HEROES FOR GENDER TRANSFORMATIVE ACTION PROGRAMME

'Because all young girls, boys, and women in Uganda should fully enjoy their sexual and reproductive health & rights and live in a gender-equal society free from SGBV'

ANNUAL REPORT

(Period October 2021 – July 2022)

Table of Contents

Acronyms 3

Key Definitions 4

Executive Summary 6

1. Introduction 8

1.1 Heroes4gta Programme Context 9

2. Programme Achievements In Period 2 11

2.1 Performance Against Key Targets Of Period 2 11

3. Programmatic Activities 12

3.1 Result Area 1: Better Information And Greater Freedom Of Choice For Young People About Their Sexuality. 12

3.2 Result Area 2: Better Public And Private Healthcare For Family Planning, Pregnancy And Childbirth, Including Post-Abortion Care 16

3.3 Result Area 3: More Respect For Sexual And Reproductive Rights For All. 25

3.4 Result Area4: Enabling Environment For Young Girls And Women's Elimination Of Violence Against Girls And Women. 31

4. Monitoring Evaluation Research And Learning Activities 36

4.1 Deep-Dive Assessment Of Heroes Program 38

5. Communication, Knowledge Management And Documentation 40

6. Programme Governance And Management 41

7. The Program Catch-Up Plan 42

8. Implementaion Guiding Principles/Strategies During Period 2. 42

9. Challenges And Opportunities In Period -2 44

9.1 Challenges Affecting The Programme 44

9.2 Opportunities To Leverage In Period 3 46

10. Risks Assessment And Mitigation Strategies 48

11. Conclusion Recommendations 51

11.1 Conclusion 51

11.2 Recommendations 51

12. Heroes Programme Period -2 (Oct 2021-Jul 2022) Financial Performance 52

13. Annexes 54

13.1 Annex 1: Heroes Program Sustainability Plan 54

13.2 Annex 2: Heroes Program Catch-Up Plan 57

13.3 Annex 3: Heroes Program Result Matrix 60

13.4 Annex 4: Messages Developed On Srhr/Sgv 65

ACRONYMS

ANC	Antenatal Care
CEmONC	Comprehensive Emergency Obstetric and New-born Care services
DHIS 2	District Health Information System II
DHMT	District Health Management Team
DHO	District Health Officer
DLG	District Local Government
BEmONC	Basic Emergency Obstetric and Neonatal Care
HMIS	Health Management Information System
HSD	Health Sub District
HUMC	Health Unit Management Committee
MNCH	Maternal, New born and Child Health
MPDSR	Maternal and Perinatal Death Surveillance & Review
MUAC	Mid Upper Arm Circumference
OPD	Out Patient Department
PNFP	Private Not for Profit Health facility
SOP	Standard Operating procedure
HEROES 4GTA	HEROES for Gender Transformative Action
SRHR	Sexual Reproductive Health Rights
SGBV	Sexual Gender based Violence
IWD	International Women's Day
MoUs	Memorandum of Understanding
TOR	Terms of Reference
CSO	Civil Society Organization
YLO	Youth Led Organization
WLO	Women Led Organization
MHN	Maternal Health and Nutrition
VSLA	Village Saving Loans Association
RBF	Result Based Financing
WRA	Women of Reproductive Age

KEY DEFINITIONS

First-line support is the immediate care a GBV survivor should receive upon first contact with the health or criminal justice system. The WHO defines "first-line support" using the acronym "LIVES": Listening, Inquiring, Validating, Ensuring safety, and Support through referrals.

Gender refers to the economic, social, political, and cultural attributes and opportunities associated with being women and men. The social definitions of what it means to be a woman or a man vary among cultures and change over time. Gender is a sociocultural expression of particular characteristics and roles that are associated with certain groups of people regarding their sex and sexuality.

Gender-based violence (GBV) is any form of violence against an individual based on that person's biological sex, gender identity or expression, or perceived adherence to socially defined expectations of what it means to be a man or woman, boy or girl. The most common forms are sexual assault, intimate partner violence and child abuse, but GBV also includes physical and psychological abuse, threats, coercion, arbitrary deprivation of liberty, and economic deprivation, whether occurring in public or private life. GBV is rooted in gender-related power differences, including social, economic and political inequalities. It is characterized by the use and abuse of physical, emotional, or financial power and control. GBV takes on many forms and can occur across childhood, adolescence, reproductive years, and old age.

Gender Identity refers to a person's internal, deeply felt sense of being a man or woman, or something other or in between, which may or may not correspond with the sex assigned at birth. Because gender identity is internal and personally defined, it is not visible to others.

Sex refers to the biological differences between males and females. Sex differences are concerned with males' and females' physiology.

Transgender refers collectively to people who challenge strict gender norms by behaving as effeminate men or masculine women, adapting "third gender" roles, or embarking on hormonal and surgical treatment to adjust their bodies to the form of the desired sex. Transgender persons often find that the sex assigned to them at birth does not correspond with the innate sense of gender identity they experience in life. Transgender may include transsexuals (people whose physical sex conflicts with their gender identity as a man or a woman); transvestites (people who cross-dress for sexual gratification but do not wish to be a person of the other sex); and intersex persons (people whose sexual anatomy is neither exclusively male nor exclusively female).

Pay for Performance (P4P), Performance-based Payment and Performance-Based Incentives (PBI): Can all be considered synonyms for Results-Based Financing. Performance in these labels means the same thing as results, and payment means the same thing as financing. These terms do not introduce any additional distinctions. **Performance-Based Financing (PBF):** This is a systematic approach to innovative financing that links the financing of health care providers to the achievement of pre-determined performance indicators. It is a form of RBF distinguished by three conditions. Incentives are directed only to providers, not beneficiaries; awards are purely financial; cash payment is by Fee-For-Service for specified services; and payment depends explicitly on the degree to which services are of approved quality, as defined by protocols for processes or outcomes.

Results-Based Financing (RBF): Is a form of pay for performance, where the principal, who provides the funding, pays the agent (who implements the project, provides the service, or takes other agreed actions) upon achieving predefined results and payment depends explicitly on the degree to which services are of approved quality, as defined by protocols for processes or outcomes. It includes both demand side and supply side pay approaches.

Verification: Verification refers to the process of carefully reviewing the agreed RBF indicators that have been reported by the facility to confirm that the results are of the desired quantity and quality i.e. verification of quantity services delivered (monthly), quality service delivered (quarterly) and client satisfaction (quarterly).

Advice Centre: The advice centre is essentially a safe platform (physical and virtual) for the provision of emergency care and support to survivors and for advancing individual and collective power to claim rights. It provides a springboard from which to increase legal and social accountability and challenge GBV concerns and issues as well as other human rights violations.

SGBV Champions: These are women and men, trained and supported to navigate existing legal systems to achieve gender justice for survivors of SGBV

Safe Spaces: Safe spaces are physical and virtual platforms where beneficiaries come together and freely express themselves with confidence, and no fear of criticism, discrimination, harassment or any emotional or physical harm.

EXECUTIVE SUMMARY

The 'Integrated Sexual and Reproductive Health & Rights Programme in High Burden Districts of Uganda' (ISPHD)/HEROES programme targets young girls and boys (age10-24) and women of reproductive age (age 25-49) including underserved groups, in the districts of ***East Central***: Kalangala, Bugiri, Mayuge, Iganga & Namayingo; and the ***East:*** Mbale, Budaka, Bukwo, and Kween. This is a four-year programme implemented by a consortium of four partners Amref Health Africa in Uganda, Cordaid, MIFUMI[1] and the International Centre for Research on Women (ICRW). The partners have a shared goal of "***All young people and women of reproductive age in 9 high burden districts of Uganda to fully enjoy their*** SRHR ***and live in a gender-equitable society free from SGBV."***

This report describes the accomplishments in the 10-month Period 2 (Oct 2021 – July 2022) and programme activities that have been implemented during this period. Below is a summary of high-level achievements in period-2.

The key milestones included the following:

- The programme trained and deployed 806/1080 (75%) community facilitators in 54 communities located in the 9 target districts. These included facilitators for five different curricula i.e. Journeys Plus, Sinovuyo programme-Y, Men-engage and Family health curricular. Through these facilitators a total of 239,624 (82,449M 157,175F) people have been enrolled for comprehensive SRHR education through the different curricula at different community safe spaces, among these 65,790 have completed the curricula.
- Strengthened the DHMT for all the 9 districts through trainings on transformational leadership and governance; mentorship on their roles and responsibilities and supporting them execute their supervisory roles on advancing SRHR and preventing SGBV in the districts.
- Trained 51 out of the expected 54 HUMC on their roles and responsibilities in order to strengthen the leadership and governance of health facilities and linkage to the communities for SRHR. The other three in Mayuge district weren't yet constituted.
- Reactivated the District Committees on Adolescent Health (DCAH) in all the 9 districts through supporting the orientation on their roles and responsibilities plus quarterly planning and coordination meetings.
- Successfully built the capacity of over 246 health workers in various SRHR care packages (CQI, BEmONC, Family planning, Adolescent and Young Friendly health care packages) through one off workshops and monthly peer led CMEs and targeted mentorship by regional/ district mentors.
- A total of 18 health facilities were enrolled for the RBF programme and received subsidies showing improved indicators.
- All the 58 health facilities have been supported to strengthen the collaborative Quality improvement activities in the health facilities, despite some health workers having negative attitude.
- Trained and deployed 229 CHEs in Bugiri, Iganga, Namayingo and Mayuge on DMPA-SC and Family Planning. During a 3-day refresh course, the CHEs regained new information on family planning and business skills.
- Reactivated SGBV steering committees in the 9 districts. The committees now meet to analyse the SGBV situation in the districts and recommend actions to address critical areas concerning SGBV.

- The programme also participated in the 16 days of Activism where they held outreaches that brought integrated services of SRHR, SGBV and others closer to the communities. They also shared messages, entertainment and IEC materials on the same (see annex 4).
- Ten (10) relevant national laws targeting the elimination of major forms of violence were identified and translated. Sensitization of communities on these laws commenced in period 2.
- The Social Norm Measurement Training (SMNT) was conducted as a capacity building activity for staffs and CBOs in selected Districts. The teams are now able to rationalize formative research and action context-specific gender inequalities in the 3 clusters of Kalangala, Mbale and Iganga.
- Activated the 9 advice centres (1/district) that have been set up and manned with trained SGBV champions to receive and support SGBV survivors in interventions at a hotspot.
- In collaboration with Reach a Hand Uganda, an e-voucher system to facilitate access to services by SGBV survivors was established. SGBV survivors are now able to access SGBV services and justice services.
- A programme database was developed, where data is entered and analysed on the dashboard, which has improved visualisation and tracking programme performance.
- Baseline study was successfully conducted in 9 intervention and 3 control districts. The findings are ready for dissemination.
- Heroes for Gender Transformative Action Programme was successfully launched in Mbale District on the 28th of October 2021.
- In commemoration of the world immunisation week, Heroes for Gender Transformative Action joined Amref Health Africa in hosting young people and youth to a Twitter space chat that provided critical information about vaccinations in particular HPV, COVID-19 and others.

Despite this progress, the programme has experienced challenges in the delivery of comprehensive SRHR education especially completion of the different SRHR curricula due to the intense academic programme of schools, attrition of facilitators and drop out of learners. There is good progress on SRHR service delivery with many indicators showing improved SRHR service quality and utilization. Campaigns to promote respect for SRHR commenced in the period but there is limited effort for duty bearers to proactively take to this task. Access to justice is also a challenge as there remain several socioeconomic barriers to justice. Contributing to these challenges is the slow opening and poor resourcing of government departments, agencies and public/private social service institutions at district level after the covid19 lockdown. This has led to limitations in the extent to which they can take on programme interventions. As a result, some key milestones haven't been well met. As such the programme has developed a catch-up plan to enable it reach these milestones.

The Heroes Programme would like to thank the Netherlands Embassy in Uganda for the support provided to the program through funding, creating of relations and collaboration with other partners. This support has been a great contribution to the improvement of the sexual reproductive health and rights of young people and women in the program implementation districts.

1. INTRODUCTION

The 'Integrated Sexual and Reproductive Health & Rights Programme in High Burden Districts of Uganda' (ISPHD) programme now known as the Heroes for Gender Transformation Action (GTA) is an integrated intervention that has been established to address Sexual and gender-based violence (SGBV) which one of the most severe forms of gender inequality and discrimination in Uganda. SGBV remains a critical Sexual and Reproductive Health and Rights (SRHR) problem where national GBV indicators show that 56% of people in Uganda aged 15 – 49 have experienced Intimate Partner Violence (IPV), of which the far majority are girls and women. SGBV is an issue that affects women disproportionately, as it is directly connected with the unequal distribution of power between women and men. Therefore, Amref Health Africa in Uganda, Cordaid, MIFUMI and the International Centre for Research on Women (ICRW) have combined their strengths to empower young girls, boys, and women in nine selected hard to reach districts of Uganda to fully enjoy their SRHR and live in a gender-equitable society free from SGBV.

The programme is targeting young girls and boys (age 10-24) and women of reproductive age (age 25-49) including underserved groups, in the ***districts of East Central: Bugiri, Mayuge, Iganga and Namayingo; Central: Kalangala and the East: Mbale, Budaka, Bukwo, and Kween***, to address the root causes of SGBV and unfavourable SRHR outcomes. These districts of implementation are some of the highly burdened districts regarding poor SRHR outcomes and SGBV. The programme addressing the lack of empowerment of young girls, boys and women regarding SRHR and SGBV decision-making, low quality of SRHR and SGBV service provision, which are not well integrated, lack of action by gatekeepers and communities regarding unequal gender norms and practices and weak SGBV response systems. The COVID19 pandemic has further complicated this situation by creating fear and heightened vulnerabilities among young girls, boys, and women, having disrupted social services. The programme is employing the socio-ecological model at the individual, relational, communal, and institutional levels because evidence shows that standalone interventions do not address the synergistic nature of SRHR violations and SGBV. The programme is investing in the empowerment of young girls, boys and women regarding SRHR/SGBV, strengthening SRHR/SGBV service delivery, working with gatekeepers to reject gender-negative norms and practices, and enhancing access to justice. Throughout the HEROES programme, a gender transformative approach is being used.

The objectives are: (i) Better information and greater freedom of choice for young people about their sexuality; (ii) Better public and private healthcare for family planning, pregnancy and childbirth, including post-abortion care (PAC); (iii) More respect for sexual and reproductive rights for all; (iv) Enabling environment for young girls and women's elimination of violence against girls and women.

To achieve these objectives, key evidence-based approaches have been selected. One of them is the delivery of rights-based, comprehensive, and transformative SRHR education that includes discussions on gender norms and roles. Another is health systems strengthening through the fully functional site model to facilitate SRHR/SGBV care integration at all service delivery points (SDPs). A third key

approach is results-based financing, which uses contracting to formalize the relationship between health system actors and will link payments to results, which are defined in quantity, quality, and client satisfaction terms. Also, the programme intends to apply value clarification processes to challenge and reject gender negative norms and practices. Alongside the SRHR/SGBV interventions, the programme is integrating interventions to address COVID19 and its impact on the overall SRHR/SGBV landscape in target districts.

The programme has purposed to work meaningfully with young girls and boys and women from the target districts to design and lead the interventions, as well as in monitoring and research. In addition, the programme has established close collaboration with district duty bearers, CSOs, Ministries of Health, Gender, Education and Justice and implementing partners of similar projects such as the SRHR Alliance, DKT, PSI UNFPA, and UN Women. The programme is aligned to the goals and objectives of target district sector strategic plans, the National Development Plan (NDP III), and the Multi-Annual Country Strategy (MACS) of the Netherlands Embassy in Uganda.

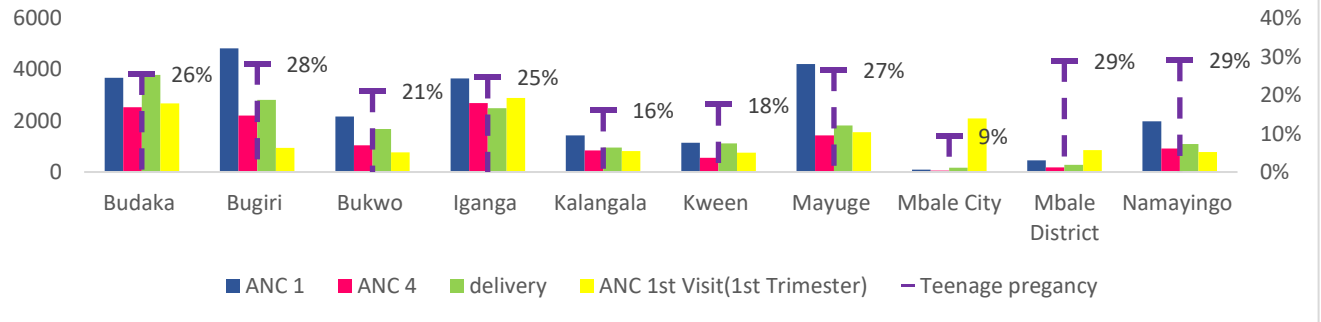
This report provides details of what has been achieved in period 2 of the programme. It also describes challenges and opportunities in chapter 4, guiding principles in chapter 5, risks and mitigation measures in chapter 6, conclusions in chapter 7, and a summary of the financial report in chapter 8. Annexes are in chapter 9 of the report.

1.1 HEROES4GTA PROGRAMME CONTEXT

The Uganda Bureau of Statistics, reveal that the combined total population of the 54 sub-counties where the Heroes programme is intervening has a population of 1,354,666. Of these, 460,586 (34%) are aged 10–24 years and 433,493 (32%) are women of women in the reproductive age group. The majority of the population are subsistence farmers, while those saying around the lake are e.g. in Kalangala, Namayingo and Mayuge are fisherfolks.

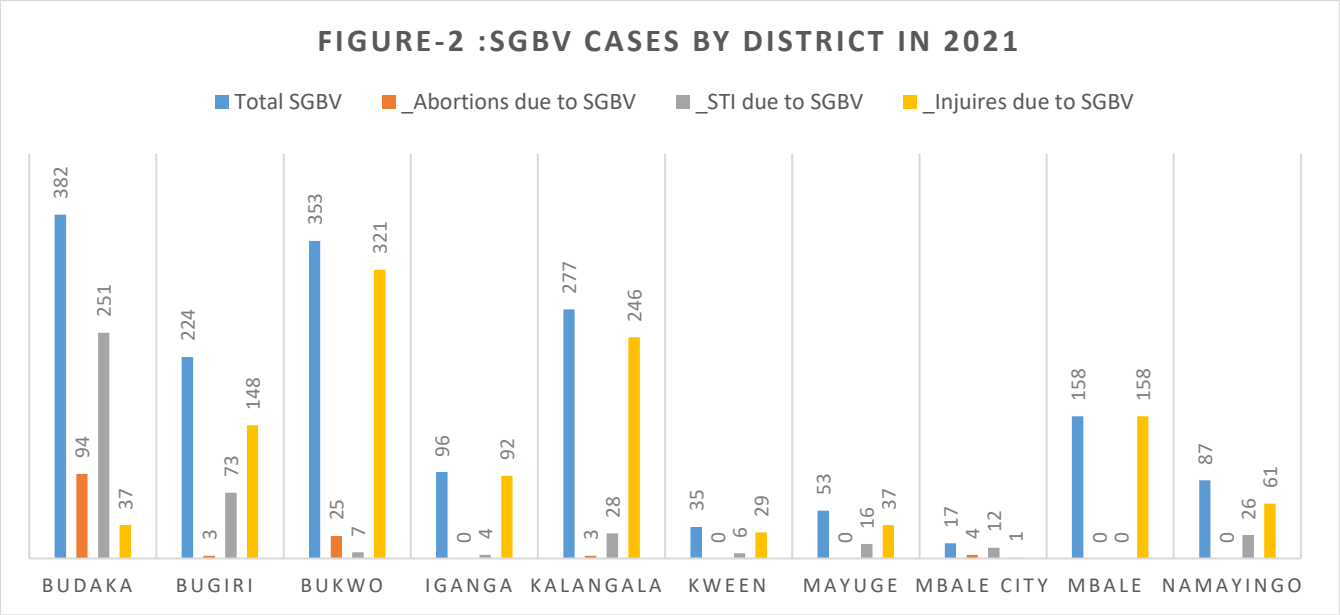
Analysis of 2021/22 maternity data from the 58 programme health facilities in the nine districts reveal an average teenage pregnancy rate of 25% similar to the national figure (UDHS,2016). However, the districts of Bugiri, Mayuge, Namayingo and Mbale districts have a teenage pregnancy rate >28% while Kween district has the lowest at 16% (Figure 1).

FiIGURE 1: HEROES PROGRAM DISTRICT ANC-DELIVERY CASCADE 2021



Like the rest the country, the 9 program districts were affected by Covid19 lockdowns where schools were closed for two years. The lockdowns increased young girl's vulnerabilities majority of the program districts saw a surge in teenage pregnancy. Majority of the teenage mothers have not returned to school despite the back to school policy of government. This is attributed to the high stigma on the teenage mothers and schools' lack of capacity to support them

This population in the Heroes programme districts is also equally affected with Sexual Gender Based Violence the highest numbers were registered in Budaka, Bukwo and Bugiri districts (Figure 2)



The information from the community dialogues across the programme districts reveals that the root causes of sexual gender-based violence are negative social norms, poverty and this was escalated with the COVID19 lockdown.

The most reported incidents were physical assault (32%), defilement (16%), caregiver neglect (17%), threats of harm (10%) and teenage pregnancy (7%). Among the drivers and vulnerabilities to SGBV are harmful use of alcohol (32% of cases), the existence of multiple partners (23%), polygamy (17%) and the lack of supportive networks (9%). Although few in numbers, it is worth noting that serious cases of sexual violence were also received including 9 cases of rape and attempted rape, 6 of sexual assault and 1 of sex trafficking. Four cases of Child marriage were reported. Harmful practices and sexual violence remain key priority focus areas for the project. The reported incidents may appear few, but this is more a reflection of the barriers to reporting and uptake of services than of the scale of the problem. Additional information in the community dialogues in Kween and Bukwo show that FGM remains prevalent however it is conducted outside the district and only return for celebrations.

Access to justice remains a big problem, especially in communities in Kalangala and Bukwo. This was particularly difficult in the Covid19 lockdown. Even when the country opened up, there has been slow reactivation of the justice processes.

2. PROGRAMME ACHIEVEMENTS IN PERIOD 2

This section provides a summary of performance against the key programme targets and the achievements according to the different result areas. Overall, the programme is on track as illustrated with the colour coding in the table below:

2.1 PERFORMANCE AGAINST KEY TARGETS OF PERIOD 2

The **table-1** below show a summary of performance against the key programme targets.

Table1: Performance against period 2 Targets

Impact/Outcome/output	Indicator	Target	Achievements	% Achievement	Comments
Output 1.1: Young girls, boys and women reached with comprehensive, correct information and skills SRHR and SGBV.	# of young girls, boys and women reached with comprehensive, correct information on sexuality, SRHR, SGBV and life skills trainings.	296,791	239,624	81%	There was a slow start of enrolment and data entry which has improved with CBO onboarding. This figure was updated in the result frame after the end of period-2
Output 2.1: Private and public health systems strengthened to scale up SRHR & SGBV services for young girls, boys and women	# HCWs trained on SRHR/SGBV service provision	270	433	160 %	This is more reflective of the training contacts.
	# of service points where the quality of offered interventions is considered good and appropriate to the needs expressed by the target group (young people, women.	54	54	100 %	All the facilities are now providing services regarded appropriate
	# of facilities that adopt and implement youth friendly SRHR/SGBV services,	54	54	100 %	All the programme supported facilities are providing youth friendly serves after training of staff and we shall continue tracking
	# Of women and girls using modern contraceptives.	60,457	66,083	109 %	This is on track
	# of young girls, boys and women provided with SRH services at health facility/static & outreaches sites	388,800	242,519	62%	The mobilization for outreaches will be strengthened in period-3
Output 3.1: Strengthened capacities of CSOs (YLOs/WLOs) & key influencers to lobby and advocate against harmful practices related to gender and SRHR/SGBV	# Of CSOs and Advocacy networks with increased lobby & advocacy capacities.	18	9	50%	Only 50% of the CBOs have been supported with
	# of community members reached through the different mobilization (education & sensitization) strategies.	90,000	60,551	67%	Deliberate efforts will be made to scale-up mobilization in period-3
Output 3.2: Changes in bi laws, guidelines, ordinances, and practices leading to decrease of barriers to SRHR services	# of laws, policies , practice , and strategies blocked, adopted or improved to eradicate all forms of violence against women and girls in public and private life	10	10	100 %	Dissemination is underway.
Output 4.1: Improved SGBV service provision and case management	# of multi sector actors/responders trained on SGBV response	630	591	94%	This is on track
	# of girls and women who present cases of sexual violence or domestic abuse	2,700	1,443	53%	SGBV stigma reduction interventions will be scaled up.
	# of survivors provided with access to justice through the programme	1,430	1,443	101 %	This is on track
	# of SGBV cases taken to court	200	53	27%	Evidence collection process long so it takes time for the cases to be concluded.
	% of cases concluded through the court system	53	6	11%	Evidence collection process long so it takes time for the cases to be concluded.

Output 4.2: Young girls, boys and women have access to SRHR and SGBV safe spaces	# of individuals using SGBV social services	2700	1,841	68%	More engagement of duty bearers in period-3

3. PROGRAMMATIC ACTIVITIES

This section describes core activities that have been implemented under each result area in the period Oct 2021 – July2022.

3.1 RESULT AREA 1: BETTER INFORMATION AND GREATER FREEDOM OF CHOICE FOR YOUNG PEOPLE ABOUT THEIR SEXUALITY.

In the period, the Heroes program rolled out SRHR message dissemination and learning for young people and women in reproductive age-group 15-49 years. The main activities, outputs and their impact are summarized in the table 2 below for result area1

Table 2 Summary of Key activities under result Area1

#	Activity	Output	Relevance & Impact on Program
1.	Conduct 5 days content design workshop to test and approve SRHR/SGBV information, channels and language to meet age specific needs for 10-14, 15-19 and 20-24 year olds.	• 6 SRHR messages were developed and approved by the Ministry of Health for dissemination i.e. Issues on Menstrual hygiene, access to contraceptives and flow chart on SGBV services • A total of 32 (10 F, 22 M) participated in the workshop and the key deliverables generated were draft messages that have been submitted for approval to the Ministry of Health.	These have created an increase in access to SRHR services at the health facilities and also improved the management of SGBV cases in the community and at health facilities.
2.	Adopt, print and distribute assorted SRHR/SGBV education materials in schools, markets, bars, lodges, and "*boda-boda* stages "among others to increase awareness on SRHR/SGBV	1800 bumper stickers were developed and distributed in the 9 districts. These were given to schools, youth heroes, and SGBV advisory centers - for those that had the SGBV toll-free number.	The bumper stickers focused on providing short inspirational messages about facts on SRHR, popularizing the toll-free number for access to help in case of SGBV issues, they also created awareness among the target audience about their SRHR. Increased knowledge on what to do in case of a challenge based on rights, access and care.
3.	Engage Men in Gender Transformative Education Sessions	A total of 134 male champions drawn from the 9 programme districts were trained to deliver a minimum information package to the target audiences and after the training they have reached a total of 7,984 men with SRHR /SGBV information in two months of operation. The trained champions acquired skills to mobilize mainly men for SRHR services and SGBV prevention.	Effective male engagement contributing to improved uptake of SRHR services and reduced SGBV.
4.	Conduct 1 session per term with 90 school clubs on policies, regulations and laws that should protect the young people and women from SRHR violations including SGBV	Communities around 50 schools were sensitized on the key policies and laws that protect young people including the Domestic Violence Act 2010, the management of teenage pregnancy in schools using the revised back to school guidelines for the prevention and management of teenage pregnancy in schools.	The dissemination of policies helped create a supportive environment for the SRHR/SGBV programme implementation.

#	Activity	Output	Relevance & Impact on Program
		A total of 4,131 people were reached (1609 M, 2522 F) in collaboration with the district leadership.	
5.	Hold Bi-annual meetings with 15 members of school management committees, teachers and PTA representatives to discuss SRHR/SGBV issues affecting students at school.	90 schools were supported to hold SMC and PTA meetings to discuss SRHR/SGBV issues affecting young people. These were one-day meetings held in the schools. 432 SMC/PTA, head teachers and SWT/SMT were reached (141 f, 291 m). These included two females and 16 males with disabilities.	The meetings promoted sustainability by enhancing the school leadership participation and ownership of the SRHR/SGBV programme.
6.	Training a total of 1080 peer educators and community champions (young people, representatives of women of reproductive age and religion per district) from 9 districts to become agents of change for SRHR/SGBV issues affecting the young people and women.	A total of 806(365 M 441F) peer educators and community change agents were trained to roll-out the five curriculum-based interventions.	The use of community-based agents enhances sustainability and has led to the reach of 239,624 people with SRHR/SGBV information.
7.	Conduct quarterly review and reflection meetings on SRHR with peer educators/change agents per district	District level quarterly reflection meetings were held with the community facilitators and 569 attended these meetings. Performance was discussed and action plans for improvement developed,	The meetings provide a platform to share experiences and discuss challenges.
8.	Hold community SRHR/SGBV education sessions for 296,791 girls, boys, women and men in the adapted curricula	Through the 806 community facilitators, 239,624 (82,449M 157,175F) individuals have been enrolled on the different curriculum based programmes while 65,790 completed these sessions representing 27% of the target. Of the people reached with SRHR curriculum based interventions, a total of 2,935(1,082M 1,853F) were persons with **disabilities** out of 239,624 People have been reached through the different curriculum. A further categorization of the disabilities show that 1,033(409M 624F) were lame, 641(221M 420F) had visual impairment and 322(130M 190F) were deaf. For the other 939(281M 658F) the disability Could not be easily categorised. The Figure 3 below shows the performance by district.	The roll-out of the SRHR curricula in communities was designed to enhance comprehensive knowledge and SRHR service-seeking behaviours. Heroes was able to reach PWDs but noted challenges in effectively providing SRHR education to the blind and deaf, In period 3 deliberate efforts will be made to strengthen collaboration with organizations that provide services to the PWDs to ensure the delivery of a complete package of SRHR services.
9.	Conduct pre-recorded radio and live talk shows and spot messages to advocate for awareness of and response to young people and women's SRHR/SGBV issues	27 interactive talk shows were held across the 9 districts covering issues of SRHR and SGBV with accompanying DJ mentions /radio spots reaching an estimated listenership reach of 641,000 people. Information was provided on the SRHR risk reduction behaviours and the available service outlets. The panellists included the district duty bearers (Gender officers, ADHOs, women representatives) and young people across the Heroes supported districts	Interactive talk shows create awareness as such complementing efforts by the community agents/facilitators. These were designed to promote risk reduction behaviours especially around teenage pregnancy and STI infection including HIV &AIDS. Early ANC attendance was also promoted.

Key Areas of Progress Under Result Area 1.

The interventions under this result area targeted to reach young girls, boys and women with comprehensive, correct information and skills SRHR and SGBV. This was done through multiple set of interventions as described in the table above. In addition to access to information these interventions play a role of promoting self-efficacy risk reduction and health seeking behaviours. Some highlights are provided on the key emerging issues for some of the interventions in the narrative below:

i. **SRHR/SGBV Curricula Based Education Interventions:** The main intervention that contributed to this result area is the provision of SRHR/SGBV education through the 809 community

facilitators and peer educators distributed in the 54 communities that are supported by the Heroes programme. These facilitators targeted different age groups with five different curricula namely: Journeys-Plus (9-14 years), Programme-Y (15-24 years), Family Health for Women in reproductive age group (15-49years), Sinovuyo for parenting and Men-Engage for boys and men. Overall, a total of 239,624 people out of the expected 296,791 were reached with SRHR information representing 81% of the target. However, the completion rates for these curricula was 27% across all the programme districts.



A COMMUNITY FACILITATOR ENGAGES YOUNG PEOPLE ON MAKING REUSABLE MENSTRUATION PAD MAKING



FAMILY HEALTH EDUCATION IN SESSION IN KALANGALA DISTRICT

ii. ***High enrolment but low completion:*** The programme has been able to enrol 81% of the targeted SRHR learners. The enrolments were highest in Mbale and Namayingo (figure 3) and for programme -Y curriculum for the adolescents and lowest for men-engage (figure 4). The enrolment for programme-Y and Journeys –Plus for period 2 was on track however the completion was low. The Men Engage minimum package was also rolled out in the last 2 months of the after training of male champions and is gaining ground was in the last two months of period 2 and is gaining ground. The men being targeted are boda-boda riders, fisherfolks and men in education institutions and places of worship. Despite men not being very enthusiastic, it believed will likely to improve significantly in period 3.

Figure 3: Heroes Program SRHR Education cascade of young people by district in period 2

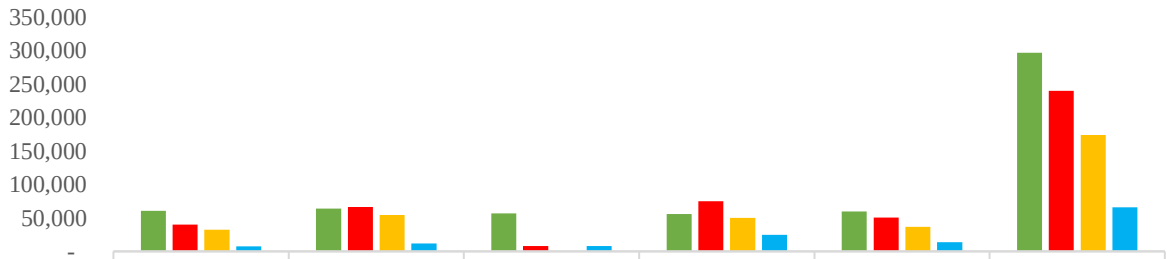


	Budaka (BD)	Bugiri (BG)	Bukwo (BK)	Iganga district (IG)	Kalangala district (KA)	Kween (KW)	Mayuge (MA)	Mbale district (MB)	Namayingo (NA)	Total
_Target	26,712	47,899	11,880	44,520	5,940	13,272	59,358	60,492	26,718	296,791
_Enrolled	29,609	16,700	19,707	11,357	25,319	12,570	48,616	30,977	44,769	239,624
_Ongoing	20,107	12,178	16,291	8,423	19,569	8,526	33,789	22,797	32,154	173,834
_Completed	9,502	4,522	3,416	2,934	5,750	4,044	14,827	8,180	12,615	65,790
_%Completion	32%	27%	17%	26%	23%	32%	30%	26%	28%	27%

Regarding completion, the average completion rates were only 27% due to intense academic programs in schools, attrition of SRHR facilitator's learners who have moved to different locations after the

covid19 lockdown and the lengthy learning sessions. To catch-up, the programme will abridge and digitize the curricular, train more facilitators and apply a whole school approach.

Figure 4: Heroes Program SRHR/SGBV Education Cascade by Curriculum



	Family Health Groups (FH)	Journies Plus (JP)	Men engage (ME)	Program Y (PY)	Sinovuyo (SN)	Total
_Target	60,630	64,162	56,627	55,975	59,397	296,791
_Enrolled	40,047	66,343	7,984	74,767	50,483	239,624
_Ongoing	32,386	54,405		50,197	36,846	173,834
Completed	7,661	11,938	7,984	24,570	13,637	65,790

iii. ***Performance Reviews for SRHR/SGBV Education :*** Review of the performance and quality delivery of SRHR/SHBV education sessions was conducted quarterly with SRHR education facilitators in each district. The facilitators reported that of all the learning groups, young people were keen to learn. However, there has been some challenges.

Firstly, there are higher monetary expectations from facilitators and learners. This is attributed to the comparison of what other similar programs are giving. Secondly, some faith based institutions were not quite keen in the beginning but have been slowly convince after reviewing the curricular. The Heroes program has committed to addressing these challenges through enhancing the facilitation package but tagging it to the performance and completion of learning sessions.



Figure 1: Community facilitators attending a review meeting in KALANGALA DISTRICT

iv. ***Evidence Based Message Design:*** In collaboration with the Ministry of Health a three day evidence based SRHR/SGBV message development workshop was successfully held. The 32 participants included the beneficiaries' representatives (youth, women, religious and cultural leaders) from all the programme districts. In addition, there were the duty bearers (Police, health workers and teachers). The key out-puts to this of this workshop were 6 SRHR messages that have received approval from the Ministry of Health Uganda.

v. ***Interactive Radios and Digital SRHR Communication platforms:*** In period 2 the programme embarked on the process of conducting interactive live radio talk-shows. Through these shows an opportunity was provided to discuss the topical issues that included teenage pregnancies and low early ANC attendance. Community solutions were derived to reduce the teenage pregnancies and also promote health seeking behaviours. These

talk-shows provided an opportunity to mobilise for the integrated community outreaches. In the reporting period 27 interactive talk shows radio were held reaching an estimated population of about 620,000 people. Below is one of the photos of some of the talk shows. In period 3 plans are under way to integrate the digital communications in the interactive radio-talk-shows.

3.2 RESULT AREA 2: BETTER PUBLIC AND PRIVATE HEALTHCARE FOR FAMILY PLANNING, PREGNANCY AND CHILDBIRTH, INCLUDING POST-ABORTION CARE.

The activities under this result area aimed at strengthening all the six building blocks of the health system in 58 target health facilities and to enable them to provide comprehensive SRHR services. In addition, the programme targeted to improve referrals from the communities to health facilities and also reach communities through outreaches. The achievements under this result area for period 2 are summarised in the table 3 below:

Table-3 Summary of Key activities under result area-2

#	Activity	Output	Relevance & Impact on Program
1.	Train 54 Health unit management committees and 9 DMHTs in leadership and governance for SRHR/SGBV	Worked with Ministry of health experts to train 456(252M 204F) health managers on leadership and governance. This aimed at strengthening leadership and governance skills plus competencies among DHMT members and HUMCs in executing their supervisory and management functions at their levels of appointment. A total of 150 DMHT members and 306 HUMC members were trained using the Ministry of Health guidelines.	Leadership and governance are critical for an effective health system. There is improved planning and allocation of resources both Human and finances at the district level. HUMCs at the 54 health facilities now meet more regularly and provide linkages with the host communities.
2.	Hold a 2 days Orientation of DICAH (District committee on Adolescent Health)	Working with the Ministry of Health Adolescent Health Team District Committees on Adolescent Health (DCAHs) from 9 districts were oriented on their roles and responsibilities.	The DCAHs serve as advisory committees for adolescent health in all the programme districts and this would also enhance the sustainability and ownership of the SRHR /SGBV Programme.
3.	Train 270 Health Care Workers in Family Planning PAC, BeMOC, CeMOC, Human Rights-Based Approaches, and Adolescent SRHR Including Sex-Positive Rights.	Assessment using the MOH facility assessment tool (version 2020) on the 6 HSS building blocks in the 54 health facilities to inform the trainings. A total of 246 health workers through 433 contacts were made in the reporting period.	Capacity building of health workers enhanced the quality of service delivery across the 54 programme supported health facilities.
4.	Conducting facility-based mentorship at 54 health facilities.	With the guidance of the QI mentorship SOPs, the mentorship targeted poor performing indicators following the review of facility registers at 58 health facilities. A total of 674 mentorship contacts were made to health workers across the 58 Heroes supported facilities.	Onsite mentorship is more effective in improving the skills of health workers and this contributed to improvement in the quality of and uptake for services.

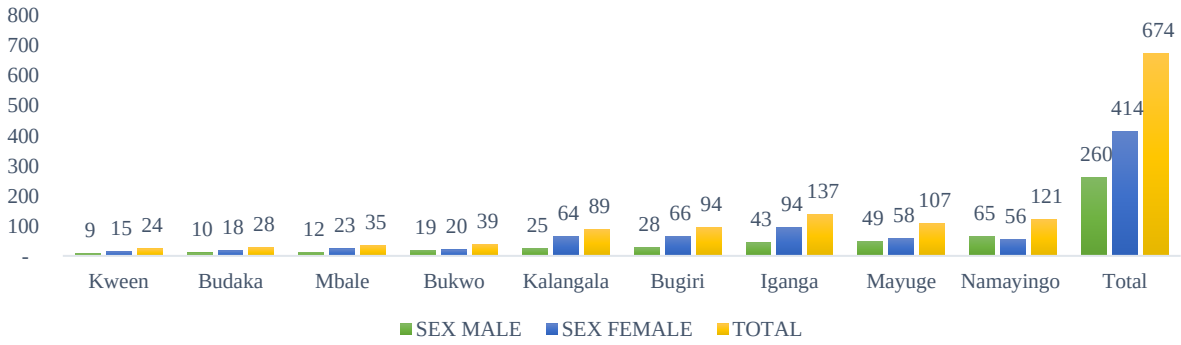
#	Activity	Output	Relevance & Impact on Program
5.	Facilitate peer-led monthly Continuous Medical Education (CME) on SRHR/SGBV in the 54 health facilities.	A total of 489 (193M 296F) health worker CME attendance sessions were conducted on the SRHR gaps identified during the mentorships.	The CMEs followed up in addressing the key gaps among the health workers as such improving quality of SRHR services across the 58 health facilities.
6.	Conduct integrated 216 outreaches for hard-to-reach areas to serve 25,900 people in hard to reach areas.	113 Integrated outreaches in 54 sub-counties of operation were conducted. The services provided included Family planning services, HIV testing services, Antenatal, Adolescent Youth Friendly services (AYFS), SGBV, Postnatal care (PNC) and HPV. A total of 17,585(4,150M 13,435F) received services. The detailed outputs are in the able below:	The outreaches provided SRHR serves the hard to reach communities
7.	Partner with HE to train and deploy 540 VHTs and 180 SGBV survivors as CHEs for increased community-level SRHR services and linkages to the health facility, legal and psychosocial services.	A total of 529 VHTs from 4 districts have been trained to be healthy entrepreneurs out of the planned 540 who in turn provided SRHR information to 264,500 people.	Training of healthy entrepreneurs promotes continuity of services in the absence of the Programme interventions.
8.	Conduct a three-day RBF refresher training for health facility staff and health unit management committees in the 5 RBF districts	This training offered a basic understanding of RBF for 38 health Workers and 15 key district officials in the 5 RBF districts. Participants' capacity was enhanced, and they also received tailored support to develop business plans detailing their quarterly targets as well as strategies for realization of strategies and set goals. Among the discussed topics were	Efficient delivery of the RBF approach
9.	Contracting of 18 Health facilities and 5 Districts for RBF	5 DHMTs and 18 health facilities contracted for RBF. Business plans developed per facility	Contracting defines clear deliverables and obligations for both the District and HFs
10	Conduct Quarterly review meetings with all targeted RBF HF	20 Review meetings were conducted (4 per RBF district)	Review of progress towards implementation of business plans enables the programmes to assess progress on incentivized indicators and develop performance improvement plans for poorly performing indicators
11	Conduct quarterly quality assessments by EDHMT	12 quality verification exercises were conducted by DHMT across all 18 facilities of the 5 districts	Quality verification ensures the quality of care at the health facility
12	Conduct quarterly client satisfaction surveys by CBOs	4 Quarterly client satisfaction Surveys were conducted for all the 5 districts	The surveys inform facilities and districts on clients perceived quality of care, which further informs quality improvement initiatives at facility level
13	Conduct monthly RBF verification of Quantity outputs	12 visits were conducted focusing on 18 health facilities. 63 HWs mentored on data management and reporting 8 facilities were supported to get SGBV registers	This ensures out-put based financing, verification also ensures fidelity to the RBF principles and the key indicator quality definitions
14	Backstopping quality visit by Cordaid global office	Cordaid RBF Experts conducted a support visit to the HEROES RBF program in November 2021	Quality implementation of the programme. This provided an opportunity for technical feedback by the global team.

#	Activity	Output	Relevance & Impact on Program
15	Learning visit by the Shifo foundation team	Roll out of SPT in 18 facilities	The Heroes team hosted the Shifo Foundation team (technical partner on Smart Paper Technology (SPT) on a learning visit in March 2022 in Budaka district. Key issues of discussions were the ongoing process of adjusting district indicators to outputs, upcoming rolling out of the SPT to alleviate the verification expenses and fatigue on verification team. SMART actions to facilitate support supervision by the district leadership and most importantly leveraging on the already ongoing use of SPT for COVID 19 by Ministry of Health.
16	Quarterly Quality Monitoring Visits	4 visits conducted	These were conducted by the Cordaid national team, mainly focusing on support and supervision to ensure progress in line with set targets and desired standards. The visits focused on both the programmatic and financial aspects of the project.
	Output 2.2: Increased access to quality friendly services by young girls, boys & women in hard-to-reach areas		
17	Support health facilities with RBF Subsidies based on verified performance	A total of 348.395.320 UGX results-based financial incentives paid	Approximately 60% improvement on ANC 1 in 1st trimesters for young people 10-24yrs, 160% in adults (25-49 yrs.). 86% increment in the utilization of short-acting contraceptives, and 131% for long acting reversible contraceptives 553% increment on clients receiving comprehensive post abortion care

Key Areas of Progress Under Result Area 2.

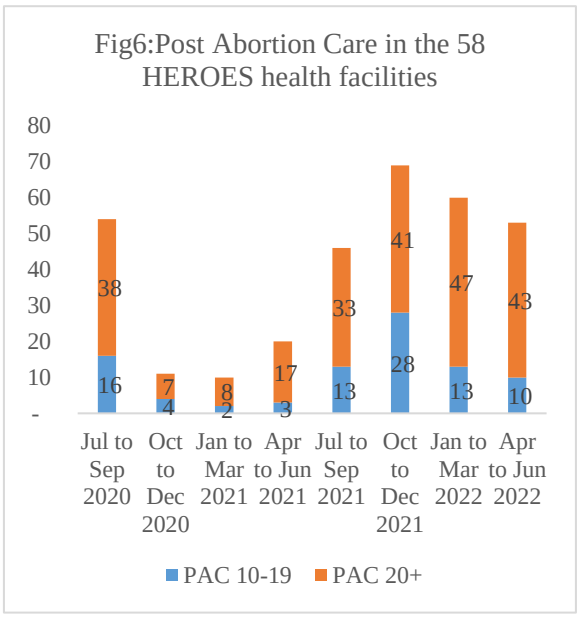
i. ***Skilling of Health Workers on SRHR Services Delivery***: The programme adopted the onsite skilling of health workers as opposed to classroom training workshops. Using this approach, 647 (414 f, 270m) were mentored on delivery of the adolescent/youth friendly service package, of MOH SGBV screening tool, post abortion care, family planning, use of partograph to monitor labour, management of 3rd stage of labour, and helping baby to breath.

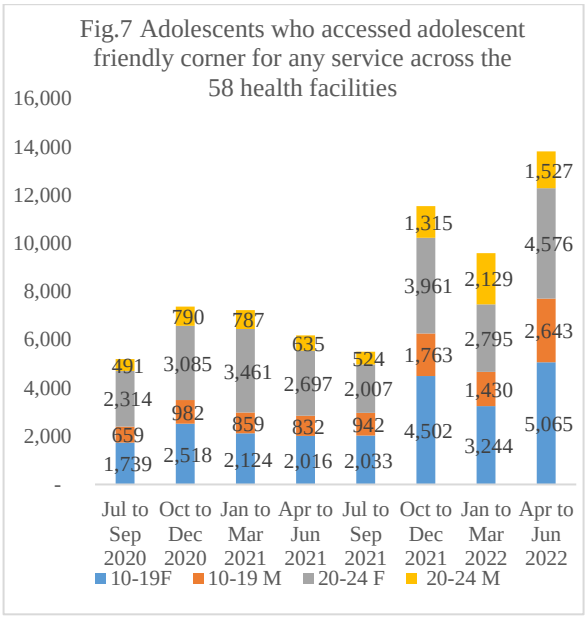
Figure5: Health workers Mentorship contacts by sex across the 9 districts



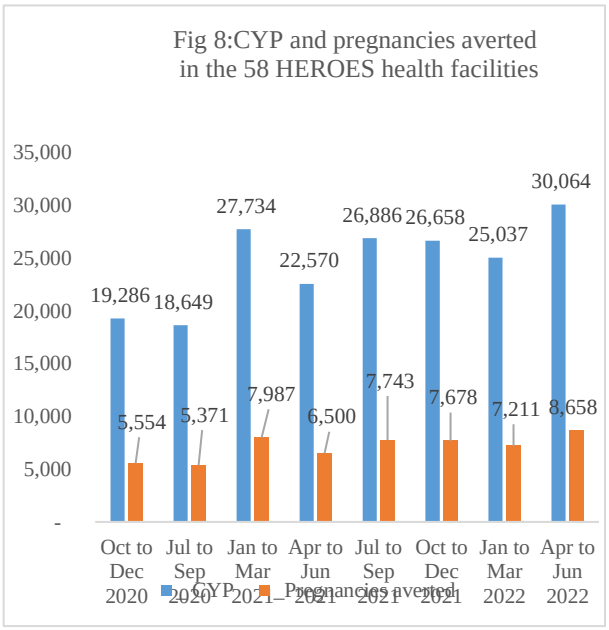
ii. ***Quality Improvement in SRHR Services*:** the programme has functionalized quality improvement (QI) committees and teams at all the 58 targeted health facilities. Furthermore, the programme mentored health workers on how to apply the common QI frameworks such the 5S which is used to organize workspaces and 'plan, study, do , act' (PDSA) which is used to strengthen skills and

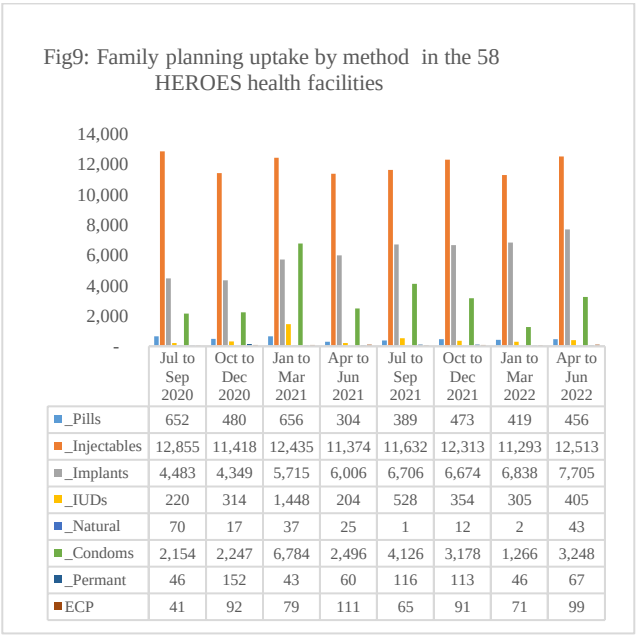
practices. As a result, for quality improvement interventions, the programme has observed an increase in delivery of post abortion care services and adolescent friendly services (see figures 6 &7)





iii. ***Family Planning***: The programme realized in improvement in uptake of family planning compared to period 1. The CYPs reached > 30,000 while and averted pregnancies reached >8,500 per quarter for the first time (figure8). The improvement is attributed to mentorship and application of RBF at selected facilities. The method mix has remained good, with injectables, implants and condoms being the most utilized methods. The emergency contraceptive is available but not utilized,

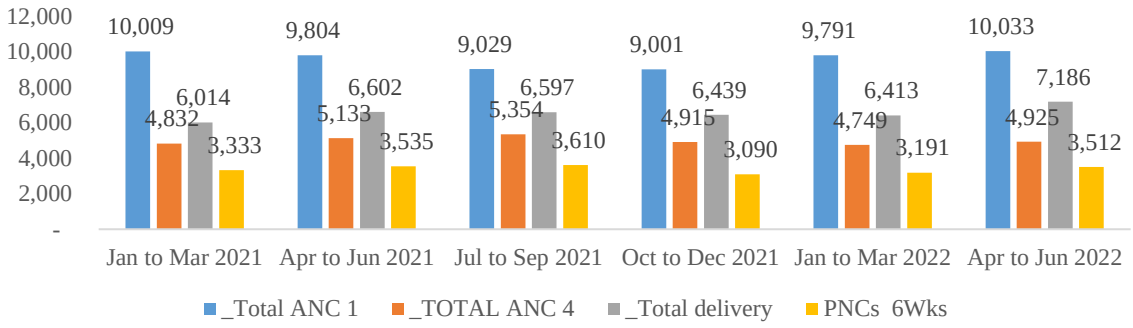




	Jul to Sep 2020	Oct to Dec 2020	Jan to Mar 2021	Apr to Jun 2021	Jul to Sep 2021	Oct to Dec 2021	Jan to Mar 2022	Apr to Jun 2022
_Pills	652	480	656	304	389	473	419	456
_Injectables	12,855	11,418	12,435	11,374	11,632	12,313	11,293	12,513
_Implants	4,483	4,349	5,715	6,006	6,706	6,674	6,838	7,705
_IUDs	220	314	1,448	204	528	354	305	405
_Natural	70	17	37	25	1	12	2	43
_Condoms	2,154	2,247	6,784	2,496	4,126	3,178	1,266	3,248
_Permant	46	152	43	60	116	113	46	67
ECP	41	92	79	111	65	91	71	99

iv. ***Maternal Health Services***: Nine (9) maternal deaths were recorded in period 2 and were caused by obstructed labour (6) and eclampsia (3). All the deaths were reviewed through the MPDSR approach and a response package implemented in the sites where the deaths occurred by the assistant district health officers in charge of maternal health.

Figure 10 MCH cascade across the 58 health facilities



The maternity cascade continues to show a high ANC1 attendance and nearly 70% health facility delivery for all those who start ANC1. Just about 50% of those who start ANC 1 complete 4 ANC visits. The programme will focus on improving this in period 3.

v. ***SRHR Service Outreaches***: the programme has continued to support health facilities to conduct integrated outreaches which offered family planning (long and short acting methods), HIV testing, child immunization, SGBV services and the associated education. Through the outreaches the 17,585 clients were provided with various SRHR/SGBV services.

Table-4 showing outreach services by Gender

Services	M	F	Total
FP	836	3,363	4,199
HIV Testing Services	966	3,865	4,831
ANC		2,023	2,023
AYFS	504	2,410	2,914
PNC		951	951
SGBV	409	1,009	1,418
HPV Vaccination		1,249	1,249
Grand Total	**2,715**	**14,870**	**17,585**

vi. ***Healthy Entrepreneurs (HE)*** is a Heroes Programme strategic partner contributing to increased access to SRHR information, commodities and services outcome area 2, (output 2.2. i.e. Output 2.2: Increased access to quality friendly services by young girls, boys & women in hard to reach areas) . The HE approaches have enabled the Heroes programme to empower typically village health teams (VHT) with technology and income that helps them to extend services beyond health facilities to last mile communities thereby solving the problem of barriers to accessing SRHR services. In addition, the CHE approach is helping the Heroes Program to study how last-mile delivery of SRHR services can be sustained. In period-2, HE trained and deployed 450 (M148/302F) Community Health Entrepreneurs (CHEs) in the rural sub-counties of the districts

of Bugiri, Namayingo, Iganga, Mayuge and Kween. Through these CHEs 264,500 (M66, 125/F198, 375) people were reached with information while 3,178 contraceptive products were distributed.



In period 3, the CHEs supported by HE will continue to provide SRHR health products including contraceptives and online consultative technical support to the community health entrepreneurs. This is expected to continue since they would be gaining through the sales of these healthcare products. Together with HE, the Heroes Programme will assess the effectiveness of the CHE approach and use the learnings to improve and advocate for sustainable SRHR service delivery at the last mile.

vii. ***Partnerships to Ensure Availability of Commodities, Supplies, and Services***: In period 2, HEROES programme continued to collaborate with other implementing partners conducting similar activities to support such as Reproductive health Uganda and Marie stopes Uganda. These have supported targeted facilities with long-term and permanent FP methods.

In addition, Heroes has collaborated with population services international Uganda (PSIU) in skilling health workers to promote self-care in family planning under their Delivering Innovation in Self-Care (DISC) program. The program is promoting the self-injection contraceptive DMPA-SC in Uganda an in the Heroes districts of Iganga, Bugiri, Mayuge.

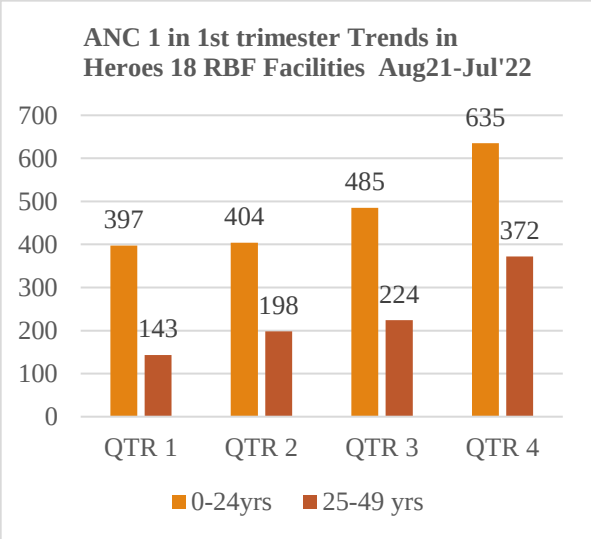
Heroes also established working relations with DKT international under the ACUATE programme to increase access to SRHR commodities in the private health facilities. This DKT has also provided links to SRHR training which Heroes is using to train health workers in Kalangala districts.

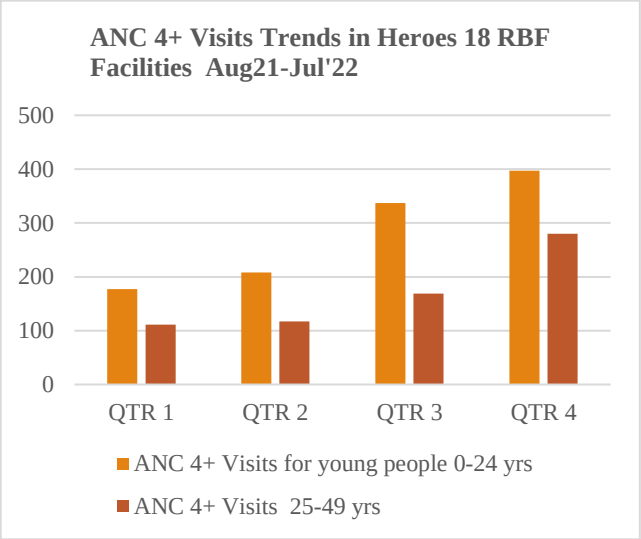
These Heroes programme has also worked with District Medicine Management Supervisors (DMMS) who have actively supported redistribution of reproductive health commodities across health facilities. This has ensured reduced stock-outs although some commodities still run out of stock. However, with governments' new policy of one warehouse, there is likely improvements on stocks.

viii. Progress and Effect of Results Based Financing (RBF) on Selected SRHR Indicators in target Health Facilities

The Heroes programme has been applying results-based financing in 18 RBF health facilities to improve service indicators in selected health facilities. Below is the progress made so far.

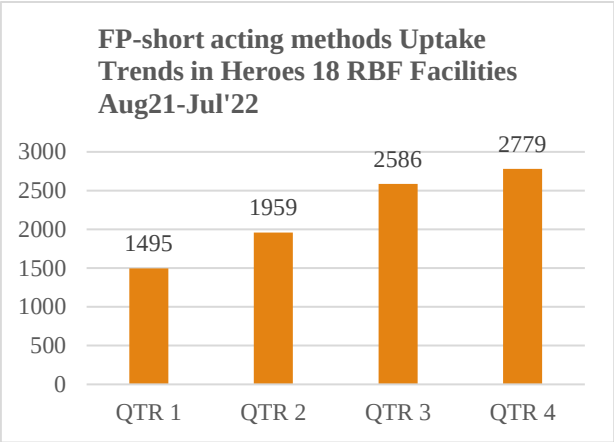
a) ***Improved Antenatal Care***: Data from the RBF intervention indicates that RBF has improved ANC1 in the first trimester as well as completion of 4+ ANC visits.

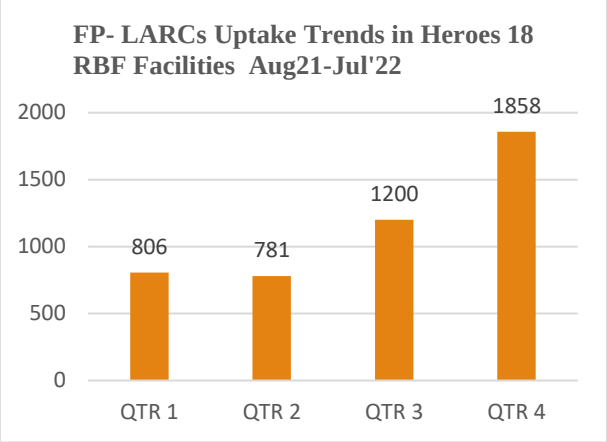




Antenatal care attendance by the young people has increased by half (50%). The increasing trend is also noted for the 4+ visits which speaks to the quality of services offered at the facilities which can retain young people in care. Through funds earned under RBF, facilities were able to purchase HCG pregnancy test kits which they use to confirm all suspected pregnancy at OPD and immediately enrol the mother for ANC, this is greatly contributed to early initiation of antenatal care especially for the young people to. RBF funds also supported integrated out reaches which have greatly improved access to maternity services for inaccessible communities like the island and the mountainous communities of Bukwo.

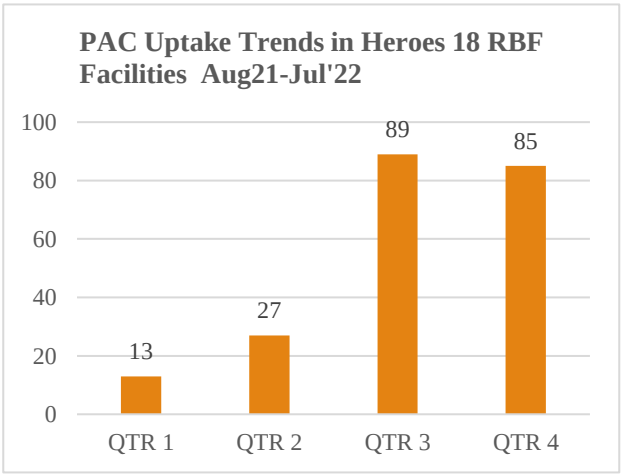
b) **Increased Uptake of Family Planning Methods:** There is a noted improvement in uptake of FP in the 18 RBF facilities. This was achieved by health facilities using RBF funds to conduct FP mobilization drives and SRHR education sessions, conducting FP targeted outreaches, working with community health volunteers including TBAs to reach women and girls. In addition, health facilities have been able to hire locum staff, especially midwives using RBF funds to boost the HRH capacity at facility level. This is illustrated in the figures below:





c) **Increased Provision of Post-Abortion Care for Women and Girls**

"*We had MVA kits that were supplied by the district, but I didn't even know how to assemble the kit, we referred most of abortion clients to the HC IV because I didn't think we would be able to handle the client"*- midwife, Syanyonja HC III



The target health facilities have achieved this by utilizing RBF funds to train their staff in prior to RBF, several facilities and health workers did not offer PAC because of technical capacity and the legal environment around abortions. Through RBF, the health workers were oriented on the legal guidelines regarding PAC and abortions, they were taken through Value clarification and attitude change towards PAC. Through RBF funds, the facilities without MVA kits were able to acquire them, and through continues mentorship, coupled with the incentive attached to PAC, referral of uncomplicated abortions cases was reduced. The target facilities have also built partnerships and linkages with private clinics in their coverage areas, and they have registered referrals from private clinics for comprehensive Post Abortion Care. This greatly worked for Kasekulo HC and Mulabana HC in Kalangala district.

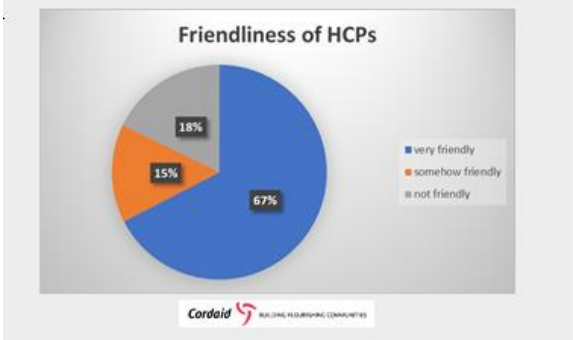
d) **Improvement in Client Perception on the Quality of Care:** The quality of the SRHR services were assessed by Community Based Organizations engaged by the Heroes Programme. The CBOs followed up directly with the users of the services i.e. young people and WRA and assessed the waiting time, the friendliness of health workers and community rating of services. Below is a summary of their views on various aspects of quality regarding waiting time, friendliness of health worker and health service rating.



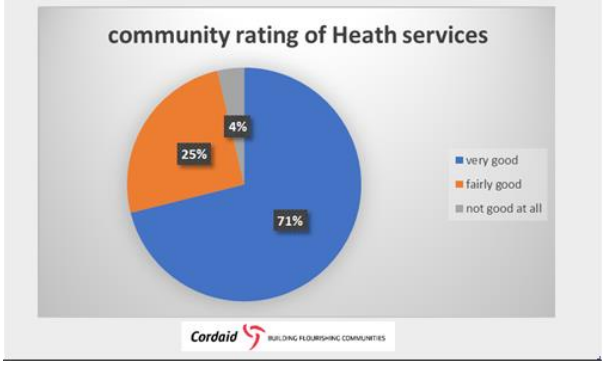
Client waiting time: The results from the Q4 survey indicated that 55% of the clients reported receiving services in less than one hour, this is quite a bit lower than the 63% that was reported in the Q1 survey. This could have been lower; however, it is attributed to the increasing client-to-health-worker ratio at the facilities. Data has shown great increase in the number of clients receiving services at RBF supported health facilities and yet the human resource at these facilities remains low.

The Programme has been engaging the districts in this regard, and 8 midwives have over the last quarter been allocated to boost the human resource at RBF supported facilities. Five facilities have also been able to hire locum staff through their RBF funds to boost human resource especially in maternity.

Health worker friendliness: The majority of the clients interviewed by the CBOs said that the health workers were friendly. The greatest numbers were reported in Bukwo district (73%) and Budaka district (71%). This is attributed to the HEROES programme efforts in making youth services friendly for the young people through training of HWs, the functionalization and equipping of adolescent spaces at health facility and meaningful engagement of peer educators in service delivery, planning and monitoring



Community Rating of SRHR Services: Despite the relatively long waiting time reported by almost half of the respondents, 71% rated the services they received as very good. This is attributed to the functionalization of Youth friendly services by the HEROES program, and good technical capacity of health care providers.



3.3 RESULT AREA 3: MORE RESPECT FOR SEXUAL AND REPRODUCTIVE RIGHTS FOR ALL.

The activities under this result area aimed at strengthening capacities of CSOs to lobby and advocate against harmful practices related to gender and SGBV/SRHR. The achievements under this result area for period- 2 are summarised in the table 5 below:

Table- 5: Summary of Key activities under out-come-Area-1

#	Activity	Output	Relevance & Impact on Program
1	Train selected 32 (20 female and 12 male) members of 2 CBOs per district in social norms, gender transformative/rights-based approaches	17 (seventeen) trainings have happened, reaching a total number of 559 members of CBOs across the 9 intervention Districts. 54.2% of the Trainees were between the ages of 25 to 49 years while 45% of the trainees were female. There are still limited participation of women and young people in civic leadership. The program will continue to call for greater inclusion of young people and women in civic leadership.	The training was relevant to increasing SRHR/SGBV awareness, participation, ownership and capacity in SRHR/SGBV advocacy. Following the training the Heroes programme will work with these CBOs to cascade SRHR/SGBV advocacy at various levels of the community to increase respect for SRHR. The trained CBOs members form a critical mass of SRHR/SGBV advocates/ champions who the programme is building to sustain the promotion of respect of SRHR for all in the community. The trained champions are also activists who carry out awareness, hold perpetrators accountable and provide support for survivors at community level, increasing the availability of a support network and community based solutions
2	Participate in commemoration of international days to advocate for action towards SGBV prevention and response.	15 events were commemorated across the 9 beneficiary districts, reaching 14,880 beneficiaries (6,811M, 7,244F) directly and indirectly. These events included 16 days of activism, International Women's Day, and Day of the African Child; during the events, various activities were conducted which include radio talk shows, community events led by champions, round table discussions, legal aid clinics and community sensitizations. The focus of the discussions during the events were on child marriages, Teenage pregnancy, re-victimization and stigmatization at service points.	The activity was relevant for the increase in participation, visibility and ownership as Young people's voices were amplified through their participation. This increased agency, voice confidence, self-organization and self-mobilization of young people, survivors and the community. This evoked action among the leaders, for example in Kalangala, Iganga, Bukwo, Mayuge, and Budaka, the members of the steering committee made commitment and signed a joint resolution on improved collection, storage and usage of data on SGBV and adolescent health, improved systems on birth registration, improved quality of service and resource allocation.
3	Conduct mobile community dialogues/interactive sessions	28 community dialogues were held in the intervention districts. The sessions reached a total of 3,716 beneficiaries (1,542M, 2,174F), 51 PWD (25F, 26M)	This was relevant in building community capacity to increasing awareness on SRHR/SGBV laws, improving attitude and action against Harmful practices. Communities now understand the laws on SGBV, SRHR and harmful practices (from the annual assessment 67% of the respondents reported awareness of laws/policies against child marriage and teenage pregnancy and 58% knew the penalties for child marriages.

#	Activity	Output	Relevance & Impact on Program
4	Conduct targeted awareness on SGBV and prevention through Community Champions	60 targeted awareness sessions were carried out across the 9 intervention Districts by community response and prevention champions. A total number of 31,468 beneficiaries were reached (17612F, 13856M, and 232 PWD) through 421 GBV champions traversing their communities	This was relevant to increasing visibility of survivor experiences reducing the burden, change in attitude to violence and change in action
5	Hold monthly inter-generational dialogues with multi-sector partners at the community level	22 events were held across the nine intervention districts, reaching 2,085 (1,018F, 1,067M, 69 PWD) direct beneficiaries through monthly dialogues, listening sessions, medical and legal outreaches. 10 medical and legal sessions in the young person's support groups reaching 1,016 girls and 1,042 boys	This has been relevant in increasing young people's access to power holders, power to make choices, giving them voice, increased access to service, increased understanding of rights and improved their decision making on SRHR and wellbeing. During the listening sessions, roundtable discussions, medical and legal outreaches, young people raised their concerns on stigmatization when they seek services especially antenatal service, negative attitude by service providers, challenges faced by teen mothers who would like to return to school, norms that contribute to child marriages and teenage pregnancy and their undermined participation and involvement in leadership and decision making bodies As a result, more young people are seeking services and referring others for instance 237 out of 1443 cases received in period 2 were referred by young people, and a total of 36 cases were self-referrals by young people 28(12M, 16F) young people now sit on the SGBV steering committee and from an assessment they see their participation to be meaningful. 9 young people survivor support groups have been created to increase safe spaces for the young people.
6	Conduct engagement meetings with 30 different team actors with a focus on capacity	3 events were implemented, which lasted 5 days and saw a team of high-level actors who included members of the steering committee, selected leaders and staff, share learning, experiences and skills.	Strengthened terms of delivering gender-mainstreamed support and services to beneficiary communities in the target districts**.**
7	Simplify and translate laws and guidelines on SGBV and SRHR.	10 laws have been selected and simplified. the penal code Act, The Constitution, Bride price ruling, Domestic Violence Act, the Teenage pregnancy policy, the Prohibition of FGM Act, the strategy on teenage pregnancy, Trainer's guide, Trainer's leaflet for health	This was relevant in lifting barriers to seeking redress, better treatment from service provider's positive experience for survivors who seek justice. This was also relevant in access to justice and power to challenge discrimination within frameworks.

#	Activity	Output	Relevance & Impact on Program
		professionals, guide to filling police forms and its protocols.	
8	Train and mentor 30 (12 female and 18 male) Champions per district	72 one-day trainings took place across the 9 Districts of intervention, reaching total of 415 prevention champions (219m, 196f) against a target of 150 for the period	This was relevant to increasing visibility of survivor experiences reducing the burden, change in attitude to violence and change in action
9	Conduct campaigns against harmful practices targeting 90, 000 people	The programme working with various groups has created a grass root base and movement in each district comprising of; 70 response and prevention champions, 40 local leaders and 32 CBOs, 30 steering committee members, 415 SSG members (226 women189 girls and 2boys). This movement has worked together to campaign against harmful practices.	This was relevant in linking beneficiaries to services, increasing agency, confidence and voice. This was relevant to increasing visibility of survivor experiences reducing the burden, change in attitude to violence and change in action. The awareness is also preparing these groups to self-mobilize and act on SGBV
10	Orient 40 leaders (10 LCs, 10 religious' leaders, 5 cultural leaders, 5 political leaders	20 engagements took place with selected leaders across the 9 Districts of intervention. A total of 639 leaders were reached during the period (428m, 211f). 73.5% of the leaders trained were men aged between 25-49 years of age	Changes in laws, guidelines, (health) policies and practices leading to decrease of barriers to SRHR services

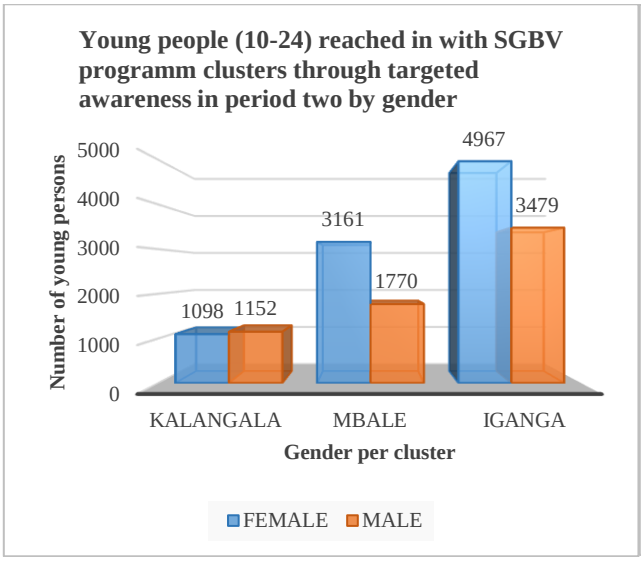
Key Progress Areas Regarding Respect for SRHR for All

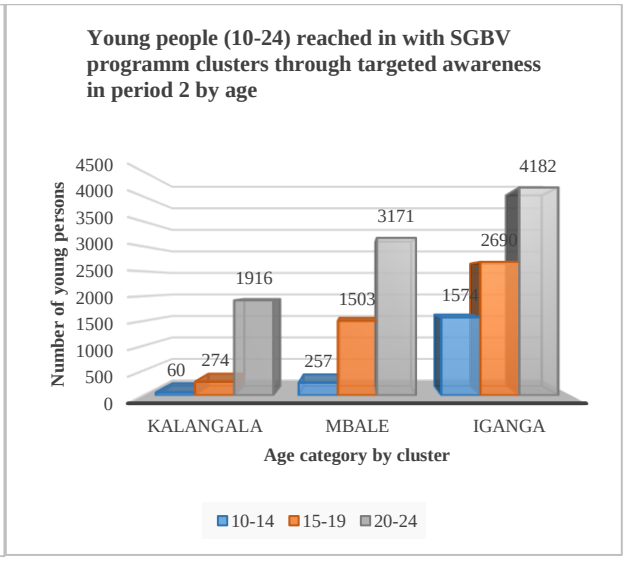
i. **Building Capacity of Local CBO to Promote Respect for SRHR for All:** 18 youth/women-led CBOs (2/district) were identified assessed for basic competencies SRHR/SGBV work. After the assessment these were contracted to roll-out the programme in the 9 programme districts. They were provided training in the advocacy, provision of SRHR education and monitoring of the community resource persons. Currently, the CBOs have been supported to technically support community resource persons in three sub-counties each and through these initiatives reporting for the community resource persons has greatly improved. The CBOs have also played a role in mobilising for the integrated outreaches across the catchment areas of the 58 Heroes supported health facilities. In period -3 the role of the 18 WLO/YLO will be strengthened further.

ii. **Targeted SRHR/SGBV Awareness:** In period 2 the programme engaged groups that include the local leaders, champions, members of the CBOs have been organised into a movement of activist that carry out door to door activities, dialogues, outreaches and other community mobilisation and awareness activities. Communities have been sensitised on , stages of change, power relations, violence against women and children, gender based violence, (its causes, triggers effects and SGBV response and prevention methods), rights of women and children, gender roles, harmful practices of Child marriage and teenage pregnancy, as well as laws, procedure and policies on SGBV as well as safeguarding and disability inclusion

The communities are showing increased knowledge in their rights, where to report cases of violence, nature of cases and roles and responsibilities of duty bearers for example in an incident of defilement, the community members took it upon themselves to take a survivor to the health centre in time, another community team worked with the local council defence to apprehend the perpetrator and delivered him to police, and then called the helpline to notify the MIFUMI team of this case for follow up. This reaction from the community shows that they have gained knowledge how to respond when violence occurs, where to report cases of violence. In addition, the assessments show that the communities are more aware of their rights, at least 58% of the respondents were completely opposed to child marriage have supportive attitudes, and they know where to report cases. On the other hand, cases persist with 40% of the respondents knew of a girl under 18years from their neighbourhood who got married in the last one year. This has led us to believe that a lot of progress has been made in terms of what people know and feel about harmful practices, but more remains to be done in terms of what individuals and communities do about the problem

The programme has been very deliberate on reaching the young people with the districts of implementation. The figures below show the number of young people reached during the targeted awareness sessions.





iii. **Simplifying and translating laws and guidelines on SGBV and SRHR**: In period 2, the GBV technical team was facilitated through an exercise to identify, prioritize, and simplify relevant laws. This process took account of who the intended users of the product was, their profile and ultimately their needs in as far as SGBV services were concerned. The 11 laws simplified include: 1) The penal code Act Cap 120, 2)The Constitution of the Republic of Uganda, 3) Bride price ruling, 4)Domestic Violence Act, 5) The Domestic Violence Regulations 2011, 6) The Succession(Amendment Act 2022, 7) the Prohibition of Female Genital Mutilation Act, 8)The National strategy to End Child Marriage and Teenage Pregnancy 2022, 9) The Uganda Gender Policy 2007, 10) The Prevention of Trafficking in Persons Act 2009, 11) The Children(Amendment) Act 2016.These are currently undergoing review and validation and will be printed and disseminated in period 3. In addition

MIFUMI has also produced a training design based on the Mifumi manual titled health workers guide on SGBV management which will be used in period 3 to deliver medical legal training to frontline responders as part of our effort to strengthen coordinated multi sectoral work at the hotspot level, Trainer's leaflet for health professionals, guide to filling police forms and its protocols This will help in the areas of improvement practice, implementation of laws, and accountability by duty bearers. The above laws will be translated in Luganda, Lusoga, Samia, Lugwere, Ateso, Japhdola, Lugisu, Kupsabiny and Kiswahili. These will be disseminated in period 3 targeting local leaders, youth and women. The programme is working with the districts of Namayingo and Bukwo is enact by-laws on "night fundraising" and alcoholism respectively that have exposed young people to sexual abuse.

iv. **Campaigns Against Harmful Practices :** The programme working with various groups has created grassroots movements to lead campaigns against harmful practices in each district. These movements comprising of; SGBV response and prevention champions (70), local leaders (local council members, clan leaders, religious leaders, Nabakyala, Senga, opinion leader, traditional healers) (40) and youth/women lead CBOs (32), SGBV steering committee members (30), SGBV survivor support group (SSG) members 415 (226 women189 girls and 2 boys). This movement has worked together to campaign against harmful practices. In Kalangala, the champions have held door to door sessions as part of the "back to school" campaigns for the teen mothers, the door to door activities were carried out to identify teen mothers and encourage the parents to take them back to school. During the assessments conducted in July, one of the champions mentioned that out of 14 girls she identified through the household visit, 6 have returned to school. Normally all the 14 girls should have returned to school, however there are still some barriers that include poverty, long distances to the school, fear of stigmatization and lack of care givers for their children.

From the campaigns against teenage pregnancy and child marriages, various districts have seen increased reporting of cases on sexual violence, teenage pregnancy and child marriages. Communities are now aware of the harmful practices, they recognize and appreciate why they are unacceptable, they are more conscious of their existence and the harm they could cause. These activities also involved men as allies in the campaigns against teenage pregnancy and child marriages.



Young people calling on the leaders and decision makers during the campaigns on child marriage and teenage pregnancy.

Youth participation was one of the key achievements in the campaigns held by MIFUMI during the women's day and the day of the African Child. The young people participated in community match displaying SRHR/SGBV messages, they made presentations through poem, songs, drama and skits and this enabled them voice their issues before the duty bearers and community members present.





In the picture on the right, MIFUMI gifted all the girls that participated with reusable sanitary pads. This was mainly because through the listening sessions and the young people support groups, one of the things that keeps the girls out of school is their menstrual periods.

https://www.newvision.co.ug/category/health/teenage-mothers-match-against-early-pregnanci-140411

https://www.mayuge.go.ug/ending-teenage-pregnancies-and-child-marriages-mayuge-district

https://www.mayuge.go.ug/ending-teenage-pregnancies-and-child-marriages-mayuge-district

https://newvisionapp.page.link/AX4VPrUbkEusLxoY9

3.4 RESULT AREA4: ENABLING ENVIRONMENT FOR YOUNG GIRLS AND WOMEN'S ELIMINATION OF VIOLENCE AGAINST GIRLS AND WOMEN.

The activities under this result area aimed at improving SGBV service provision and case management. The achievements under this result area for period-2 are summarised in the table-6 below:

Table-6: Summary of Key activities under out-come-Area-4

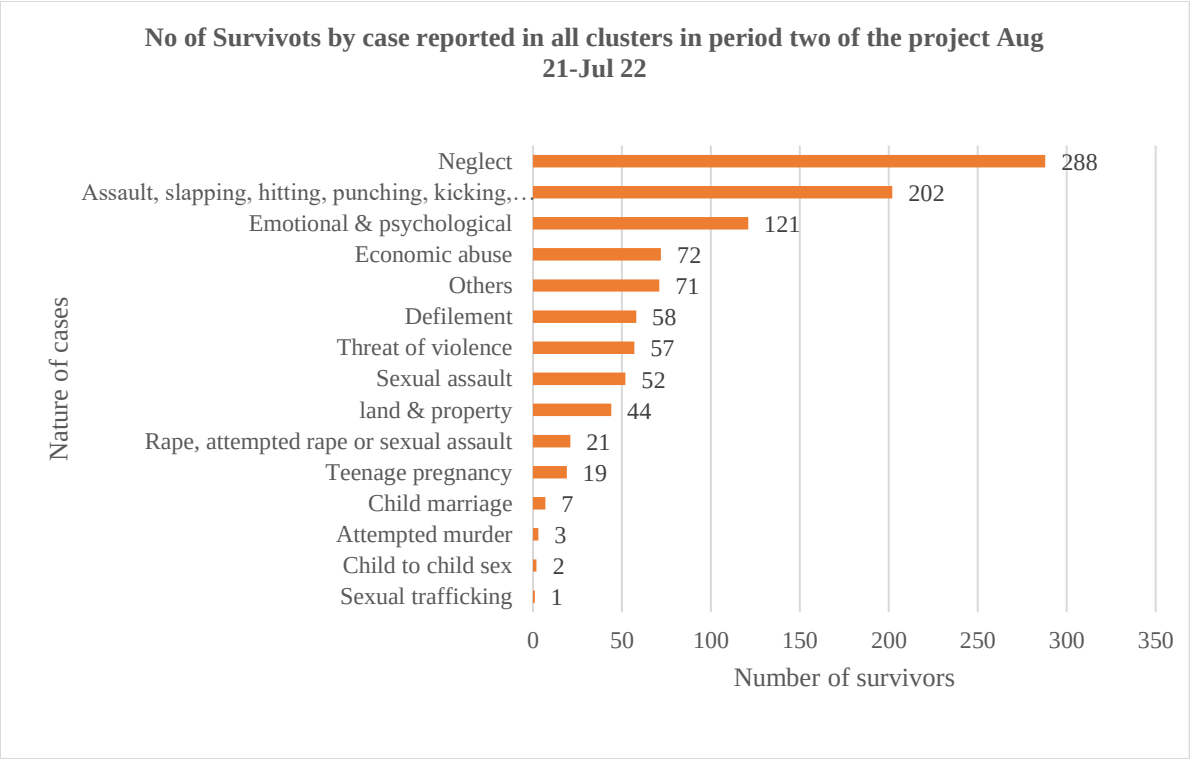
#	Activity	Output	Relevance & Impact on Program
1	Train 30 responders (5 district leaders i.e., probation officer, gender officer, D/CDOs, 5 teachers, 5 police, 3 Health workers s, 7 LCs and 5 selected representatives of YLOs and WLOs) on SGBV response in each of the districts.	9 trainings have happened, reaching a total of 270 responders (141M, 129F). The duty bearers that participated in the trainings included the District Medical Officer, probation officer, gender officer	This was relevant in lifting barriers to seeking redress, better treatment from service provider's positive experience for survivors who seek justice. This impacted on timely, effective and friendly response to survivors
3	Train 40 female SGBV response champions on action planning, prevention, monitoring and response	18 trainings took place, reaching a total of 796 response champions (11m, 785f). 75.2% of the beneficiaries were women between the ages of 25 to 49 years old	This was relevant to safety and well-being of survivors, teenage mothers and young people. This was relevant to increasing visibility of survivor experiences reducing the burden, change in attitude to violence and change in action
4	Support rehabilitation and reintegration of SGBV survivors	A total of 23 survivors were resettled reintegrated with their families, these had a total of 24 children. This resettled and integration involves conducting community sensitization in the homes were the survivors were being resettled, the survivors were provided with psychosocial support and some with start-up packs to enable them take care of themselves as they recover from the violence	This contributed to well-being and safety of survivors and their beneficiaries.
5	Establish and Strengthen SGBV response committees (survivor support groups).	20 Survivor support groups have been established with 413 members (9 young person's groups and 11 adult survivor support group)	This contributed to, safety, well-being, confidence, independence, self-reliance, creating safe spaces for individual and collective empowerment, as vehicles for social assets building for survivors, facilitating connections between survivors, champions, and other community actors to raise awareness of SGBV/SRHR issues,
6	Establish/ Strengthen SGBV Steering Committees.	In total, 35 steering committee meetings were held across the 9 Districts of intervention, reaching 1,050	This was relevant in lifting barriers to seeking redress, better treatment from

#	Activity	Output	Relevance & Impact on Program
		committee members. These platforms have proven to be very critical to support local advocacy for the H4GTA programme	service provider's positive experience for survivors who seek justice. This was relevant to increasing visibility of survivor experiences reducing the burden, change in attitude to violence and change in action Better support at community policy level.
7	Maintain SGBV Advice Centres	9 advice centers were fully activated. 1,841 individuals have been supported to access and use social services (1443f, 399m)	This was relevant to safety and well-being, Self-mobilization, self-organization, self-reliance, independence choice and agency.
8	Support Existing Shelters to Reach Minimum Standards of Care.	MIFUMI has supported 2 existing shelters to reach minimum standards of care which are outside the programme areas but used in the respective region by other programmes. These have included the shelters in Tororo and Mbarara, where survivors were temporarily sheltered as they were supported through the justice system.	Safety and well- being, increased knowledge and ability to make choices
9	Supporting volunteer costs for the helpline	The helpline supported over 616 callers with information, advice and referral services	Increased access to justice, timely services
10	Facilitate JLOS to conduct pre-emptive campaigns in targeted hotspots (Mobile Legal Aid Clinics).	10 mobile legal aid clinics were conducted during the period, reaching a total of 3738(2096F, 1642M). 41 PWD- 16F, 25M beneficiaries. Over 500 males sought the services of SGBV legal aid, an indication that there is demand for services among men	Access to justice and services, increased knowledge.
11	Monthly onsite visits to child and family protection unit (CFPU)	108 visits in total throughout the year. The visits will be conducted by the SGBV team and will take a form of a meeting with the respective CFPU head and key relevant stakeholders.	Young people and women have access to SRHR and SGBV safe spaces
12	Establish and popularize the referral system.	3086 community members, 280 champions, 160 leaders, 128 CBO leaders and 120 steering committee members were reached with various IEC material, including toll-free helpline promotion fliers, 270 copies of PF3, PF3A and PF24A as well as copies of the GBV referral pathway.	lifting barriers to seeking redress, better treatment from service providers positive experience for survivors who seek justice
13	Develop a voucher programme for vulnerable YP and WRA for SRHR and SGBV services	CORDAID Launched the E-Voucher and e-referral app to boost access and utilization of health services for SGBV survivors. The initiative has proven to boost access to health services for SGBV survivors in the last one year as shown in the graph below	Young people and women have access to SRHR and SGBV safe spaces
14	Re fresher Training in Voucher Management (Health workers and village teams)	To strengthen e- voucher interventions, this refresher training was conducted for 36 health workers and 24 peer educators in all 12 RBF health facilities in four districts focusing on the e-voucher system and processes as well as SGBV.	Young people and women have access to SRHR and SGBV safe spaces

Areas of Progress Under Result Area 4

i. **SGBV Case Management:** A total of 1, 426 women reported cases to the Heroes programme in period 2. Majority of the cases were physical assault and neglect ranked the highest. The distribution

of different case included: rape, defilement, assault, child neglect, forced marriages, child marriages, attempted murder, threatening violence, emotional violence, land and property. This is illustrated in the figure below:

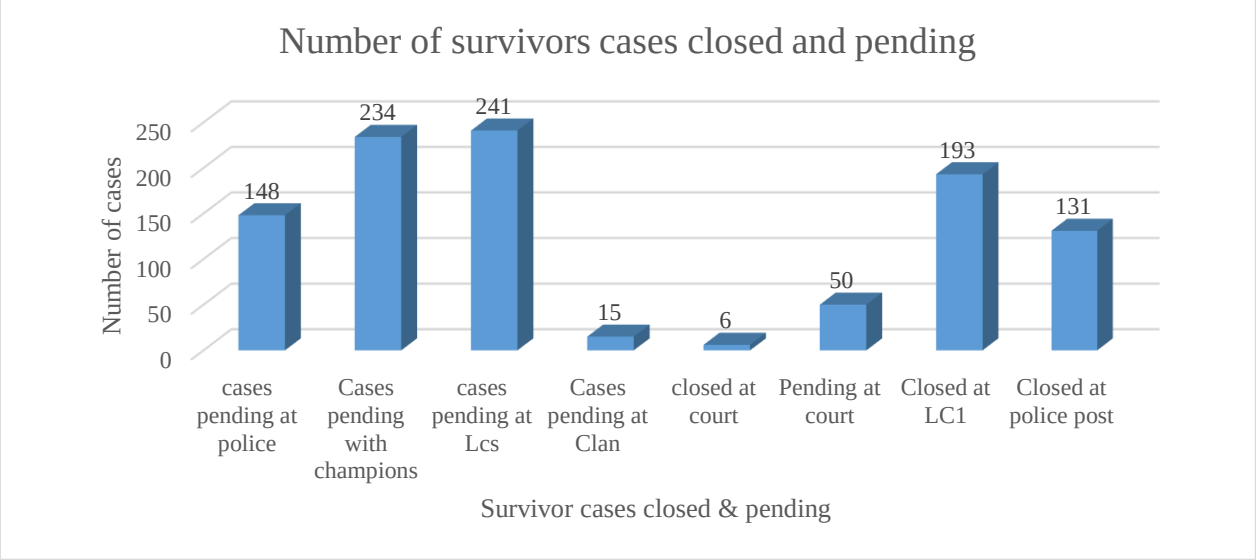


Note: From the graph above**,** although teenage pregnancy and child marriages show a low percentage, these are the ones that have reported directly to the advice centres. The Programme has however supported a total of 154 teenage mothers across the 9 districts. These came through the survivor support groups that meet at the advice centres and have been offered various forms of support ranging from empowerment, legal advice, psychosocial support and educational sessions

ii. ***Increasing access to Justice***: The establishment of advice centres by the Heroes programme has increased the number of cases reported. However, many SGBV cases go unreported due to the fact that the services are far, the service providers have negative attitudes that turn survivors away and cases that are not concluded or handled make survivors lose confidence and hope in the system. To address these issues, the program trained service providers, established 9 advice centres that are managed by 2 champions, 630 champions have been selected and trained to support survivors and to create awareness on available services.

iii. ***Addressing Barriers to Access to Justice***: Access to justice still difficult in programme districts due to several barriers and the programme is trying to address these barriers. For example, in Kalangala district, Bheta parish, police officers and health workers were charging survivors 30,000 shs (8 Euro) for Police Form 3 that was only available at one stationery shop, this challenge was raised by champions and during the steering committee, it was agreed that PF3 forms are made available at the sub county offices where survivor can access them free of charge. This action was taken and PF3

forms are now available. This will be used as benchmark to discuss the improvement to access to PF3 forms in the other 8 districts of implementation



A total of 46 have been taken to court these include, 36 defilement, 3 rape, 5 physical assault, 2 matrimonial property and 2 maintenance cases. These cases all still ongoing in the courts of laws. MIFUMI has supported the progress of these cases in the following ways; legal representation of the survivors, conducted pre-court training for all the survivors and witnesses, facilitated survivors and witnesses to attend court and also supported in the follow up of the cases.

iv. **Strengthen Collaboration between SGBV response Actors (GBV Steering Committee):** The steering committees were platforms that have proven to be very critical to support local advocacy for the H4GTA programme.

Through the steering committee meetings and the multiple trainings conducted, service providers, duty bearers and decision makers have been trained on SGBV, laws, policies and legal procedure, case management, referral pathway, evidence collection and preservation. In Kalangala District, it was because of the effective collaboration and coordination between the Sub-county and District level SGBV steering committees that a GBV Shelter was awarded by the District and Advice Centre space by the Sub-county, both very critical structures to advance the impact of the intervention of the H4GTA program. Moreover, during the recently celebrated International Day of the African Child, advocacy commitments and resolutions were signed by steering committee members renewing their deliberate agenda to tackle SGBV and SRHR violations. These commitments are testament to the intention of the movement to jointly seek for opportunities to jointly tackle SGBV/SRHR violations.

In addition, the steering committee has supported in the implementation of guidelines and policies within the districts. In Buhemba sub-county in Namayingo district, the sub county steering committee is working on a bye-law to put an end to night fundraising which has exposed any young people to abuse use of drugs, teenage pregnancies and child marriages. In Bukwo district, the district is in the process of enacting a bye laws on alcoholism which to them has contributed to sexual violence cases. During the assessment in Kalangala, one of the respondents mentioned that most of the other local leaders and duty bearers prefer ventures that have personal gain, and they gave an example

" As champions, we collected money to transport and handhold a survivor from Kasekulo to Mugoye Health center, when she reached there, she was asked to pay 10,000shs which we paid, she was then referred to the police post to fill a Pf3 form, at police she was referred to a specific stationery shop to pick the PF3 forms, at that shop the survivor was asked for 20,000sh, it's at that point that we lost our patience and went to the members of the sub county steering committee raised our concern. We challenged the fact that PF3 forms are distributed from a stationery shop meant for business and profit. Gladly, the sub county steering committee held a meeting, they cautioned the police and the health center, and it was resolved that the forms be withdrawn from the stationery shop and be placed in all the sub county offices, advice centers, police and health centers," Rose, Champion Mugoye sub county.

v) Establish and strengthen response committees Survivor Support Groups: The programme has established 20 Survivor Support Groups with 413 members (9 young person's groups and 11 adult survivor support group), which are spaces for individual and collective empowerment, as vehicles for social assets building for survivors, facilitating connections between survivors, champions, and other community actors to raise awareness of SGBV/SRHR issues, empower teen mothers in the program to support **them** through life skills, knowledge on right, parenting and collective action to increase their voice, visibility efficacy and participation, across the 9 districts



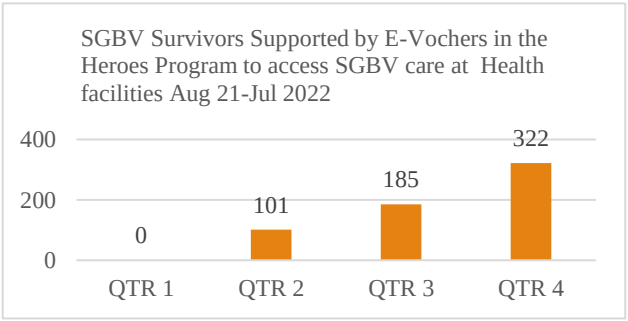
A survivor support group meeting taking place in Bwanalira Sub County



Young women in Betta village, Mugoye sub-county attending a medial outreach on SRHR

Deployment of the e-voucher programme for vulnerable YP and WRA for SRHR and SGBV services

In July 2021 CORDAID Launched the E-Voucher and e-referral app to boost access and utilisation of health services for SGBV survivors. The initiative has proven to boost access to health services for SGBV survivors in the last one year as shown in the graph below. The E-voucher also helped eliminate user fees on filling the police form and transport facilitation for the HW to testify in court.



The Project has also trained and mentored HWs on management of SGBV, which has boosted their skills and confidence in screening and provision of services. The project also integrated SGBV screening at all service delivery points.

4. MONITORING EVALUATION RESEARCH AND LEARNING ACTIVITIES

The activities under this result area aimed at strengthening data quality, improving the research agenda, tracking learning practice for decision making. The achievements under this result area for period 2 are summarised in the table-7 below:

Table-7: Summary of Key activities under Monitoring and evaluation

#	Activity	Output	Relevance & Impact on Program
1	Hosting of the developed programme database	A comprehensive programme database was developed to support real-time data collection and monitoring. The database is hosted on the survey CTO server that requires an annual subscription.	The Survey CTO application enables data collection by the different programme and community players and this facilitates smooth aggregation of the programme data.
2	Conduct Baseline survey	The programme conducted a baseline survey that covered 9 districts where the programme is being implemented (Mbale, Kween, Bukwo, Iganga, Namayingo, Bugiri, Kalangala, Budaka, Mayuge) and 3 control districts (Kapchorwa, Kaliro and Manafwa).	The purpose of the study was to establish the baseline program indicators as defined in the results framework to guide the measurement of future performance and to inform the validation of the Theory of Change (TOC).
3.	Train partners and programme staff on programme M&E tools and processes	The programme trained 806 community facilitators, 162 health facility staff, 54 WLOs/YLO representatives and 15 programme staff in data collection tools and processes	This has helped to improve the quality and use of data for programming and decision-making at all levels of implementation.
4	Print and distribute data collection tools for community interventions	3,240 copies of Standard Operating Procedures (SOPs) for data collection, training manuals (Journeys plus, Programme Y, Family Health and the parenting tool), support supervision tools, and quality improvement manuals were printed and distributed to be used by the peer educators/facilitators.	This has helped to improve the documentation of programme data for decision-making at all levels of implementation.
5	Conduct joint monitoring visits	Five (5) joint monitoring visits were conducted across the 3 clusters of Kalangala, Iganga and Mbale. Among these visits were two donors visit where we had the deep drive in Kalangala and another visit in Iganga	These were done to assess progress of programme interventions, give hands on support supervision to staff and stakeholders, promote efficiency and promote sustainability.
6.	Conduct routine data quality assessments/data reviews	The programme successfully conducted 160 DQAs with an average of 3 per health facility in the 9 districts and this has improved on the reporting timelines at the various health facilities.	The DQA exercise routinely assesses the levels of compliance as well as finds areas of further support meant to improve the availability and quality of data at the facilities.
7	District quarterly performance review and learning sessions	The programme executed quarterly review meetings in each of the 9 districts. A total of 322(151 M and 171F) people participated in the reviews.	Learnings from the reviews provide room for cross learning and objective deliberations in order to improve the programme quality
8	Conduct Annual CLA	HEROES team agreed on routine learning and schedule on learning Mondays, so far 6 collaborative learning meetings have been held	This has helped to assess the performance of key programme areas in the different clusters
9	Routine performance data collection	Programme staff supported the selected youth to collect and enter over 239,624 people have updated and over 1,540,218 sessions entered in the database.	This has helped to enhance data for better decision making through the use of dashboards that are generated from the entered data in the database.
10	Print and distribute Buffer stocks of data collection tools	More than 600 copies of existing HMIS and SGBV tools (referral forms, HMIS registers, SGBV case forms, files) were	This helped to overcome the challenge of stock out of data collection tools and

#	Activity	Output	Relevance & Impact on Program
		printed and distributed to 58 health facilities, Community health workers, CBOs, SGBV shelters and SGBV community response structures	improve monitoring and tracking of SRHR and SGBV indicators.
11	Conduct Learning exchange visits	The HEROES team members facilitated learning amongst themselves as part of sharing best practices that were yielding in the various clusters.	This has fostered the learning amongst the members.
13	Conduct Client exit/satisfaction surveys	One Client satisfaction survey was conducted in each of the 54 health facilities across the nine districts to assess the quality of care. Overall 71% of the clients said they were satisfied with the quality of care they received from the health facilities.	Client satisfaction surveys assess the level of satisfaction for the services provided.
14	Donor reporting (Narrative, IATI and financial)	Several donor reports have been written and shared these include Work plan narration, Baseline report, Annual narrative report and financial reports these will updated in IATI as well.	Reporting means accountability for the funds received from the donor.
15	Monitoring of Programme Principles	The programme tracked the application programme principles in implementation through review meetings and support supervision activities.	Improves the implementation of the programme
16	Capacity Building for young people and women-led in participatory research and local advocacy	Social Norm Measurement Mapping and Profiling for Staff: 30 (21 Female and 9 Male) program field and national staff on gender social norm measurement, the training was virtual Scaling up Social Norm Training for YLOs and WLOs: One training was held in Kalangala where *16 (4M and 12F) YLO and WLO* representatives attend for 2 days	The training applied feminist principles on gender lens programming and develop staff capacity on social norm tools, how to diagnose social norms, and how to distinguish them from other social constructs, like customs or conventions.

4.1 DEEP-DIVE ASSESSMENT OF HEROES PROGRAM

In April 2022, the program conducted the program conducted a deep dive assessment in Kalangala district. The assessment was conducted by the Netherlands Embassy Team led by the first secretary for SRHR and the SRHR Policy Office as well as the Heroes Program Consortium staff. Through vising programme sites including health facilities, schools and outreaches, the assessment assessed the following;

- Methods of SRHR education in and out of school, the support provided by schools and opportunities for sustainability. The program was found to have rolled out SRHR education in and out of schools. However, challenges such as bulky modules, laborious processes of demonstrating

some SRHR concepts such as menstruation, bulky manuals and lengthy SRHR sessions affecting completion.

- SRHR/SGBV service delivery in public and private health facilities as well as opportunities for collaboration. The program was found to be working well in public health facilities. The embassy team was able to officiate at the opening of a youth friendly corner in Kalanga. In addition, the Embassy was able to create the collaboration between the Heroes Program and DKT international which are currently working together to increase access to SRHR/SGBV services.



SRHR First Secretary and Policy officer from the Netherlands embassy in Uganda interact with a police officer on sgbv management in Kalangala district during a visit to the heroes programme

- Action towards promoting respect for all especially by key duty bearers such as local governments. The program was found to be engaging several actors at local government (districts and sub counties and parishes) and community members. Challenges concerning the pathway to sustainability were identified. The need to leverage government opportunities such as the parish development model were raised.
- Actions towards improving access to justice for SGBV survivors. The program was found to have set up an advice centres in addition to health facilities as part of the multisectoral model of health, psychosocial support, justice and protection model to create and environment to service SGBV survivors. Challenges of slow access to Justice were identified.



Deputy Ambassador H.E Joost van ettro and srhr policy officer see handiwork made by *pupils at kinawansa primary school in iganga district in uganda

From the visit, recommendations to improve SRHR education for young people, SRHR service delivery, promoting respect for SRHR for all and access to justice were made.

In July 2022, the Heroes program had the privilege of hosting His Excellency the Deputy Ambassador of the Netherlands in Uganda in Iganga, one of the Heroes program districts. The Ambassador met

with the Iganga district local government leadership, visited one of the program schools, teenage mothers and community SGBV response champions. The Ambassador was pleased with the programme work. He emphasised to great relations the Netherlands had with Uganda and called on communities to use this opportunity to build their capacities to address the current development challenges from their root causes.

5. COMMUNICATION, KNOWLEDGE MANAGEMENT AND DOCUMENTATION

Communication activities in this period were aimed creating visibility of the Heroes program and its interventions. The following were the main activities.

i. ***Program Launch***: The Program was launched on the 28 of October 2021 in Mbale by Honourable State Minister of Gender Hon. Peace Mutuuzo and State Minister for Health Hon Margaret Muhanga. The event was also graced by the SRHR First Secretary and SRHR Policy officer from the Netherlands embassy in Uganda, representatives of the Heroes Program District local governments and members of the program advisory group. The launch was preceded by a youth event held on the 25th of October 2021 which brought together 80 young people on a virtual space to under the theme "Together let us promote dignified SRHR services and gender equity for young people. A call to action was developed and submitted to duty bearers for action. The Call to action can be found here; https://amref.org/uganda/download/heroes-for-gender-transformative-action-call-to-action-by-the-youth-to-all-duty-bearers/



ii. ***Development Dissemination of Program Materials***: The Heroes program has developed several materials addressing SRHR/SGBV issues. These materials have been displayed in health facilities, schools, duty bearer offices, on social media and have been utilized in key events such as the 16 days of activism. The material serve as reminders to all persons on issues of SRHR/SGBV. Sample messages are in annex 4.

iii. ***Activity on Social Media***: The programme has been activity has been actively engaging on social media especially on tweeter with under the handle @GenderHeroes. This engagement on

tweeter has enabled the program to engage several stakeholders with minimal effort on key SRHR issues.





In February 2022, we joined various spaces to advocate against FGM/C we shared tweets under the hash tag Say No to FGM/C your body is your pride. In the same month, Norah Malinga a peer educator of youth in Bukwo was among the youth invited to dine with the New Minister for Foreign Trade and International Cooperation Her Excellency Liesje Schreinemacher during her official visit to Uganda. The main topic of discussion during the meeting was the impact COVID-19 has had on the youth and young people in Uganda. Present along with Norah were six other youth from different organisations supported by the Dutch Government. This engagement was shared widely on the social media platform to inspire other youth to development, health and social wellbeing for a better life.

In March 2022 we joined the rest of the world to celebrate women's day. Staff were involved in using social media to take a stand against Gender inequalities and district-level events were organised to create awareness among communities about the value of embracing gender transformative action. We also developed key messages to support in increasing knowledge, creating awareness and taking responsibility of one's health https://we.tl/t-Pj4ox9MTFz to the folders with key messages and samples of some posters that were used with in the period.

6. PROGRAMME GOVERNANCE AND MANAGEMENT

The program maintained a one-team structure with all consortium members working together. the management structure included the Senior Leadership Team (SLT), Senior Management Team (SMT), Programme Management Team (PMT) and Programme Advisory Group. These were supported by the MERL, Finance and communication working groups. In addition, guidance was also provided through the quarterly performance review meetings with the donor, which were rotational. The key highlights are described below:

The Senior Leadership Team (SLT) the SLT which comprises of consortium organization leads met quarterly to obtain updates and to address challenges in the program. The main areas of discussion have been on strengthening the intervention content, accelerating the program implementation and addressing operational challenges.

Programme Advisory Group: In period 2 this advisory group was fully constituted and met once where updates were provided about the programme. They also participated in the key programme events which included the programme launch and other programme events like the deep dive in Kalangala and visit by the Netherlands Deputy Ambassador in Iganga.

Quarterly Performance Meetings with the Donor: In the reporting period, three donor check-in meetings were held and the hosting was rotational. In these meetings, an opportunity was given to each of the partners to present the implementation status and key operational gaps. In each of the meetings feedback was provided by the donor and action plans developed.

Senior Management Team (SMT): The Senior Management Team led by the technical manager meets on weekly issues to fast track implementation of programme activities and provide guidance to the teams. This has been expanded to include the cluster coordinators as key focal persons of implementation. These provided platforms for providing operational and technical guidance.

7. THE PROGRAM CATCH-UP PLAN

In consideration of the less than the desired performance achievement of period 2, the programme will accelerate the program implementation through the following strategies;

i. Expanding access to SRHR information, the program will train more peer educators and provide improved incentives, and enrol more learners in and out of school. To improve completion rates, shorter and digitized curricular will be introduced to make learning less tedious.
ii. To improve access to SRHR services, the program will strengthen quality of services by training health worker competences using quality improvement mechanisms. Furthermore, the program will expand the partnerships with existing and new IPs to expand access to SRHR services.
iii. To promote better respect for SRHR for all, the program will expand the awareness and promotion of SRHR/SBV positive laws, expand the campaign on traditional harmful practices especially early and forced marriage as well as teenage pregnancy. The campaigns will now focus on supporting communities to act against disrespectful acts on SRHR for all.
iv. To increase access to justice against SGBV, the program will deploy more community champions to identify and report cases, improve documentation and processing of evidence by training duty bearers and providing free PF3 forms.

A detailed catch-up plan is provided in the Annexes.

8. IMPLEMENTAION GUIDING PRINCIPLES/STRATEGIES DURING PERIOD 2.

In period 2, the programme continued to implement the guiding principles as summarized in the table below:

Table 10 Status of Application of Programme principles

Programme Principle	Application steps
Ubuntu: espouses the spirit of Ubuntu which is an alignment of the interrelationship between Humanity ("I am because you are and you are because I am").	As a consortium and with all partners, we have worked together towards the goal of the programme. This has been made possible through the setup of one integrated team that plans, organizes and implements interventions together. The individuals on the team are backing up each other. This is shared in reaching out to the beneficiaries.
Respect for human rights	The programme is being implemented with respect for the human rights of the program team and the beneficiaries. There have not been any incidents of the rights of team members or beneficiaries. All the curricular adapted have a component on promotion of sexual reproductive health rights. Information is provided on these rights and responsibilities of communities. The beneficiaries' especially young people are supported to have competencies to make effective informed decisions including choices of friends and people to relate with. The programme recognises that individual young people live in settings that influence their behaviour and decisions. Therefore, the community champions and leaders supported appropriate guidance free from the disciplinary narrative.
Equity	The programme has sought out the people of most need to benefit from the program. We continue to uphold and lift the most vulnerable including people with disabilities.
Inclusivity	Therefore, the program has sought to engage beneficiaries without discrimination. A proactive effort has been made to engage all the youth, women and persons with disabilities (PWDs) in all the activities. We note that the programme may need better techniques to reach persons who are currently not reached. The programme will be purposed to build this expertise. In period 3, deliberate efforts were made to ensure all the marginalised groups are supported to be centre of the programme; These included young people, women, people with disabilities and key populations. These have been targeted through their participation in the rapid assessments and through the selection of women and youth led organisations to champion the response to community SRHR/SGBV interventions. The curriculum interventions will also take consideration of the needs of people with disabilities especially the deaf who may not benefit from the type of verbal sessions delivered in the community safe spaces. This will continue in period 3 where inclusion at all levels of programme implementation will be a priority.
Gender transformative and feminist approach	The programme team has applied gender lens at all levels of the project life cycle right from planning, implementation and reporting. Planning of programme activities consider the timing and kind of place to engage girls and boys, women and men. Our data collection and reporting tools are designed to capture sex and gender Disaggregated data. The programme team has identified gender-sensitive targets and indicators to track gender-responsive implementation Data gathered is disaggregated by sex, age, ethnicity, geographically, disability etc. where we have planned for activities. The implementation has purposed to be gender-responsive by considering the needs of the beneficiaries and addressing them within the means available to us. The program continues to work to strengthen this area.
Participatory community development approach,	The programme has involved beneficiaries in planning and implementation of programme activities, which has led to community participation, and ownership of the programme. This has been done through the beneficiaries leading in assessments and implementation of programme activities. We have also strengthened local organizations with on boarding of 18 WLO/YLOs.
A multi-sectoral approach	The programme has collaborated with different organisations and partners working in sectors as well as communities and people, working together to achieve policy outcomes and also enhanced information and data sharing between different organisations and partners. District line departments are part of the programme implementation. Specifically, the programme has worked with the education, community development, health, police/internal affairs and justice sectors in rolling out the key interventions in the respective

	districts. At national level, guidance has been sought from the line ministries to ensure the alignment of interventions to government standards and policies. Of All these play a role in meeting the community needs.
Collaboration with other Dutch government-funded programmes	The programme is working closely with RHU,DKT and SRHR Alliance which have had Dutch government funding. Heroes are active in this network. In addition, the programme is working closely with USAID RHITES Programmes in the respective regions. This collaboration will continue with the upcoming local partners who have taken over some of the interventions with effect from October 2021 in line with the second period,

9. CHALLENGES AND OPPORTUNITIES IN PERIOD -2

9.1 Challenges Affecting the Programme

In period two, the programme experienced some challenges. The table 9 below describes some of the challenges.

#	Challenge	Mitigation Measures Established
1.	High and escalating cost of implementation acro the program	The programme has continued to integrate more the implementation of activities. In addition, the program is holding off demands to expand and focusing on the parish and the main island as a unit of implementation to minimize cost escalations.
2.	The Covid19 scare in early 2022 threatened program implementation.	The programme adopted a remote/virtual working allowing coordination between the program team and stakeholders. Covid19 SOPs for the program were established and are being used in the program. These have enabled a level of business continuity.
3.	Resistance of some schools to SRHR education	The programme mobilized and commenced to train members of school management committees, teachers from target schools as facilitators in preparation for SRHR education in schools. Alternative entry points such as the fight against teenage pregnancy has been more acceptable. Support of some district education officers and local leaders has been obtained to enable to tenacity of SRHR education.
4.	Attrition trained peer facilitators	The programme sought understand the causes of attrition and found that this was due to the low incentives and facilitation they were getting. This will be improved in period 3.
5.	Mobile technology literacy among le among VHTs being enrolled as community Health Entrepreneurs (CHEs) is still low.	The program through the partner Health Entrepreneurs will mentor the CHEs on use of mobile devices.
6.	Data gaps have been observed in health facilities, police stations regarding SGBV cases. The gaps are attributed to poor quality or lack of records on SGBV including the PF3 form. Health workers are also not comfortable filling in forms.	The programme worked with the respective duty bearers and refreshed the SGBV cases management, provide copies of PF3 forms and conduct data quality assessments.
7.	The programme found that some critical platforms such as the district committees on adolescent health (DCAHs), although established by policy to address adolescent SRHR issues, are not functional.	The programme purposed to activate the DCAHs in the program area and so far, all, 9 DCAHs have been activated. These DCAHs will provide a platform for advocacy and actions on SRHR in the districts.
8.	Youth presence in the Health Unit Management Committees is almost existent in target health facilities making it difficult to champion issues of adolescent SRHR at governance structure.	The programme is lobbying to have youth represented on HUMCs. However, this needs a guideline change allow youth to be on HUMCs
9.	Stock out of SRHR commodities such as emergency contraceptives, medicines used in managing complications of labour was reported to be quite prevalent.	The programme will mentor health workers on essential medicines and health supplies systems (EMHS) with a specific focus on ordering, management and prescription of SRHR medicines and supplies, advocate for redistribution from areas that are overstocked and collaborate with partners to improve stock levels of SRHR service products.
10	Limited communication infrastructure at health facilities and communities in hard to reach areas has affected communication with persons demanding data and airtime, not initially anticipated.	The programme has already planned to provide internet data to peer educators. The program will explore how to support other actors.
11	In the island district of Kalangala, we noted the presence of multiple ethnicities including Kenyans and foreigners who impact the SRHR but do not easily subscribe to national programme interventions.	The program will use an institutional approach such as hotels, places of work to reach these unique populations. Furthermore, collaboration with existing organizations and layering of Heroes interventions upon them will be applied.

12	The inclusion of disadvantaged people such as persons with disabilities (PWDs) has not been as expected despite the engagement of CBOs and PWD	In period 3, Heroes will continue to purpose to ensure disadvantaged people are identified. The programme will seek support to build capacity on inclusivity techniques.
13	Volunteerism is not fully embraced in communities.	Linkage with other supportive programmes like the Parish Development Model.
14	Slow adoption of SRHR policies	Building a network of CBOs and CSOs and advocating for SRHR policies e.g. back to school policy
15	Stock out of SRHR commodities such as emergency contraceptives, medicines used in managing complications of labour was reported to be quite prevalent.	The programme will mentor health workers on medicine ordering and management, advocate for redistribution from areas that are overstocked and collaborate with partners to improve stock levels of SRHR service products.
16	Weak district SRHR leadership structures	We are activating them e.g., District Committees on Adolescent Health
17	High unmet need for economic empowerment for the survivors	We are linking beneficiaries to socioeconomic empowerment programs e.g. parish community association in the Parish Development Model

9.2 OPPORTUNITIES TO LEVERAGE IN PERIOD 3

i. In period 2, the programme was presented with a number of opportunities that we shall continue to harness in the course of implementation in period 3. These include availability and willingness of the local governments in the nine programme districts. These presented us with a conducive environment to apply the multi-sectoral approach where the different relevant heads of department participated in programme implementation.

ii. In period 2 18 CBOs were assessed. Out of this process, a total of 18 youth and women led CBOs have been contracted to work with the programme starting from period two onwards and these would promote sustainability.

iii. The up-coming rollout of the Parish Development model by government of fostering development. In this model, priorities would be set at parish level and a deliberate effort will be made to form CBOs where the programme will harness these as platforms for SRHR and SGBV programming.

iv. Existence of the law against FGM. The program will work with cultural institutions to reach out to the community on cultural practices affecting women. We shall work towards building relations with cultural institutions and government institutions to enforce adherence to the law. Our efforts will be building strategies towards ensuring that the community gets sensitised through interpretation and dissemination of the basic law in the local language, engage with peers, media and champions to reach out to the community with packaged information so as to be able to realise a big mass behind our advocacy work towards the fight against practices that undermined the rights of women and girls in the community as well as taking options of alternatives rights to passage.

v. Existence of the local structures; local councils, religious institutions, cultural institutions, VHTs and the education sector. We are building on the networks to ensure that we pass messages, communication on SRH/ SGBV to the community. With the present acceptability, we are able to communicate our interests and they will able to reinforce our interests using their local networks because the community believes in them and so we shall empower them with all the information on SRHR/ SGBV and use them to reach the community for acceptability, sustainability and ease of communication with the communities. To ensure completion, the programme working together with schools and community

development officers intend to take the whole school and whole community approach to have all young people enrolled and other key resource persons like teachers be brought on board to conduct the sessions.

vi. Existence of the Government /formal institutions like health facilities and also the traditional birth attendants will help to increase access to medical health services, we are able to make linkages with institutions and because they are stakeholders it has become easy for us even to advocate for the improvement of health services across all the districts in which the programme works and reaching out to the communities through reaches, use of school's clubs, radio talk shows.

vii. Strong collaboration with other implementing partners i.e. Reproductive Health Uganda, CBOs, Power to youth, Reach A Hand Uganda, Mariestopes Uganda USAID RHITES-E, USAIDRHITES-EC (and the transition partners), PSI and DKT. These are all the opportunities that we are using to reach the community with our messages and to achieve goals. We have even collaborated with these implementing partners in cost sharing in some activities like the district partner review and joint monitoring as such promoting synergies.

10.RISKS ASSESSMENT AND MITIGATION STRATEGIES

Through the programme period, risks have been monitored, updated and mitigation strategies implemented.

Risk Category	Risk Statement/Description	Likelihood Rating	Potential Impact Rating	Risk Mitigation Action Plan
Beneficiaries Risk	Sustained negative attitudes to improved access SRHR/SGBV services, resistance to change	Low	High	The program witnessed resistance to accepting return of pregnant girls or those who have delivered back to some faith-based schools. We shall continue to consciously address their fears, prejudices and misconceptions. the program will target hotspots with activist approaches targeting individual gatekeepers if required
	Unintended harm or backlash	Low	High	This has not been encountered. Heroes will continue to conduct Gender, Youth and Social Inclusion and Power Analysis before programme implementation and create programme, community, and stakeholder-specific actions, strategies, and resources to ensure the safety of programme teams and beneficiaries during any reported or perceived unintentional harm or backlash. Concerning Health entrepreneur medicines causing harm, we have built their capacity and provided help-line support to reduce the risks related to providing medicines such as contraceptives by lay people. We are also providing age appropriate sexuality education and content to limit the risk of backlash.
	Left out districts and communities complain	Low	Medium	In Kalangala and other district, we have been asked to expand to other parishes/locations. We have responded by providing clear evidence-based selection criteria and articulated the limitations of the program. In addition, we advising districts to focus on integration and sustainability before scale up.
	High expectations from the beneficiaries to meet other needs beyond the programme scope	Medium	Medium	These have been a frequent occurrence. We have continuously sensitized beneficiaries on programme scope, create linkages to other opportunities.
Contextual Risks	Lack of political support for SRHR and SGBV interventions	low	High	We have received good political support after the memoranda signed with the district and continuous work with district leadership (Political and technical)

Risk Category	Risk Statement/Description	Likelihood Rating	Potential Impact Rating	Risk Mitigation Action Plan
	Hostile policy environment: (e.g. ban on 2018 Sexuality Education framework)	Medium	High	Generate more evidence, and use evidence-driven proposals to encourage policy dialogue to cause an appreciation of SRHR and SGBV reforms. Some of the SRHR education programmes under use approved by the line Ministries and Based on the national sexuality frame-work Strengthen collaboration with MoH relevant technical working groups and utilize such platforms to contribute to completion and approval and roll out of the pending CSE framework.
	worsening systemic gaps target districts including high staff turnover, lack of supplies/commodities	High	High	Leverage resources from other donors/partners and harmonize service delivery. Seek donor consent to address emergency cases only procure essential SRH commodities for critically affected districts to ensure access for young girls, boys and women of reproductive age.
	Uncooperative stakeholders/ departments	Low	High	The programme will remind districts of the signed MOUs which clearly articulate terms of engagements, and in implementation, make sure to abide by agreed terms. Trigger higher-level authorities to address bottlenecks
	Stakeholders (districts, health facilities, cultural institutions) ignore the programme interventions and relevance.	Low	High	The programme will continuously engage stakeholders in planning and programme implementation. Additionally, the programme shall adopt a long-term evidence-based approach to the social norm change interventions and will have cultural and religious gatekeepers actively involved as partners for change.
Programme Implementation Risks	Internal external fraud	Low	High	There was an occurrence which was dealt with firmly. All programme staff have been oriented on fraud, compliance, and whistle-blower policies. Non-compliant persons will continue to be dealt with firmly and decisively. All high-value items of the programme will be insured.
	Staff technical capacity gaps and/or high turnover.	low	Medium	The programme on boarded competent and experienced staff but also continuously build capacity through coaching and mentoring.
	Provider-discrimination	High	High	Continue to provide training on personal safety and risk management. Enhance existing Safeguarding Policy
	Bureaucratic processes by partners and districts frustrate the timely delivery of programme interventions.	Low	High	The programme will continue to be guided by a clearly articulated and jointly agreed implementation plan with clear timelines, assigned tasks and performance-based indicators to minimize any implementation bottlenecks.

Risk Category	Risk Statement/Description	Likelihood Rating	Potential Impact Rating	Risk Mitigation Action Plan
	Sexual exploitation and harassment of or by staff, stakeholders, partners and beneficiaries.	Low	High	All staff and partners, stakeholders and beneficiaries were oriented, and be mandated to read and consent to the Amref anti-sexual harassment, bullying, and abuse policy documents with consequences of a breach immediately applied.
Partner organizations Risks	Programme partners cannot implement interventions according to stipulated timelines and standards	Low	High	Amref will continue to ensure that partners on the programme have proven & excellent track record, make continuous follow up, monitoring and provide technical support to where necessary. Total failure to perform will lead to replacement with able partners.
	Conflict among programme partners interrupts the programme	Low	High	Partners will continue to be engaged through a partnership agreement with a clear scope and code of conduct and clear dispute resolution mechanisms. The layered programme management structure, open channels of communication among partners and regular meetings will continue to be held to avoid conflict. Strengthen team building among partners. Plan more team building and join reflection activities to strengthen one-team approach and appreciation of unique partner niches and complementarity.
COVID19	The COVID-19 pandemic may disrupt programme implementation and focus.	Medium	High	The programme will ensure all staff comply with national and district-specific guidelines on COVID-19. The programme will ensure that areas of operations follow and apply measures described by SOPs to manage the pandemic. The programme staff will be encouraged to be vaccinated including receiving booster doses.
Environmental Risks	Hard terrains and risky waterways mudslides	Medium	Medium	The programme trained orient staff on emergency response protocols and provided helplines, taking group personal accident insurance to cover rescue teams. The programme also secured and provided protective equipment such as life jackets.

11.CONCLUSION RECOMMENDATIONS

11.1 CONCLUSION

An assessment of period two shows that the programme is on track in the realisation of its main objective of strengthening the programme strategy to optimally attain the set goal and objectives.

Specifically, the programme has registered a couple of key achievements like finalising the baseline survey, provision of the various SRHR services to young people and women of reproductive age and building capacity of services providers and duty bearers which is an indicator that programme is progressing fairly well to attain the desired goal. In addition, the programme has established various collaboration with like-minded organizations and is already leveraging these synergies. These partnerships will complement the efforts of the program.

Despite the interruptions by COVID-19 containment measures, the Heroes programme has set a firm foundation for continuous implementation. This is further strengthened by the baseline findings and continuous adaptation in the remaining 2 years of the programme.

11.2 RECOMMENDATIONS

Learning from the events pf the second period, the program must accelerate to catch-up on the targets that are not yet attained. The following are specific recommendations arrived at by the program for the next period.

Intevervention areas	**Recommendations**
SRHR/SGBV Education	• Abridge and digitize the SRHR education curricula to simplify learning and enable completion of learning session. • Adopt the whole school approach enrol more facilitators to accelerate SRHR Education. • Discuss with key actors the pathway to sustaining SRHR education in and out of school. • Actively pursue mechanisms to effectively engage young people with disabilities in SRHR education. • Develop simple, ready-to-use SRHR massages to accelerate learning and practice of SRHR interventions.
SRHR SGBV Service Delivery	• Strengthen quality improvement in SRHR/SGBV services through the application of RBF. • Strengthen SRHR commodity availability and access through redistribution in health facilities and health entrepreneurship to people at the last mile. • Strengthen the competences of health workers in SGBV case management and advocate for health facilities to get more staff in order to ensure service availability. • Strengthen data quality and reporting on services. • Expand the use smart paper technology to ensure improved data capture and reporting.
Promotion of Respect for SRHR for All	• Expedite the process of communities and duty bearers acting against SGBV in the communities. • Adopt a campaign mode targeting duty bearers to act concerning harmful practices the i.e. teenage pregnancy and child marriage in program districts. • Strengthen linkages between SGBV survivors with livelihood programs such as the PDM in order to address the livelihood needs of survivors.
Improved quality of SGBV services and access to Justice	• Advocate for the improvement in the turnaround of delivery of Justice. This must include collaborating with more actors . • Strengthen the linkages in the service pathway to enable quicker services for SGBV survivors.

	• Expand the Heroes social media campaign to reach more actors and expand the debate on respect SRHR for all. • Improve the competences of key actors i.e. police, health workers and justice actors in the case management of SGBV cases especially in the areas of evidence management.
Monitoring, Evaluation Research & Learning	• Conduct a midterm assessment on the relevance and sustainability of the program interventions. • Disseminate the program baseline findings widely and use the evidence therein to advocate for better SRHR and SGBV responses.
Governance and program management	• Activate the PAG to strengthen their contribution to the program.
Communication & visibility	• Increase participation in MOH and other platforms to showcase program activities and interventions • Expand presence on key platforms and deploy knowledge materials from the program in a knowledge repository
Sustainability	• Conduct a program-wide assessment of the prerequisites for sustaining program interventions. All stakeholder engagements need to discuss this matter as a standing agenda.

12. HEROES PROGRAMME PERIOD -2 (OCT 2021-JUL 2022) FINANCIAL PERFORMANCE

The performance of the programme as at July 30, 2022 (end of period 2) was 78% against the period budget. There has been an improvement in performance of the programme in second period compared to the first period whose performance was at 62%.

There was a slow start to the second period implementation of activities due to the existence of some government COVID 19 restrictions in the first months of the period which majorly affected school-based activities since the schools were closed until the end of the year 2021.

This affected activities like: Conducting 1 session per term with 90 school clubs on policies, regulations and laws that should protect the young people and women from SRHR violations including SGB.

However, with the lifting of the restrictions the programme managed to accelerate implementation of activities and hence an improved performance

Summary of period two partner performance

Partner	Period 2 Budget (Eur)	Period 2 Actual Expenditure (Eur)	Balance (Eur)	Performance (%)
AMREF	1,622,379	1,408,760	213,619	87%
CORDAID	525,651	284,243	241,408	54%
ICRW	150,348	128,141	22,207	85%
MIFUMI	820,834	622,867	197,967	76%
TOTAL	**3,119,212**	**2,444,011**	**675,201**	**78%**

Summary of period two category performance

Category	Period2 Budget (€)	Period 2 Expenditure (€)	Budget Balance (€)	Performance
Communication and Knowledge Management	13,597.83	13,817.54	(219.70)	102%
Human Resources	673,517.14	677,422.88	(3,905.74)	101%
Indirect cost	465,124.89	366,651.85	98,473.04	79%
Office Running costs	171,057.98	157,131.70	13,926.28	92%
Output 1.1	259,449.16	205,829.31	53,619.86	79%
Output 2.1	208,358.38	156,670.94	51,687.44	75%
Output 2.2	425,946.49	274,905.39	151,041.10	65%
Output 3.1	221,955.68	100,589.75	121,365.93	45%
Output 3.2	81,300.17	72,099.94	9,200.23	89%
Output 4.1	114,172.48	67,794.59	46,377.89	59%
Output 4.2	115,634.83	77,921.69	37,713.14	67%
PMEAL	220,174.54	168,935.32	51,239.22	77%
Travel	148,922.60	104,282.53	44,640.07	70%

Summary of funds

Cash B/F from period 1	695,765
Cash received (period 2)	2,423,447
Total	**3,119,212**
Amount Spent	2,444,011
Cash Balance	**675,201**

13.ANNEXES

13.1 ANNEX 1: HEROES PROGRAM SUSTAINABILITY PLAN

What has been identified for sustainability	Barriers to sustainability	Actions in year 3 to unlock barriers	Who is being prepared to sustain the intervention (By whom and where)	Indicator of success/How to measure success	Resources required
Outcome Area-1: Better information and greater freedom of choice for young people about their sexuality.					
Sustained teaching of the Journeys Plus & Program Y Curriculum in schools	i.Limited acceptance by school SMC. ii.Few trained teachers iii.Demand for facilitation to conduct sessions. iv.Lack of funds to reprint curricular v.Curriculum too long	i. Advocate for schools to take on the whole school approach ii. Digitize the curriculums to eliminate the need to reprint iii. Support local CBOs to facilitate the training of facilitators in schools iv. Production of abridged Journeys plus and Programme-Y curricula v. Supporting creation of 108 community safe spaces and youth-friendly spaces	i. Chief executives of 8 YLO and 8 WLO in the district are being linked to schools ii. Headteachers and Teachers are to be trained	i. Budgets allocated in schools to teach the curriculum ii. # of additional teachers trained iii. Local YLOs and WLOs take over support to schools & linking programme beneficiaries to key	i. Facilitation of activities ii. Stationery iii. Funds to print IEC Materials, manuals and attendance registers. iv. Digital curricula versions. **v.** Illustrative flip charts for the curricula
Functional District Committees on Adolescent Health (DCAHs)	i. Limited attention given to adolescent health issues by the district. ii.Lack of budget provisions for adolescent Health committees.	i. Hold advocacy meetings with stakeholders to make budgetary provisions. i. Conduct joint quarterly support supervision and mentorship with all stakeholders.	i. District Education Officers ii. Probation officers iii. District Community development officers iv. District planners v. Chief Administrative Officers vi. District Health officers	- Minutes of the meetings held will be tracked in addition to the budget allocation for these meetings and progress on the actions	Stationery Facilitation for meetings
School management support for SRHR education in schools	i. Low attention to SRHR and SGBV in schools i. Limited capacity to advocate for SRH and SGBV issues	i. Facilitate SMC and PTA meetings in schools i. Conduct joint supervision with line departments. i. Secure circular from the Ministry of Education and Sports	i. School management committees (SMCs) ii. Parents Teachers Association (PTA) iii. Board of Governors (BoG) iv. Directors	i. Programme interventions integrated with school improvement plans ii. Community responsiveness and perceptions about SRHR and SGBV changed	Stationery, venue and transport refund.
Outcome Area-2: Better public and private healthcare for family planning, pregnancies and childbirth, including post-abortion care.					
Quality improvement interventions for improved SRHR service delivery at 54 Health facilities	i. -No schedule for monthly meetings ii. -QI Meetings are not being held regularly (Monthly) as expected	i. - Work with stakeholders to come up with monthly meeting Schedules. ii. Hold facility sustainability planning meetings	i. Health facility in-charges, DHT, District QI focal person, HEROES program focal person at the district level	i. Shared schedule for Monthly ii. SRHR Quality improvement projects	Airtime for district program focal person to coordinate with all facility in-charges in the selected dates

What has been identified for sustainability	Barriers to sustainability	Actions in year 3 to unlock barriers	Who is being prepared to sustain the intervention (By whom and where)	Indicator of success/How to measure success	Resources required
Continuous quality improvement on SRHR services	i.-No customized dashboards for Quick data review ii.-Integrated quarterly HUMC and performance review meetings not happening as expected	. Work with facility and district teams to generate customized facility-based dashboards. . Program focal person to work with facility in-charges to generate an integrated quarterly facility-based performance schedule	i. -Health facility team members with community structures involved ii. -HUMC & DHT members	i. Customized dashboard developed and shared with facility teams ii. An integrated schedule for Quarterly performance review per health facility shared by the district the HEROES program focal person	Refreshments for participants during facility-based quarterly performance review meetings
Integrated SRHR Outreaches targeting adolescents	i.Current facility work plans do not reflect costed quarterly integrated outreaches ii.New administrative units not yet included in the catchment area map for health facilities	i. Support health facility teams to generate costed integrated outreach plans using available resources	i. Health facility in-charges ii. MCH department in-charges iii. Community department led by HA/HI	i. Integrated Quarterly/Monthly costed outreach schedule developed ii. Integrated outreach data reported on Monthly /Quarterly report	-Facilitation (Transport and SDA) for district HEROES program focal person for spot checks during the proposed dates for outreach implementation
Provision of SRHR Services by Community Entrepreneurs:	i. Inadequate stocks for sale ii.Limited demand for the healthy products sold by CEs	i. Hold joint meetings between Community health entrepreneurs and supporting health facility staff in 5 districts (Namayingo, Mayuge, Iganga, Bugiri and Kween). i. Community mobilization for CHEs services	i. Health facility leaders at the selected health facilities in 5 districts i. Community entrepreneurs and other community agents.	**i.** The success would be measured through tracking reports submitted to district structures.	Transport refund for the meeting participants**.**
Outcome Area-3: More Respect for Sexual Reproductive Health Rights for All					
Self-driven actions by SGBV Champions including Provision of information, advocacy, local activism and referrals.	i. Dropout of the trained champions ii.Inadequate knowledge of laws, policies and procedures i. Community backlash	i. The Programme will strengthen and consolidate the training of championship in acting against SGBV i. Provision of resources that include simplified laws, training manuals and SOPs i. Enhance linkages with community-based resources.	i. Champions ii. Local leader iii. Selected stakeholders, these will include the community development officer,	i. Champions demonstrate commitment to community mobilisation, awareness raising, provision of information and referral, and campaigns. ii. Periodic assessments using the movement capacity assessment tool iii. Reports by the champions and the supervision by the community development officers.	Funds for support supervision and dissemination of laws.
Outcome Area: 4- Enabling environment for young girls and women's elimination of violence against girls and women.					
The functionality of	i. Inadequate facilitation for the volunteers.	i. Increased training, exposure and support for the champions running the advice centres.	i. Champions ii. Survivor support committee	i. Capacity of support groups and the existence and capacity	Minimal funds for operational costs

What has been identified for sustainability	Barriers to sustainability	Actions in year 3 to unlock barriers	Who is being prepared to sustain the intervention (By whom and where)	Indicator of success/How to measure success	Resources required
09 SGBV Advice centers	ii. Resistance from the host communities iii. Inadequate capacity of the volunteers	ii. Programme will strengthen management and supervision by attaching Community development officers and parish chiefs to the advice centres for hands-on support and capacity building.	iii. Community Development Officers iv. Sub-county Chiefs	of champions attached to the advice centers ii. Supervision reports by the community development officers and the parish chiefs. iii. The budget allocation by the community development officers will also be tracked. iv. Advice Centre reports will also be an indication of success	
Survivor support groups, the programme has established 20 support groups in the 9 districts of implementation.	i. Community stigma in associating with groups	i. The Programme will continue training the various groups to build their knowledge and confidence. ii. The Programme will continue to create spaces for individual and collective empowerment, as vehicles for social assets building for survivors, facilitating connections between survivors, champions, and other community actors to raise awareness of SGBV/SRHR issues, build confidence, and supportive relationships, to voice concerns and demand action iii. Programme will also hold activities that bring all the movement members together and these will include campaigns, awareness sessions, etc.	i. Sub county and parish CDOs ii. Survivors iii. Teen mothers iv. Young people v. champions	i. The programme will track collective self-initiated empowerment activities, meetings and available documented stories of change. ii. Continued enrolment of survivors into the groups	Funds to facilitate the community development officers to orient the groups.
Integrated, coordinated, multi-sectoral networks of SGBV response and prevention services,	i. Staff turnover among the duty bearer ii. Lack of adequate knowledge iii. Staff Attitude challenges	i. Convene accountability meetings and dialogues between the steering committee and the champions and community members. ii. Hold joint activities including monitoring and learning. iii. Scale-up capacity building among the members of the steering committee and multi-sectoral actors.	i. District Community Development officers, ii. Police officers iii. Sub-county community development officers, iv. Sub-county/Parish chiefs v. SGBV champions	i. The steering committee is active and engaged. ii. Improved service delivery (accessibility, availability, attitude, timeliness, quality) iii. The programme will track survivor satisfaction with services. iv. Minutes of the meetings at the district and sub-county level. v. We shall also track the allocation of budgets and any form of integration of SGBV work in the existing meetings.	- Meeting costs - Monitoring costs
Response Champions actively self-mobilizing to prevent and	i. Dropouts ii. Community backlash iii. Lack of communication	i. Strengthen and consolidate training SGBV response champions ii. Provision of resources that include simplified laws, training manuals and SOPs	i. Champions, ii. Community development officers iii. Parish chiefs	i. Champions demonstrate commitment to community mobilisation, awareness raising, provision of information and referral, and campaigns.	- Meeting costs - Communication materials

What has been identified for sustainability	Barriers to sustainability	Actions in year 3 to unlock barriers	Who is being prepared to sustain the intervention (By whom and where)	Indicator of success/How to measure success	Resources required
end SGBV including the Provision of information and referrals.	materials and resources	iii. Enhance linkages with community-based resources		ii. Success will be tracked through periodic assessments using the movement capacity assessment tool iii. The reports submitted by the champions and the supervision by the community development officers	

13.2 ANNEX 2: HEROES PROGRAM CATCH-UP PLAN

Output/Outcome Area not on track	Gap to catch up	Catch strategies	Resources required	Key assumptions
Outcome Area 1: **Better information and greater freedom of choice for young people about their sexuality.**				
% increase of young girls, boys and women with comprehensive/correct knowledge on SRHR/HIV at 55% of the expected target at end of period 2	45% of the expected target of 296,791 was not reached.	i. Train and deploy more facilitators at 90 targeted schools (2-6) targeting onboarding more 360 facilitators ii. Enrol more learners in the various programs in a whole school approach iii. Conduct quarterly evidence-based review meetings to share progress towards achieving targets. iv. Hold refresher training for SMC and PTA to champion SRHR and SGBV in schools and communities v. Build capacity of 9 YLOs and 9 WLOs to conduct mentorship and support supervision in communities and schools vi. Engage YLOs and WLOs to enter data collected on time. vii. Utilize Digital platforms to disseminate the curriculum-based interventions.	- More funds to facilitate 360 additional facilitators - Funds to host digital platforms both in and out of school.	- Availability of funds - Schools authorities recognize the importance of the sessions - Parents recognize the importance of sessions to the children - A network of community members will champion enrolment at the community level
Outcome Area 2: **Better public and private healthcare for family planning, pregnancies and childbirth, including post-abortion care**				
Number of young girls, boys and women provided with SRH services at health facility/static & outreaches sites(ANC1, ANC4, Delivery, NC& PAC)	Only 25% of the desired target of 231,362 has been reached by end of year 2	i. Support Monthly Integrated outreaches across Health facilities ii. Use of traditional birth attendants as referral agents iii. Provision of policy frameworks and protocols for quick reference by health workers iv. Strengthening inter-facility referral v. Leverage on other community structures such as VHTs and local leaders for advocacy and health education vi. Quarterly Mentorships to enhance skills and knowledge of health workers	- Funds to facilitate increased integrated outreaches on monthly basis across the 54 supported health facilities in the nine districts (UGX 220,000.000). Already costed in the period 3 budget. - Facilitate printing of missing protocols across the supported Health facilities in the 9 districts once (UGX 6,000,000), already cost in the period 3 budget.	- Availability of funds - We continue implementing in mapped health facilities

Output/Outcome Area not on track	Gap to catch up	Catch strategies	Resources required	Key assumptions
		vii. Leverage on QI approaches to identify poorly performing indicators and address the roots causes accordingly viii. Use grouped antenatal approach for young people		
Number of women and girls using modern contraceptives	Only 31% of the desired target of 87,202 has been attained by end of year 2	i. Redistribution of RH Commodities with support from DMMS/MMS persons ii. Continue with the collaboration and partnerships with other IPs providing SRHR services such as PSIU, RHU, DKT and Marie Stopes supporting health facilities with their buffer stocks following the one warehouse MOH/NMS policy iii. Use of RBF funds for procurement of out-of-stock RH commodities among HEROES RBF-supported health facilities iv. -Increase the frequency of integrated outreaches v. -Integrate services at all entry points vi. -Functionalize youth and adolescent-friendly corners with games to attract more young women and girls vii. -Work with CBOs to increase advocacy and mobilization towards the uptake of family planning viii. -Advocate for male involvement to aid family planning uptake among Women	- Funds to facilitate fuel and SDA for 2 MMS persons on monthly basis across the 9 districts (UGX32, 400,000), already costed in the period 3 budget. Funds to facilitate the purchase of items like chess /scrabble/Ludo boards and balls for schools (UGX 54,000,000). Each district will cost 6 Million	All DMMS/MMS persons have motorcycles issued under the RHITES-E Regional Programs The Mapped IPs like RHU, Marie Stopes and others continue operating across the 9 HEROES districts of Implementation The RBF facilities remain the same across the selected districts
Outcome Area 3: More Respect for Sexual Reproductive Health Rights for All				
# of community members reached through the different mobilization (education & sensitization) strategies.	Only 11% of the life of the Programme target was achieved at end of period 2	Increase community outreaches and conversations by including the oriented leaders.	- Training costs. Already costed in the period 3 budget.	All champions and trained leaders to carry out all sessions as planned.
Outcome Area: 4- Enabling environment for young girls and women's elimination of violence against girls and women.				
# of girls and women who present cases of sexual violence or domestic abuse	29% of the life Programme met in the second period	i. Increase SGBV awareness sessions on services targeting women and girls ii. popularize the toll-free line to have more women and girls reporting cases iii. facilitate champions to identify and handhold cases for reporting iv. Increase service access through legal aid clinics	- Champions &Communication materials already included	A quick change in attitude.
# of survivors provided with access to justice through the program	16% of the life of the Programme target achieved	i. Increased community conversations	- Champions - Communication materials	Transport refund for facilitators
% of survivors who access health services within three days of the assault	Only 7% of the life of the programme target met	i. Provide for free the PF3 forms at all service points	- Training costs & - Monitoring costs already included in the budget	- All the cases are reported within 3 days of the occurrence.

Output/Outcome Area not on track	Gap to catch up	Catch strategies	Resources required	Key assumptions
		ii. Train more health workers and police on evidence collection and preservation iii. Improve case identification and periodic monitoring of the SGBV register at health facilities iv. Increased awareness of the availability of services v. Expand access to the e-voucher		- That all the health workers and police officers are well versed in filling the forms
# of SGBV cases taken to court	0% of the life of the programme target realized.	i. Train more health workers, police and socio worker on medical-legal processing of cases ii. Strengthening linkages and referral system between health facilities, police and the justice system. iii. Case follow-up and monitoring iv. Facilitate survivors to be present at the time of case hearings	- Training costs already included in the budget	- That all cases will be reported to the advice centers or through the Heroes' program - All survivors are interested in the justice system.

13.3 ANNEX 3: HEROES PROGRAM RESULT MATRIX

Impact/Outcome/ output/	Indicator	Disaggregation	Baseline	Data source	Reporting Frequency	Planned Cumulative Target Y1 & Y2	Achievements		Cumulative Achievements (A)	% Against Cumulative targets	Targets		Life of Prog (B)	Performance against LOP A/B%	Comments
							Y1	Y2			Y3	Y4			
Impact: All young girls, boys and women in 9 hard to reach districts of Uganda fully enjoy their sexual and reproductive health & rights and live in a gender equal society free from SGBV															
Outcome 1: Better information and greater freedom of choice for young girls, boys and women about their sexuality	% increase of young girls, boys and women with comprehensive/correct knowledge on SRHR/SGBV	By age, sex	44.00 %	survey	Base/End-line	N/A	N/A	N/A	N/A	N/A	N/A	60%	60%	N/A	To be determined at endline
	Reduction in teenage pregnancy/adolescent birth rate	By age, by district,	25%	survey	Base/End-line	25%	N/A	N/A	N/A	N/A	N/A	N/A	20%	N/A	To be determined at endline
	% of individuals who demonstrate self-efficacy to negotiate reproductive health choice in a relationship	By age, sex, district	41%	survey	Base/End line	N/A	N/A	N/A	N/A	N/A	N/A	60%	60%	N/A	To be determined at endline
Outcome 2: Better public and private healthcare for family planning, pregnancies and childbirth, including post abortion care	Decrease in facility maternal mortality ratio	By age	59	Health Facility Data	Annual	N/A	59	29	N/A	N/A	43	36	36	N/A	On track
	Increased Couple Years of Protection (CYP)	N/A	45,770	Health Facility Data	Annual	96,117	45,770	68,664	114,434	119%	36,550	15,665	166,649	69%	On track
	# unintended pregnancies averted	By district	13,182	Health Facility Data	Annual	27,682	13,182	19,775	32,957	119%	7,545	7,493	47,995	69%	On track
	% increase in the number of women, boys and girls using modern contraceptives	By age, sex	32%	survey	Base/End-line	37%	N/A	N/A	N/A	N/A	N/A	N/A	55%		To be determined at endline
	% increase of births attended by skilled health personnel in Heroes Health facilities	N/A	56%	Health Facility data	Annually	61%	0%	70%	70%	115%	71%	81%	81%	86%	On track

	% increase in client satisfaction rates of young girls, boys and women for SRHR services in the supported health facilities.	N/A	68%	survey	Annually	74%	68%	71%	N/A	N/A	79%	84%	84%		On track
Outcome 3 : More respect for sexual and reproductive rights for all	% decrease of ever partnered women and girls aged 15 years and above subjected to physical, sexual or physiological violence by a current or former intimate partner in the previous 12 months	By form of violence, age , District	35.90 %	Survey	Base/End-line	N/A	N/A	N/A	N/A	N/A	N/A	21.80 %	21.80 %		To be determined at endline
	% increase of men who support the use of modern contraception for themselves or their partners	By age	56%	survey	Base/End-line	N/A	N/A	N/A	N/A	N/A	N/A	65%	65%		To be determined at endline
	% of individuals that demonstrate positive shifts away from harmful SRH and SGBV norms (Measurement level attitudes /intentions/ behaviours)	By respondent type, cadre, sex, age	50%	survey	Base/End-line	N/A	N/A	N/A	N/A	N/A	N/A	35%	15%		To be determined at endline
Outcome 4: Enabling environment for young girls and women's elimination of violence against girls and women	% of survivors who are satisfied with the SGBV response procedures/system	By age, sex	67.80 %	survey	Base/End-line	N/A	N/A	N/A	N/A	N/A	70%	80%	80%		To be assessed in period 3&4
	% of SGBV survivors who receive access to justice.	By age, sex, case	37%	judicial reports	Base/End-line	N/A	N/A	N/A	N/A	N/A	67%	80%	80%		To be assessed in period 3&4
OUTPUTS															
Outcome 1: Better information and greater freedom of choice for young people about their sexuality															

Output 1.1: Young girls, boys and women reached with comprehensive, correct information and skills SRHR and SGBV.	# of young girls, boys and women reached with comprehensive, correct information on sexuality, SRHR, SGBV and life skills trainings.	By Sex , Process channel and Age	N/A	Activity Reports	Annually	296,791	0	239,624(82,449M 157,175F)	239,624	81%	443,964	283,212	890,372	27%	The unmet target will be carried forward to Yr3 & Yr4
Outcome 2: Better public and private healthcare for family planning, pregnancies and childbirth, including post abortion care															
Output 2.1: Private and public health systems strengthened to scale up SRHR & SGBV services for young girls, boys and women	# HCWs trained/mentored (contacts) on SRHR/SGBV service provision	By training type, sex & facility ownership	N/A	Training reports	Annually	1,035	485 (230M 255F)	433(234M 199F	918	89%	432		1350	68%	Ontrack
	% of trained health care workers demonstrating improved attitudes to deliver rights-based, gender transformative SRHR& SGBV services***	By training type, sex & facility ownership	30%	survey	Annually	50%	N/A	N/A	N/A	N/A	70%	85%	85%		To be assessed in period 3 &4
	# of health facilities where the quality of offered interventions is considered good and appropriate to the needs expressed by the target group (young people, women.	By facility level & ownership	18	CQI reports	Annually	45	N/A	30	30	67%	45	54	54	56%	On track
	# Health facilities providing FP Method mix (both short- and long-term methods)	By facility level & ownership	N/A	DHIS	Quarterly	50	50	58	58	107%	58	58	58	100%	Increased the HFs to 58
	# of facilities that adopt and implement youth friendly SRHR/SGBV services,	by facility level & Ownership	N/A	HMIS registers, DHIS	Quarterly	54	0	58	58	107%	54	54	54	107%	On track
Output 2.2: Increased access to quality friendly services by young girls, boys & women in hard to reach areas	# Of women and girls using modern contraceptives.	By age, method	N/A	DHIS	Quarterly	123,197	1,103	87,202	88,305	72%	66,503	69,526	259,226	34%	The unmet target will be carried forward to Yr3 & Yr4
	# of young girls, boys and women provided with SRH services at health facility/static &	By gender ,age and type of services	N/A	DHIS	Quarterly	388,800	2,889	242,519	245,408	63%	405,481	256,311	907,200	27%	The unmet target will be

	outreaches sites(ANC1,ANC4,Delivery,PNC& PAC)														carried forward to Yr3 & Yr4
Outcome 3: More respect for sexual and reproductive rights for all															
Output 3.1: Strengthened capacities of CSOs (YLOs/WLOs) & key influencers to lobby and advocate against harmful practices related to gender and SRHR/SGBV	# Of CSOs and Advocacy networks with increased lobby & advocacy capacities.	By category	N/A	Activity reports	Annually	0	N/A	N/A	N/A	N/A	18	18	18		Indicator to be measured in Period 3 & 4
	% of youth who participate in decision-making bodies (DCAHs/SGBV Committee) who perceive their participation as meaningful.	By age, sex	40%	Survey	Annually	0%	N/A	N/A	N/A	N/A	60%	70%	70%		Indicator to be measured in Period 3 & 5
	# of community members reached through the different mobilization (education & sensitization) strategies.	By sex, age	0	Activity reports	Monthly	90,943	943 (322 M 621F)	59,608(26,527M, 33,018F) 3363PWDs	60,551(26,849M 33,639F) 322PWDs	66%	192,474	192,474	445,500	14%	The unmet target will be carried forward to Yr3 & Yr4
Output 3.2: Changes in bi laws, guidelines, ordinances, and practices leading to decrease of barriers to SRHR services	# of laws, policies, practice , and strategies blocked, adopted or improved to eradicate all forms of violence against women and girls in public and private life	By district	0	Activity reports	Quarterly	10	0	10	7	70%	10	10	10	70%	On track
Outcome 4: Enabling environment for young girls and women's elimination of violence against girls and women															
Output 4.1: Improved SGBV service provision	# of multi sector actors/responders trained on SGBV response	By category, sex, age	N/A	Activity reports	Quarterly	630	32 (27F 13M)	559	591	94%	630	630	630	94%	On track

and case management	# of girls and women who present cases of sexual violence or domestic abuse	By age	N/A	DHIS, police reports, LC reports, advice centres	Quarterly	1430	179 (119 W, 60M)	1443	1622	109%	2,050	1,795	5,400	30%	The unmet target will be carried forward to Yr3 & Yr4
	# of survivors (of girls and women)provided with access to justice through the program	By age, type of case	N/A	Activity Reports	Quarterly	1430	37 (23 W, 8 girls & 6 men)	1,443	1,480	60%	1,435	1,256	4,171	35%	The unmet target will be carried forward to Yr3 & Yr4
	% of survivors who access health service within three days of assault.	By sex, age	N/A	DHIS, police reports,	Annually	30%	21%	5%	N/A	N/A	65%	75%	75%	7%	Not on track
	# of SGBV cases taken to court	By type of case	N/A	Activity Reports, court reports	Annually	100	7	53	60	60%	90	90	240	25%	Not on track
	% of cases concluded through the court system	By type of case	1%	Activity Reports, court reports	Annually	100%	0%	10%	10%	6%	N/A	N/A	2%	N/A	
	% of individual with improved attitudes towards SGBV survivors or services.	By respondent type, sex, age	40%	survey	Annually		0%	0%	0%	N/A	60%	70%	70%	0%	To be assessed in period 3 &4
Output 4.2: Young girls, boys and women have access to SRHR and SGBV safe spaces	# of individuals using SGBV social services	By type of service provided	N/A	Activity reports	Annually	2700	142	1,841	1,983	73%	4,446	2,700	9,129	22%	The unmet target will be carried forward to Yr3 & Yr4

13.4 ANNEX 4: MESSAGES DEVELOPED ON SRHR/SGV



