General Information

Fund	MPTF_00209: UN COVID-19 MPTF
Title	Funding: Promoting innovative service provision models to support the health system response to Covid-19
MPTFO Project Id	
Start Date	
End Date	

Contacts

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Description

This joint programme proposal aims to promote innovative service provision models that will facilitate uninterrupted access to essential health services among vulnerable groups while supporting the health system response to Covid-19 in Turkey. These innovative models are deploying mobile health units in the field and piloting telemedicine in primary health facilities.

The joint programme proposal is composed of three interconnected Components:

Component 1. Mobile health for efficient service delivery among vulnerable population: Appropriate Covid-19 prevention, surveillance, detection, filiation and referral services are provided via Mobile Health Units (MHUs) in two selected provinces.

Component 2. Telemedicine for increased access and coverage of services: A Telemedicine service delivery platfom is piloted in primary health care facilties to increase access to services among vulnerable populations**.**

Component 3. Enhanced Risk communication: Persons in need are able to access the protection services either physically or remotely, including COVID-19 specific awareness raising activities and GBV response interventions.

The joint programme addresses continuous vulnerable populations such as the elderly, refugees, irregular or seasonal migrants and people with specific needs, such as pregnant and lactating mothers, people with disabilities, people with or at the risk of getting chronic/non-communicable diseases, HIV/AIDS; and GBV survivors.

Universal Markers

Gender Equality Marker	Risk	OECD-DAC
• GEM3 - GEWE is the principal objective of the Key Activity	• Low Risk	

<table>
<tr><td rowspan="4">Fund Specific Markers</td><td>Fund Windows</td><td colspan="4">Fund Windows
• Window 1: Enable Governments and Communities to Tackle the Emergency</td></tr>
<tr><td>Human Rights Based Approach to COVID19 Response</td><td colspan="4">HRBA integrated
• Yes</td></tr>
<tr><td>Primary Socio-Economic Pillars</td><td colspan="4">Pillars
• Pillar 1: Health First</td></tr>
<tr><td>Concept Note Type</td><td colspan="4">Type
• Funding</td></tr>
<tr><td rowspan="2">Geographical Scope</td><td>Geographical Scope</td><td colspan="2">Name of the Region</td><td>Region(s)</td><td>Country(ies)</td></tr>
<tr><td>• Regional</td><td colspan="2"></td><td>• Asia</td><td>• Turkey</td></tr>
<tr><td rowspan="2">Participating Organizations and their Implementing Partners</td><td>Participating Organizations</td><td>NGOs</td><td>New Entities</td><td colspan="2">Implementing Partners</td></tr>
<tr><td>• UNFPA
• WHO</td><td></td><td>Other</td><td colspan="2">UNHCR: Key
implementing partner and the Co-financier of the UN Joint Programme
Ministry of Health: partner institution Ministry of Family, Labour
and Social Services: partner
institution</td></tr>
<tr><td rowspan="3">Programme and Project Cost</td><td>Budget</td><td>Agency</td><td>Amount</td><td colspan="2">Comments</td></tr>
<tr><td>Budget Requested</td><td></td><td>$1,000,000</td><td colspan="2"></td></tr>
<tr><td>Total</td><td></td><td>$1,000,000</td><td colspan="2"></td></tr>
<tr><td>Keywords</td><td colspan="5"></td></tr>
<tr><td rowspan="3">Programme Duration</td><td>Anticipated Start Date</td><td colspan="4">Oct 01, 2020</td></tr>
<tr><td>Duration (In months)</td><td colspan="4">14</td></tr>
<tr><td>Anticipated End Date</td><td colspan="4">Dec 01, 2021</td></tr>
</table>

Comments

From: Olga Aleshina <olga.aleshina@undp.org>
Sent: Tuesday, January 19, 2021 7:24 AM
To: Alvaro Rodriguez <alvaro.rodriguez@un.org>
Cc: Jens Christian Wandel <jens.wandel@un.org>; Tom Delrue <delrue@un.org>; Bulent Acikgoz <bulent.acikgoz@un.org>; Eser Pirgan <eser.pirgan@un.org>
Subject: Re: COVID 19 MPTF - (UNFPA, WHO, UNHCR Joint Programme Proposal)

Dear Alvaro,

Hope this note finds you well. I am replying to your email on behalf of Jens.

The grant management system designed to support MPTFs follows the definition of RUNO, as per the MOU, as a UN organization that receives funds through the COVID-19 fund and assumes programmatic and financial accountability for those funds received under the COVID-19 MPTF. As per MPTF Office procedures, Organizations that do not receive funds can thus technically/legalistically not be called Recipient UN Organizations. The option of USD 2,000 transfer fell short of the UNDG guidelines on transfers (min USD 100,000).

We fully understand and appreciate the UNCHR concern. A clearer mention of agencies co-financing the programmes in the grants management system and in the cover page of the ProDoc may help but the system is what it is right now.

From the Secretariat side we will be happy to have UNCHR:

- Clearly described in the narrative part of the ProDoc as a co-funder of this programme
- Have them sign the ProDoc (the signature page could be customized)
- Recognize efforts of UNHCR, while not directly funded under the COVID-19 MPTF, in the narrative reporting (country level and global reports). Please note the MPTF Office won't be able to include UN organizations that did not receive funding in financial reporting/statements.
- Recognize UNHCR in other visibility opportunities

We are also exploring if creating a USD 1 budget in the system will get the UNCHR in the cover page of the ProDoc in the System as RUNO. But this option may not be acceptable to MPTF Office, given the definition of RUNOs they strictly follow.

Kind regards, Jens

From: Alvaro Rodriguez <alvaro.rodriguez@un.org>
Sent: Friday, January 15, 2021 1:45 PM
To: Jens Christian Wandel <jens.wandel@un.org>; Olga Aleshina <olga.aleshina@undp.org>
Cc: Tom Delrue <tom.delrue@one.un.org>; bulent.acikgoz@un.org; eser.pirgan@un.org
Subject: COVID 19 MPTF - (UNFPA, WHO, UNHCR Joint Programme Proposal)

Dear Jens and Olga,

Greetings from a windy and snowy Ankara!

As you may be aware, Turkey has been requested to prepare the UNJP proposal on Promoting innovative service provision models to support the health system response to Covid-19 (MPTF_00209_00211) a joint initiative by UNFPA, WHO and UNHCR, a process currently being undertaken.

	Within the UNJP proposal, UNHCR was committed to contribute actively to the components of the UNJP and provide staffing and resources to lead on some of the activities. Based on this positioning of the UNHCR, we asked MPTFO whether UNHCR could be a PUNO based on the conditions that (i) it requests zero-funding for its contributions for the implementation of the UNJP and (ii) no fund transfers will take place from UNFPA/WHO to UNHCR during the implementation. In response to this inquiry, we were advised by the MPTF Office that "from a programmatic point of view, UNHCR could be a PUNO (based on the two conditions we have pointed out above - which could be outlined for clarity in the prodoc) and could appear in the ProDoc and Annual Reports." Based on this guidance and in line with the scope of the UNJP, UNFPA and WHO designed their activities and shared the budget of the UNJP, where no budget was associated with the UNHCR activities/commitments. After submission of the first stage of our proposal, the MPTF office informed us that the each PUNO should have at least 100.000 USD out of the overall UNJP budget – which is an information that wasn't available in the guidelines and/or communicated with us at earlier stages of the UNJP design process. The MPTF Office suggests that instead of a PUNO, UNHCR can be positioned as "implementing partner and co-financier" of the UNJP. Through this option, UNHCR will not be considered as a PUNO and its status in the UNJP will not be the same with UNFPA and WHO with respect to visibility at the HQ levels, communication of the UNJP, existence in global catalogues, visibility with government, etc, etc. Indeed, this option is not welcomed by UNHCR, as they want to be at the same level with the other two Agencies. **Based on our discussion with the PUNOs today on the way forward; UNHCR would like to seek at the MPTF senior management level whether it would still be possible for the UNHCR to be treated as PUNO as same as the UNFPA and the WHO at least with respect to visibility/communication and recognition globally? Would this be acceptable?** Looking forward to your consideration. With warmest regards. Alvaro

Narratives

Title	Text	Comments

CN_I. What is the specific need/problem the intervention seeks to address? Summarize the problem. Apply a gender lens to the analysis and description of the problem. Be explicit on who has established the need (plans, national authorities, civil society, UN own analysis, or citizens).

The Covid-19 pandemic crisis has stretched even the strongest health systems around the world. Besides the health challenge posed by the pandemic itself, the pressure of containing the disease through routine testing, contact tracing, isolation, quarantine and treatment procedures puts a strain on health care systems that may affect its capacity to provide other essential health services effectively. As the country responds to COVID 19, there has been reduced access to available essential health services due to the prioritization of mitigation/distancing measures for Covid-19 cases in health facilities; and on the other hand, fear of infection and a reluctance to visit health facilities, specifically among vulnerable groups, such as elderly, people with comorbidities, and refugees and migrants -largely because of language barriers and health insurance coverage- and a general lack of physical access for those living remotely and to regular and updated information on service delivery during Covid-19. These barriers have negatively impacted the demand and utilization of essential services, such as vaccination, treatment of non-communicable diseases, safe motherhood, antenatal and postnatal care and sexual and reproductive health (SRH).

As of August 29, Turkey has reported 267,064 cases and 6284 deaths, while 917 patients were seriously ill. The highest number of new cases belongs to the 25-49 age group with 50%, followed by the 50-64 age group with 19.3% of new cases. The number of infected cases is higher among male of 25-49 age; whereas the number of newly infected female cases is higher in the 50+ age group. Overall, data indicates that the probability of Covid-19 contact is higher among men. Since 1 June 2020, the Government of Turkey has taken some normalization measures however these may have led to the continuation of the first wave in Turkey. In August 2020, the number of new COVID-19 cases has again started to increase and reached around 1,500 cases per day. Although the Ministry of Health (MoH) stopped sharing the number of patients treated in intensive care units (ICUs), the Minister of Health (MoH) stated during a press conference on 20 August 2020 that ICUs are 64.8% full, and that 53.3% of service beds and 31.7% of ventilators are being occupied. These are national statistics and there is no official data showing the provincial distribution. Several professional medical associations and chambers have indicated that intensive care units (ICUs) are already full, especially in the provinces with the highest number of Covid-19 cases, such as Ankara. Considering that the flu season and winter time is approaching, the path to response and recovery will need to be combined with strategic and innovative actions that contain and mitigate the adverse impacts of Covid-19, as well as ensure continuity of quality essential care, especially for vulnerable groups and people at risk for the health system recovery, in accordance to the national action plans such as Covid-19 Coronavirus Emergency Action Plan.

Individual health is not only influenced by medical care and individual choices and behavior but also by social, economic and environmental determinants (SEEDs) and dimensions of inequality such as the opportunities available in places where people are born, live, grow, work and age. All these factors are being significantly influenced by Covid-19. (see for further information Annex B. UN Turkey, Covid-19 Socio-Economic Impact Assessment Report, July 2020) Evidence shows that factors such as unemployment, stress, levels of income and education, sex, geographical location, social exclusion, and lack of social support put health at risk and influence health outcomes. Although, in April 2020, a legislation was issued allowing everyone living in Turkey to have free access to have diagnosis and treatment services for Covid-19, the pandemic is exacerbating these factors, putting already-vulnerable populations at a further disadvantage. For instance, the 'Inter-Agency Protection Sector Rapid Needs Assessment Analysis of Turkey', revealed that refugees found health services and health service providers the hardest to reach throughout this period with 44% of Afghans and over 55% of Iranians facing difficulties to seek health care. Almost one third of refugees interviewed during the assessment stated that they had not accessed health services because they were afraid of leaving the house during the pandemic, and 25% of those who tried to access were unable to receive the service due to de-prioritization of non-COVID related services or because of inactivation of health insurance (20%). Covid-19 will only deepen inequalities and worsen a pre-existing high burden of NCDs (diabetes, cardiovascular diseases, cancer, and chronic respiratory diseases), mortalities and morbidities due to gender-based violence and delayed/limited access to essential maternal and sexual and reproductive health (SRH) services.

Reviewer#1: Overall score & comments: 18/25
Reviewer#1: A strong, well written concept note that is clearly linked to the country's COVID-19 Socio-Economic response Offer (Plan). The proposed targets, intervention, roles of partners are all clear laid out. Some linkages (e.g. with leveraging of other resources) could have been stronger/ clearer.
Reviewer#1: A very clear, up to date analysis of the situation looking at both COVID-19 situation but also disruptions to social services esp Health. Shows clear understanding of gender perspective and the needs of vulnerable populations.

The COVID-19 pandemic has had widespread health impacts, revealing the particular vulnerability of those with underlying conditions primarily NCDs. In Turkey, NCDs are a major health challenge causing disability and premature deaths and having a significant negative impact on the productivity of the workforce and socio-economic development. NCDs are responsible for 87.5% of all deaths (36.6% cardiovascular disease (CVD), 38.9% cancer, 7% chronic respiratory diseases, 5.8% diabetes). Evidence from several countries (including Italy, Spain, China, and the USA) has shown an association between COVID-19 severity and NCDs. Further, evidence from COVID 19 and previous pandemics suggest that without proper management, chronic conditions can worsen due to stressful situations resulting from restrictions, insecure economic situations, and changes in normal health behaviors. The postponement of routine medical appointments and tests can delay NCDs management, while physical distancing, restricted access to primary health care units, pharmacies, and community services, alongside a reduction of transport links, all disrupt continuity of care for NCD patients. This disruption of routine health services and medical supplies risks increasing morbidity, disability, and avoidable mortality over time in NCD patients. At the same time, prevention of NCDs is important since the true scale of at-risk groups may be underestimated, given that many cases of hypertension and diabetes are undiagnosed.

Sexual and reproductive health (SRH) and rights is a significant public health issue that demands urgent and sustained attention and investment. Health and social systems across the globe are struggling to cope with disrupted SRH services during Covid-19. The situation is especially challenging in humanitarian and development nexus country contexts, like Turkey, where health and social systems are stretched. Services to provide SRH care risk being sidelined, which will lead to higher maternal mortality and morbidity. According to the 'Inter-Agency Protection Sector Rapid Needs Assessment Analysis of Turkey', 38% of female respondents stated they had difficulties in accessing SRH services, while around 50% of both Iraqi women and those of other nationalities responded that they did not access SRH services, either because they were unable or did not attempt to access these. All women and girls must have access to a continuum of sexual and reproductive health services, including antenatal, perinatal and postnatal care, and screening tests according to national guidelines and standards.

The pandemic is also compounding existing gender inequalities and gender based violence. In Turkey, before Covid-19 outbreak, 2 out of every 5 women and 1 out of every 3 white-collar worker women have experienced domestic violence. Since March 2020, 42,693 GBV cases have been reported and 33 women died, according to the Ministry of Interior (MoI). 64% of these women were killed in their homes and almost all of them (93%) were killed by intimate partners or family members. According to Women's rights NGOs, there has been a serious backlash in women's access to GBV response services, such as shelters, hotlines owned by the state and legal services. Official representative data on GBV prevalence amongst refugee women is currently lacking. However, considering that refugee women have already been living in vulnerable conditions, with a high prevalence of GBV pre-COVID-19, it is assumed that they are also suffering from increased GBV. It has become more important than ever to improve the risk communication to respond to this 'shadow pandemic' which exacerbates the existing gender inequalities. GBV prevention and response services need to be resilient against all odds and under any crisis situation.

The above mentioned challenges require the promotion of efficient and effective service provision models to build resilience and uninterrupted access to the health system for the most vulnerable groups. To that end, the below intervention proposes innovative actions to reach vulnerable groups through mobile health and telemedicine to tackle above mentioned barriers and increase the uptake of essential health services.

P_I. Immediate Socio-Economic Response to COVID19 and its impact	As of January 12, 2021; Turkey ranks as the 7th highly affected country in the world with a number of total cases reported as 2,346,285, and a total number of death reported as 23,152. (Reference: worldometers.) The UN agencies in Turkey have been assessing the impacts of the Covid-19 pandemic in Turkey, since the announcement of the first case in the country and adjusting their programming to respond to extra demands and emerging needs due to the Covid-19 crisis. Simultaneously, the UN Country Team (UNCT) has established a Task Team to assess the economic and social impacts of the pandemic and to prepare a short to medium-term response offer to support of the Government of Turkey in its efforts to contain and reverse the negative consequences of the Covid-19 crisis along with the national development priorities outlined in the 11th Development Plan and in line with UN agency mandates and priorities, as well as to pave the way for a better recovery, which is inclusive, gender-equal, fair and green. The Covid-19 Socioeconomic Impact Assessment Report has been developed by the UNCT as part of this ongoing process and intended to serve as a contribution to further discussion and dialogue. Based on this report, the United Nations has developed the Socio-Economic Response Offer, with a time span of 18 months to support the Government and other development partners. This offer was also in line with the draft UN Sustainable Development Cooperation Framework (UNSDCF) 2021-2025, due to be signed by the beginning of 2021, as well as the global United Nations Framework for the Immediate Socio-Economic Response to Covid-19. Its aim was to align the ongoing and planned Covid-19 response, recovery and building-back-better activities of the UN in Turkey. The UN responds to the socio-economic impacts of the Covid-19 crisis via adhering to the principles of "leaving no one behind", "human rights'', "gender equality" and "economic and environmental sustainability" and to the long-term vision set by the SDGs. The proposed project was developed in line with the 'Pillar 1. Health First' defined in above mentioned response mechanisms, as an immediate socio-economic response to Covid-19 and its impact. Accordingly, its aim is to improve access to healthcare services delivery related to Covid-19 and also other essential needs, such as routine maternal and child health services like vaccination and antenatal/postnatal care; prevention and treatment of non-communicable diseases (NCDs). This will be achieved through promotion of innovative service provision models which are scaling mobile health units up for Covid-19 response and piloting telemedicine in primary health facilities, as well as enhancing risk communication in the field for the most vulnerable refugees. It is therefore envisaged that with innovative service models available to vulnerable populations and awareness of where and how to access them, there will be increased demand and utilization of essential services resulting in improved health outcomes while evidence from the service models could inform health system policy decisions in the country. In the context of the risk communication component, in consultation and coordination with the Ministry of Health, the project will provide the beneficiaries and target groups with up-to-date information on the use of Covid-19 vaccines, that has recently been initiated by the Government of Turkey. The theory of change is further articulated in annex 3: **Implementation modalities:** Project timeframe will be 1 February 2021-31 March 2022. The UNFPA Turkey will act as Administrative Agent and lead implementing the Result 1 and 3, in coordination with the MoH, in Ankara and Konya provinces. Supervision to Mobile Health Units (MHUs) and Field Associates will be conducted through regular field visits, monitoring meetings and periodic reporting. WHO will act as PUNO, and lead the implementation of Result 2, in coordination with the MoH, in Ankara, Konya and Samsun. Through the MoH, WHO in collaboration with UNFPA will explore the inclusion of mother and childcare (including sexual and reproductive health) into the telemedicine service. UNHCR will act as the key implementing partner and the co-financier of the UN Joint Programme, contributing actively to the implementation of Result 3 in Ankara and Konya provinces and the informational awareness activities under Results 1 and 2. For these, UNHCR will allocate staffing time and make its resources and information platforms available to the joint project. UNHCR requests zero-funding for its contributions for the implementation of the UNJP and no fund transfers will take place from UNFPA/WHO to UNHCR during the implementation.	Please refer to email sent on 19 Jan 2021

	If required, partnership might also be established a UNFPA existing Implementing partner (IP) to support procurement of medical equipment and hiring of health staff under Result 1	

CN_II. Results expected to be achieved and a clear explanation of tangible results or changes that will be achieved through this collaborative programme Describe the results expected to be achieved and how it contributes to the Covid-19 response and the SDGs. Describe programme approaches, methods, and theory of change, and explain why they are the appropriate response to the problem. Please highlight a) how the solution(s) is data driven (especially on population being targeted) b) if and how it employs any innovative approaches; c) if and how it applies a human rights-based approach and how is it based on the principle of "recover better together" d) if and how the theory of change reflects the Gender Equality Marker score selected in this solution	The overall impact of the intervention will be to improve health outcomes among vulnerable population groups during and after Covid-19 by providing better protection from adverse impacts of Covid-19 with containment and mitigation measures, and ensuring continuity of quality essential care. The impact will be supported with the objective of improving access to healthcare services delivery related to Covid-19 and also other essential needs, such as routine maternal and child health services like vaccination and antenatal/postnatal care; prevention and treatment of non-communicable diseases (NCDs), Sexual and Reproductive Health (SRH) services. This will be achieved through promotion of innovative service provision models which are scaling mobile health units up for Covid-19 response and piloting telemedicine in primary health facilities, as well as enhancing risk communication in the field for the most vulnerable refugees. It is therefore envisaged that with innovative service models available to vulnerable populations and awareness of where and how to access them, there will be increased demand and utilization of essential services resulting into improved health outcomes while evidence from the service models could inform health system policy decision in the country. Intervention modalities: The modalities will be based on piloting and scaling innovative healthcare provision models, which propose strategic, innovative and long-term solutions to ease the burden on the health system in Turkey. These modalities are the following: **Scaling mobile health services up to Covid-19 response:** The processes of testing, tracing, treating and isolating need to continue to counter Covid-19 in Turkey. Due to limited capacity of state services, access of people at risk to health prevention and response services is very limited. Therefore, there is a need to enhance resilience capacities of health care facilities, especially at the primary level, to cope with challenges of Covid-19 through early detection and information dissemination through effective mobile healthcare services and to provide specialized essential health care service provision for people at risk at their own location without requiring them to visit a hospital, therefore decreasing the burden on the health care system. Mobile health units, as a modality complementing the overall health service provision system, are already implemented in Turkey at a smaller scale in order to reach out to the rural refugees and seasonal agricultural migrant workers. In this intervention, the modality will be scaled up to the Covid-19 response of Turkey. **Piloting telemedicine to improve access and efficiency in the health system:** To avert indirect morbidity and mortality and prevent exacerbation of chronic conditions, the proposal will also focus on using Telemedicine as a health care delivery platform in the prevention, control, and management of NCDs and related risk factors. In Turkey, the probability of premature death (death before the age of 70 years) from one of the four major NCDs for a person living in Turkey was around one in six (16.8%) in 2015, with a higher probability for men (22.5%) than women (11.6%) while an economic burden analysis found that the economic cost of NCDs to the Turkish economy in 2016 was TRY69.7 billion, which is equivalent to 3.6% of the country's annual gross domestic product. A WHO survey on the health status of Syrian refugees showed that 15.2% of the total sample reported having a chronic disease, the most common conditions being hypertension, psychiatric disorders, asthma, diabetes, and cardiac disease. Further, WFP assessment of the knowledge, practices and impact of COVID-19 amongst in-camp refugees in Turkey revealed that practices such as eating more than usual and eating less healthy had increased while efforts to reduce smoking decreased as refugees struggled to cope with the impact of COVID 19. In Covid-19, internet access and availability have morphed from a choice to an absolute necessity, especially under Tele-Health. With 5G bandwidth coming to mainstream Turkey in the next 2-5 years, laying a foundation of broad-based Telehealth should be prioritized. This platform will offer a convenient, timely, efficient medium for access to and take-up of primary health care (PHC) services (NCDs, mental health, maternal health, SRH, daily outpatient services etc.) – not least in rural areas.	Reviewer#1: Two areas of interventions, with clearly articulated results, and clearly identified target provinces and population along with proposed activities contributing to the targets set. Reviewer 2: The overall score 16. The CN is quite weak in presenting its theory of change, especially in articulating the outcomes and in developing indicators to measure the impact on the target groups. In its situation analysis, too, the CN uses data at national level instead of using data specific to the target groups and regions. It is therefore not clear weather the issues the project intends to solve are in fact prevalent in the target region and groups.

Target provinces and groups: This intervention will be implemented in two provinces of Turkey which are Ankara and Konya. The provinces were selected based on the following criteria: the rate of Covid-19 cases compared to other cities in the country, the capacity of health services to meet the demand, the size of geographical area and distance of settlements, the willingness of Provincial Health Directorates for implementing and needing such innovative models. These criteria were explained per each city in Annex A.

The target group of this intervention is vulnerable populations, which are defined as the elderly, refugees, seasonal agricultural workers and people with specific needs, such as pregnant and lactating mothers, people with disabilities, people with or at the risk of getting chronic/non-communicable diseases, HIV/AIDS; and GBV survivors.

There will be three results of this intervention, which are explained in detail below.

Result 1: The accessibility of vulnerable groups to health services enhanced through mobile systems;

This result will respond to the need of comprehensive and mobile Covid-19 screening and tracking. In addition, the response will provide uninterrupted access to essential health counselling, services and referrals through provision of primary health care via mobile health staff. These will be achieved with the establishment of 6 Mobile Health Units (MHUs) in 2 provinces. This solution is data driven, as evidenced by the problem statement in the first section. This is an innovative approach to the healthcare system in Turkey because it changes the mode of receiving services and makes primary health care more accessible.

Activity 1: Recruitment and training of mobile health unit (MHU) service providers

Three MHUs will be established in each of the two selected provinces. Each unit will be composed of a full-time health staff, 1 translator, 1 driver. There will also be procurement of rental car services and of relevant medical equipment required to conduct mobile primary health services. The personnel of each mobile health unit will be supervised by the health staff of the unit. The health staff of each MHU will be supervised by the Public Health Experts at District Health Directorates. The MHU teams (health staff and translator) will be trained on Covid-19 prevention and response services based on the most updated MoH Covid-19 Guide. In addition, they will receive additional in-service training in their area of their work (primary health care including management of Covid-19, GBV identification, data collection, etc.).

Activity 2: Mobile health service provision through MHUs

Following the recruitment and procurement processes, appropriate Covid-19 prevention, surveillance, detection, filiation and referral services will be provided through MHUs in Ankara (3) and Konya (3). The Provincial Health Directorates will be responsible for the overall coordination in each province. The MHUs will also be identifying the most vulnerable individuals through home visits to provide counselling, treatment on primary health care, safe motherhood, SRH and refer them to appropriate specialized services, including GBV response mechanisms if needed. For this purpose, capacities of MHU personnel will be developed on identifying major primary health care risks and emergency signs and symptoms of main health problems including SRH and GBV.

Result 2: Accessibility and coverage of services in primary health care increased through telemedicine;

Working with the Ministry of Health (MoH), WHO will pilot the use of Telemedicine in delivering health care services related to prevention, control, and management of NCDs and related risk factors with a view of scaling successes in services options and geographical coverage. Doctors and nurses in Family Health Centres (FHCs), Healthy Living Centres, and Refugee Health Centres (RHC) will use Telemedicine to support

people with or at the risk of getting chronic/non-communicable diseases and NCD patients with comorbidities. As an innovative approach in the context of Turkey, Telemedicine will reduce the physical presence of patients in health facilities as a COVID 19 mitigation measure, empower patients in self-management of conditions and increase access to care. The Telemedicine pilot platform will enable vulnerable populations such as the elderly, women, rural populations, refugees, and migrants that are likely to be left behind to overcome access barriers to during and post COVID 19. Telemedicine is already used in other industrialized regions; through this intervention, WHO will support MoH to test the platform as an approach for recovering better.

Activity 1: Development of guidelines and a support framework for the implementation of Telemedicine.

In collaboration with MoH, guidelines for technology platforms that will enable Telemedicine will be developed and rolled out in pilot provinces. Practice guidelines will be developed for healthcare professionals (doctors, nurses, midwives, dieticians and physiotherapists etc.). In addition, other materials such as teleconsultation flowcharts (online consultation algorithms) and training materials will be developed to support implementation.

Activity 2: Development of ethics, data privacy, and confidentiality procedures.

Medical ethics and data protection are critical in Telemedicine. As such, WHO will work with MoH and ICT to define and develop mechanisms and procedures for ethics, data privacy and confidentiality, including patient consent forms and management of digital records.

Activity 3: Procurement of software and hardware for technology-based patient consultation

In pilot centers, the required software will be procured or strengthened where it already exists. Hardware such as mobile or landline phones, headphones, computers etc. will be procured to support patient consultation and data management.

Activity 4: Training of service providers

With the Telemedicine guidelines, procedures, and implementation support materials developed and the soft/hardware in place, health workers in pilot centers will be trained to equip them with the knowledge and skills required to deliver services through Telemedicine successfully. Language interpreters will also be trained to support telemedicine to facilitate access to services among refugees and migrants,

Activity 5: Public awareness on telemedicine

Working with MoH, UNFPA and UNHCR an awareness campaign will be developed to build public awareness about when and how to access telemedicine services.

Result 3: Risk communication on Covid-19, essential health services and social protection services through multiple channels.

A concerted and regular risk communication will be conducted in order to provide specific information regarding Covid-19, preventive measures (hand-washing, hygiene, social distancing, use of masks, mobility restrictions) and response (accessing to hospitals, cost of treatments, registration status, consequences of seeking help), how to access the essential health services and how to access the protection services (both state and non-state) either physically or remotely (both online and over the phone) during Covid-19. The risk communication will also aim to raise public awareness about the telemedicine services and mobile health services promoted in this intervention. The Field Associates and MHUs will be responsible for this Result under the leadership of the Project Manager. This result will increase the knowledge of the target group on mobile health units and telemedicine piloted within this intervention but also of how to access the correct tools and verified information already in place.

Activity 1: Developing Standard Operating Procedure (SOP) document on how to do risk communication

A SOP will be developed to guide Field Associates and MHU staff on how to conduct the risk communication in the field. The SOP will list the existing tools and means. These tools and means will range from map-based Services Advisory of UNHCR, verified and official social media accounts of governmental, non-governmental and local authorities and verified Whatsapp trees. The SOP will also have a section on how to use more traditional methods of risk communication through community leaders, community health workers, mukhtars and Imams. Field Associates and MHU staff will be trained on the SOPs.

Activity 2: Networks with community leaders and local institutions

Field Associates will have regular meetings with the community leaders in selected neighbourhoods to understand the needs and gaps in terms of accessing knowledge on Covid-19, measures, other essential health and protection services and to provide the lifesaving information sessions. Field Associates will be responsible for coordinating the risk communication with local governmental and non-governmental institutions.

Activity 3: Outreach of risk communication to vulnerable populations

MHUs will be responsible for the outreach of risk communication tools and relevant information to the beneficiaries, in coordination with Field Associates. The MHUs will disseminate the communication materials and make updates about which measures to take to be protected from the virus, what to do when there are symptoms for the virus, which provisions are implemented nationally and locally for Covid-19 and how to access services at the times of Covid-19. Messaging and risk communication tools will be distributed in accordance with the language the beneficiary speaks, as well as they will be gender and age appropriate to reach the various population groups. Information on service availability will be coupled with risk information on NCDs, and sexual and reproductive health information and how the innovative services can provide further information and support in addressing these.

How the intervention contributes to the Covid-19 response and the SDGs:

This intervention contributes to Covid-19 response of the Ministry of Health and also the response offer prepared by the United Nations in line with the Covid-19 Socio-economic Response Plan, Pillar 1 (Health First) through promotion of innovative health service provision models, mobile health units and telemedicine, as well as contribution to national and local Covid-19 response and better health outcomes for the most vulnerable groups. For this purpose, the intervention will partner with Ministry of Health and Provincial Health Directorates. They will be direct agents of change in this intervention as they will contribute to project results with their staff, capacity and resources. The intervention will also be in direct contact with other relevant governmental and non-governmental institutions so that outreach of project activities are increased. The intervention, therefore, seek to support the Government of Turkey to stay on track for Sustainable Development Goal (SDG) 3 (Good Health and Well-Being) and SDG 10 (Reduce Inequalities) despite Covid-19 pandemic through strengthening the resilience of the health system in Turkey and addressing the social determinants of health by focusing on vulnerable populations.

Human rights and Gender equality approach:

The proposed intervention is based on a **human rights based approach** as it proposes innovative healthcare solutions to ensure the practice and realization of the rights to health and life for vulnerable populations. This also ensures leaving no one behind principle as it considers the socio-economic and psychosocial situation of the most vulnerable populations and proposes solutions accordingly. As it also accompanies healthcare solutions with risk communication, it also addresses the gap of mis-communication and lack of easily accessible verified information for vulnerable populations, especially during pandemic conditions, such as lockdown and

	quarantine, due to lack of means and support they have socially and financially. Hence, it also ensures the rights to information via ensuring access to accurate and timely information. The intervention is designed as a GEN 3 project as it will increase access of women, girls, men and boys to essential health counseling and services, including SRH services in the times of Covid-19. Women in reproductive age groups suffer more from SRH problems, whereas it is reported from many resources that men are more vulnerable to Covid-19 infection. Thereafter, assistance and risk communication will be adapted to the specific needs and capacities of all individuals keeping in mind their gender, including gender identity and sexual orientation, age and diversity. In addition, mobile health and the risk communication components of the intervention will have specific focus on supporting GBV prevention and response mechanisms through information dissemination, referrals to relevant services. Women beneficiaries will be always accompanied by female health workers if they need to be referred for advanced services to prevent any protection risk.	

CN_III. Catalytic impact and nexus Describe how the intervention is catalytic by mobilizing or augmenting other financial or non-financial resources including from IFIs, foundations, the private sector. Describe how the proposed intervention supports medium to long-term recovery for example by enabling other actors to engage, generates an enabling environment for longer-term development.	The proposed interventions are **catalytic** due to the fact that they will provide an opportunity to expand access to health services and allow the piloting and testing of unconventional and innovative health care provision models in Turkey. In the short and mid-term, Telemedicine will increase access to health care during the COVID pandemic augmenting the government of Turkey COVID 19 response by providing an additional service platform that will especially reach vulnerable populations. Telemedicine service platforms will catalyze government efforts to control NCDs with significant potential for scale up in the long term. Scaling up Telemedicine in terms of service package and geographical coverage will bring national gains in access, equity, quality, and cost-effectiveness of health care. With an established policy and implementation framework that this intervention will contribute to, Telemedicine could be expanded to the private sector. Mobile healthcare provision has already been tested in Turkey, especially among rural refugees and seasonal agricultural migrant workers. As it proved to be very effective to reach remote areas and the most vulnerable groups, the Ministry of Health (MoH) may consider to integrate mobile health service provision at a larger scale to its overall health system as public and private funds are available. This intervention will also scale this model up further for the Covid-19 response, as per the request and need from the MoH. This proves that not only UN agencies but also the national authorities find this innovative model catalytic. Therefore, it is used and will be used to augment possible financial and non-financial resources in the future, also from IFIs and the private sector. This catalytic impact will be achieved through securing commitment and ownership from the Government, IFIs and private sector. The tools partners in this intervention will be using consist of regular communication and advocacy with the donor community; preparing policy recommendations to the Government of Turkey based on the results of this intervention and establishing systemic dialogues with the IFIs and private sector. The proposed intervention will be implemented in collaboration with the MoH as an approach to health system strengthening at the same time meeting urgent health care needs for the most vulnerable groups under the principle of 'leaving no one behind'. In addition, it proposes solutions for medium to long-term recovery through the testing and piloting of mobile health service and telemedicine at the provincial health institutions. Through the implementation of this intervention, institutional level guidelines will be tested with a view of future development into institutional level policies while capacities of health staff in the MoH will be enhanced allowing sustainability of intervention's results. Hence, the intervention increases the resilience capacity of both people in need and Provincial Health Directorates in 2 provinces. Individual resilience capacities to cope with challenges of Covid-19 will be enhanced through early detection and information dissemination thanks to effective mobile healthcare services. Working closely with the MoH at the national and provincial level to implement this intervention provides an enabling environment for longer-term sustainability of intervention results while the joint collaboration of the three UN agencies will leverage United Nations' mandate and expertise in the country in addressing the problems identified.	Reviewer#1: One already tested and one new approach proposed. Reviewer 3: Overall score: 19. General comments: A strong proposal which clearly seeks to respond to the most vulnerable groups, employing digital approaches with potential for upscaling. The proposal has a very strong focus on health. However, it points to important links to socio-economic recovery. The activities are linked to planned projects suggested in the SERP, it would therefore benefit from providing an outline of the budget and align it with the budget in the SERP

CN_IV. Who will deliver this solution List what Recipient UN Organizations (no less than 2 per concept note) and partners will implement this project and describe their capacities to do so. Include expertise, staff deployed, as well as oversight mechanisms that determine the monitoring and evaluation (M&E) arrangements and responsibilities. Use hyperlinks to relevant sites and the current portfolios of RUNOs so the text is short and to the point.	This programme will be implemented by UNFPA, as the lead agency, WHO and UNHCR, as participating UN Agencies. There will be regular coordination meetings with the focal point of each PUNO in order to monitor the project progress. United Nations Population Fund (UNFPA) is the UN's reproductive health agency, promoting gender equality, human rights as well as delivering humanitarian aid in the health and protection field. As part of its health response, UNFPA Turkey has been implementing 'Improving access of rural refugees to health and protection services in Turkey' project, funded by the Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG ECHO) funded action. This project provides primary health care (PHC) and protection services through 12 mobile service units (MSUs) in 5 provinces. The MSUs are designed to reach particularly to the refugees in rural areas such as seasonal migrant agricultural workers. In addition, since the Covid-19 outbreak started in March 2019 in Turkey, UNFPA Turkey has incorporated and mainstreamed Covid-19 response into its health and protection programmes that target the most vulnerable groups via personal protective equipment (PPE) procurement for its service providers, roll-out of Covid-19 service protocol guidelines on RH and GBV, dissemination of Information and Education Communication (IEC) on Covid-19 through social media and TV, distribution of dignity/hygiene kit to vulnerable groups and those in quarantine, provision of Covid-19 (risk) detection, referral and case management for vulnerable groups including rural refugees/seasonal migrant workers, key refugee groups and women at reproductive age - through the UNFPA's health and protection units. Hence, UNFPA Turkey has the operational and programme capacity to implement the proposed programme. UNFPA's collaborative advantage in this intervention will be its current experience on implementing MHUs, its field presence via Field Associates, gender equality expertise via Women's Empowerment Expert, SRH expertise via SRH Coordinator and health and protection services in humanitarian settings via Humanitarian Programme Coordinator. The programme activities and budget for the first and third component will be managed and monitored by the UNFPA Project Manager (PM). However, since UNFPA is the lead agency, the PM will also be responsible for the overall coordination of programme activities with WHO and UNHCR. The expert will be developing the programme training materials, delivering and supervising the training in the field, and will be in contact with the government partners to make sure that the programme is on track with the government's plans. UNFPA Field Associates will provide support to the implementation of the programme at provincial level through communicating with local governmental and non-governmental institutions, as well as community leaders in neighborhoods. The UNFPA core team in the Turkey office will also be supporting the programme on visibility issues with its Communication Expert. World Health Organization (WHO) will lead the piloting of telemedicine under result 2. WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. Since 1959, WHO has been implementing activities in Turkey as regards to public health, especially on prevention, control and management of NCDs and its risk factors in close cooperation with governmental and non-governmental institutions. As the lead agency for the health sector in Turkey, WHO will provide necessary support to partner agencies ensuring that interventions and implementation modalities are aligned to national priorities. WHO has a mandate to support the Ministry of Health in achieving goals for population health and well-being. As such WHO has a strategic relationship at the national and provincial level that will be leveraged for successful implementation of the intervention. The United Nations High Commissioner for Refugees (UNHCR) will support information dissemination efforts under Result 3. Under the 3RP Refugee Response Plan, UNHCR is the information management lead and is managing Services Advisor (https://turkey.servicesadvisor.org/en), a map-based platform providing information	Reviewer#1: Key implementing partner and supporting partners mentioned with clear distribution of roles and responsibilities.

	about services available to refugees and host communities in Turkey. Additionally, UNHCR chairs the “Communication with Communities” Working Group and supports the RCO in chairing the “Communications Task Force” around COVID-19 under the “ERP WG”.	

P_V. Target population	**TARGET PROVINCES:** Ankara, Konya and Samsun, in line with the criteria explained in Annex A. The target population for this project are vulnerable populations, defined as elderly (65+), refugees, seasonal agricultural workers and people with specific needs, such as pregnant and lactating mothers, people with disabilities, people with or at the risk of getting chronic/non-communicable diseases, and GBV survivors in the target provinces of Ankara, Konya and Samsun. The project will target the beneficiaries regardless of their nationality, race, age, sex orientation, and legal status. The project will directly target 11,000 people by mobile health services; 204,175 people with telemedicine and 30,000 people with targeted risk communication. The mobile health services will be concentrated in Ankara and Konya provinces. The mobile health units (MHUs) will specifically target the vulnerable populations with Covid-19 screening and tracking, as well as essential health counselling, services and referrals. The project provinces have higher birth rates than the country average, including among refugees. This indicates the increasing need for maternal and newborn health services without interruptions in provision. To that end, both risk messaging, SRH and related awareness raising activities will be conducted to support the overall country response within the project. A total of 2,1 million women of reproductive health age live in Ankara and Konya, of which 50,100 are refugee women. The mean household size is 6 people for refugee families and 3 people for host communities in Ankara and Konya. Based on the household size, it is assumed to reach more refugee women than host communities per household visit. This increased the ratio of refugees among total beneficiaries relative to the total number of refugees among the host community. Through mobile services, it is targeted to reach and provide awareness raising services to 7,737 women at reproductive age, including 1,200 refugee women. In addition, the percentage of the elderly (aged 65+) are higher than the country average in Ankara and Konya and this age group is under the highest risk in terms of Covid-19 based mortality and morbidity burden. Therefore, elderly people will be one of the important beneficiary groups for mobile services and risk communication activities. Only 13 percent of the host community and 2 percent of refugees are elderly, in total in Ankara and Konya there are 1 million elderly people. It is assumed that through mobile health services, the project will reach 3,941 beneficiaries who are 65+ of whom 90 are refugees. Due to legislation related to Covid-19 response, refugees have been exempted from all prevention and treatment costs of Covid-19, which enable them to access health services for free. However, due to other socio-economic vulnerabilities, their accessibility is still less than other vulnerable populations. Each mobile unit will have a translator, mobile units will also frequently visit the regions/districts, where refugees mostly live, for mobile services and tests, so the ratio of refugee beneficiaries is expected to be higher than provincial rates. 1,800 refugees and 9,200 host community members via mobile health services; 5,200 refugees and 24,750 host community members via risk communication services will be expected to be reached out within the framework of the project. The Telemedicine pilot platform will enable vulnerable populations such as the elderly, women, rural populations, refugees, and migrants who are likely to be left behind to overcome access barriers to, during and post Covid-19. The estimated host population of people aged 18 and above in the project area is 2,601,731 and 60,274 refugees. Based on the NCD prevalence and the prevalence of NCD risk factors, the project will reach an estimated 198,413 (100,160 females and 98,252 males) people in the host population and estimated 5,762 (2,658 females and 3,104 males) refugees with services through telemedicine. Of the host population it is estimated that 22,830 will be aged 65+ while among refugees 213 will be aged 65+. Telemedicine is already used in other industrialized regions; through this intervention, WHO will support MoH to test the platform as an approach for recovering better. The project will be implemented in Ankara, Konya and Samsun provinces.	Please refer to email sent on 19 Jan 2021

SDG Targets

Target	Description
Main Goals	
Goal 3. Ensure healthy lives and promote well-being for all at all ages	
TARGET_3.4	3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
TARGET_3.8	3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
Secondary Goals	
Goal 10. Reduce inequality within and among countries	
TARGET_10.2	10.2 By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status

SDG Indicators

Indicator Code	Description
No data available.	

Contribution to SDGs

Participating Organization	% TARGET_3.8	% TARGET_3.4	% TARGET_10.2	% Total
UNFPA	60	30	10	100
WHO	25	60	15	100
Total contribution by target	**85**	**90**	**25**	
Project contribution to SDG by target	**42.5**	**45**	**12.5**	**100**

List of documents

Document	Document Type	Document Source	Document Abstract	Modified By	Modified On
COVID-19 SOCIO-ECONOMIC IMPACT ASSESSMENT REPORT.pdf	Other Docs	Concept	This is the Covid-19 Socio-Economic Impact Assessment Report COVID 19 that has been developed by the COVID 19 Impact Assessment and Response Task Team as a collective inter-agency effort among UN agencies in Turkey	zikusookam@who.int	Aug 31, 2020

NCD investment business case-tur-eng.pdf	Other Docs	Concept	Noncommunicable diseases (NCDs) such as cancer, cardiovascular diseases, diabetes and chronic respiratory diseases and their risk factors are an increasing public health and development challenge in Turkey. This report provides evidence through three analyses that NCDs reduce economic output, and discusses potential options in response, outlining details of their relative returns on investment. An economic burden analysis shows that economic losses from NCDs are equivalent to 3.6% of gross domestic product. An intervention costing analysis provides an estimate of the funding required to implement a set of policy interventions for prevention and clinical interventions. A cost–benefit analysis compares these implementation costs with the estimated health gains and identifies which policy packages would give the greatest returns on investment.	zikusookam@who.int	Aug 31, 2020
Annex A. Selection criteria explained for Ankara and Konya_FINAL.pdf	Other Docs	Concept	This document summarizes the criteria for selection of provinces targeted for project implementation	zikusookam@who.int	Aug 31, 2020
Reviewer#1_Turkey_Funding promoting innovative.xlsx	Other Docs	Concept Narrative		fshafique@unicef.org	Sep 09, 2020
Reviewer 2 TURKEY Innovative Service Provider.xlsx	Other Docs	Concept Narrative		azeema.adam@un.org	Sep 10, 2020
Turkey_Gem Assessment.docx	Other Docs	Concept	Feedback on disability and gender	kalie.marsicano@undp.org	Sep 16, 2020
Annex C. Theory of change.docx	Other Docs	Project Narrative	Theory of change	zikusookam@who.int	Jan 13, 2021
UN Turkey Covid-19 Socio-Economic Response Offer.pdf	Other Docs	Project Narrative	UN Turkey Covid-19 Socio-Economic Response Offer	zikusookam@who.int	Jan 13, 2021
COVID-19 SOCIO-ECONOMIC IMPACT ASSESSMENT REPORT_teksayfa_REV.pdf	Other Docs	Project Narrative	UNCOVID-19 SOCIO-ECONOMIC IMPACT ASSESSMENT REPORT_REV	zikusookam@who.int	Jan 13, 2021
Annex B. Target beneficiaries.docx	Other Docs	Project Narrative	Target beneficiaries	zikusookam@who.int	Jan 13, 2021

Annex A. Selection criteria explained for Ankara,Konya and Samsun.docx	Other Docs	Project	Project site selection criteria	zikusookam@who.int	Jan 13, 2021

Project Results

Outcome	Output	Description
Outcome 2		Increased access to immediate health and socio-economic support to respond to the health and social impact of the COVID-19 pandemic
	Mobile health service provision for enhanced outreach to vulnerable populations	This output will respond to the need of comprehensive and mobile Covid-19 screening and tracking. In addition, the response will provide uninterrupted access to essential health counselling, services and referrals through provision of primary health care via mobile health staff. These will be achieved with the establishment of 6 Mobile Health Units (MHUs) in 2 provinces. This solution is data driven, as evidenced by the problem statement in the first section. This is an innovative approach to the healthcare system in Turkey because it changes the mode of receiving services and makes primary health care more accessible.

Activities

Title	Description	Lead Participating Organization	Participating Organization	Other Organizations
Mobile Health Units	Recruitment and training of mobile health unit (MHU) service providers	UNFPA - United Nations Population Fund	• WHO - World Health Organization	Ministry of Health Ministry of Family, Labour and Social Services (partner organization).
Service provision	Mobile health service provision through MHUs	UNFPA - United Nations Population Fund	• UNHCR - UN High Commissioner for Refug	Ministry of Health Ministry of Family, Labour and Social Services (partner organization).

Outcome	Output	Description
	Telemedicine for increased access and coverage of services in primary health care	The project will pilot the use of Telemedicine in delivering health care services related to prevention, control, and management of NCDs and related risk factors with a view of scaling successes in services options and geographical coverage. Doctors and nurses in Family Health Centres (FHCs), Healthy Living Centres, and Refugee Health Centres (RHC) will use Telemedicine to support people with or at the risk of getting chronic/non-communicable diseases and NCD patients with comorbidities

Outcome	Output	Description

Activities

Title	Description	Lead Participating Organization	Participating Organization	Other Organizations
Legal framework for telemedicine	Development of guidelines and a support framework for the implementation of Telemedicine.	WHO - World Health Organization		Public Health department, Department of Chronic Disease and Elderly Health, General Directorate of Health Information Systems, General Directorate of Health Services, General Directorate of
Data protection regulations	Development of ethics, data privacy, and confidentiality procedures.	WHO - World Health Organization		Ministry of Health , Data Protection Authority
Procurement of soft/hardware	Procurement of software and hardware for technology-based patient consultation	WHO - World Health Organization		Ministry of Health
Training	Training of service providers	WHO - World Health Organization		Ministry of Health General Directorate of Health Information Systems, General Directorate of Health Services, General Directorate of Health Promotion, Social Security Institution ,Turkish Pharmacist Association, Turkish Medical Association
Public awareness on telemedicine	Public awareness on telemedicine	WHO - World Health Organization	• UNFPA - United Nations Population Fund • UNHCR - UN High Commissioner for Refug	Ministry of Health General Directorate of Health Information Systems, General Directorate of Health Services, General Directorate of Health Promotion, Social Security Institution ,Turkish Pharmacist Association, Turkish Medical Association

Outcome	Output	Description
	Risk communication on Covid-19, essential health services and social protection services through multiple channels	A concerted and regular risk communication will be conducted in order to provide specific information regarding Covid-19, preventive measures (hand-washing, hygiene, social distancing, use of masks, mobility restrictions) and response (accessing to hospitals, cost of treatments, registration status, consequences of seeking help), how to access the essential health services and how to access the protection services (both state and non-state) either physically or remotely (both online and over the phone) during Covid-19. The risk communication will also aim to raise public awareness about the telemedicine services and mobile health services promoted in this intervention. The Field Associates and MHUs will be responsible for this Result, supported by communications staff, under the leadership of the Project Manager. This result will increase the knowledge of the target group on mobile health units and telemedicine piloted within this intervention but also of how to access the correct tools and verified information already in place

Outcome	Output	Description

Activities

Title	Description	Lead Participating Organization	Participating Organization	Other Organizations
SOPs for risk communication	Developing Standard Operating Procedure (SOP) document on how to do risk communication	UNFPA - United Nations Population Fund	• UNHCR - UN High Commissioner for Refug	Ministry of Health Ministry of Family, Labour and Social Services (partner organization).
Network for risk communication	Engage networks with community leaders and local institutions	UNHCR - UN High Commissioner for Refug	• UNFPA - United Nations Population Fund	Ministry of Health Ministry of Family, Labour and Social Services (partner organization).
Outreach	Outreach of risk communication to vulnerable populations	UNHCR - UN High Commissioner for Refug	• UNFPA - United Nations Population Fund • WHO - World Health Organization	Ministry of Health Ministry of Family, Labour and Social Services (partner organization).

Signature Indicators

Indicator Title	Component Title	Description	Category	Cycle	Scope	Value Type	Baseline Value	Baseline Year	Target Value	Target Year	Linked Out Output
Outcome 2.3		Number of people accessing services (education, health, social protection, etc)	Beneficiaries	Yearly	Country	Number	N/A	2020		0	**Outcome:** 2
	By Sex	Male	Beneficiaries	Yearly	Country	Number		0		0	
	By Sex	Female	Beneficiaries	Yearly	Country	Number		0		0	
	By Age Group	0-14 years	Beneficiaries	Yearly	Country	Number		0		0	
	By Age Group	15-24 years	Beneficiaries	Yearly	Country	Number		0		0	
	By Age Group	25-59 years	Beneficiaries	Yearly	Country	Number		0		0	
	By Age Group	60 years and over	Beneficiaries	Yearly	Country	Number		0		0	
	By risk population	Women	Beneficiaries	Yearly	Country	Number		0		0	
	By risk popylation	Older persons	Beneficiaries	Yearly	Country	Number		0		0	
	By risk population	Adolescents; children and youth	Beneficiaries	Yearly	Country	Number		0		0	
	By risk population	Persons with disabilities	Beneficiaries	Yearly	Country	Number		0		0	

	By risk population	Persons with mental health conditions Indigenous peoples	Beneficiaries	Yearly	Country	Number		0		0	
	By risk population	Migrants; refugees; stateless and internally displaced persons	Beneficiaries	Yearly	Country	Number		0		0	
	By risk population	Minorities	Beneficiaries	Yearly	Country	Number		0		0	
	By risk population	Persons in detention or in institutionalized settings	Beneficiaries	Yearly	Country	Number		0		0	
	By risk population	Slum dwellers; informal settlements; homeless persons	Beneficiaries	Yearly	Country	Number		0		0	
	By risk population	People living with HIV/AIDS	Beneficiaries	Yearly	Country	Number		0		0	
	By risk population	Small farmers; fishers; pastoralists; workers in informal and formal markets	Beneficiaries	Yearly	Country	Number		0		0	
	By risk population	The food insecure	Beneficiaries	Yearly	Country	Number		0		0	
	By risk population	People in extreme poverty	Beneficiaries	Yearly	Country	Number		0		0	
	By risk population	Marginalized people	Beneficiaries	Yearly	Country	Number		0		0	

Imported Fund Outcome / Output Indicators

Indicator Title	Component Title	Description	Category	Cycle	Scope	Value Type	Baseline Value	Baseline Year	Target Value	Target Year	Linked Outcome / Output
No fund indicators available.											

Project Indicators

Indicator Title	Component Title	Description	Category	Cycle	Scope	Value Type	Baseline Value	Baseline Year	Target Value	Targe Year

Indicator Title	Component Title	Description	Category	Cycle	Scope	Value Type	Baseline Value	Baseline Year	Target Value	Targe Year
6 MHUs are operational		6 Mobile Health Units will be established and operationalized with procuring rental cars and hiring the staff.	Capacity	Twice a year	Country	Numberra	0	2021	6	2021
	No components available.									
18 personnel in the MHUs and 2 Field Associates trained		18 personnel will receive training for their orientation and for smooth run of the MHUs. 2 Field Associates will also receive the relevant modules of the training for their orientation to the project	Capacity	Twice a year	Others	Numberra	0	2021	20	2021
	No components available.									
# of beneficiaries receiving services from 6 MHUs		This indicator is about the number of people who will be reached out by MHUs	Beneficiaries	Twice a year	Others	Numberra	0	2021	11,000	2022
	No components available.									
# of beneficiaries reached through risk communication		This indicator is about the number of people who will be reached out by the project team (i.e. Field Associates and MHU team) and by the online platforms used within the framework of the project	Beneficiaries	Twice a year	Country	Numberra	0	2021	30000	2022
	No components available.									
Information Platform on service delivery regularly updated		This indicator is to measure whether the online platform on service availability is updated and accurate	Capacity	Twice a year	Country	Yes/Nora	No	2021	Yes	2021

Indicator Title	Component Title	Description	Category	Cycle	Scope	Value Type	Baseline Value	Baseline Year	Target Value	Targe Year
	No components available.									
18 modules of Telemedicine guidelines, algorithms, and patient information materials developed		6 modules will cover 6 areas: Hypertension, CVS risk assessment, Diabetes and Obesity, Elderly Health, NCDs Risk Factors and Use of Telemedicine for 3 groups: Doctors, nurses, patients	Capacity	Twice a year	Country	Number ra	0	2021	18	2021
	No components available.									
Draft Regulation on telemedicine and personal data protection is developed		draft regulation will comprise circulars, by-laws or a law submitted to MoH for approval/endorsement	Policy	At closure	Country	Text ra	none	2021		2022
	No components available.									
10 HLC and 3RHC equipped with hardware for technology based patient consultation		10 HLS and 3 RHC equipped with computers and microphone headsets	Investment	Twice a year	Others	Number ra	0	2021	13	2022
	No components available.									
222 FHC center employees trained on telemedicine		This is the number of doctors and nurses in FHC that will be trained to provide telemedicine services	Capacity	Twice a year	Others	Number ra	0	2021	222	2022
	No components available.									
80 HLC center employees trained on telemedicine		This is the number of doctors, nurses and dieticians HLC that will be trained to provide telemedicine services	Capacity	Twice a year	Country	Number ra	0	2021	80	2022
	No components available.									

Indicator Title	Component Title	Description	Category	Cycle	Scope	Value Type	Baseline Value	Baseline Year	Target Value	Targe Year
# of beneficiaries reached through telemedicine		This is the number of people that will be reached with telemedicine services	Beneficiaries	Twice a year	Others	Number ra	0	2021	204,175	2022
	No components available.									
40 RHC center employees trained on telemedicine		This is the number of doctors, nurses and dieticians RHC that will be trained to provide telemedicine services	Capacity	Twice a year	Country	Number ra	0	2021	40	2022
	No components available.									
3 press conferences to promote telemedicine are conducted			Other	Twice a year	Country	Number ra	0	2021	3	2022
	No components available.									

Risks

Event	Category	Level	Likelihood	Impact	Mitigating Measures	Risk Owner

Incompliance of MHU personnel to UN Code of Conduct and project specific SOPs.	• Operational	Low	Rare	Major	All personnel will be provided with orientation training, such as on specific information on the beneficiaries, exercising Code of Conduct in the field, communication techniques with beneficiaries and legal perspective on the services and related to beneficiaries, etc., that will develop their capacities about the main framework of the project. UNFPA will closely monitor the service provision through the monitoring visits, provision of supervision and other relevant methods. UNFPA will ensure that all new project personnel and service providers are well informed on the UNFPA policy for the 'prevention of sexual exploitation and abuse'. UNFPA will hire two field associates to monitor activities on the ground	ecekaraduman@unfpa.org
Difficulty in timely procurement of equipment and supplies, as well as recruitment of qualified candidates for Mobile Health Units due to Covid-19 and long procurement process for medical equipment	• Operational	Medium	Possible	Major	UNFPA has a well-established and experienced procurement system and in-house staff. In case there is a difficulty, UNFPA will consider working with an Implementing Partner. In addition, UNFPA and the MoH have wide networks in the health care sector which can be used in circulating the calls for applications in order to identify qualified candidates.	ecekaraduman@unfpa.org
Challenges in coordination and cooperation of district health directorates	• Organizational	Low	Rare	Major	Verbal and written agreements were granted from two district health directorates involved in the project. In addition, UNFPA has a MoU with MoH. Hence, the central authority can step in when there is limited coordination and cooperation with the local authorities	ecekaraduman@unfpa.org
Challenges in coordination and cooperation of district health directorates	• Political	Low	Unlikely	Major	Continued engagement with MoH especially new office bearers to ensure that project objectives and interventions are fully explained and supported by political level leadership.	zikusookam@who.int

Delays in development of legislation for telemedicine	• Regulatory	Low	Possible	Major	Commence preparation of the relevant legal documents at the project onset and involving all relevant stakeholders throughout to avoid delays	zikusookam@who.int

Budget by UNSDG Categories

Budget Lines	**Description**	**UNFPA (7%)**	**WHO (7%)**	**Total**
1. Staff and other personnel		124,336	54,504	178,840
2. Supplies, Commodities, Materials		3,500	12,800	16,300
3. Equipment, Vehicles, and Furniture, incl. Depreciation		7,040	0	7,040
4. Contractual services		392,000	143,394	535,394
5. Travel		3,000	9,000	12,000
6. Transfers and Grants to Counterparts		0	0	0
7. General Operating and other Direct Costs		29,435	15,384	44,819
Sub Total Project Costs		**559,311**	**235,082**	**794,393**
8. Indirect Support Costs		39,152	16,456	55,607
Total		**598,463**	**251,537**	**850,000**

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