coherence and accountability in the gender-related work of all UN entities. UNFPA has been implementing the UN-SWAP since 2012, and UN-SWAP 2.0 since 2018. Through this work, UNFPA has ensured the Gender Equality Strategy is "fit for purpose" and responds to the 2030 Agenda, and that progress is measured, evaluated, reported, and communicated at all levels. The UN-SWAP provides performance indicators to measure progress across all institutional operations and strengthen coherence across the United Nations system.

<sup>114</sup> UNFPA/UNICEF's MTR Report, February 2022

with limited or no gender transformative approach, such as in the GBV prevention and in technical assistance to the parliamentarians for preventing harmful practices.

On the case of pilot project in South Sulawesi, which was facilitated by UNICEF, norms on the importance pf preventing child marriage and increasing awareness about menstrual hygiene management were established through the use and dissemination of materials to the community, which were carried out by women ulemas from the Muslimat NU and Aisyah. Regular discussions at the Majelis Taklim or community meetings were effectively conveyed messages about MHM, SRHR, and child marriage. It was expected that male ulemas would also be invited to participate in the pilot project, recognizing that male prayers have stronger influence than that of the female prayers on gender equality promotion in the strong male dominated society, such as South Sulawesi. UNICEF's team on the ground found that future programmes can benefit from integrating stronger and more systematic gender transformative.

Changes in the gender equality norms of youth and adolescents, boys and girls, in both the Pilot Project in North Lombok and Bone (South Sulawesi) were demonstrated by end-line studies, where gender equality norms of the boys increased higher than that of the girls<sup>115</sup>. Nevertheless, analysis using gender disaggregated on the findings may need to be further analyzed for lessons.

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<sup>115</sup> End-line survey of UNICEF's facilitated LSE in Bone District and in end-line evaluation of UNFPA's facilitated youth forum in two villages of North Lombok

## Chapter 5: Conclusion

BERANI is a joint UNFPA-UNICEF programme, supported by Global Affairs Canada. The programme was intended to contribute to the current effort in improving the SRHR for women and girls in Indonesia by tackling the priorities issues, with a special attention given to disadvantaged populations - gender, socio-economic status, disability status and those with multiple vulnerability factors (intersectionality). These include SRH service quality, access to ASRH service, and promoting gender equality and women empowerment.

Based on the findings from the MTR and additional data analysis, the evaluation draw the following conclusions:

1. BERANI has achieved the intended targets at the output level. Meanwhile contributions of output to the outcome level can solely be qualitatively justified, as the programme's scope is fairly small compared to the national/joint or GoI effort. Nevertheless, the GoI, stakeholders and IPs appreciate and acknowledge the contributions made by UNFPA and UNICEF through the BERANI programme.
2. UNFPA and UNICEF have followed up most of the recommendations made in the MTR report. One of the crucial aspects being simplification/streamlining of the logic model in accordance with the GAC monitoring framework. By doing so, the logic pathway is becoming clearer than the initial developed one.
3. The overall BERANI programme (and each component) is relevant with the current GoI priorities. The programme has supported government and related stakeholders (national and subnational) in generating evidence, facilitating policy dialogue, contributing to policy/programme design, including establishing a governing body, and critical capacity building.
4. Overall, BERANI has an integrated approach to capacity building, initiated with evidence generation needed, capacity building design, module development, and pilot project implementation. Furthermore, in the area of GBV, FGM/C and child marriage prevention, The programme has built a series of capacity development models in the prevention of GBV, child marriage and FGM/C, which presented in the provision of a TOT manual for HSR to GBV, protocols for HSR to GBV, Standard Operating Procedures (SOP), quality assurance mechanism, which were replicated in other districts/villages and/or planned to be integrated into the regular MoH's capacity development programmes.
5. UNFPA and UNICEF have effectively utilized their established international and national networks in implementing the BERANI programme. This is a key success factor leading to the programme's acceptability by stakeholders, hence contributing largely to its achievements. In addition, this has also enabled BERANI to provide the required technical expertise, international and nationally.
6. BERANI has contributed to the national policy development in the related SRH, ASRH, prevention of GBV, FGM/C and child marriage. Through the policy dialogue, parliamentary works, provision of funding and technical expertise, UNFPA and UNICEF through the BERANI programme have contributed to the development and endorsement of policy products at national and subnational levels.
7. At the service provision levels, BERANI interventions have been seen to be useful and beneficial for both direct (health workers and health services) and end beneficiaries (clients). UNALA, for example, is seen as an innovative method to attract adolescents to access health services. This is

not solely due to its branding but also a result of capacity building given to the health workers in interacting with youth. For GBV service at health facilities, most of the interventions in the prevention of GBV were considered meeting technical aspects, environmental requirements, and applying systematic planning and M&E. While capacities of both health staff and non-health staff increased, GBV survivors reported being satisfied with the services and the excellent infrastructures.

8. Numbers of pilot project innovations have been replicated (fully or partially) by subnational and national governments, hence increasing its odds of sustainability. Among others, it includes MoH funding commitment to Poltekkes as Midwifery CoEs, adaptation of UNALA module for posyandu remaja, translation of STRANAS to Prevent Child Marriage into STRADA and replication of Bone's child marriage Model into Wajo and Luwu Utara District by the local government. In some cases, Pilot Projects have been successfully implemented with significant results in addressing the development challenges. For example, the Bone's Pilot Project has been very successful in reducing child marriage cases and leading to most villages having Zero Child Marriage cases, making the Bone district government achieve various awards from the Ministry of Empowerment of State Apparatus and Bureaucratic Reform (PANRB) with a *Public Service Innovation Award*. Not only that, when the District government submitted the child marriage prevention strategy adopted from BERANI model, the Bone District government was awarded Top 30 Public Service Innovations at provincial level and Top 45 at national level among 3,478 innovations submitted from all over Indonesia.
9. The Joint programme's design and implementation has identified and incorporated the needs of women and girls, including vulnerable, marginalized ones, and those with disabilities in ASR, GBV and harmful practices' preventions. GEDSI transformative in SRH components is identified as male's involvement in FP, and improvements are still needed in SRH capacity building, including disability friendly SRH services.
10. As many other development programmes, COVID-19 has brought a great challenge to BERANI programme implementation, including delayed or canceled activities. An example, the provision of technical assistance to the Indonesian Forum of Parliamentarians on Population and Development (IFPPD)'s activities on GBV, FGM/C and Child Marriage as well as capacity development to advocate on the draft of sexual violence law with parliamentarians was missed.
11. During the COVID-19 pandemic, BERANI has managed to act in an adaptive manner, putting notable effort in alternating the approach (to online or hybrid models) and responding to the national agenda on pandemic response (series of COVID-19 webinars, PPE provisions). Regardless of the pandemic's impact on the programme, the era has also brought an opportunity for the programme to be innovative, being one is the use of digital technology for GBV services, and CoP initiation for COVID-19, later expanded for ASRH.
12. While BERANI is designed as a joint-programme, the coherence across thematic components, and between overlapping issues addressed by UNFPA and UNICEF, are still lacking. Each component of the BERANI programme has different pilot sites and partners despite having similar target groups (e.g. health service providers). The scattered areas of project intervention resulted in a lack of collective contributions to the shared-outcomes. Another example, the two pilot projects on the prevention of harmful practices in Bone district and North Lombok districts applied different models, and lacked coherence on the design and implementation. Upon pointing out, a cross learning event was initiated and resulted in a better approach for replication. Furthermore, it was highlighted by the MTR that, as a Joint programme, which was funded by the Global Affairs of Canada, BERANI has been in line with the GAC requirements of gender analysis and collecting disaggregated data, for analysis, reporting, and accountability. Nevertheless, there was no gender analysis jointly developed by UNFPA and UNICEF during the

design of the joint programme and the pilot projects. Following up the MTR's recommendations, UNICEF, UNFPA, and UN Women sat together with GAC and reviewed findings and recommendations of the MTR Report, and identified ways and made thorough gender analysis to improve it for future programming

13. As a Joint programme, BERANI has been successful in advocating sensitive issues, such as child marriage and FGM/C prevention and comprehensive sexuality education (CSE), which considered to be the UNFPA and UNICEF's comparative advantage. More broadly, comparative advantages of the BERANI programme within the UN system are rather difficult to justify. This is largely due to the difficulties in specifying BERANI contributions within the current UN reporting system, which is reported at the outcomes and agency level. Meanwhile for CSE, BERANI has been successfully advocating the MoECRT in supporting teachers training and adaptation of CSE for youth with disabilities.

# Chapter 6: Recommendations

## General Recommendation for Joint programming

The following general recommendations are proposed based on the lessons learned from BERANI programme implementation. These recommendations are not made specifically for the continuation of the BERANI programme rather for multi-thematic programming. In principal, it is recommended that future joint-programming to:

1. Maximize the use of each agency's expertise, and extend collaboration beyond proposal stage development. Having a joint specific intervention in a cross cutting/overlapping issue such as gender has the potential to have a greater impact. Learning from the BERANI joint-programme, having no joint-intervention (i.e. shared areas of interventions, jointly developed pilot projects) has its own weaknesses. Having a joint intervention would not only creating a larger coverage, but more importantly can enriched the technical content and joint-forces for policy changing
2. Strengthen the high-level engagement in the future joint-programme. Most BERANI programme interventions are heavily focused on technical aspects, with a limited engagement with high-level government officials. To achieve a greater policy impact and potential for sustainability, regular engagement with high-level officials for advocacy purposes at the earliest time is recommended, while maintaining engagement with the technical level for the programme design, implementation, monitoring and evaluation.
3. Promote gender transformative approaches, with a potential expansion to address intersectionality in the future joint-programme to achieve gender equality and sexual reproductive health and rights. It is recommended to explicitly address the underlying causes of gender inequality in policies, legislations, institutions, norms, and stereotypes through engagements with the non traditional groups, including males, youth, taking into account the intersectionality factors that can lead certain groups of populations to be further marginalized
4. In a humanitarian context, the BERANI programme has taught an important lesson on the importance of programme adaptability and flexibility in a pandemic era. As shown, programme adaptability during pandemic or emergency situations should cover both responding to the needs and alteration in project approach/method of delivery.

## Strategic Recommendation by Theme

These groups of recommendations are proposed at a strategic level for each theme, based on BERANI programme implementation. These recommendations are to be considered during design and implementation to create an enabling environment during programmatic implementation.

### Sexual and Reproductive Health

1. **Maintain the established network** with professional association (IBI, AIPKIND), midwifery collegium, Ministry of Health, and BKKBN.

*Priority:* High

*Target of Recommendation:* UNFPA

*Potential action plan:*

- Maintaining close engagement with governing bodies in developing and implementing short and long-term agenda to improve the SRH service and education quality.
- Continue to facilitate the collaboration between Ministry of Health, IBI, AIPKIND with the MoECRT

2. Continue to **play an advocacy role at the national level**, either as advocate or facilitating policy dialogue.

*Priority:* Medium

*Target of Recommendation:* UNFPA

*Potential action plan:*

- Facilitate cross-country learning to address priorities issues in Indonesia. This may include sharing lessons learned from other countries in SRH services, HRH capacities, and global standard guidelines
- Develop policy advocacy materials based on evidence generated in SRH programme, combining with global programmes lessons learned for policy changes in Indonesia. Among others, critical themes in SRH include inclusive contraceptive services, strengthening midwifery roles in SRH services, and midwifery education.

### Adolescent Sexual and Reproductive Health

1. It is suggested for future programmes to **embed sustainability plans as well as its exit strategy at earliest time as possible** during the programme design.

*Priority:* High

*Target of Recommendation:* UNFPA

*Potential action plan:*

- Design a health system approach to improve ASRH services. This can be initiated with identifying the established services platform for ASRH services, the connection between those services, and the gaps where improvements are required
- Conduct a stakeholders mapping (including potential resources, area of expertise, roles) across the programme design to increase the odds for sustainability

- Promoting the youth meaningful participations in programme design, implementation, and monitoring evaluation to ensure their needs are addressed, and services provided are utilized

2. **Maintaining and strengthening the collaboration with MoECRT** is suggested, in order to convince the importance of this subject.

*Priority:* High

*Target of Recommendation:* UNFPA

*Potential action plan:*

- Continue to facilitate a close collaboration between MoH and MoECRT in ASRH programme and policy development and implementation
- Generate lesson learned from CSE's implementation experiences, align with other school-based ASRH programme (such as UKS, PIK-R) for policy advocacy materials to MoECRT

## Gender Equality and Women Empowerment

### Prevention of GBV

Strengthen systemic Health Sector Approach for GBV, through the promotion of a combination of supply and demand side approach in the HSR to GBV in future programming

Priority level : High

Target of recommendation : UNFPA

Potential Action Plan for UNFPA

- On the supply side, to continue advocating to MoH for assuring HSR to GBV is institutionally integrated in the MoH's mandates and to promote the implementation of SOP in the GBV services in the health service points in Indonesia.
- On the demand side, to increase accessibility of marginalized groups and disadvantaged women to access comprehensive services, including HSR to GBV through the promotion of gender responsive budgeting at the district level to facilitate relevant NGOs and legal aid foundations to work with survivors of GBV
- To facilitate linkages of the referral system of the HSR to GBV at the health service points and the NGOs and/or community based initiatives (psychological, social and legal) to support survivors of GBV

### Prevention of Child Marriage

Continue systematic efforts and advocacy works along the National Strategy to Prevent Child marriage, which have been facilitated by BERANI to meet the Sustainable Development Goal target to end child marriage by 2030

Priority level : High

Target of recommendation : BAPPENAS, UNFPA, and UNICEF

Potential Action Plans for BAPPENAS

- To strengthen multisectoral coordination among Ministries, Agencies, NGOs/CSOs and other institutions to prevent child marriage in the national and sub-national level
- To facilitate development, adoption, and replications of workable tool kits that accompanied the STRANAS for use at the local level
- For the sub-national levels, BAPPENAS can ask UN Agencies to help support local government to develop budgeted and multisectoral Regional Action Plans to Prevent Child Marriage
- To facilitate coordination to strengthen the child protection and welfare services, including health services such as Posyandu and PUSPAGA to provide information and counseling to adolescents
- To coordinate relevant ministries to engage with adolescent-led organizations to disseminate information on ASRH, MHM, and CM, among others
- To work with relevant ministries, i.e. the MoWECP and the MOHA to advocate for the development of PUSPAGA, CBCP, UPTD PPA, as well as Forum Anak at subnational levels to support child marriage prevention efforts

**Prevention of FGM/C**

Continue systematic efforts and advocacy works along the 2030 Roadmap on the Prevention of FGM/C to meet the Sustainable Development Goal target to end FGM/C by 2030

Priority level : High

Target of recommendation : UNFPA

Potential Action Plans for UNFPA

- To maintain the established working relationships with the MoWECP, Bappenas, MoH, the KUPI networks, and the Indonesia's Midwife Association in the future programming for preventing FGM/C for building continuation in the work to eliminate FGM/C
- With relevant GoI's agencies, to explore the development of firmed and clear GoI's regulations on the prohibition of FGM/C, which will be a critical basis for promoting action to eliminate FGM/C, especially for the health service providers so that they have a legal basis in rejecting parents and prohibiting FGM/C.
- To explore cultural strategies for carrying out FGM/C campaign to eliminate negative prejudice/gender bias/discrimination against girls and women, which perpetuate FGM/C practices

## Programmatic Recommendations

The following programmatic recommendations are proposed in a spirit of continuing what have been achieved by BERANI, by thematic component.

### Sexual and Reproductive Health

1. **Ensure the endorsement of the National Standard and Curriculum for Midwifery Education by the Ministry of Education.** While the endorsement is postponed due to the synchronization of health law, a close monitoring and advocacy to ensure the process is critical. Coordination between UNFPA, Ministry of Health and BAPPENAS are needed in this matter.

*Priority: High*

*Target of recommendation:* UNFPA, IBI, AIPKIND, MoH

*Potential action plan for UNFPA:*

- Provide technical assistance to IBI in advocating MoH and MoECRT on the importance of the national standard and curriculum for midwifery education. Knowledge products generated during the BERANI programme (on midwifery education) can be translated into advocacy materials for this matter.
- Facilitate policy dialogue and coordination among high-level officials from the Ministry of Health, Ministry of Education, and BAPPENAS
- Continue giving support to MoH and IBI in responding to the policy dynamic changes related to human resource for health and public health needs, particularly those related to demand of midwifery service, level of competencies and authorities.

2. **Identify and provide the support needed to continue the midwifery CoEs and its plan for knowledge hub and “institution-mentoring” mechanism.** MoH commitment to provide funding support for CoEs reflects GoI's commitment and this should be supported to achieve its optimum impact. In addition, a monitoring and supervision system to maintain the CoE's quality and the extended mentoring mechanism is also a part that requires further support.

*Priority: Medium*

*Target of recommendation:* UNFPA, IBI, AIPKIND, MoH

*Potential action plan for UNFPA:*

- Support MoH and IBI in conducting process and outcomes evaluation of CoEs, potentially covering the quality of CoEs, identify each CoE's strength, and obtaining inputs for strengthening midwifery education
- Ensure the CoE quality and performance through introducing strategic interventions that are developed together with the Family Health Directorate, MoH as the main user of midwives (midwifery services)
- Provide technical support to MoH in implementing the CoEs network (knowledge hub) and institution mentoring mechanism
- Support IBI and AIPKIND to strengthen partnerships with education hospitals for students' skill practice

3. **Assist IBI in replicating the supervision and coaching mechanism.** Prior to the nation wide scale-up, review of the pilot project is needed to identify strengths, weaknesses, and improvement needed. This would need a collaborative effort between IBI and the Ministry of Health

*Priority: Medium*

*Target of recommendation:* MoH, UNFPA

*Potential action plan for UNFPA:*

- Support IBI in embedding the online supervision and coaching mechanism (Telebidan) into the core IBI platform, this may include operability test
- Support IBI in conducting process and outcomes evaluation of supervision and coaching mechanism, including identifying potential approach for adding offline session in hybrid model

4. In consultation and collaboration with the key stakeholders, **develop a grand design for midwifery pre-service quality improvement with a strengthened GEDSI component.**

*Priority: High*

*Target of recommendation:* UNFPA

*Potential Action for UNFPA:*

- Provide technical assistance to generate lesson learned from similar context (countries) in mid-term and long-term plan to improve quality of midwifery education
- Provide technical support to IBI, AIPKIND, Collegium, Concile and MoH in developing milestones and targets for midwifery education improvement
- Facilitate activities/workshops involving the related stakeholders such as IBI, AIPKIND, Collegium, Concile to develop either roadmap or strategic action plan, complemented with milestones and targets, to both direct and facilitate monitoring and evaluation processes.

5. Develop a **strategic approach for FP2030 in addressing key challenges of FP programme** with a strong involvement of relevant MoH units.

*Target of recommendation:* BKKBN, UNFPA

*Potential action plan (short-term):*

- Initiate technical discussions among the FP2030 partners to agree on the root causes and potential actionable solutions to address the stagnancy of the family planning programme's achievements

## Adolescent Sexual and Reproductive Health

1. **Expanding the target beneficiaries and programme coverage of UNALA beyond health service providers.** In order to increase the potential of programme sustainability, UNALA should also aim to work with the health service's management level. In many cases, the type of services provided in private clinics are mainly decided by the clinic management. Having the service to be available would mean advocating and convincing the management on how and why the service is

important. As private clinics has a profit oriented component, costing and pricing analysis of UNALA service can be conducted as an information/advocacy materials

*Target of Recommendation:* UNFPA, YSSI

*Priority:* High

*Potential action plan for UNFPA:*

- Prioritise engagement with the health service's management level to increase the chance of programme's sustainability
  - Conduct a cost analysis for these services in private clinics, in order to provide better projection regarding its feasibility
  - Initiate policy dialogue on the health financing aspect of ASRH. This may include initial dialogue with BPJS Kesehatan on its coverage towards health promotion services for private health service providers. Discussion/dialogue can be initiated involving MoH, and MoWECP.
  - In collaboration with ASRH network, provide support to MoH to expand the public private partnership for ASRH beyond health service delivery - but to further cover other elements of the health system. This may include financing, capacity building of HRH, and digital technology advancement.
2. **Better coordinate and strategize the established Community of Practice (CoP).** As it is founded on a shared vision and advocacy agenda, cultivating and strengthening on communication strategy beyond improving knowledge and awareness, but also call for actions are suggested.
- Priority:* Medium
- Target of Recommendation:* UNFPA
- Potential action plan for UNFPA:*
- Continue giving support to the CoP as they have developed networks which is a valuable intangible asset.
  - Support for the CoP goes beyond financial contributions; it also involves putting them in the spotlight by introducing them to UNFPA's partners so they can get greater exposure.
  - Expanding the youth-participations beyond identifying the topics of interest for webinar. When initiating new projects regarding ASRH, prioritize those which come from, organized, and executed by young people. The bottom-up approach has been exemplified in the CoP, particularly when they organize webinars, where the members discuss and vote on the theme and speakers.
  - Expanding the CoP network to involve other youth platform such as Forum Anak Nasional, and others
3. **Document lesson learned, and evaluate the effectiveness of CSE in the pilot project, and provide evidence for replication/scale up**
- Priority:* Medium
- Target of Recommendation:* UNFPA
- Potential action plan for UNFPA:*

- Facilitate evaluation for CSE implementation. This applied to process and potentially outcomes evaluation to teachers receiving training during BERANI programme, as well as its adaptation for youth with disabilities
- Develop policy advocacy materials from the above mentioned process and outcomes evaluation

## **Gender Equality and Women Empowerment**

### **Prevention of GBV**

1. UNFPA to facilitate the MoWECP to monitor and advocate the MOH's work to adopt the BERANI's capacity development model on HSR to GBV in its regular capacity development programme, based on the BERANI's lessons learnt.

Priority - High

Target of recommendation : UNFPA and the MoWECP

Potential Action Plan for UNFPA (short term)

- To facilitate the MoWECP to meet relevant senior level of MoH officials and the MoH's Gender Focal Points to discuss progress and lessons from the BERANI's capacity development model on HSR to GBV as well as the implementation of the Pilot Project on the HSR to GBV at the health service points in Cirebon District
  - To facilitate the MoWECP to meet MoH for discussing the progress of the MoH's plan to integrate the BERANI's capacity development models and training activities and material on HSR to GBV into the MoH's regular capacity development and training programme
  - To facilitate the MoWECP to regularly monitor the progress of the MoH's capacity development plan through the Gender Focal Points' meetings.
2. UNFPA to facilitate the MoWECP to continue promoting the use of digital technology and online reporting of GBV cases in wider P2TP2A/UPT PPA in Indonesia

Priority : High

Target of recommendation : UNFPA and the MoWECP

Potential Action Plans to UNFPA (short to medium term)

- To work with the MoWECP to explore the dissemination and replication of BERANI's good experiences in adopting the use of digital technology and online reporting of GBV cases to non-targeted P2TP2A/ UPT PPA in Indonesia;

- To facilitate the MoWECP to advocate and encourage relevant local governments to adopt the use of BERANI's experiences in using digital technology and online reporting of GBV cases to non-targeted P2TP2A/ UPT PPA in Indonesia

### **Prevention of Child Marriage**

1. To disseminate the good practice and lessons learnt on the approaches and implementation of the BERANI's programme to prevent child marriage at the national level and the local level, including the pilot project in South Sulawesi to wider stakeholders (relevant government units, donor organizations, universities, and NGOs/CSIs), for further adoption and replication of the workable approaches and models and do necessary follow up

Priority : High

Target of recommendation : UNFPA, UNICEF, GAC, the Government of Indonesia.

Potential Action Plans to UNFPA and UNICEF (short to medium term)

- UNFPA, UNICEF, and GAC to meet the MoWECP and Bappenas to discuss the progress of child marriage prevention, good practice, as well as lessons learnt in the prevention of child marriage at the national and local level, including effective replication models, effective approaches to design pilot projects, LSE's modules, and ustazah's Booklets, as well as the adaption of workable gender transformative approach
- To jointly encourage the MoWECP and Bappenas to disseminate and advocate other provincial and district governments as well as donor organizations to learn and replicate the workable approaches and practices that BERANI has successfully introduced
- To facilitate the MoWECP and Bappenas to monitor workable adoption/replication of BERANI's approaches at the national and local level for documenting results at the broader level.

2. To better use of data and evidence building and generation on the prevention of child marriage at the sub-national level

Priority : High

Target of recommendation : UNICEF

Potential Action Plans to UNICEF (medium)

- To utilize evidence generated throughout BERANI programme to advocate for sub national governments to replicate BERANI model to prevent child marriage
- To engage with the universities and research centers in child marriage prevention programme through the development of evidence-based strategies, including how to transform social norms
- To advocate universities and research centers to carry out relevant researches on the root causes of child marriage in different local context, including on the nature of Nikah Siri and its implications to women and children, for policy development on the prevention of child marriage

3. To promote stronger multisectoral approach for related government institutions and sectors to address child marriage in Indonesia

Priority : High

Target of recommendation : UNFPA and UNICEF

Potential Action Plans to UNFPA and UNICEF

- To sit together to identify strategies for facilitating the MoWECP and BAPPENAS to have better synergy in coordinating the prevention of child marriage in different ministries, including MORA, MOECRT and Faith Based Organizations and various sectors in Indonesia
- UNFPA and UNICEF to strengthen the MoWECP and BAPPENAS' joint leaderships in preventing child marriage in different ministries and sectors Indonesia, including in developing and designing capacity development plan and advocacy strategies of different ministries
- To monitor the progress of multisectoral approach's implementation facilitated by the MoWECP and BAPPENAS

#### **Prevention of FGM/C**

1. UNFPA and the MoWECP to facilitate KUPI to disseminate the KUPI's Fatwa on FGM/C to wider stakeholders, including female and male ulemas in Indonesia

Priority High

Responsibility : UNFPA

Potential Action Plans for UNFPA :

- To meet with the MoWECP to discuss the Government of Indonesia's plan for following up efforts to prevent FGM/C from what have facilitated by the BERANI programme
- To meet with the MoWECP and KUPI to discuss plans and respected resources (human resources and funding) for disseminating the KUPI's Fatwa to wider audiences, including female and male ulemas, including MUI, women's prayers groups, and Islamic boarding schools (Pesantren)

2. UNFPA and the MoWECP to continue engagements with MoH, IBI, and IDI as well as with women movements, including PUSPAGA, youth forums, and cultural based organizations to prevent FGM/C

Priority : High

Target of recommendation : UNFPA

Potential Action Plans to UNFPA (short-term) .

- To meet the MoWECP to develop strategies to continue working with MoH, IBI and IDI to prevent FGM/C at hospitals and private practices
- To work with the MoWECP to develop systematic strategies to work with PUSPAGA to optimize advocacy, dialogues and awareness raising to prevent FGM/C to women and families, considering that earlier studies carried out by universities and NCVAW indicated that decision makers of FGM/C practices have been done mostly by elderly women in the families (mothers, grand mothers).

- To work with the MoWECP to further identify collaborations with Islamic boarding schools (Pesantren) to prevent FGM/C from the education aspects;
- To work with the MoWECP to explore the development of a strategy to work with cultural based organizations to prevent FGM/C through the use of non-violence approach

## Annex 1

Inception report /design document:

<https://docs.google.com/document/d/1Av-sfNQb8pb7xKuoVCw0zLFXweo1dt0h/edit?pli=1#>

## Annex 2

Assumptions assessed	Indicators	Sources of information	Methods and tools for the data collection
<b>Relevance: Evaluation question 1</b>			
<b>Assumption 1:</b> The design and implementation of the BERANI Joint programme have considered and incorporated the various SRH needs of the adolescents and young people population, including vulnerable and marginalized groups and people with disabilities.	Evidence that the needs of women and girls, including vulnerable, marginalized ones, and those living with disabilities, were identified and incorporated into the BERANI joint programme	MTR report Annual report Minutes of technical work groups; and List of partners	Document Review
<b>Assumption 2</b> The needs of vulnerable and marginalized women and girls and those with disabilities to be free and protected from GBV and harmful practices were incorporated and responded into the BERANI joint programme	Evidence that the needs of women and girls, including vulnerable, marginalized ones, and those with disabilities to be protected from GBV, including, physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty; whether occurring in public or private life were identified and incorporated into the	MTR report Annual report Activity reports Partners and direct beneficiaries	Document Review Interview with programme team, Interview with stakeholders, partners, direct beneficiaries

Assumptions assessed	Indicators	Sources of information	Methods and tools for the data collection
	BERANI joint programme		
<b>Assumption 3:</b> The targeted outputs and outcomes of the BERANI Joint programme are in line with the GoI priorities in SRH, adolescent and youth SRH, SDG5 and ICPD and other international commitments.	Evidence that the BERANI joint programme is in line with the National Development Plan (RPJMN), relevant Government strategies and policies regarding SRHR, ASHR and GE, GB and harmful practices .	MTR report Annual report Government stakeholders	Document Review Interview with Bappenas, BKBN Interview with DHO

### Effectiveness: Evaluation question 2

To what extent have the expected outputs of the BERANI joint programme been achieved, including in responding to COVID-19 situation? Likewise, to what extent have these outputs contributed to the achievements of the outcomes (immediate, intermediate, and ultimate outcomes) of the BERANI joint programme? What were the factors that influenced the achievement and/or the non-achievement of the results?

<b>Assumption 1:</b> Strategies and instruments exist to strengthen the CoE midwifery (including monitoring system), and midwifery association	<ul style="list-style-type: none"> <li>• Centre of Excellence are selected and assisted in accordance to the strategy developed</li> <li>• National curriculum for midwifery education are developed and in line with the ICM</li> <li>• Measured progress of midwifery association in advocacy</li> </ul>	MTR report Annual report IBI AIPKIND	Document Review Interview with UN Interview with IBI, AIPKIND
<b>Assumption 2 :</b> Long-term partnerships exist to increase the capacity of duty barriers in planning, implementation, and coordination to prevent GBVs and Harmful Practices (Child Marriage and FGM/C), which lead to the formation and adoption of behaviour, practices	Evidence on the availability and use of: - capacity development models to prevent GBV and harmful practices	MTR report Annual report 2022 Activity reports, UNFPA and UNICEF staffs, Stakeholders (P2TP2A, KUPI, Heath Units, MoWECP), IPs	Document Review Interview with programme team, stakeholders,

Assumptions assessed	Indicators	Sources of information	Methods and tools for the data collection
and values in Indonesia, including during the COVID-19 pandemics	<p>-guidelines, Protocols, SOP, including quality assurance system, and TOT manuals of One Stop Service for GBV Survivor in pilot health services and GBV Case Management of P2TP2A to response to Covid 19</p> <p>Evidence of networks and Forums established and functioned</p>		partners, direct beneficiaries
<b>Assumption 3:</b> FP2020 goals were achieved better by establishing and strengthening partnerships and a strong foundation for FP2030 is initiated	Evidence showing strengthened partnerships towards FP2030	UNFPA staff BKKBN Activity reports related to FP2020, FP2030	Document Review Interview with UNFPA, BKKBN

### Effectiveness: Evaluation question 3

To what extent has the BERANI programme delivered Gender Equality results at all levels (making long term sustainable transformative changes for women and girls that address the root causes of gender inequalities with regard to rights, decision-making and access/control of resources)?

<b>Assumption 1</b> Adolescent SRHR programmes implemented are being uptake by local or national government and implementing partners	<ul style="list-style-type: none"> <li>● Module on adolescent reproductive health developed</li> <li>● CSE training system are developed and endorsed by the national government</li> <li>● Community of practice on ASRHR is established</li> </ul>	MTR report Annual report UNFPA staff Direct beneficiaries Activity report, module, digital content created	Document Review Interview with UNFPA, MoEC, implementing partners (YSSI), and direct beneficiaries (youth content creators, master teachers)
<b>Assumption 2:</b> Promotion of gender equality and women empowerment exist to deliver gender equality results in the prevention of GBV and harmful practices, including in the COVID-19 pandemics contexts, through policy	Evidence on the availability and adoption of : <ul style="list-style-type: none"> <li>● National Strategies and Action Plan development</li> </ul>	MTR report Annual report 2022 Activity reports, UNFPA and UNICEF staffs, Stakeholders and IPs	Document Review, Interview with programme team (UNFPA/UNICEF), P2TP2A, KUPI and

Assumptions assessed	Indicators	Sources of information	Methods and tools for the data collection
development and implementation, which lead to the formation and adoptions of new behaviour, practices, and values	<ul style="list-style-type: none"> <li>assisted and adopted at the national and sub-national level</li> <li>Gender assessment and analysis development assisted, based on systematic data</li> <li>Strategic leaderships and advocacy models to prevent GBV and harmful practices</li> </ul>	(P2TP2A, KUPI, Heath Units, MoWECP)	its network members, health unit, MoWECP

#### **Effectiveness: Evaluation Question 4.**

Did stakeholders (organizations, institutions, indirect target groups) benefit from the interventions in terms of institutional capacity-building in the area of gender mainstreaming and the development of gender competence among their staff?

<b>Assumption 1</b> Strategies and knowledge on improving demands to SRHR, including ASRH are developed to ensure service sustainability	<ul style="list-style-type: none"> <li>Evidence on the strategy for SRH service and demand creation</li> </ul>	<ul style="list-style-type: none"> <li>Annual reports, Relevant studies;programme Document / TOR on-demand creation;</li> <li>UNFPA and UNICEF staffs CSO partners/members of community of practices MOH, MOECRT, Bappenas</li> </ul>	Document Review Interview with UNFPA, MoEC, implementing partners (YSSI), and direct beneficiaries (youth content creators, master teachers)
<b>Assumptions 2 :</b> Capacity building plan for implementing gender responsive SRH, including for youth and adolescence, and in the prevention of GBV and harmful practices in the BERANI's partner organizations	Evidence on : -the availability and use of data system on cases of GBV and harmful practices for analysis and policy development	MTR report Annual report 2022 Activity reports, UNFPA and UNICEF staffs, Stakeholders (P2TP2A, KUPI, Heath Units, MoWECP), IPs	Document Review Interview with programme team, stakeholders, partners, direct beneficiaries

Assumptions assessed	Indicators	Sources of information	Methods and tools for the data collection
developed/strengthened/implemented with sufficient funding	<ul style="list-style-type: none"> <li>- gender responsive SRH services, including for youth and adolescence planned, implemented, funded by the government and partners</li> <li>-availability and adoption of capacity building models and tools for the provision of health service response to GBV</li> <li>-availability of programmes and activities to prevent GBV and harmful practices (child marriage and FGM/C) developed and implemented with sufficient funding from the government and other stakeholders</li> </ul>		

#### **Efficiency: Evaluation Question 5.**

Are the means and resources being used efficiently to achieve results in terms of improved benefits for both women and LNOB groups? Have the results for women and LNOB groups been achieved at a reasonable cost, and have costs and benefits been allocated and received equitably?

<b>Assumption 1:</b> Activities within BERANI programme were implemented in timely manner and reaching the intended/target beneficiaries	Evidence showing all activities were completed and being reported in a timely manner Evidence that the activities are reaching the women and LNOB	MTR Report Annual Report UN Project team, implementing partners, direct beneficiaries	Document review, interview with UN Project team, implementing partners, direct beneficiaries
<b>Assumption 2 :</b>  BERANI's workplan with partners delivered medium-term outcomes and ensured no interrupting services or unmet demands for preventing GBV and harmful practices	Evidence showing activities to prevent GBV and harmful practices were completed and scaled out, using BERANI's budget, cost sharing, additional resources triggered from the	MTR report Annual report 2022 Activity reports, UNFPA and UNICEF staffs, Stakeholders (P2TP2A, KUPI, Heath Units, MoWECP), IPs	Document Review Interview with programme team, stakeholders, partners, direct beneficiaries

Assumptions assessed	Indicators	Sources of information	Methods and tools for the data collection
	<p>government and other stakeholders</p> <p>Evidence on prevention of GBV and harmful practices (child marriage and FGM/C) becomes the priority within the government and partners' budget</p>		
<b>Coherence: Evaluation Question 6.</b>			
What are the main comparative and collective advantages of the BERANI Joint programme, particularly in relation to other organizations operating in the country and how well were these utilized to achieve the results?			
<b>Assumption 1 :</b> BERANI joint programme has some comparative advantages in relation to other organizations in implementing SRH, ASRH, GBV, Child Marriage and FGM/interventions	<ul style="list-style-type: none"> <li>Evidence that the BERANI joint programme has some comparative advantages in relation to other organizations in implementing SRH, GBV, Child Marriage and FGM/interventions</li> </ul>	UN country strategy Annual Report MTR report	Document review Interview with project team, UNRC, Bappenas, MoH
<b>Assumption 2 :</b> UNFPA and UNICEF's collective capacity to advocate the government agencies, feminist movements and other partners to act on the prevention of GBV and harmful practices, by influencing the national and local laws and regulations to conform to new norms.	Evidence on UNFPA and UNICEF's joint initiatives offered comparative advantage strategies and tools (gender transformative models/pilots, data system) to further facilitating the implementation of national strategies, policies and regulations to prevent GBV and harmful practices at the national and sub-national level	UN country strategy Annual Report MTR report UNICEF and UNFPA staffs	Document review Interview with project team, UNRC, UNICEF and UNFPA staffs, Bappenas

Assumptions assessed	Indicators	Sources of information	Methods and tools for the data collection
<b>Assumption 3 :</b> Technical assistance and activities are carried out to fill the existing gaps in SRH, ASRH, GBV and improve SRH, ASRH and GBV services to avoid duplication and overlapping stakeholders' time and resources.	Evidence on ASRH initiatives as filling the gaps, avoid duplication and overlapping	UN country strategy Annual Report MTR report	Document review Interview with project team, UNRC, Bappenas, MoH
<b>Coherence: Evaluation Question 7.</b> To what extent did the UNFPA and UNICEF contribute to the good functioning of coordination mechanisms and to an adequate division of tasks (i.e. avoiding overlap and duplication of activities/seeking synergies) within the United Nations system?			
<b>Assumption 1 :</b> Technical assistance and activities are carried out to fill the existing gaps in SRH, ASRH, GBV and improve SRH, ASRH and GBV services to avoid duplication and overlapping across the UN system	Evidence on ASRH initiatives as filling the gaps, avoid duplication and overlapping across UN system	UN country strategy Annual Report MTR report	Document review Interview with project team, UNRC, UnWomen
<b>Assumption 2 :</b> The BERANI programme continues facilitating dialogues on the importance of preventing of GBV and harmful practices (child marriage and FGM/C) in the political and programmatic agenda at all levels.	-Technical Working Group - UNFA and UNICEF's initiatives to advocate specific issues on GBV and harmful practices (eg. in specific bill drafting on child marriage, Criminal code etc) -Data and information as well as pilots produced by the BERANI programme used as advocacy materials for integrating GBV and harmful practices' prevention in the join policy development	MTR report Annual report 2022 UNFPA and UNICEF staffs, Stakeholders	Document Review Interview with programme team, government stakeholders
<b>Sustainability: Evaluation Question 8.</b> To what extent did the programme establish mechanisms to ensure the sustainability of the programme benefits, including for women and those who left behind groups?			

Assumptions assessed	Indicators	Sources of information	Methods and tools for the data collection
<b>Assumption 1</b> Initiated programme during BERANI implementation are being replicated/scaled up through a systematic approach	<ul style="list-style-type: none"> <li>● SRH, ASRH, GBV, child marriage, and FGMC strategies are developed at local or community level</li> <li>● Evidence that initiatives are being replicated/scaled up</li> </ul>	MTR report Annual report Midwifery curriculum Supervision system/strategy documents (CSE and midwives) UNFPA staff Direct beneficiaries Activity report, module, digital content created	Document Review Interview with UNFPA, MoEC, implementing partners, and direct beneficiaries
<b>Assumption 2 :</b> Strategies, plans, and models exist that continue addressing the GBV, Child Marriage and FGM/C in the relevant government agencies and partners	Evidence on the national governments and Ips's endorsements for replications at the national and sub-national level  Evidence on continuing policy dialogues for preventing GBV and harmful practices	MTR report Annual report 2022 UNFPA and UNICEF staffs, Stakeholders	Document Review Interview with UNFPA, MoEC, implementing partners, and direct beneficiaries (local governments)

### Connectedness and Coverage: Evaluation Question 9

To what extent are the BERANI joint programme interventions and approaches to addressing Sexual Reproductive Health and Rights, Gender-based Violence (GBV) and harmful practices, youth in COVID-19 settings in line with the principles of coverage and connectedness? To what extent has the programme been inclusive of and responsive to the needs of persons with disabilities during humanitarian preparedness and response?

<b>Assumption 1.</b> The BERANI joint programme interventions helped address SRH H issues in COVID-19 settings and has been inclusive and responsive to the needs of persons with disabilities	Evidence that the needs of SRH of marginalized people and persons with disability SRH related interventions in COVID-19 settings were met	MTR report Annual report 2022 UNFPA and UNICEF staffs, Stakeholder	
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Assumptions assessed	Indicators	Sources of information	Methods and tools for the data collection
<p><b>Assumption 2.</b></p> <p>The BERANI joint programme interventions addressed GBV, Child Marriage and FGM/C issues in COVID-19 settings has demonstrated coverage, coherence and connectedness</p>	<p>Availability of data on targeted population groups participated in capacity development initiatives to prevent GBV and harmful practices within the COVID-19 Pandemics setting</p> <p>Evidence that proper actions were done to ensure accessibility of victims of GBV to quality services, especially among marginalized adolescents and youth</p> <p>Use of virtual or blended work for optimizing capacity development interventions for greater coverage within the context of COVID-19 pandemics</p>	<p>MTR report Annual report 2022 UNFPA and UNICEF staffs, Stakeholder</p> <p>Same as the above</p>	<p>Desk review, Interview with UNFPA and UNICEF staff</p> <p>Same as the above</p>
<p><b>Assumption 3.</b></p> <p>The BERANI joint programme interventions addressed SRH Issues in COVID-19 settings and has been demonstrated coverage, coherence, and connectedness</p>	<p>Evidence that affected adolescents and young people were mapped and disaggregated.</p> <p>Evidence that proper actions were done to ensure accessibility to quality ASRH, especially among marginalized adolescents and youth.</p>	<p>MTR report Annual report 2022 Minutes of cluster and sub- cluster meetings.</p>	<p>Desk review, Interview with UNFPA and UNICEF staff in charge of COVID-19 response</p>

### Annex 3

List of Stakeholders Consulted

Theme	Participants	Method
SRH	UNFPA Maternal and RH team	Online interview
	IBI	Secondary data - best practice interview
	BKKBN - Deputy of Family Planning and Reproductive Health	Secondary data - best practice interview
	Ministry of Health - Ketua Tim Penyiapan Lulusan Tenaga Kesehatan di Industri dan Dunia Kerja	Secondary data - best practice interview
	Airlangga University - Kaprodi Pendidikan Bidan	Secondary data - best practice interview
	Supervisor - IBI Jawa Timur	Secondary data - best practice interview
	Supervisee - private midwives	Secondary data - best practice interview
	Midwifery students - Airlangga University	Secondary data - best practice interview
ASRH	UNFPA Youth team	Online interview
	Yayasan Siklus Sehat Indonesia	Offline interview
	UNALA health service partners	Offline interview
	District Health Office - Sleman	Offline FGD
	Coordinator - Posyandu Remaja Satria Girimulyo	Offline interview
	Kader Remaja Posyandu Remaja Satria	Offline FGD
	CoP members	Secondary data - interview for lesson learned and best practice Secondary data - best practice interview

	KISARA	Secondary data - best practice interview
	Ministry of Education	Secondary data - best practice interview
GEWE	UNFPA Gender Team	Online interview
	UNICEF Team (Jakarta)	Online Group Interview
	UN Women, National programme Coordinator	Online Interview
	UNICEF Makassar Team	Offline Group Interview
	YSI Makassar	Offline Group Interview
	LPSDM	Online interview
	LPA	Online interview
	State Ministry of Women Empowerment	Online interview
	Health Staffs (medical doctor, midwives, nurses) and management staffs of Hospitals and Puskesmas of Bogor District	Online FGD
	Health Staffs (medical doctor, midwives, nurses) and management staffs of Hospitals and Puskesmas of Palu City	Online FGD
	Dinas of Population Control, Women Empowerment, and Social Welfare, Wajo District	Offline FGD
	Dinas of Education, Wajo District	Offline FGD
	Dinas of Village Development and Community Empowerment, Wajo District	Offline FGD
	Ministry of Religious Affairs, Wajo	Offline FGD

	District	
	Lurah, Tempe village, Wajo District	Offline FGD
	District Facilitator for LSE, Wajo District	Offline FGD
	School Facilitator for LSE, Wajo District	Offline FGD
	Teacher of BP integrating LSE, Wajo District	Offline FGD
	School Supervisor, Wajo District	Offline FGD
	Women Ulema of Wajo District	Offline FGD
	Women Prayer's Group Activities Wajo District	Observation activity of Group Prayer
	KUPI, Secretary	Online Interview
	TA for the parliament	Online Interview

## Annex 4

Data collection tools:

### **Sexual Reproductive Health and Youth**

#### Tools 1 - Target Participants: UNFPA Reproductive Health and Youth Team (Interview)

##### **Introduction**

1. What is your current position? How long have you been in this organization? Is this post specifically established for the position?
2. What are your roles in the BERANI project? Which phase of the project have you been involved?

##### **Project Design and partners selection (EQ1, EQ2)**

1. Did you involve in the BERANI project design? (phase of involvement, type of involvement, experience in project design)
2. What is your opinion towards the project design? (aims, approach, strategy, initial partners, confirm project logframe, contribution of intervention selection to achieving the goal) Is there anything that you wish were different than the initial project design?

##### **Project implementation (EQ3, EQ4, EQ5, EQ6)**

1. In general, what do you think about the project implementation? (*process, challenges, level of success, design vs implementation*)
2. Follow up on the challenges, what did the project do to overcome it? Did it work? What did you learn from it?
3. In your opinion, was there any alteration or unintended process during the project implementation? (*why? Impact of the alteration towards the project and achievement, why it was unforeseen? Partners?*)

##### **Achievement (EQ7, EQ8)**

1. In general, what do you think about this project achievement? (*likert scale? Achieved as intended? Any unintended achievement? Why is that? What are the main achievement: policy, evidence informed policy/technology, coordination and communication*)
2. In what way that the project contributed to policy changes? Any other factor?
3. What would you think of the project's sustainability? What does the factor contribute to future related project and your organization's country strategy?
4. What is the main lesson learned that you gain from the project? Is there anything that you would wish to change from the project design or implementation? Why?

## Tools 2 - Target Participants: Direct beneficiaries (youth content creators midwives, teachers)

### **Introduction**

1. Before we start our discussion, would you please let us know your name or what you prefer to be called
2. How long have you been working in your current position and in your puskesmas/school (midwives, teachers)?
3. How long have you been involved in adolescents activities (youth)

### **Context and Project Design (EQ1, EQ2)**

1. Can you tell us your opinion on the current situation of youth/adolescents in your neighborhood (working areas, school - *any priority issues? Adolescents risk behavior? Access to formal education?*)
2. In specific for reproductive health, in your opinion, what is the most priority issues among adolescents (*knowledge, false information, risk behavior, access to reproductive health behavior*)
3. In your opinion, what would be the best way to address those issues mentioned above?

### **Project implementation (EQ3 - EQ6)**

1. Have you been involved in any training or workshops related to adolescent reproductive health? Who organized the training?
2. What do you think about the training? (*benefit of receiving the training, the relevance with issues you have expressed before, how it is in line with the local strategies - for midwives and teachers*)?
3. What is lacking in the capacity building you have received? What would you expect differently?
4. Following the capacity building, what are the follow up/activities that you have conducted? (*Target participants, materials delivered, approach you used to deliver the message?*)
5. How satisfied are you with the activities conducted? Were the activities well-received by the participants (adolescents, students)?
6. Did you get all the support you need to effectively implement the intended activities? What kind of support you received and not received, from who?

### **Achievements and Results (EQ7- EQ9)**

1. In general, what do you think the activities have achieved? (*for yourself, target audiences, non-direct beneficiaries*)
2. Would you continue the current activities? If yes, what kind of supports you need to continue to implement the project? How would you do the approach differently based on your lesson learned?

## Tools 3: UNRCO

### **Introduction**

1. What is your current position? How long have you been in this organization? Can you tell us a little about your roles?

### **Project Coherence with UN-Country Strategy (EQ1, EQ6, EQ7)**

1. Can you tell us the goals with the UN country strategy on reproductive health and adolescents?
2. Can you tell us the main UN programmes within those issues (*UN agencies implement the programme, single or multiple UN agencies, ways of working?*)
3. To the extent of your knowledge, what is the role of UNFPA within those issues? Are you familiar with any UNFPA programme related to those issues? How about BERANI?
4. In your opinion, what are the comparative advantages of BERANI within the UN system? How about its contribution to the collective advantages?

### **Coordination**

1. What is the role of UNRCO in a multi-UN agencies programme, like BERANI?
2. Have you been involved in any stage of BERANI project? What do you know about the project?
3. In the future, do you see UNRC roles in multi-agencies project? What would you (in your role) to ensure coordination and coherence across UN agencies programmes that might be overlapped?

## Tools 4 - Target Participants: Government Stakeholders

### **Introduction**

1. What is your current position? How long have you been in this organization and position?
2. What is the role of your institution in the field of SRHR and adolescence?

### **Context and Project Relevance (EQ1, EQ2)**

1. Can you tell us your opinion on the current situation of SRHR, and youth/adolescents in Indonesia? (*any priority issues? Risky behavior, access to service, quality of service? Supply management - for Family Planning*)
2. In your opinion, what would be the best way to address those issues mentioned above?
3. Can you tell us the main/most significant programmes or policies in your ministries/agencies in responding to sexual reproductive health, adolescents and GBV

- (underlying reason in formulating the programme/policy? Time of endorsement and implementation, ministries and partners supported the programme?)
4. What are the challenges in implementing those policies and programmes? Is there any collaboration with UN agencies, in specific, UNFPA in addressing those challenges?
  5. Have you been involved in SRHR, youth and FP project implemented or supported by UNFPA? At what stage are you involved? What is your opinion towards the project?
  6. What do you think about the project synergy with the government's priority? What do you expect to be done differently to support the government's effort?

### **Project Contribution/Achievement (EQ5, EQ6)**

1. In your opinion, what does the project contribute the most to the current government priorities in SRHR/FP/youth?
2. How satisfied are you with the project contribution? Any aspect that you wish to be designed or implemented differently?
3. In your opinion, what can your institution take from the BERANI project/UNFPA programme in SRHR, adolescent and FP?
4. Is there any advice/direction that you want to express for future UNFPA project in SRHR, adolescent and FP?

### **Gender Equality and Women Empowerment**

#### Tools 1 - Target Participants: UNFPA Gender Team

#### **Introduction (Q1, Q 2, Q3, Q 4)**

1. As both of you were part of key informants during the MTR and involved in the design of the BERANI programme, can we start out discussion with the progress of outstanding activities indicated in the MTR Report and how much you have follow up the MTR's recommendations
2. Have you found any challenges in completing the outstanding activities/issues? How do you overcome the challenges? Any lessons from that process?
3. Have there been any modification or alterations or unintended process during the project implementation, which you would like to share? Why ? What have been the lessons?

#### **Achievement (EQ7, EQ8)**

1. Adding up with achievements of the implementation/completion of the outstanding activities into the results from the MTR, in general, what do you think about this overall project achievement, in GEWE? Explain about the intended, the unintended achievements. *What are the main achievement: policy, evidence informed policy/technology, coordination and communication*
2. What significant changes have you recorded from the GEWE's initiatives ?
3. In what way did the project contribute to policy changes? Any other factor?

4. What would you think of the project's sustainability? What factors contribute to the future related project (BERANI 2)? To UNFPA/UNICEF's organization's country strategy?
5. What is the main lesson learned that you gain from the project? Is there anything that you would wish to change from the project design or implementation? Why?

**Tools 2 - Target Participants: UNICEF Team (National)**

**Introduction (Q1, Q 2, Q3, Q 4)**

1. What is your current position? How long have you been in this organization? Is this post specifically established for the position?
2. What are your roles in the BERANI project? Which phase of the project have you been involved in?

**Project Design and partners selection (EQ1, EQ2)**

3. What is your opinion towards the project design? (purposes, approach, strategy, initial partners, confirm project logframe, contribution of intervention selection to achieving the goal) Is there anything that you wish were different than the initial project design?

All project's activities were completed during the MTR. No questions about the implementation of the project. Questions are only related to the learning from the potential future design

**Tools 3 - Target Participants : UNICEF Team (Provincial/District)**

**Introduction**

As both of you were part of key informants during the MTR, questions will focus on how you follow up outstanding issues outlined in the MTR Report

- a. What have you done in following up findings and recommendations from the MTR Report?
- b. What have been the results?
- c. Have you found any challenges in completing the outstanding issues with regard to coordination and alignment between the pilot activity of UNICEF and UNFPA on the prevention of child marriage? How do you overcome the challenges? Any lessons from that process?
- d. Have there been any modification or alterations or unintended process during the project implementation, which you would like to share? Why ? What have been the lessons?

### **Achievement (EQ7, EQ8)**

1. Adding up with achievements of the implementation/completion of the outstanding activities into the results from the MTR, in general, what do you think about this overall project achievement, in the LSI and the prevention of child marriage? Explain about the intended, the unintended achievements. *What are the main achievement: policy, evidence informed policy/technology, coordination and communication*)
2. What significant changes have you recorded from the LSE and the prevention of child marriage pilot's initiatives ?
3. In what way did the project contribute to policy changes? Any other factor?
4. What would you think of the project's sustainability and replication? What factors contribute to the future related project (BERANI 2)? To UNICEF's organization's country strategy?
5. What is the main lesson learned that you gain from the project? Is there anything that you would wish to change from the project design or implementation? Why?

### Tools 4 - Target Participants : Direct Beneficiaries (LSE Facilitators, Teachers)

#### **Introduction**

1. Before we start our discussion, would you please let us know your name or what you prefer to be called
2. How long have you been working in your current position and in your school?
3. How long have you been involved in the LSE initiatives?

#### **Context and Project Design (EQ1, EQ2)**

1. Can you tell us your opinion on the current situation of adolescents , girls and boys in your neighborhood (working areas, school - *any priority issues? Adolescents risk behaviour? Access to formal education, gender issues, social exclusions, pluralism?*)
2. In specific for sexual reproductive health and menstrual hygiene, in your opinion, what is the most priority issues among adolescents (*knowledge, false information, risk behaviour, access to reproductive health behaviour*)
3. In your opinion, what would be the best way to address those issues mentioned above?

#### **Project implementation (EQ3 - EQ6)**

1. Have you been involved in any training/facilitating discussions related to LSE activities? To be the trainer/facilitators, did you receive any training?
2. What do you think about the training? (*benefit of receiving the training, the relevance with issues you have expressed before, how it is in line with the local strategies - for facilitators and teachers?*)

3. What is lacking in the capacity building you have received? What would you expect differently?
4. Following the capacity building, what are the follow up/activities that you have conducted? (*Target participants, materials delivered, approach you used to deliver the message?*)
5. How satisfied are you with the activities conducted? Were the activities well-received by the participants (adolescents, students)?
6. Did you get all the support you need to effectively implement the intended activities? What kind of support you received and not received, from who?

### **Achievements and Results (EQ7- EQ9)**

1. In general, what do you think the activities have achieved? (*for yourself, target audiences, non-direct beneficiaries*)
2. *Among target audiences, boys and girls, do you find any differences, in terms of results by gender? Any significant changes of values you have recorded?*
3. Would you continue the current activities? If yes, what kind of supports you need to continue to implement the project? How would you do the approach differently based on your lesson learned?

### **Tools 5 - Target Participant : Direct Beneficiaries (KUPI)**

#### **Introduction**

1. As you were part of key informants during the MTR of BERANI programme, can we start out discussion with the progress of outstanding activities indicated in the MTR Report and how much you have follow up the MTR's recommendations with regard to the KUP's conference
2. Have you found any challenges in completing the outstanding activities/issues? How do you overcome the challenges? Any lessons from that process?
3. Have there been any modification or alterations or unintended process during the project implementation, which you would like to share? Why ? What have been the lessons?

#### **Achievement and Results (EQ7, EQ8)**

4. Adding up with achievements of the implementation/completion of the outstanding activities into the results from the MTR, in general, what do you think about this overall project achievement, in GEWE? Explain about the intended, the unintended achievements. *What are the main achievement: policy, evidence informed policy/technology, coordination and communication)*

5. What significant changes have you recorded from the prevention of FGM/C initiatives?
6. What lessons have you taken from the work to engage with female, male and youth ulemas, and the non-violence culture groups?
7. In what way did the project contribute to policy changes? Any other factor?

## **Sustainability**

7. What would you think of the project's sustainability? What factors contribute to the future related project? What is the main lesson learned that you gain from the project? Is there anything that you would wish to change from the project design or implementation? Why?
8. Did you get all the support you need to effectively implement the intended activities? What kind of support you received and not received, from who?

## **Tool 6 - Target Participants: Implementing Partners (LPA – LPDSM – North Lombok)**

### **Introduction**

1. Before we start our discussion, would you please let us know your name or what you prefer to be called
2. How long have you been working in your current position and in your school?
3. How long have you been involved in the LSE initiatives?

### **Context and Project Design (EQ1, EQ2)**

1. Can you tell us your opinion on the current situation of adolescents , girls and boys in your neighborhood (working areas, school - *any priority issues? Adolescents risk behaviour? Access to formal education, gender issues, social exclusions, pluralism?*)
2. In specific for GBV and harmful practices, what is the most priority issues among adolescents (*knowledge, false information, risk behaviour, access to reproductive health behaviour*)
3. In your opinion, what would be the best way to address those issues mentioned above?
4. How the BERANI programme contribute to objectives and mandates of your organization

### **Project implementation (EQ3 - EQ6)**

1. What/how you involved in the BERANI Project? What approach and methodology that have been used to implement your collaboration with the Project?
2. What do you think about the initiatives ? (*benefit of receiving the support, the relevance with issues you have expressed before, how it is in line with the local strategies - for facilitating the community, families, youth, girls and boys?*)

3. What is lacking in the collaboration you have worked with BERANI? What would you expect differently?
4. Following the initiatives you have collaborated with BERANI, what are the follow up/activities that you have conducted? (*Target participants, materials delivered, approach you used to deliver the message?*)
5. How satisfied are you with the activities conducted? Were the activities well-received by the participants (community, families, youth, religious groups)?
6. Did you get all the support you need to effectively implement the intended activities? What kind of support you received and not received, from who?

### **Achievements and Results (EQ7- EQ9)**

1. In general, what do you think the activities have achieved? (*for yourself, target audiences, non-direct beneficiaries*). *What significant changes were the initiatives produced/recoded?*
2. *Among target audiences, families (females and males) and youth ( boys and girls), do you find any differences, in terms of results by gender?*
3. Would you continue the current activities? If yes, what kind of support do you need to continue to implement the project? How would you do the approach differently based on your Lesson learned?

## **Tool 8 Target Participants : Local Government of South Sulawesi Province dan Wajo District**

### **Introduction**

1. What is your current position? How long have you been in this organization and position?
2. What is the role of your institution in the field of GBV and Harmful Practices (Child marriage and FGM/C)?

### **Context and Project Relevance (EQ1, EQ2)**

1. Can you tell us your opinion on the current situation of GBV and harmful practices as in South Sulawesi District? (*any priority issues? Risky behavior, access to service, quality of service? Supply of the services?*)
2. In your opinion, what would be the best way to address those issues mentioned above?
3. Can you tell us the main/most significant programmes or policies in your agency in responding to GBV (underlying reason in formulating the programme/policy? Time of endorsement and implementation, ministries and partners supported the programme?)

4. What are the challenges in implementing those policies and programmes? Is there any collaboration with UN agencies, in specific, UNFPA in addressing those challenges?
5. Have you been involved in GBV and harmful practices project implemented or supported by UNFPA? At what stage are you involved? What is your opinion towards the project?
6. What do you think about the project synergy with the government's priority? What do you expect to be done differently to support the government's effort?

### **Project Contribution/Achievement (EQ5, EQ6)**

1. In your opinion, what does the project contribute the most to the current government priorities in GBV and harmful practices?
2. How satisfied are you with the project contribution? Any aspect that you wish to be designed or implemented differently?
3. In your opinion, what can your institution take from the BERANI project/UNFPA/UNICEF programme in GBV and harmful practices
4. Is there any advice/direction that you want to express for future UNFPA/UNICEF project in GBV and harmful practices?

How do you see the replication of the initiatives on LSE and the Prevention of Child marriage to other districts, such as Wajo and North Luwu? Why do you think such replications are happening? What are the positive of the model so that the Prov Government of S Sulawesi

Tool : 9 Target Participant : UNWomen

### **Introduction**

1. What is your current position? How long have you been in this organization? Can you tell us a little about your roles?

### **Project Coherence with UN-Country Strategy (EQ1, EQ6, EQ7)**

1. Can you tell us the goals with the UN country strategy on the prevention of GBV and harmful practices (child marriage and FGM/C)
2. To the extent of your knowledge, what is the role of UNFPA within those issues? Are you familiar with any UNFPA programme related to those issues? How about BERANI?
3. In your opinion, what are the comparative advantages of BERANI within the UN system? How about its contribution to the collective advantages?
4. In the future, how do you see UNWomen roles in multi-agencies project? In what way? What collective comparative advantage would you see by participation in the future BERANI Joint programme?

### **Coordination**

5. What would you do (in your role) to ensure coordination and coherence across UN agencies programmes that might be overlapped?

## EVALUATION QUESTIONS FOR GBV, CHILD MARRIAGE AND FGM/C

### EFFICIENCY CRITERIA

***EQ1. To what extent was the BERANI joint programme support of the country programme able to (i) address the various needs of the population, including vulnerable and marginalized groups, as well as people with disabilities; (ii) align with government priorities; and (iii) respond to changes in the national development, including COVID-19 contexts, during its period of implementation?***

Have the needs of vulnerable and marginalized women and girls and those with disabilities to be free and protected from GBV and harmful practices been incorporated in and responded to the BERANI joint programme ?

***Have the outputs and outcomes of the BERANI joint programme been in line with the GoI priorities, SDG5, and the ICPD and other international commitments ?***

Have the BERANI strategic interventions responded to the national needs and priorities of women, girls and vulnerable women during the COVID-19 contexts ?

Have the BERANI increased the capacity of duty barriers to produce and implement policies and programmes and to coordinate, to address the prevention of GBVs and Harmful Practices (Child Marriage and FGM/C) in Indonesia ?

***EQ2. To what extent have the expected outputs of the BERANI joint programme been achieved in the development, including in responding to COVID-19 situation? Likewise, to what extent have these outputs contributed to the achievements of the outcomes of the BERANI joint programme? What were the factors that influenced the achievement and/or the non-achievement of the results?***

Have the BERANI increased the capacity of duty barriers to produce and implement policies and programmes, and to coordinate addressing the prevention of GBVs and Harmful Practices (Child Marriage and FGM/C), which lead to the formation and adoptions of new behaviour, practices, and values during the COVID-19 pandemics.

Have the BERANI's initiatives and resources have promoted gender equality and women empowerment, to deliver gender equality results in both core initiatives and in the COVID-19 pandemics contexts.

***EQ3 To what extent has the BERANI programme delivered Gender Equality results at all levels (making long term sustainable transformative changes for women and girls that address the root causes of gender inequalities with regard to rights, decision-making and access/control of resources)?***

Have the BERANI's initiatives and resources have leveraged and developed a more integrated approach of expertise in sexual and reproductive health and reproductive rights, including for youth and adolescence

and for stopping GBV and harmful practices (child marriage and FGM/C) focusing on strengthening social norm change work and gender-transformative approaches to deliver significant and long term changes.

Have stakeholders and beneficiaries of the BERANI joint programme received the human, financial and administrative resources as planned and accountable, in economical, quality and timely manner, including to respond to the context of COVID-19 pandemics.

#### EFFICIENCY CRITERIA

***EQ4. To what extent has the BERANI joint programme made good use of its human, financial and administrative resources, and used an appropriate combination of tools to demonstrate accountability to stakeholders and pursue the achievement of the outcomes defined in the BERANI project document in a timely manner?***

Have the stakeholders and beneficiaries of the BERANI joint programme received the human, financial and administrative resources as planned and accountable, in economical, quality and timely manner, including to respond to the context of COVID-19 pandemics.

Have the stakeholders and beneficiaries of the BERANI joint programme received the human, financial and administrative resources as planned and accountable, in economical, quality and timely manner, including to respond to the context of COVID-19 pandemics.

Has the BERANI used appropriate combination of tools to achieve GBV, Child Marriage and FGM/C to contribute to results in a timely manner

***EQ5. What are the main comparative advantages of the BERANI joint programme, particularly in relation to other organizations operating in the country and how well were these utilized to achieve the results?***

Has the BERANI joint programme had some comparative advantages in relation to other organizations in implementing GBV, Child Marriage and FGM/interventions

Has the main comparative advantages of the BERANI programme been well utilized to achieve its results

#### SUSTAINABILITY CRITERIA

***EQ6. To what extent has the BERANI joint programme been able to support implementing partners and beneficiaries (rights-holders), in developing capacities and establishing mechanisms to address the challenges to ensure ownership and the durability of effects?***

Have capacities of IPs and beneficiaries been improved by the BERANI joint programme in following through addressing GBV, Child Marriage and FGM/ challenges they face, including in respond to COVID-19 pandemics

Have Implementing Partners of the BERANI had sustainability strategies and plan in place

***EQ7. To what extent has the UNFPA and UNICEF established, maintained and leveraged different types of partnerships to utilize UNFPA's and UNICEF's comparative strengths to achieve the outputs and outcomes of the BERANI joint programme?***

Has the BERANI Joint programme achieved the GBV, Child Marriage and FGM/C related outputs and outcomes of different types of partnerships and adequately utilized UNFPA's and UNICEF's comparative strengths

#### COORDINATION CRITERIA

***EQ8. To what extent did the UNFPA and UNICEF contribute to the good functioning of coordination mechanisms and to an adequate division of tasks (i.e. avoiding overlap and duplication of activities/seeking synergies) within the United Nations system?***

Have the UNFPA and UNICEF mandates addressed GBV, child marriage and FGM/C and incorporated into BERANI's strategies and activities

Have the UNFPA and UNICEF had a clear division of tasks within the United Nations system in the GBV, Child Marriage and FGM/C areas from the beginning of the joint programme to avoid overlap and duplication of activities

Have mechanisms for coordination on GEWE mandates been in place within the UNFPA, UNICEF, and GAC

Have Technical Working Groups effectively operated

#### COVERAGE AND CONNECTEDNESS (INCLUDING RESPONSES TO COVID-19) CRITERIA

***EQ9. To what extent are the BERANI joint programme interventions and approaches to addressing Sexual Reproductive Health and Rights (R), Gender-based Violence (GBV) and harmful practices, youth in COVID-19 settings in line with the principles of coverage, coherence and connectedness? To what extent has the programme been inclusive of and responsive to the needs of persons with disabilities?***

Has the BERANI joint programme interventions addressed GBV, Child Marriage and FGM/C issues in COVID-19 settings

On principles of coverage, has the the BERANI joint programme made available data to measure the extent to which targeted population groups facing COVID-19 Pandemics were reached by the Joint programme

On the connectedness, has there been linkages between the BERANI's response and the COVID-19 pandemics' phase

## Annex 5

List of Regulations Produced in the Prevention of Child Marriage.

### **South Sulawesi Provincial's Regulations**

- Regional Regulation of South Sulawesi Province, Number 4 of 2013 concerning Child Protection System, Article 7: Responsibilities and Community Participation; and Article 9 Responsibilities of Parents, one of which is to protect and prevent, and not to allow child marriage to occur
- Regulation of the Governor of South Sulawesi, Number: 80/2018 concerning the Implementation of Regional Regulation No. 4/ 2013 concerning SPA, Article 14: Development of family resilience programmes, and facilitating the development of community-based child protection systems through strengthening and changing norms, improving life skills, and responding to child violence.
- South Sulawesi Governor Instruction Number 1 of 2018 concerning Stop Child Marriage in South Sulawesi.
- Road Map on Prevention of Child Marriage in South Sulawesi for 2019-2023.
- Regulation of the Governor of South Sulawesi, Number: 31 of 2021, concerning the Regional Strategy for the Prevention of Child Marriage (STRADA PPA), supported by AIPJ.
- Regional Action Plans for the Prevention of Child Marriage - ongoing.
- Joint Movement Activities (Geber) Prevention of Child Marriage
- Joint Movement for Marriage Education for Child Welfare in South Sulawesi in 2021
- Integrity Pact on Prevention of Child Marriage by the Regional Secretary, DPRD Sulsel, related OPD Leaders and Provincial Structural Institutions, Regents/Mayors of 12 Regencies/Cities and Development Partners/Community Organizations in South Sulawesi in 2021.
- Governor's Decree No. 177/I/2022 concerning the establishment of a communication forum for the prevention of child marriage.

### **Bone District's Policies and Regulations.**

4 Circular Letters have been disseminated to support LSE implementation and child marriage prevention. The circular letters are below:

Circular Letter of Bupati Bone on Appointment Schools for LSE Implementation.

Circular Letter of Department of Education Bone on additional 2 hours for LSE

Circular Letter of Kemenag Bone to support campaign of Child Marriage Prevention in Madrasah.

Circular Letter of Bupati Bone about Effort to Improve Public Health

### **Peraturan Bupati or Perpub (District Head Decree) for LSE implementation**

The regular meeting to discuss the Draft of Perpub regarding the implementation of life skills education was conducted in August and November 2020. Through the Perpub, it's expected that many students in Bone will get more benefits from life skills education. Perhaps, LSE will be

recorded on Data Pokok Pendidikan or Dapodik (Basic Education Data) in the future. The draft of Perpub is currently in the finalization process in the Law department.

- Village Regulation (PERDES)

To support the advocacy on child marriage prevention through village regulation, the coordination meeting was conducted on 25 August 2020. 5 Village regulations in 5 intervention villages have been established and socialized to the community. 1 Village is currently on finalization processes which are currently under review of the village council (Badan Permusyawaratan Desa, BPD) of Bone.

- - Village Regulation (PERDES) Malimongeng No. 03/2020
- - Village Regulation (PERDES) Lamuru No. 06/2020
- - Village Regulation (PERDES) Lilina Ajangale No. 06/2020
- - Village Regulation (PERDES) Cumpiga No. 07/2020
- - Village Regulation (PERDES) Abbumpungeng No. 03/2020
- - Village Regulation (PERDES) Welado No. 11/ 2022

- Regional Strategy (Strategi Daerah, STRADA)

The action plan after coordination meeting with local stakeholders regarding STRADA for prevention and management of child marriage in Bone District will be finalized by Bappeda to be recorded on the decree.

- Local Regulation (PERDA)

Local Regulation regarding child marriage prevention and management in Bone District has been initiated by Bone Regional House of People's Representative Council to be drafted in 2021.

### **Wajo District's Policies and Regulations**

- Bupati Regulation for Preventing Child Marriage of Wajo District,
- Costing Analysis Report
- Mechanisms for Preventing and Handiing Child Marriage.

### **North Lombok District of Nusa Tenggara Province**

- District Regulation on the Prevention of GBV and Harmful Practices
- 8 village regulations in North Lombok, including 2 (two) Village Regulation on 1) GBV Prevention (Tenige Village) and 2) Child Marriage (Tanjung Village)

## Annex 6. List of People Interviewed

No	Name	M/F	Title	Institution
1	Woro Srihastuti Sulistyaningrum, ST, MIDS	F	Director, Family Development – Women, Children, Youth and Sports	KPAPO/BAPPENAS
2	Yosi Diani Trisna	F	Head of Division, Women Empowerment and Child Protection	KPAPO/BAPPENAS
3	Sari Narulita	F	Chair	The Indonesian Women Ulema Network, KUPI
4	Samidjo	M	Consultant – BGV SRH support to Parliamentarian	Consultant of UNFPA
5	Dwi Yuliawati Faiz	F		UN Women
6	Sylvia Manengkey	F	Health Staf	PKM Pantoloan, Palu
7	Eli	F	Midwife	Puskesmas Ciawi, Bogor
8	Fatmawati	F	Nurse	
9	Rusyepi Maspaitella	F	Medical Doctor	Palu
10	Rizkawanti Abram	F	Midwife	Puskesmas Bulli, Pal

11	Sandita A Sobe	F	Midwife	Puskesmas Sangurara, Palu
12	Sri Sugiyanti	F	Midwife	RSUD Cibinong, Bogor
13	MK Wiwik	F	Midwife	Puskesmas Leuwiliang, Kabupaten Bogor
14	Helmi Adam	M	Manager	
15	Ita Rosita	F	Medical Doctor	RSUD Bogor, Kabupaten Bogor
16	Ratu Qurroh Ain	F	Midwife	Health service point, Bogor
17	Dr. Annisa Rahmah,	F	Medical Doctor	RS Antapura, Palu
18	Ellyana	F	Staff	District Health Unit Kabupaten Bogor
19	Sulistyawati	F	Staff	City's Health Unit, City of Palu
20	Dipta	F	Midwife	Puskesmas Ciawi, Kabupaten Bogor
21	Dr Azzahra Zeaputri Z, PK	F	Medical Doctor	Puskesmas Leuwiliang

22	Musmarina	F	Midwife	RS Bhayangkara Palu
23	Leni	F	Midwife	Health service point, Bogor
24	Nina Nurul	F	Midwife	Puskesmas Cimandala, Bogor
25	Mila Karmila	F	Nurse	RSU Leuwiliang, Bogor
26	Dr Desanti	F	Medical Doctor	Health service point, Bogor
27	Amasil	F	Midwife	Health service point, Bogor
28	Andi Ika Yudikartika	F	Teacher	SMPN 1 Majauleng
29	Agung Setyawan	F	Teacher	SMPN 1 Majauleng
30	Libertine Spd	F	Teacher	SMPN 2 Mamangpijo
31	Ika Indrawaty	F	Teacher	SMPN 2 Mamangpijo
32	Abidin	M	Head of Division	Dinas of Education Kabupaten Wajo
33	Nurjannah	F	Head of Division : Human Resource – Teachers	Dinas of Education Kabupaten Wajo

34	Najmiah	F	Head of Section	Dinas of Education Kabpuaten Wajo
35	Putu Ayu Widhi Lestari	FF	Child Protection Consultant (BERANI) -	UNICEF
36	Dr Sarifa Halijah	F	Ustadzah	
37	Ahmad Jahran	M	Head	DinsosPKBPPA
38	Prawati Perosi	F	Head of Division	DKK Kab Wajo
39	Rahmawati	F	Head of Divison	Balitbangda
40	Andi Suba	M	Head of Division	Dinas PMD
41	A Asmira	F	Lurah	Kelurahan Tempe
42	Muhammad Adam	M	Head of Division	Ministry of Religious Affairs
43	Rohika Kurniadi Sari Sh, MSI	F	Assistant to the Deputy for Child Protection	MoWECP
44	Ririen Hajudiani	F	Director	Lembaga Pengembangan Sumber Daya Mitra (LPSDM )
45	Sukmayanti	F	Ketua Divisi Organisasi	Lembaga Perlindungan Anak (LPA) Lombok

46	Nurcahyo Waskito	M	GEWE Unit	UNFPA
47	Risya Aryani Kori	F	GEWE Unit	UNFPA
48	Tristiana UNICEF Amelia,	F	Child Protection Consultant	UNICEF
49	Farida Aryani	F	Consultant, LSE Design	YIM Makassar
50	Yori Novrianto	M	UNFPA M&E analyst	UNFPA
51	Samuel Olam	M	Coordinator of BERANI	UNFPA
52	Muhammad Zubedi Koteng	M	Child Protection Coordinator	UNICEF
53	Fauzia Firdanisa	F	Child Protection Officer	UNICEF
54	Erlangga Agustino Landiyanto	M	Development Coordinator	UNRC