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'

INCEPTION REPORT

(Period November 2020 – September 2021)

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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 system approach of 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, or 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 (age 10-24) 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 in 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 what the accomplishments in the 10-month inception phase period (November 2020 – September 2021) and some programme, activities that been implemented during this period. The inception phase has achieved the following;

- ***Reviewing of the programme strategy***: consortium partners were able to review the programme strategy, goal and objectives, activities, risks, assumptions and principles and which in turn created a shared understanding of the programme. In addition, operation plans were developed to implement inception phased and some core activities. This enabled the commencement of implementation.
- ***Mobilization of inputs***: All staff planning of the programme have been recruited, programme field offices and other logistics have been secured. In addition, programme structures such as the Programme Advisory Group (GAP), the Senior Leadership Team (SLT), Senior Management Team (SMT), Programme Management Team (SMT), Monitoring, Evaluation, Research and Learning (MERL) working group and Programme Management Implementation Team (PMT) have been functionalized.
- ***Securing relations with stakeholde***rs; all 9 districts have signed MOUs paving the way for implementation. This has enabled the programme to establish the programme, district and community level structures to support programme implementation. Engaging schools have also been engaged but they remain closed due to covid19 risks. The programme has also reactivated district adolescent health committees in target districts.
- ***Conducting baselines surveys***. Protocols for baseline surveys have been completed and have received the first comments from the ethics committee at Mildmay Uganda. The survey itself will commence in quarter 1 of year 2. They did, however, conduct a rapid mapping exercise which helped identify target beneficiaries e.g. schools, youth and women groups, health facilities, SGBV hotspots and community-based organizations.
- ***Finalizing intervention approaches***: the programme has been able to appropriate technical materials, establish implementation manuals and key SOPs. However, due to the baseline delay, there are critical gaps to be filled by baseline data and findings. The finalization of the strategy will be conducted in the first quarter of year II when the baseline findings are available.

The programme has also been able to commence some core programme activities and the key result areas. These have included sexuality education content development, training of peer educators, capacity building in RBF, engagement of duty bearers on planned SGBV interventions as well as providing SGBV services to some SGBV cases. The details of these actives toes are provided in chapter 3.

Despite these achievements, the programme has been interrupted by Covid19 to which the programme is adapting through integrating recommended SOPS into programme operations. There has also been increasing threats to the civic space although the programme is not yet directly affected. The programme continues to monitor these risks.

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: Kalangala, Bugiri, Mayuge, Iganga and Namayingo; 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 seeks to address 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, strengthen SRHR/SGBV service delivery, work with gatekeepers to reject gender negative norms and practices, and enhance access to justice. Throughout the HEROES programme, a gender transformative approach will be 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,

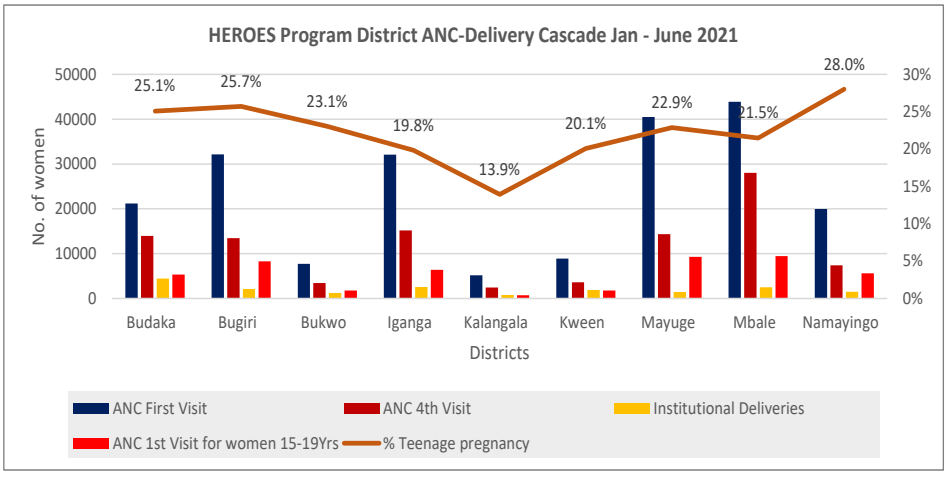
Gender, Education and Justice, implementing partners of similar projects such as the SRHR Alliance, UNFPA, and UN Women. The programme is aligned to the goals and objectives of target district sector strategic plans, the National Development Plan (NDP III), and the Multi-Annual Country Strategy (MACS) of the Netherlands Embassy in Uganda.

So for the programme has implemented a 10-month inception phase (November 2020- September 2021) programme in which the programme setup has been implemented. This inception phase involved setting up the programme field offices, recruiting of staff, district stakeholder entry activities as such setting all the foundations for the programme (details in 2). It also provided a platform for refining the strategies, methodologies and tools used in programming including informing the results framework. In addition, core programme activities have also been started.

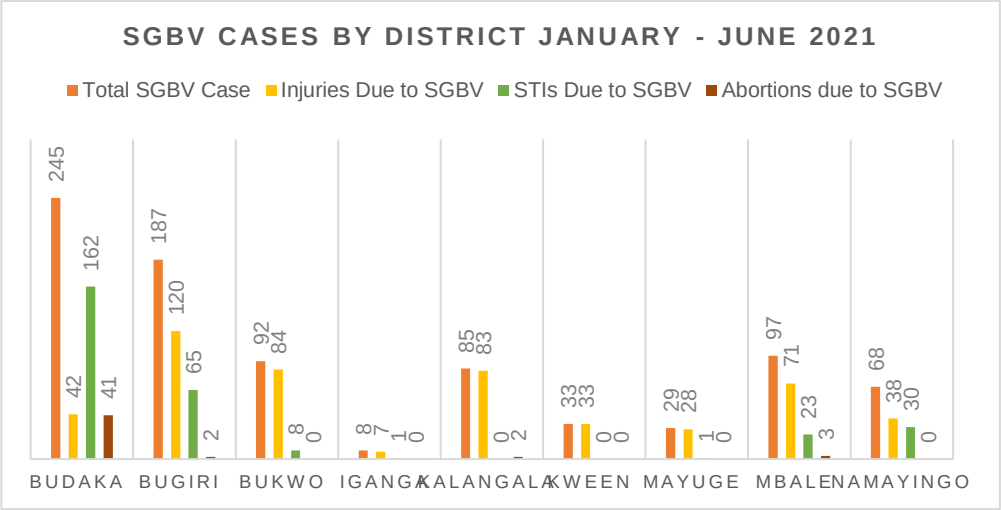
This report provides details of what has been achieved regarding the inception phase of the programme and some core activities, in chapters 2 and 3 respectively. The report also describes challenges and opportunities in chapter 4, potential changes in the programme strategies in chapter 5, risks and mitigation measures in chapter 5, guiding principles in chapter 6, the risk matrix in chapter 7, conclusions in chapter 8, and a summary of the financial report in chapter 9. annexes are in chapter 10 of the report.

1.1 Heroes Programme Context

Accord to the Uganda 2021district population estimates from the Uganda Bureau of statistics, the program the 9-program district of the have a combined total population of 2,342,200 people of whom 75% are less than 30 years old. The majority of the population are subsistence farmers and fisher folks especially in the island district of Iganga, Namayingo and Kalangala. Further analysis of the district data has shown that young people aged 10–24 years constitute over a third (35%) of the population. A rapid assessment conducted by the Heroes program has found that adolescent girls (15-19 years) and young women (20-24) continue to bear a high SRHR/SGBV burden as evidenced by the high teenage pregnancy rates. In some districts, e.g. Namayingo the rates are higher (28% vs 25%) than the national average. Anecdotal data from stockholders in the district have liked these unintended pregnancies to unsafe abortions, HIV/STI transmission and maternal death among this adolescent girl and young women in the program districts. The root causes of these predicaments are strongly attributed to the existing sexual gender-based violence such as rape, early and forced marriage which has escalated in the wake of the covid19 pandemic measures including the closure of schools. Anecdotal data also suggests that the practice of harmful practices against girls such as FGM has also increased in the border districts of Bwuko and Kween with cutting going on from across the border in Kenya. The escalation in FGM is reported to be fuelled by economic hardships where cutters benefit from gifts for the cutting and families from bride price. Similar young girls have fallen victim to persons offering relief from such hardship. Other forms of violence such as domestic violence, defilement, child neglect have continued to be prevalent in the programme districts.



Underpinning the above situation in the programme districts are the strong social norms and beliefs that precipitate SGBV and poor SRHR. Testimonies from the Kween district show that girls are considered commodities that fetch bride price, do not have rights to property and women cannot make decisions. From the fishing communities recent engagements heard that "at landing sites, there is no child" meaning that no child (young girl) is safe from sexual activities. The community and local leaders have remained ineffective in confronting such negative norms and beliefs the prevalence of such beliefs and norms. Similarly, the cultural and religious institution, although they have voiced concern on the rising violence and teenage pregnancy during the covid19 lockdowns, they have not been effective. The heroes programme will work with these institutions to address these negative norms. Albeit the foregoing situation, the program districts have social and institutional structures, which have the potential to address these challenges. All 9 districts have fully constituted local governments (local council leaders and committees at all levels) following the conclusion of elections early in early 2021. There are also administrative and technical offices such as the office of the chief administrative officer (CAO), the district health officers (DHO), Community Development (CDO) as well as the justice, law and order sectors (JLOS). These structures are mirrored at the sub-county and parish level. Of specific interest to the Heroes Programme, Gender Steering Committees and District Committees, which have not been active e to lead in improving SHRHR for young people in the districts.



The education sector in the programme districts has largely been non-functional. The closure of schools in March 2020 has eliminated the protective and educative effect of the school environment. The closure has also curtailed the opportunity for the programme to use the school platform to reach young people. While the Government of Uganda has directed that schools can open in 2022 if all teaching and non-teaching staff are fully vaccinated, the exact time of schools for programmes like Heroes remains uncertain. The programme intends to focus on community-based activities until the schools open up fully possibly in mid-2022.

The health care delivery system continues to function but under difficult circumstances. Just 67% of the required workforce is available but also exhibit high rates of absenteeism. A rapid training needs assessment done in the regions shows that the workforce has limited skills in SRHR/SGBV services delivery, especially in rights-based approaches. Stock-outs of periods of SRHR supplies range up to 30%. There are, however, opportunities observed in the sector. All 9 districts are enrolled on the RBF program of the ministry of health although this doesn't cover all facilities. The additional funding completed by that from the Heroes program should lead to improvement in service delivery. The presence of other programme partners such as USAID RHITES, Health Entrepreneurs, RAHU, SRHR Alliance and Community Based Organizations working in systems strengthening has created the opportunity for synergies to complement the Heroes Programme effort. The districts also have village health teams and a youthful population will to volunteer and work with the Heroes programme. At the national level, working groups at the Ministries of Health and Gender have continued to show goodwill to support that programme.

Similarly, a good network of SRHR focused organizations supported by the Netherlands Embassy is forming. The Heroes programme will leverage all these opportunities.

The Justice, Law and Order Sector (JLOS) in the programme districts has continued to function but with challenges. At the community level, cases of SGBV have been heard at the local council 1 (LCI) level and the majority do not go beyond that level. The practice negotiations between perpetrators and survivors continue to happen, resulting in no justice. A rapid assessment of both new and old local council leaders are not conversant with the laws regarding SGBV. They lack tools to guide their decisions as they arbitrate these cases. Furthermore, the advent of covid19 has made the pathway to justice more challenging. The police in the target districts have had fewer resources and there have been poor linkages to the health sector. In addition, the heroes programme has found an acute shortage of tools such as the PF3 form used to process SGBV cases and noted fear and apathy among health workers to fill in the forms. As a result, records and data on SGBV and cases management are extremely poor.

At the district level, just 4 (Mbale, Iganga, Mayuge and Budaka) out of the 9 districts have a consistent magistrate. However, all districts had a very slow system of administering justice usually through the police. The districts also lack survivor protection shelters. The Heroes program need to build capacity at district, parish and local council levels as well as the police by orienting them on the relevant SGBV deterrent laws. Clarity of the referral system and helping SGBV survivors navigate it is a priority. Collaboration with entities in the JLOS sector is also required to ensure the SGBV survivors get justice.

Overall, the main factor that has modified the programme context has been covidd19. The pandemic has had a disruptive impact on social and institutional systems, escalating sexual and gender-based violence in its path. Access and uptake of services have been negatively affected. As such, the Heroes program has found it important to adopt and integrate covid19 SOPs in its programming to continue implementation. This adaption will continue in the subsequent period of the programme.

2. OBJECTIVES AND ACHIEVEMENTS OF THE INCEPTION PHASE

2.1 Key Milestones of the Inception Phase

The inception phase of the programme was aimed at starting up the programme by unpacking the strategy, mobilizing programme inputs, securing the buy-in from stakeholders conducting based lines and revising the strategies from lessons learned through this phase. The table below shows what has been achieved.

#	Objective	Activity Package	Deliverable	Status	Outputs, Outcomes and implications
1	**Review programme strategy**	Consortium unpack programme vision, scope & strategy, clarification of concepts, value clarification	A shared understanding of programme strategy	Completed	The consortium partners reviewed the programme strategy at the beginning (February 2021) of the programme. This enabled a common understanding of the programme, indemnification of synergies and areas of integration. This also enabled the set-up of programme structures which are now functional.
		Review risks, assumptions mitigation strategies	Consortium TOR Developed	Completed	This has been a continuous process by all partners. So far, the election delays and Covid19 risk has held true impacting the programme. The programme continues to adapt and mitigate the resultant effects.
		Elaboration of Programme concepts integration, gender and gender transformation	refined conceptual framework	Completed	All programme staff have been oriented on key programme concepts through virtual meetings. These include Meaningful youth predication, gender transformation. Additional training will be required to cover all programme stakeholders.
		Defined strategic needs of the consortium, TORs of assessments	Strategic needs confirmed	Completed	Strategic needs including greater engagement of national and district actors, upholding of programme principles, ensuring a one-team approach, have been discussed at different levels especially in consortium SLT meetings. These the SLT continues to track and address these aspects of the programme.
		Define operational issues including governance	Agreements of Partners Signed	Completed	Programme Governance structures are now established and functional with clear TORs by concurrence with all consortium partners.
2	**Mobilize & Establish Programme inputs**	Recruit Critical Staff	Critical staff on board	Completed	Completed by all partners.
		Recruit operational staff	operational staff on board	Completed	Completed all partners
		Secure office Space	Office space	Completed	Amref has supported the establishment and equipping of field offices. they are fully functional in Iganga, Kalangala & Mbale and are used by all consortium partners
		Mobilize content evidence-based tools and materials	relevant content material available to programme	Ongoing	Sexuality education/gender transformative curricula, (journeys +, Programme Y, Programme P etc.), RBF manuals and MIFUMI manual on SGBV have been appropriated by Amref Cordaid and MIFUMI respectively. These have been adapted for use in schools, health facilities, districts and community interventions. Training of activity facilitators on how to use these manuals has commenced.
		Procure Critical Equipment	Key Staff equipped to commence work	Completed	All programme equipment is on board and in use.
3	**Secure relations of key stakeholders**	District Inception meetings	Minutes of Deliberations	Completed	Inception meetings were held for all 9 districts with all consortium partners participating and enlighten the districts on the program.
		Secure MOUs with Districts/ Relevant Institutions	MOUs	Completed	Amref led the district entry activities and secured MoUs for all 9 districts. This has enabled the consortium to commence activities in the target districts without any inhibitions.
		Map Target facilities/schools/institutions	Stakeholder maps completed	Completed	Completed and draft reports compiled. 89 schools and 54(9 private and 45 public health facilities) Health Facilities (18 on RBF) have health facilities, 28 CBOS/CSO (of which 18 will work with the program – see annexe 5) have been identified. The programme will work with these institutions to deliver the programme. The health facilities are indicated in annex 10.1. And Annex 5.

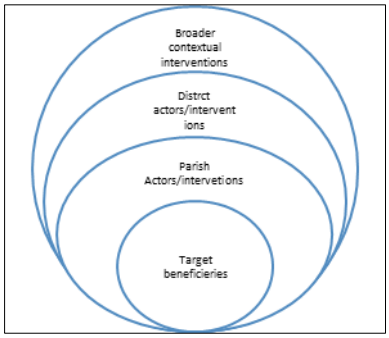
#	Objective	Activity Package	Deliverable	Status	Outputs, Outcomes and implications
		Mapping of existing resources e.g. working groups, champions, trainers,	Detailed resource map	Completed	Key community resource persons have been identified including 90 SGBV champions, 540 VHTs and 1080 peer educators.
4	**Conduct baselines and assessments**	Develop TORs for baseline survey consultancy and consultant recruitment	TORs	Started	The Baseline survey protocol has been developed with the leadership of ICRW and submitted to IRB at Mildmay Uganda for approval. First comments have been received and are being addressed.
		Conduct a baseline survey	baseline report	Not started	Baseline to be implemented in October 2021
		Conduct an assessment to map specific SRH needs of youth and women and contextualize specific norm values- and gender discriminatory-related practices driving identified SRHR violations and SGBV	Youth and women SRH needs assessment report	Partially done	The majority of this content is dependent on the baseline survey.
		Mapping of SGBV hotspots	Hotspot map report	Completed	9 Hotspots mapping at the parish level has been identified with the leadership of MIFUMI. these, in line with the national parish development model, will be centers of interventions on sexuality education and SRHR/SGBV services
		In-depth Health Facility Assessment	Facility Assessment Report	Not started	These will be part of the Baseline assessment.
5	**Finalize intervention approaches/ content adaptation**	Refining and further contextualize intervention approaches	Refined intervention approaches	Ongoing	Refining of strategies has commenced based on mapping exercises and interaction with stakeholders. There is now more geographical and institutional focus. Additional refinement will be done in Q1 Of year 2 after the baseline results are available.
		Develop Year 2 work plan	Year 2 work plan developed	Ongoing	This has been developed and is to be submitted on 30 September 2021.
		Content Design workshop	Final SRHR/SGBV content	Completed	Messages have been developed in collaboration with the Ministry of Gender and other CSOs in the Gender technical working group. The appropriate messages will be adopted into the programme.
		Development & Adaption of Tools and Messages	Final Tools and Messages	On track	Some adaptations of messages Completed
		Refining of evaluation and learning agenda with all partners, YLOs/WLOs) and other stakeholders to finalize learning agenda key themes and questions	Final evaluation and learning Agenda/plan	Ongoing	Review meetings have been held to review the learning agenda. The current draft research and learning agenda will be further reinforced by the baseline survey.
		Finalize the programme Theory of Change	Final Theory of change	Ongoing but behind schedule	The finalization of the TOC has not been achieved although, through mapping exercises and implementation experiences, lessons are pointing towards the need to adjust the programme approach. For instance closure of schools has meant that the majority of young people need to be found in the community through safe spaces. The programme will take an adaptive approach to the theory of change.
		Design and conduct a 3-day partner workshop to develop a gender transformative project effectiveness measurement framework with clear indicators, means of verification and milestones.	Final M&E framework and plan	Completed	HEROES data collection tools have been developed collaboratively by all partners and endorsed for use
		Develop and lead a two-day training for consortium partners on youth inclusion and gender transformative approaches	Training report	Completed	30 Programme staff were trained on gender transformative approaches led by ICRW and the SRHR Alliance. The programme will continue to monitor from within how the staff adopt these approaches.
		Lead a two-day training for consortium partners on socio and gender norm measurement	Training report	Not Completed	The activity to be implemented in October 2021
		Develop TORs for research uptake and learning dissemination shared learning portal platforms	TORs	Not due	To be finalized in October after assessing the needs

#	Objective	Activity Package	Deliverable	Status	Outputs, Outcomes and implications
		Inception Phase Report	Inception Phase Report	Ongoing	Draft report compiled and final version to be submitted by 5th October 2021

The overall assessment of the inception phased puts the program on track on a majority of the programme inception phase objectives except those dependent on the baseline. The programme team is working to expedite the realization of the remaining objectives.

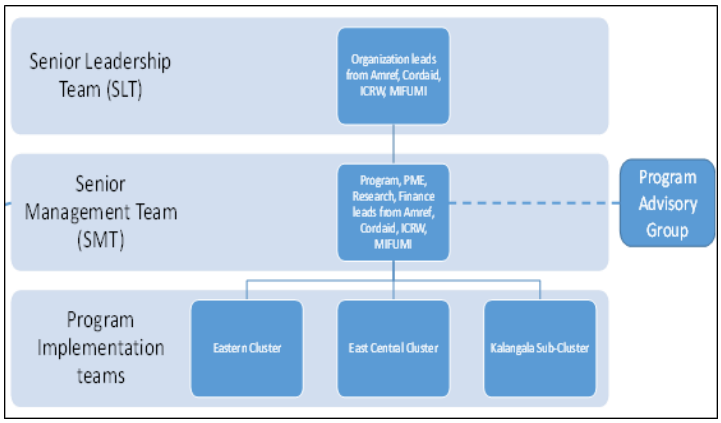
2.2 Program Setup

The programme maintained the cluster approach where districts group in clusters for easy management. Following the district entry and stakeholder engagement exercise where program implementation models were discussed, the parish model was recommended to be the most acceptable model and is also in line with the national parish development model. As a result, the program has now been set up with a parish where the parish with the highest burden of SGBV/SRHR morbidity incidence has been selected to be the unit of implementation. In each of the 9 districts, such a parish has been identified to benefit from program interventions on the 4 results areas will be implemented. To support this implementation, the parish leadership, surrounding health facilities, schools the JLOS sector and communities will be engaged in the implementation of the programme. Duty bearers i.e. district leadership and other relevant sectors such as health, gender, education, community development, the police, justice and key influencers such as religious and cultural institutions at the district level will constitute the support structure. The selected parishes in each district are provided in annex 1.



2.3 Program Governance & Management

Establishing the program governance structure: The initially proposed governance structure was a review by leads of the consortium based on a TOR prepared by Amref. The TOR described the various structures and accountability levels including a senior leadership team (SLT) which comprises of the consortium organizational leads and is concerned with programme strategic issues, the senior management team (SMT) which is concerned with the technical issues and the program management team (PMT), communications, finance team and the monitoring, evaluation research and learning (MERL) teams which are concerned with the respective technical issues. Each of these teams has all consortium partners represented. The teams have reviewed their and adopted the TORs. Through mutual agreement, this structure was approved and is now operational. The establishment of these structures has enabled the program to address key operational strategic issues in the programme and to enhance the one



team approach. The SLT meets quarterly while the SMT and Teams meet weekly to plan[2] and implement interventions.

The Programme Advisory Group (PAG): This group has been established to provide additional strategic guidance and as well serve as a platform for the beneficiary voices. The membership includes seasoned individuals with over ten years' experience in public health management, representatives from four-line ministries; Ministry of Health; Ministry of Education and Sports, Ministry of Gender and Social Development; Ministry of Justice and Constitutional Affairs, representatives from the local governments, representatives of Civil society organisation, representatives from religious and cultural institutions. In quarter one of year 2, the programme will convene a meeting of the PAG to orient them about the programme and their terms of reference. Thereafter the PAG team will be meeting every six months or as appropriate to address any issues at hand.

2.4 District Entry Meetings

The main objective of the entry meetings was to introduce the programme and solicit support from the key stakeholders. In the reporting period, inception meetings have been held for all the nine programme districts namely: Kalangala, Iganga, Namayingo, Bugiri, Mayuge, Budaka, Mbale, Bukwo and Kween. The activity involved presentation and stakeholder engagement. The stakeholders included Chief Administrative officers Resident District commissioners; District chair persons; Heads of departments; Religious, cultural and Political leaders, health workers, NGO representatives, representatives of persons with disabilities (PWD), and youth representatives. The stakeholders' participation provided all stakeholders with full opportunities to share their views, needs and knowledge on SRHR/GBV and also played a vital role in building consensus through bringing together a diverse range of stakeholders to share needs, information, ideas and knowledge and harmonize the objectives of individual groups to reach common programme goals In all the districts the stakeholders committed to supporting the Heroes 4 GTA programme through the development of sector-based action plans. The programme staff have also established working relationships as a follow-on of these entry meetings in all the programme districts.



FIGURE 1: 1PARTICIPANTS OF THE MBALE DISTRICT ENTRY MEETING

[2] Cluster Planning SOPs: https://drive.google.com/file/d/1BZS32j00anSd_euBRHQju1lXTZkUGZkF/view?usp=sharing

2.5 Selection and Engagement of Partners

Beyond the consortium members and the 9 target districts, the programme purposed to identify a number of partners to work with. So far, the program has established significant networks of partners with whom to work. The table below shows a summary of some of the partners engaged and the areas of collaboration.

#	**Partner**	**Area of collaboration**
1.	Youth and women-led organisations (annex 5).	18 of these, 2/district have been selected to work with the programme in engaging communities. Five of these are supporting RBF by working directly with Cordaid.
2.	SRHR Alliance, Reproductive Health Uganda	These sharing technical content sexuality education materials
3.	Reach A Hand Uganda	Is working in collaboration with Cordaid to establish a safe digital referral system for young people i.e. Sauti Plus
4.	USAID RHTES Programs, URMCHIP mentorships programmes	These have been approached to support health systems strengthening as there are already in the region supporting some health facilities and community activities.
5.	Ministry of Gender – GBV technical working group	the program is providing upstream information and receiving guidance on national policy and strategic areas
6.	Ministry of Health RMNCAH, Adolescent health, RBF technical working groups	These are platforms where policy and strategic level information and guidance is shared about and with the program
7.	EKN and centrally supported SRHR including UNFPA	Amref has worked with UNFA to share and learn of the program as practices and experiences, as well as share technical materials.

2.6 Human Resource Recruitment and Procurement of Assets and Equipment

Through an open competitive system, the program has brought on board 33 full time technical and support staff as per the table below:

Consortium partner	**Number**	**Comments**
Amref Health Africa	18	All staff on board
MIFUMI	10	All staff on board
Cordaid	3	All staff on board
ICRW	2	One staff not yet recruited
Total	33	

The senior staff include Mr Michael Muyonga a sociologist from Amref with 12 years of public health experience as the program manager, Naome Wandera a Senior Gender Research and Evaluation Specialist from ICRW with 15 years' experience as the gender and research lead, Immaculate Akello, a legal officer and SGBV management practitioner as SGBV coordinator of the program and Brenda Nanyonga, a systems strengthening specialist from Cordaid as the RBF coordinator. This team is supported by program officers as frontline implementers and administration officers supporting program teams with logistics and a finance team providing financial support to the program. All staff were oriented on the programme goal, objectives and principles including standard operating procedures and regulations. These have been further reinforced by individual organizations' regulations.

Procurement of assets and Equipment

Through established procurement systems, assets and office supplies were procured. The key assets procured included: three vehicles, 27 laptop computers for all the full-time technical staff, projectors, printers, cameras, generators, office space, furniture and various branded materials to increase the programme visibility and brand. Currently, all the offices are fully functional. In support of the RBF e-

voucher Sauti Plus system, 38 Smart phones and 12 tablets were procured by Cordaid. The will be used by peer educators to collect data and issue e-vouchers.

Adaptation of Standard Operation Procedures on Covid19,

The Programme adopted MOH guidelines for the prevention of COVID-19 when undertaking various programme implementation activities. The guidelines were contextualised to suit the working environment and all staff and key partners were oriented on the same.

2.7 Monitoring and Evaluation Activities in the Inception Phase

Through the program monitoring and evaluation research (MERL) team led by ICRW, the program achieved the following monitoring and evaluation milestones in the inception phase.

i. Completed the development of the performance-monitoring plan (PMP), the indicator racking tables and the associated development of the programme data collection tools. These tools are now available for use in the programme.
ii. Conducted rapid mapping exercises to establish the available community resources and assets. This exercise identified 54 target health facilities, 89 schools, 9 SGBV hot spot communities. In addition, over 1080 community facilitators and 540 VHTs were identified to work with the program.
iii. Developed and completed the baseline protocol and the associated data collection tools. The protocol and tools have since been submitted to the Mildmay Uganda Research Ethics Committee (MUREC). The baseline data collection is expected to commence in October 2021 following study registration and second-tier approval with the Uganda National Committee for Science and Technology (UNCST).
iv. Development of program data dashboards and maps. This activity commenced in September 2021 and aimed at improving the visualization of data and aiding decision making. When completed, dashboards will help in visualizing the data and aiding decision making as well as advocacy.
v. A research and learning agenda and plan was developed (see annex 7). it will be continuously improved based on emerging areas of interest in the course of the programme.
vi. The programme is commencing the digitization of data collection tools. This is being enabled by a tool known as Survey CTO which is a mobile data collection platform that enables collection and easy visualization of data. Program staff have been introduced to the tool and are familiar with it. When digitization is complete, will be able to collect and instantly transmitted data to a server hosted at Amref and the program can access, analysed and visualized easily.

2.8 Review of the TOC and Programme Strategies

In February 2021, the programme held a workshop to unpack the program strategies referring to the theory of changes. In these meetings, a clear understanding of the program goal objectives, strategies and inputs were clarified. With the inception phase having been largely been occupied by the entry and program setup activities, there has not been an opportunity to test the different interventions and assumptions. Consequently, the theory of change is yet to be revised. Going forward, the program proposes to use the first two-quarters of year 2 to study and adapt the TOC. The programme also proposes to take on an adaptive approach while strongly maintaining the program goal and result areas.

2.9About the baseline survey

The purpose of the study is to benchmark and monitor the status key performance areas as defined in the program key outcome indicators; conduct a power mapping of stakeholders and service providers; carry out a gender and vulnerability analysis concerning access/utilisation of improved Sexual Reproductive Health and Rights (SRHR) and Gender-Based Violence (GBV) services, and to enhance sustainability measures of the programme.

- It will assess men's, women's, adolescent boys' and adolescent girls' practices and attitudes to inform interventions and policy development that promote gender equality, sexual and reproductive health, and Gender-Based Violence prevention, including efforts that involve boys and men. The baseline will also help us to understand norms and practices related to SRHR and S/GBV that the program can positively shift.
- The study will assess the relevance and appropriateness of the proposed programme strategies, sustainability measures for the programme, enhance subsequent tracking of programme performance, and serve as the basis for monitoring, evaluation, learning and quality control of Programme interventions over time.
- The baseline findings will be used to adjust indicator targets and milestones as needed, guide technical strategies and intervention approaches, feed the Theory of Change, inform Collaborative Learning and Adaptation processes, and avoid duplication of effort. It will also be used to measure the outcome of the Programme by comparing the end line results to baseline findings.

The Specific Objectives Of The Baseline Survey

The baseline survey has been purposed to assess the following;

i. Assess the level of knowledge, beliefs, perceptions, attitudes, and norms (empirical and normative) about SRHR and SGBV across key structures and beneficiaries in the ISPHD districts.
ii. Establish baseline values for specific Programme key performance outcome indicators as stipulated in the ISPHD Programme Results framework.
iii. Establish the power dynamics and influence concerning the program overall objective – (stakeholder and power mapping) of stakeholders and service providers in the target districts.
iv. Establish the current level of commitment of key structures to gender equity and SRHR services. This should be based on the minimum intervention services package, capacity including the quality of services, resources, and protocols, among others.
v. Assess the extent of involvement of beneficiary groups in implementation, monitoring and improving services, satisfaction and/or perceptions of beneficiary groups about the quality of existing mechanisms in meeting their needs.
vi. Identify existing policies, laws, and ordinances and establish how these impact power inequity concerning SRHR and GBV service provision and utilization.
vii. Identify SGBV and SRHR inequality hot spots in the target districts to facilitate differentiated implementation and targeting.
viii. Assess the relevance, validity, and sustainability measures for the ISPHD program including validation of risks and assumptions concerning the TOC.

Questions To Be Answered By The Baseline Survey

- How are gender roles, relations, and dynamics – masculinities and men's roles –shaped and constructed in the context of program geographies?

- How do gender roles, relations and dynamics affect vulnerability to sexual gender-based violence, and affect access to and utilisation of sexual and reproductive health and rights in target communities
- How do gender roles, relations and dynamics affect men and women, boys and girls in different social spheres such as the home, caregiving, public life, and others?
- What works to positively transform gender roles, relations and dynamics related to the prevention and response to sexual gender-based violence and improve access to/utilisation of sexual and reproductive health and rights services
- What works to transform unequal gender roles, relations and dynamics, to foster gender equality and equity in different social spheres such as the home, caregiving, public life, and others?

Primary Hypotheses To Be Tested By The Baseline Survey The Study Will Also Test The Following.

- H1: adolescents, young people, and adults reached by the program are more likely to have improved knowledge of SRHR/SGBV risks, reject harmful SRHR/SGBV norms, and engage in more appropriate responses to incidents of SGBV risk and exposure in schools, homes, and the wider community including making healthier choices on sex, sexuality and seeking health services when needed.
- H2: ISPHD program health facilities, schools and communities are more likely to have strengthened SRHR-SGBV service and prevention and response mechanisms that meet the required quality standards to foster increased access to information and SRHR-SGBV services.
- H3: ISPHD program health facilities, schools and communities are more likely to have gender-transformative SRHR-SGBV systems and mechanisms that foster increased gender-equitable and protective access to information and SRHR-SGBV services.
- H4: ISPHD program communities using the evidence-based initiatives on SGBV prevention and response are more likely to have strengthened institutions, improved issue management, increased access to justice, and better collaborations among SRHR protection actors than not.

The resulting information will be used to evaluate strategies, inform tools to adjust any of the areas of the strategy or inputs to ensure that program outcomes are achieved and measurable.

3. PROGRAMMATIC ACTIVITIES

The program core activities were planned to commence in July 2021, alongside inception phase activities. This section describes core activities that have so far been implemented under each result area in the period July – September 2021.

3.1 Result Area1: Better information and greater freedom of choice for young people about their sexuality.

Under result area1, the program planned to conduct three main activities i.e. Review and adaption of sexuality education materials for various target groups, train peer educators and facilitator develop and disseminate critical SRHR information in various forums. The table below summarises what has been achieved.

#	Activity	Output	Relevance & Impact on Program
1.	Conduct content design workshops to test and approve SRHR and S/GBV information channels	Amref working with consortium partners, SRHR Alliance and RHU the conducted this workshop. The workshop considered content from Programme-Y Programme-P; Stepping-stones; Sinovuyo, Uzazi and Journeys plus. Four Curricular for sexuality education have been adopted i.e. Journeys-plus for VYAs (10-14) years, Program -Y for young people 15-24 years and Sinovuyo[34] for parents and other adults.	These curricula are being used to train peer educators and facilitators (for VYAs) who will cascade the training to targeted cohorts in year2.
2.	Training 270 peer educators and community champions per district.	• A total of 594 (55% of the target) peer educators (15-24) years of which 414 (69.6%) females were identified the rough a community-led selection process ad will be trained to be trained in programme-Y. • The remaining 486 peer educators have been reserved for school-based activities year II when schools open • As of 25 September 2021, 42/162 peer educators (20 girls and 22 boys) had undergone a 5-day training on programme-Y in Bukwo, Kween and Mbale. The remaining trainings will be completed in quarter 1 of year II. • Similarly, 68 /162 (33 females/ 35 males) facilitators who were mainly teachers and community development have been trained on Journeys-plus in Kalangala and Iganga districts. The remaining trainings will be completed in quarter 1 of year II.	The identified peer educators will cascade training of young people cohorts (each cohort targets to reach 20 young people/ 12-week training cycle) in the community. Similarly, the facilitators trained on journeys-plus will commence training for cohorts of VYA aged 10-14 in the community starting in quarter 1 of year II. each facilitator will have to train a cohort of 20 VYAs in a 12-week cycle
3.	Partner with Healthy Entrepreneurs 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.	Health Entrepreneurs has been engaged to comment activities. As a result, an initial assessment of the target districts has been conducted, a process that will inform the final implementation sites. Training of the VHTs in health entrepreneurship is slated for quarter 1 of year 2.	The heath entrepreneurs program will enrol, train and equip 540 village health team members (VHT) to extend SRHR information and services into communities. the trained VHTs will complement other information and service outlets in the program
4.	Disseminate SRHR/SGBV through radio talk shows and spot messages. Young people/women - adult-led Radio talk shows (pre-recorded and live) advocating for young people and women's SRHR	Through an adaptive message design approach based on audience needs to develop messages, the program engaged young people and designed messages promoting risk reduction regarding teenage pregnancies, SGBV including rape, domestic and intimate partner violence. Additional messages were designed to promote uptake of SRHR services including, contraception and its benefits, maternity and STD/STI/HIV/AIDS prevention and treatment services. The messages also integrated COVID19 prevention. These messages were aired on radio through 350 radio spots, 20 talk shows and 147 DJ mentions (referrals) and in the community through drive-by sessions. Panellists on radios included The panellists included District health educators, young people and women leaders as	The radio and drive-by messaging approaches were adopted to create community awareness on the SGBV burden, morbidities related to poor SRHR during the Covid 19 outbreak where direct community engagement was not feasible. Over 19,837 (9485 female, 10352 male) people were reached directly with messages. Radio messages are

[3] https://www.unicef-irc.org/files/documents/d-3994-Manual_%20Sinovuyo%20for%20Teens_%20Facilitator_English_final.pdf

[4] https://www.unicef-irc.org/files/documents/d-3995-Manual_%20Teens-Family-guidebook_English_final.pdf

#	Activity	Output	Relevance & Impact on Program
		meaningful youth involvement, as well as political leaders.	estimated to have reached over 1 million people.

Due to school closure in the containment of Covid19, school-based activities including engaging of school management teams, training of teachers, engagement of school management committees have not been possible. The program intends to reach young people in and out of school through community safe spaces.

About Journeys-Plus

The Journeys - Plus is a Ministry of Health approved facilitator-led curriculum under the school health program that targets the very young adolescents (VYAs) 9-14 years. The content promotes competencies in self-awareness and management, social awareness and responsible decision making (agency). The program takes about 12 weeks per cycle to complete and graduate learners. The training of facilitators on Journeys-Plus has been necessitated by the fact that VYAs may find it difficult to educate fellow peers. The HEROES Program is training facilitators, mainly school teachers to roll out this program.

About Program-Y

Program-Y is a tested comprehensive SRHR education curriculum that builds knowledge and competencies on gender, sexuality, pregnancy, sexual vulnerabilities, substance abuse, communication skills, life skills, family planning, menstrual hygiene and relationships among others. The curriculum has already been used in Uganda resulting in the improved agency of young people regarding SRHR. This curriculum is has been adopted by the heroes program to provide comprehensive sexuality education to young people aged 15-24 years.

Overall, intervention in this result area taking share, although they have been interrupted by COVID19. The effect of covid19 containment measure including restricted community and travel for most of the implementation period is lost time. This means that it will take longer to realise the number of targeted people. The programme is adapting to cover the lost ground by working more in the communities under this result area.

3.2Result Area 2: Better public and private healthcare for family planning, pregnancy and childbirth, including post-abortion care.

Under this result area, the program planned to engage and build the capacity of health facilities in leadership and governable for SRHR, RBF and to engage CBOs supporting RBF. The following has been achieved.

#	Activity	Output	Relevance & Impact on Program
1.	Training of Health Unit Management Committees	Working with Cordaid and MIFUM, f HUMCs of 51out of 54 Health Facilities were refreshed on their roles and responsibilities in promoting quality SRHR/SGBV services, ensuring that these services are allocated	HUCMs are governing bodies for health facilities. The program is relying on them to improve service

#	Activity	Output	Relevance & Impact on Program
		resources. The refresher training also covered gender and rights-based approaches in service delivery. So far, A total of 455 members (222M and 233F) from 51 facilities were trained. Members from 3 health facilities will be trained in year 2.	access and quality for young people.
2.	Training of Health workers in critical SRHR services	Amref in collaboration with MIFUMI have commenced orientation of health workers on the critical SRHR/SGBV services. This hybrid training is a primer for additional planned mentorships in SRHR, professionalism and code of ethics, Gender Transformative Programing and Meaningful youth participation as key principles in programme implementation. In addition, the training also focused on key components of SHRH including the provision of youth responsive services, Family planning, life skills, and SGBV and quality improvement. So far, 30 (8 Male, 22 Females) /270 health workers from Kalangala. Other districts will be trained in year 2.	These trainings are critical considering that a rapid assessment in health facilities found a skills gap in both new and experienced staff. The orientation pieces of training will be followed up by mentorships to enhance skills in SRHR/SGBV service delivery.
3.	Training of program staff on RBF	Cordaid conducted A 3-day RBF orientation f0r the program to enable a common understanding of RBF, its principles, goal, strategy and approaches, the key outputs and how it operates. The orientation led to the development of activity terms of references (ToRs) and budget breakdowns for RBF start-up activities.	All 26 program staff now have a clear understanding and can support RBF activities in the 18 targeted health facilities.
4.	Development of programme implementation manual (PIM)	The PIM was jointly developed with the RBF team of experts from the Cordaid Country and Global office. The PIM details the design, indicator package, costing, Processes and RBF tools that will be utilized throughout the life of the project. Document reviews were conducted for the currently running RBF programs in Uganda like the MoH URMCHIP programme, ENABEL RBF programme and the Cordaid Pioneer RBF project. This was aimed at ensuring consistency in design, learning and informing Risk management strategies for the RBF project. The PIM was jointly reviewed and validated by District Health Teams from the RBF selected facilities through a 3-days workshop. Indicators were further defined and realigned to parameters measured through the MoH HMIS tools. Clear verification strategies were clearly defined and realigned based on the districts' experience in implementing the MoH URMCHIP programme.	The PIM will enable the programme to implement RBF in a standardized way and focus on the SRHR priorities for young people and women rather than the broader health systems objectives.
5.	Identification and Prequalification RBF Health Facilities or Heroes Program	Results-Based Financing (RBF) prequalification assessments were conducted in the targeted five RBF districts using the Ministry of Health RBF prequalification assessment tool. The objective of the exercise was to identify and select high volume (> 60 deliveries/month) health facilities with the capacity to offer quality health services, protect patients' rights and enhance public safety to be enrolled onto RBF. In addition, these facilities to be those not currently implementing RBF or the indicators of interest. The deliverables of facilities are listed in Annex 10.2. All the high volume facilities in the five districts were assessed on the basic requirements for RBF using the prequalification tool and eighteen (18) health facilities -	18 out of 54 target health facilities have been contracted on RBF in the HEROES programme. In these facilities, the quality of SRHR will be enhanced through RBF. These facilities will also be case facilities to provide learning on how SRHR/SGBV services can be enhanced by RBF.

#	Activity	Output	Relevance & Impact on Program
		Kalangala (3), Budaka (3), Bukwo (4), Kween (4) and Namayingo (4))were selected to be part of the RBF programme (annex 3).	
6.	Training of district and health facility staff on RBF	Cordaid conducted RBF training 38 health facility staff, 15 members of district health management teams (DHMTs) and 8 program staff. The training covered[5] topics such as RBF principals, standards, tools and utilization of RBF funds aligned to the ongoing RBF programs in Uganda. The training was further reinforced by a site visit to Kamuli where Cordaid is has implanted another RBF programme.	This training enabled the contracting of the 5 districts and 18 health facilities. The health facilities commenced the implementation of RBF in July 2021 (see Annex 3). Together with contracted CBOs, the trained persons are performing RBF verifications.
7.	Develop the e-voucher system	Working with Reach A Hand Uganda (RAHU), Cordaid has developed an e-voucher referral system. The system is based on Sauti Plus, a web-based SRHR system that enables young people to access SRHR/SGBV information and services. Within this collaboration (RAHU) will provide e-vouchers to young people and women through peer educators who will ensure that venerable people receive these vouchers. So far communities around 12 health facilities have been earmarked to use the e-voucher system in the districts of Budaka, Bukwo, Kween and Namayingo. Kalangala will be supported directly by Cordaid. This Digital Referral System will also enable tracking services and or beneficiaries over time across diverse service points.	The e-voucher system will enhance safety, choice, inclusion and access to SRHR/SGBV services. Furthermore, the digital referral system will enable the program to analyze for types of services accessed, the uptake of services and to obtain feedback on the quality of services. Beyond enabling access to services under result area 2, this system will also facilitate SGBV survivors to access services under result area 4.
8.	Training of Peer on use of e-vouchers	36 (20 female, 16 male) peer educators in 4 districts have been trained to issue e-vouchers to peers through the use of mobile Apps /SMS on Sauti Plus. These peer educators are equipped with mobile phones and internet data to run the e-voucher system. Additional set such educators will be trained in year 2 to cover the programme	These peer educators are key drivers to enhancing access to SRHR services. The effectiveness will enhance the program results
9.	Engagement of CBOs to support RBF	5 CBOs were identified and have been contracted to support RBF by representing the community in verifying service quality in 18 contacted facilities, the distribution of CBOs is shown in Annex 3.	Contracting of CBOs will is promoting meaningful youth participation, beneficiary ownership and ultimately the sustainability of programme interventions

[5] Basic concepts (RBF, PBF, P4P, demand and supply sides of RBF etc.); RBF cycle, principles of RBF,RBF processes: prequalification, contracting, verification, payments ,RBF output performance Indicators ,Incentivizing Quality of care in RBF, Pricing and payments , RBF as a tool for community empowerment ,Demand side RBF – case of vouchers for SGBV, Business planning.

4.2.1 QUARTERLY PERFORMANCE REVIEWS MEETINGS IN KWEEN, BUKWO AND BUDAKA DISTRICTS

As part of a strategy to strengthen the delivery of SRHR/SGBV services, the HEROES programme jointly convened performance review meetings that were attended by the District health management team, Health facility in-charges, District Community Officers, Resident District Commissioners, District political heads and the implementing partners from the 3 districts of Kween, Bukwo and Budaka. The purpose of the activity was to review the performance of the health systems strengthening blocks of service delivery, health workforce, health information systems, access to essential medicines, financing and leadership/governance within the districts regarding SRHR/SGBV. The programme shared with the participants the status of SRHR/SGBV services in the districts noting the following;



FIGURE 2: PARTICIPANTS DURING BUKWO DISTRICT ANNUAL PERFORMANCE REVIEW MEETING IN BUKWO DISTRICT

- Over 50% were below 20 years while over 18% do not deliver in the health facilities.
- Poor quality of antenatal care services evidenced by macerated still births rates being at 58% of all still births. The dropout from ANC 1 – 4 was also found to be high.
- Low performance of maternal and perinatal death reviews (MPDSR) creates missed opportunities to address the high perinatal deaths.
- Poor records regarding SRHR/SGBV services. In addition, reports delay and are poorly analysed and data is not being used to make decisions.
- Staff absenteeism leading to limited utilization of SRHR services and therefore requiring interventions by district leaders.

Action points were developed for implementation by the District Health Officers, Health Facility Leads and by Health facility management committees. Probation officer, on the other hand, were charged to take more proactive effort towards addressing the teenage pregnancy rate us in the target districts.

4.2.2 COMMUNITY HEALTH DRIVES

Whereas this activity wasn't initially planned, the HEROES programme led by Amref responded to the demand from district and community leaders on the need to provide services and health information to-hard-to reach communities because people were hesitant to go to health facilities. HEROES in partnership with the district leadership adopted community health drives provided information and SRHR/SGBV services. The services provided included antenatal care, family planning, treatment of common illnesses especially malaria and respiratory tract infections. A headcount number was 19,837 (10,352 females, 9485 Males) people reached with the information while 7,188 (5024 females, 2164 males) were reached with several SRHR services. Community health drives will be adopted as an alternative measure of information and service delivery when lockdowns are reinstated.



4.2.3 INTEGRATED COMMUNITY OUTREACHES

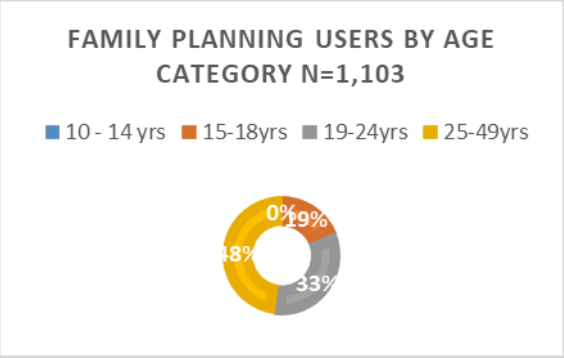
As a means of reaching the hard-to-reach communities whose situation was worsened by the COVID-19 resurgence the programme implemented integrated outreaches in collaboration with the district local governments.

Outreaches were implemented to expand access to SRHR/SGBV services whose uptake had slumped during the covid19 lockdown. At the time, young people were particularly affected. To improve access for young people, the identified peer educators and VHTs supported the identification of outreach sites and beneficiaries and mobilised the community to identify services. The programme facilitated health workers from public health facilities to conduct integrated outreach services in sites identified by VHTs and community peer educators. Peer educators were also provided with lunch and transport as they supported the outreaches. During these outreaches, integrated services to include family planning, ANC, STI screening, immunization, health education, SGBV screening among other services were provided. A total of 24 outreaches were conducted reaching 2889 (1962 female, 927 male) with selected SRHR/SGBV services.



FIGURE 3: HEALTH WORKER ATTEND TO A CLIENT DURING AN OUTREACH IN KALANGALA

Districts	ANC	FP New User	FP Re attendance	SGBV/SRHR Consultations	Total
Namayingo	86	7	102	0	195
Bugiri	36	13	57	0	106
Budaka	65	26	129	0	220
Kalangala	47	36	159	105	347
Iganga	50	41	389	943	1423
Mayuge	50	1	32	0	83
Mbale	95	5	106	309	515
Total	**429**	**129**	**974**	**1,357**	**2,889**



Outreaches were initially supported by the programme to improve access to services. Subsequently, health facilities will be expected to plan for the outreached and implemented outreaches using resources from RBF.

3.3Result Area3: More Respect for Sexual and Reproductive Rights for All.

Regarding this result area, the programme planned to orient program staff on approaches that would use in promoting respect for SRHR for all, identify community assets, resources and champions to facilitate campaigns against SGBV, appropriate and simplify relevant laws against SGBV, to identify SGBV champions and to establish advice centers (SGBV case management centers). The table below summarizes the activities implemented so far.

#	Activity	Output	Relevance & Impact on the Programme
1.	Orientation of staff on SGBV	MIFUMI held internal strategy discussions with staff to enhance clarify and build a shared understanding of the methodologies, content, desired change, target beneficiary	All 26 program staff now have a clear understanding of approaches to be used under result area 3 and

#	Activity	Output	Relevance & Impact on the Programme
	prevention campaign methodologies	populations and stakeholder groups that would be engaged in the programme. Some of the key stakeholders analyzed the discussion based on their power and interest as well as rights-based roles and responsibilities. They included survivors, duty bearers, gatekeepers, men and boys, girls and women, survivor support groups and the general community. In addition, the workshop involved carrying out an analysis of where we want them to be and how we shall get them to that point. Education series were also conducted with staff on mental health, staff wellbeing and safeguarding.	how the SGBV prevention will be conducted.
2.	Identification & simplification of laws to be used in SGBV prevention for all.	MIFUMI identified Laws and policies to promote SRHR and SGBV prevention. These laws included the Domestic Violence Act (2010), The Local Council Courts Act (2006), the Penal Code Act (Cap. 120) and the National Strategy on Sexual Harassment (The Employment Act), The National Strategy on Ending Child Marriages and Teenage Pregnancy (2014/2015-2019/2020 - under review) and Adolescent Reproductive Health-related policies among others. This is an ongoing process and the next steps are to contextualize and produce simplified versions of the laws and to translate them into the local languages.	The simplified laws will be used to orient duty bearers on their roles in the prevention of SGBV and promoting SRHR during the program. They will also be used to educate communities on deterrents of SGBV during SRHR/SGBV advocacy
3.	Identification of community SGVB prevention champions	The program has so far identified 541 (335 female (4 are PWD), 206 male SGBV prevention champions. These champions were identified through a community-led process where volunteers who included religious, cultural, opinion and clan leaders were nominated by the community.	These champions will be trained to undertake SRHR SGBV advocacy at the community level.
4.	Activation of gender district /Parish Gender steering committees	These committees where are established under the ministry of gender has been activated in the districts of Bukwo, Bugiri, Namayingo, Kween, Mbale, Bugiri and Kalangala. They comprise duty bearers responsible for the prevention of SGBV (see annex 4). the 2 remaining districts will be activated quarter	The establishment of these structures will enable the program to elicit actions by duty bearers following advocacy for better SRHR and prevention of SGBV

Programme Activities on Relevant National and International SRHR/SGBV Advocacy Events.

The International Women's Day; International Women's Day was commemorated in Budaka and Kalangala districts under the theme '*Women in leadership achieving an equal future in a COVID19 world*'. In Kalangala district, Women groups from the Lutoboka landing site and Kalangala Town council joined the rest of the world to celebrate their women`s Day under the theme " A successful woman amidst all the challenges". The HEROES programme team participated in the planning meetings of these activities and contributed resources towards the celebrations.

A total of 809 (head count 311 female, 498 male) people attended the event and were sensitized SRHR/SGBV, and received SRHR/SGBV services including (HIV Counselling & Testing (HCT), Family planning, STI screening and management, condoms, health education, SGBV screening), legal and psychosocial support. Eighteen (18) people (11female, 7male) sought support and help on SGBV and they were given psychosocial support and legal advice on maintenance, domestic violence, land and property. There was the publicity of the MIFUMI helpline (toll-free) and the programme name. `In the district of Budaka, the International Women's Day was commemorated under the theme: "*Building on women's*

strength for a better future in a COVID-19 world". The Programme staff participated and provided financial resources for promotional materials and service delivery. In total, 143 people (45 Men and 98 Women) were reached with information about the programme, what it intends to do in Budaka district and district leaders were urged to support women economic empowerment and the rights of women in shared decision making, particularly at the household level.

Day of the African Child: The day of the African Child is commemorated on the 16th of June yearly. However, in the inception phase, the outbreak of the Covid 19 pandemic affected the commemoration across all the districts. However, amidst the challenge, the districts of Mayuge, Iganga, Namayingo, Bugiri and Kalangala decided to carry out virtual celebrations and these included holding virtual meetings, radio talk shows and many more activities.



FIGURE 4: A CHILD MOTHER, SENIOR PROBATION OFFICER AND LEGAL OFFICER PRESENT DURING A TALK SHOW IN IGANGA

The HEROES programme led by MIFUMI held 05 radio talk shows, one in each district. The key discussion topics were on the impact of COVID 19 on the African child, how parents can support their children while out of school, where communities can report Child abuse cases during and the lockdown. Following the talk show, 2 cases were received in Kalangala after the abused survivors listened to the talk shows. The radio talk shows helped the program to create awareness on SGBV, the rights of children, young people and women despite the covid19 lockdown

International Youth Day: The 2021 International Youth Day (IYD) was held on 12 August 2021 under the theme "Transforming *Food Systems: Youth Innovation for Human and Planetary Health".* Amref organized you led activities where you organized dialogues with stakeholders on how SGBV could be eliminated and how better SRHR ensure for young people. The activities also included visits to health facilities by young people to highlight in promotion of meaningful youth involvement in SRHR service delivery, in addition, youth presented on radio talk shows to discuss SRHR/SGBV concerns.



FIGURE 5FIGURE 5: YOUTH IN IGANGA VISITING A CHILD MOTHER ON THE INTERNATIONAL YOUTH DAY

The concerns covered SRHR/SGBV in the wake of Covid 19, prevention of COVID-19 SOPs, stigma, vaccination and home-based care for the COVID patients in their talk shows. Two radio programs were carried out on BABA FM and EYE FM following which 10 calls were

received. The community drives and health outreaches reached a total of. Overall, the youth day activities involved 943 (621 females, 322male) youths.

3.4Result Area4: Enabling environment for young girls and women's elimination of violence against girls and women.

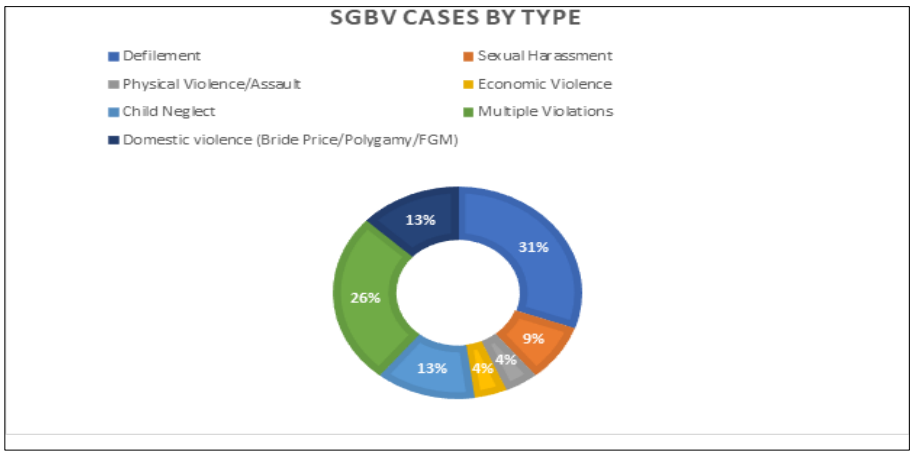
Under this result area, the programme focused on setting up SGBV management structures, mobilization actors in the various sectors and orienting them about the program and providing services to SGBV survivors. The table below summarizes the key achievements.

Activity	Output	Relevance & Impact on the Programme
Setup of community advice centers	Through advocacy led by MIFUMI, 8 of the 9 advice center spaces have been offered in the districts of Budaka, Kween, Bukwo, Namayingo, Kalangala, Mbale, Bugiri and Mayuge. The advice centers are located in the sub-county where the SGBV hotspot parish is and will provide SGBV services and referrals. The programme is now furnishing these centers and will commission most of the in quarter 1 of year II.	The advice centers are physical community spaces established to receive cases of SGBV into the care cascade. Their location at the sub-county level will enable action by the relevant stakeholders during the programme. They will also be the source of data to stimulate evidence-based action.
Identification of champions(SGBV) responders	194 (103 female, 91 Males) SGBV responders have been identified in the districts of Kalangala, Mbale and Bugiri. These comprise of VHTs and other volunteers are chosen by the community.	The SGBV response champions will be trained and commissioned to identify and enter SGBV cases into the care cascade including referral and issuing of e-vouchers for services.
Support at least 3 existing shelters/safe spaces to meet minimum standards of care	So far, no established safe spaces have been identified. Similarly, there are no existing shelters in the district. However, 11 cases (5 women, 1 young mother with disability, 3 girls and 3 boys) needing shelter services have been supported by the programme. Two children neglected in Bugiri have been sheltered at Jinja Babies Home, two children from Kalanga have been sent to Mbarara shelters and 7 cases from Namayingo, Mbale and Iganga have been sheltered in Tororo. the shelters in Mbarara and Tororo managed by Mifumi	Physical safe spaces (and shelters) remain important for the programme especially for the protection of survivors of SGBV who face the risk of recurrence in the short term. The programme is continuing to find possible ways of collaborating to attain such services.
Establish a helpline	An SGBV helpline already existing with MIFUMI **0800200250** has been accessed by the HEROES program. As of September 2021, 142 survivors had been reported through this helpline (see details in 3.4.2 below).	This helpline is one of the safe spaced where SGBV is being reported and obtaining services. The programme is popularizing this helpline to increase access to SGBV care services.
Training of stakeholders of e-voucher referral system	32 health workers (22 female, 10 male), 8 (5 female, 3 male) district staff from 4 districts (Budaka, Kween, Namayingo and Bukwo) and 8(6 female, 2male) program staff have been trained by MIFUMI and Cordaid on how the e-voucher system will support SGBV cases management. This training will continue in year 2 to build capacity and strengthen linkages between health services delivery and SGBV care (result areas 2&4).	The training is important to enable all stakeholders to understand how the e-voucher will be working to avoid inconveniences to beneficiaries but also enhance the utilization of the vouchers.

3.4.1 SGBV CASE HANDLING AND MANAGEMENT

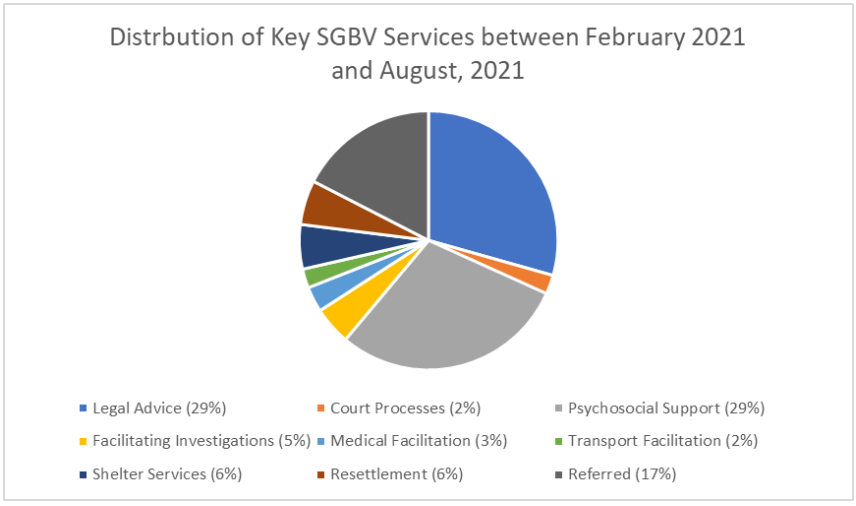
The programme has commenced seeing cases of SGBV. So far, 142 cases of SGB have been served by the programme. Of these 37 (13 women (one with disabilities), 08 girls, 06 men, 02 boys) SGBV survivor cases were handled directly through various interventions. A key feature of the support offered to the survivors was the inter-agency collaboration across different critical service providers, including Police, District Probation Office, and health facilities. Furthermore, the need for temporary shelter spaces has been emphasized by the case handling process so far.

FIGURE 6: DISTRIBUTION OF SGBV CASES BY TYPE



In the 6 months leading up to August 2021, the commonest form of violence (31%) was found to be sexual harassment. The next two highest forms of violence recorded were Domestic Violence in the form of multiple violations (26%) and Defilement and Child neglect both at 13%. Other cases reported included child neglect and physical assault. One survivor with a disability was supported by Mayuge District.

Anecdotal Observations reveal that cultural norms and practices are important drivers of the violence so far recorded in the 9 intervention districts. For example, in Namayingo District, at a Steering committee meeting, the Resident District Commissioner lamented on how bride price was still a key issue driving domestic violence in the Busoga region. In Kalangala District, a major fishing community, the locals have a saying "*tewali mwana kumwalo*" which when translated means that there is no "child" at a landing site…suggesting an indifference to child sex or associated sexual offences. In the community of Kalangala, according to residents, defilement is not looked at as a significant offence.



The helpline established by MIFUMI has started to receive cases. So far 110 (76 women, 34 men) cases have been reported since February 2021. The cases handled at the helpline included the following: Land and property (23), domestic violence (11) Psychological violence (08), bride price (02), family neglect (24), physical assault (10), Child custody (05) Child neglect (07), Information/ inquiry (19), Polygamy (01), Defilement (6), Rape (01), Economic violence (8) and lost child (10), child abuse (02), Rape (1), sexual violence (02), early/forced marriage (02). A specific case study is documented in annex 7.

3.5Result Area 5: Core Monitoring Evaluation Research and Learning Activities

Beyond the actives described under section 2.7. The program has been accomplished the following key programmatic M&E activities.

Activity	Output	Relevance & Impact on the Programme
Establish a program database	This is has been developed and is being digitized. additional elements will be added after the baseline survey is completed	The database will enable centralized data storage, analysis and visualization
Training of staff in the program M&E system.	Initial training of 26 program staff was conducted. However additional training will be conducted as and when required.	This is training will enable better data collection, analysis and presentation.
Conducting data quality assessments (DQA)	Initial Monitoring visits have been conducted to establish relations in 9 districts to district data officers in health, probation, police and other sectors. Verification visits for RBF have been conducted in facilities that have started offering services and RBF. So far, finding show a good understanding of RBF and indication of improving uptake of services. Data is being analyzed to see the emerging trends. Typical DQAs will be conducted once the data collector has taken ground.	DQAs are a critical part of the program and are being conducted to ensure the reliability of the data.

The program M&E system design is still ongoing including digitization. This process is expected to be concluded in quarter1 of year 2.

3.6Results Area 6: Communication, Knowledge Management and Documentation

Activities under this objective have been implemented by the communications workgroup of the programme which is comprised of communications leads in the consortium organization. The following achievements have been realised.

Activity	Output	Relevance & Impact on the Programme
Program Launch	This hasn't been accomplished due to challenges regarding Covid19 containment restrictions. The program launch is slated 28th of October 2021 in Mbale.	The launch activity is important to create awareness of the program, to escalate the campaign on SRHR/SGBV and to mobilize stakeholders towards the common goal of addressing SRHR/SGBV.
Branding of the Program offices & sites	The programme communications team developed a catch name for the program "Heroes 4 Gender Transformative Action" shortened as HEROES. This has been used to brand all program sites including other communications channels such as Twitter, radio and all documents. a program logo was also developed.	Branding is critical for the promotion of the causes of the programme. The label HERO also refers to an individual who will champion the cause of SRHR violations and SGBV.
Documenting life changes stories	This is already ongoing in the programme as testimony on the impact of the program. The following items have been completed; i. Twitter handle @Gender Heroes ii. Program brief (the link is in the annex)	The communication materials are important in inspiring program actions, providing implementation guidelines and creating awareness

Activity	Output	Relevance & Impact on the Programme
	iii. Women day statement iv. Y-Heroes (youth heroes media clips). v. Success stories.	about the program. These items will be used in variant program activities.

Links to some of the materials developed by the communications working groups are shared in annex 7.

4. CHALLENGES AND OPPORTUNITIES IN THE INCEPTION PHASE

4.1 CHALLENGES IN IN THE INCEPTION PHASES

The programme has experienced some challenges and established mitigation measures to address them as follows;

#	Challenge	Mitigation Measures Established
1.	High cost of implementation especially in the island district of Kalangala	• The programme is focusing on the parish as a unit implementation to minimize cost escalations.
2.	Covid19 containment measures established in July 2021 affected programme operation making it difficult to operate normally. in addition, community engagement activities have been restricted to just 20 participants affecting the coverage of interventions	• 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. • Staff are being encouraged to get vaccinated to reduce the likelihood of morbidity due to covid19. • Radio talk shows and drive-by messaging were used more to air SRHR messages.
3.	School closure due to Covid19 has not allowed preparatory activities planned to ensure schools are ready for the programme. Even when they open, it is already known that they will be on a marathon academic program making it difficult to work with students.	• The programme planned to work in safe spaces in communities until schools can open up to the programme. • The programme has integrated covid19 risk reduction messages in talk shows where school teams are encouraged to get vaccinated with a view of increasing the possibility of opening schools.
4.	The baseline has not been carried out in the anticipated timeline. This has affected the strategy review process that was anticipated.	The programme is expediting the baseline implementation. Furthermore, a retrospective perspective in the baseline inquiry will be taken to account for gaps in the time-lapse.
5.	Data gaps have been observed in health facilities especially 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 will refresh health workers on SGBV cases management, provide copies of PF3 forms and conduct data quality assessments.
6.	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.
7.	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.
8.	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.

#	Challenge	Mitigation Measures Established
9.	Escalating food prices occurred in Kalangala Kwen and Bwuko.	Staff were provided with pooled food items. A hardship allowance is being considered to enable staff to work well.
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 will 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 organization and yerning of Heroes interventions 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 year 2, Heroes will purpose to ensure disadvantaged people are identified. The programme will seek support to build capacity on inclusivity techniques.

Addressing the challenge of program location. The case of Kalangala District.

One of the challenges faced during the inception phase was securing consensus on where the programme would be located. In the case of the Kalanga district, a debate arose in the inception meeting on where the program should be located. Quickly, the program team identified a risk of people feeling left out since community representatives were complaining about being left out as observed by the Kalangala district leadership by arguing that identified sub-county selected for the Hot-Spot wasn't consistent with their preferences. This difference of opinion created an impasse that needed to be resolved. To address this, separate meetings were held with some stakeholders about the criteria used for the selection of Bbeta Parish in Mugoye Sub-County as the substantive hotspot for the Kalangala District. However, the district leadership team proposed that the hotspot be hosted in Bubeke Parish, in Bubeke Sub County since it was more hard-to-reach with limited services. This impasse was resolved after a comprehensive mapping and engagement of all the key stakeholders who included: District Chairperson; District Community Development Officer; Chief Administrative Officer; District Biostatistician; Head of Child and Family Protection Unit, Police; Inspector of Schools; District Gender Officer; District Police Commander; Town Clerk; Secretary for Social Services; District Education Officer and Inspector of Schools. These stakeholders jointly reviewed the population and SGBV incidence data and went through the data-driven selection criteria. It is only after this engagement that district stakeholders unanimously agreed that the methodology and selection process was acceptable to them.

4.2 OPPORTUNITIES IDENTIFIED IN THE INCEPTION PHASE

Despite the challenges encountered in the inception phase, the programme has been able to identify and leverage some opportunities:

i. ***Leveraging on existing administrative and institutional structures:*** The programme has benefited from the already existing local government and service delivery strictures such as the offices of the DHO, Community Development Officer and the Gender Officer at district and sub-county levels. This has made it easy to introduce the program. Health facilities and VHTs have also shown enthusiasm for the project.
ii. ***Leveraging work resources from work done previously:*** the availability of precedent evidence-based materials and effective platforms from organizations like RAHU, RHU and the SRHR alliance have eliminated the likelihood of reinventing the wheel. The programme led by Amref has

adopted technical materials such as Journeys Plus, Program –Y, Program-P and Sinovuyo to provide sexuality education to young people.

iii. ***Leveraging innovative technology:*** the programme led by Cordaid collaborating with RAHU to utilize the already tested Sauti-Plus platform for the e-voucher based referrals. This approach will enable an instant reach of young people seeking SRHR services. Furthermore, Cordaid is exploring the use of smart paper technology (SPT) which is a solution that digitises primary paper records. Cordaid has identified the opportunity to work with a services provider to strengthen the quality, precision and accuracy of records, making it easy to verify elements in the RBF process.

iv. ***Existence of a Government Result Based Financing Programme:*** The programme observes the model of RBF programme districts that are already in phases 2 and 3 of the MoH URMCHIP RBF programme will give a scalable learning opportunity of this partnership as the existing schemes maximize governance, PAC and Health services decentralization. The programme focused on contracting high volume and high burden health centres to ensure equal quality of care at the lowest level of services delivery and strengthen appropriate referral.

v. ***The National Parish Development Model:*** The government of Uganda has rolled out the parish development model as a development stimulus for the country. The programme will leverage this opportunity by ensuring that programme beneficiaries such as the youth and SGBV survivors are linked to access resources from this development strategy**.**

vi. ***Availability of Government Data, Monitoring, and Reporting System***: The government of Uganda under the MGLSD has a GBV data and reporting system (The national GBV database). The database aims to collect, store, and analyses GBV incident data across all districts. The database uses the GBV incident report form to ensure that all actors (e.g., police, health facilities, community development departments, etc.) collect consistent GBV data. In addition, the Ministry of Health has the HMIS data collection system that collects data on SRH and GBV and the programme will use these platforms for the generation of data in the programme areas.

vii. ***Extra funding:*** Cordaid secured Euro 170,000 to implement a complementary project alongside the HEROES programme. The project is known as "***Making Health Systems work for Adolescents and Youth"*** is an 18 months project by Cordaid that kicked off in May 2021 to complement the ongoing HEROS programme in 12 RBF health facilities. The project is an innovative service delivery model that (i) prepares service providers for providing truly adolescent SRHR &SGBV friendly services, (ii) that creates a demand for such services through a digital voucher arrangement model, and (iii) builds this model on ingenious state-of-the-art communication and results-based financing arrangements while carefully integrating aspects of COVID19. The resources in this project are contributing to the scale-up of the e-voucher referral system.

5. MAJOR AND POTENTIAL PROGRAMME CHANGES

5.1 DESCRIPTION OF MAJOR CHANGES IN ORIGINAL PROGRAMME STRATEGIES

The implementation experiences of the inception phase have been indicated to the programme. Some of the envisaged changes, although not major are as follows:

Result Area	Change	Rationale
Result Area1	25% Reduction in the outputs regarding the number of young people with gender-transformative information	This reduction is due to the late start of the activities regarding the training of young people in curriculum-based interventions. Secondly, the school closure due to covid19 has curtailed the opportunity of using schools to engage young people in the curriculum-based intervention Thirdly, the restricted gathering of people will affect how many people can be reached at a time. Learner's cohorts are so far restricted to 20 per instance. This will also affect learning for older cohorts.
	Out of school learning ahead of in-school learning for school-going adolescents	While this is not a real shift, the programme, in recognition of the uncertainty regarding school opening, will start without school learning sessions for school-going adolescents until schools open.
	Enhancing learning for women of reproductive age and parenting	This is will be enhanced with a curriculum on parenting e.g. Sinovuyo and a family health outcome improvement.
Result area 2	Change in targeted level of health facilities for RBF support from health centre IVs and health centre IIIs to include health Center IIs	The inclusion of Health Center IIs in the program has been necessitated by the fact that most of Health Center IVs and IIIs are already covered under the national RBF under the URMCHIP program. The health centre Iis identified are also high in volume (see many young people and women) and are located in hard to reach areas within districts. Districts have also indicated that these will be transitioned to health Center IIIs in 2022. Heroes program will therefore contribute to accelerating the upgrading of these facilities.
	innovation using smart paper technology	This is an innovation that helps reduce paperwork and ultimately workload. It is being introduced to support the RBF records and to simplify the verification processes therein.
	Health Drives and outreaches for	Although this is not new to the programme, several of such drives may be necessary of such outreaches will be conducted as a means of reach communities when COVID19 containment measures that restrict people movement are instituted.

5.2 POTENTIAL CHANGES TO THE ENTIRE PROGRAMME IDENTIFIED DURING THE INCEPTION PHASE.

The Heroes program has received a great reception from the target districts, health facilities and communities. All stakeholders, to who the programme intervention has been described appreciate the solution the programme has come with. Therefore, as at the end of the inception phase, there is no indication of major changes rather than what is described in section 5.1. It must be not must be noted however that most of the programme interventions were rolled out in the last quarter of the inception phase meaning, there has not been sufficient time to test the assumption that would warrant a change. These assumptions will be tested early in the year to adaptations will be made then.

6. GUIDING PRINCIPLES/STRATEGIES DURING THE INCEPTION PHASE.

The programme continued to implement the guiding principles as summarized in the table below:

Table 6.1 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 program. This has been made possible through the set up of one integrated team that plans, organizes and implements interventions together. The individuals on the team are backing up each other.
Respect for human rights	The program 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.
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.
Inclusivity	So, 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 technics to reach persons who are currently not reached. The programme will be purposed to build this expertise.
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 takes into account 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 taking into account 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
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 and parcel of the programme implementation.
Collaboration with other Dutch government-funded programmes	The programme is working closely with RHU and SRHR Alliance which have had Dutch government funding. Heroes are active in this network.

7. RISKS ASSESSMENT AND MITIGATION STRATEGIES

Through the programme period, risks have been monitored, updated and mitigation strategies implemented. In table 7.1 below, the colour coding indicates ***(green= has not occurred, yellow=occurred and was managed, red= occurred and was not managed)*** the status of occurrence during the reporting period.

Table 7.1: Risk and Mitigation Matrix

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	Through continuous engagement, the program will address fears, prejudices and misconceptions, target hotspots with activist approaches and target individual gatekeepers with culture-sensitive messaging.
	Unintended harm (e.g. perceived offence by stakeholders) or backlash	High	High	Conducted 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
	Left out districts and communities complain	Low	Mediums	An incident happened in Kalanga where a debate was held over where a hotspot would be located. Using clear evidence-based selection criteria of target communities, the stakeholders understood the basis of selection and gave their approval.
	High expectations from the beneficiaries to meet other needs beyond the programme scope	Medium	Medium	Districts and communities have been presenting demands to the programme. With a clear explanation, these demands have been resolved.
Contextual Risks	Lack of political support for SRHR and SGBV interventions	High	High	Working closely with national TWGs and rolling out some of the curricula approved by the government like the journeys plus based on the sexuality education framework of government.
	Hostile policy environment: (e.g. withdrawal of 2018 Sexuality Education framework,)	Medium	High	Generating more evidence, and use evidence-driven proposals to encourage policy dialogue to cause an appreciation of SRHR and SGBV reforms.
	Political unrest in 2020/21 elections post-election period and shrinking civic space	Medium	High	The programme implementation team stayed clear of any political bias/inclination during the election and post-election period The program is now monitoring the shrinking space. So far, the consortium is not yet affected.
	Worsening systemic gaps target districts including high staff turnover, lack of supplies/commodities	High	High	So far the programme is leveraging mainly on resources from the regional USAID integrated Projects which support some of the systemic gaps like essential SRH commodities. The rollout of RBF will provide extra resources to commodities. in addition, the Health Entrepreneurs in year 2 will extend SRHR commodities to the communities. We shall collaborate with RHU, Marie stopes and DKT international to mobilize and deliver SRHR commodities.
	Uncooperative stakeholders / departments	Low	High	The programme has signed MOUs with the districts with clearly articulated terms of engagements, and in implementation, make sure to abide by agreed terms.
	Stakeholders (districts, health facilities, cultural institutions) ignoring the programme interventions and relevance.	Low	High	The programme has continuously engaged 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	The program-oriented staff on the zero tolerance of fraud, compliance, whistle-blower policies. All high-value items of the programme will be insured. There was a case of a non-compliant staff who was dealt with firmly and decisively. The case was reported to EKN.

Risk Category	Risk Statement/Description	Likelihood Rating	Potential Impact Rating	Risk Mitigation Action Plan
	Staff technical capacity gaps and/or high turnover.	low	Medium	The programme on-boarded competent staff but also continuously builds capacity through coaching and mentoring
	Provider-discrimination	High	High	Provided training on personal safety and risk management. Enhance existing Safeguarding Policy
	Bureaucratic processes by p artners and districts frustrat ing timely delivery of programme interventions.	Low	High	The programme is guided by a clearly articulated and jointly agr eed implementation plan with clear timelines, assigned tasks and performance-based indicators to minimize any implementation bottlenecks.
	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 wi th consequences of a breach immediately applied.
Partner organizations risks	Programme partners cannot implement i nterventions according to st ipulated timelines and standards	Low	High	Amref ensured that partners on the programme have a proven & excellent track record, make continuous follow up, monitoring and provide technical support where necessary. Total failure to perform will lead to replacement with able partner s. Monthly and quarterly review meetings held
	Conflict among programme partners interrupt program me	Low	High	Partners are 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 regula r meetings are held to avoid conflict.
COVID19	COVID-19 pandemic may disrupt pr ogramme implementation a nd focus.	Medium	High	The programme has ensured that all staff comply with national a nd district-specific guidelines. The programme will ensure that areas of operations follow and apply measures described by SOPs to manage the pandemic. In the event of an uncontrollable community spread, the programme will engage the EKN on cessation of activities until the situation normalizes. Request to repurpose resources towards pandemic control may be presented to EKN for approval. Staff are also being encouraged to get vaccinated.
Environmental Risks	Hard terrains and risky wat erways mudslides	Medium	Medium	The programme will train orient staff on emergency response pro tocols and provide helplines. , take group personal accident insurance to cover rescue teams. The programme has secured and provided protective equipment such as life jackets, umbrellas and raincoats

8. CONCLUSIONS AND RECOMMENDATIONS

8.1 CONCLUSIONS

An assessment of the implementation phase shows that the programme is on track in the realisation of its main objective of strengthening the programme strategy to optimally prepare for full programme implementation. Specifically, the programme setup had concluded successfully with team fully constituted and and offces arefunctional in the three cluster offices. Key stakeholder buy-in and working relationships have been established with MOUs signed with host districts. There is clear knowledge of programme health facilities, schools and communities. In addition, the prrogram has establisued verious collablration with like minded organizations and is already leveraging these synergies. this partnerships will complement the effors of the program.

in the last quarter of the iception phase, the programm has rolled out intervention undet the for result areas. these are being will recived which is an indication that mots of the program strategies are acceptable. however, the programme will continue to monitor the reception the programme interventions and adapt the approaches and strategies of the course of implmentation without compromising the program outcomes and goal. despite the interruptions bey covid19 containment meeasures, the Heroes programme has set a

firm foundation for implementaion. This will be further stregthened with baseline findings and continous adaptation in the remaining 3 years of the programme.

8.2 RECOMMENDATIONS

i. Expedite the finalization of the baseline

The baseline inception phase concluded with the baseline at the approval stage of the implementation phase. Its finalization will be given the highest priority in quarter 1 of year 2 so that it informs the implementation by quarter 1 of year in year two.

ii. Scale-up Publicity for the Toll –free help-line in the Programme Area

It was noted especially at the programme inception that 70% of the calls were from outside of the programme districts despite the stigma-free information need among SGBV survivors in the programme districts. It is therefore recommended that all partners and other stakeholders scale up publicity for the toll-free helpline on platforms like radio, face to face meetings and other collateral materials produced by the programme.

iii. Programme participation in National Technical working groups

Whereas the programme is sub-national, it works within the context of national policies and standards. As a means of continuous alignment with the government frameworks, the Heroes 4 GTA programme will continue to attend and utilize the nationally set standards as articulated in the different policies and the National Technical Working Groups (TWGs).

iv. COVID-19 related Adaptations and Innovations

As a response to the current challenges of the COVID-19 surge, the programme plans to continue with implementation adaptations including setting up community safe spaces for the in and out of school adolescents. In addition, virtual engagements will be promoted across the board. Online CTO COVID-19 screening platforms will also be utilised for both staff and major community engagements like the Baseline surveys and other assessments.

v. Integration of COVID-19 risk reduction messaging

Observations at the community level show limited adherence to COVID-19 messaging. It is therefore recommended that COVID-19 messaging should be integral in all the community engagements made by the programme. The programme should promote vaccination internally and externally to foster a quick return to normalcy.

vi. Support redistribution of contraceptives and other SRH products

As a means of addressing stock-outs in addition to collaboration with other partners, there is a need to work with the DHMT to redistribute to facilities experiencing stock-out of medicines and other SRH products Support health facilities in building capacity to making correct orders for Reproductive Health-related commodities. In addition, Healthy Entrepreneurs will be on board in year 2 to extend SRHR commodities in the community. Health facilities will also guide to use of RBF funding to improve commodities and supplies.

9. SUMMARY OF FINANCIAL EXPENDITURE

Of the total approved programme budget, euro 1,840,112 and was disbursed to Amref and distributed to the consortium members as indicated in the table below. The performance for year one as of September 30, 2021, is at 43% against the budget for year one but 57% of the funds received. The low performance is attributed to mainly the Government COVID 19 restrictions which adversely affected the project activity implementation. The activities that have been partially implemented or not implemented at all in period one have been carried forward to period two for completion.

Summary of Year one performance

Partner	**Year One Budget (Eur)**	**Period Actual Expenditure (Eur)**	**Balance (Eur)**	**Performance (%)**
AMREF	1,503,365	720,719	782,646	48
CORDAID	343,502	91,124	252,378	27
ICRW	125,179	71,998	53,181	58
MIFUMI	524,880	179,752	345,128	34
TOTAL	**2,496,926**	**1,063,593**	**1,433,333**	**43**

A cash balance of Euro 776,518 was available as of 30/09/2021.

Summary of funds

Funds Received	1,840,112
Amount Spent	1,063,594
Cash Balance	**776,518**

we note the significant underspend especially on the activity lines due to interruptions during implementation. The carry-over has been carried into the year 2 budget. The detailed budget is shared separately.

10. ANNEXES

10.1 Annex 1: Programme Health Facilities Sub-counties and Parishes by District

District	Sub-county	Health facility	Hot Spot Parish
1. Kalangala	1. Kalangala Town council	Kalangala HCIV	Bbeta Parish
	2. Mugoye	Mugoye HCIII	
	3. Mazinga	Mazinga HCIII	
	4. Bufumira	Bufumira HCIII	
	5. Kyamuswa	Bukasa HCIV	
	6. Bujjumba	Buwedero HCIII	
2. Namayingo	1. Bukana	Bugana HC III	Buhemba Parish
	2. Buhemba	Bukimbi HC III	
	3. Banda	Banda HC III	
	4. MUtumba	Mulombi HC II	
	5. Buyinja	Syanyonja HC III	
	6. Sigulu	Sigulu HC III	
3. Mayuge	1. Imanyiro	Nkombe HC III	Misoli Parish
	2. Bukabooli	Buyugu HC III	
	3. Wairasa	Busuyi HC III	
	4. Buwaya	Buwaiswa HC III	
	5. Kigandalo	Kigandalo IV	
	6. Bukatube	Bukatube HC III	
4. Iganga	1. Nawandala	Nawandala HC III	Iwawu/Mwira Parish
	2. Nambale	Nambale HC III	
	3. Nabitende	Bugono HC IV	
	4. Bulamagi	Bulamagi HC III	
	5. Nakigo	Buswobi HC III	
	6. Nawanyingi	Bunyiiro HC III	
5. Bugiri	1. Bulidha	Bulidha HC III	Wakawaka Parish
	2. Budhaya	Mayuge HC III	
	3. Kapyanga	Kayango HC III	
	4. Buwunga	Buwunga HC III	
	5. Buluguyi	Buluguyi HC III	
	6. Muterere	Muterere HC III	
6. Mbale District	1. Northern Division	Namakwekwe HC III	Bumusopa Parish
	2. Industrial Division	Namatala-HC IV	
	3. Bukiende	Bukiende- HC III	
	4. Busoba	Lwangoli- HC III	
	5. Namabasa	Kolonyi- HC IV	
	6. Busiu	Makhonje III	
7. Budaka	1. Kameruka	Kameruka HCIII	Chaali Parish
	2. Nansanga	Nansanga HCIII	
	3. Budaka	Sapiri HCIII	
	4. Budaka Town Council	Budaka HCIV	
	5. Kakule	Namusita HCIII	
	6. Kaderuna	Kebula HCII	
8. Kween	1. Kwanyinyi	Kwanyinyi HCIII	Kisonji/Kaptum Parish
	2. Kitawoi	Mengya HCII	
	3. Kaproron Town council	Kaproron HCIV	
	4. Chepsukunya Town council	Chepsukunya HCII	
	5. Kapkwata	Kworus HCII	
	6. Moyok	Kabelyo HCII	
9. Bukwo	1. SUAM	Kwirwot HCIII	Kapsekek Parish
	2. Bukwo T/C	Bukwo general Hospital	
	3. Bukwo T/C	Bukwo HCIV	
	4. Chepkwasta	Chepkwasta HCIII	
	5. Brim	Brim HCIII	
	6. Amanag	Amanag HCIII	

10.2 Annex 2: Health facility Deliverables on RBF

1. Developing an annual and quarterly Performance Improvement Plan (PIP), which outlines the targets for the RBF indicators, the strategies that will be employed to attain the targets, as well as the resources required;
2. Planning and budgeting for the RBF funds, while ensuring that revenues and expenditures are balanced;
3. Ensuring that the facility meets the expected SRHR/SGBV service quality standards.
4. Ensuring that all incentivized services are accurately recorded in the appropriate registers and HMIS forms;
5. Preparing timely monthly reports and invoices
6. Ensuring that the facility has all the necessary staffs, systems (quality improvement initiatives, performance review meetings) and infrastructure for providing quality, equitable services;
7. Ensuring that the facility has arrangements that will enhance the delivery of quality services (Both incentivized and non-incentivized services)
8. Ensuring that the facility has a functional HUMC committee that meets monthly
9. Functionalization of youth responsive services
10. The programme aims to optimize SRHR/GBV management outcomes through the selection of the same 18 health facilities for other interventions on top of RBF. A 36 health facilities have been selected for the other Health System Strengthening

10.3 Annex 3 Health facility Deliverables on RBF

District	Contracted CBO(indicating youth or women led)	Facility name and level	Functionality of RBF
Kalangala	V Kids Trust-Youth Led	1. MULABANI H/C II	1ST/Oct/2021
		2. KASEKULO H/C II	1ST/Oct/2021
		3. KACHANGA H/C II	1ST/Oct/2021
Budaka	Budaka Health worker – Women Led	4. NAMUSIITA H/C III	1st/July/2021
		5. BUTOVE H/C II	1st/July/2021
		6. KEBULA H/C II	1st/July/2021
Bukwo	Rhema Foundation - Women Led	7. KWIROT H/C II	1st/July/2021
		8. CHEPKWASTS H/C II	1st/July/2021
		9. BRIM H/C II	1st/July/2021
		10. AMANAG H/C II	1st/July/2021
Namayingo	Sigulu integrated Women AIDS Organization (SIWAO) – Women Led	11. SYANYONJA H/C II	1st/July/2021
		12. MULOMBI H/C II	1st/July/2021
		13. BUKIMBI H/C II	1st/July/2021
		14. BUGANA H/C II	1st/July/2021
Kween	Sebei Diocese –Code Youth Led	15. MENGYA H/C II	1st/July/2021
		16. KABELYO H/C II	1st/July/2021
		17. KWORUS H/C II	1st/July/2021
		18. CHEPSUKUNYA H/C II	1st/July/2021

10.4 Annex 4: Membership of the district and parish gender steering officers

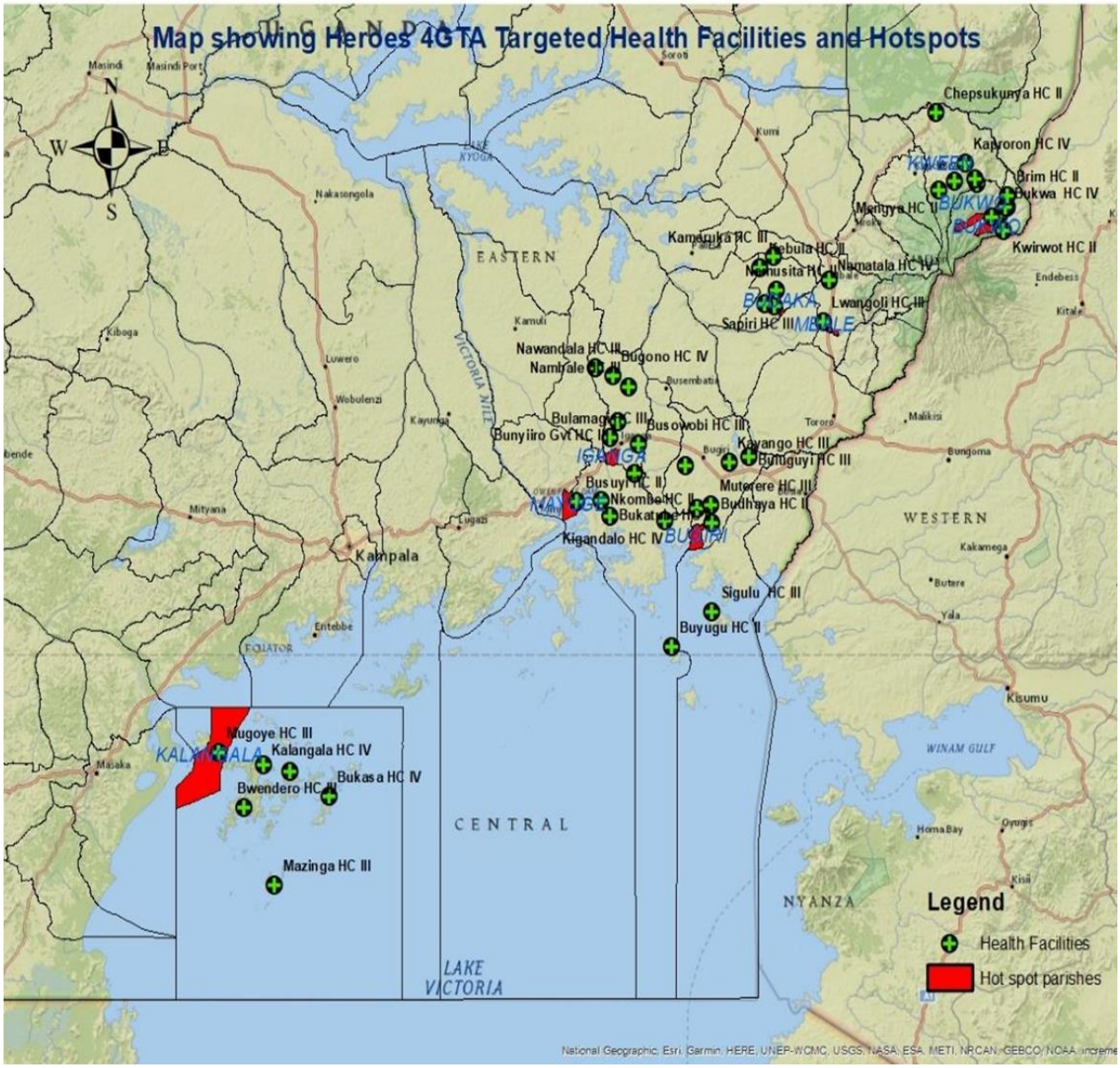
The HEROES programme re-activated the existing District and Sub-County level GBV coordination committees in line with the MGLSD Guidelines (2020), completing the exercise in 6 out of 9 Districts, and leading to the re-activation of 12 committees. Because the hotspots are established at the Parish level, the programme will make deliberate efforts to increase engagement with Parish level structures and ensure participation of the Parish Chief and selected Parish level leaders in the Sub-County steering committee. During the inception phase, meetings have been held with all the 12 steering committees in the 6 Districts to introduce the Heroes 4 GTA programme, to negotiate roles, responsibilities and benefits and to clarify expectations, determine meeting patterns and agree on how to work together. Their roles will include policy development and implementation at the district and sub-county levels, resource allocation (personnel and financial), lobbying and advocacy at the local level and ultimately strengthening the service delivery mechanism for SRHR/SGBV services in their jurisdictions.

Structure	**Membership**
District Gender Steering Committee	At the District level, the steering committee includes DHO, DPC, Magistrate, RSA, District community development officer (DCDO), and District Criminal investigations Department (CID) officer, CPFU, Resident District Commissioner (RDC), SGBV Desk Officer, Gender Officer, District education officer (DEO), Probation Officer and this structure is chaired by the Chief Administrative Officer.
Sub-county Parish Steering Committee	At the ***Sub-county*** level, the steering committee consists of sub-county and parish level leaders that is; Sub-county Chief, community development officer (CDO), Parish Chief, In-charge Health Centre 111, Police OC station, CPFU, Woman Councillor, LC111 Chairperson, Cultural and religious leaders, PWD representative, LC 11 chairperson and WLO and YLO representative.

10.5 Annex 5: List of CBOs identified to work with the programme

DISTRICT	**#**	**NAME OF THE ORGANIZATION**	Youth-Led/Women-Led
BUKWO	1.	Rhema Development Foundation	YLO
	2.	Bukwo Gender-Based Champions Association (BGBCA)	YLO
KWEEN	3.	Sebei Initiative Young Youth Association	YLO
	4.	Sebei Diocese community and empowerment organization	WLO
MBALE	5.	Jire Community Media	YLO
	6.	Nabulwa Rural Development (NARIDE)	YLO
BUDAKA	7.	Kadama Widows Association	WLO
	8.	Budaka Health Workers Group	YLO
KALANGALA	9.	M-Lisada	YLO
	10	Vkids Trust Uganda (VTU)	WLO
BUGIRI	11	WAMA development foundation	WLO
	12	Inclusive Community Development	YLO
MAYUGE	13	Odur Foundation	WLO
	14	Hope and Grace Youth Empowerment Group	YLO
IGANGA	15	Girly Network	WLO
	16	Hope and Grace youth Empowerment Group	YLO
NAMAYINGO	17	GENERATIONS'AID	WLO
	18	Sigulu Women AIDS Awareness Organization (SIWAAO)	WLO

10.6 Annex 6: Location of Programme Sites and Project Area



10.7 Annex 7: Links to important program Communication Materials

Item / Document Link	Link / Icon
Heroes for Gender Transformative Action in Uganda Program Brief :	https://amref.org/uganda/download/heroes-for-gender-transformative-action-in-uganda-program-brief/
Heroes for Gender Transformative Action in Uganda Brand	Guidelines: https://amref.org/uganda/download/heroes-for-gender-transformative-action-in-uganda-brand-guidelines/
Heroes for Gender Transformative Action in Uganda Communication Strategy	https://amref.org/uganda/download/heroes-for-gender-transformative-action-in-uganda-communication-strategy/

Case study: ***HEREOES4GTA advancing survivor protection and safety in partnership with lower Local Governments***	 Learning Case 1- HEREOES4GTA advan
Heroes4 GTA Research and Learning Agenda	 Heroes Research and Learning Agenda Plar