HEROES FOR GENDER TRANSFORMATIVE ACTION

Supporting Community Solutions for Sustainable Health Outcomes

HEROES FOR GENDER TRANSFORMATIVE ACTION PROGRAMME



Annual Report Period 4

(August 2023–July 2024)

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

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Acronyms

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

Key Definitions

Advice Centre: A safe platform, both physical and virtual, designed to provide emergency care and support to survivors. It also serves to advance individual and collective power to claim rights, increase legal and social accountability, and address gender-based violence (GBV) and other human rights violations.

Gender Equality and Social Inclusion (GESI): This concept includes two key components:

- **Gender Equity:** Addresses and transforms inequalities in opportunities, choices, and resources for individuals of all genders, particularly girls, women, and non-binary individuals, to ensure equal power and participation in shaping their lives.

- **Social Inclusion:** Involves improving the ability, opportunity, and dignity of individuals and groups historically excluded from decision-making and social participation based on their identity, enabling them to fully participate in society.

Gender Referencing Group: A diverse range of community members (women, men, girls, and boys) selected based on specific criteria and trained by staff. It includes response champions, prevention champions, young champions, survivor support group members, community-based organization (CBO) representatives, and local leaders.

Gender Transformative Action/Approaches: These are programmes and interventions that actively challenge traditional gender norms, promote women's social and political influence in communities, and address power imbalances between genders. Gender-transformative approaches go beyond merely including women as participants, by aiming to create an environment that facilitates meaningful gender transformation.

Pay for Performance (P4P), Performance-Based Payment, and Performance-Based Incentives (PBI): These terms are often used interchangeably with Results-Based Financing (RBF) to describe mechanisms where payment or incentives are tied directly to achieving pre-defined results. In these contexts, "performance" and "results" are synonymous, as are "payment" and "financing."

Period: Programme implementation timeframe. This report covers Period 4, which runs from August 1, 2023, to July 31, 2024 (12 months).

Reproductive Health Supervision Performance Recognition Strategy (RH SPARS): This strategy focuses on quality improvement in four main areas: education, management, on-the-job training, and support supervision. It collects data on five key indicators to assess the accessibility and availability of reproductive health commodities.

Results-Based Financing (RBF): A financing approach where funds are provided based on the achievement of specific, predefined results. The principal (funding provider) pays the agent (project implementer or service provider) based on the degree to which agreed-upon results are achieved, which are defined by protocols for processes or outcomes. RBF encompasses both demand-side and supply-side approaches to payment.

Safe Spaces: Both physical and virtual environments where beneficiaries can openly express themselves without fear of criticism, discrimination, harassment, or harm.

SGBV Champions: Trained individuals who support survivors of sexual and gender-based violence (SGBV) by navigating legal and health systems to promote gender justice.

Verification: The process of confirming that reported results for RBF indicators meet required standards of quantity and quality. Verification involves assessing the quantity of services delivered (monthly), the quality of services (quarterly), and client satisfaction (quarterly).

EXECUTIVE SUMMARY

During Period 4, the Heroes Programme focused on consolidating advancements in providing comprehensive sex education and cultivating a culture of ownership and political commitment to enhance services in nine hard-to-reach districts in Eastern and Central Uganda. These areas, which experience high levels of violence against girls and women and have limited access to sexual and reproductive health and rights (SRHR) services, have benefited significantly from programme interventions.

Key achievements during this period include:

- **Increased Adoption and Enrolment of SRHR Education:** Authorities at the school, community, and district levels have increasingly embraced a comprehensive SRHR education curriculum, resulting in nearly double the number of young people engaged through in-person and digital learning platforms.
- **Integration of Gender, Equity, and Social Inclusion:** The Heroes Programme has integrated gender, equity, and social inclusion across all its intervention areas and extended it to health and education institutions within the programme's scope.
- **Strengthened Health Facility Capacity**: Sixty-five health facilities across the nine districts are better able to address the specific and diverse needs of their populations, providing improved maternal care, family planning, and post-abortion care services.
- **Challenging Gender Norms:** The programme has made strides in challenging harmful traditional gender norms that perpetuate gender-based violence by establishing and reinforcing civic structures that respond to and mitigate these issues.

These efforts have continued amid increasing concerns over the national government's adoption of a strict anti-homosexuality law, which could impose severe penalties for "aggravated homosexuality". Although this development has yet to directly affect programme activities, it poses a potential risk to the overall operational environment and community reception of progressive SRHR initiatives. Despite these challenges, the Heroes Programme remains committed to engaging at all levels of government and collaborating closely with both governmental and non-governmental partners. Key collaborations include the UNFPA Survivor Treatment and Obstetric Fistula Prevention (STOP) and EYE programmes, the ACTUATE initiative by DKT International, the Power to Youth programme, Healthy Entrepreneurs, TRAC FM and the USAID Uganda Health Activity.

Our outreach facilitates candid discussions about the detrimental effects of traditional gender norms perpetuating gender-based violence, limiting girls' access to education and employment, and suppressing women's voices. There is a growing openness among stakeholders to address these issues, though deeply entrenched beliefs and adverse policy decisions, such as the anti-homosexuality law, present significant challenges. The extension of the Heroes Programme offers an encouraging opportunity for extended community dialogue and the potential for new perspectives to take hold.

The Heroes Programme is successfully implementing recommendations that emerged from the Midterm Review, emphasizing relevance, effectiveness, and alignment with local, national, and international priorities. Our 95% budget utilization demonstrates that resources are being efficiently managed to deliver high-impact SRHR and anti-GBV interventions. The ongoing support from the Netherlands Embassy in Uganda will enable the programme to expand and consolidate its activities through 2026.

Introduction

The Heroes for Gender Transformation Action (GTA) is an integrated programme seeking to make substantive progress against harmful traditional gender norms that have perpetuated gender inequity and discrimination in Uganda, leading to some of the highest rates of SGBV globally.

Implemented in nine districts across East and Central Uganda, the programme targets adolescents (ages 10-24) and women of reproductive age (ages 25-49), including marginalized and underserved groups. Its goal is to improve their ability to make informed decisions about their SRHR, and to mitigate and avoid consequences from SGBV, while also working across communities to address entrenched harmful gender norms. These districts are particularly affected by high rates of teen pregnancy, HIV incidence among young women and girls, and severe interpersonal violence largely driven by inequitable gender power dynamics.

The programme aims to empower these communities by providing: (i) better information and greater freedom of choice for young people to access SRHR information and commodities; (ii) improved public and private healthcare for family planning, pregnancy, childbirth and post-abortion care (PAC); (iii) enhanced respect for sexual and reproductive rights for all; (iv) an enabling environment to eliminate SGBV against girls and women.

Led by Amref Health Africa, Cordaid, and MIFUMI, the programme employs a socio-ecological model to effectively tackle SRHR and SGBV challenges at individual, relational, community, and institutional levels. This comprehensive, multi-sectoral strategy fosters collaboration among the health, education, and social service sectors, ensuring a cohesive and coordinated response.

Grounded in evidence, our approach delivers rights-based, comprehensive, and transformative SRHR education that incorporates essential discussions on gender norms and roles. We utilize site-based models within the health system, extending from community level to the Ministry of Health, to facilitate the universal integration of SRHR and SGBV services at all service delivery points (SDPs). Furthermore, we are exploring results-based financing mechanisms, which link financial compensation to the health system's performance based on established criteria for service quality, quantity, and client satisfaction.

Heroes is committed to advancing gender transformation and social inclusion for marginalized groups, by providing essential support and fostering dialogue to challenge negative gender norms. The programme empowers young people, women and marginalized communities with leadership and mentorship opportunities to tailor initiatives to their specific needs and improve their social and political influence.

We facilitate collaboration among duty bearers and implementing partners, emphasizing the need for coordination and alignment with Uganda's own National Development Plan (NDP III and IV), the Netherlands Embassy's Multi-Annual Country Strategy (MACS), and the global Sustainable Development agenda.

1.2 The Heroes Programme Context

According to population estimates from the Ugandan Bureau of Statistics, the nine districts served by the Heroes programme have a total population of approximately 2,995,200 people, with 1,354,666 identified as direct beneficiaries. Among this population, 34% are young people aged 10-24 years, and

17% are aged 13-19 years. Women and girls of reproductive age (15-49) comprise 32% of the population, with additional fertile individuals outside this range.

These districts are predominantly rural, with 80% of households relying on subsistence farming and maintaining extended family structures. As agricultural work is increasingly undertaken by older generations, young people are seeking opportunities in urban and peri-urban areas. Access to media primarily occurs through mobile phones[1].

The communities are largely Christian (80%) and Muslim (20%), with deeply ingrained cultural and traditional beliefs. Discussions about sexuality are often considered taboo, and SGBV is prevalent, frequently tolerated in silence. Traditional governance structures, such as the Kingdoms of Busoga, Buganda, Bamasaba and Bugwere in the East Region and the Elders Associations in Sebei, are recognized and engaged in the programme.

The recently released 2022 Uganda demographic health survey report[2] highlights significant SRHR indicators, underscoring the need for ongoing investment in sexual and reproductive health (SRH) and gender equity. Key findings reveal that 50% of the population is under 15 years of age, and one in three households is headed by women. A higher percentage of men have completed higher education. The fertility rate is reported at 5.2 children per woman in 2022, down from 5.4 in 2016, with higher rates of 5.7 to 6.5 observed in the regions served by the Heroes programme. The demand for family planning continues to rise, with unmet need reported at 22%. Maternal mortality rates have declined from 336 to 189 per 100,000 live births from 2009 -2015 to 2016-2022. However, SGBV remains a pressing concern, with a reported prevalence of 11% among women aged 15-49 in the year prior to the survey.

In these nine districts, over 22% of pregnancies are carried to term by mothers under age 18, although this figure is lower than the national average of 25%.

Table one shows a district-level disaggregation of key population indicators relevant to the Heroes Programme.

Table 1: SRHR indicators Heroes programme supported districts July 2022 to June 2023

District	Maternal mortality ratio/100,000 live births	Teenage pregnancy rate	Adolescent birth rate/1,000 live births	Total GBV cases	Abortions due to GBV	STI from SGBV	Injuries due to GBV	Anxiety Disorder due to GBV	CYP (including natural)	FP new users
Central										
Kalangala	458	11%	115	1,168	6	92	795	275	15,563	3,062
East Central										
Bugiri	0	26%	246	803	4	244	524	31	11,419	4,375
Iganga	0	23%	169	499	1	93	405	-	9,186	3,766

[2] https://www.ubos.org/wp-content/uploads/2024/03/UDHS-2022-Main-Report-Powerpoint-Presentations-1.pdf

Mayuge	0	23%	225	2,509	4	68	1,222	1,215	10,550	4,165
Namayingo	58	26%	275	1,365	11	318	929	107	13,806	4,995
Eastern										
Budaka	28	22%	218	2,544	32	871	1,270	371	18,847	4,858
Bukwo	133	20%	194	1,841	18	111	1,377	335	6,102	1,553
Kween	0	20%	158	619	59	35	486	39	8,938	3,552
Mbale	23	19%	156	669	6	108	417	98	14,521	5,058
Grand Total	**40**	**22%**	**203**	**12,017**	**181**	**1,940**	**7,425**	**2,471**	**108,933**	**35,384**

Source: DHIS2 extracted August 2024

Policy relevance

The Heroes Programme is strategically aligned with Uganda's National Development Plan III and the upcoming Plan IV, focused on identifying key transformational priorities at service delivery and policy levels. This alignment allows both quantitative and qualitative evidence generated by the programme to inform, reform and improve implementation of existing policy frameworks.

The programme adheres to crucial polices and guidelines across various sectors, including education, health, gender, and social development. Specifically, it aligns with the National Health Policy (NHP) to ensure equitable access to quality health services; the National Health Sector Development Plan (NHSDP) for maternal and child health priorities; the Reproductive Health Policy to improve maternal health and enhance family planning access; the Adolescent Health Policy Guidelines & Service Standards 2012, which addresses the sexual and reproductive health and rights (SRHR) needs of adolescents; the Constitution, National Gender Policy, Domestic Violence Act, and other relevant legislation; and also international commitments such as the Sustainable Development Goals (SDGs).

The recent enactment of the Homosexuality Act 2023 has presented challenges, however, resulting in slower progress in the approval of specific SRHR and SGBV curricula – contributing to adverse effects on overall programme effectiveness.

1.0 Programme Achievements in Period 4 by Result Area

This section provides a comprehensive overview of programme performance during the reporting period, with results generated from regular evaluations of progress against the theory of change. This reflective process contributes to flexibility in developing and pursuing new solutions and approaches that include mitigation strategies and strategic adjustments.

The following summary highlights progress in Period 4, incorporating valuable lessons learned that will guide adaptation of future interventions, particularly those focused on shifting behaviours and attitudes among communities, policy makers, and duty-bearers.

A. Result Area 1: better information and greater freedom of choice for young people about their sexuality

This component seeks to empower young girls, boys, and women with accurate and comprehensive information on sexuality that helps them make informed health choices. This initiative spans 54 sub counties and 93 schools, aiming to create environments free from SGBV and unplanned pregnancy.

In Period 4, the programme targeted 507,636 beneficiaries for education on sexuality, SRHR, SGBV, and life skills. Additionally, it aimed to introduce Personal Hygiene and Sanitation Education (PHASE) in 90 schools, emphasizing menstrual hygiene management, and strengthening school governance structures for effective SRHR/SGBV education integration. Age-appropriate information was distributed through a variety of communication channels across supported districts.

The table below summarizes the results achieved during this period.

Table 2: Performance against Period 4 Targets (Green is for performance >75%, yellow 50-75%, red <50%)

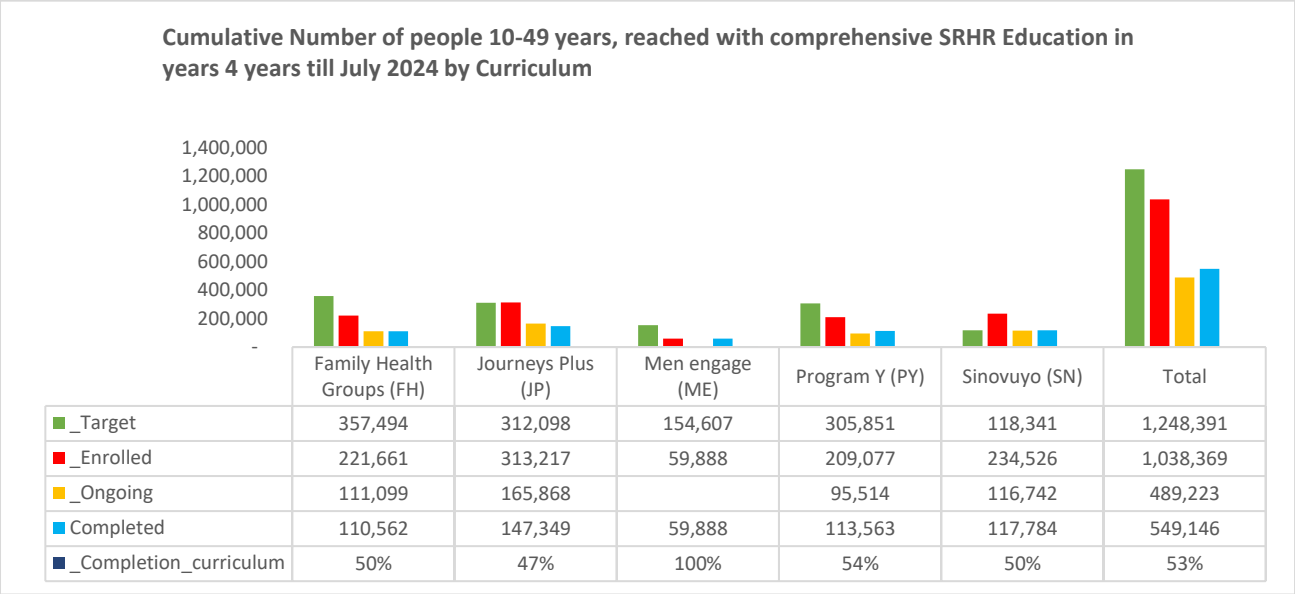
Impact/Outcome/output	Indicator	Target	Achievements	% Achievement	Comments
Outcome 1: Better information and greater freedom of choice for young girls, boys and women about their sexuality	Reduction in teenage pregnancy/adolescent birth rate (DHIS 2)	22	22	100%	Highest in Bugiri and Namayingo with 26%, Iganga& Mayuge at 23%, Kween & Bukwo at 20%, Mbale at 19% and lowest in Kalangala at 11%
Output 1.1: Young girls, boys and women reached with comprehensive, correct information on SRHR and SGBV	# of young girls, boys and women reached with comprehensive, correct information on sexuality, SRHR, SGBV and life skills training. (Programme database)	507,636	510,579	101%	Enrolment target reached with completion rates averaging 53% across districts

Impact/Outcome/output	Indicator	Target	Achievements	% Achievement	Comments
Output 1.1.1: Pupils reached with hygiene information and services	# of schools supported with basic menstrual hygiene kits (Programme reports)	90	93	103%	Three additional schools were onboarded, surpassing the target
Output 1.1.2: Schools integrate Sexual Education and WASH services within the schools' program and budge	# of district affirmative actions taken to strengthen delivery of SRHR/SGBV information to in/out of school young people. (Programme reports)	4	2	50%	Bugiri and Namayingo district have integrated Journeys plus into the education supervision checklist
	# of schools that formally integrate delivery of Sexual Education within the school timetable. (Programme reports)	36	32	89%	Greater school integration: Iganga, Mayuge, Bugiri (15), Kalangala (7 schools) and Mbale, Bukwo, Kwen(10 schools)
	# of schools that take and implement affirmative actions that to strengthen finance for WASH, menstrual hygiene management within schools. (Programme reports)	27	23	85%	Heroes participating schools implementing PHASE programme

Source: Programme Data & DHIS II.

Age-appropriate educational curricula are being delivered in person to various age groups: **Journeys Plus** targets early adolescents aged 9-14; **Programme-Y** serves youth aged 15-24; and **Family Health for Women** materials cater to women of reproductive age. Additionally, specific modules such as **Sinovuyo** engage parents, while the **Men-Engage** module promotes male involvement and thoughtful masculinity. The **Journeys Plus** component is the largest SRHR educational programme, with a total enrolment of 1,038,369 individuals, achieving 83% of our four-year target (see Table 3 below). Continued growth is anticipated from a soon-to-be launched digital campaign to expand online delivery of SRHR education modules.

Table 3: Cumulative number of people aged 10-49 years, reached with specific comprehensive SRHR education modules over four years to July 2024



	Family Health Groups (FH)	Journeys Plus (JP)	Men engage (ME)	Program Y (PY)	Sinovuyo (SN)	Total
_Target	357,494	312,098	154,607	305,851	118,341	1,248,391
_Enrolled	221,661	313,217	59,888	209,077	234,526	1,038,369
_Ongoing	111,099	165,868		95,514	116,742	489,223
Completed	110,562	147,349	59,888	113,563	117,784	549,146
_Completion_curriculum	50%	47%	100%	54%	50%	53%

Source: Programme Data & DHIS II.

The programme is cultivating support within a growing community of stakeholders, including parents, authorities, teachers, elders and religious leaders. This consensus is critical to counter opposition and backlash, and it should be reinforced through ongoing dialogue as the programme progresses into 2026. The aim is to normalize knowledge, promote gender equity and encourage informed decision-making within these communities.

In line with global comprehensive sexuality education (CSE) approaches, some schools have begun integrating SRHR education into daily lesson plans. Additional SRHR education club activities engage learners in outdoor activities, such as soap making and stove building for retail sale, to foster self-reliance and financial dependence, while reducing vulnerability to transactional sexual encounters identified in the recent "No More Silence Campaign" (See Box 1).

BOX 1: The "No More Silence Campaign"

The campaign was conducted Jan- July 2024 to assess and communicate drivers of teenage pregnancy. It identified accidental pregnancy from transaction sex, lack for accountability from men, pressure on girls to sustain their families and the stigma that curbs use of contraception as key drivers.

As the programme evolves and digital opportunities expand, it is crucial to address opposition to SRHR education, which has emerged from faith-based institutions and certain government departments. Expanding the Men-Engage component is a priority, as adult men have been less involved in educational processes. The programme team will also work to better engage with religious leaders to leverage their influence to promote dialogue. Continued advocacy will be directed to encourage government departments to approve digital CSE tools.

Managing community expectations is vital, particularly regarding the nature of the learning experience. Some communities expressed dissatisfaction when informed that no financial compensation would be provided at the end of in-person sessions.

Key lessons learned:

1. **Tailored Educational Approaches Foster Community Trust:** Developing customized materials for specific groups and selecting facilitators with established connections within communities proved essential for gaining trust and acceptance. Engaging trusted community influencers, such as out-of-school adolescents, individuals with disabilities, and pregnant women, created a safe environment conducive to effectively delivering sensitive content.

2. **Clear Guidelines Ensure Accountability and Transparency:** Providing school management committees with structured guidelines on fund allocation for SRHR-related commodities, including menstrual hygiene management products, promoted transparency and accountability. This approach set clear expectations about what financial support was available and strengthened stakeholder trust in the program.

3. **Civil Society Engagement Enhances Program Impact:** Collaborating with civil society, particularly youth networks like the Mbale Network of Young People Living with HIV (MNYPA), was instrumental in enhancing outreach and peer education efforts. The personal experiences and involvement of these groups significantly improved engagement with young people, positioning them as credible facilitators and mentors.

4. **Effective Resource Management Supports Menstrual Hygiene Initiatives:** Implementing the PHASE approach to menstrual hygiene management has been critical to addressing stigma and ensuring young women have access to essential products, supporting their continued engagement in SRHR education.

As the programme progresses through 2026, our focus will be on institutionalizing key lessons learned and integrating them into our best practices. The following recommendations will be implemented in upcoming phases:

- **Institutionalize a comprehensive whole-school approach:** Expand educational opportunities to ensure inclusivity, tailoring content to meet the needs of students with disabilities and diverse learner groups.

- **Strengthen facilitator capacity and retention*:*** Introduce continuous training and coaching, including a train-the-trainer model, to develop a robust network of peer educators. This approach will also address high attrition rates through targeted support and district-level discussions.

- **Enhance MHM interventions:** Continue prioritizing menstrual hygiene education and support as a key element of SRHR programming. Addressing stigma while ensuring access to essential products for menstrual health management, fosters an enabling environment for young women.

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

This result area enhances SRHR service delivery capabilities across 65 health facilities, for improved access to and utilization of high-quality, inclusive, and integrated SRHR and SGBV services at both public and private facilities, as well as within communities, particularly in underserved areas.

During Period 4, the programme emphasized leadership development, optimized supply chains, and refined referral pathways, incorporating Continuous Quality Improvement (CQI) methods to ensure sustainable service delivery. Various committees, including district adolescent health and health unit management committees, were activated to conduct regular supervision and address gaps, such as stockouts of SRHR commodities and resource allocation for SRHR/SGBV services.

Notable improvements were achieved at facility level, with the percentage of children born under skilled care increasing to 72% from 60% at the programme's start. More women are successfully completing the maternity care cascade, demonstrating the improved quality of maternity care.

Figures 1 and 2 depict the improvements over the programme period.

Figure 1: Early ANC and Skilled Birth Attendance

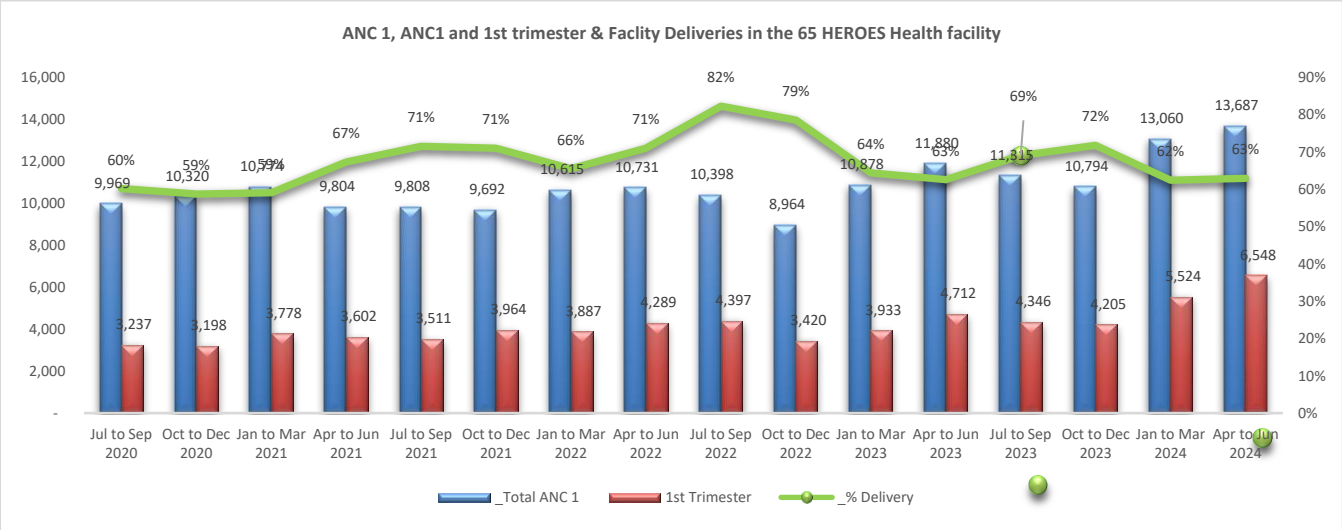
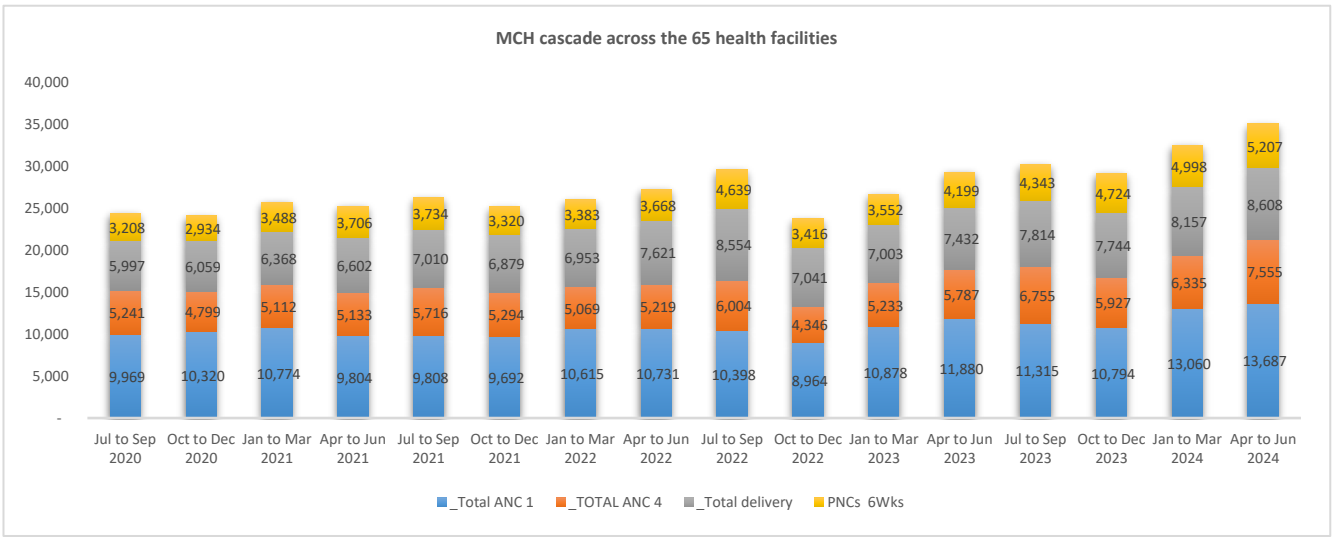


Figure 2: Completion of the Maternity Cascade



Among maternity care patients, 66% of women who attended their first antenatal care visit had a safe childbirth at a facility and completed the post-natal care cascade. The programme achieved a 40% rate of attendance for a first ANC visit during the first trimester of pregnancy, facilitated by community pregnancy mapping and referrals for high risk mothers. However, the percentage of girls aged 10-19

attending their first antenatal care visit decreased from 24% in 2020 to 22% during the reporting period. It is possible that the combination of SRHR education under result area 1, improved access to contraception by girls in their teens under result area 2, the advocacy against teen age pregnancy under result area 3 as well as other interventions from other actors are contributing to the reduction in teenage pregnancy.

Family planning utilization results continue to improve, with use of modern contraceptives resulting in 108,933 Couple Years of Protection (CYPs), preventing 31,373 pregnancies. Success is attributable to improved counselling by service providers, an optimal method-mix (see annex 10.1), and community-based distribution of contraceptives, as well as the broad programmatic focus emphasizing community education.

Quality improvement (QI) projects implemented across the 65 health facilities have also improved responsiveness and connectivity between Village Health Teams (VHTs) and health entrepreneurs to improve referral rates. We will document best practices in coordination and referral during the next programme period to institutionalize these approaches as part of our sustainability strategy for full public sector ownership.

Table 4 depicts indicators from the facility level of service delivery.

Table 4: Facility Care Indicators ((Green is for performance >75%, yellow 50-75%, red <50%)

Impact/Outcome/output	Indicator	Target	Achieved	% Achieved	Comments
Outcome 2: Better public and private healthcare for family planning, pregnancies and childbirth, including post abortion care	Increased CYP. *(DHIS 2)*	80,234	108,933	136%	Attributed to improved FP commodity availability and community-based distribution
	# unintended pregnancies averted. *(DHIS 2)*	20,291	31,373	154%	Drawn from estimated CYP
	% increase of births attended by skilled health personnel in Heroes Health facilities *(DHIS 2)*	80	66	83%	To be enhanced with pregnancy mapping by VHTs
	% increase in client satisfaction rates of young girls, boys and women for SRHR services in the supported health facilities. *(Client exit interview reports)*	79	62	78%	Client feedback is driving quality improvement of conditions in facilities
	% of health facilities experiencing no stockouts of at least three modern FP methods over a period of three consecutive months***. (DHIS 2)***	65	45	69%	45/65 health facilities did not have stockouts of tracer FP commodities
Output 2.1: Private and public health systems strengthened to scale up SRHR & SGBV services for young girls, boys and women	# HCWs trained/mentored (contacts) on SRHR/SGBV service provision. *(Programme reports)*	290	236	81%	45 (Kalangala), 78 (Mbale), 113 (Iganga)
	# of health facilities where the quality of offered interventions is considered good and appropriate to the needs	58	45	78%	Clients in 45/58 assessed facilities classified SRHR services as good.

Impact/Outcome/output	Indicator	Target	Achieved	% Achieved	Comments
	expressed by the target group *(Client exit interview report)*				
	# of health facilities providing FP method mix (both short- and long-term methods) *(DHIS 2)*	58	58	100%	Introducing the e-LMIS has helped in ensuring a good method mix.
	# of facilities that adopt and implement youth friendly SRHR/SGBV services *(DHIS 2)*	58	56	97%	Heroes has created YFS spaces in health facilities, mentored staff and engaged youth
	# of health facilities with functional e-LMIS system for supply management *(Programme reports)*	65	58	89%	Lack of electricity is preventing functional e-LMIS in remaining 7 facilities. Heroes is lobbying leadership in affected districts.
	# of health facilities reporting non-stock outs of SRHR commodities in quarter. *(DHIS 2/Programme Reports)*	20	58	325%	Mentored staff are able to ensure that the 20 basket commodities (vital medicines for ANC, FP, laboratory and testing kits for HIV/Syphilis) are available in all 65 supported facilities
	# of VHTS enrolled into HE and distributing SRHR commodities at last mile. *(Programme reports)*	450	504	112%	CHE supporting last-mile SRHR commodity distribution
Output 2.2: Increased access to quality friendly services by young girls, boys & women in hard to reach areas	# of women and girls using modern contraceptives. *(DHIS 2)*	102,150	95,036	93%	FP promotion ongoing
	# of young girls, boys and women provided with SRHR services at health facility/static & outreach sites (DHIS 2)	335,723	260,667	73%	Heroes will intensify community engagement to increase service use

Source: Programme Data & DHIS II.

Outreach for Adolescent and Sexual Health Service Delivery

The programme evolved its approach to adolescent sexual health based on feedback from young people. In addition to the SRHR education and referrals mentioned in section 2.1, the programme organized joint outreach efforts that combine SRHR/SGBV services with legal aid clinics, creating one stop service points. To further support vulnerable young people, the programme provided SRHR vouchers to subsidize the cost of SRHR/SGBV services. This model yielded 53,860 contacts for various SRHR services, as per Table 5.

Table 5: Services provided through Heroes outreach model (August 2023 - July 2024)

Services	10-14		15-19		20-24		25>		Total male	Total Female	Total
	M	F	M	F	M	F	M	F			

Family Planning	66	137	807	2,415	1,008	3,960	907	4,938	2,788	11,450	14,238
ANC 1	-	37	-	670	-	913	-	942	-	2,562	2,562
ANC 4	-	25	-	280	-	548	-	699	-	1,552	1,552
ANC4+	-	16	-	267	-	527	-	707		1,517	1,517
SGBV	-	-	103	263	124	331	-	-	28	594	622
AYHFS (counselling, physical assessment, growth, development, MHM, nutrition, Mental Health, vaccination)	-	-	2,309	4,294	1,802	3,671	-	-	787	7,965	8,752
HTS/STI services	384	622	2,147	3,942	2,784	5,709	2,937	4,830	2,430	15,103	17,533
PNC	-	13	-	250	-	678	-	688	-	1,629	1,629
HPV	-	68	-	5,357	-		-	-	-	5,425	5,425
PAC	-	8	-	1	-	9	-	12	-	30	30
Total	450	926	5,366	17,739	5,718	16,346	3,844	12,816	6,033	47,827	53,860

Source: Programme Data

Strengthening the SRHR Supply Chain

The programme partnered with the Ministry of Health to introduce e-LMIS and RH-SPARS (Reproductive Health Supervision Performance Recognition Strategy) to improve SRHR service delivery including commodity management, provider skills, and staff performance. ICT equipment was provided to support RH_SPARS implementation. Increased reach of the SRHR education curriculum contributed to a higher demand for services, including counselling, contraception, HIV testing, STD/STI treatment, HPV and TT vaccination, post abortion care and family planning. Figures 4 and 5 depict uptake of vouchers, which together with the figures in Annex 3 show notable uptake among girls and young women aged 10-19.

Fostering Inclusivity in SRHR Services

Heroes' commitment to inclusivity extends to socio-economic status, ensuring poverty is not a barrier to SRHR education or care. A voucher programme supported 577 women and girls- 242 of whom were under age 19 – with access to medical care, family planning, and counselling services (see figures 7 and 8). Moving forward, the programme aims to refine voucher distribution and acceptance and leverage partnerships to better support these vulnerable groups.

Figure 4: Voucher Utilization by District

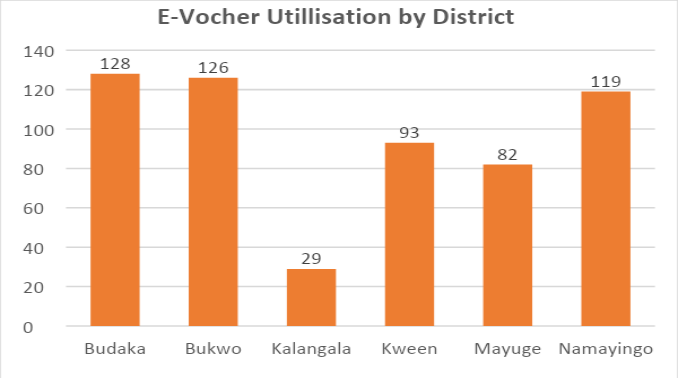
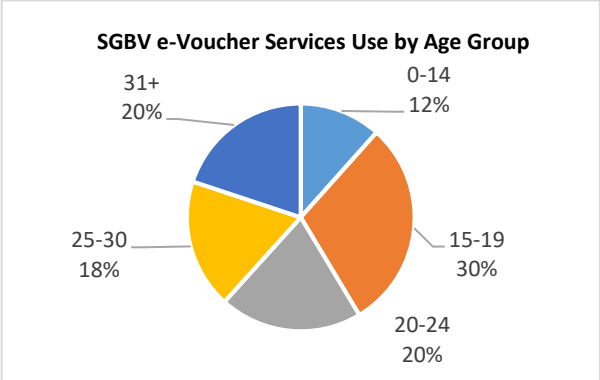


Figure 5: Voucher Utilization by Age Group



Family planning remains a core component of service delivery under Heroes. Injectable contraceptives are the widely preferred method across the districts, which indicates the high value placed on longer-acting, discreet options. There is also increased demand for emergency contraception, implants and post-abortion care, reflecting enhanced autonomy among women. More and more women are choosing self-care options, with more than 3,000 women choosing to administer their own first dose of the DMPA-SC injectable during the programme period. Improvements to commodity control will be prioritized in the next period to prevent stockouts.

Community-tailored education, led by relatable health champions and community health workers, is driving impact. Civil society organizations (e.g. V-KIDS and M-LISADA) are improving health worker presence and quality of service delivery, reporting absenteeism to district health authorities and providing complementary SRHR services to maintain trust in the health system.

Progress of Results Based Financing (RBF) specific interventions

Results based financing (RBF) was strategically deployed to improve SRHR services in 24 out of the 65 target health facilities, focusing on early ANC attendance, completion of 4+ ANC visits, delivery of post-abortion care (PAC), increased uptake of long-acting reversible contraceptives (LARCs) and youth friendly services (see Figures 6 and 7).

Figure 6: Trends in ANC 1 in RBF target facilities

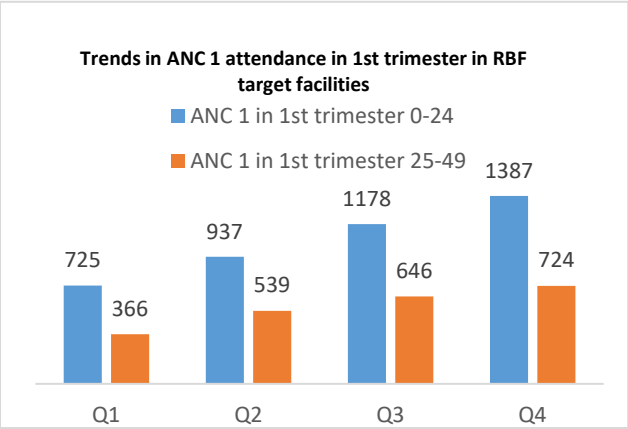
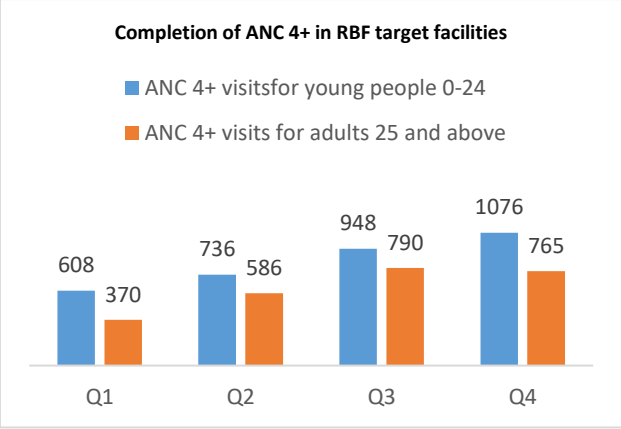


Figure 7: Completion of ANC 4+ in RBF target facilities



RBF incentives boosted uptake of LARCs and PAC (Figures 8 and 9) though collaborations with Reproductive Health Uganda, which provided hands-on training for how to use implants safely, and

Marie Stopes, which supported training and mentorship of health workers in PAC services. Commodities for these services were procured using RBF funds.

Figure 8: Trends in uptake of long acting contraceptives

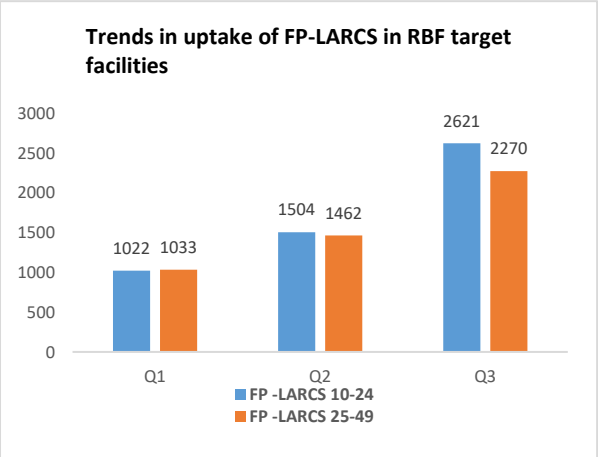
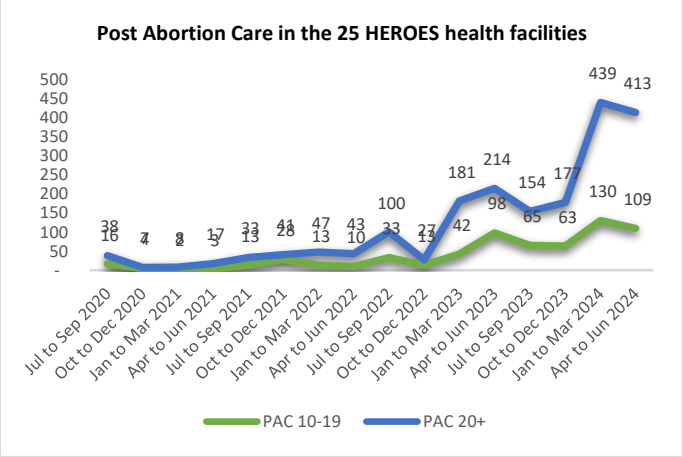


Figure 9: Trends in uptake of PAC in RBF supported facilities



Empowering Village Health Teams to Deliver SRHR Services in the Community

Village Health Team (VHT) volunteers deliver SRHR education and services to remote and hard-to-reach areas. Transport challenges were addressed through a collaboration with World Bicycle Relief, which provided 300 bicycles to VHTs in Iganga district, half of whom were women, on a loan-to-own basis. Twin benefits of this initiative included improvements in service delivery as well as in the VHTs' own livelihoods.

Key lessons learned:

1. **Systematic Training and Monitoring**: effective training requires sustained mentorship and oversight, requiring innovation to overcome continued constraints on health workforce participation. Better resource allocation and stronger domestic co-financing are vital to meeting the health workforce shortages.
2. **Service Innovations**: active pregnancy screening at all care points increased ANC and maternity service enrolment, contributing to safer facility births and reduced maternal and infant mortality.
3. **Supply Chain Management**: improvements in supply shortage management in districts using eLMIS and RH-SPARS tools indicate the need for wider adoption of these tools.
4. **Results-Based Financing (RBF)**: Enrolled facilities are improving their implementation of the approach, but the extent of support required at start-up means the programme must adjust its human resource strategy to meet those intensive needs for support.

Recommendations to be implemented in the next programme period include:

- **Strengthen School-Based Programming**: investing in school-based SRHR education and services (e.g., HPV/TT vaccinations, pregnancy screenings) offers high returns due to the large student population. This requires increased staffing and financial resources.

- **Enhance District Coordination**: better coordination of networks and partnerships at the district level is essential to avoid overlaps and maximize resources.

- **Voucher Programme Reform**: revisions of the voucher program to optimize impact for the poorest and most vulnerable groups are vital.

- **Expand Commodity Management Platforms**: More effective supply chain management will result from promotion of wider use of eLMIS and RH-SPARS.

- **Shift RBF Focus**: with the government's upcoming RBF targeting HCIIIs, HEROES will refocus on high-volume HCIIs to complement the national strategy.

C. Result Area 3: More respect for sexual and reproductive rights for all

The programme aimed to promote respect for SRHR by strengthening the capacity of CSOs (including youth and women-led organizations) and key influencers to advocate against harmful practices and reduce barriers to SRHR/SGBV services through changes in bylaws, guidelines, and practices.

Strengthening Civil Society Capacity to Respond to SRHR Violations

Recognizing that behaviour and perspective change are long-term processes, Heroes has focused on cultivating trust and dialogue among district authorities, civil society, and communities. The programme trained 32 CSO representatives from nine districts, involving key stakeholders such as police and judiciary, religious and traditional leaders to ensure a multi-sectoral approach.

Heroes has also built the capacity of 18 CSOs to monitor SRHR service quality through client satisfaction surveys, helping them to identify gaps and advocate for improvements. For example, the Mbale Network of Young People Living with HIV/ADS (MNYPA) successfully lobbied the district government for an annual allocation of 36 million Uganda shillings (9,000 Euros) for family planning.

At community level, Mifumi organized 615 SGBV survivors into 17 registered CBOs, supporting the groups to provide both protection for survivors and economic empowerment opportunities with skills training and links to potential finance like the Parish Development Model (PDM) and *Emyoga* funds. Table 6 shows indicators for community engagement.

Table 6: Community & CSO engagement Indicators ((Green is for performance >75%, yellow 50-75%, red <50%)

Impact/Outcome/output	Indicator	Target	Achieved	% Achieved	Comments
Output 3.1: Strengthened capacities of CSOs (YLOs/WLOs) & key influencers to lobby and advocate against harmful practices related to gender and SRHR/SGBV	# Of CSOs and advocacy networks with increased lobby & advocacy capacities. *(CBO assessment report)*	18	11	61%	Advocacy capacity will be a focus in the next programme period
	% of youth who participate in decision-making bodies (DCAHs/SGBV Committee) who perceive their participation as meaningful. *(Programme report)*	48	36	75%	This was determined in a meaningful participation assessment by the programme.
	# of community members reached through the different mobilization (education & sensitization) strategies. *(Programme database)*	241,661	248,983	103%	This was GBV awareness raising GRGs in new hotspot locations (F136,428, M 112,555) PWDs F1618, 1474M
	# of measures introduced by the GRGs to increase protection of	9	7	78%	Iganga, Bugiri, Namayingo,

	children, young people women and PWDs. *(Programme reports)*				Mayuge and Kalangala districts
Output 3.2: Changes in bylaws, guidelines, ordinances, and practices that lower barriers to SRHR services	# of laws, policies, practice, and strategies blocked, adopted or improved to eradicate all forms of violence against women and girls in public and private life. *(Programme reports)*	10	9	90%	9 simplified laws targeting GBV including rape, bride price, assault etc.

Activating Communities to Reject Harmful Practices

The Heroes programme engaged in community hotspot dialogues led by GRG of local authorities, community actors, police, and citizens, ranging over issues including teenage pregnancy; early/ forced marriage, rape, and physical abuse.

Intergenerational dialogues involving parents, teachers and community leaders have challenged harmful social norms, empowering young people to initiate change. As a result:

- **244 young people** (138 females and 106 males) who had dropped out of school were reintegrated with community support.
- **495 teenage mothers** received literacy education, skills training, VSLA training, medical legal support, and psychosocial support, with over 50% engaging in income-generating activities and 27 returning to school.
- **34 girls** were rescued from child marriages through alerts from community members.

BOX 2: Shamimu, the Young Hero

In Bukhiende, Mbale District, Shamimu, a 15-year-old champion of the Back-to-School campaign, identified five girls (two in Senior 3 and three in P6) who were not attending school due to their parents' refusal to pay fees. Through mediation sessions, she successfully reintegrated these girls into Mulatsi Secondary School to sit for their exams. Shamimu also intervened in cases where girls were being pressured to marry instead of continuing their education, using family dialogues to facilitate their return to school.

Outreach to Include People with Disabilities

To address weaknesses in outreach to Persons with Disabilities (PWDs), Heroes partnered with Liliane Fonds and Katalemwa Cheshire Homes, to train 30 staff members using the Washington Guide and Gender Equity and Social Inclusion (GESI) training. These newly trained staff went on to reach **1,861 PWDs** with SRHR information, through dialogues, legal aid clinics, and service planning meetings, reducing stigma and improving respect for PWDs.

Reforming Policies and Practices to Reduce Barriers to SRHR Service Access

HEROES distributed 3,000 copies of SGBV-related laws (Domestic Violence Act, the Constitution of the Republic of Uganda, the Penal Code Act, the Domestic Violence Act of 2021 regulations, the Gender Policy, and the Adolescent Health Framework) across the nine districts, targeting local courts, paralegals, and citizens to improve legal awareness. Community actions that followed include:

- Formation of the **Parish Peaceful Court of Laws** in Wakawaka Iganga District: a self-mobilized group of 30 (13 women and 17 men) local leaders, champions, CBOs, and young people who raise awareness about SRHR violations, mediate cases, and receive referrals.

- **Muhuwa, Namayingo District**, abolished a clan rule preventing girls from inheriting property and is enforcing the girls right to property.

- Local governments enacted bylaws against harmful practices such as **Namayingo District's Child Protection Ordinance No. 1 of 2023**, which prohibits using girls for sexual exploitation, and **Bukwo District's alcohol and cattle rustling bylaw,** which was certified by the district council in July 2023. Five additional bylaws are currently under review and should be enacted by early 2025.

Progress does not mitigate the deeply rooted community beliefs and norms around GBV. While Heroes is empowering institutions and communities to respond more proactively, many CSOs still lack the resources needed for effective action. Heroes is committed to collaborating with these organizations and leveraging its expertise to build their capacity and strengthen community-led responses.

Key lessons learned:

1. **Awareness creation** is slow but impactful when citizens lead actions against harmful practices. In some areas, a few determined voices shifted norms from silent acceptance of SGBV to active prevention and response. Civil society, including faith communities, is key to sustaining this leadership and uniting stakeholders.

2. **Resource gaps** hinder dialogue and community consensus-building; sustainable funding is needed. Dialogue and consensus-building can be costly, and for local governments with limited budgets, these efforts often stall without resources. For instance, in Iganga district, a draft ordinance on teenage pregnancy remains undiscussed due to lack of funds to convene community members. In the next programme period, Heroes will ensure the dialogue happens.

3. **Coordination** among champions, CSOs, and local governments is critical for countering misinformation and building unified responses. Local governments are key partners but need more support to engage effectively with gender groups, survivor networks, and community champions. HEROES will continue to equip them with the evidence, tools, and strategies needed to drive lasting change.

D. Result Area 4: Enabling Environment for Young Girls and Women's Elimination of Violence Against Girls and Women

During Period 4, the Heroes programme made significant progress in strengthening restorative justice for survivors of SGBV through an expanded Alternative Dispute Resolution (ADR) system. Key initiatives built the capacity of both formal and informal justice actors, such as paralegals, local council members, and stakeholders involved in SGBV response, while empowering survivors and young people to navigate the justice system. This was achieved by creating Survivor Support Groups (SSGs), providing legal training, and promoting collective action. Through these interventions, the programme aimed to improve implementation and enforcement of laws and policies. Targeting better case outcomes and accountability among duty bearers is critical to achieving progress across each stage of SGBV case management.

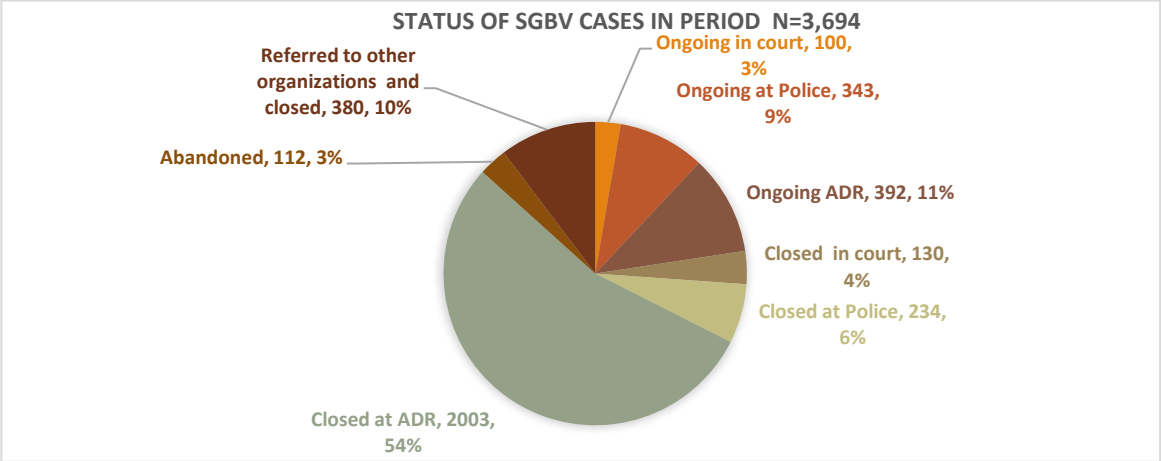
The programme established safe spaces including advice centers, shelters, and gender-specific sessions, to support the healing process and empower individuals with resources and services to improve informed decision-making. Additionally, the programme developed a broad network of linkages and support systems to enhance access to justice for survivors, including helplines, trained health workers, and integrated justice systems. Key outcomes from these initiatives include:

1. ***Improved access to justice:***

- The programme actively promoted restorative justice, leveraging ADR approaches at the local level through trained local council courts supported by paralegal social workers.

- During this period, 54% of the cases were resolved through ADR, resulting in more amicable settlements for survivors and their families, reducing case backlog in formal courts, and creating safer environments for those involved. Figure 10 depicts the status of SGBV cases during the programme period.

Figure 10: Case settlement status in Heroes 2023-24



2. ***Improved medical management of cases***:

- A total of 3,694 cases (2,845 females and 849 males) were processed, including 1,910 criminal cases. Trained and prequalified medical officers handled these cases, significantly improving access to medical evidence collection and treatment for SGBV survivors.

- This innovation reduced delays in medical examinations and enabling prompt case resolution. As a result, the number of sexual and physical assault cases receiving medical examinations within three days rose from 37 in 2020 to 654 in 2024.

3. ***Improved psychosocial support:***

- A total of 954 survivors received psychosocial support and were successfully rehabilitated and reintegrated onto their communities. A client satisfaction survey showed that 86% of survivors felt safer in their environments six months post-support.

- Linkage to 24 Survivor Support Groups (SSG) across all nine districts strengthened community empowerment by providing survivors with life skills and legal knowledge, reducing their dependence on perpetrators, and fostering economic independence.

- SSGs were linked to local government resources, such as the Parish Development Model (PDM) funds, which improved their likelihood of sustainability.

4. ***Enhanced survivor protection and safety:***

- Nine operational advice centers provided critical services, including counselling and legal advice, and handled 2,716 cases during the period.

- The programme supported 265 female survivors with temporary shelter, adhering to the Ministry of Gender's minimum standards of care to ensure wellbeing and safety. The programme also runs a 24-hour helpline, which in Period 4, handled 637 calls with vital legal and psychosocial support.

5. ***Disability Mainstreaming:*** The program took deliberate steps to identify and support people with disabilities (PWDs) experiencing SGBV, assisting 802 survivors to recover and reintegrate. This effort increased awareness and inclusion, ensuring that PWD survivors received appropriate support and services.

Key lessons Learned:

1. ***Addressing catalysts of violence***: Dispute resolution highlighted that drivers of violence, particularly in areas with high rates of poverty and limited opportunities, are often linked to financial instability, substance abuse, and infidelity. Addressing these root causes is essential for creating long-term solutions.

2. ***Community complicity:*** Silence and passive acceptance of violence in communities can only be overcome with shared understanding of its drivers and consequences. Civil society, local authorities, community SGBV champions, health workers, survivors, local councils, religious and traditional leaders must work together for transformative change.

3. ***Importance of Health and Justice Coordination:*** Integrating health and justice responses, particularly for SGBV survivors undergoing medical examinations, reduces exposure to stigma and judgement, and helps survivors feel supported and understood throughout reporting and judicial processes.

4. ***Role of gender reference groups (GRGs):*** GRGs have emerged as leaders in creating a compassionate approach that aligns with community standards and traditions, promoting positive changes in attitudes and behaviours.

Innovations and Best Practices

One key innovation in the Heroes programme is the **GBV Helpline**, which has gained significant traction through community outreach efforts. Recently, the helpline managed 637 calls, providing confidential support and advice to survivors. This initiative, alongside other programme components, shows promise for scaling-up in other regions, ensuring timely assistance for survivors of SGBV (see Figure 11).

Figure 11: Issues registered from the SGBV helpline.

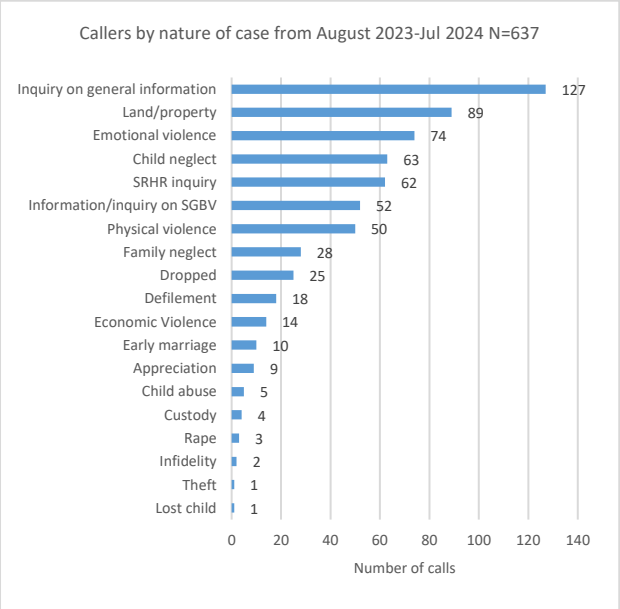
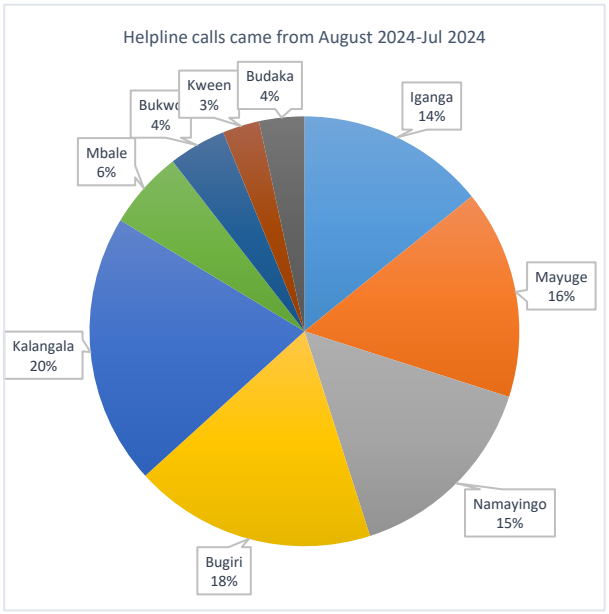


Figure 12: Call distribution by Heroes districts



In communities where SGBV has often been condoned through silence, **Survivor Support Groups (SSGs)** have become vital mechanisms for support. These self-directed groups, linked to the district-level advice centers, empower survivors to seek healthcare and justice. Some SSGs have formalized their operations by registering with Community Development Officers, allowing them to access government funding. The collective strength and resilience fostered within SSGs enhances survivor independence and confidence.

A significant gap remains in promoting **economic independence** for survivors. Helping them develop financial self-sufficiency is crucial for long-term autonomy. Heroes aims to leverage its networks to identify opportunities that support SGBV survivors in building new lives.

Additionally, there is need to strengthen coordination between **formal and informal sectors** to improve access to justice. With most cases resolved through the informal ADR, building the capacity of community level SGBV responders to document cases accurately is essential for minimizing mishandling of SGBV cases.

Conclusion

Through innovations like the SGBV Helpline and the establishment of SSGs, along with a focus on economic empowerment and enhanced sector coordination, the Heroes programme is committed to empowering survivors and fostering supportive community environments for a sustainable response to SGBV.

2.0 Programme Monitoring Evaluation, Research, and Learning Activities

The programme achieved significant progress in generating and disseminating evidence for informed decision-making, both internally and in the districts, it supports. Key accomplishments include:

1. ***Improving district capacity to collect accurate SRHR/SGBV data***: The programme collaborated with biostatisticians to conduct data quality assessments (DQAs) through joint district-led supervisions. By comparing source documents from health facilities with data in the Health Management Information System (HMIS), the assessments revealed a quality index of 88%, ensuring reliable data for decision-making. HMIS registers were provided to ensure consistent data capture. The data collection exercises led to prioritization opportunities for policy and resourcing; for example, the high figures of teenage pregnancy and HIV infection in Budaka district resulted in greater resources allocated to tackle these challenges.

2. ***Enhancing M&E capacities of CBOs***: The programme worked with 18 local CBOs to hold the public system accountable for delivering quality SRHR services. Data collection tools were distributed to help CBOs perform service quality assessments and advocate for improvements.

3. ***Validating programme outcomes***: The programme conducted monthly reflections on its theory of change, incorporating intervention details and outcome harvests among stakeholders to flag significant changes. Deep dive visits in Namayingo, Mayuge, Kalangala, and Budaka allowed stakeholders to assess progress and offer support. For example, a visit to Budaka revealed that some political leaders lacked understanding of SRHR data, leading to the establishment of biannual performance review meetings for district leaders.

4. ***Disseminating research findings:*** The programme shared findings from previous studies, including a midterm review and research on socio-cultural barriers to addressing teenage pregnancies and CSE. Dissemination methods included boardroom presentations, panel discussions, and online publications, effectively engaging key stakeholders and prompting calls for action.

5. ***Collaboration, Research, Learning and Adaptation***: The programme held learning sessions to analyse findings from the Heroes MTR and two research studies on teenage pregnancy and CSE. These findings are being prepared for publication. In collaboration with TRAC FM, the program conducted the radio-based *"No More Silence Campaign,"* to take a frank look at the drivers of the high rates of teenage pregnancy in the districts and the need for greater male accountability. These insights will inform community engagement efforts.



Figure 3: Summary findings of the "No more silence" Campaign

6. ***Partnership for learning and advocacy:*** Heroes partnered with Amref International University (AMIU) to support its learning agenda, resulting in the development of policy briefs and a barrier analysis on SRHR response, slated for completion in Period 5. Collaborations with AMREF Netherlands, Katalemwa Cheshire homes and Liliane Fonds, have contributed to learning that will inform more equitable and inclusive interventions that meet specific targets on gender, equity, and the inclusion of people with disabilities.

7. ***National overview of programme achievements and future directions:*** The programme's findings were presented at the Uganda Safe Motherhood Conference and the 7th RHNK Adolescent and Youth SRHR Scientific Conference. These discussions aimed to enhance adolescent access to contraceptives and highlighted the role of youth-led organizations in advocating for accountability in SRHR services (see annex 10.3).

Overall, the programme's efforts have led to the identification, documentation, and validation of intended and unintended outcomes, significantly enhancing its effectiveness and impact in the communities it serves.

3.0 Programme Communication, Knowledge Management and Documentation

Programme activities have been communicated effectively since 2020 through a comprehensive communications plan that includes web stories, social media posts and newsletters. Key coverage highlights include a **Cordaid International** report on e-vouchers helping to combat SGBV in 24 health facilities across six districts in eastern Uganda; an **Amref Newsroom** piece addressing SGBV concerns, and an article in Uganda's leading daily newspaper, **The Daily Monitor**, discussing socio-cultural drivers of teenage pregnancies and child marriages in districts like Mbale, Namayingo, Kween, and Kalangala. The programme also maintains a YouTube presence and on X (*@GenderHeroes*), where updates and stories are regularly featured.

For more stories, visit: https://amref.org/uganda/success-stories/creating-awareness-on-sgbv-success-story-of-survivors/ and here: https://amref.org/uganda/news/no-more-silence/. These communication efforts have effectively highlighted the programme's impact and raised awareness of critical issues related to SGBV and teenage pregnancies in Uganda.

4.0 Programme Governance and Management

Governance structures remain unchanged and operational, with a Senior Leadership team (SLT), the Programme Management Team (PMT) and Programme Implementation Teams (PIT): Programme M&E Team and the Programme Advisory Group (PAG) continuing to oversee, lead and course correct on Heroes interventions.

The Senior Leadership Team (SLT) held multiple meetings to review implementation progress, provide strategic guidance to the PMT, and address programme bottlenecks. The Programme Advisory Group (PAG) was revitalized with new members, including the Ministry of Health Assistant Commissioner for Adolescent Health and a representative for persons with disabilities (PWDs). The PAG actively participated in programme activities, such as dissemination efforts and monitoring visits.

5.0 Risk & Risk Management

During Period 4, the HEROES programme developed a more focused approach to monitoring risk from implementation of its programme interventions, looking both at the risks for beneficiaries of SGBV and SRHR initiatives and the broader contextual factors that could make programme execution vulnerable, including environmental and health challenges and challenges with partner organizations. While beneficiary risks, such as negative attitudes toward SRHR/SGBV education, did not materialize, contextual risks emerged due to a hostile policy environment following the 2023 anti-homosexuality act, which has had an impact on the review process for a wider introduction of the programme's digital SRHR education curricula. Heroes has actively engaged with MoH reviewers to finalize these materials.

To mitigate programme implementation risks, internal audits were conducted, identifying issues that were subsequently addressed in collaboration with EKN. Amref has also supported partner organizations facing performance challenges and will continue to monitor their performance closely. Additionally, with the recent outbreak of Mpox declared by the MoH, Heroes has activated a contingency plan and engaged in risk communication and community outreach using MoH resources. Overall, the program emphasizes a proactive approach to risk management, with a detailed risk matrix included in annex 10.4.

6.0 Challenges and Opportunities

The HEROES programme encounters significant challenges that are attributable to the chronic shortage of human resources at the health facility level, especially at those recently upgraded under the Ministry of Health's UGIFT program. Health workforce mobility can impede capacity development, which has prompted recommendations that wage allocations be institutionalized, especially at facilities using the RBF – resulting in an allocation of 60% of investment funds to the hiring of locum staff. High mobility of teachers and health workforce also can complicate and delay programme implementation due to the need to train and retrain new personnel.

The MoH needs for repeated review of a digital SRHR curriculum has stalled its roll-out. The programme is leveraging its strong relationships within the MoH to accelerate the reviews and achieve the target for roll-out, even as attrition among peer educators complicates implementation. The need to train recruits on a rolling basis can be frustrating and does contribute to delays in the intervention of programme activities, but can potentially be seen as a net benefit for the health workforce, as an ever-greater number of personnel are becoming conversant with the subject matter within the Heroes curricula.

Stockouts of essential medicines and family planning commodities remain critical issues. To address this, the programme plans to enhance capacity-strengthening initiatives, such as Rx solution training, and improve inventory management through ICT solutions. The programme is evolving its approach to ensuring PWDs are able to effectively and consistently report any SGBV cases, developing user-friendly reporting channels and training community volunteers to assist PWDs.

Cultural practices, such as wife inheritance and bride price, remain major drivers of child marriage and teenage pregnancy in the Mbale and Budaka regions. Community awareness initiatives will be focused in those regions on the legal implications of these practices, through collaboration with cultural and religious leaders.

Reluctance among health workers and police officers to engage with the justice system continues to obstruct evidence collection. Targeted training will empower these individuals and enhance their confidence in legal processes. To address delays in legal proceedings that risk evidence tampering, witness loss, and psychosocial distress among survivors, the programme will strengthen legal support through partnerships with legal aid organizations and advocate for prioritizing SGBV cases in the judicial system, ensuring timely assistance for survivors.

7.0 Sustainability of the Heroes Programme

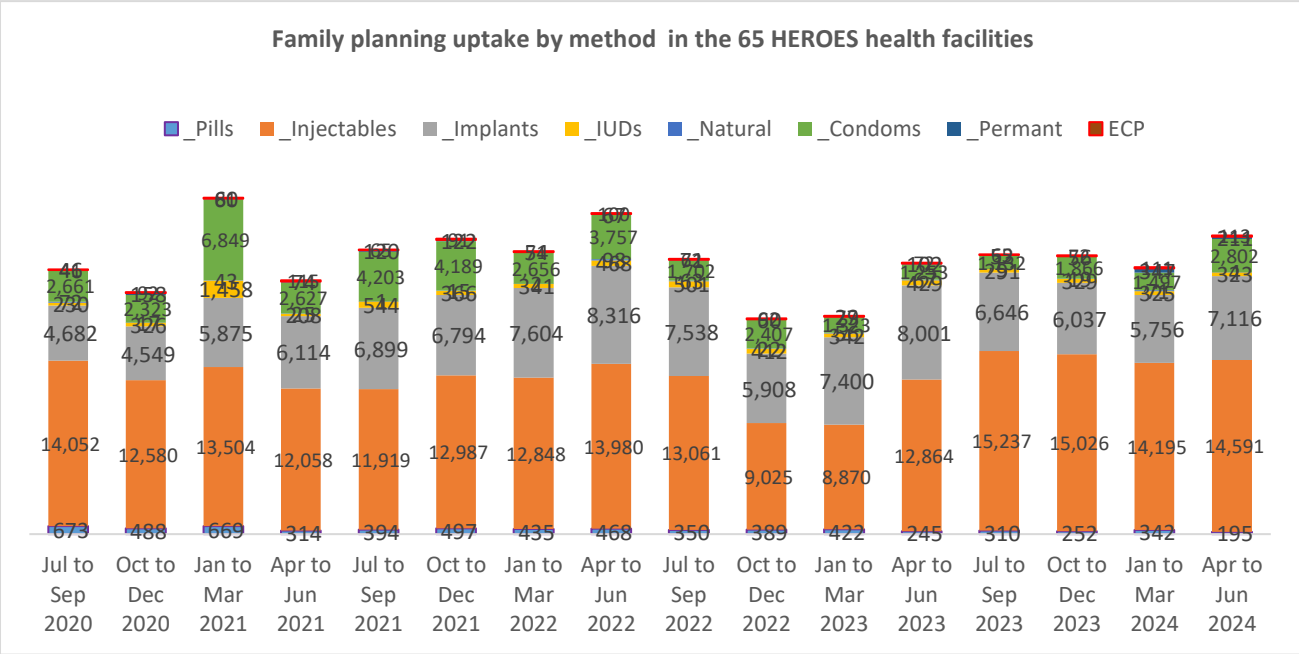
The programme is taking steps to ensure the sustainability of key interventions by addressing human, social, economic, and environmental considerations. By working to enhance the leadership and service capacities of the existing system of local government, health education actors and civil society, it aims to sustain and institutionalize processes, approaches and ideas within the nine districts to eventually normalize and enshrine SRHR within local health service delivery and normalize the opposition to SGBV as a cultural norm. The programme also promotes women's entrepreneurship and links women to government initiatives, while advocating for local budget allocations for women and girls. Heroes prioritizes eco-friendly practices as a recognition that climate change affected areas are also the locus for SRHR violations. A detailed sustainability plan is included in annex 10.5.

8.0 Conclusion

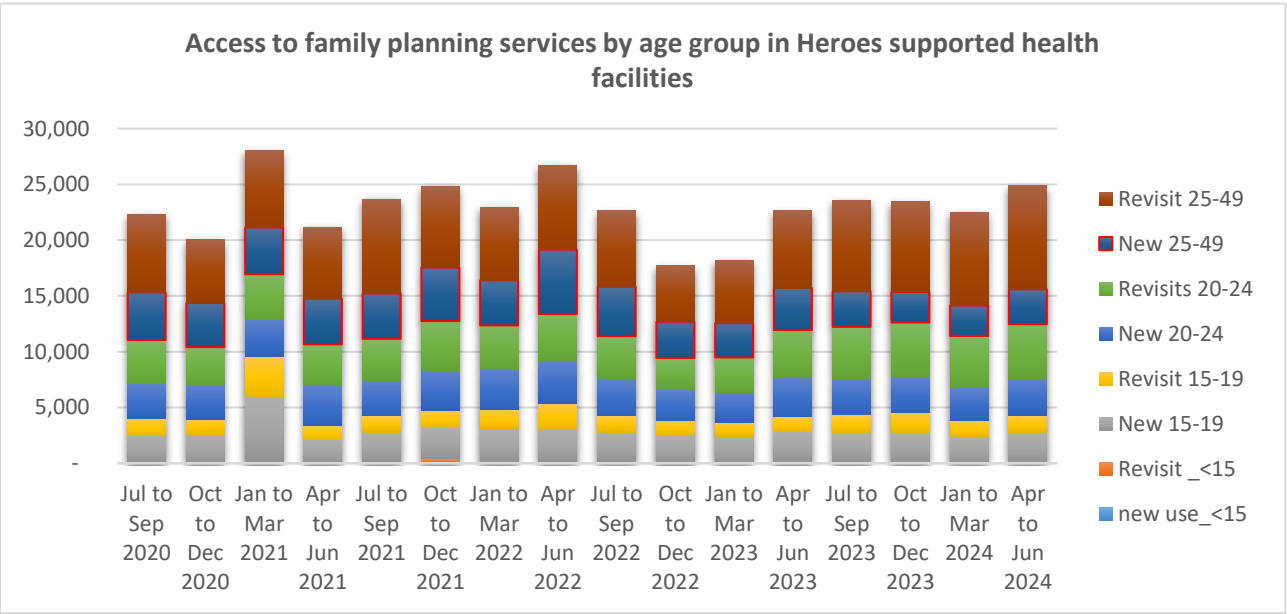
Period 4 for the Heroes programme marked a phase of expansion and intensification, leading to significant advancements in SRHR education, increased uptake of SRHR services, enhanced stakeholder dialogue, and improved access to justice for survivors of SGBV. These achievements resulted from accelerated implementation and robust collaboration with various partners. However, we identified gaps in our execution and capacity deficits among technical, governmental, civil society, and other partners that need addressing. Moving forward, we will focus on intensifying our engagement in SRHR education, and cultivate better health system performance and reliable commodity distribution. We will prioritize inclusive dialogue to transform behaviours, perspectives, and social norms, despite government policies that reinforce harmful beliefs and restrict access to essential SRHR information. We remain committed to being a strong partner to the government while staying true to our principles of promoting SRHR for all.

9.0 Annexes

9.1.1. Annex 1: Trends in the uptake of family planning method mix provided in Heroes supported health facilities



9.1.2. Annex 2: Access to family planning services by age group in Heroes supported health facilities



9.1.3. Annex 3: Heroes work presented at 7th RHNK Adolescent and Youth Sexual and Reproductive Health and Rights (AYSRHR) Scientific Conference in June 2024



Assessing health care providers' Knowledge, Attitudes, Practices on Use of the Medical Eligibility Criteria (MEC) for Contraceptive Methods provision in Uganda

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9TH RHNK ADOLESCENT AND YOUTH SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS SCIENTIFIC CONFERENCE 2024

HEROES FOR GENDER TRANSFORMATIVE ACTION
Supporting Community Solutions for Sustainable Health Outcomes

BACKGROUND / SIGNIFICANCE

- The Ministry of Health adopted the 2015 WHO medical eligibility criteria for contraceptives to improve quality of care for family planning services.
- Provider attitude and bias related to client age, parity and marital status, remains a significant barrier to initiation and continued use of contraceptives.
- MEC utilisation is critical for quality and accessible family planning services.
- There is limited evidence on using medical eligibility criteria to initiate or continue contraceptive use in Uganda.
- The research aims to shed light on this underexplored area, addressing gaps in provider competency, attitudes, and adherence to MEC guidelines.

OBJECTIVES

To assess the Knowledge, Attitude, and Practice of Service providers on the use of the medical eligibility criteria in the provision of contraceptive methods in the selected Health facilities in Bugisu, Busoga, Lango, Acholi, Bukedi, and Central regions of Uganda.

SPECIFIC OBJECTIVES

1. To investigate how the competency of healthcare workers affects the use of MEC when providing contraceptive services in selected facilities in six regions of Uganda.
2. To evaluate the Knowledge and attitudes of healthcare workers towards the use of medical eligibility criteria during contraceptive services provision across six regions of Uganda.

METHODOLOGY / INTERVENTIONS

- Cross-sectional research design using two stage cluster random sampling method.
- Qualitative and quantitative quantitative data collection methods.
- Data collected electronically using Computer-assisted Personal Interviews (CAPI)
- Modified WHO FP provision assessment tool used to assess provider practices using Medical Eligibility Criteria and reviewed facility records.

DATA ANALYSIS

- Cross-sectional research design using two stage cluster random sampling method.
- Qualitative and quantitative quantitative data collection methods.
- Data collected electronically using Computer-assisted Personal Interviews (CAPI)
- Modified WHO FP provision assessment tool used to assess provider practices using Medical Eligibility Criteria and reviewed facility records.

RESULTS

Distribution of Family planning provider profession (% respondents)

NURSING ASSISTANTS	LAB TECHNICIANS
1.14%	1.72%

COMPREHENSIVE NURSES/ MIDWIVES-REGISTERED	ENROLLED NURSES/ MIDWIVES	MEDICAL CLINICAL OFFICERS
14.74%	74.11%	8.30%

Training on insertion and removal of different contraceptive methods by Family planning providers

	INSERTION	REMOVAL
INJECTABLES - DEPO PROVERA - SAYANA PRESS	100%	
IMPLANT	98.5%	97.5%
COPPER INTRA-UTERINE DEVICE (CU-IUD)	71.98%	63.56
LEVONORGESTREL-RELEASING INTRAUTERINE DEVICE (LNG-IUD)	62.3%	44.26%

The competence of Family planning providers influences the use of the medical eligibility criteria in contraceptive services

CONCLUSION

Providers displayed varied Knowledge and practices related to initiation and timing for different methods using MEC. Provider attitudes towards MEC were mixed with some displaying misconceptions, while others recognising its importance for client-centred care. The study's findings indicate prioritizing targeted interventions to address knowledge, attitudes, and practices gaps to enhance the quality and accessibility of contraceptives.

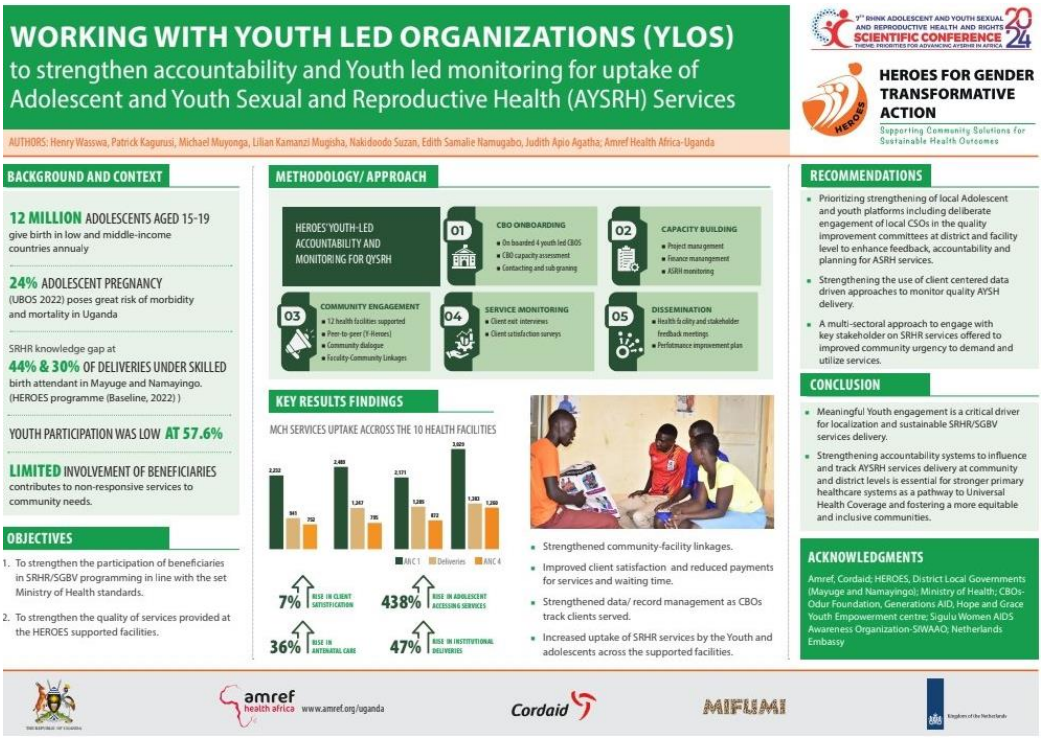
RECOMMENDATIONS

- Emphasis should be placed on disseminating MEC guidelines through user-friendly mobile applications to enhance provider adherence.
- Comprehensive training, especially in IUD insertion and removal, should be prioritised.
- Task-shifting strategies should be expanded to ensure a wider pool of trained providers.
- Interventions should address misconceptions and enhance attitudes towards MEC to foster more client-centred care.

ACKNOWLEDGMENTS

Reproductive Health Uganda
IPPF African region
With support from FCDO

amref health africa www.amref.org/uganda Cordaid MIFUMI



WORKING WITH YOUTH LED ORGANIZATIONS (YLOS)
to strengthen accountability and Youth led monitoring for uptake of Adolescent and Youth Sexual and Reproductive Health (AYSRH) Services

AUTHORS: Henry Wasswa, Patrick Kagurusi, Michael Muyonga, Lilian Kamanzi Mugisha, Nakidoodo Suzan, Edith Samalie Namugabo, Judith Apio Agatha; Amref Health Africa-Uganda

9TH RHNK ADOLESCENT AND YOUTH SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS SCIENTIFIC CONFERENCE 2024

HEROES FOR GENDER TRANSFORMATIVE ACTION
Supporting Community Solutions for Sustainable Health Outcomes

BACKGROUND AND CONTEXT

12 MILLION ADOLESCENTS AGED 15-19 give birth in low and middle-income countries annualy

24% ADOLESCENT PREGNANCY (UBOS 2022) poses great risk of morbidity and mortality in Uganda

SRHR knowledge gap at **44% & 30%** OF DELIVERIES UNDER SKILLED birth attendant in Mayuge and Namayingo. (HEROES programme (Baseline, 2022))

YOUTH PARTICIPATION WAS LOW **AT 57.6%**

LIMITED INVOLVEMENT OF BENEFICIARIES contributes to non-responsive services to community needs.

OBJECTIVES

1. To strengthen the participation of beneficiaries in SRHR/SGBV programming in line with the set Ministry of Health standards.
2. To strengthen the quality of services provided at the HEROES supported facilities.

METHODOLOGY/ APPROACH

HEROES' YOUTH-LED ACCOUNTABILITY AND MONITORING FOR QYSRH

01 CBO ONBOARDING
- On boarded 4 youth led CBOS
- CBO capacity assessment
- Contracting and sub-graning

02 CAPACITY BUILDING
- Project management
- Finance management
- ASRH monitoring

03 COMMUNITY ENGAGEMENT
- 12 health facilities supported
- Peer-to-peer (Y-Heroes)
- Community dialogue
- Faculity-Community Linkages

04 SERVICE MONITORING
- Client exit interviews
- Client satisfaction surveys

05 DISSEMINATION
- Health facility and stakeholder feedback meetings
- Performance improvement plan

KEY RESULTS FINDINGS

MCH SERVICES UPTAKE ACCROSS THE 10 HEALTH FACILITIES

7% RISE IN CLIENT SATISFICATION
438% RISE IN ADOLESCENT ACCESSING SERVICES
36% RISE IN ANTENATAL CARE
47% RISE IN INSTITUTIONAL DELIVERIES

- Strengthened community-facility linkages.
- Improved client satisfaction and reduced payments for services and waiting time.
- Strengthened data/ record management as CBOs track clients served.
- Increased uptake of SRHR services by the Youth and adolescents across the supported facilities.

RECOMMENDATIONS

- Prioritizing strengthening of local Adolescent and youth platforms including deliberate engagement of local CSOs in the quality improvement committees at district and facility level to enhance feedback, accountability and planning for ASRH services.
- Strengthening the use of client centered data driven approaches to monitor quality AYSH delivery.
- A multi-sectoral approach to engage with key stakeholder on SRHR services offered to improved community urgency to demand and utilize services.

CONCLUSION

- Meaningful Youth engagement is a critical driver for localization and sustainable SRHR/SGBV services delivery.
- Strengthening accountability systems to influence and track AYSRH services delivery at community and district levels is essential for stronger primary healthcare systems as a pathway to Universal Health Coverage and fostering a more equitable and inclusive communities.

ACKNOWLEDGMENTS

Amref, Cordaid; HEROES, District Local Governments (Mayuge and Namayingo); Ministry of Health; CBOs- Odur Foundation, Generations AID, Hope and Grace Youth Empowerment centre; Sigulu Women AIDS Awareness Organization-SIWAAO; Netherlands Embassy

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9.1.4. Annex 4: Risk Monitoring Report in Period 4

Risk Category	Risk Statement/Description	Risk Mitigation Action Plan
Beneficiary Risk	There were a few incidents in faith-based schools where the improved access to SRHR/SGBV services were challenged by those resistant to change	The programme continuously addressed their fears, prejudices and misconceptions, targeting school authorities and community members using data to show the risks of not educating young people and communities on SRHR/SGBV. The programme also sensitized communities on existing laws that prohibit all forms of SGBV.
	Unintended harm or backlash: There were incidents where peer educators were confronted and their SRHR education kits were destroyed in Kween district.	The programme temporarily interrupted the SRHR education and re-engaged the community on the purpose of SRHR education in addressing SGBV and harmful practices. This was understood and education outreach resumed in safe spaces.
	Left-out parishes and communities demanded that programme interventions be extended there.	The programme has to the extent possible stretched the interventions to reach the demanding parishes. In Period 4, the programme has extended to nine new hotspots that are adjacent to the current hotspots.
	High expectations from beneficiaries to meet needs beyond the programme scope	The programme has continuously sensitized beneficiaries on the programme's scope and its finite resources, and created linkages to other opportunities.
Contextual Risks	Heroes has not experienced any lack of political support for SRHR and SGBV interventions	The programme has continued to work with district leadership (political and technical) in meetings and joint monitoring visits.
	Hostile policy environment: The implementation of the 2018 Sexuality Education framework remains banned and government enacted the 2023 anti-homosexuality act (AHA, 2023)	The programme has oriented staff on the risk and asked them to act safely. In addition, the programme is continuously engaging relevant local authorities to inform them that the programme is not violating the act.
	Worsening systemic gaps target districts including high staff turnover, lack of supplies/commodities	The programme worked with district authorities through joint supervisions and stock monitoring visits to address gaps such as SRHR commodity stockouts and implement commodity redistribution to avert shortages. Heroes has also advocated for the minimization of unnecessary staff transfers to ensure consistency in service delivery. RBF facilities have been able to hire locum staff.

Risk Category	Risk Statement/Description	Risk Mitigation Action Plan
	Uncooperative stakeholders/ departments	Heroes has continued promoting district-led programming. Most stakeholders remain cooperative.
	Stakeholders (districts, health facilities, cultural institutions) ignoring the programme interventions and relevance.	The programme will continuously engage stakeholders in planning and implementation including cultural leaders and institutions.
Programme Implementation Risks	Internal, external fraud	The programme maintains zero tolerance of fraud. All known pockets of fraud have been removed. In addition, the programme held internal and external audits and tasked partners to close all areas of risk.
	Staff technical capacity gaps and/or high turnover	The programme continued to assess staff performance and ensured they were competent in their work.
	Sexual exploitation and harassment of or by staff, stakeholders, partners and beneficiaries.	Heroes did not experience this risk in the period under review. Heroes continues to sensitize both staff and community resources persons on the programme against sexual harassment of survivors, any person they encounter.
Partner organisations Risks	Programme partners cannot implement interventions according to stipulated timelines and standards	One of the partners, ICRW, was not able to perform the scope of work given to them. As such, they separated from the programme. Amref has on boarded internal capacity to fill the gap.
	Conflict among programme partners interrupt programme	The programme has continuously addressed areas of disagreement through regular meetings at different levels. meetings, performance reviews and resolution of disputes.
Environmental Risks	Hard terrains and risky waterways mudslides	● The programme trained and oriented staff on emergency response protocols and provided helplines, as well as taking group personal accident insurance to cover rescue teams. ● The programme also secured and provided protective equipment such as life jackets.
Pandemic risk	The MOH, Africa CDC and WHO announce the outbreak of the Mpox virus disease as a disease of international public health concern.	Heroes has responded by engaging in risk communication and community engagement, integrated in routine programme activities. Heroes will continue to monitor the situation and respond teach scenario as appropriate.

9.1.5. Annex 5: Heroes Program Sustainability Plan

What has been identified for sustainability	Barriers to sustainability	Actions in year 4 to unlock barriers	Who is being prepared to sustain the intervention (By whom and where)	Indicator of success/How to measure success	Resources required
Outcome Area-1: Better information and greater freedom of choice for young people about their sexuality.					
Sustained teaching of the Journeys Plus & Programme Y Curriculum in schools	i. Limited acceptance by school SMC. ii. Few trained teachers iii. Demand for facilitation to conduct sessions. iv. Lack of funds to reprint curricular v. Curriculum too long	i. Advocate for schools to take on the whole school approach ii. Digitise the curriculums to eliminate the need to reprint iii. Support local CBOs to facilitate the training of facilitators in schools iv. Production of abridged Journeys plus and Programme-Y curricula v. Supporting creation of 108 community safe spaces and youth-friendly spaces	i. Chief executives of 8 YLO and 8 WLO in the district are being linked to schools ii. Headteachers and Teachers are to be trained iii. Local Govt Education Department iv. MOH, Education	i. Rollout of digital curricular ii. Budgets allocated by schools to teach the curriculum iii. # of additional teachers trained iv. Local YLOs and WLOs take over support to schools & linking programme beneficiaries to key	i. Facilitation of activities ii. Stationery iii. Funds to print IEC Materials, manuals and attendance registers. iv. Digital curricula versions. v. Illustrative flip charts for the curricula
Functional District Committees on Adolescent Health (DCAHs)	i. Limited attention given to adolescent health issues by the district. ii. Lack of budget provisions for adolescent Health committees.	i. Hold advocacy meetings with stakeholders to make budgetary provisions. ii. Conduct joint quarterly support supervision and mentorship with all stakeholders.	i. District Education Officers ii. Probation officers iii. District Community development officers iv. District planners v. Chief Administrative Officers	i. Minutes of the meetings held will be tracked in addition to the budget allocation for these meetings and progress on the actions	Stationery Facilitation for meetings

What has been identified for sustainability	Barriers to sustainability	Actions in year 4 to unlock barriers	Who is being prepared to sustain the intervention (By whom and where)	Indicator of success/How to measure success	Resources required
			vi. District Health officers		
School management support for SRHR education in schools	i. Low attention to SRHR and SGBV in schools ii. Limited capacity to advocate for SRH and SGBV issues	i. Facilitate SMC and PTA meetings in schools ii. Conduct joint supervision with line departments. iii. Secure circular from the Ministry of Education and Sports	i. School management committees (SMCs) ii. Parents Teachers Association (PTA) iii. Board of Governors (BoG) iv. Directors	i. Programme interventions integrated with school improvement plans ii. Community responsiveness and perceptions about SRHR and SGBV changed	Stationery, venue and transport refund
Outcome Area-2: Better public and private healthcare for family planning, pregnancies and childbirth, including post-abortion care.					
Quality improvement interventions for improved SRHR service delivery at 54 Health facilities	i. No schedule for monthly meetings ii. QI Meetings are not being held regularly (Monthly) as expected	i. Work with stakeholders to come up with monthly meeting Schedules. ii. Hold facility sustainability planning meetings	i. Health facility in-charges, DHT, District QI focal person, Heroes programme focal person at the district level	i. Shared schedule for Monthly ii. SRHR Quality improvement projects	Airtime for district program focal person to coordinate with all facility in-charges in the selected dates
Continuous quality improvement on SRHR services	i. No customised dashboards for Quick data review ii. Integrated quarterly HUMC and performance review meetings not happening as expected	i. Work with facility and district teams to generate customised facility-based dashboards. ii. Programme focal person to work with facility in-charges to generate an integrated quarterly facility-based performance schedule	i. Health facility team members with community structures involved ii. HUMC & DHT members	i. Customized dashboard developed and shared with facility teams ii. An integrated schedule for quarterly performance review per health facility shared by the district the HEROES program focal person	Refreshments for participants during facility-based quarterly performance review meetings

What has been identified for sustainability	Barriers to sustainability	Actions in year 4 to unlock barriers	Who is being prepared to sustain the intervention (By whom and where)	Indicator of success/How to measure success	Resources required
Integrated SRHR Outreaches targeting adolescents	i. Current facility work plans do not reflect costed quarterly integrated outreaches ii. New administrative units not yet included in the catchment area map for health facilities	i. Support health facility teams to generate costed integrated outreach plans using available resources	i. Health facility in-charges ii. MCH department in-charges iii. Community department led by HA/HI	i. Integrated Quarterly/Monthly costed outreach schedule developed ii. Integrated outreach data reported on Monthly /Quarterly report	Facilitation (Transport and SDA) for district HEROES program focal person for spot checks during the proposed dates for outreach implementation
Provision of SRHR Services by Community Health Entrepreneurs(CHEs):	i. Inadequate stocks for sale iii. Limited demand for the health products sold by CEs	i. Hold joint meetings between Community health entrepreneurs and supporting health facility staff in 5 districts (Namayingo, Mayuge, Iganga, Bugiri and Kween). ii. Community mobilization for CHEs services	i. Health facility leaders at the selected health facilities in five districts ii. Community entrepreneurs and other community agents.	i. The success would be measured through tracking reports submitted to district structures.	Transport refund for the meeting participants
Outcome Area-3: More Respect for Sexual Reproductive Health Rights for All					
Self-driven actions by SGBV Champions including Provision of information, advocacy, local activism and referrals.	i. Dropout of the trained champions ii. Inadequate knowledge of laws, policies and procedures iii. Community backlash	i. The Programme will strengthen and consolidate the training of championship in acting against SGBV ii. Provision of resources that include simplified laws, training manuals and SOPs	i. Champions ii. Local leader iii. Selected stakeholders, these will include the community development officer, iv. Women groups, GRGs	i. Champions demonstrate commitment to community mobilization, awareness raising, provision of information and referral, and campaigns. ii. Periodic assessments using the movement capacity assessment tool	Funds for support supervision and dissemination of laws

What has been identified for sustainability	Barriers to sustainability	Actions in year 4 to unlock barriers	Who is being prepared to sustain the intervention (By whom and where)	Indicator of success/How to measure success	Resources required
		iii. Enhance linkages with community-based resources.		iii. Reports by champions and supervision by community development officers	
Outcome Area: 4- Enabling environment for young girls and women's elimination of violence against girls and women.					
The functionality of 09 SGBV Advice centres	i. Inadequate facilitation for the volunteers. ii. Resistance from the host communities iii. Inadequate capacity of volunteers	i. Increased training, exposure and support for the champions running advice centres. ii. Programme will strengthen management and supervision by attaching Community development officers and parish chiefs to the advice centres for hands-on support and capacity building.	i. Champions ii. Survivor support committee iii. Community Development Officers iv. Sub-county Chiefs v. District local governments vi. Ministry of Gender	i. Capacity of support groups and the existence and capacity of champions attached to the advice centres ii. Supervision reports by the community development officers and the parish chiefs. iii. The budget allocation by the community development officers will also be tracked. iv. Advice Centre reports will also be an indication of success	Minimal funds for operational costs
Survivor support groups, the programme has established 20 support groups in the 9 districts of implementation.	i. Community stigma in associating with groups	i. The Programme will continue training the various groups to build their knowledge and confidence. ii. The Programme will continue to create spaces for individual and collective empowerment, as vehicles for social assets building for survivors, facilitating connections between survivors,	i. Sub county and parish CDOs ii. Survivors iii. Teen mothers iv. Young people v. champions	i. The programme will track collective self-initiated empowerment activities, meetings and available documented stories of change. ii. Continued enrolment of survivors into the groups	Funds to facilitate the community development officers to orient the groups.

What has been identified for sustainability	Barriers to sustainability	Actions in year 4 to unlock barriers	Who is being prepared to sustain the intervention (By whom and where)	Indicator of success/How to measure success	Resources required
		champions, and other community actors to raise awareness of SGBV/SRHR issues, build confidence, and supportive relationships, to voice concerns and demand action iii. Programme will also hold activities that bring all the movement members together and these will include campaigns, awareness sessions, etc.			
Integrated, coordinated, multi-sectoral networks of SGBV response and prevention services,	i. Staff turnover among the duty bearer ii. Lack of adequate knowledge iii. Staff Attitude challenges	i. Convene accountability meetings and dialogues between the steering committee and the champions and community members. ii. Hold joint activities including monitoring and learning. iii. Scale-up capacity building among the members of the steering committee and multi-sectoral actors.	i. District Community Development officers, ii. Police officers iii. Sub-county community development officers, iv. Sub-county/Parish chiefs v. SGBV champions	i. The steering committee is active and engaged. ii. Improved service delivery (accessibility, availability, attitude, timeliness, quality) iii. The programme will track survivor satisfaction with services. iv. Minutes of the meetings at the district and sub-county level. v. We shall also track the allocation of budgets and any form of integration of SGBV work in the existing meetings.	i. Meeting costs ii. Monitoring costs

What has been identified for sustainability	Barriers to sustainability	Actions in year 4 to unlock barriers	Who is being prepared to sustain the intervention (By whom and where)	Indicator of success/How to measure success	Resources required
Response Champions actively self-mobilising to prevent and end SGBV including the Provision of information and referrals.	i. Dropouts ii. Community backlash iii. Lack of communication materials and resources	i. Strengthen and consolidate training SGBV response champions ii. Provision of resources that include simplified laws, training manuals and SOPs iii. Enhance linkages with community-based resources	i. Champions, ii. Community development officers iii. Parish chiefs	i. Champions demonstrate commitment to community mobilisation, awareness raising, provision of information and referral, and campaigns. ii. Success will be tracked through periodic assessments using the movement capacity assessment tool iii. The reports submitted by the champions and the supervision by the community development officers	i. Meeting costs ii. Communication materials

9.1.6. Annex 6: Heroes Programme Results Matrix

Summitted as a separate excel document.