Sweden
Sverige

2gether 4SRHR

2gether 4 SRHR Programme
Phase 1 (2018–2023)

Close-out Report

UNAIDS

UNFPA

unicef
for every child

World Health Organization

2gether 4 SRHR Programme
Phase 1 (2018–2023)

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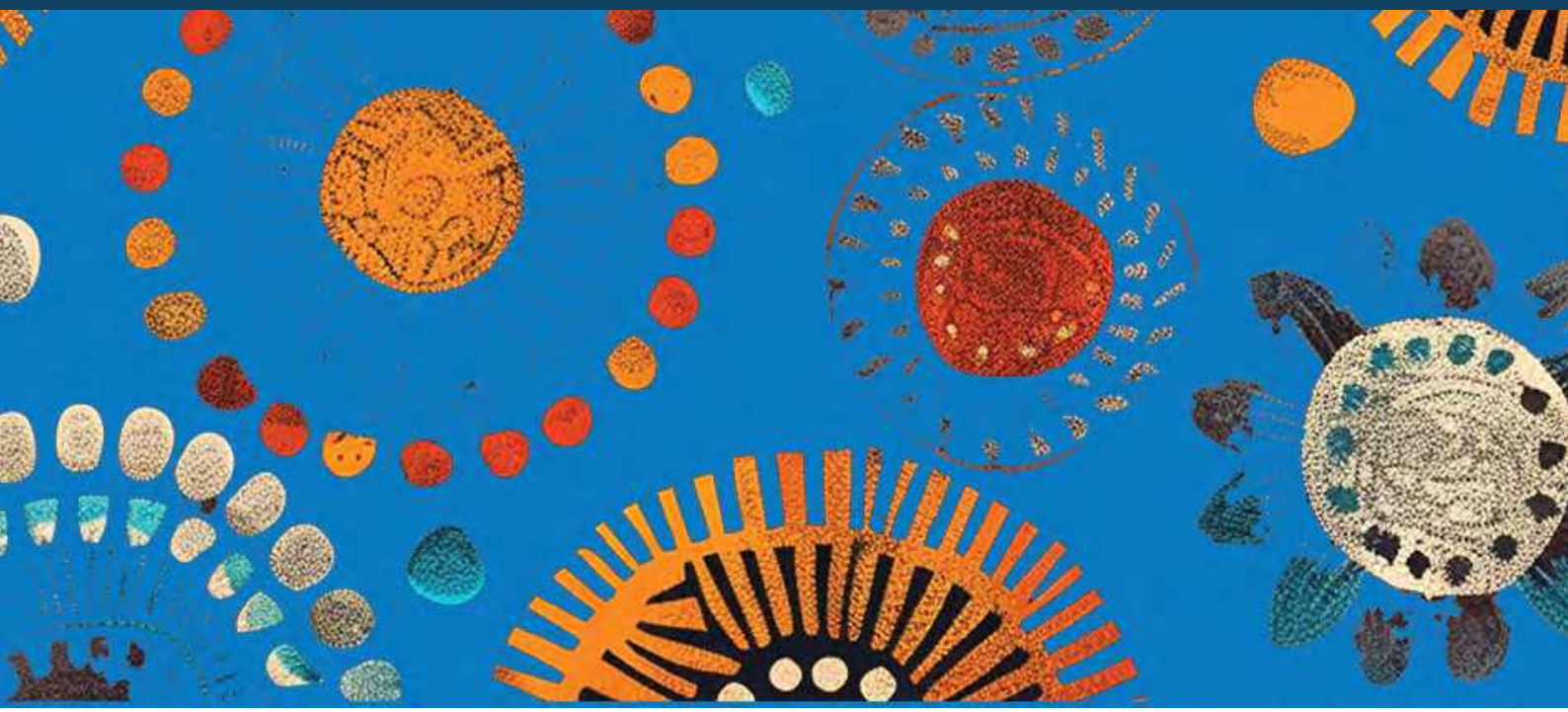

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Foreword

Charting a Path of Transformation: Realising Sexual and Reproductive Health and Rights for all in East and Southern Africa

The 2gether 4 SRHR Programme, a joint effort that brings together the combined efforts of UNAIDS, UNFPA, UNICEF, and WHO, stands as a beacon of collaboration and progress in East and Southern Africa.

Generously supported by the Government of Sweden, this program has not only achieved significant milestones but has embodied resilience, innovation, and partnership. Working closely with Regional Economic Communities, governments, parliamentary forums, civil society, and grassroots organizations, we have elevated SRHR to the regional forefront and paved the way towards a future where every individual's sexual and reproductive health and rights are not just acknowledged, but fully realized.

This report is a testament to the power of aligning our collective resources and expertise, driven by our shared dedication to deliver as One United Nations to advance SRHR in the region.

Our strategic interventions in twelve countries have made tangible improvements in expanding rights and choices for all embodied in the regional and national laws, policies and strategies that have been developed. We have increased accountability for progress through the population of periodic scorecards that track progress, and enable us to course correct and identify promising practices. We have expanded access to quality integrated services that prioritize human rights and dignity through developing guidelines, training health care workers, and testing models of integrated service delivery. We have invested in strengthening the meaningful engagements of networks of adolescents and youth, and key populations and have addressed harmful gender and social norms. Learning from COVID-19 we are working hard to ensure the continuity of the minimum essential SRHR services in times of crisis.

Despite progress made, ongoing challenges such as maternal mortality, limited access to contraceptives, HIV, and gender-based violence remain. The lessons learned from the implementation of this programme have illuminated our path forward in addressing these, emphasizing adaptive leadership, tailored solutions, and the transformative impact of community engagement. By building on our past successes and pushing boundaries, we are determined to continue the journey to shape a future where SRHR is a reality for all.

We extend our deepest gratitude to the Government of Sweden, and acknowledge with appreciation the valuable contribution of governments, civil society partners, and communities across the region who have contributed to the successful implementation of this programme.

Together, we have initiated a process of change and we remain committed to this joint effort to craft a future of hope, resilience, and the empowerment in which all people are able to exercise their sexual and reproductive health and rights.

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Acknowledgements

This close-out report documents the results and lessons learnt from the implementation of the Joint United Nations Regional Programme, 2gether 4 SRHR implemented between 2018 and 2023, that aims to improve the sexual and reproductive health and rights (SRHR) of all people in East and Southern Africa (ESA).

The programme was conceived and implemented under the leadership of Regional Directors for the Joint United Nations Programme on HIV/ AIDS (UNAIDS), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), and World Health Organization (WHO). Oversight and strategic direction was provided by the Deputy Regional Directors of the four participating agencies.

Appreciation is expressed to the Representatives and technical teams of the participating agencies in Botswana, Eswatini, Kenya, Lesotho, Namibia, South Africa, South Sudan, the United Republic of Tanzania, Uganda, Zambia, and Zimbabwe for their stewardship, and implementation of the country programmes from which results and lessons have been harvested that are shared in this report.

Appreciation is also expressed to the Executive Secretary of the SADC Secretariat, and the Directorate of Social and Human Development, the Secretary General of the East African Community, the Secretary General of the SADC Parliamentary Forum, the Speaker and General Purpose Committee of the East African Community for their partnership in the implementation of this programme.

This report is a joint effort of the Regional Interagency Working Group and the Monitoring and Evaluation Working Group. The Communications Advisers of the four participating agencies oversaw the design and layout of the report that was undertaken by the Communications Task Team of the Joint Programme. Appreciation is also expressed to the administrative and finance teams of the Joint programmes for their support to the programme. .

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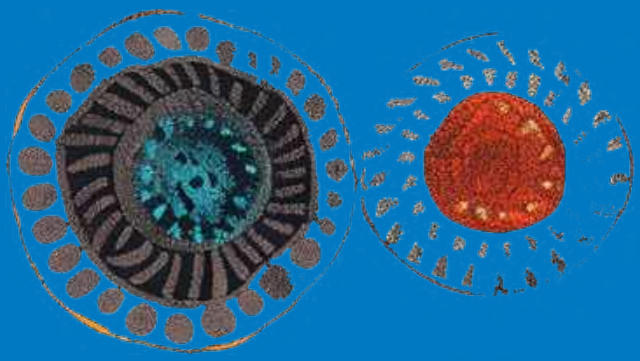
Contents

Acronyms

AA-HA!	Accelerated Action for the Health of Adolescents
AGYM	Adolescent girls and young mothers
AI	Artificial intelligence
ANC	Antenatal care
APHRC	African Population and Health Research Center
ART	Antiretroviral therapy
ASRHR	Adolescent sexual and reproductive health and rights
AYFS	Adolescent and youth-friendly services
AYP	Adolescents and young people
CAC	Comprehensive abortion care
CATS	Community Adolescent Treatment Supporters
CHAI	Clinton Health Access Initiative
CMIS	Client Management Information System
CSE	Comprehensive sexuality education
CSW	Commission on the Status of Women
CSO	Civil society organization
DCS	Division of Communications and Strategic Partnerships
DHIS2	District Health Information Software 2
DQA	Data quality assurance
EAAR	Expanded Accelerated AIDS Response
EAC	East African Community
EALA	East African Legislative Assembly
EMTCT	Elimination of Mother-to-child Transmission
ESA	East and Southern Africa
ESARO	East and Southern Africa Regional Office
FCDO	Foreign Commonwealth and Development Office
FIGO	International Federation of Gynaecology and Obstetrics
FSW	Female sex worker
GBV	Gender-based violence
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
HLM	High-level meeting
HMIS	Health management information system
HPV	Human papilloma virus
IARH	Inter-Agency Emergency Reproductive Health
ICASA	International Conference on AIDS and STIs in Africa
ICPD	International Conference on Population and Development
ICT	Information and communications technology
IoGT	Internet of Good Things
IPPF	International Planned Parenthood Federation
JSF	Joint SRHR Fund
JUNTA	Joint United Nations Team on AIDS
KEPH	Kenya Essential Package for Health
LGBTQI	Lesbian, gay, bisexual, transgender, queer, and intersex
M&E	Monitoring and evaluation
MHTF	Maternal and Newborn Health Thematic Fund
MISP	Minimum Initial Service Package



MOU	Memorandum of Understanding
MPDSR	Maternal and perinatal death surveillance and response
MVA	Manual vacuum aspiration
NASA	National AIDS Spending Assessments
NEHIP	National Essential Health Interventions Package
NGO	Non-governmental organization
ODSS	Organizational Development and Systems Strengthening
OHTA	Optimizing HIV Treatment Access
PAC	Post-abortion care
PEP	Post-exposure prophylaxis
PF	Parliamentary Forum
PHC	Primary health care
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PUNO	Participating United Nations Organization
RACI	Responsible, accountable, consulted, and informed
REC	Regional Economic Community
RISC	Regional Interagency Steering Committee
RIWG	Regional Interagency Working Group
RMNCAH	Reproductive, maternal, newborn, child, and adolescent health
RPSC	Regional Programme Steering Committee
SAA	Standard Administrative Agreement
SADC	Southern African Development Community
SAM4SRHR	Social Accountability Model for SRHR
SBC	Social and behaviour change
SDG	Sustainable Development Goals
SDP	Service delivery point
Sida	Swedish International Development Cooperation Agency
SLF	Strategic Leadership Forum
SOP	Standard operating procedure
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TB	Tuberculosis
UBRAF	Unified Budget, Results and Accountability Framework
UHC	Universal health coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNDG	United Nations Development Group
USAID	United States Agency for International Development
V-CAT	Values clarification and attitude transformation
WFP	World Food Programme
WHO	World Health Organization
WLHIV	Women living with HIV

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Executive Summary

Background

East and Southern Africa (ESA) faces numerous challenges in sexual and reproductive health and rights (SRHR) including high rates of maternal mortality, human immunodeficiency virus (HIV), unintended pregnancies, gender-based violence (GBV), unsafe abortion, and early marriage. Key drivers include inadequate health-care infrastructure, limited access to comprehensive sexual education (CSE), persistent socioeconomic disparities, gender inequalities, gender and social norms, and stigma and discrimination.

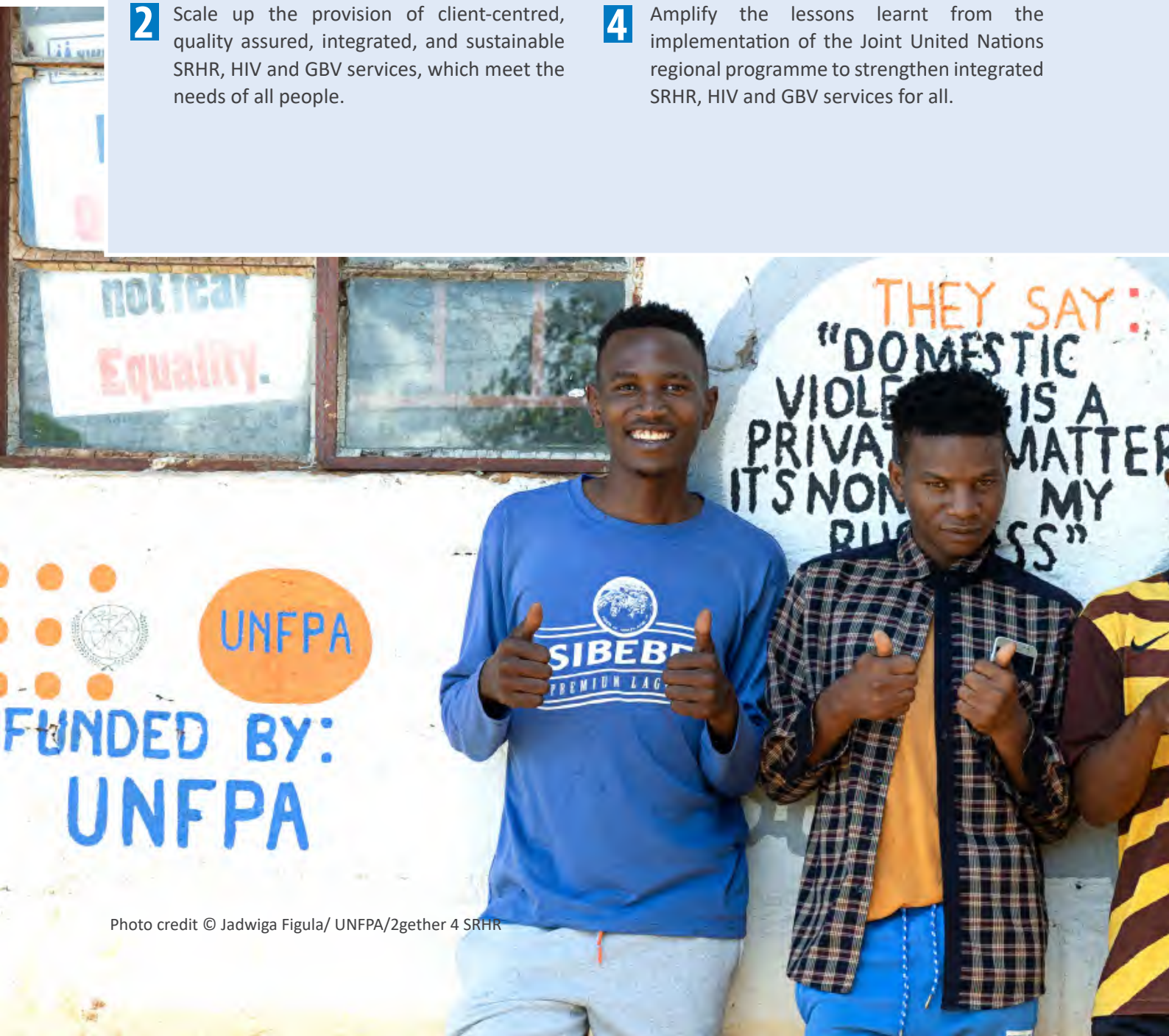
2gether 4 SRHR is a comprehensive Joint United Nations regional programme with applied learning in countries implemented by four United Nations agencies (UNAIDS, UNFPA, UNICEF and WHO) in ESA. **Initiated in 2018, Phase I of the programme was funded by the Government of Sweden through the Regional SRHR Team of Sweden with a total award of US$ 59,627,295.13.**

Vision of the programme

All people, particularly adolescent girls, young people and key populations in the ESA region are empowered and supported to exercise their sexual and reproductive health (SRH) rights and access quality integrated SRHR services, so that they can enjoy a healthy life.

Programme objectives

1. Create an enabling legal and policy environment that empowers all people to exercise their SRH rights and access quality integrated SRHR, HIV and GBV services.
2. Scale up the provision of client-centred, quality assured, integrated, and sustainable SRHR, HIV and GBV services, which meet the needs of all people.
3. Empower all people to exercise their SRH rights, adopt protective and promotive behaviours, and access quality integrated services in a timely manner.
4. Amplify the lessons learnt from the implementation of the Joint United Nations regional programme to strengthen integrated SRHR, HIV and GBV services for all.



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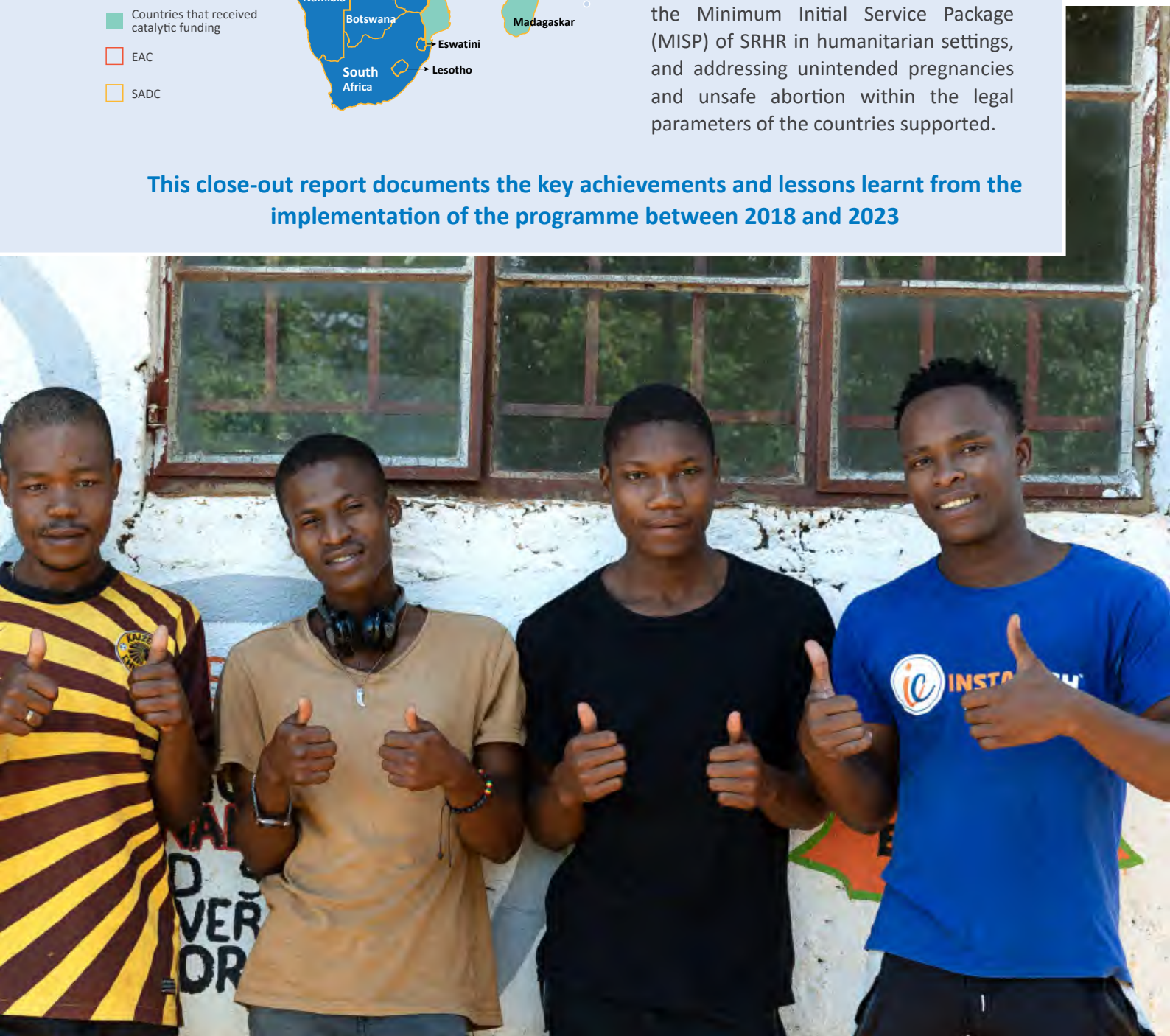
The programme worked in partnership with continental and Regional Economic Communities (RECs), regional civil society organizations (CSOs) and networks of communities to advance SRHR in the region. Applied learning was supported through predictable funding provided to 12 countries to implement programmes aligned to the vision, mission and objectives of 2gether 4 SRHR over the period of programme implementation. Catalytic financial and technical support was provided to other countries in the region to address emerging or neglected areas, such as tracking the disruption of services due to COVID-19, assessing the preparedness of countries to provide the Minimum Initial Service Package (MISP) of SRHR in humanitarian settings, and addressing unintended pregnancies and unsafe abortion within the legal parameters of the countries supported.

This close-out report documents the key achievements and lessons learnt from the implementation of the programme between 2018 and 2023



Results of the 2gether 4 SRHR Programme

Contributed to the health and well-being of

640 million

people in the ESA region

Improving SRHR for

296 million

people in 12 focus countries supported for applied learning

Objective 1: Create a legal and policy environment that empowers all people to exercise their SRHR rights and to access quality integrated SRHR, HIV and GBV services.

10 Laws reviewed or enacted to protect SRHR

34 Strategies developed to outline actions and align resources for SRHR

19 Policies developed to guide decisions on equitable access to SRHR

8 Countries supported to mobilize domestic and international funding

5 countries supported to undertake investment cases

Photo credit © United Movement!/ 2gether 4 SRHR

Objective 2: Scale up the provision of quality client-centred integrated services for SRHR, HIV and GBV, which meet the needs of all people.

60 Guidelines developed to guide health-care workers on providing quality services

14 Training curricula developed to enhance knowledge, skills, and competencies

44,704 Health-care workers capacitated to deliver quality SRHR services

10 Countries successfully scaled-up or piloted the integration of SRHR, HIV and GBV services

23 Countries supported to track and sustain service delivery during COVID-19

10 Countries strengthened HMIS

3 Countries piloted integrated services for key populations

Objective 3: Empower all people to exercise their SRH rights, adopt protective behaviours and access quality, integrated services in a timely manner.

Civil society organizations, community members, community leaders, religious and traditional leaders and networks of adolescents and young people supported in 12 countries, increasing access to information, addressing gender and social norms, and creating demand for services.

Objective 4: Amplify the lessons learnt from the implementation of the programme to strengthen SRHR, HIV and GBV services for all.

85+ Knowledge products developed

15 regional and **34** national communities convened to share lessons

4 Joint missions conducted

6 Countries adapted lessons learned from South-South exchanges

Regional SRHR Symposium facilitated

SRHR Knowledge Hub created

Programme achievements

Informed by the four guiding objectives, the 2gether 4 SRHR programme achieved significant results under the theme of the United Nations Delivering as One, and in the harmonization and domestication of regional and global commitments by countries.

The programme piloted and scaled-up the integration of SRHR, HIV and GBV services, and strengthened SRHR in universal health coverage (UHC). It focussed on adolescents and young people (AYP), as the largest and fastest growing proportion of the general population in ESA, and made substantial efforts towards ending unintended pregnancies and increasing access to comprehensive abortion care (CAC) within the confines of the laws of each country. Through all levels of the programme, activities addressed negative social norms which perpetuate and normalize GBV. In the face of the COVID-19 pandemic and amidst climate-related disasters and ongoing conflict in the region, the programme enhanced countries' capacity to provide SRHR in humanitarian settings; and to collect and utilize strategic information and data on SRHR.

The United Nations Delivering as One

The decision to create a Joint United Nations Regional Programme was driven by the need for a coordinated and cohesive approach by the four partner agencies to advance progress on SRHR in the ESA region.

The governance structure of 2gether 4 SRHR prioritized coherence, mutual accountability and joint ownership by the Participating United Nations Organizations (PUNOs), regional partners and the governments of the countries supported by the programme. With UNFPA as the Administrative and the Convening Agent, the programme was guided by the Strategic Leadership Forum (SLF) made up of the Regional Directors of the PUNOs and the leadership of Sweden's Regional SRHR team. The Regional Programme Steering Committee (RPSC) comprising representatives from the Swedish International Development Cooperation Agency (Sida), Regional Directors or their delegated representatives from each of the PUNOs, and Permanent Secretaries or their delegated representatives from country Ministries of Health.

The Regional Interagency Steering Committee (RISC), comprising the PUNO Deputy Regional Directors and Sida, provided programmatic oversight and ensured alignment with the agreements concluded with Sweden and harmonization with other joint United Nations initiatives and agency-specific global and regional strategies. During the programme period, the RISC replaced the RPSC as a more agile decision-making body for the programme. The Regional Interagency Working Group (RIWG) comprising senior technical advisers from the PUNOs, managed daily programme implementation, supported by the Monitoring and Evaluation (M&E) Technical Working Group and a Communications Task Force.

Harmonization and domestication of regional and global commitments

Enhancing SRHR through the harmonization and domestication of regional and global commitments can transform principles into actionable, context-specific policies for tangible impact at the country level. The programme provided technical support for the development and updating of regional frameworks against which countries could benchmark their national responses aligned to the Sustainable Development Goals (SDGs), the International Conference on Population and Development (ICPD) Programme of Action, the Maputo Protocol, and the Maputo Plan of Action.

At the regional level, these included support for processes around the renewed ESA Commitment to advance the SRHR of AYP, and support to the Secretariat of the East African Community (EAC) to develop regional standards on the integration of reproductive, maternal, newborn, child, and adolescent health (RMNCAH) and HIV. The programme supported the Secretariat of the Southern African Development Community (SADC) in the development of the SADC SRHR Strategy (2019–2030) and the SADC SRHR Scorecard, a high-level peer accountability tool to track progress in achieving the SDG targets. It provided support for the development of the SADC Regional Strategy for HIV Prevention, Treatment and Care and SRHR among Key Populations and the SADC Parliamentary Forum Minimum Standards for the Protection of

Key Populations, providing various protections for citizens of the region, and supported the adaptation of the SADC Minimum Standards on SRHR to guide the provision of integrated services.

Greater regional sharing and learning was fostered through convening regional forums of SRHR/RMNCAH and HIV managers in the EAC and SADC regions, and facilitated the involvement of regional CSOs in forums and platforms convened by the RECs, and brought together partners in a series of dialogues to prioritizes advocacy initiatives for the region.

Investments led to increased accountability for progress in meeting global, regional, continental, and national commitments through the use of peer accountability frameworks. The programme provided financial and technical support for the development of the SADC SRHR Scorecard, and assisted SADC Member States to track progress through populating the scorecard in 2019, 2021 and 2023. While the EAC RMNCAH Scorecard was developed in 2011, the programme provided assistance to populate the 5th version of the EAC RMNCAH Scorecard in 2021, with the 6th version of the scorecard under review in 2024.

The programme also facilitated numerous regional and national processes to extend the legal provisions to protect and advance SRHR in the region. It supported the East African Legislative Assembly (EALA), coordinated technical input by eight United Nations agencies, and facilitated dialogues by civil society and regional stakeholders on the East African SRHR Bill, and worked with the SADC Parliamentary Forum (PF) on the development of a Model Law on GBV.

Supporting the expansion of rights in countries

Support for advocacy and legislative processes at the country level resulted in 10 laws being passed which promoted the expansion of SRHR for AYP in Botswana and Zambia, greater awareness on the public health implications and the rights of women to access comprehensive abortion services in Malawi, Namibia and Zimbabwe, and protection from GBV with expanded prosecution of perpetrators of violence in Eswatini, Lesotho and Uganda.

Guided by the regional frameworks, the programme supported countries to align 19 national policies and 34 strategies and frameworks related to various SRHR and RMNCAH elements to global, regional and continental frameworks. Sixty (60) national guidelines were developed or updated to ensure the provision of quality-integrated services, aligned to global norms and standards.

The programme also strengthened national coordination on SRHR, built the capacity of countries on the latest developments on SRHR, and facilitated the sharing of emerging practices and case studies. This was facilitated through convening national and subnational multisectoral coordinating mechanisms for SRHR, HIV and GBV.

Strengthening sexual and reproductive health and rights in universal health coverage

The programme embedded SRHR within UHC to foster holistic well-being, recognizing SRH as a fundamental human right and an integral component of comprehensive healthcare which is accessible to all. Programme investments contributed towards advancing SRHR in UHC in the region, increasing the availability of strategic information and building country capacity on incorporating SRHR in UHC.

A nine-country study into the existence of essential packages provided insight into which of the nine essential elements of SRHR (as proposed by the Guttmacher-Lancet Commission) have been incorporated into health packages; and supported national processes towards the development of essential health packages in Kenya and Tanzania. A capacity-building workshop held in 2023 resulted in eight country roadmaps being developed with representatives from the governments of Eswatini, Kenya, South Africa, South Sudan, United Republic of Tanzania, Zambia, and Zimbabwe and CSOs, outlining tangible steps that countries will take to advance SRHR in UHC. The workshop contributed towards a pool of SRHR in UHC consultants from the region being capacitated and they have been added to the 2gether 4 SRHR Technical Assistance Hub.

Technical and financial support facilitated the development of spending assessments in Lesotho, Zambia and Zimbabwe; and the development of costed national or district plans to guide domestic financing and financial protection mechanisms for SRHR in seven countries (Botswana, Eswatini, Kenya, Lesotho, Uganda, Zambia and Zimbabwe). These processes have resulted in a better understanding of the financial resources required to implement SRHR, HIV and GBV programmes, allowing governments to develop budgets and consider the allocation of resources to ensure that SRHR services are adequately funded.

Technical support and continued advocacy contributed to the unlocking of domestic resources for the funding of condoms and contraceptive commodities in Kenya, Namibia and Zimbabwe; and for the HIV response in Uganda and training health-care workers in Botswana. Botswana, Lesotho, Namibia, and South Africa unlocked funding from the Unified Budget, Results and Accountability Framework (UBRAF) and the Global Fund.

Integration of sexual and reproductive health and rights, HIV and gender-based violence services

As the challenges of SRHR, HIV and GBV are interlinked in the region, the integration of related services is crucial to creating a comprehensive health ecosystem, addressing these interconnected challenges and promoting holistic care. The programme piloted the integration of SRHR, HIV and GBV services in select facilities in Kenya, Malawi, South Africa, Uganda, and Zambia. It scaled up the provision of integrated services in Botswana, Eswatini, Lesotho, Zambia, and Zimbabwe. This has resulted in an increase in facilities offering integrated services, with a recorded increase in the uptake of SRHR services. Funding for joint programming to strengthen the SRHR, HIV and GBV response for AYP and key and vulnerable populations was provided in Tanzania; and to advance access to SRHR and improve referrals for women and girls in South Sudan; resulting in improved access to quality integrated services and information for targeted populations in those countries.

Alignment, coordination and collaboration between relevant government departments at national, district and facility levels, and with other donor programmes and CSOs was improved, creating support for the integration of SRHR, HIV and GBV services and ensuring the sustainability of this approach in the region. Strategic assessments on integration were conducted in Botswana, Eswatini, Kenya, and South Africa, providing relevant stakeholders with insight into the effectiveness of integrated service delivery, identifying areas for improvement and guiding the strategic allocation of resources.

The programme also supported the development of policy platforms and normative guidelines to build systems capacity, providing guidance to countries to domesticate global, regional and national frameworks and priorities to inform the implementation of integrated services. All 12 countries supported by the programme adopted either the EAC or SADC frameworks on the integration of SRHR to guide the provision of rights-based, integrated services. All countries reported an increase in four or more of the indicators measured to track integration, with the most widespread increase being nine countries recording an increase in HIV testing offered at antenatal care (ANC) service delivery points (SDPs).

Human resources for health have been enhanced, and the capacity of health-care workers (including community health workers) to provide integrated SRHR services was built through developing or updating training curricula in Botswana, Lesotho and Zimbabwe, and providing training, mentoring and supportive supervision on the provision of integrated services to 44,704 health-care workers in facilities and communities in eleven of the twelve countries supported by the programme (Namibia did not undertake capacity-building on integrated services).

These efforts have resulted in improved service delivery, improved client retention, reduced time spent by clients at facilities, a reduced patient load for health-care workers, and improved case identification for GBV cases. Facilities also reported improved satisfaction for both health-care workers and their clients. These effects have cascaded to facilities not targeted by the programme through the movement of trained staff and sharing of experiences.

Engagements with traditional, religious and community leaders on the SRHR challenges faced by their communities have resulted in greater health awareness and empowered more people to access services. This has resulted in increased service uptake, most notable with changes to maternal health seeking behaviours in Botswana and Kenya. Innovative community-based integrated service delivery models were introduced across the region, providing greater access to services needed, particularly for populations otherwise left behind.

Working with adolescents and young people

As young people are the fastest growing segment of the population in the ESA region, prioritizing SRHR interventions for AYP is imperative, fostering a supportive environment that empowers this demographic with accurate information, skills and appropriate services to ensure their well-being.

The programme enhanced capacity for regional networks of AYP to meaningfully engage in regional and national legal and policy processes to advance and protect SRHR, through supporting engagements with Members of Parliament, facilitating linkages with strategic partners, and building capacity for networks on programme implementation, governance, project and financial management, advocacy, and M&E.

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Regional and national networks of young people were empowered and engaged to hold leaders to account for commitments made and to advocate for laws, policies and programmes that are responsive to the needs of adolescents and young people. This led to the voices of young people being heard during deliberations on the EAC SRHR Bill, renewal of the ESA Commitment, and ICPD Programme of Action. National processes in Botswana, Eswatini, Lesotho, Malawi, Zambia, and Zimbabwe resulted in young people engaging around

laws related to the age of consent to sex, and the age of consent for SRHR services and information; and placed adolescent SRHR on the agenda for decision-making bodies.

AYP have also been supported in engagements resulting in shifts in education policies, with greater access to CSE in Botswana, Lesotho, Namibia, Uganda, and Zambia, and the removal of barriers for pregnant girls to continue their education in Botswana, Lesotho, Namibia, and South Africa.

Youth-related policies have been adopted in Eswatini, Namibia and Uganda, and health strategies have been adopted in Lesotho, Uganda, Zambia, and Zimbabwe; further protecting the rights of young people to access services that meet their needs. This has increased access to adolescent and youth friendly services (AYFS) to reduce unintended pregnancies, HIV infections and increase the uptake of contraceptives.

AYFS has been adopted as a principle in all twelve countries supported by the programme, informed by national guidelines and supported in its implementation by the training of 10,000 health-care workers on AYFS. Service delivery has included youth and peer-led models, strengthened school health and referral systems, and adjusted opening hours to accommodate AYP.

The programme also supported peer-led community-based and information and communications technology (ICT)-supported interventions which contributed towards social and behavioural change among young people, and evidence from these has been used to inform policies, programmes and tools to improve service uptake delivery. The support for peer programmes for young mothers in particular has seen impressive results in improved HIV testing for male partners and infants, greater viral load suppression, and an increased focus on early childhood development. While loosely based on the Mothers2Mothers Mentor Mother Model for adolescent mothers living with HIV, these peer programmes were tailored for the countries in which they were implemented, based on research conducted into the unique needs of young mothers in each country.

The knowledge base for programming for AYP has been enhanced through operational research on young mothers, the drivers of adolescent risk, and the SRH needs of AYP. Knowledge products have been shared to support cross country learning and South-to-South collaboration.

Ending unintended pregnancies and unsafe abortions

Enhancing access to modern contraceptives to end unintended pregnancies and ensuring access to CAC guided by the legal frameworks of the countries to prevent unsafe abortion, are vital steps towards safeguarding reproductive and bodily autonomy, reducing maternal mortality, and fostering women's health and rights.

Regional inter-agency collaboration through 2gether 4 SRHR, and supported by the Access Project (under the UNFPA Supplies Programme), resulted in strengthened programming by 11 countries working on unintended pregnancies, contraceptives and unsafe abortion. Country roadmaps were developed to guide programming on these areas of work. A regional Research and advocacy group made of up of United Nations agencies, CSOs and academia collaborated to generate evidence, share research findings and to engage policy makers.

The programme placed the issue of unintended pregnancies, contraceptives and unsafe abortion on the policy agenda through engagements with Members of Parliament, CSOs and faith-based and traditional leaders, and through regional and national dialogues. This has to some extent transformed stigmatizing attitudes that prevent women from accessing these essential services.

The evidence base around the drivers of unintended pregnancies, barriers to contraceptives and unsafe abortion in the region was strengthened, through conducting strategic assessment to inform and guide future programming in Botswana, Eswatini, Lesotho, and Namibia. Investment studies and costing exercises were supported in Kenya, Mozambique, Namibia, and Zambia, giving insight to guide advocacy and resource mobilization.

The provision of quality-integrated contraceptive and safe abortion care services according to the legal frameworks of the countries was also strengthened. This included support to three countries to domesticate the 2022 WHO guidelines on abortion care (South Africa, Zambia and Zimbabwe), and conducting value clarification and attitude transformation (V-CAT) activities or clinical training with 2,295 health-care providers and policy-makers across nine countries, and training 1,813 health-care workers in seven countries on family planning and contraception.

The programme also strengthened strategic information on contraceptives and unsafe abortion to inform programming through a scoping review on the unmet need for family planning, unsafe abortion and GBV among female sex workers (FSWs). The MISP Readiness Assessment was used to undertake a sub-analysis of the extent to which countries are able to provide services in times of emergencies.

Routine monitoring and reporting through health management information systems (HMIS) was boosted, with a review of contraception and abortion monitoring tools and support for the development of registers and log-books on post abortion care (PAC) in Malawi and Uganda, and its inclusion in District Health Information Systems 2 (DHIS2) in Zimbabwe. The development and sharing of knowledge products, emerging practices and case studies further enhanced action in the region.

Support provided to **3 countries** (South Africa, Zambia and Zimbabwe) to domesticate the 2022 WHO guidelines on abortion care, and conducting **V-CAT activities** or clinical training with **2,295 health-care providers and policy-makers across 9 countries**, and training **1,813 health-care workers in 7 countries** on family planning and contraception.

Addressing harmful social norms and gender-based violence

Challenging harmful social norms and addressing GBV are critical to dismantling the barriers that impede SRHR, fostering an environment of equality, where individuals can exercise their SRH rights free from discrimination and violence, and the programme investments have gone some way towards addressing these in the region.

Capacity was built at the regional and national levels to enhance legislative and policy frameworks that address GBV. This included technical assistance on the EAC SRHR Bill, and for the SADC Model Law on GBV, and the framework and policy guidance tool to advance the SRH and rights of key populations and the SADC adoption of the United Nations Commission on the Status of Women (CSW) Resolution 60/2 on women, children and the girl child.

At the country level, technical support contributed towards the development or amendment of a range of laws and policies that prevent harmful gender norms, with consequences for perpetrators of violence, that go some way to addressing the prevalence of GBV in the region. Laws in Botswana, Eswatini, Lesotho, Malawi and Uganda were impacted in this regard.

The programme also supported the development of guidelines and policies on GBV services, and built capacity to enhance the GBV response and services for survivors of violence, with 4,222 health-care workers receiving specialized training in the provision of integrated SRHR and GBV services.

Male engagement was enhanced through the development of a framework for action for male engagement in the HIV response, and support for the facilitation of community dialogues and engagements with traditional and religious leaders and groups of men and boys, to create awareness and bring about a change of attitude towards SRHR and GBV.

Strategic information on gender and GBV has been collected and shared, through gender assessments conducted in Kenya, Malawi, Namibia, South Africa, South Sudan, and Tanzania; a rapid assessment of behavioural drivers related to SRHR service uptake and an assessment of the SRHR needs of adolescent boys and young men in five countries: Lesotho, Malawi, Uganda, Zambia and Zimbabwe; the development of an evidence-to-action brief in South Africa; and a regional review of gender-transformative approaches. The programme also saw enhanced data collection on experiences of violence.

Providing sexual reproductive health and rights in humanitarian settings

Delivering SRHR services in humanitarian settings safeguards the health and dignity of displaced populations by ensuring access to essential healthcare amidst crises.

The programme rapidly and effectively responded to provide technical guidance to monitor and ensure the continuation of SRHR services during COVID-19. This included the development of data collection tools and a data dashboard to provide policymakers with the information they needed. Regional guidance was developed to ensure the continuity of SRHR services, personal protective equipment provided, and 12,390 health-care workers were trained on the management of COVID-19.

The programme also successfully advocated for and supported governments to ensure the continuity of services and access to commodities and supplies during emergencies, through promoting the use of innovative approaches, such as tele-medicine, virtual counselling, multi-month dispensing, and community-based distribution channels, reducing the potential for increased HIV morbidity and mortality, unintended pregnancies and disruptions to the response to GBV.

The region is now better prepared to respond to future humanitarian crises through undertaking the MISP Readiness Assessment and developing country action plans in 22 out of the 23 countries in the region to ensure the continuity of SRHR and GBV services in emergency settings, through incorporating MISP in national disaster and preparedness response plan.

A suite of harmonized tools was also developed to strengthen the evidence-base for SRHR, HIV and GBV to be integrated into vulnerability assessment tools and coordination mechanisms across the ESA region, to improve a comprehensive understanding of the complex interplay between SRHR, HIV and GBV, enabling more efficient resources allocation for targeted and effective interventions, and improved coordination and collaboration.

Strategic information and data on sexual and reproductive health and rights

Robust strategic information and data on SRHR provide a foundation for evidence-based policymaking, programme effectiveness and resource allocation, driving informed decision-making and fostering accountability.

The programme strengthened tracking and accountability against regional and national SRHR commitments and frameworks through the development and updating of the SADC SRHR Scorecard and the EAC RMNCAH Scorecard to inform planning, prioritization and programming.

Country-level HMIS were enhanced to capture relevant SRHR indicators including demographic data, health outcomes and information on access to SRHR services. A regional review of country health information tools identified monitoring gaps, and the programme provided technical support to update their M&E frameworks and to develop country road maps to strengthen data capturing, reporting and use, thereby providing crucial information for evidence-based policy decisions.

Tools and job aids to enhance reporting were developed, and the capacity of health facility and district staff was built to generate user-friendly information products from routine data and other information systems, and to guide programming and service delivery. Eight countries were supported to strengthen their maternal and perinatal death surveillance and response systems, resulting in advocacy for the provision of quality maternal and newborn health services. Data mentoring in eleven countries has resulted in the development of country operational plans to address gaps in vertical transmission programmes, to advance the triple elimination of HIV, syphilis and hepatitis B.

Support for the development of platforms for the real time review of data in South Africa, Zambia and Zimbabwe allowed for the better use of information to guide timely decision-making at the facility and district levels, and the programme supported advocacy for the digitization of HMIS and strengthened capacity-building on DHIS2, as well as supporting efforts to pilot the WHO digital adaptation kits in Kenya, Malawi and Namibia, support for the procurement of equipment in Zambia, and the adoption of a digital health strategy in Zimbabwe.

The programme also strengthened community-led monitoring initiatives in Lesotho, Malawi, Namibia, South Sudan, Tanzania, and Zimbabwe, building a sense of ownership and accountability among community members for their own health outcomes and sustained support for SRHR initiatives.

Peer learning has been encouraged through shared approaches and resources for data and strategic information, resulting in improved collection and use of data and information and driving regional advocacy efforts to support developments in data and strategic information.

Key lessons learned throughout the programme include

- Agile and responsive leadership structures and some flexibility within the programme are needed to address contextual and operational challenges as they arise.
- Applying a regional lens to SRHR allows for a context-specific, coordinated approach that addresses the common challenges and opportunities within the region, and can foster peer learning and accountability for tailored and effective strategies at country-levels.
- Processes to create a more enabling environment for SRHR take time, and careful engagements with communities and cultural, political and religious leaders can help to facilitate access to SRHR and align local practices with national and regional frameworks.
- Useful and timely data, government leadership, the involvement of multiple stakeholders, clear guidelines and tools, and updated curricula and training on clinical management and attitudes, can enhance the integration of SRHR services for more effective service delivery.
- Policy measures and guidelines for the engagement of AYP are not fully operationalized, and building capacity for networks of young people can ensure that they are able to engage and hold decision-makers and providers to account on meeting their health needs.
- Misinformation leading to continued stigma around the issues of comprehensive abortion care, adolescent sexuality, CSE and key populations can be reduced through further engagements with communities, families and gatekeepers to ensure that the SRHR needs of all people are met.
- Innovative approaches to service delivery and to communication around SRHR, involving community-led approaches and harnessing new technology can enhance people's understanding, acceptance and uptake of health services.
- Supply-side challenges which impede access to SRH commodities, both in emergency and non-emergency settings, need to be addressed to ensure that all people can access the services that they need.
- Experiences from the COVID-19 pandemic can be used to guide future responses to crises, and more work is needed to ensure that SRHR, HIV and GBV are included in emergency response and preparedness plans.

These insights will inform Phase II of 2gether 4 SRHR, which will be implemented from 2023–2028.

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Based on the lessons learned from the programme, recommendations for Phase II include

- Encourage adaptive leadership and programme flexibility to respond to the changing context in the region.
- Further the regional approach to SRHR, through working with the African Union, EAC and SADC.
- Build on the progress made to date on creating an enabling environment for SRHR in the region, and strengthen engagements with communities, and political, religious and cultural leaders, to combat misinformation, reduce stigma surrounding SRHR, and enhance access to services.
- Continue to enhance the integration of SRHR, HIV and GBV services through the provision of timely data, government leadership, involvement of multiple stakeholders, clear guidelines, updated curricula, and training, ensuring effective service delivery.
- Operationalize policies for AYP through building the capacity of regional networks of young people.
- Embrace innovative approaches to service delivery and communication, including self-care, community-led strategies and leveraging new technology, such as digital health.
- Prioritize addressing supply-side challenges that impede access to SRH commodities in both emergency and non-emergency settings, ensuring equitable access to essential services for all people.
- Ensure the inclusion of SRHR, HIV and GBV in emergency response and preparedness plans, utilizing insights gained to guide future responses to crises effectively.

Sustainability and scalability

The programme's sustainability is anchored in its strategic approach, working at the regional level with the RECs, regional parliamentary forums, civil society and development partners and at the country level with Ministries of Health, fostering enduring collaborations and coordinated efforts, and laying the groundwork for sustained partnerships and shared responsibility among participating countries. The regional approach allows successes at the country level to be shared for scale-up, both within countries and within the region.

The likely long-term impact of the programme on SRHR outcomes is supported by the process of creating an enabling environment for SRHR through the development of laws, policies, strategies, and guidelines that empower and protect people to exercise their rights, and to access quality integrated services that meet their needs. Engagements with political, religious and traditional leaders and communities have established lasting relationships that will contribute to sustained support for SRHR initiatives.

Government leadership and stakeholder involvement in the integration of SRHR, HIV and GBV services has enhanced the programme's resilience and effectiveness over time, and the proven success of the integration approach means this is likely to be continued in the countries supported by the programme, and may cascade to other countries in the region.

Overall, the programme has had a significant impact on SRHR in the region. Report provides insight into the programme achievements, results and lessons learned and how these are being used to inform phase II.

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1 Introduction

2gether 4 SRHR is a comprehensive joint United Nations sexual and reproductive health and rights (SRHR) regional programme implemented by four United Nations agencies in East and Southern Africa (ESA). The programme was funded between 2018 and 2023 by the Government of Sweden through the Regional SRHR Team of Sweden with an award of US $59,627.295.13. This report documents the key results and lessons learnt from the implementation of the first phase of the programme between 2018 and 2023.

The vision of the programme is that all people, particularly adolescent girls, young people and key populations in the ESA region are empowered and supported to exercise their sexual and reproductive health (SRH) rights and access quality integrated SRHR services, so that they enjoy a healthy life.

Fostering the 'Delivering as One' agenda of the United Nations, the programme combines the unique strengths and contributions of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO) to provide catalytic support to Regional Economic Communities (RECs), regional forums of parliamentarians, governments, civil society and communities in the ESA region to contribute towards fast-tracking the attainment of the SRHR-related targets of the Sustainable Development Goals (SDGs), specifically SDG 3 (Good Health and Well-being) and SDG 5 (Gender Equality) in ESA.

The UNFPA Resource Mobilization Branch, Division of Communications and Strategic Partnerships (DCS) served as the Administrative Agent for the Joint Programme, and UNFPA East and Southern Africa Regional Office (ESARO) served as the convening agent for the Joint Programme.

Programme scope

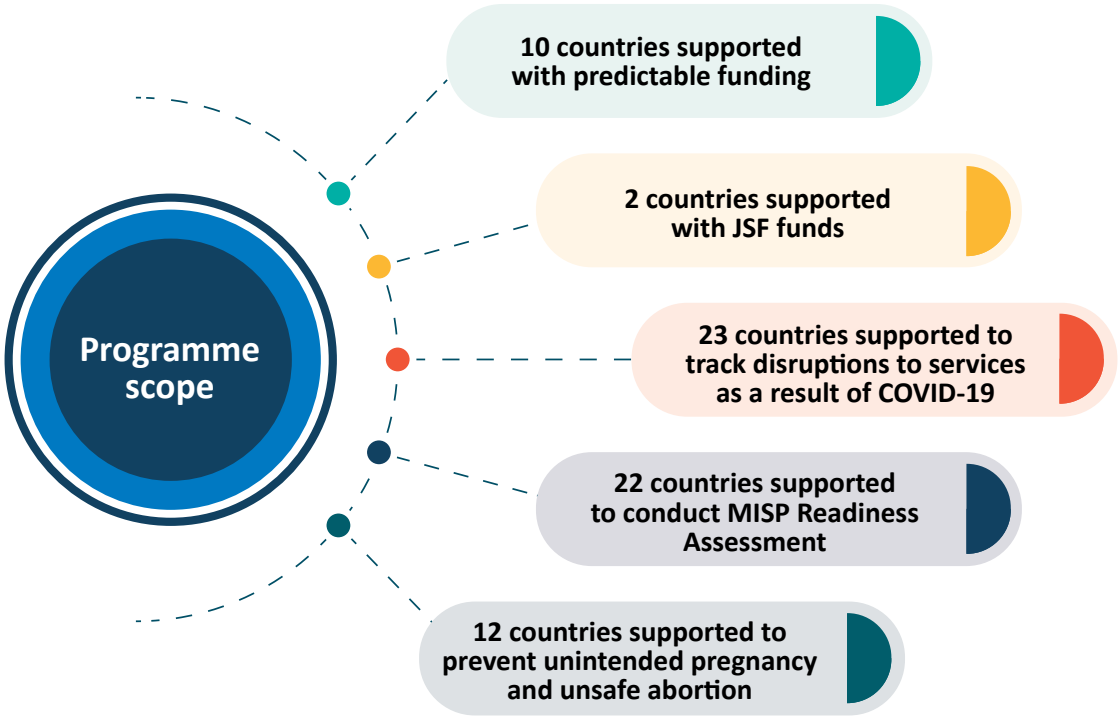
The programme is regional in scope with applied learning in countries. At the regional level, the programme worked in partnership with the Southern African Development Community (SADC) and the East African Community (EAC), regional forums of parliamentarians, human rights institutions, regional civil society organizations (CSOs) and networks of beneficiaries to harmonize the response through supporting the development of regional frameworks, norms and standards, and peer accountability tools (such as scorecards) linked to continental and global commitments.

While the programme provided support for CARMMA Plus and the African Union Youth Humanitarian Summit; systematic strategic engagement with the African Union was limited during the programme period. Greater engagement at this regional level is prioritized for Phase II of the programme.

The programme supported applied learning in countries through providing predictable funding to teams of the four Participating United Nations Organizations (PUNOs) in five focus countries, namely: Lesotho, Malawi, Uganda, Zambia, and Zimbabwe. This was later expanded to nine countries, with the inclusion of Eswatini, Namibia, South Sudan, and Tanzania, through the Joint SRHR Fund. Botswana, Eswatini, Kenya, Namibia, and South Africa were supported with predictable funding through UNFPA. Predictable funding allowed the countries to develop four-year plans to test or scale up models and approaches to strengthen SRHR outcomes from which lessons could be learnt, documented and amplified across the region.

Catalytic financial and technical support was also provided to countries to address emerging or neglected areas. For example, the programme supported all 23 countries in the region to undertake quarterly tracking of the disruption of services owing to COVID-19, and supported 22 countries to assess their preparedness to provide the Minimum Initial Service Package (MISP) of SRHR in humanitarian settings. Eight countries initiated efforts to address unintended pregnancies and unsafe abortion within the legal parameters of their country, and this support expanded to 12 countries at the end of the programme period.

High-level and continuous advocacy and technical assistance, including by the PUNO leadership, has also been extended to countries outside of the 12 countries supported by the programme, and has resulted in legal and policy changes towards securing greater access to SRHR across the region.



Report outline

This close-out report provides an overview of the results of Phase I of 2gether 4 SRHR informed by baseline and endline data collected at the regional level by the supported countries; regional and country PUNO close-out reports; documented emerging practices, case studies, human interest stories; knowledge-sharing workshops held in and between the participating countries; regional annual reports; the mid-term review (2018–2019), the 2021 programme evaluation, the 18-month programme report (January 2021–June 2022), and the report of the 2022 Regional SRHR Symposium.

While previous reporting on the programme has been arranged under the four programme objectives, this close-out report is presented by thematic area to allow for a more holistic perspective of the programme's achievements. The report reflects how the programme objectives are interconnected, how progress in one area influences or supports progress in another, and how different programme elements interact and contribute to the changes effected as a result of the programme.

For this reason, the results of the programme are clustered under key thematic areas where there has been significant learning and where the programme investments have brought about change.

These include:

The United Nations Delivering as One;	Harmonization and domestication of regional and global commitments;	Strengthening SRHR in UHC;
Integration of SRHR, HIV and GBV services;	Working with adolescents and young people;	Ending unintended pregnancies and unsafe abortions;
Addressing social norms and GBV;	Providing SRHR in humanitarian settings;	Strategic information and data on SRHR.

Under each section of the report, specific results are highlighted and the achievements that led to these results are outlined. Practical examples are presented as case studies, and the conclusions drawn on each thematic area are reflected as lessons learned which will inform Phase II of the programme. The conclusion of the report reflects on how the achievements under these thematic areas have led to the programme meeting its objectives, with considerations on the sustainability of the programme investments.

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Programme Context

While there has been significant progress on SRHR in the region during the course of the programme, this has been uneven for some demographic groups and on some SRHR issues. Key obstacles to advancing SRHR in the region include a dominant negative cultural framing of SRHR issues, a growing anti-rights movement, legal restrictions on the provision of some services to some populations, and in some instances, limited political leadership and commitment to implement comprehensive rights-based approaches and to fund SRHR policies and programmes.

The negative framing of SRHR has led to some restrictions on SRH rights and access to services in the region over the period of implementation, including a ban on public advertising of contraception and the provision of condoms for key populations (Tanzania, 2018 and 2019), policy proposals on women requiring spousal consent before accessing contraceptives (Uganda, 2019), a ban on the distribution of female condoms in public health facilities (Zambia, 2019), and a proposed new law to increase the legal age of marriage from 18 to 21 years (Malawi, 2021). Restrictions on the freedom of expression and association of lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) groups in Eswatini, Kenya, Malawi, Tanzania, and Uganda have been noted.[1] The rise of the anti-rights movement in the region, which seeks to criminalise same-sex relationships with penalty, has resulted in growing discrimination, harassment, personal attacks and and the displacement of LGBTQI people. At the same time, several countries have repealed Acts that discriminate against LGBTQI.

Added to these threats are the growing population of young people in the region, high fertility rates, poor sanitation and hygiene, malnourishment, a lack of gender equality, high levels of violence against women and children, high levels of HIV, limited capacity in health and medical care, ongoing violence and conflict in some parts of the region, and the impact of climate change and increased incidence of natural disasters.

Many of the threats listed above were exacerbated by outbreaks of disease such as cholera (in Malawi, Kenya, Zambia, and Zimbabwe) and Ebola (in Uganda), and most significantly by the COVID-19 pandemic. Numerous climate events impacted on the region, and this series of humanitarian disasters, a weakened health system, geopolitical tensions, the increased cost of living and the ongoing economic shock of the COVID-19 pandemic have reduced the fiscal space for the SRHR response, while the pandemic itself increased the poverty gap and exacerbated inequality in the region.

In this challenging context, the programme worked in partnership with the African Union, the EAC, the SADC, governments, and regional CSOs and networks of communities to advocate for and advance SRHR in the region.

[1] Southern African Litigation Centre (2022) and Human Rights Watch (2023).
[2] https://www.hrw.org/news/2024/04/04/uganda-court-upholds-anti-homosexuality-act.

Laws and Policies Impacted by 2gether 4 SRHR Programme 2018 - 2023

Integration of SRHR, HIV & GBV

Adoption of regional guidelines
Botswana; Eswatini; Kenya; Lesotho; Malawi; Namibia; South Africa; South Sudan; Uganda; United Republic of Tanzania; Zambia; Zimbabwe.

Development of national frameworks and plans
Botswana; Lesotho; Kenya; Malawi; Uganda; Zambia; Zimbabwe.

Integrated services accessible
Botswana; Eswatini; Kenya; Lesotho; Malawi; Namibia; South Africa; Uganda; Zambia; Zimbabwe.

Unintended Pregnancy and Comprehensive Abortion Care

Termination of Pregnancy Act
Malawi; Zimbabwe.

Comprehensive abortion care legislation
Namibia; Botswana

Costed plans or investment case
Kenya; Mozambique; Namibia; Zambia.

Adolescent and youth-friendly services

11 Laws
Botswana (2); Eswatini; Lesotho; Malawi; Namibia(2); Uganda(2); Zambia (2); Zimbabwe.

Gender-Based Violence

9 Acts and Laws
Botswana (2); Eswatini(2); Lesotho; Malawi; Namibia; Uganda(2).

1 Regional Law
SADC GBV Model Law.

Key Populations

Botswana: ***Penal code (Amendment) Act, 2018***
Uganda: ***The Sexual Offences Bill.***

Regional Policy:
SADC Parliamentary Forum (SADC-PF) Minimum Standards for the protection of the SRHR of key populations in the SADC region.

Family Planning

Botswana (2), South Africa (2), Malawi, Zimbabwe, Namibia (2)

SRHR in UHC

Costed national plans and assessments:
Botswana; Eswatini; Kenya; Lesotho; Namibia; Uganda; Zambia; Zimbabwe.

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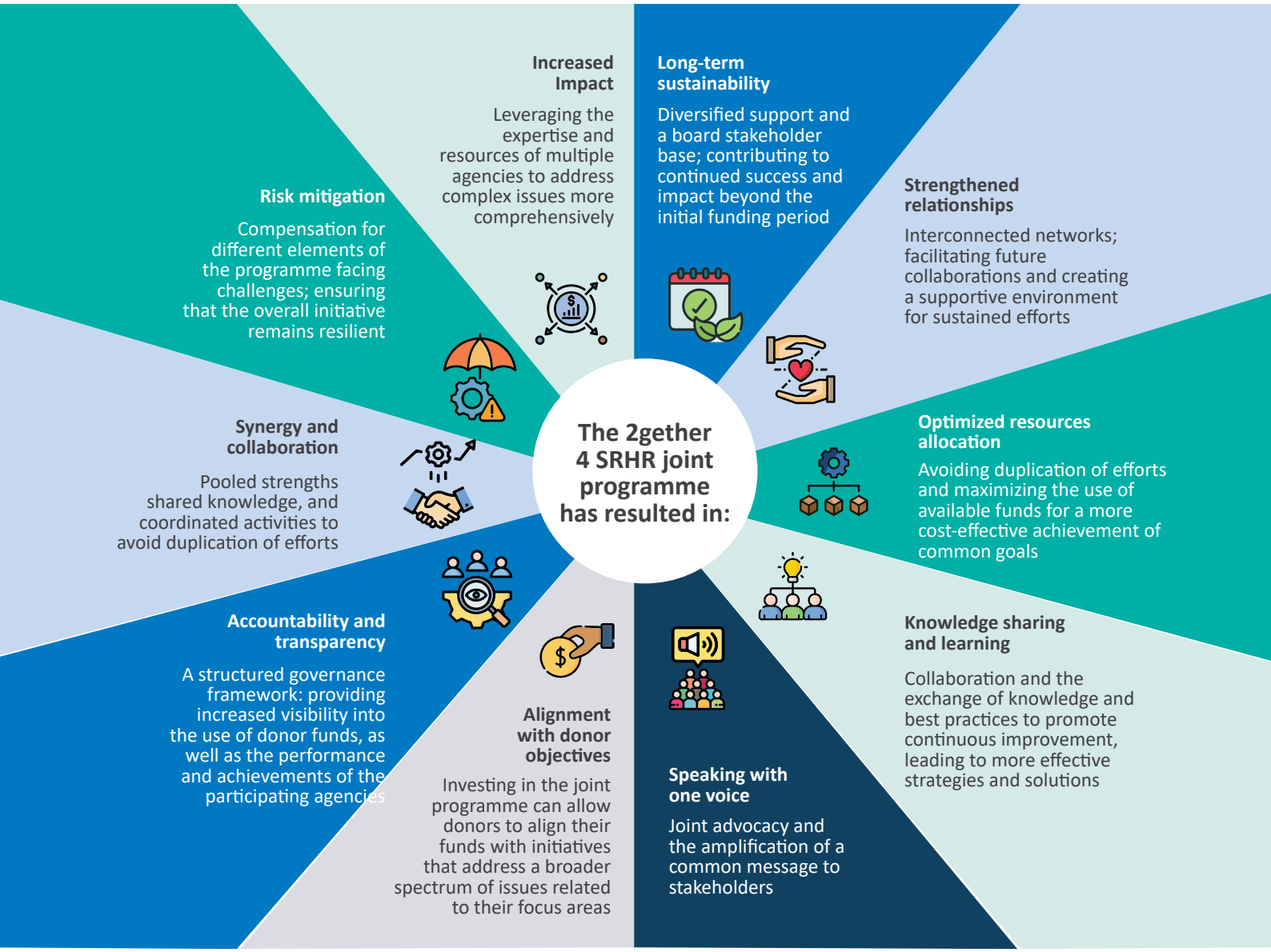
Photo credit © Canva

3 The United Nations Delivering as One

Delivering as One is a core principle of United Nations' programmes that emphasises the need for a more coordinated and cohesive approach among different United Nations agencies, funds and programmes operating in a specific country, and is a guiding principle of the 2gether 4 SRHR programme. The programme adapted the United Nations Development Group (UNDG) guidance notes to inform the development and implementation of the Joint Programme at regional level, including its leadership; the development of joint workplans and budgets aligned to regional priorities as defined by the RECs; and communicating as one.

The UNFPA Resource Mobilization Branch, DCS, served as the Administrative Agent, and UNFPA ESARO was the convening agent for the programme in compliance with the 2015 UNDG guidelines.

Benefits of Delivering as One



The relationship between the Regional SRHR Team of Sweden and UNFPA was guided through a Standard Administrative Agreement that outlines the responsibilities of UNFPA as the Administrative Agent of the Joint Programme, including donor liaison.

The relationship between UNFPA as the Administrative Agent and the four PUNOs was governed by a MOU outlining the terms and conditions governing the relationships, implementation, M&E, and financial management of the programme. Programme implementation was coordinated by UNFPA ESARO who established a programme management unit led by a Programme Manager, a Programme Coordinator, an M&E Specialist, a Financial Analyst and a Programme Administrator.

Leadership

The Strategic Leadership Forum (SLF), consisting of PUNO Regional Directors and the leadership of the Regional SRHR Team of the Swedish International Development Cooperation Agency (Sida), engaged in strategic conversations on key issues affecting SRHR in the region. While the plan was to convene SLF meetings annually, only three virtual SLF meetings were convened during the programme period. These allowed leadership to address the continuity of SRH services during COVID-19, the emergence of the anti-rights movement in the region, and how the restrictive legal and policy environment impacts on the ability of people to exercise their SRH rights. The Regional Programme Steering Committee (RPSC) was the highest decision-making

body of the Joint Programme. It comprised the Regional Directors from each of the PUNOs or their delegated representatives, representatives from the Secretariats of the EAC and SADC, and the Permanent Secretaries or their delegated representatives from the Ministry of Health of the countries supported by the programme for applied learning. The Regional SRHR Team of Sweden participated as an observer to the RPSC.

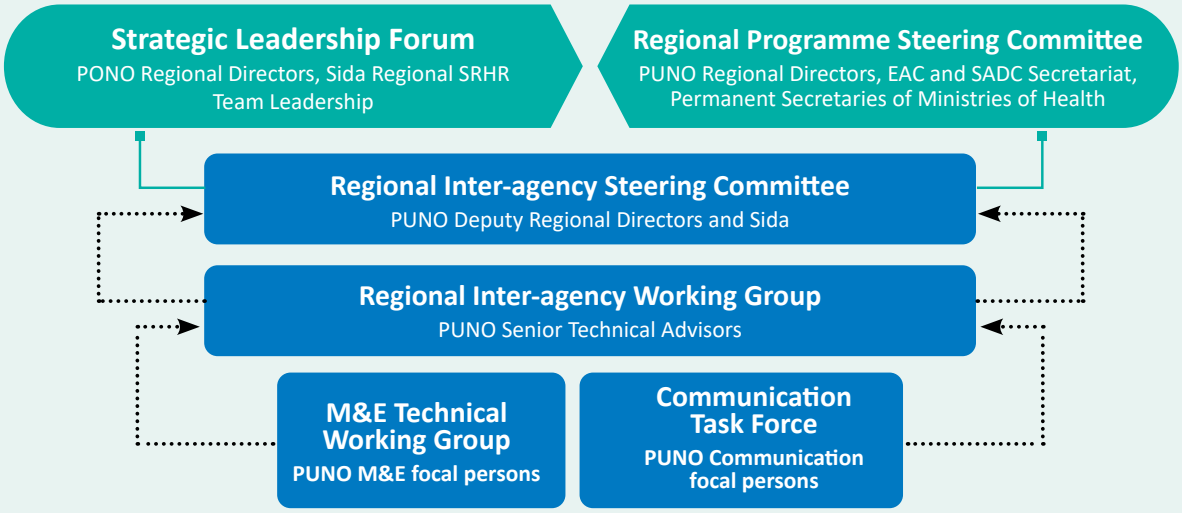
The RPSC met annually to review and approve the annual workplan and budget, provide strategic guidance to programme implementation, monitor progress and results as defined in the Joint M&E Framework. The RPSC served as a platform to sensitize countries on regional priorities as defined by the RECs, a forum for sharing emerging practices, south-to-south learning, and an opportunity for the PUNOs and governments to engage on areas of mutual interest. RPSC meetings were moved to a virtual platform during COVID-19, which limited the time and quality of engagement.

While EAC and SADC were members of the RPSC, they seldom had the capacity to attend meetings, and bringing together all members of the RPSC was not an effective approach to decision-making. To ensure greater efficacy, efficiency and the use of resources, the RPSC was transitioned to the more agile Regional Interagency Steering Committee (RISC), composed of the PUNO Deputy Regional Directors and Sida. This transition was based on the evolution of the programme in the last 2 years of Phase I of the programme, from a multi-country programme with predictable funding, to regional programming providing technical support, catalytic funding, knowledge management and learning.

The RISC strengthened programmatic oversight, alignment and harmonization with other joint United Nations initiatives and agency-specific global and regional strategies. The RISC reviewed and approved the annual workplans and budgets, monitored programme implementation to ensure that programmatic and financial implementation were aligned to the Joint Programme document, and worked to resolve any inter-agency conflicts or barriers to implementation. The RISC also served as a platform to identify common areas for promoting SRHR in the region and to respond to emerging issues, risks and changes, such as the COVID-19 pandemic. RISC meetings were held quarterly from 2021–2023 to coincide with the last 2 years of programme implementation.

The formation of the RISC also recognized that most countries drew on existing coordination mechanisms to coordinate programme implementation, review workplans, progress made and financial expenditure that included their government counterparts. Mechanisms used by countries included increasingly structures aligned to the United Nations Development Assistance Framework (UNDAF) or the United Nations Sustainable Development Cooperation Framework, the Joint United Nations Teams on AIDS (JUNTA), and the H6 partnership.[3]

Programme structure



[3] The H6 partnership (formerly H4+) harnesses the collective strengths of UNAIDS, UNFPA, UNICEF, UN Women, WHO, and the World Bank Group to advance the Every Woman Every Child Global Strategy and support country leadership and action for women's, children's and adolescents' health.

Management

The Regional Interagency Working Group (RIWG), composed of senior technical advisers from the four PUNOs, oversaw the day-to-day implementation of the programme, and facilitated inter-agency collaboration and synergy on key areas drawing upon regional technical experts from across the four PUNOs to support programme implementation.

The programme adopted the responsible, accountable, consulted, and informed (RACI) model to ensure a coordinated approach towards Joint Programme implementation, monitoring and reporting. The RACI model is used by UNICEF, one of the participating agencies, and was chosen as a suitable model to delineate roles of the different the four PUNOs at the level of activity. The RACI model provided clarity in terms of the roles and responsibilities of the PUNOs, leveraging off their respective mandates and strengths. During the work planning process, the roles and level of involvement of each PUNO were identified against a corresponding activity.

The RIWG focal persons from the four participating agencies coordinated the development of the annual joint workplan and annual reports within their respective agencies. The RIWG reviewed the joint annual workplans and budgets developed by the PUNO technical teams in consultation with national government structures from the countries supported by the programme. These were submitted to the RPSC, and later to the RISC for approval. The development of a consolidated workplan aligned to the programme document and five subsequent amendments ensured that programme implementation, monitoring and reporting were aligned.

The work of the RIWG was coordinated through monthly meetings, mid-year review meetings, and annual progress meetings to track and report on progress. The RIWG also used ad-hoc communication as required to ensure that decisions were made timeously to ensure the efficient and effective implementation of the programme.

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Communication

Under the guidance of the RIWG, a regional Communication Task Force, led by UNICEF, oversaw the implementation of the 2gether 4 SRHR communication strategy. The Communication Task Force built on each agencies' communication architecture regionally and in-country, capitalizing on the expertise of their communication specialists.

A brand guide informed the branding and the use of the 2gether 4 SRHR name and logo on knowledge products developed by the programme. This guide emphasised the importance of communicating as 'One United Nations Voice', rather than four separate agencies, each with their own distinct logos and branding styles. This approach made certain that recognition was given to the collective efforts of 2gether 4 SRHR, rather than any single agency.

The joint communication strategy and brand guide promoted collective ownership, and a harmonized approach to the development, branding and sharing knowledge resources produced through the programme. Knowledge products produced by the Joint Programme were shared through the programme website which was embedded as a microsite within the UNFPA ESARO website, and were compiled into a published compendium of knowledge products. The recognition that more could be done to increase the visibility of the programme, knowledge management and sharing of resources led to the development of the Knowledge Hub in 2023, as a one-stop-shop for knowledge products. A beta version of the site has been launched for inputs.

The sharing of global and regional technical guidelines, knowledge products, and the amplification of emerging practices, and case studies were further disseminated through the meetings of regional SRHR and reproductive, maternal, newborn, child and adolescent health (RMNCAH) managers convened with the EAC and SADC and through RPSC meetings.

The programme convened the Regional SRHR Symposium in Zimbabwe in 2022, which served as a platform to share country experiences and to demonstrate the impact of the programme's investments and the success of Delivering as One United Nations. The learnings shared through the symposium, together with programmatic research and other relevant knowledge products are available on the Knowledge Hub.

Monitoring and evaluation

The regional M&E Technical Working Group, led by UNFPA and comprising technical representatives from the four participating agencies, developed the joint M&E Plan for the programme, developed the baseline, and tracked results against the joint results framework. The M&E Technical Working Group oversaw programme reviews including the mid-term review and end-of-programme evaluation, provided technical support to PUNO technical teams in the countries supported by the programme, and provided input into the development and dissemination of knowledge products.

Guided by the joint results framework, a common data platform, Data for All, was used to track and report on progress on regional and country-level programme activities and results. This was useful in joint evidence generation and analysis, which informed programme implementation.

The M&E framework was integral to informing programme decisions and steering programme implementation. The M&E system tracked performance of workplans and progress at activity level, which were compiled into annual reports consolidated against the outcomes and outputs of the programme.

An internal mid-term review conducted in 2020 recommended modifications to strengthen the programme management and implementation. This included prioritizing advocacy for the translation of regional SRHR policies and strategies into national action, and for scaling up the integration of SRHR, HIV and GBV services; and collaborating more closely with other regional and global initiatives. The review recommended strengthening support for integrated services through the development of a Technical Assistance Hub, improved data and HMIS and convening regional fora to share experiences. It further recommended strengthening work on gender, key populations and adolescents and young people (AYP), strengthening joint advocacy on SRHR among organizations in the region, and boosting regional, national and social accountability. These recommendations were taken into the second half of the programme, and are reflected in this report.

An external evaluation of the programme was commissioned by the Regional SRHR Team of Sweden in 2021. The evaluation assessed the progress of the programme and documented lessons learned, and informed how implementation can be improved in a potential new phase of the programme. The evaluation was limited by the short time allocated, deadlines that could not be extended and COVID-19 that limited visits by the evaluators to countries. Key findings and recommendations were used to inform the proposal for Phase II of 2gether 4 SRHR.

As the programme drew to a close, an end-line survey was conducted to collect data against the 2018 baseline indicators (collated in the baseline report). Each country developed a narrative close-out report, reflecting on their achievements, challenges and lessons learned. These provided insights into changes that can be attributed or that the programme has contributed towards in each country as a result of its implementation. This is reflected in the collated programme data.

Administration

As the Administrative Agent, the UNFPA Resource Mobilisation Branch, DCS, were accountable for requesting and receiving and disbursing funds from the Regional SRHR Team of Sweden. Based on the approved workplan and budget, funds were disbursed to the four participating agencies, using a pass-through modality.

Each agency then disbursed funds to their respective regional and country offices, using their own financial policies and procedures, to support the implementation of regional activities, and to promote applied learning in the supported countries.

Inter-agency adaptations and new ways of working

The differing systems of the four respective agencies did raise some operational challenges which required new ways of working. For example, incompatible information technology system constrained knowledge management, as PUNOs use different document-sharing platforms. The RIWG devised solutions to work around these, developed new SOPs for various internal procedures, such as review and approval of communications products, and used the workplan and RACI model to divide responsibilities for jointly convened meetings and activities.

Throughout the implementation period, the programme had to adapt to shifting needs, priorities and funding cycles. Five amendments to the original agreement were developed, submitted, revised, and processed. The amendment processes involved constructive dialogues between partners, as well as programmatic and budgetary deliberations to develop programme documents, workplans and budgets. The lessons from the programme are captured in a report on Delivering as One United Nations.

Lessons learned from Phase I	Application in Phase II
PUNO country offices experienced some complexity with coordination and delays due to different mandates, financial systems, and unaligned financial years between agencies.	Phase II will include concerted efforts from technical staff to apply the principle of Mutual Recognition and put in place compatible systems to meet the minimum operational requirements of each PUNO, to facilitate programme delivery.
Lighter governance structures allow for a nimbler decision-making body, and the agile RISC ensures strategic engagement at the regional level.	The RISC will continue to oversee Phase II of the programme, will the RIWG as the dedicated management team.
A more strategic approach is possible when approaching global commitments through a regional lens, with leadership commitment from all partners.	Phase II will focus on efforts at the regional level through providing support for the RECs and working with other regional actors.
Increased capacity and budgets for programme monitoring and evaluation at the country level would result in better monitoring and reporting.	Phase II will include capacity building and a shift towards results-based reporting on the programme, and increased budgets for M&E.
The brand identity of the programme can be boosted.	Phase II will use the standalone website www.2gether4srhr.org, capacity will be built for the communications focal points from each PUNO, and an updated branding guide will be developed to enhance the visibility of the programme.

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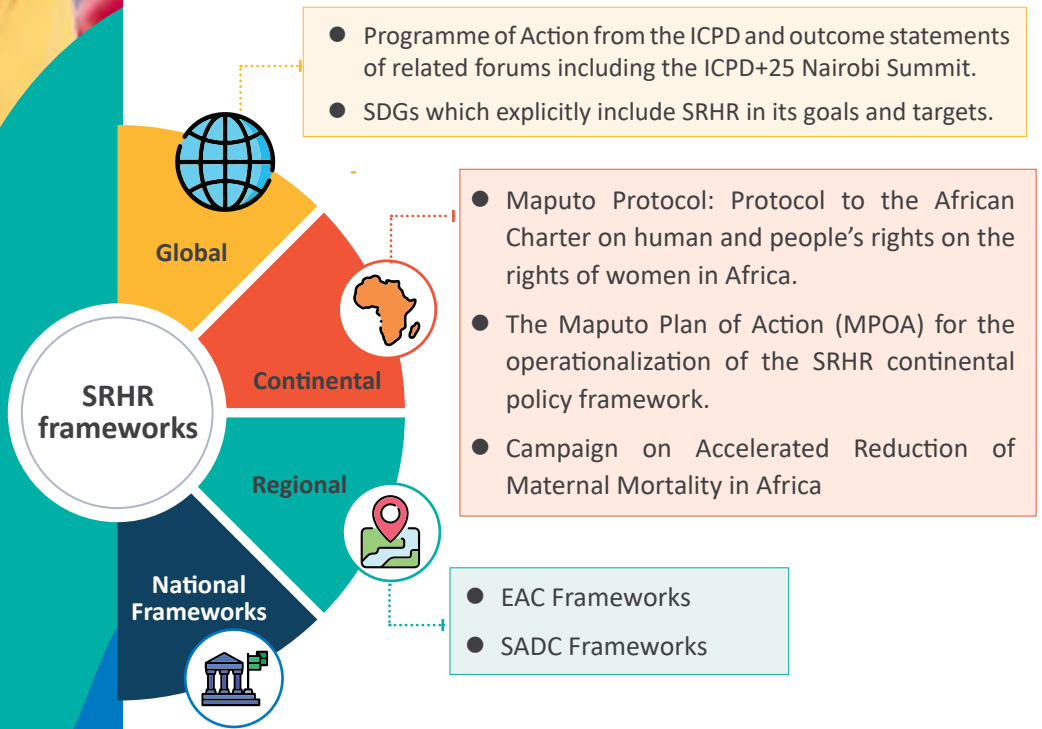
Harmonization and Domestication of SRHR Commitments

The 2gether 4 SRHR programme is informed by global, continental and regional frameworks on SRHR. Translating these commitments into national policies, norms and guidelines can be hampered by cultural, political and religious sensitivities, resulting in selective and sometimes rushed domestication; and impacting on the implementation of national SRHR programmes.

Efforts towards harmonizing and domesticating commitments enables the integration of globally recognized standards and best practices into local frameworks to enhance SRHR, strengthening countries' accountability within the region and to the international community, and fostering a collaborative environment that encourages shared learning and the exchange of successful strategies to advance SRHR.

SRHR frameworks guiding the programme



The programme ensured that regional frameworks were benchmarked against global and continental frameworks and were developed or updated accordingly; and in turn that national frameworks were benchmarked against the regional frameworks. Although the programme referenced global and continental frameworks to inform programming and supported monitoring on these frameworks, the bulk of the interventions was to support regional and national frameworks to harmonize the regional SRHR response.

Achievements in the harmonization and domestication of commitments

SRHR advanced and **protected** through the review, amendment or enactment of **3 regional laws and standards and 10 national laws**

Standardization enhanced through the development of **5 regional frameworks** against which countries can benchmark their response

SRHR advanced at country level through the development of **19 policies and 34 strategies**

Quality, standardized **service delivery** guided by the development of **60 national guidelines**

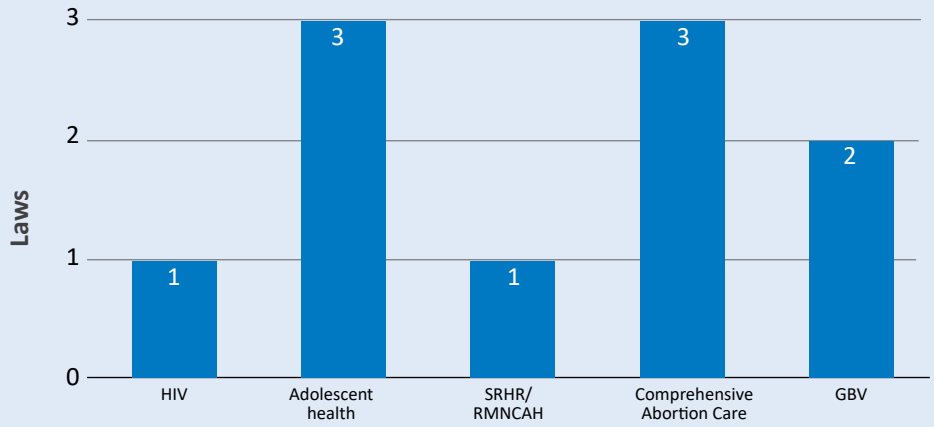
Regional and national **coordination** and **capacity** strengthened across **23 countries**

Accountability for meeting progress against SRHR commitments increased through the development of the **SADC Scorecard** and enhancement of the **EAC Scorecard**

Consistency enhanced through the alignment of **6 national accountability mechanisms** to regional scorecards

Lessons learned **amplified** through the development of **6 related knowledge products**

National Laws per thematic area



Objective 1

RESULT 1: The programme facilitated regional and national processes to extend the legal provisions to protect and advance SRHR in the ESA Region.

EAC SRHR Bill: The programme provided technical support to the East African Legislative Assembly (EALA), working in partnership with legislatures, the EAC Secretariat and civil society partners to develop the EAC Sexual and Reproductive Health Bill. The programme supported the General Purpose Committee to incorporate contents of the Bill with inputs from technical experts from the EAC Partner States, United Nations agencies, civil society and others towards aligning the provisions of the Bill with global, continental and regional commitments agreed to by Partner States of the EAC. The programme supported sensitization and engagement of key actors in the EAC on key areas of SRHR and the need to address social and gender norms that frame discourses and undermine the ability of people in the EAC to exercise their SRH rights. The programme also supported the development of fact sheets on key areas of SRHR and communication products around the SRHR Bill, in advance of the public hearings around the Bill, which took place in the second quarter of 2022. The Bill was saved when the EALA was disbanded following elections for new members of the Assembly. The intention with saving the Bill is to allow the newly appointed EALA to take forward the Bill when constituted. Although not passed, the draft bill and the regional dialogues have allowed for open discussions on SRHR which could result in prioritization and resourcing of key SRHR issues. When passed into an Act, the Bill has the potential to significantly expand SRH rights and services to the 117 million citizens who reside in the six Member States of the EAC, namely: Burundi, Kenya, Rwanda, Uganda, Tanzania, and South Sudan.

SADC Model Law on GBV: A model law refers to a legal framework developed by SADC Member States to provide guidance and harmonization on specific issues within the region. These model laws serve as templates or benchmarks for Member States to use in formulating or amending their own national legislation to ensure alignment with regional standards and objectives. The programme provided financial and technical supports for regional stakeholder consultations and communications processes towards the development of the SADC Model Law on GBV. UNAIDS, UNFPA and UNICEF were part of a technical working group that led the development, crafting and review of the Model Law and provided support on the development of related workplans and processes for its finalization. The SADC Model Law on GBV was finalized in 2021, and popularization and adaptation of the Model Law across the countries are in process. The SADC Model Law will ensure enhanced GBV prevention and response, impacting especially on women, who make up more than half of the 345 million people in the SADC region.

SADC Parliamentary Forum Minimum Standards for the Protection of Key Populations in the SADC region: The programme supported the finalization of the SADC Parliamentary Forum (SADC-PF) Minimum Standards for the protection of the SRHR of key populations in the SADC region. They set out comprehensive guidelines to provide a minimum threshold of acceptable protection for key populations, and include reducing stigma and discrimination, ending violence against key populations, monitoring and reforming laws and policies, and ensuring access to information and services.

Advancing SRHR for key population in Botswana

In May 2022, a dialogue was held with Members of Parliament on advancing the SRHR of populations left behind in Botswana. The two-day dialogue brought together 21 Parliamentarians from four parliamentary committees together with civil society and development partners. The dialogue developed a common understanding of the factors that facilitate vulnerability to negative SRH outcomes and identified opportunities and recommendations for Parliamentarians to advance SRHR and HIV and AIDS-related services for those left behind, specifically persons living with disabilities and KPs.

The programme supported legislative processes and contributed to advocacy efforts by other programmes in nine countries to extend SRHR:

- Botswana upheld a ruling decriminalizing same-sex relationships in 2019. Before this ruling, same sex was punishable by up to 7 years in jail.

- The Botswana Penal Code was amended, raising the age of consent to sex from 16 to 18 years. While this is recognized as being designed to protect young people; given that the median age of sexual debut in the region is between 15 and 19 years, with a significant proportion indicating sexual debut below the age of 15;[4] there is a risk that sexual activity between consenting adolescents will be criminalized if the age of consent is set too high. The Botswana Penal code included a 'Romeo and Juliet clause' making allowances for this, ensuring that consensual sex between young people is not criminalized when there is not more than a 2-year age difference between them.

- Zambia finalized the minimum age of consent to information at 10 years, and has set staggered ages of consent for adolescent SRHR, HIV and GBV services by type of service to be provided. The details of these ages are currently embargoed.

- Namibia, Malawi and Zimbabwe engaged in national processes to expand the rights of women to access comprehensive abortion care (CAC). Although not passed, these processes opened up discussions in areas that were previously not discussed and provided insights and lessons learnt on actions to be taken to extend these rights in future.

- Laws in Eswatini, Lesotho and Uganda were supported to make provisions for GBV. Eswatini's Sexual Offences and Domestic Violence Act (2018) was passed and includes provision on the offence of sexual harassment and protection of victims with special measures to protect children.

- Lesotho enacted the Counter Domestic Violence Act that increases the measures to protect survivors and address perpetrators. Uganda's Sexual Offences Bill was passed by Parliament, but not yet fully accented to, and it makes provisions towards addressing sexual violence.

Photo credit © United Movement!/ 2gether 4 SRHR

[4] (Ref: 3 Ferry, B et al. "Comparison of key parameters of sexual behaviour in four African urban populations with different levels of HIV infection." AIDS August 2001, Vol 15, p S41 – S50; Zaba B et al. "Age at first sex: Understanding recent trends in African demographic surveys." Sexually Transmitted Infections 2004, Vol 80, p ii28 – ii35.

Objective 1

RESULT 2: The programme advanced and protected SRHR in the ESA region through the development and updating of regional frameworks against which countries could benchmark their national responses aligned to the SDGs, the International Conference on Population and Development (ICPD) Programme of Action and continental frameworks such as the Maputo Protocol and the Maputo Plan of Action.

ESA Commitment: The programme supported the renewal of the *ESA Ministerial Commitment to enhance the education, health and well-being of youth* in the region. Efforts were led to and coordinated by the ESA Commitment Working Group comprising of SADC, the EAC and six United Nations Agencies (i.e. UNESCO, UNFPA, WHO, UNICEF, UN Women, and UNAIDS). Together with the Safeguard Young People programme which is managed by UNFPA; 2gether 4 SRHR provided financial and technical support to the EAC to commission an evaluation of the previous ESA commitment, to identify areas that could be strengthened to further advance the health and well-being of AYP. This included strengthening the linkages to the Education Plus initiative[5] and expanding the focus beyond comprehensive sexuality education (CSE) to include a focus on the health and well-being of AYP. Country and regional stakeholders were engaged on the successes, achievements and barriers of the previous ESA Ministerial Commitment and its importance. The programme provided support for the development of an accountability framework, indicator reference sheet, and the harmonization of monitoring and reporting tools to support the roll-out and reporting on the commitments. It further provided country-level support for engagements around the status of endorsement of the commitments.

EAC Minimum Standards for the integration of RMNCAH and HIV: The programme provided technical and financial assistance for a study on the status of integration of RMNCAH and HIV and AIDS services across all six EAC Partner States, and by reviewing and providing comments on the study. This study informed the EAC Minimum Standards for the integration of RMNCAH/HIV which was finalized by the Health Secretariat of the EAC and adopted by the EAC Council of Ministers. The programme was also instrumental in the cross-regional exchange between SADC and EAC, where EAC adapted some learnings from the SADC Minimum Standards. The resulting draft Minimum Package aims to harmonize and standardize delivery of integrated RMNCAH and HIV interventions and services across EAC Partner States and will serve as an advocacy tool for RMNCAH and HIV integration. Additionally, the Partner States will use the Minimum Package in mobilizing resources for delivery of integrated RMNCAH and HIV services.

Facilitation of processes around the ESA commitment in Tanzania

In Tanzania, three multi-sectoral stakeholder meetings were conducted with representatives from AYP groups, the Prime Minister's Office, Regional Authority and Local Government, Ministries, United Nations agencies and development partners to discuss key SHRH and HIV issues affecting young people and the status of ESA commitments endorsement. The meetings acted as a catalyst for the release of the endorsed ESA commitments documented by the Government and preparation of the ESA commitment action plan.

SADC SRHR Strategy 2019–2030: The programme provided technical support to the Governments of Eswatini, Namibia, South Africa, and the SADC Secretariat to develop the SADC SRHR Strategy 2019–2030. This was adopted by SADC Ministers of Health in 2018. The strategy is aligned and guides regional efforts to operationalize the SDGs, the African Union's Maputo Plan of Action, and the Maputo Protocol. The strategy provides a framework for Member States to benchmark their SRHR programming to achieve regional SRHR outcomes and for development partners and civil society partners to align their interventions. The strategy has informed SRHR programming through

[5] Education Plus is a joint high-level advocacy initiative between UNAIDS, UNESCO, UNFPA, UNICEF, and UN Women to address the high rates of HIV among adolescent girls and young women in sub-Saharan Africa.

discussions and recommendations from the SADC SRHR Managers' Meetings to the SADC Ministers of Health Meetings that provide the political mandate for countries to take action, and allocate resources to achieve the 10 outcomes of the strategy as measured in the SADC SRHR Scorecard (discussed further below).

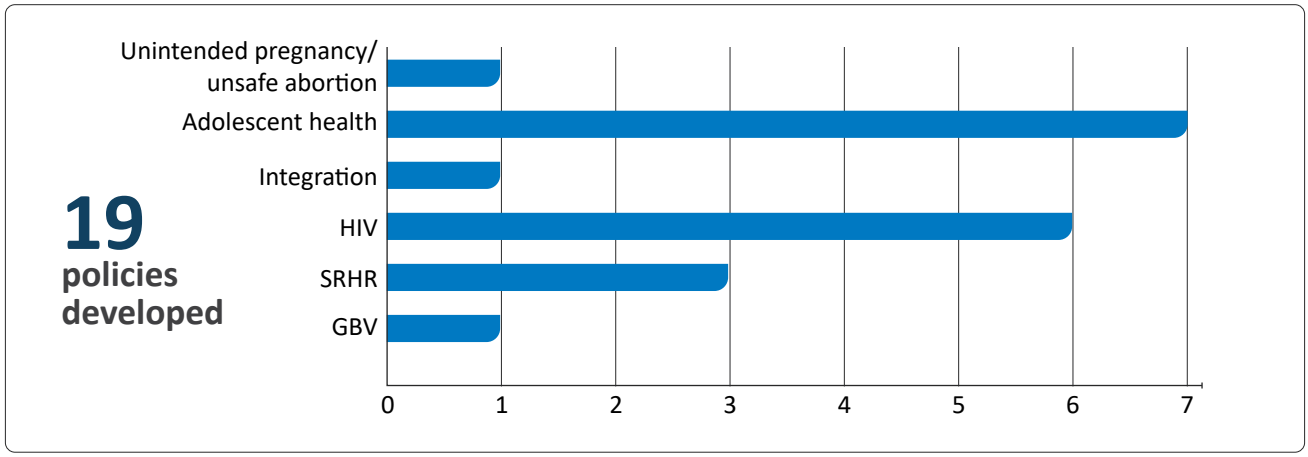
SADC Regional Strategy for HIV Prevention, Treatment and Care and SRHR Among Key Populations: The programme provided technical support to the SADC Secretariat to develop a SADC Guidance Document on Key Populations in accordance with the Global Coalition Roadmap and the SADC Key Population Strategy. The guide is intended to assist Member States scale up their programmes for key populations. It provides guidance supported by case studies from the SADC region. Areas for guidance include developing minimum service packages; developing a scale-up plan; differentiated service delivery and integration; and resource mobilization and sustainability.

SADC Minimum Standards on SRHR: The programme supported the adaptation of the SADC Minimum Standards on SRHR to guide the provision of integrated services. The Minimum Standards benchmarked and harmonized the provision of integrated SRH and HIV interventions and services among SADC Member States, with a view to accelerating the effective delivery of quality and comprehensive health and related social services for all people, irrespective of age, sexual orientation, marital status and gender; and also served as an advocacy tool which highlights the need for and benefits of an integrated SRH and HIV response. The countries supported through the programme benchmarked their frameworks, strategies and implementation on these minimum standards. A review of the harmonization of these standards reflects that all but one of the programme countries (Namibia) have reviewed policies to ensure integration of the two streams of SRH and HIV; and all of the countries supported by the programme have reviewed or developed policies that integrate SRH and non-communicable diseases.

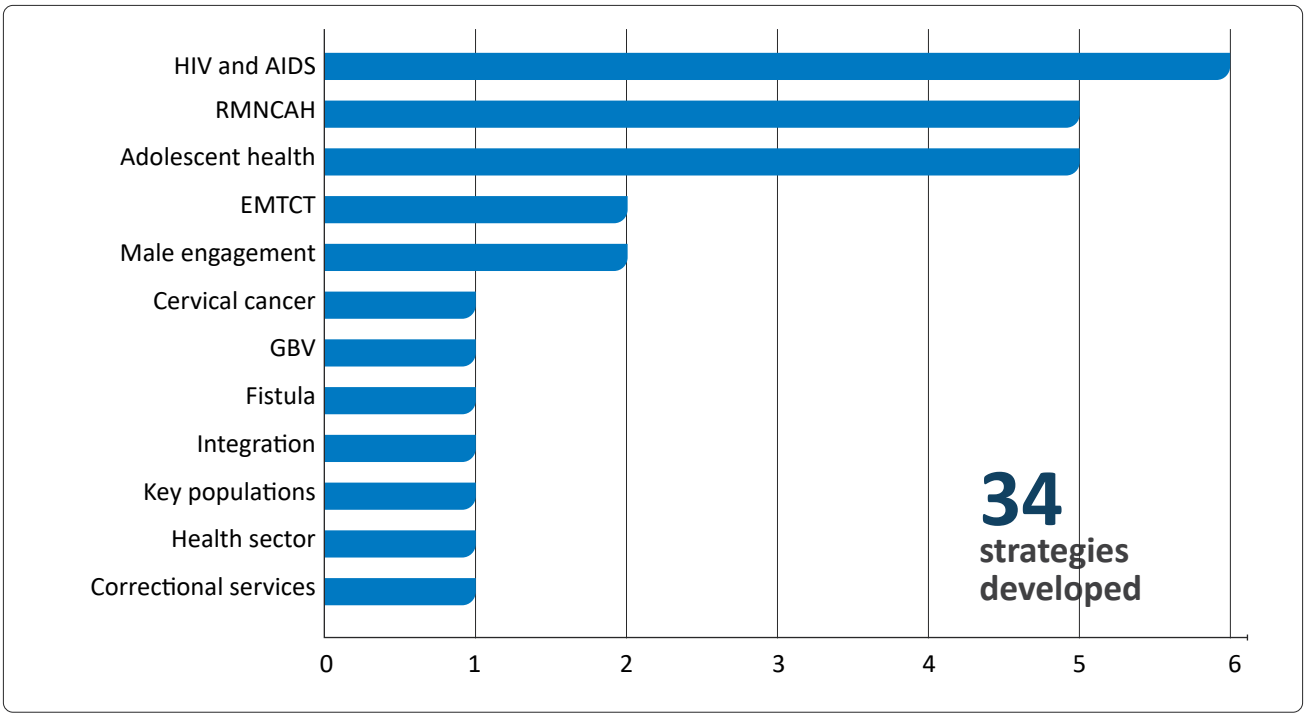
Objective 1

RESULT 3: The programme supported the development of national policies and strategies to protect and advance SRHR at the national level.

National policies, strategies and frameworks: Nineteen (19) policies and 34 national strategies on various key SRHR elements were updated and disseminated, and relevant stakeholders were orientated to ensure a harmonized national approach to ensuring that people can exercise their SRH rights and access quality services. This enhanced the delivery of SRHR services in eleven ESA countries and reached a population of close to 233 million people.[6] Most of the policies and strategies were aligned to global, continental and regional SRHR and HIV frameworks, and incorporated the principle of integration.

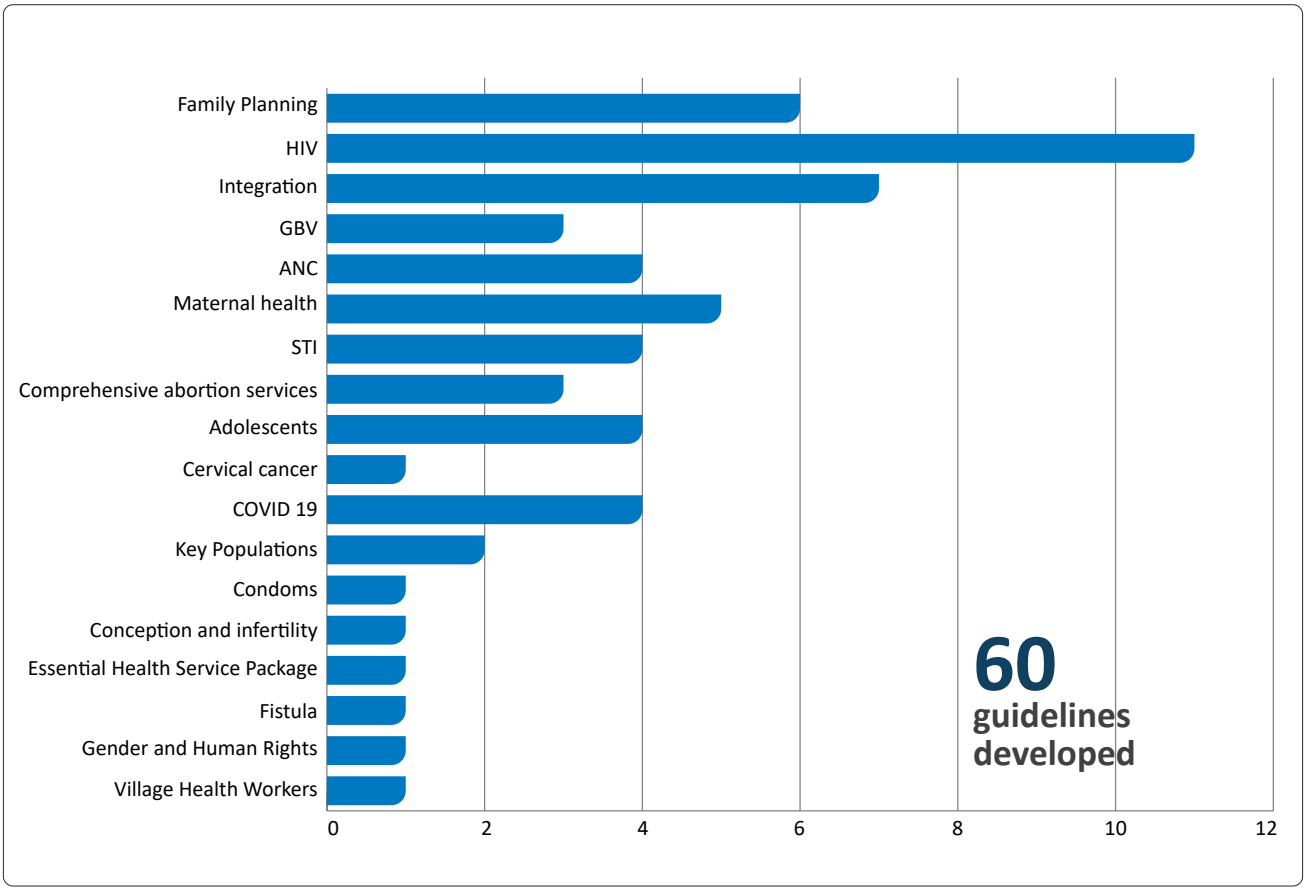


[6] All of the supported countries, except for Tanzania, updated relevant policies or strategies.



Objective 2

Guidelines: Sixty (60) national guidelines were developed or updated to guide and ensure the provision of quality services, aligned to global norms and standards that incorporated the principle of integration. There was also focus on updating family planning, HIV and SRHR integration guidelines with five countries (Botswana, Lesotho, Malawi, Uganda, and Zimbabwe) reviewing their guidelines, and with two countries updating their GBV guidelines (Botswana and Eswatini). Namibia developed a clinical handbook on the healthcare of survivors subjected to intimate partner or sexual violence.



Objective 1

RESULT 4: The programme strengthened regional and national coordination on SRHR, built the capacity of countries on the latest developments on SRHR, and facilitated the sharing of emerging practices and case studies.

Objective 4

Regional Economic Communities Managers' Meetings: The programme strengthened regional coordination that contributed towards the development of regional frameworks and guidelines, monitoring of progress on SRHR, sharing of emerging practices and lessons learnt through supporting the convening of meetings of the Member States by the RECs and Regional Parliamentary Forums. These meetings strengthened the harmonization of efforts between regional and national actors, and fostered sharing and learning between countries.

National coordination: The programme supported the convening of national and subnational multi-sectoral coordinating mechanisms for SRHR, HIV and GBV by the Ministry of Health, with relevant national stakeholders, including United Nations agencies, United States Agency for International Development (USAID), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), CSOs, and other relevant stakeholders. These coordination mechanisms ensured synergy in programme implementation and the monitoring of relevant national policies and strategies; and reduced duplication and ensured that the available resources were utilized effectively to achieve joint outcomes, and to strengthen programme implementation.

Objective 1

RESULT 5: The programme increased accountability for progress in meeting global, regional, continental, and national commitments through the use of peer accountability frameworks.

Objective 4

The SADC SRHR Scorecard (2019–2030): The SADC SRHR Scorecard is a high-level peer review tool to track progress in meeting the ten outcomes of the SADC SRHR Strategy, and the SRHR targets of the SDGs. The programme provided technical and financial assistance in convening SADC Technical Working Group meetings for the development of the scorecard under the leadership of the Governments of Eswatini, Namibia and South Africa, the SADC Secretariat, United Nations agencies and regional CSOs. The development of the SADC Scorecard leveraged off the technical assistance and experiences of the EAC Secretariat who developed their first scorecard in 2011. The programme also assisted with on-boarding the consultant that developed and designed the scorecard which is housed on the SADC website.

With support from the programme, and working in partnership with PUNO country offices, all 16 SADC Member States populated the baseline scorecard, 14 Member States populated the first milestone scorecard (2021) and all 16 populated the second milestone scorecard (2023). In 2023, the programme supported the development of an electronic data collection platform that allowed countries to populate the scorecard in real time, eliminating errors caused by moving data from one platform to another. A qualitative component was also added to the 2023 milestone scorecard to provide context, achievements, challenges, and opportunities for each indicator. This requires further refinements in subsequent scorecards. The 2021 and 2023 scorecards were endorsed by the SADC Ministers of Health and launched at the sides of the Ministers of Health Meetings (in Malawi and Angola respectively). Recommendations coming from the scorecards are used to inform programming by the Member States and used by the Ministers to decide on key SRHR priorities and resource allocation.

EAC Scorecard: The EAC Scorecard is completed every 2 years. Through the PUNO country offices, the programme provided some technical support for the population of the EAC Regional RMNCAH/HIV

Integrated Scorecard by the Partner States of the EAC and these were used to generate discussions at the Ministerial level on progress made. For example, the programme provided technical and financial support in the compilation of the EAC scorecard for Uganda, with detailed analysis of the country status to inform the ministerial commitments at the sectoral council of Ministers of Health. The 5th scorecard was adopted by Ministers of Health on 23 April 2021, and the 6th scorecard which is digital and awaiting approval.

National accountability frameworks: National accountability was strengthened through support for the regional scorecards, periodic data collection and peer review. Botswana, Eswatini, Lesotho, Uganda, Zambia, and Zimbabwe aligned their peer accountability mechanisms to the SADC SRHR Scorecard.

Botswana held discussions on how to link the national RMNCAH Strategy to the SADC SRHR Strategy 2019–2030.

Eswatini supported orientation sessions with the National SRHR CSO Consortium on the SADC SRHR Scorecard.

Lesotho developed a national SRMNCAH Scorecard in line with the SADC SRHR Scorecard indicators.

Uganda used the EAC Scorecard as a peer review mechanism to track progress, and improve and sustain SRHR outcomes.

Zambia harmonized the SADC SRHR scorecard with other regional scorecards, and oriented provincial and District Health Directors on the strategy.

Zimbabwe embarked on a process to institutionalize the use of the SADC Scorecard.

Objective 3

The programme also supported countries to develop and make use of other peer review mechanisms, such as the adolescent scorecards, SRHR Indexes, CSO shadow scorecards, and HIV prevention scorecards as accountability and advocacy tools that promote improved SRHR outcomes. CSOs play a critical role in holding governments accountable to their commitments, but they also require investments and capacity-building to play this oversight role. The programme provided some capacity-building to CSOs in Phase I, and this will be extended in Phase II of the programme.

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Lessons learned from Phase I	Application in Phase II
A regional approach to the programme allows common challenges in the region to be dealt with in a coordinated manner.	Phase II will sustain high-level advocacy and strategic dialogues through the African Union, RECs, and parliamentary forums including the Pan African Parliament, East African Legislative Assembly, and the SADC Parliamentary Forum, and regional human rights instillations.
Processes around laws, policies and strategies which enable people to exercise their SRH rights require time to enable proper engagement, dialogue and discussion.	Phase II will sustain advocacy in partnership with civil society and rights holders, and provide technical assistance to countries to harmonise national SRH policies and strategies in line with global, continental and regional frameworks.
Peer learning and guidance provided by RECs can facilitate the domestication of continental and regional frameworks.	Phase II will support the RECs to convene regional multispectral forums to share updated programmatic guidance, develop and monitor roadmaps, and identify promising and emerging best practices that can be amplified across the region, and provide technical assistance to support countries to monitor and report on progress.
Cultural, political and religious sensitivities play a large part in facilitating the legal and policy processes that facilitate access to SRHR.	Phase II will make use of the draft advocacy strategies developed to guide work with cultural, religious and political groups; with a particular focus on addressing harmful social norms.
While policies and laws may have been developed, there remains misalignment between, these and local practices, particularly in rural areas.	Phase II will include working with traditional and cultural leaders and advocacy for the alignment between formal law, customary law and cultural practices, particularly in relation to ending child marriage.
More work is needed to hightlight the relevance of regional policy frameworks to local contexts.	Phase II will provide support for research and the generation of strategic data to provide the evidence necessary to inform the development of laws and policies, and promote delivery of integrated services that meet the needs of specific population groups.

Sustainability of programme investments

The sustainability of efforts on the harmonization and domestication of commitments is likely due to the updating of regional and national frameworks aligned with international commitment, and alignment with community SRHR needs, ensuring ongoing relevance and support. Partnerships forged through convening regional forums, involving CSOs, and collaborating with stakeholders and champions in advocacy initiatives further bolsters sustainability by fostering collaboration and resource-sharing. The development of regional scorecards and the capacity built to report on SRHR indictors furthers the continuity of efforts. The programme's impact on policy through supporting advocacy and legislative processes at regional and country levels, lays a foundation for ongoing progress in advancing SRHR and addressing GBV in the region, and communication centred around these changes in laws and policies will ensure that people are able to exercise their rights.

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5 Incorporating SRHR in Universal Health Coverage

Universal health coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship; and is one of the SDGs.

Some ESA countries have developed essential health-care packages as they make progress towards UHC, but many do not make these benefit packages explicit, and none include all nine of the recognized SRHR services (as proposed by the Guttmacher-Lancet Commission) in the bundle of services offered.[7,8] Abortion care, CSE, the response to GBV and harmful practices, reproductive cancers, fertility, and menstrual health are often excluded from benefits packages, which do not always cater to the needs of the most vulnerable populations. The programme provided technical and financial support to address some of these gaps, and to catalyze funding to support the pathway to UHC.

[7] The Guttmacher-Lancet Commission proposed a comprehensive definition of SRHR which goes beyond the ICPD definition to cover sexual rights and includes a package of nine essential interventions which are cost-effective, cost-saving, and inexpensive; suggesting that these interventions should form part of a set of investments for low-income countries and lower-middle income countries who must meet the needs of growing populations on limited public health budgets. These include: CSE; counselling and services for a range of modern contraceptives; antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care; safe abortion services and treatment of complications of unsafe abortions; prevention and treatment of HIV and other STIs; prevention, detection, immediate services, and referrals for cases of GBV; prevention, detection, and management of reproductive cancers, especially cervical cancer; information, counselling, and services for subfertility and infertility; and information, counselling, and services for sexual health and wellbeing. (Ref: Starrs et al. (2018) Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. DOI: https://doi.org/10.1016/S0140-6736(18)30293-9).

[8] ICPD 25: https://www.unfpa.org/sites/default/files/pub-pdf/SRHR_an_essential_element_of_UHC_SupplementAndUniversalAccess_27-online.pdf

Achievements in incorporating SRHR in UHC

Guidance on domestic financing and financial protection mechanisms for SRHR provided through the development of **costed national plans** or assessments in **8 countries** and **investment cases** in **5 countries**

Additional resources for SRHR mobilized through **domestic resources in 5 countries** and **donor resources in 4 countries**

People able to access SRHR services through **essential health packages** developed in **4 countries**

Roadmaps towards UHC developed in **1 country**

Capacity built for incorporating SRHR in UHC in **7 countries** and among **CSOs**

Objective 2

RESULT 1: The programme increased the availability of strategic information and built country capacity on incorporating SRHR in UHC.

Strategic information on existing health packages

The programme supported a nine-country study into the contents of essential packages and found that most countries do not include all nine of the recognized SRHR services in the bundle of services and are not explicit about what is included or excluded. It also found that financing and financial risk protection for minimum essential service packages and UHC benefit packages is fragmented, and on-the-ground delivery does not always match the packages available on paper.

Objective 4

Capacity-building efforts

A capacity-building workshop was convened by WHO and UNFPA under the 2gether 4 SRHR programme in April 2023 to advance the inclusion of SRHR in discussions and country roadmaps towards UHC. This workshop resulted in building capacity of representatives from the Governments of Eswatini, Kenya, South Africa, South Sudan, United Republic of Tanzania, Zambia, and Zimbabwe, CSOs, and a pool of consultants on a range of tools developed to assist countries to assess their existing health benefits packages, assess the costs of services and resources, and systematically define the contents of health benefits packages and their levels of service delivery.

Objective 2

RESULT 2: The programme supported the development of essential health packages and country roadmaps towards UHC.

Support for data and engagements to develop health packages: Evidence shows the effectiveness of Ministries of Health working together with civil society to address gaps in health benefits packages, and the programme provided technical support for participatory processes involving community engagement and national-level stakeholders, and for data collection on priority interventions for inclusion into health packages.

These processes resulted in the development of the Kenya Essential Package for Health (KEPH), a costed essential health-care package in Eswatini, the Tanzania mainland National Essential Health Interventions Package (NEHIP), the Essential Services Package in Zanzibar, and a review of the roadmap towards UHC in Zambia. The development of these packages and roadmaps goes some way to ensuring that people in the region are provided with SRHR services free of charge.

Objective 1

RESULT 3: The programme facilitated the development of costed national plans and assessments to guide domestic financing and financial protection mechanisms for SRHR.

To ensure that services are accessible for those who need them, financing and financial protection mechanisms for SRHR must be considered. Investment cases for SRHR minimum services packages and readiness assessments for service provision can inform how to progressively include SRHR into UHC packages.

Spending assessments: The programme provided support for the National AIDS Spending Assessments (NASA) to track HIV expenditure in Lesotho and in Zambia, and the National Health Spending Assessment integrating HIV and SRH in Zimbabwe. These assessments were used to advocate with Parliament and relevant government ministries to increase domestic investments in SRHR, HIV and GBV in view of the transition to domestic financing and sustainability of the response.

Costed plans: The programme supported the development of costed national SRHR, HIV and GBV scale-up plans in Botswana, and eight programme districts in Uganda were supported to develop district costed plans for family planning and provide clear programme-level information on the resources that districts must raise domestically and from partners to implement the plan.

In Kenya, costing studies of the Female Sex Workers and First Time Young Mothers programmes provided insights into the costs of delivering such programmes, and informed understandings of how the provision of services for key and vulnerable populations can be considered in health benefits packages.

In Namibia, the programme provided technical support for the development of regional budget plans which include activities on SRHR, HIV and GBV integration; and these have resulted in the national government allocating resources to these activities.

The programme also provided technical support for the costing of the National Health Sector Strategic Plan and the National Operation Plan to guide youth programming and resource mobilization in Eswatini, the National HIV Operational Plan and RMNCAH+N Strategy in Lesotho, a costed operational plan for the Adolescent Health Strategy in Zambia, and the National Community Health Strategy in Zimbabwe.

Financing strategies: In Malawi, the programme provided support for the development of a Health Financing Strategy which is expected to facilitate the creation of a unified plan, through a single budget and one monitoring and evaluation system.

This will see all donor activities being mapped to strengthen integration at a high level which will trickle down to implementation by all partners. This is likely to result in a more coordinated, efficient and accountable health-care system, leading to improved SRH outcomes.

These processes have resulted in a better understanding of the financial resources required to implement health programmes, allowing governments to develop budgets and consider the allocation of resources to ensure that SRHR services are adequately funded.

Objective 1

RESULT 4: The programme contributed towards the unlocking of domestic and donor resources for SRHR.

Unlocking domestic resources: Domestic financing establishes a stable and sustainable funding base for UHC, strengthens health systems, expands service coverage, and enhances the overall resilience and responsiveness of health-care delivery. The programme contributed to the unlocking of domestic resources through technical support and continued advocacy with Members of Parliament in Zimbabwe, which resulted in the establishment of a budget line for the funding of contraceptive commodities from domestic resources. Advocacy and technical support also resulted in the release of domestic funding for condoms in Kenya, for reproductive commodities in Namibia, and for the HIV response in Uganda. In Botswana the programme efforts resulted in unlocking domestic funding to train health-care workers in the new protocols on the response to GBV.

Unlocking additional funding: The programme also provided support for the Ministry of Health in Lesotho to apply for funding under the UNFPA Supplies Partnership Unit for the procurement of reproductive health commodities. It helped to unlock funding from the Unified Budget, Results and Accountability Framework (UBRAF) to reach sex workers with integrated services in South Africa; and it catalysed funding from the Global Fund for integrated services in Botswana and Namibia. These efforts ensured the scale-up of services to reach those who need them.

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Sustainability of programme investments

The sustainability of efforts on incorporating SRHR in UHC is likely due to the strategic positioning of SRHR as an essential part of comprehensive health-care accessible to all. This approach ensures that efforts remain focused on addressing the holistic well-being of individuals. Sustained funding for SRHR is likely due to the strategic information generated from spending assessments, costed plans, and unlocking of domestic resources achieved through the programme period. Partnerships built between governments and CSOs have fostered collaborative approaches to advancing SRHR in UHC, and the capacity built for countries and consultants, with roadmaps developed, will ensure that this work continues beyond the programme period.

Lessons learned from Phase I	Application in Phase II
The presence of existing political will, strong leadership from Ministries of Health, a robust policy environment, and constitutional commitment to the right to heath form the foundation for advancing SRHR in UHC.	Phase II will undertake high-level advocacy with Ministries of Health and Finance at regional and country levels to include SRHR in UHC benefit packages, financing mechanisms, financial protection mechanisms and waiver schemes.
Skilled and informed technical teams, quality data, robust stakeholder engagement frameworks, and existing tools for prioritization improves planning and implementation to enhance the inclusion of SRHR in UHC.	Phase II will support countries to undertake annual national health accounts that include an analysis of the reproductive health sub-account, and develop regional guidance to support the implementation of country-specific roadmaps to include comprehensive SRHR in UHC benefit packages, National Health Strategic Plans, and National Health Development Plans, as well as costing, financing and financial protection mechanisms.
Collaborative partnerships between donors, governments, the private sector, and civil society and regular knowledge exchange between countries provides learning opportunities and boost advocacy efforts that contribute to the successful realization of UHC and SRHR goals.	Phase II will bolster capacity and support civil society and networks of key stakeholders to play a more active role in regional efforts to advance SRHR in UHC, and will identify, support and document promising practices on public-private partnerships to increase domestic resources for SRHR.
The challenges associated with complex, lengthy, labour-intensive, and costly mobilization and consultative processes underscore the importance of streamlining these activities for the efficient and cost-effective development of health benefits packages.	Phase II will strengthen the capacity of governments to undertake resource mapping and optimization, and to advocate for the harmonization and alignment of SRHR donor funding; and will provide technical assistance to countries to strengthen investments in SRHR, HIV and GBV that leverage multilateral and bilateral development investments.

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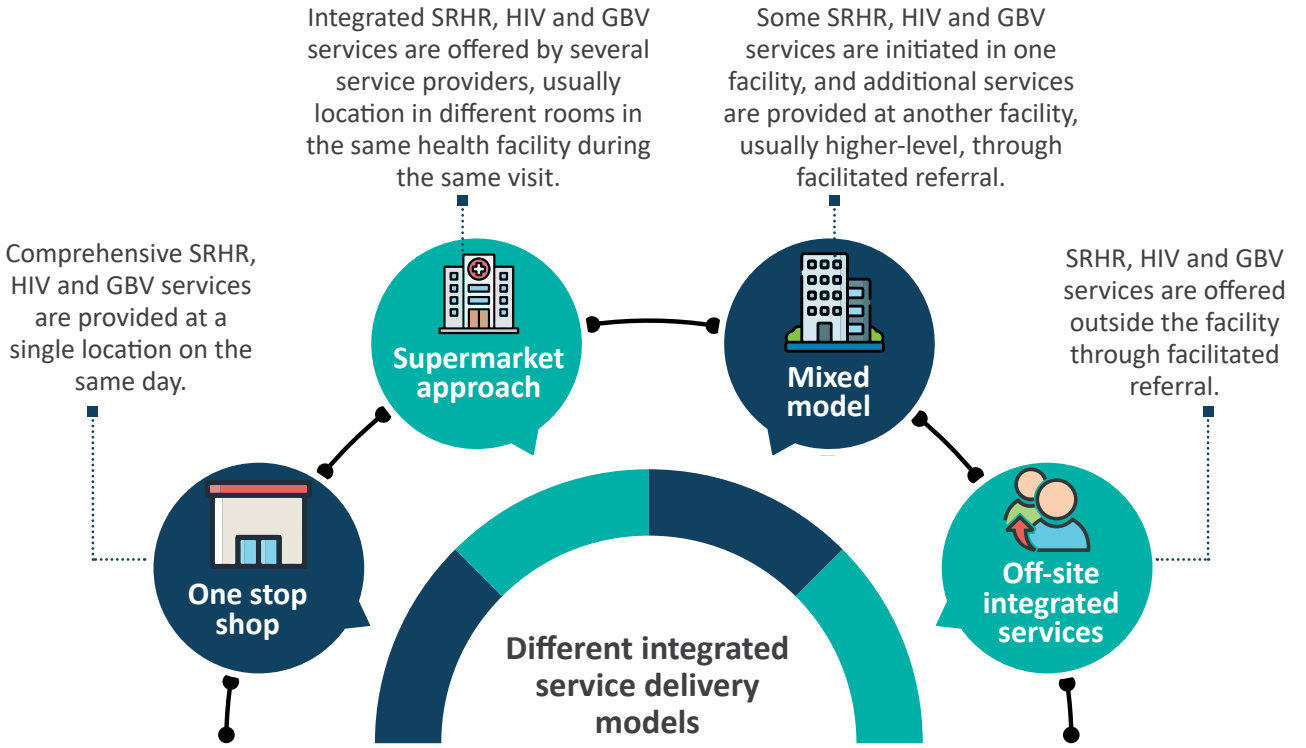
6 Integration of SRHR, HIV and GBV Services

SRHR, HIV and GBV are interlinked issues, and making connections between them at policy, programmatic and service delivery levels have benefits for individuals and health systems. Integration involves considering the impact of each of these three health factors , and on the other hand, at the policy level, and providing SRHR, HIV and GBV information and services together rather than separately. This promotes a more holistic and comprehensive approach to healthcare.

No formal study has been done on the cost-effectiveness of integrated services, but anecdotal evidence suggests that there are cost savings for both the facility and the patients when services are provided at one time and in one centre. Integrating SRHR, HIV and GBV results is more efficient and increases access to service for individuals reducing the need to visit multiple health-care facilities for different aspects of their health; and allowing them to receive a comprehensive package of services that respond to their individual needs in one visit to the clinic.

Integration also facilitates the identification of risks and vulnerabilities across different health domains, enabling early detection and intervention. Different models of providing integrated services are used in different countries, considering unique structural, geographic and cultural factors.



Building on the SRHR and HIV Linkages Project conducted in the region from 2011–2015,[9] 2gether 4 SRHR has had a substantial impact on the integration of SRHR, HIV and GBV services. The programme supported the piloting of integrated services in five countries (Kenya, Malawi, South Africa, Uganda, and Zambia) and scale-up in five countries (Botswana, Eswatini, Lesotho, Namibia, and Zimbabwe), and tested a model of catalytic funding for joint programming in countries through the Joint SRHR Fund (JSF) in Tanzania and South Sudan.

Achievements in the integration of SRHR, HIV and GBV services

Normative guidelines strengthened to build systems capacity, **12 countries** adopted **regional guidelines** and **7 countries** developed or updated **national frameworks and plans**

Integration assessments conducted in **4 countries**

Capacity to provide quality integrated services strengthened through development of **15 training curricula** across 11 countries and training for **44,704 health-care workers**

People more able to access quality SRHR services and linkages to other services through the provision of **integrated services in 10 countries**

Communication, ownership and participation to create demand strengthened in **12 countries**

Insights and learning shared through the development of **15 knowledge products** on integration

[9] Funded by the European Union and the Governments of Sweden and Norway to promote linkages between SRHR and HIV policies, systems and services in Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia, and Zimbabwe.

Objective 1

RESULT 1: The programme strengthened regional and national accountability, coordination, insights, and learning among entities.

Alignment and coordination: The programme facilitated alignment, coordination and collaboration between relevant government departments at national, district and facility levels and with other donor programmes. This included ensuring buy-in through their involvement in the selection of districts and facilities for piloting and scaling up integration; the identification of resource and capacity needs; and agreement on strategic direction and operational approaches. Where national technical working groups considered integration, these efforts were cascaded and replicated at the district and facility levels. Improved coordination and collaboration were also fostered among the PUNOs and substantial engagements were improved with the RECs and CSOs.

Coordination with integrated services in Kenya

Following the development and dissemination of the National SRH/HIV/GBV and TB integration Frameworks in Kenya, coordination between government services improved data sharing which resulted in increased access to GBV prevention and management and justice for survivors. In Kilifi County, access to justice was increased by 10 per cent when the programme provided resources to identify gaps causing a delay in processing of GBV cases and proposed mitigating measures. As a result of this, health-judiciary linkage was enhanced through advocacy and the facilitation of clinicians to attend court as witnesses.

Sharing and partnerships

Objective 4

Integration has provided opportunities for government departments and non-governmental organizations (NGOs) to share what they are doing, to learn from other frameworks on SRHR, HIV and GBV, and to build new partnerships. This has resulted in a shift away from vertical approaches to planning, implementation and budgeting towards a more coordinated approach.

Integration assessments: The programme also supported conducting assessments to provide implementers and other relevant stakeholders with insight into the status and needs of integration of SRHR in primary health care (PHC) services. At various stages of implementation, assessments were carried out in Botswana, Eswatini, Kenya, and South Africa which built an understanding of the effectiveness of integrated service delivery, identification of areas for improvement, and the strategic allocation of resources.

Photo credit © Jadwiga Figula/ UNFPA/2gether 4 SRHR

Objective 1

RESULT 2: The programme supported the establishment of policy platforms and normative guidelines at the regional and national levels to build systems capacity, with the development and updating of national frameworks and plans for providing integrated services.

Frameworks and guidance: Programme efforts resulted in the development and updating of regional and national SRHR frameworks (discussed fully in Section 4 on Harmonization) which incorporate the principle of integration and supported countries to make use of these frameworks and priorities to guide the implementation of integrated services. It supported countries to use the Minimum Standards for the Integration of HIV and SRH in the SADC Region to guide integration; and provided technical assistance to the EAC to develop the Minimum Standards for the Integration of RMNCAH/HIV, leveraging off the SADC framework.

All 12 countries supported by the programme adopted either the EAC or SADC Minimum Standards to guide the provision of rights-based, integrated services. Technical and financial support provided to countries has ensured that integration is featured more prominently in national strategic and operational frameworks, guided by the regional standards. These laws, policies and strategies safeguard SRH rights, confer on health-care workers the ability to deliver services without fear or constraint, and structure the way in which services are delivered and have resulted in a more coordinated, impactful approach to addressing interconnected health issues.

Country frameworks developed to guide integration of services

While many countries developed frameworks which incorporate integration principles, seven countries were supported to develop or update frameworks to specifically guide integration. South Africa developed a National Integrated SRHR Policy (2020), Uganda revised the National Strategy on SRH/HIV/TB/GBV Integration (2021–2025), and Botswana, Lesotho, Malawi, Uganda and Zimbabwe developed guidelines on the integration of SRHR services.

Objective 2

RESULT 3: The programme strengthened the capacity of countries to provide quality integrated SRHR services.

Development and updating of training curricula: Fifteen (15) curricula and training modules on the provision of integrated services and for specific SRHR services incorporating integrated principles, were developed or updated through both technical and financial support from the programme.

Improved human resources for health: To strengthen integrated services, specific activities were incorporated into national and subnational human resource plans for health-care workers, including task-shifting. The process of integration was recognized as improving teamwork and task-sharing, reducing burnout and improving morale among health-care workers. These efforts resulted in more consistent service delivery, and better support and coordination mechanisms in facilities. Skills mapping exercises resulted in the redistribution of skilled and trained health-care workers to better meet the needs of their clients. The strengthened coordination between different role players in service delivery has resulted in a less siloed approach, with benefits for patients who are able to access all services under one roof; and this has reduced congestion at the facility level and reduced the burden for health-care workers. These achievements have built greater trust between health-care workers and their clients, and improved the uptake of and retention in care. The reduction in financial and time burden for clients, with reduced clinic visits and associated costs, has further enhanced client satisfaction.

New curricula and training modules on integrated service delivery

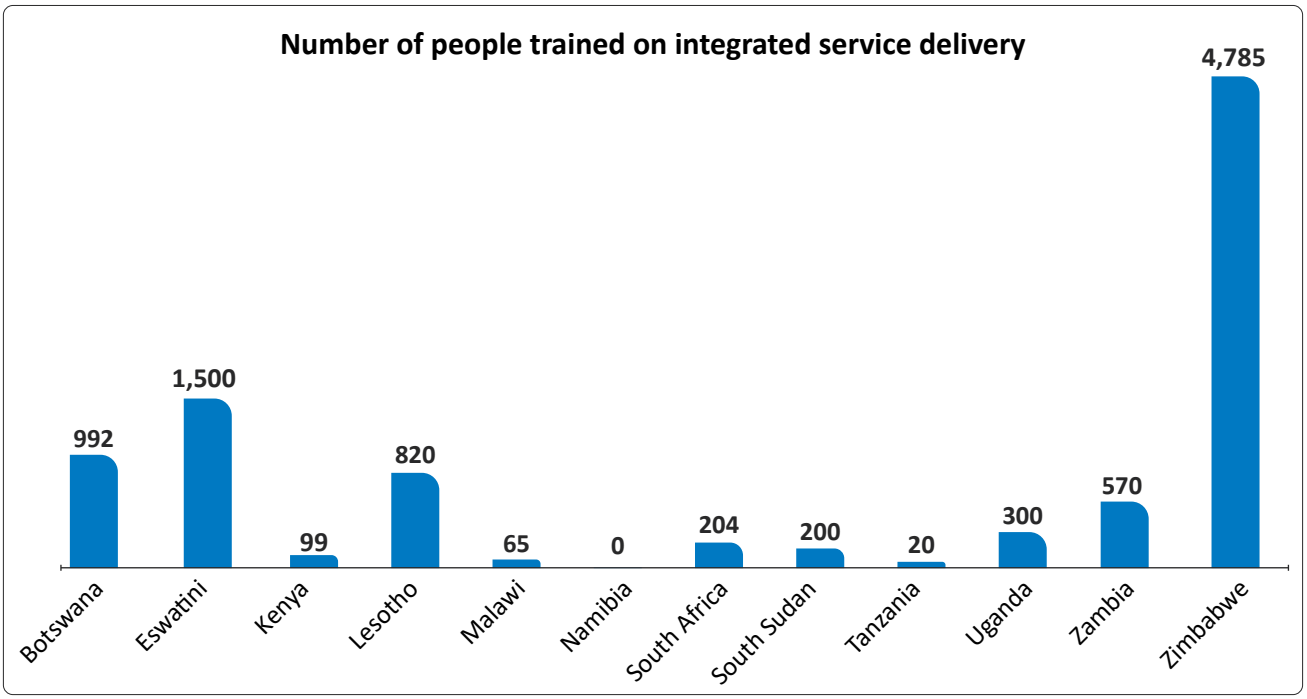
- **Botswana** was supported to develop a curriculum for integrated health services, including TB, HIV, SRHR, and RMNCAH and nutrition (RMNCAH+N) that addresses vertical programming and the duplication of efforts that have developed over time in HIV and RMNCAH programmes at the national level, in donor funding priorities and at the level of service delivery.
- **Zimbabwe** successfully integrated SRHR-related issues into the pre-service training curricula of schools of nursing and midwives, and developed a training module on the integration of SRHR, HIV and GBV for in-service training.
- In **Lesotho**, a training manual on integrated intrapartum, emergency obstetric and post-partum care was developed to standardize, and thus, improve the quality of care. The programme also supported processes in Lesotho resulting in a review of the public health nursing and neonatology curricula at the pre-service level, the development of a competency-based midwifery curriculum, and the development of a training manual on GBV.

Training and mentoring for health-care workers: Using the integration approach, all 12 countries supported by the programme trained health-care workers on various key SRHR elements, with a total of over 44,704 health-care workers (including community health workers) trained on a range of SRHR topics, and 9,555 trained specifically on the provision of integrated SRHR, HIV and GBV services.

Combined with mentoring and supportive supervision efforts, this has resulted in significant improvement in the quality of health-care services provided in the region. Training, mentoring and supportive supervision have focused on attitudes and practices and have contributed towards recognized changes in the attitude of health-care workers, who are reported to be more motivated, more sensitive to the needs of clients, and have improved knowledge and skills; resulting in greater competence in implementing quality integrated services.

Capacity-building activities had additional benefits through cascading the training to facilities beyond those supported through the programme through the movement of staff, resulting in the provision of integrated services in those facilities.

Virtual trainings have also increased the reach of the effects of the programme, and districts not otherwise directly supported have benefited from these.



- Spill-over effects of the programme are observed outside the targeted districts as a result of staff movements (Malawi)
- Some of the trained and mentored staff kept on moving to other facilities in non-programme districts or to non-targeted health facilities (Uganda)
- We have enhanced our skills because now not only one person knows specific knowledge (Zambia)

Objective 2

RESULT 4: The programme has supported the provision of integrated SRHR, HIV and GBV services which has in turn increased access to SRH information and services and linkages to other services.

Scaling up of integrated services: Integrated service delivery has been scaled-up in Botswana, Eswatini, Lesotho, Namibia, and Zimbabwe where a 10 per cent to 30 per cent increase in the facilities providing integrated services was recorded from baseline (2018) to endline (2022) as shown in the graph below.

- **Botswana** scaled up the provision of integrated services from 54 to 123 sites in 13 districts. The extent of integration at national level was estimated to be 46 per cent which was a significant increase from the national baseline estimate of 16 per cent in the first quarter of 2018. High integration was reported for antenatal-care (ANC) and HIV testing as well as HIV-positive women who delivered and were on a prevention of mother-to-child transmission (PMTCT) treatment regimen. The least reported integration indicators were safe abortion care or post-abortion care (PAC) and STI screening.

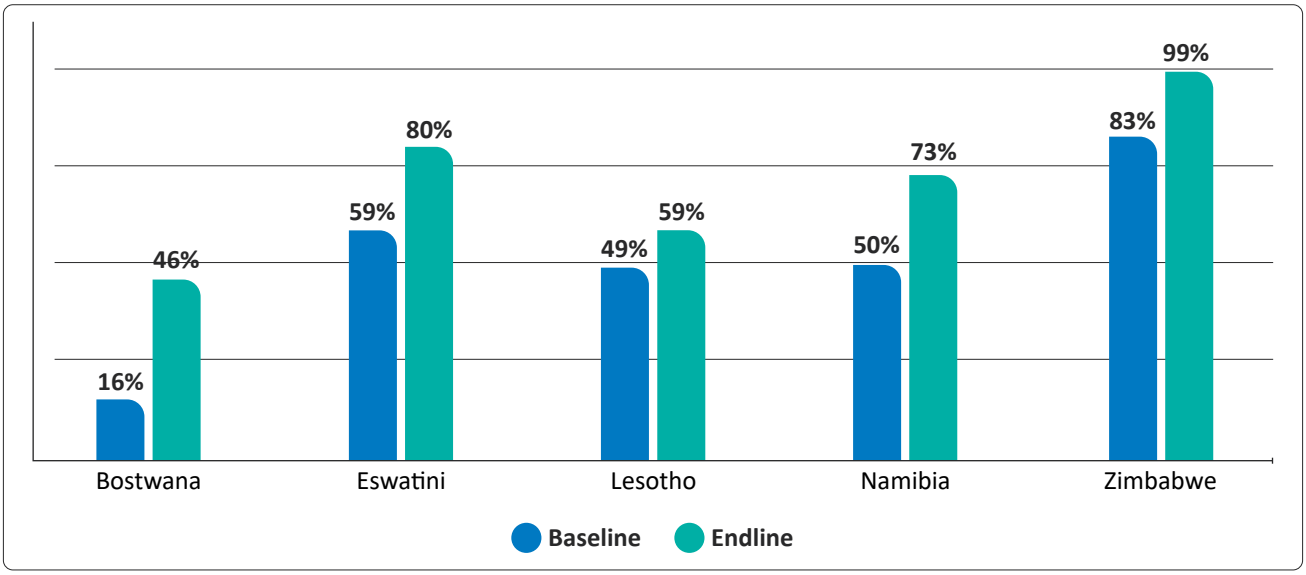
- **Eswatini** strengthened the national provision of integrated services with a focus on GBV, safe abortion care services and integration of family planning into HIV services through the values clarification approach and the orientation of health-care workers on national GBV guidelines. Over 80 per cent of health facilities now provide integrated services of SRHR, HIV and GBV against a baseline of 59 per cent.

- **Lesotho** scaled up the provision of integrated services in all 10 districts, including 18 hospitals, with a shift from 49 per cent to 59 per cent of facilities in these districts offering integrated services. Major improvements in integration are demonstrated at HIV and ANC service points, while progress is evident in proportions of GBV and PAC patients who benefitted from complimentary care services during the programme implementation period. Family planning services scored low with regards to the integration of HIV testing and cervical cancer screening. The decline in PAC patients provided with family planning methods is a missed opportunity within the programme.

- **Namibia** increased the number of sites providing integrated services using its 'one room, one provider and one package of services' approach from seven pilot sites to 107 sites, representing an increase from 50 per cent at baseline to 73 per cent in the eight target districts at endline. Model sites are being used as centres of learning for other sites introducing the integrated service delivery model. A significant increase is recorded in the number of clients receiving services at HIV service delivery points (SDPs) that received modern family planning services and were tested for HIV.

- **Zimbabwe** supported selected health facilities in 13 focus districts to provide integrated SRHR, HIV and GBV services through capacity-building and supportive supervision. An assessment of the capacity to provide integrated SRHR, HIV and GBV services was conducted in 49 health facilities and all facilities were providing integrated services.

Percentage of facilities providing integrated services at baseline and endline



Integration indicator increases in Zimbabwe

Clients receiving PAC services that

Tested for HIV increased from **41% to 76%**

Screened for STI increased from **63% to 78%**

Received family planning services increased from **60% to 93%**

Piloting of integrated services: Improved SRHR outcomes were recorded in Kenya, Malawi, South Africa, Uganda, and Zambia where the piloting of integrated services was supported in select facilities.

- **Kenya** integrated SRHR, HIV and GBV services for female sex workers (FSWs) and their clients using a Drop-In Centre model, including a static health centre, peer education and a mobile clinic. A positive upward trend in the key integration indicators was observed, for example the percentage of clients receiving services at HIV SDPs and at family planning SDPs that were screened for STIs increased from 54 per cent at baseline to 65 per cent at endline.

- **Malawi** piloted the provision of integrated services in five health facilities and scaled up to reach 23 facilities across three districts. An upward trend in integration indicators was recorded, particularly on GBV integration, with the percentage of clients accessing GBV services at health facilities provided with the full package of post-exposure prophylaxis (PEP) within 72 hours of an incident and being tested for HIV increasing from 56 per cent at baseline to 78 per cent at endline.

- **South Africa** piloted an initial 15 sites in 2019 and scaled up integrated services to 73 facilities in 2021 in two districts aligned to the Ideal Clinic Model streams (including acute, chronic and mother, child and women's health). A significant increase in the number of clients that received modern family planning methods at HIV SDPs and the number of family planning clients tested for HIV and screened for cervical cancer was recorded.

- **Uganda** piloted 26 model facilities for integration with mentorship and supportive supervision provided by Regional Referral Hospitals in eight districts, guided by a package of standardized programme interventions, RMNCAH Point of Care guidelines and the national SRHR/RMNCAH quality improvement guidelines.

- **Zambia** supported the provision of integrated services in 24 health facilities across four districts. While their reports do not provide a percentage figure, there was an increase in the number of family planning clients provided with HIV testing services and a marked increase in the proportion of women screened for cervical cancer was recorded (from 1,389 to 5,977). An increase in the number of PAC clients receiving family planning and HIV testing were also recorded.

Across all the countries there has been:

- Increased uptake of SRHR services;
- Improved client retention;
- Reduced time spent at facility;
- Reduced patient load; and
- Improved case identification for GBV cases.

Integration is not only evident in ANC and HIV where it has been strongest and continues to grow, but other SRHR areas are increasingly benefitting from the integration drive in all countries.

At GBV SDPs, the provision of PEP, HIV testing and STI screening services as part of GBV services are observed. At CAC SDPs, substantial increases on the integration of HIV testing, STI screening and family planning as part of PAC services are recorded and a general increase in accessing some previously left-behind SRHR services, such as cervical cancer, is observed.

The chart on the following page reflects the number of countries reporting an increase or decrease in service uptake, and those with no change or with no data.

Shifts in service delivery: Where there is a decrease in the uptake of services, this is attributed to shifts in national policies, the significant impact of COVID-19, and poor data collection. Data is largely available at HIV, family planning and ANC SDPs with a few exceptions. Eswatini, Namibia, South Africa, and Zambia show data gaps in the GBV SDPs, as in some countries this is seen as a justice issue rather than a health issue and data collection is not prioritized at health facilities. Safe abortion care data is not available for most countries as this is often interpreted as providing abortion services to clients who request it, which is not accepted by the provisions of the abortion laws in most countries. PAC services are widely accepted and offered as indicated by the availability of data.

Integration indicator increases in Uganda

- ANC clients screened for STI increased from **11.6% to 72.7%**
- GBV clients provided with PEP within 72 hours of an incident increased from **74.8% to 97.5%**
- GBV clients screened for STIs increased from **62% to 74%**
- PAC clients receiving family planning services increased from **42.1% to 58.1%**
- PAC clients screened for STIs increased from **38% to 67.4%**

An increase in the provision of integrated services is observed across all countries from the 2018 baseline and a spill-over effect is observed in non-targeted facilities and districts resulting in strengthening of SRHR outcomes.

Efforts at integration have resulted in significant shifts in the region, including optimizing the use of resources, infrastructure, personnel, and data systems that have reduced duplication and improved the overall efficiency of health-care delivery. This resulted in a clear improvement in systems in health-care facilities and in the provision of health-care services.

Challenges to scaling up integration included competing priorities, resource limitations and ill-equipped facilities; limited private sector and donor involvement, and reluctance from private facilities to offer integrated services; and historical departmental siloing, resulting in weak accountability, supervision and bottlenecks to the effective implementation of guidelines. These challenges will be addressed in Phase II of the programme.

KEY

Increase from baseline	Decrease from baseline	N/A - services not applicable in the FSW programme	No change	No data

Service delivery point	Additional service provided	BOTSWANA	ESWATINI	KENYA	LESOTHO	MALAWI	NAMIBIA	SOUTH AFRICA	UGANDA	ZAMBIA	ZIMBABWE
HIV SDP	Family planning										
	STI screening										
FP SDP	HIV testing										
	STI screaning										
	Cervical cancer screaning										
ANC SDP	HIV testing			N/A							
	STI screaning			N/A							
WLWHIV	ART for risk reduction										
Tailored PMTCT/SRH				N/A							
GBV SDP	Full PEP package in 72 h										
	HIV testing										
	STI screaning										
SAC SDP	HIV testing										
	Family planning										
	STI testing										
PAC SDP	HIV testing										
	Family planning										
	STI testing										

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Objective 3

RESULT 5: The programme strengthened communication, ownership and participation to create demand for integrated services.

Community and leadership engagement: The demand for integrated services was improved through engagement with traditional, religious and community leaders, partnerships with the private sector and CSOs, and training for community health workers. These efforts helped to demystify misconceptions about healthcare, and community members spoke more openly about health, actively volunteered for outreach initiatives, and recommended services to others.

Community dialogues were recognized as having reduced myths and misconceptions, particularly around family planning, and resulted in increased service uptake. Engagements with young people, key populations and people living with disabilities, have empowered these groups to monitor service delivery, resulting in more appropriate services provided, and an increase in demand for services by these populations.

Engaging religious and traditional leaders in Botswana

Community-leader dialogues facilitated with traditional and religious leaders included briefings followed by question-and-answer sessions, to enhance awareness on the right to health. These covered topics such as adolescent health, maternal health, comprehensive abortion care, reproductive cancers and GBV. The dialogues elevated advocacy for protective behaviours and improving the uptake of integrated SRHR, HIV and GBV services.

Eswatini

Community-oriented SRHR, HIV and GBV service delivery models for AYP, pregnant and breastfeeding women and key populations were scaled-up, and champions in communities were mobilized through men and boys' networks.

Lesotho

Family planning and other SRHR services were provided to women through community outreach activities in the catchment areas of the Christian Health Association of Lesotho (CHAL) health facilities, and young mentor mother support was initiated in two districts.

Malawi

- Mentor mothers were supported to provide psychosocial support, education and referrals for adolescent mothers with HIV.
- Community Based Distribution Agents were supported with commodities and training to provide family planning and referrals.
- Cervical cancer awareness campaigns and screenings were undertaken with women living with HIV.
- Teen support lines and clubs were supported to strengthen services for adolescents living with HIV.

Namibia

Community Health Extension Workers were prepared communities for implementation of the integration or SRHR, HIV and GBV services.

South Africa

Community maps were developed and displayed in SRHR and HIV sites showing the referral pathway between the clinics, Ward Based Outreach Teams and Communities.

Zambia

Engagement with men and boys' networks has allowed men and boys to mobilize as champions in their communities, and refer other men for services.

Zimbabwe

- A Young Mentor Mother peer-support model for adolescent mothers living with HIV was implemented.
- A service package was developed to guide the provision of integrated services to pregnant and breastfeeding adolescent and young mothers living with HIV, and those who are HIV negative.

Increased support for pregnant women and mothers: Building capacity for support groups for pregnant adolescents, women and mothers in communities has empowered them to make informed choices about their health, resulting in an increase in seeking skilled birth attendants in Kenya, and early ANC registrations, increased early HIV infant diagnosis, and reduced home deliveries, births before arrival and non-bookers in Botswana.

Greater health awareness: Working with communities in all countries under the programme has resulted in a better health awareness by citizens, greater recognition of the importance of taking joint and personal responsibility for health at the community level, and proactivity in seeking prevention services beyond just treatment for SRH. Improved SRHR outcomes were recorded at community levels following the use of community-based approaches to provide integrated services to populations in need, particularly given the high levels of poverty, the distances between health facilities and communities, and the limited space within facilities.

Objective 4

RESULT 6: Lessons from the integration of services were documented and shared to ensure that promising practices are taken up by other countries.

Impact on other programmes: The 2gether 4 SRHR implementation framework and the programme model and learnings have been used to inform other programmes in the region, including in the GAPS programme in Zambia and the 'Count Me In' programme in South Africa.[10] Experiences of integration were the focus of one of the regional 'Friday dialogues'[11] facilitated by the programme to encourage sharing between countries, and one of the plenary sessions at the Regional SRHR Symposium in 2022.

A successful South-South Exchange between UNFPA China and programme staff and partner organizations from Botswana, Uganda and Zimbabwe showcased models on integration from their respective regions, and were the focus of a UNFPA news article. Integration successes were also included in a number of human-interest stories and articles in the region.

Sustainability of programme investments

The sustainability of efforts on integrating SRHR, HIV, and GBV services is likely due to strategic alignment, robust partnerships, and comprehensive capacity-building initiatives. The development of policies on integration has institutionalized the approach, scaling up service provision including using community approaches; and capacity building has strengthened human resources for health, with a likely cascading of information and skills within the sector. Engagement with community leaders and communities has increased service awareness; and while the demand for integrated services continues, it is likely that these efforts will be sustained. The enhanced alignment, coordination, and collaboration between government departments, donor programmes, and CSOs has bolstered support for integration, and the visible public health benefits of offering integrated services are likely to ensure sustained investment in and support for this area of work.

[10] A joint UNFPA and UNICEF programme initiated in 2020, working with the South African Government and funded by the High Commission of Canada, to strengthen district-level institutions and communities in order to enable adolescent girls and young women to realize their SRHR while building effective referral, coordination, capacity-building, and coordination between health and social services.

[11] The 'Friday dialogues' were a series of online workshops facilitated to allow country offices to share learnings and experiences from implementation of the 2gether 4 SRHR programme.

Lessons learned from Phase I	Application in Phase II
Government leadership, and the involvement of CSOs and community structures in providing strategic direction can build consensus on integration, and enhance sustainability.	Phase II will work with the RECs to advocate for integration and provide technical assistance to countries, and will engage with CSOs and community networks to enhance integration efforts.
Taking time to analyse the country's context and conduct resource and capacity assessments to inform the approach to integration is essential for the sustainability of integration.	Phase II will provide technical assistance to countries to undertake strategic assessments that assess and improve the state of integration and quality of care.
Plans, guidelines and tools can enhance the sustainability of integration.	Phase II will provide technical assistance to countries to develop these together with technical and clinical guidelines and SOPs to strengthen the delivery of integrated services and will support South-South exchanges and triangular cooperation to adopt and scale up integration models and packages aligned to global, regional, and national guidelines.
Building capacity for health-care workers has an amplifier effect with knowledge generated infused into facilities and beyond, and in-service capacity development, pre-service training, ongoing mentorship, supportive supervision and whole-site orientation can enhance integration.	Phase II will use regional platforms to advocate and provide technical assistance to review and update training curricula, and use a blended learning approach that strengthens the capacity of regional professional associations and national trainers to strengthen the capacity of countries to deliver integrated services.
Technical assistance on M&E to Ministries of Health can strengthen the generation and use of quality data and strategic information on integration to monitor progress and inform programming.	Phase II will work with RECs to develop a regional framework and a roadmap to support countries to transition to the use of digital health platforms to strengthen national health information systems, and undertake operational research to support innovative evidence-informed practices to promote delivery of integrated services.

Photo creit © United Movement!/ 2gether 4 SRHR

7 Advancing SRHR for Adolescents and Young People

The ESA region has a high rate of unintended pregnancies and new HIV infections among AYP aged 15–24 years. Adolescent and young women have a high unmet need for contraception, and pregnant adolescents are at higher risk of HIV infection during pregnancy. Those living with HIV have lower rates of retention in care and treatment, and an increased likelihood of vertical transmission of HIV, syphilis and hepatitis B.

Contributing to these vulnerabilities are social, cultural and gender norms that dissuade intergenerational discussions on sex and sexuality and limit CSE, inhibiting young people's ability to make informed decisions about their sexual health. Socioeconomic barriers, such as school fees, high levels of unemployment, limited financial resources, and persistent stigma and discrimination, particularly towards marginalized groups, hinder the ability of young people to access SRHR services.

The 2gether 4 SRHR programme supported numerous interventions to protect and advance the sexual rights of young people, strengthen the provision of adolescent and youth friendly SRHR services (AYFS), and to support young people to demand and access these services. These efforts have been guided by the principle of ensuring the meaningful involvement of AYP underpinned by the slogan of 'Nothing for us without us'.

Achievements in advancing SRHR for adolescents and young people

Capacity for **regional and national networks of AYP in 14 countries** enhanced to meaningfully engage in regional and national legal and policy processes to advances and protect SRHR.

Networks of AYP empowered to hold leaders accountable to commitments: AYP in **7 countries** capacitated on **EAC SRHR Bill** and in **11 countries** capacitated on **ICPD+25.**

CSE enhanced in **5 countries.**

Protections for **pregnant school learners** secured in **4 countries.**

AYP polices and strategic plans developed in **7 countries.**

Access to **AYFS** increased in **12 countries**, through **capacity building** for **9,715 health-care workers.**

Young mentor mothers' programmes supported in **6 countries.**

Peer-led, community-based and ICT-supported interventions for behaviour change supported in **12 countries.**

Peer-provider community programmes strengthened in **10 countries.**

Knowledge base for AYP programming strengthened through operational research, cross-country learning and south-south collaboration, with **20 knowledge products developed.**

Objective 1

RESULT 1: The programme enhanced capacity for networks of AYP to meaningfully engage in regional and national legal and policy processes to advance and protect SRHR.

Young people's engagement with leaders: The programme meaningfully engaged AYP in advocacy efforts to engage policy and decision makers, including Members of Parliament, to address legal and policy barriers that limit access to SRHR information and services for AYP, and increase their vulnerability to health risks, stigma and potential legal consequences.

The programme invested in the leadership and meaningful participation of AYP through providing technical and financial support, facilitating linkages with strategic partners, and establishing platforms for co-creation and learning.

Stronger youth networks in the region: The programme supported the Y+ Global Ground UP project[12] in 10 countries, which resulted in stronger partnerships and coordination and has increased programme, financial and governance capacity for country-level youth-led networks, which has further resulted in increased resources for youth-led advocacy on key HIV and SRHR issues.

The Y-ACT (Youth in Action)[13] partnership with AfriYan[14] used the Organizational Development and Systems Strengthening (ODSS) model to strengthen the organizational capacity of youth-led organizations in 14 countries in Africa. This model assesses the ability of youth-led organizations to undertake strategic planning, project management, M&E, sustainability, networking, advocacy, and stakeholder involvement. A key finding was that many organizations lack financial management structures to effectively manage projects. Technical assistance was provided to ten youth-led organizations who participated in financial reporting training, and went on to develop capacity improvement plans based on the gaps identified during the Organizational Capacity Assessment conducted in 2021 and 2022.

To ensure greater synergy across programming with AYP, the programme convened the United! Leadership Summit to strengthen coordination and exchange among youth-led SRH, HIV and AYP networks from 14 countries in ESA. This led to the formation of the United Movement, a youth-led movement of young leaders to drive advocacy and social accountability towards unmet HIV and SRHR commitments.

Objective 1

RESULT 2: The programme empowered and engaged regional and national networks of young people to hold leaders to account for commitments made and to advocate for laws, policies and programmes that are responsive to the needs of adolescents and young people.

Objective 3

The programme strengthened the meaningful engagement of AYP to engage leaders and policy makers at regional and country level to protect and advance the rights of AYP, and to institutionalize programmes that address their needs.

Enhanced calls for accountability: At the regional level, the Y-Act Programme mobilized the voices of young people in the EAC in support of the EAC SRHR Bill through providing small grants to youth-led organizations to lead youth dialogues on the Bill in the Member States of the EAC. Using a mix of communication channels, young people identified

[12] Y+ Global is a global network of young people living with HIV with the mission to mobilize young people living with HIV around the world to promote the right to live healthy and fulfilling lives. (https://www.yplusglobal.org/)
[13] Y-ACT is a youth-led movement which provides tailored training, mentorship, coaching and coalition-building support to African youth advocates and youth organizations. (https://yactmovement.org)
[14] The African Youth and Adolescents Network which aims to increase youth participation in Africa's development agenda. (https://www.facebook.com/AfriYANetwork/)

areas in which the bill could be strengthened to respond to their needs and identified areas in which adolescent sexual and reproductive health and rights (ASRHR) services could be strengthened in their own countries. In support of the ICPD+25, Y-Act led a series of activities with youth networks in 11 countries to strengthen their capacity on social accountability using the ICPD Programme of Action. This initiative strengthened the understanding of youth-led organizations of the ICPD Commitments and their relevance for AYP, identified the need for greater youth engagement in ICPD processes, and put in place mechanisms to facilitate that engagement.

Advocacy for greater access to SRHR for AYP in Zimbabwe

In Zimbabwe, the programme undertook high-level advocacy with the Office of the First Lady, and provided a framework for engagement which resulted in the Office of the First Lady becoming a key platform for advocacy engagements on HIV, SRHR, GBV and gender equality. These engagements resulted in greater public awareness, knowledge and understanding of the vulnerability of AYP to unintended pregnancy, HIV acquisition and experiencing GBV; and the Office of the First Lady advocated for greater access to SRHR services for young people.

Young people were also supported to engage in national processes in Botswana, Eswatini, Lesotho, Malawi, Zambia, and Zimbabwe regarding the age of consent to SRHR services.

Botswana

The programme supported youth engagement to ensure that the amendment to the age of consent to sex laws included safeguards for young people engaging in consensual sex, with a 'Romeo and Juliet' clause.

Eswatini

Youth issues were placed on the national agenda through the National Youth Policy and a draft Bill.

Lesotho

Policy dialogues led to Members of Parliament pledging support for AYP programming and raising relevant questions and motions in Parliament.

Malawi

Malawi increased awareness among young people of their rights through disseminating a booklet that translated and summarized relevant policies and laws for AYP

Zambia

Dialogues ensured that the age of consent for SRHR, HIV and GBV services was staggered by type of services, and the minimum age of consent to information was set at 10 years.

Zimbabwe

A petition by youth-led CSOs resulted in public hearings and a parliamentary report that revealed huge information and service gaps for young people and communities.

Greater access to CSE: Engagements between young people and Members of Parliament included meetings, orientation sessions and policy dialogues, and resulted in positive shifts in education policy to ensure greater access to CSE for young people in schools in Botswana, Lesotho, Namibia, Uganda, and Zambia; and Uganda developed a policy on out-of-school CSE. These shifts ensure that young people are provided with accurate information, and are empowered to make informed decisions around their SRHR resulting in better health outcomes.

Removal of barriers to continuing education: The programme supported dialogue and advocacy with Ministries of Health which resulted in the removal of barriers that prevented pregnant adolescent girls from continuing their education in Botswana, Lesotho, Namibia, and South Africa; allowing them to complete their education, pursue future opportunities, and improve their socioeconomic prospects. The programme supported the Government of Lesotho to develop an investment case study that is being used to advocate for AYP to access CSE, youth-friendly services and be retained in secondary education.

Focus on young people in national policies: Namibia, Uganda, Zambia, and Zimbabwe developed national comprehensive multisectoral adolescent health strategies and policies aligned with the global Accelerated Action for the Health of Adolescents (AA-HA!) programme. Botswana, Namibia, Uganda, and South Africa included a specific focus on AYP in their national comprehensive condom strategic plans to address the distinct needs and vulnerabilities of young people.

Objective 2

RESULT 3: The programme increased access to adolescent youth friendly services in 12 countries to reduce unintended pregnancies, HIV infections and increase the uptake of contraceptives.

The programme successfully institutionalized and increased access to AYFS in all 12 countries.

Guidelines and training on AYFS: National guidelines were developed to guide the provision of respectful, quality integrated SRHR services responsive to the needs of AYP. Knowledge and skills were transferred to 9,715 health-care workers to translate the guidelines into practice and to improve the quality of SRHR services that meet the needs of AYP. Improved service delivery was further enhanced through the provision of mentorship and supportive supervision to health-care facilities in targeted areas. Training on AYFS was provided based on the identified needs and priorities for each country, and was not facilitated across all countries supported by the programme.

Facilitating access to services: The programme also supported countries to devise innovative approaches that increased access to services for AYP. School health and referral systems were put in place in Botswana, Lesotho, Namibia, and Zambia. Lesotho instituted changes in facility opening hours or specialized days to accommodate AYP to access services and introduced innovative ways to reduce the unmet need for contraceptives among adolescent girls.

Increased access to contraceptives for adolescent girls in Lesotho

Access to contraceptive services for underserved adolescents in areas where contraceptives are not available was expanded through using village health- care workers to distribute the self-administered Sayanna Press to vulnerable adolescents. This approach was further enhanced during COVID-19 and is being institutionalized.

Informed programmes for young mothers: Together with other partners, the programme provided technical guidance and funding for the 'hey baby' study,[15] which informed the design of tailored mentor-mother models for adolescent and young mothers in Botswana, Lesotho, Malawi, Mozambique, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe; with improved outcomes for adolescent mothers living with HIV and their children. Findings from the study also informed the development of Global Fund proposals, and national social and behaviour change communication strategies.

[15] 'Hey baby' is a collaborative research study examining protective pathways to promote resilience among adolescent parents and their children in South Africa. (https://www.heybaby.org.za)

Number of Healthcare Workers Trained

Countries	Integrated SRHR, HIV & GBV	CAC/ PAC incl VCAT	AYFS	GBV	Key Population	Family Planning	Maternal Health	COVID 19	Other	
N=12	N=11	N=10	N=9	N=11	N=2	N=7	N=7	N=5	N=8	
Botswana	992	45	100	0	0	0	0	0	0	1137
Eswatini	1500	55	813	930	278	242	36	6700	330	10884
Kenya	99	0	0	292	0	0	25	0	0	416
Lesotho	820	16	0	147	0	142	346	4568	70	6109
Malawi	65	109	75	190	0	0	15	120	128	702
Namibia	0	85	7964	408	0	289	45	0	108	8899
South Africa	204	53	40	329	255	916	0	0	1200	2997
South Sudan	200	1455	0	471	0	95	0	319	1627	4167
Tanzania	20	0	50	850	0	0	0	0	50	970
Uganda	300	265	48	240	0	0	0	683	0	1536
Zambia	570	62	241	60	0	40	52	0	0	1025
Zimbabwe	4785	150	384	305	0	89	21	0	128	5862
Total	**9555**	**2295**	**9715**	**4222**	**533**	**1813**	**540**	**12390**	**3641**	**44704**

Social accountability mechanisms: Youth-led organizations were capacitated and meaningfully engaged in holding community leaders and health-care workers accountable to improve service delivery using social accountability mechanisms. The Social Accountability Model for SRHR (SAM4SRHR) model[16] in Eswatini and Zimbabwe used a scorecard that promoted open dialogue between AYP and health-care workers in the provision of respectful services through addressing health-care worker attitudes and ensured improved access to quality services, and strengthened the resilience of youth-led organizations. In Lesotho, the social accountability mechanisms improved the quality of AYFS in 77 health facilities, increased service provider knowledge on AFHS by 40 per cent, and youth advocates' knowledge of their SRH rights by 42 per cent.

Objective 3

RESULT 4: The programme supported peer-led community-based and information and communications technology (ICT)-supported interventions which contributed towards social and behavioural change among young people that reduce unintended pregnancies, new HIV infections and promote the uptake of contraceptives.

Peer- and community-led approaches: Eswatini, Lesotho, Kenya, Malawi, South Africa, South Sudan, Tanzania, Uganda, Zambia, and Zimbabwe supported peer-provider community programmes with referrals to services to reduce unintended pregnancies and new HIV infections, and promote the uptake of contraceptives among young people. These peer-community-led approaches ensured that hard-to-reach youth who could not access facility-based services are reached. Evidence from these initiatives have informed policies and programmes to improve service delivery, strengthen social support, and to foster multi-sectoral linkages and programming.

[16] The Social Accountability Model for SRHR (SAM4SRHR) seeks to build capacity for young people to enhance access to SRHR services, and is facilitated by SAfAIDS, funded by Sweden and supported by 2gether 4 SRHR.

Intergenerational conversations: CSOs, networks of young people and other key populations were capacitated to engage parents, traditional and religious leaders through community dialogues to strengthen communication, community ownership, empowerment, and participation on ASRHR. These dialogues have taken place in Lesotho, Malawi, Namibia, South Africa, Tanzania, Uganda, Zambia and Zimbabwe. These have served as a catalyst in activating community and intergenerational conversations resulting in increased community awareness and knowledge and improved attitudes regarding issues relating to sex, unsafe abortion, condom use, teenage pregnancies, and female genital mutilation. This in turn has resulted in increased knowledge and understanding of issues affecting AYP, corrected mis-information and dis-information, and built greater support for laws, policies and strategies that aim to extend access to SRH services for AYP.

Programmes for young mothers: Through collaboration with SAfAIDS, work with young women through mentorship programmes in Eswatini and Zimbabwe has led to improved HIV and SRH outcomes for young mothers and their babies. The programme has also supported young mothers' programmes in Lesotho, Malawi, South Africa, and Zambia. While loosely based on the Mothers2Mothers Mentor Mother Model for adolescent mothers living with HIV, these peer programmes were tailored for the countries in which they were implemented, based on research conducted into the unique needs of young mothers in each country.

AYP engagement with community and religious leaders

- In **Tanzania**, engagement with local leaders and young people resulted in endorsements for the ESA Commitment.
- In **Eswatini**, religious sector leaders adopted a manual on sexuality education for young people.

Photo credit © Jadwiga Figula/ UNFPA/2gether 4 SRHR

YOUNG MOTHERS'S PROGRAMMES

90%
Viral load suppression among adolescent and young mothers in Malawi, Zambia and Zimbabwe

6,200
Children of adolescent and young mothers are participating in playgroups in Malawi

84%
Male partners who tested negative for HIV started PrEP in Zimbabwe

91%
Early infant diagnosis among HIV exposed infants of AGYW in Zambia

77%
Children of adolescent and young mothers living with HIV received an HIV test by the age of 2 months in South Africa

88%
Mothers engaging in early child stimulation in Lesotho

Men's engagement and family-centered approaches have led to:

- Increased number of male partners seeking HIV testing
- Improved promotion of positive prevention for discordant couples
- Stronger support from family members

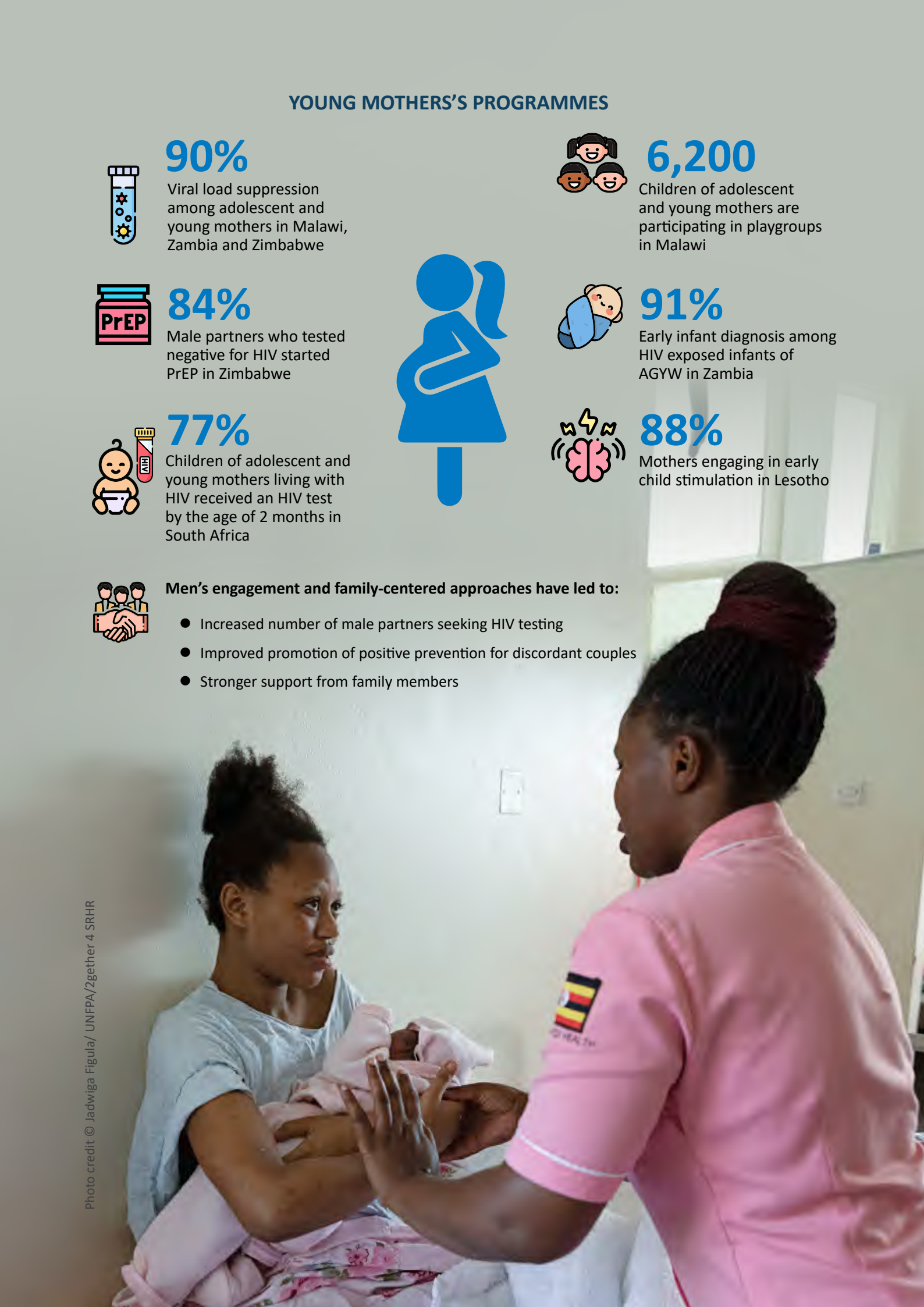


Photo credit © Jadwiga Figula/ UNFPA/2gether 4 SRHR

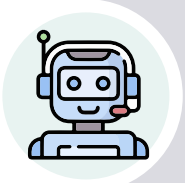
Social and behavioural change: A review of the tools in use to address challenges that adolescent girls and young women (AGYW) face in fulfilling their SRHR has strengthened risk-informed programming. A social and behavioural change (SBC) SRHR and HIV toolkit for AYP was developed in 2021 to improve knowledge and understanding, drive adolescent and youth engagement and behaviour change, and promote the uptake of HIV and SRH services. The toolkit includes a set of high-quality communication materials, and the content has been adapted for use by young people in Kenya and Malawi, where the toolkit was adapted and adopted as a national toolkit. It has been used to inform national SBC frameworks for AYP in Zambia, South Africa, Lesotho, and Uganda. Zimbabwe also developed a booklet on teen clubs that helps adolescents to work through challenges associated with HIV and SRHR. This concept has subsequently been taken up by other countries in the region. The SBC approach has guided interventions by, and for, AYP including the Zvandiri youth-led radio programme in Zimbabwe, the MTV Shuga intervention in Botswana, as well as a theatre for development approach and football and netball programmes in Malawi. These interventions have engaged young people and provided opportunities for them to raise their voices on SRHR issues and share relevant health information with other young people.

Using internet technology: Technology has been harnessed to improve SRHR programming for AYP in the region, using the Internet of Good Things (IoGT)[17] a website-building platform with SRHR content and over 10,983,191 users in ESA; and the U Report platform, a messaging and social accountability programme for AYP and community participation.[18] A report based on research conducted in 2022, noted that the IoGT has informed programming for AYP, parents and caregivers, frontline workers and service providers. It further noted that the U-Report platform has been used in innovative ways to influence programme design. There is, however, further scope for refinements and linking both platforms.

Learning between the programme countries allowed for the sharing of experiences on technological innovations, and resulted in the development of 'Hayati', an AI-driven chatbot developed by youth advocates in South Sudan to provide confidential and timely information on SRH and GBV-related issues and referrals.

Utilizing social media: The programme has also made use of social media platforms such as 'Tune Me', Facebook, WhatsApp and Twitter, which have allowed many young people to access messages on SRHR, HIV and GBV, particularly during the COVID-19 period, providing valuable information and promoting access to services.

Social listening and traditional media scans: A number of social listening and traditional media scans took place during the programme implementation period, which identified what was current and trending in the news and on social media, particularly linked to specific SRHR and COVID-19 keywords. These listening reports included a retrospective media scan which informed how the programme engages with media and maximizes the use of influencers, particularly when reaching AYP. The programme also supported working with the media, and engaging with journalists, news editors and media houses in South Sudan on reporting on CSE helped to raise public awareness and build support for ASRHR.



A chat-bot enabling young people to access accurate SRHR information in Kenya

The programme supported the Y-ACT Youth Power Hub to co-create the Ask Doki Bot, a natural language processing artificial intelligence (AI) powered counsellor for young people seeking health advice and services. Ask Doki was launched in January 2023 and designed with input from more than 80 young people. It is available in English and Swahili.

[17] The IoGT is available in 13 countries in ESA, and is designed to support users with lower literacy levels and limited experience with technology. It supports programmes by aiding dissemination of guidance on topics, such as parenting, education, healthy practices and skills-building, and allows for two-way communication and engagement, to build and maintain a dialogue with key populations, capture behavioural insights and offer training modules.

[18] U-report is available worldwide and is a messaging and social accountability platform designed to address issues that affect children and young people by collecting their insights to improve policy and programmes, and by providing timely, life-saving information.

Objective 4

RESULT 5: The programme strengthened the knowledge base for programming for AYP through operational research, and supporting cross country learning, and South-to-South collaboration.

Formative research: The programme supported research by the University of Cape Town and Oxford University which led to the development of an evidence-to-practice series of documents on the SRH needs of AYP and the drivers of adolescent risk in the context of HIV and SRH. These have been disseminated through uploading to the PUNO and 2gether 4 SRHR websites; sharing via numerous listservs including internal, broader United Nations agencies and external partners; country-level dissemination through specific country level stakeholder events or technical working groups; and integration in various country, regional and global presentations.

Documented success stories: The programme has documented case studies and human-interest stories drawing on programme implementation that have been shared with other countries to facilitate cross country learning and exchange. Malawi developed a human-interest story on improving SRHR services for AYP, Uganda on the power of peer education and Zimbabwe on the use of Community Adolescent Treatment Supporters (CATS). A short documentary video was created in Zimbabwe on the young mentor mothers' programme, and a detailed review of the Zvandiri project supported by 2gether 4 SRHR in Zimbabwe was also undertaken and shared within the region.

These knowledge products not only document and analyse project activities, but also disseminate best practices and insights gained from the programme, and can influence programming and decision-making in other contexts. They also provide tangible evidence of the impact and effectiveness of specific initiatives.

Shared experiences: The experiences generated through programme implementation have been shared through regional meetings and SRHR conferences, including the International Conference on AIDS and STIs in Africa (ICASA). Data and experiences from the programme were used at a dialogue on high impact practices to avert teen pregnancies in the SADC region organized as part of the Public Health Association of South Africa 2022 Conference, together with the Clinton Health Access Initiative (CHAI).

Knowledge generated on the needs of AYP in Zambia

- In **Zambia**, an adolescent health research symposium, evidence synthesis documents, action briefs and reports on ASRHR and HIV, on adolescents at high risk of non-adherence to ART provided useful knowledge to inform programming.
- A Think Tank and implementation brief on improving the implementation of PrEP for adolescent girls and young women have provided further insights and guidance for programmes.

Sustainability of programme investments

The sustainability of efforts in promoting SRH for AYP in the region is likely due to comprehensive capacity building initiatives, strategic partnerships, policy adoption, knowledge sharing, and tailored service delivery approaches. Empowered regional networks of AYP will ensure continued advocacy for responsive laws and policies to protect the rights of young people. The adoption of AYFS principles and the training of health-care workers on AYFS ensure sustained service delivery tailored to meet the needs of young people. Furthermore, the operational research and cross-country learning and collaboration enhances the knowledge base for programming for AYP, establishing a foundation for continued progress in prioritizing SRHR interventions for AYP in the region.

Lessons learned from Phase I	Application in Phase II
Contextually sensitive programming with a focus on improving economic and health outcomes for a AYP, and with a focus on the economic growth of the region can shift the opinions of policy-makers and gatekeepers.	Phase II will support advocacy at the regional and country level to highlight the relevance of young people's SRHR, and support interventions that equip young people for employment or entrepreneurship and ensure a healthier future.
Stigma around young people's sexuality persists, and results in barriers to young people accessing services.	Phase II will include a regional mapping exercise to inform evidence-based strategies to engage regional coalitions and networks of traditional and religious leaders, parents and other influencers, in dialogue to reduce the ongoing challenges faced by AYP when accessing services.
Policy measures and guidelines for engagement and service provision for young people are in place but are not being optimally operationalized.	Phase II will draw on regional institutions to build the capacity of national trainers to empower health-care workers and address service delivery barriers to create a more enabling environment for AYFS.
Collaborative, youth-led, peer-led and key population-led approaches are most effective in reaching AYP and other vulnerable populations.	Phase II interventions will build the capacity of regional adolescent- and youth-led networks and champions, with a focus on youth-led advocacy, leadership skills, and digital engagement to promote access to youth-friendly information and referrals to services, promoting social accountability.
SBC is not well understood, and communication with and for young people is often not accessible.	Phase II will harness new technology for social listening and support the co-creation of content with young people for more relevant, engaging, accessible and technically sound SRHR information and programmes that address the needs of AYP.

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8 Ending Unintended Pregnancies and Unsafe Abortion

There are high levels of unintended pregnancies and unsafe abortions across the ESA region. The ICPD Programme of Action and the Guttmacher-Lancet Commission on SRHR affirm that counselling and services for modern contraceptives, CAC,[19] and the treatment for unsafe abortion are an essential part of UHC and should be provided as part of a comprehensive package of SRHR services. The high unmet need for contraceptives and high levels of sexual violence in the region increase the risk of unintended pregnancies, unsafe abortion and of HIV acquisition, and the programme has prioritized action to address these risks.

[19] In the context of this report, CAC includes access to post-abortion care, a life-saving intervention that is part of emergency obstetric and newborn care and aims to reduce death and suffering from the complications of miscarriage (spontaneous abortion) and unsafe abortions.

Achievements in addressing untended pregnancy and unsafe abortion

Unintended pregnancy, the unmet need for contraception, and unsafe abortion **placed on the policy agenda** in **12 countries** to inform programming

Evidence base on unintended pregnancy, the unmet need for contraception, and unsafe abortion **strengthened**: **4** countries **conduced assessments, 4** countries developed **costed plans, 1** country conducted an **investment case**

Capacity for and **provision** of services enhanced in 12 **countries** according to legal frameworks

6 countries aligned and updated family planning **guidelines**

V-CAT Training of Trainers conducted to address health care worker attitudes and norms in **5 countries**

2,295 health-care workers trained on the **clinical management** of comprehensive abortion care across **10 countries**

1,813 health-care workers trained on **family planning** across **7 countries**

Monitoring and reporting strengthened: 2 countries developed PAC registers and logbooks, 2 countries integrated reporting into DHIS2

Strategic information on unintended pregnancy and unsafe abortion enhanced for **11 countries**, and **3 knowledge products** developed

Objective 1

RESULT 1: Regional inter-agency collaboration strengthened programming in 12 countries working on unintended pregnancies, contraceptives and unsafe abortion by the end of 2023.

Inter-agency Working Group

Objective 2

UNFPA and WHO led the efforts of the programme to address the issue of unintended pregnancies, the unmet need for modern contraceptives and unsafe abortion, guided by an annex to the agreement developed at the programmes' inception. A regional inter-agency working group, including representatives from the headquarters of UNFPA and WHO, was initiated in 2018 to guide and coordinate regional efforts, support countries and to unlock further investments in this neglected area of work.

Country roadmaps

Objective 4

In September 2018, the programme convened a capacity-strengthening workshop to engage countries on actions that can be taken to strengthen programming on unintended pregnancies, contraception and unsafe abortion with representatives from the Ministries of Health, WHO, UNFPA, health-care workers and civil society partners from eight countries supported by the programme: Botswana, Eswatini, Lesotho, Malawi, Namibia, Uganda, Zambia, and Zimbabwe. This meeting resulted in the eight countries developing country-level roadmaps with priority areas to be addressed in the following 2 years.

The Access Project: By the end of the first phase of 2gether 4 SRHR, the initial 8 countries were expanded to 12 including Kenya, Ethiopia, Mozambique, and Rwanda. This expansion was supported through the Access Project.[20] The Access Project also ensured that all participating countries were able to access commodities and supplies through the UNFPA Supplies Programme. Further funding from the United Kingdom's Foreign Commonwealth and Development Office (FCDO) has leveraged off the regional coordination platforms to ensure a harmonized approach to programming in the region.

South-south learning: Building on the 2018 capacity-strengthening workshop, follow-up regional meetings were convened. The meeting in 2021 took stock of the impact of COVID-19 on programming, with countries sharing experiences as to how they managed to ensure continued programming in light of the pandemic. Meetings convened in 2022 and 2023 updated the country roadmaps to guide programming, identified the technical assistance needs. Cross-country learning was enabled through sharing programming experiences in expanding the rights of women to access these critical SRHR services in line with global, continental and regional commitments and national laws.

Research and advocacy: In addition to the inter-agency WHO and UNFPA platform, the programme convened a research and advocacy group with academia and CSOs working on unintended pregnancies, contraceptives and unsafe abortion. Participating organizations included: Ipas, International Planned Parenthood Federation (IPPF), African Population and Health Research Center (APHRC), SAfAIDS, Guttmacher Institute, and International Federation of Gynaecology and Obstetrics (FIGO). The group shared information on activities being undertaken, and jointly developed a discussion paper[21] that explored the evidence on the impact of extending access to safe abortion care on other SRHR indicators. The group also explored opportunities to strengthen programming, and led regional dialogues to inform the development of the regional advocacy strategy and its focus on unintended pregnancies, the unmet need for contraceptives and unsafe abortion.

A session on CAC at the Regional SRHR Symposium in 2022 explored successes and strategies for moving the agenda forward and allowed countries to share their experiences.

Objective 1

RESULT 2: The programme placed the issue of unintended pregnancies, contraceptives and unsafe abortion on the policy agenda.

Engagements on laws and policies: Engagements with Members of Parliament, policy and decision-makers resulted in unintended pregnancies, contraceptives and unsafe abortion being placed on the policy agenda of the region. National and regional dialogues with policy-makers increased awareness of the costs of the existing legal and policy restrictions not only to the health system, but also to families, and its impact on the lives of adolescent girls and young women.

Engagements with Parliamentarians, policymakers and communities around to expand the legal provisions according to which women can access CAC as per the provisions of the Maputo Protocol, namely: sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus helped to dispel misinformation and disinformation and promote the rights of women in Africa.

[20] The Access Project is a dedicated project under the UNFPA Supplies Programme in close collaboration with the Maternal and Newborn Health Thematic Fund (MHTF) programme. It aims to accelerate progress towards ending preventable maternal mortality through the prevention of unsafe abortion, specifically through increasing access to safe abortion care to the full extent of the law, and post-abortion care services with a focus on medical methods of abortion. The project is funded by a large anonymous donor.

[21] Macleod, C.I., Speciale, A., and Delate, R. (2021). *Broadening the grounds on which abortion is legal: effects on sexual and reproductive health indicators.* Makhanda and Johannesburg: Rhodes and UNFPA.

Objective 3

Sensitization of leadership

In all instances, the programme supported sensitization meetings with Members of Parliament, engagements with CSOs and faith-based and traditional leaders and supported public dialogues and hearings to obtain the views of communities.

Addressing stigmatizing attitudes towards abortion in Malawi

The programme provided technical and financial support for partners to conduct training in Malawi which incorporated values clarification and attitude transformation training (V-CAT) with 75 community leaders (including parents, chiefs, religious leaders, political leaders and young people) and 20 District Executive Management team representatives (including police, health, social welfare, education, youth and judicial sectors). This resulted in a common understanding of how societal norms and values negatively impact on the SRHR outcomes for adolescents and key populations and resulted in increased community support for changes to enhance access to services.

Increasing accountability in Namibia

In Namibia, CSOs facilitated advocacy sessions with communities and Members of Parliament, which resulted in communities being able to demand accountability from governments on service delivery to reduce unintended pregnancies among other SRHR issues.

Objective 1

RESULT 3: The programme strengthened the evidence base around the drivers of unintended pregnancies, barriers to contraceptives and unsafe abortion in four countries, to inform and guide future programming.

Strategic assessments: One of the indicators of the Maputo Plan of Action is for countries to develop national reports on the situation of unsafe abortion in their countries. Botswana, Eswatini, Lesotho, and Namibia undertook strategic assessments on unintended pregnancies, contraceptives and unsafe abortion.[22] By conducting these strategic assessments, the countries facilitated a country-led process that identified and prioritized needs and potential follow-up actions related to critical SRH issues, such as the reduction of unintended and unwanted pregnancies, the unmet need for contraception and the morbidity and mortality related to the unsafe abortion.

The strategic assessments further provided an opportunity for countries to engage in dialogue about sensitive topics with communities, including to clarify the legal circumstances under which comprehensive abortion services can be provided, to advocate for the strengthening of policy and legal frameworks where necessary, and to increase people's understanding of their rights. The findings and follow-up action from the assessments have provided the evidence base for high-level policy advocacy, including with Members of Parliament on expanding the legal provisions according to which women may access safe abortion services to reduce morbidity and mortality related to unsafe abortion. This has further provided a foundation for future planning and programming aimed at addressing the barriers identified and leveraging on the facilitators to ensure effective programming for contraceptives and the prevention of unsafe abortions.

[22] The strategic assessment is the first of a three-staged WHO Strategic Approach which is based on a systems framework that examines the relationships between people, including their reproductive health needs and their perspectives, gender and human rights issues, service delivery and available health technologies.

Lesotho completed its background paper and is in the process of undertaking fieldwork for the strategic assessment. Botswana, Eswatini and Namibia have completed their strategic assessments, which are being analysed to inform evidence-based decision-making, targeted interventions and comprehensive approaches to improve reproductive health outcomes. Botswana has progressed furthest in the strategic assessment process.

Investment case and costed plans: Mozambique conducted an investment case study on this area of work, and Kenya, Namibia and Zambia have developed national costed implementation plans to strengthen efforts to address the unmet need for contraceptives. These plans provide an estimate of the resources required that must be raised domestically and from development partners if countries are to address these needs. They are being used as advocacy tools to support resource mobilization and boost last-mile delivery of commodities to improve access to services.

Policy briefs developed in Botswana

Three policy briefs were developed for the Ministry of Health in Botswana; one on contraceptives, one on unintended pregnancies and another on unsafe abortion. These have been shared with other ministries, CSOs and academia, and have increased awareness and advocacy for an enabling policy environment and further catalysed action on the implementation of priority recommendations from the strategic assessment. Further dissemination of the policy briefs aims to strengthen the capacity of policymakers and programme managers to mainstream gender, equality and rights across policies, programme implementation, and monitoring for SRHR, HIV and GBV, addressing the prevalence and consequences of unsafe abortions.

Objective 2

RESULT 4: The programme strengthened the provision of quality integrated contraceptives and comprehensive abortion care services according to the legal frameworks of the countries.

Contraception guidelines: Guidelines on the provision of contraceptives were developed or updated in Eswatini, Lesotho, South Africa (including self-care guidelines), and Zimbabwe. Kenya and Zambia have developed contraceptive self-care guidelines.

Abortion guidelines: At regional level, WHO and UNFPA collaborated on engaging countries to domesticate the 2022 WHO Abortion Guidelines. A regional meeting was convened with some countries to engage on the new guidelines and to develop a plan for the domestication of national guidelines against the WHO Guidelines. Ethiopia, Kenya, Malawi, and Mozambique undertook an assessment of the extent to which their national guidelines are aligned to the WHO Guidelines. South Africa and Zambia updated their guidelines on CAC, and Zimbabwe updated draft guidelines, pending final approval. These efforts ensure that services are delivered according to international norms and standards and inform the development of training materials, capacity-building and supportive supervision that ensure that clients receive integrated rights-based quality services.

Attitudinal change for health-care workers: One of the main constraints in providing and accessing quality services is the attitude of health-care workers and co-workers in facilities towards women accessing PAC services. The programme brokered technical assistance to Botswana, Eswatini, Malawi, Namibia, and South Africa by Ipas using a training-of-trainers modality on values clarification and attitude transformation (V-CAT), with one workshop facilitated in each country. The outcome of these trainings was that each country had a cadre of trainers that could cascade the training to facilities to ensure a full site being able to effectively support the process of service provision.

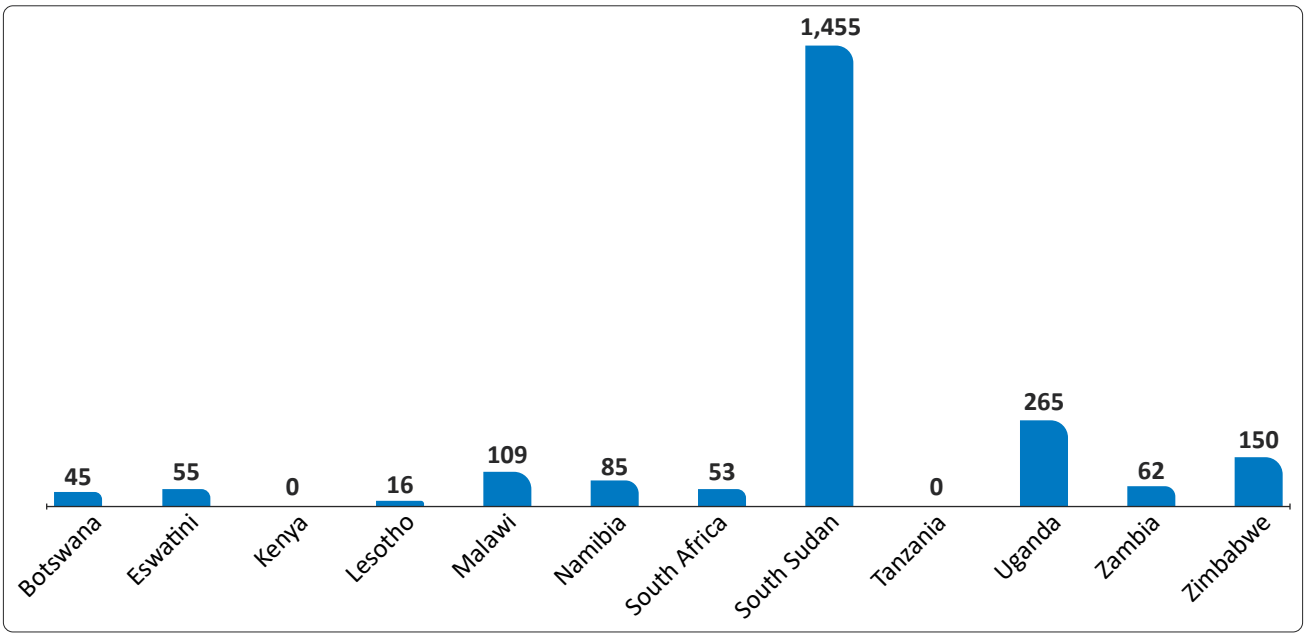
Clinical training: The programme promoted a mix of the training-of-trainers approach and training for health-care workers in 10 countries Botswana, Eswatini, Lesotho, Malawi, Namibia, South Africa, South Sudan, Uganda, Zambia, and Zimbabwe. Training included the clinical management of CAC, drawing on curricula developed by international partners, such as Ipas in instances where countries did not have an in-service training curricula or

were based on national curricula aligned to the national guidelines where available. This training strengthened the capacity of 2,295 service providers across 10 countries to provide comprehensive abortion care services, including the use of manual vacuum aspiration (MVA), medical abortion and self-care technologies.

Additional capacity-building: Other capacity-building initiatives included the development of a new modular integrated, rights-based SRHR curriculum in Botswana, a curriculum in South Africa which includes modules on comprehensive abortion care, the RMNCAH mentorship programme in Zambia including mentoring to strengthen clinical skills, and pre-service and specialist training on PAC in Zimbabwe.

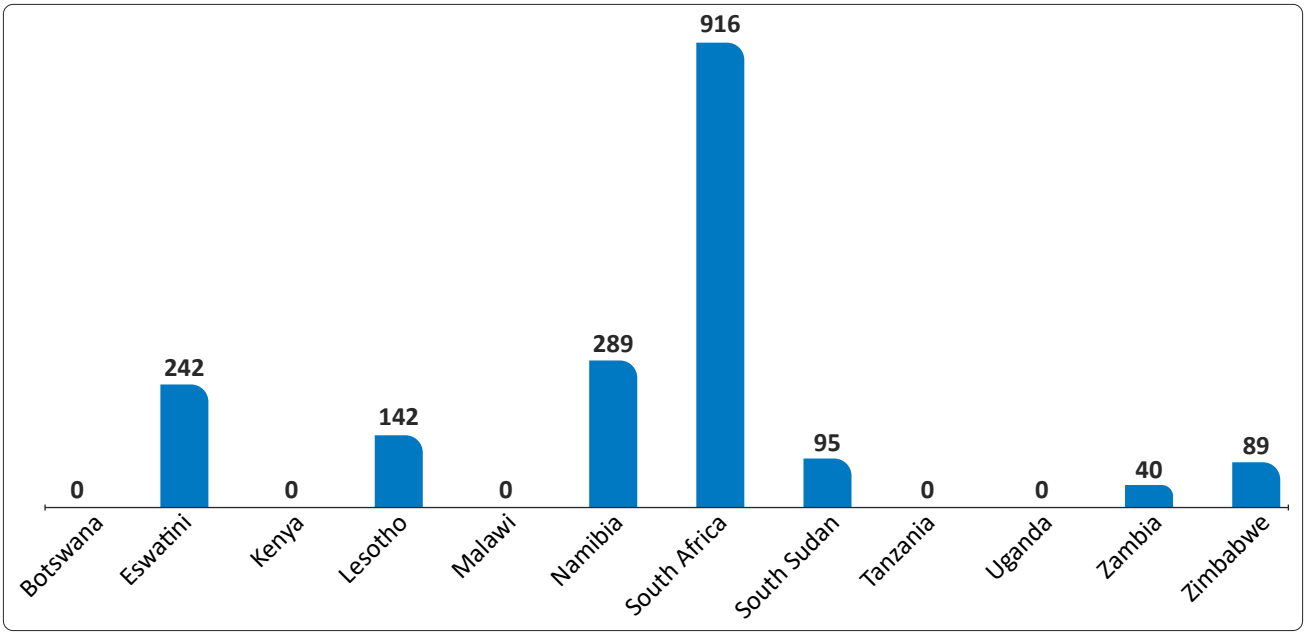
Training on CAC and V-CAT was provided according to the identified needs and priorities for each country.

Number of people trained on CAC, PAC and V-CAT



Additionally, the programme strengthened the capacity of 1,813 health-care workers in seven counties (Eswatini, Lesotho, Namibia, South Africa, South Sudan, Zambia, and Zimbabwe) on family planning, resulting in enhanced integrated provision of contraceptive services.

Number of people trained on family planning



Commodities and procurement: The programme funding from Sweden was complemented through the UNFPA Supplies Programme and the ACCESS Project to procure and distribute contraceptives and emergency contraceptives, as well as improve access to supplies for comprehensive abortion care as per the laws of each of the countries supported by the programme.

Technical assistance also resulted in Ministries of Health in Malawi being able to streamline procurement and distribution of commodities, resulting in increased contraceptive uptake, reduced unintended pregnancies, and ultimately, enhanced maternal health outcomes.

Objective 4

Success stories shared: In Lesotho, a human-interest story profiling health-care worker and client experiences of self-injectable contraception shared information about this innovation, promoting choice, and encouraging positive change in how individuals and communities approach contraception.

Objective 4

RESULT 5: The programme strengthened strategic information on contraceptives and unsafe abortion to inform programming.

The programme supported two formative pieces of research to strengthen programming for populations left behind and the provision of CAC services in humanitarian settings.

Insights into service access for FSWs: A scoping review looking at the unmet need for family planning and unsafe abortion among FSWs in the region found that rates of non-barrier contraceptive usage varied from 15 per cent to 76 per cent, unintended pregnancies from 24 per cent to 91 per cent, and unsafe abortion from 11 per cent to 48 per cent.[23]

Insights into abortion access in humanitarian situations: A sub-analysis of the MISP Readiness Assessment highlighted that access to comprehensive abortion services are limited even in development settings, but are exacerbated during emergencies, although PAC services are more readily available in emergency settings. The MISP Readiness Assessment has seen countries increasingly explore approaches on how to strengthen the provision of CAC services during emergencies.

Insights into the cost of unsafe abortion: The programme also supported studies into the economic costs of unsafe abortion, which show that exponentially more resources are used when having to offer services to save lives after an unsafe abortion, than would be required if quality voluntary abortion services were an option. The reports from these studies are still to be finalized, and will contribute to advocacy for legal and policy reform.

Findings from the scoping review with female sex workers

- Alcohol use, violence, health systems problems, and socioeconomic issues, impact on access to contraception and unsafe abortion.
- Barriers to accessing, and delaying, antenatal care were reported as common.
- Targeted interventions reduced unintended pregnancies, contraceptives and unsafe abortion among female sex workers.

[23] Macleod, C.I., Reynolds, J.H. and Delate, R. (2022). Women Who Sell Sex in Eastern and Southern Africa: A Scoping Review of Non-Barrier Contraception, Pregnancy and Abortion. *Public Health Review*, vol. 43.

Findings on abortion care from the analysis of the MISP Readiness Assessment

- Services are highly stigmatized with a negative attitude by health-care workers.
- Health-care workers and the general population lack knowledge and understanding of the existing laws, which negatively impacts access to services.
- Qualified staff, equipment, facilities, and access to commodities were largely regarded as 'insufficient'.

Objective 2

RESULT 6: The programme strengthened routine monitoring and reporting through health management information systems.

Review of monitoring tools: Using an integration lens, the programme advocated for strengthening routine monitoring and reporting on contraceptives and CAC, as provided for by the laws of the country. A review of the extent to which contraceptive and abortion monitoring tools in 10 countries capture data found that there is a lack of disaggregation by age, thus limiting the usefulness of the information in planning for the delivery of services across the life course, and ensuring that services are provided as defined in national strategies and guidelines.

In relation to family planning, the review found that there is a lack of integration of tuberculosis (TB), human papillomavirus (HPV), and sexually transmitted infections (STI) information within family planning registers. The review found that only three countries had integrated data on PAC or CAC within their national registers, however in almost all instances, countries do not report this data within their national HMIS systems.

Improved reporting tools: With financial and technical support from the programme, Malawi and Uganda developed PAC registers and log-books that included a review of their indicators to capture data relating to the provision of services. Malawi and Zimbabwe have integrated reporting on PAC within their national District Health Information Software 2 (DHIS2) systems. The programme will continue to advocate in Phase II to expand the routine reporting on CAC.

Sustainability of programme investments

The sustainability of efforts to end unintended pregnancies and unsafe abortions is likely due to comprehensive capacity-building initiatives, policy engagement, knowledge sharing, partnerships, and improved M&E systems. Capacity built for health-care workers and policymakers enhances the provision of and access to quality-integrated service delivery, including family planning and CAC. Engagements with policymakers, CSOs and community leaders have placed these issues on the policy agenda, contributing to attitudinal transformation and policy reform. Research has strengthened the evidence base and regional collaboration and partnerships have bolstered programming and advocacy efforts. Enhancements in monitoring and reporting ensure the continuous tracking of progress to inform decision-making and the development of country roadmaps will ensure ongoing efforts in this area of work.

Lessons learned from Phase I	Application in Phase II
There continues to be proactive effort at misinformation and disinformation that leads to misunderstandings of contraception and abortion at all levels of society in the region.	Phase II will provide technical assistance to countries to harmonize related national policies and strategies and support community engagements and sensitization to enhance understanding, and to promote access to necessary services.
Legal and policy level change takes time and should be regarded as an incremental process where changes are informed through dialogue and engagement to bring about shifts in norms, values and attitudes.	Phase II will undertake high-level advocacy and facilitate strategic dialogues with Heads of State, law makers, governments, senior policy and decision-makers (in partnership with civil society and rights holders), through the African Union, RECs, and other ministerial forums, to progressively expand the legal provisions for women to access safe abortion care services.
Health-care workers and communities have limited knowledge about the legal provisions of comprehensive abortion care services, and in some instances a lack of skilled personnel, and high staff turn-over result in poor quality-of-care.	Phase II will use regional platforms to advocate and provide technical assistance to review and update in-service and pre-service training curricula and enhance the skills of health-care workers to deliver a package of integrated SRH services.
Conscientious objections from health-care workers, and stigma and discrimination against those seeking services result in poor service delivery.	Phase II will support efforts to address values, attitudes, and norms among health-care workers, to create a more enabling environment for those making use of these services.
Supply-side challenges, such as stock-outs and shortages of contraceptive commodities, and inadequate equipment to provide safe abortion services result in reduced access to necessary services.	Phase II will boost efforts by the AUC and RECs to strengthen regional regulatory and procurement mechanisms, examine opportunities for regional pooled procurement, and provide incentives and guidelines to promote regional manufacturing of SRH commodities and supplies.
Reporting on indicators related to unintended pregnancies and abortion services is limited, there is a lack of standardized data capturing tools, data disaggregated by age, and sharing of data by the private sector.	Phase II will include a focus on strengthening data collection and use on these and other indicators.

Addressing Harmful Gender Norms and GBV

Gender inequalities in the ESA region can lead to disparities in accessing information, resources and quality health-care services. Harmful social norms, gender stereotyping and permissive laws on issues like child marriage, can lead to high levels of GBV and restrict access to SRHR, contributing to negative health outcomes for girls, women and key populations.

Recognizing these vulnerabilities, the 2gether 4 SRHR programme included interventions to address the structural drivers of unequal health outcomes both within and beyond the health system. The programme supported activities in the focus countries to address gender inequality and ensure that girls, women and key populations are protected from GBV and are able to access SRHR services, while men are engaged in programmes as clients, partners and advocates for women health.

Achievements in addressing gender norms and GBV

Legislative and policy frameworks were developed in **4 countries to address GBV to protect the bodily integrity of survivors.**

Gender assessments in **6 countries and rapid assessments on the SRHR needs of men and boys** undertaken to inform programming.

Capacity enhanced of health-care workers to improve the GBV response and services for survivors of violence

4 guidelines developed

2 curricula updated

4,222 health-care workers trained

Male engagement programmes in 7 **countries** shifted attitudes of men and boys towards SRHR and GBV.

12 knowledge products created

Objective 1

RESULT 1: The programme extended rights and protections for survivors of GBV through enhanced legislative and policy frameworks.

Development of laws and policies: The programme supported EALA to develop the EAC SRHR Bill and SADC PF to develop the Model Law on GBV. Both include stronger provisions to address gender based violence, and harmful practices. SADC PF produced a policy guidance tool to advance the SRHR needs of key populations. The SADC Scorecard and the EAC integrated scorecard were used to track progress on GBV to enhance accountabilty.

At the country level, technical support to strengthen the legal and policy environment has contributed towards the development or amendment of a range of laws and policies to prevent harmful gender norms.

The passing of these laws resulted in greater inter-sectoral collaboration between Ministries of Health, Police, Education and Social Protection, with information being shared across these sectors, ensuring that services for survivors of violence are better coordinated. They have also enhanced public awareness around GBV to bring about attitudinal shifts and go some way to addressing social norms that impact on the prevalence of GBV.

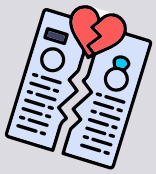
Laws impacting on GBV and social norms

Botswana: Penal Code (Amendment) Act, 2018

Estwatini: Sexual Offences and Domestic Violence (SODV) Act 2018

Malawi: Marriage and Divorce Act 2017

Uganda: The Sexual Offences Bill, 2019



Lesotho: Counter Domestic Violence Act

Adoption of United Nations Commission on the Status of Women (CSW) Resolution 60/2: Together with UN Women, the programme further provided technical support to SADC to support the review and adoption of the CSW Resolution 60/2

on women, children and the girl child, which notes that all forms of violence against women and girls, discrimination and harmful practices are among key contributing factors to the spread of HIV, and that unequal power relations and socioeconomic inequalities continue to drive young women's vulnerability to HIV. This has resulted in countries implementing the resolution, and reporting on.

Objective 2

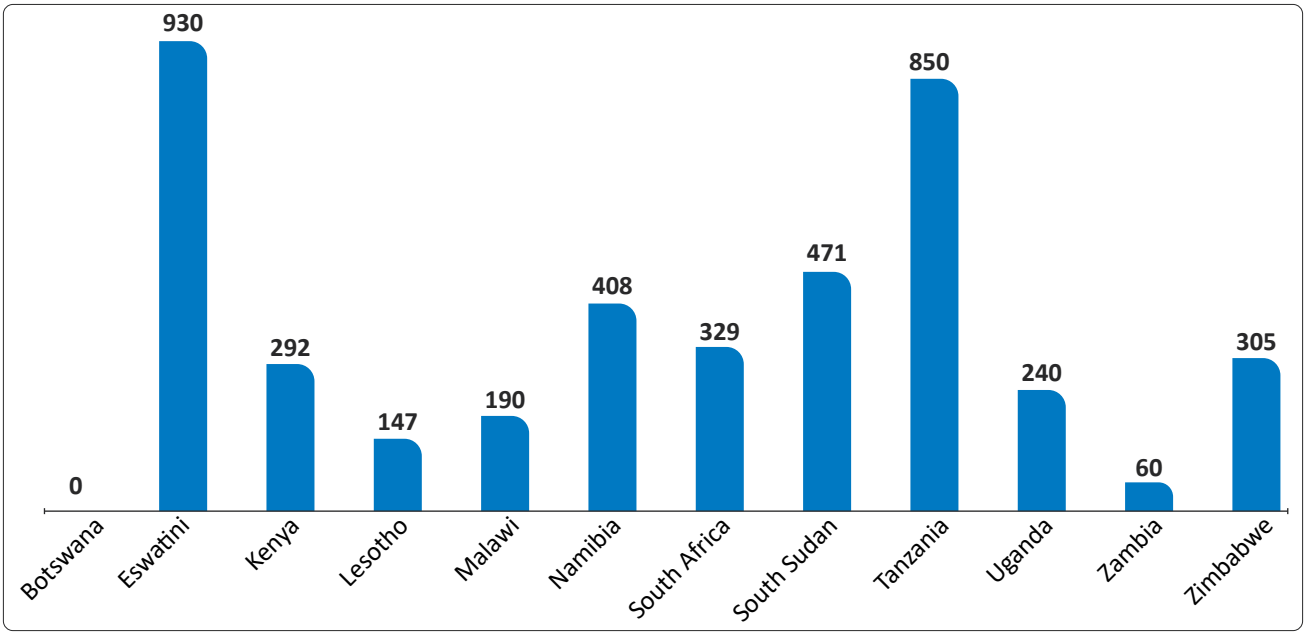
RESULT 2: The programme enhanced respectful, quality GBV services for survivors of violence.

Guidelines on providing GBV services: A key component of integrated SRHR service delivery is the inclusion of services for survivors of GBV, and in ensuring access to services for key populations. The technical support provided by the programme resulted in four countries (Botswana, Eswatini, Namibia, and South Africa) developing specific guidelines and handbooks on providing GBV services, while other countries incorporated these into guidelines on integrated services. These guidelines include standard operating procedures (SOPs) which provide principles and standards for ethical, safe and coordinated multisectoral service delivery, and outline the roles and responsibilities of each actor in the management of survivors of GBV. The guidelines have resulted in improved quality and accessibility to services and fostered a more coordinated response to GBV in these countries.

Training for health-care workers: The programme contributed to the development of a training curriculum on GBV in Lesotho and on integrated service delivery, including GBV, in Zimbabwe. These curricula ensure that health-care workers receive standardized training that ensures that survivors receive quality integrated SRHR and GBV services. While capacity-building activities in most of the programme countries included GBV in training on the delivery of integrated SRHR services, 4,222 health-care workers received specialized training in the provision of GBV services.

This training has resulted in sensitizing health-care workers to the needs of people requiring GBV services and enhancing knowledge around both the laws related to GBV and the clinical response. This has improved the delivery of standardized, comprehensive and survivor-centred services, and referrals for further supportive services.

4222 Healthcare Workers Trained on GBV



Objective 3

RESULT 3: The programme enhanced male engagement to create awareness and bring about a change of attitude towards SRHR and GBV.

As social norms and cultural practices contribute to high rates of GBV and other harmful practices, working with communities to create awareness and bring about a change in norms and attitudes has been key to addressing GBV, and in increasing awareness around the availability of GBV services and support for survivors.

A framework for action for male engagement: The programme supported the development of a new framework for action for male engagement in the HIV response, which addresses harmful social and gender norms related to HIV, and outlines the building blocks for planning interventions and strategies as well as monitoring male engagement. The framework was launched with both the EAC and SADC, and has resulted in a formal male engagement strategy being developed in Uganda, and other countries strengthening this area of work.

Programmes focussing on men and boys: The programme supported interventions that respond to the HIV and SRHR needs of men and boys, as well as guiding work with men on preventing and responding to GBV in Botswana, Eswatini, Malawi, South Africa, Uganda, Zambia, and Zimbabwe. These have resulted in the mobilization of male action groups to transform the social and structural drivers of gender inequality.

Men as champions in Uganda

Male engagements have resulted in community leaders becoming champions for SRHR, and in high-level advocacy; with specific male action groups being led by Prime Minister Peter Mayiga the king of the Buganda his royal highness Kabaka Mutebi.

Enhanced community involvement: The programme has also supported the convening of traditional, religious and community leaders in community dialogues to enhance awareness about GBV and advocate for prevention and protective behaviours and the uptake of services.

Including networks of young people and key populations on social inclusion and community-led monitoring has further enhanced public awareness of GBV and the need for a more comprehensive response. In Eswatini, an initiative engaging adolescent men and boys resulted in an improvement in norms and attitudes on sexual offences and domestic violence.

Expanded partnerships and collaboration with NGOs as partners in GBV prevention and risk communication has involved innovative community-driven approaches involving parents, adolescents and young people, and strengthened community-based referral systems for improving access to GBV services. These successes are shared in a booklet on teen clubs in Malawi and how these help young people to overcome experiences of GBV, and a human-interest story on supporting survivors of GBV in Malawi.

The programme also supported work with civil society on addressing the needs of key populations through peer-led interventions, including drop-in centres, outreach activities, mobile services and linking and referral to public health facilities, which have resulted in some progress towards attaining the SRH rights for these key populations. These engagements have resulted in increased community awareness of the availability of GBV services, which were particularly important during the COVID-19 national lockdowns, where the incidence of GBV increased in many countries.

South-South learning: To enhance South-South learning on male engagement and work with key populations, two sessions focused on these areas during the Regional SRHR Symposium held in 2022. These sessions shared experiences of working with these populations and resulted in recommendations to inform Phase II of the programme. A team from Lesotho conducted a learning visit to South Africa to learn from their male involvement strategies. This resulted in the rollout of effective strategies in Lesotho to reduce the barriers to men accessing services. A news story on male engagement was also shared to reflect the successes of this strategy.

Photo credit © Jadwiga Figula/ UNFPA/2gether 4 SRHR

Objective 4

RESULT 4: The programme enhanced the collection and utilization of strategic information on gender and experiences of violence.

Gender assessments: The programme supported gender assessments in Kenya, Malawi, Namibia, South Africa, South Sudan, and Tanzania,[24] which have informed the inclusion of gender dynamics in the development of national strategic plans, and applications for the Global Fund in Namibia and South Africa.

Rapid assessment of behavioural drivers related to SRHR service uptake: The programme facilitated a rapid assessment of structural, social and behavioural drivers that facilitate or impede uptake of SRHR services in Lesotho, Zimbabwe, Zambia, Malawi, and Uganda, and found that only Uganda had a specific policy on male involvement. None of the policy documents reviewed included a focus on how male norms contribute to harmful practices or GBV. It also noted high levels of risky sexual behaviours among men, harmful sexual norms and elevated intimate partner violence. It found that health facilities were not convenient for men, who did not trust that services provided were confidential, respectful and non-judgemental. These learnings were shared with the five countries who identified three immediate actions to strengthen programming for men and boys, including the development of male engagement strategies, promoting male friendly health services and addressing gender and social norms among men and boys.

Evidence-to-Action briefs: In South Africa, an Evidence-to-Action brief was developed on improving linkages and referral pathways between violence prevention and response and HIV care.

Review of gender-transformative approaches: A review of gender-transformative approaches and promising practices in health, nutrition and HIV programming in Africa was also supported by the programme in 2022, and draws upon empirical evidence to support the PUNOs to develop gender-transformative theories to guide Phase II of the programme.

Enhanced data collection on GBV: GBV integration was prioritized during the programme, resulting in better reporting on experiences of GBV and service-seeking, with Botswana, Eswatini, Lesotho, South Africa, Uganda and Zambia having improved tools for GBV reporting. While data was available on the indicators related to reported experiences of sexual violence in SADC countries, this was not readily available for EAC countries. However, data collection on experiences of GBV is challenging, as it is a phenomenon that is often underreported. Increases in reported cases of GBV may be a reflection of the improved availability of services and greater confidence in reporting processes; and when reported incidents are fewer, this may mean that those who experience violence face more barriers to accessing services.

Sustainability of programme investments

The sustainability of efforts to address harmful social norms and GBV is likely due to comprehensive capacity-building initiatives, policy support, male engagement strategies, and knowledge sharing activities. Capacity building at both regional and national levels has enhanced legislative and policy frameworks addressing GBV, ensuring a legal framework that protects people from violence. Male engagement efforts have fostered a supportive environment for gender equality, and the use of champions for this work is likely to ensure ongoing interest in addressing unhealthy gender norms. The collection and sharing of strategic information on gender and GBV has enhanced the evidence base and will continue to inform action and policy formulation.

[24] These assessments are a systematic analysis examining the impact of gender on various aspects of policies and programmes, with the goal of promoting gender equality and ensuring that interventions are inclusive and effective.

Lessons learned from Phase I	Application in Phase II
Strengthening regional and in-country coordination among different sectors working on gender norms and GBV is crucial for a more effective and coordinated response.	Phase II will undertake a regional mapping of programmatic interventions conducted by regional stakeholders and strengthen coordination and collaboration across networks to form a regional alliance to address social and gender norms on SRHR in the region.
Utilizing data and evidence to inform programmes is essential for targeting interventions towards addressing risky behaviours and harmful norms contributing to high GBV incidence.	Phase II will conduct a regional scoping study to identify available evidence and undertake formative research and real-time social listening exercises to address identified gaps on gender and social norms undermining SRHR outcomes to inform programming and messaging.
Collaborating with communities facilitates the development of relevant solutions to address harmful social norms, and ensure awareness of pathways to GBV services and support.	Phase II will engage regional coalitions and networks of traditional and religious leaders, as well as other influencers, in dialogue and consensus-building to address social norms undermining SRHR.
Leveraging innovative outreach strategies including online platforms, telephone services, and digital technologies enables confidential and direct outreach to AYP and key populations.	Phase II will build the capacity of regional adolescent- and youth-led networks and champions, with a focus on youth-led advocacy, leadership skills, and digital engagement to promote access to youth friendly information and referrals to service promoting social accountability.
Enhancing interventions targeting men and boys, focusing on their specific SRHR service needs, can impact norms related to health service uptake, and can foster partnerships for greater gender equality and improved HIV and GBV prevention efforts.	Phase II will engage with regional networks for men and boys to address gender and social norms to promote positive masculinity to enhance SRHR outcome.

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10 Delivering SRHR in Humanitarian Crises

The ESA region is home to several humanitarian crises occasioned by conflict, climate change and natural hazards, often characterized by displacement within and across national borders, disruption of essential health services, loss of livelihood and food insecurity. During the programme implementation period, challenges to the provision of SRHR were exacerbated by significant natural events including cyclones, flooding, drought and earthquakes; and outbreaks of disease, such as cholera and Ebola, and most significantly by the COVID-19 pandemic.

COVID-19 negatively impacted on SRHR services and health outcomes in the region with restricted population and health service provider movements, disruptions to global supply chains, lack of personal protective equipment, stock outs of commodities and supplies, increased unemployment, school closures, and deepening poverty. Increases in cases of GBV, adolescent pregnancies and harmful practices, such as child marriage were reported, and the vulnerabilities of key populations, refugees and migrants were further exacerbated owing to exclusion from social protection schemes and SRHR and COVID-19 services, including COVID-19 vaccination (UNFPA, 2021).

The four PUNOs provided support to governments to prepare and respond to crises in the region, and the 2gether 4 SRHR programme has provided vital support during the implementation period.

Achievements in delivering SRHR in humanitarian crises

Technical guidance to monitor and ensure the continuation of SRHR services, reduce vulnerability, and protect health-care workers during **COVID-19** provided in **12 countries**

The preparedness of the region to respond to future humanitarian crises strengthened through undertaking the **MISP Readiness Assessment and developing country action plans in 22 countries**

Studies into the impact of **COVID-19** on services conducted in **6 countries**

Guidelines on **COVID-19** developed in **5 countries**

12,390 health-care workers trained in management of **COVID-19** across **5 countries**

Innovative approaches supported in **10 countries**

The GBV response during crises enhanced in **6 countries**

Service continuity and multi-month dispensing of ART and contraception supported in **12 countries**

Harmonized tools developed to strengthen the evidence-base for SRHR, HIV and GBV to be integrated into **vulnerability assessment tools** and **coordination mechanisms**

Risk reduction **communication in 12 countries**

13 knowledge products created

Photo credit © Canva Premium

Objective 2

RESULT 1: The programme ensured a rapid response to monitor and ensure the continuation of SRHR services, reduce the vulnerabilities of populations, and protect health-care workers during the COVID-19 pandemic.

The programme responded efficiently and effectively to the COVID-19 pandemic despite the extra-ordinary working circumstances, including lockdowns, restricted population movements and work-from-home modalities.

Technical support: The regional team of the programme strengthened country responses through providing technical support to countries and supporting the realignment of the PUNO country workplans and budgets to advocate for, monitor and ensure the continuation of SRH services in the context of the COVID-19 pandemic.

Monitoring of service disruptions: An interagency working group of RMNCAH experts developed a harmonized data collection tool to track disruptions to essential SRHR services, and the extent to which SRHR is integrated into national response plans across all countries. The data generated was successfully used to advocate for the incorporation of SRHR into COVID-19 response plans, thereby ensuring the continuity of services. The approach and tools developed were replicated globally by other regions, ensuring that they also benefited from the investment by Sweden.

This data was visualized in a data collection dashboard that provided policy and decision-makers with a tool to assess where efforts were required to ensure the continuation of services. The data was later analysed by the University of Edinburgh who collated a report on the availability of data to inform the continuity of services and the impact of COVID-19, noting that it was one of the largest analyses of the impact of the COVID-19 pandemic and its associated mitigation measures in the ESA region.

Objective 4

Studies on the impact of COVID-19

Together with other funders, the programme provided financial support to a series of studies on the effect of the pandemic on the demand for, and utilization of, RMNCAH services in Kenya, Malawi and Mozambique, which revealed the extent to which COVID-19 impacted people's willingness and ability to access essential services, their experiences of care, and the health system's readiness to continue to provide this essential care during the pandemic.

Study on COVID-19 and SRHR indicators

The study found a wide variation between different countries with respect to the availability of indicators. Given the extensive impact that COVID-19 had across health systems, this reinforces the need to collect data on a wide range of services and health outcomes. In particular, a lack of data available on services for adolescents across many of the countries is noted, and this inclusion is recommended in all HMIS data collection efforts.

Malawi, Zimbabwe, Uganda, and Lesotho assessed the extent to which the pandemic impacted on specific vulnerable populations, including people living with HIV (PLHIV), AYP and key populations. These assessments pointed to gaps in service delivery and how the pandemic was impacting differently on different population groups. For example, a regional assessment on the needs of FSWs highlighted how they were left behind in benefiting from social safety nets put in place, resulting in high levels of hunger, starvation and in some instances death. LGBTQI populations experienced heightened stigma, discrimination and in some instances victimization. Assessments with PLHIV revealed the mental health impact of the pandemic, and the need for psychosocial support to address the vulnerabilities of young people.

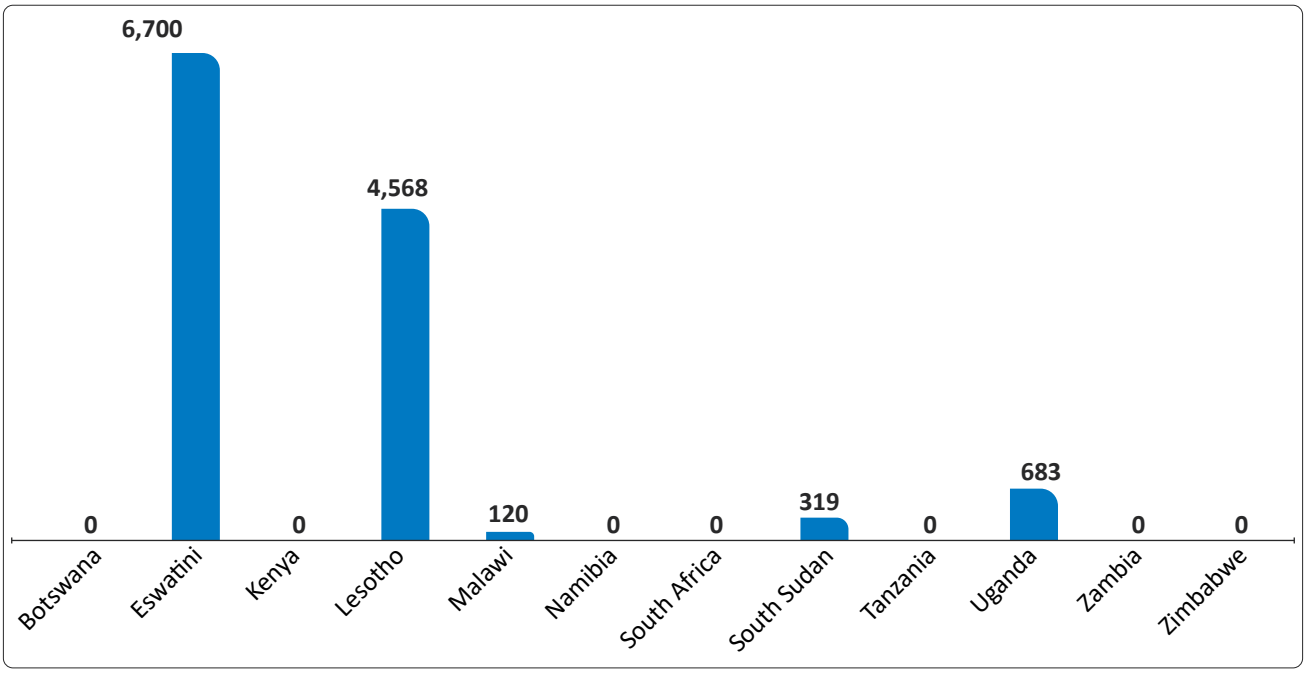
Guidance to ensure service continuity: The programme developed regional guidance and provided technical support to countries to adapt these guidelines that aided national programme managers, facility managers and health-care workers to ensure the continuity of SRHR services. Botswana, Malawi, Uganda, Zambia, and Zimbabwe developed national guidelines that ensured the continuity of SRHR services, and prevented resources from being diverted to other areas. National SRHR coordination mechanisms in all countries drew on the monitoring

data generated using the harmonized tool and the guidelines to respond to its findings, thereby further ensuring the continuity of services to those in need.

Training of health-care workers: The programme trained 12,390 health-care workers in the management of COVID-19 using virtual and blended approaches, reducing the size of groups and ensuring social distancing. This training helped to ensure that health-care workers were equipped with knowledge and skills to integrate the clinical management of COVID-19 into their routine work. Personal protective equipment, including masks, gloves and gowns were procured that reduced COVID-19 exposure and the risk of ill health or death among health-care workers.

Training on COVID-19 and the provision of SRHR services was facilitated according to the identified priorities for each country, and was not conducted across all countries supported by the programme.

Number of people trained on SRHR and COVID-19



Objective 2

RESULT 2: The programme ensured the continuity of services and access to commodities and supplies during emergencies, through the use of innovative approaches, reducing the potential for increased HIV morbidity and mortality, unintended pregnancies and GBV.

Objective 3

Support for community-based approaches

The continuity of services was ensured through support for innovative community-based approaches which were initiated or supported by the programme, and in some instances supplemented by other funding.

Strengthening the GBV response during COVID-19: To enhance GBV service delivery during COVID-19, the programme supported strengthening One Stop Centres, safe spaces and women and girls' friendly spaces in South Sudan, Tanzania, Zambia, and Zimbabwe. These efforts resulted in stronger GBV case management. Kenya, Namibia and Zimbabwe focused on improving referral pathways for GBV-related care in humanitarian situations. The programme also supported the procurement of emergency supplies and equipment, and Inter-Agency Emergency Reproductive Health (IARH) kits and dignity kits.[25]

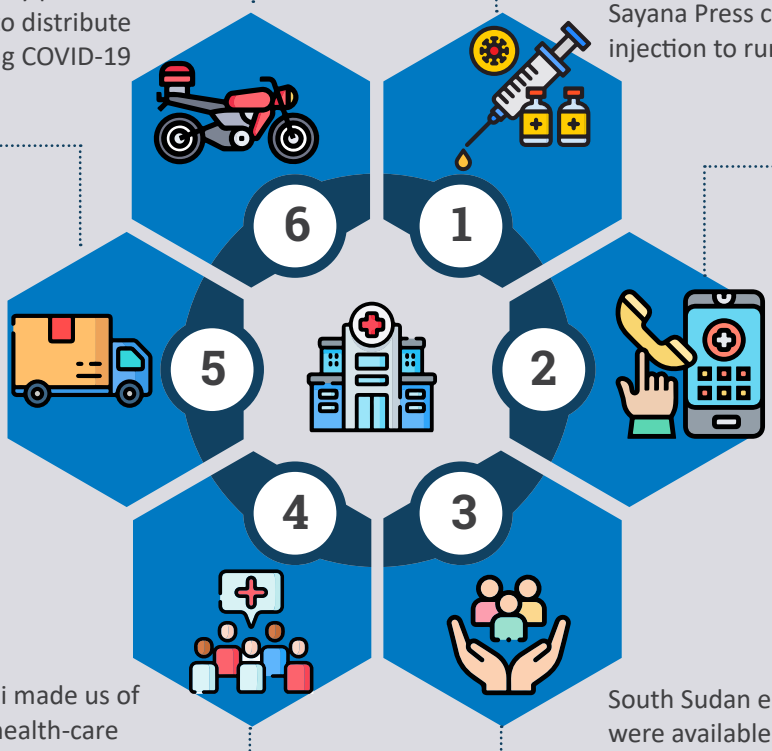
[25] The IARH kits are intended to speed up the provision of appropriate reproductive health services in emergency and refugee situations, and dignity kits help women and girls maintain proper hygiene after being displaced.

INNOVATIVE APPROACHES
DURING EMERGENCIES

Boda-boda motorbike drivers in Uganda were given permits to transport emergency patients to facilities, and to distribute condoms during COVID-19

Village health workers in Lesotho were capacitated to distribute the self-administered Sayana Press contraceptive injection to rural communities

Namibia, South Africa, and Zimbabwe used mobile services to reduce congestion at health-care facilities and to provide HIV and SRHR services to populations affected by lockdown measues, who did not have the resources to travel to health facilities



Kenya and Zimbabwe used call-centres as the first point of call for women experiencing GBV and for referral to services

Lesotho and Malawi made us of community-based health-care workers to ensue the provision of basic services and commodities to rural populations

South Sudan ensured that services were available for survivors of GBV through community-based support interventions for those in need of services during the pandemic

Support for new ways of reaching patients: The programme provided technical support to countries to redesign key elements of their existing programmes to ensure that vulnerable populations were reached with SRHR services during the pandemic. This included sharing lessons learned on mobile services, virtual service provision and support, tele-medicine, and strengthening community-based distribution channels.

Advocacy for multi-month dispensing of HIV treatment and contraceptives: Recognizing the vulnerability of PLHIV to access treatment, and adolescents and young women to unintended pregnancies, the programme worked with governments to scale-up and expand access to treatment for PLHIV. Through providing technical support to the SADC Regional Forum on COVID-19 and HIV. Guidelines were developed on the continuation of essential SRHR services in the context of COVID-19 in Botswana, Eswatini, Kenya, Malawi, Namibia,

Reaching vulnerable populations during the COVID-19 period in Kenya and Lesotho

- In Kenya, outreach and home visits were intensified, services provided at safe locations, and multi-month dispensing of ART was introduced to protect the health and well-being of female sex workers.
- Lesotho ensured continuity of services to sex workers and LGBTQI populations, making use of networks of PLHIV and other community-based networks.

South Africa, Uganda, Zambia, and Zimbabwe; peer learning and advocacy resulted in all countries using multi-month dispensing of antiretroviral therapy (ART), ensuring continuity of treatment and reducing the possibility of defaulting and drug resistance.

Drawing on the lessons from HIV, all countries also introduced the use of long-acting reversible contraceptives or multi-month dispensing of contraceptives by using self-administered methods. Alternative approaches used to distribute condoms, such as the use of *boda-boda* drivers in Uganda and partnerships with the World Food Programme (WFP) in Zimbabwe ensured that condoms were still available to marginalized communities.

For PLHIV, this ensured continuity of treatment; and for women and girls this meant that they were still able to access and use contraceptives to prevent unintended pregnancies. The introduction of multi-month dispensing and including this into community outreach activities contributed towards reducing congestion at health facilities, and reduced the risk of exposure to COVID-19 for PLHIV and AYP.

"My husband and I had to use condoms to prevent pregnancy for three weeks after we couldn't get family planning pills during the COVID lockdown from our local clinic. I have six children and the thought of getting pregnant really stressed me."

Programme beneficiary, Zimbabwe

Provision of information and communication materials: Risk reduction communication messages, based on the emerging evidence, were infused into existing mass media, social media and community outreach activities, and dispelled misinformation and myths to ensure that communities received accurate information, and continued to access services, commodities and treatment during the COVID-19 pandemic to secure their health and well-being. All countries translated risk reduction messages into local languages that were distributed through traditional mass media channels (such as radio and television), social media channels, existing youth applications (such as U-report and Tune-me), and printed materials which were distributed as part of community outreach efforts.

Communicating on maternal health during the COVID-19 period in Botswna

To increase awareness on availability the SRHR services and promote safe pregnancies, childbirth and postpartum care in the COVID-19 era; Botswana developed 10 radio messages broadcasted over 190 scheduled radio slots across three radio stations, disseminated 10,000 bilingual brochures addressing frequently asked questions on pregnancy and COVID-19 across 27 health districts, and published bilingual posters on maternal and newborn health for a period of 4 weeks on a widely read free national newspaper.

Objective 1

RESULT 3: The programme resulted in the region being better prepared to respond to future humanitarian crises through undertaking the MISP Readiness Assessment and developing country action plans in 22 countries to ensure the continuity of SRH services.

Objective 2

Readiness assessments and action plans

Technical and financial assistance was provided to 22 countries in the region to integrate MISP into their national disaster preparedness and response policies, strategies and plans through undertaking the MISP Readiness[26] Assessments. As a result of the MISP Readiness Assessment, all countries were sensitized on the importance of preparedness and the MISP in ensuring the continuity of services during times of emergencies. All countries have developed costed national action plans that bring together the combined efforts of governments, communities, United Nations agencies, and other partners to address gaps identified and to deliver life-changing essential SRHR, HIV and GBV services during humanitarian situations. This has also resulted in stronger collaboration between Ministries of Health, other stakeholders working on health and Disaster Management Authorities.

[26] Eritrea opted not to participate in the MISP Readiness Assessment process.

These national action plans ensure that SRHR policies and strategies incorporate a humanitarian lens and that disaster management plans incorporate SRHR as part of preparedness to manage future crises. There is greater incorporation of GBV interventions into the MISP; and GBV and SRHR are increasingly being included as part of humanitarian appeals. The implementation of the national action plans has also ensured greater coordination among stakeholders to mobilize financial and human resources, and create and distribute effective messaging around GBV and SRH that will enable an effective, rapid, contextualized and dignified response in the future.

Objective 4

Shared experiences for improved preparedness

The programme also supported the convening of a consultative meeting in 2022, bringing countries together to share experiences on the MISP Readiness Assessment and on integrating the GBV response into the MISP. The meeting resulted in a better understanding of the MISP, knowledge sharing on countries' MISP action plans, and advocacy for the adoption of MISP action plans in national disaster and preparedness response plans.

Findings from the MISP Readiness Assessment were also disseminated through the SADC SRHR Managers Meeting in June 2023 and the EAC RMNCAH Managers Meeting in September 2023. As a result, SADC Ministers of Health noted the need for clear guidance and funding to disaster preparedness and response linked to SRHR, and called for Member States to strengthen guidance, their national capacity for the MISP and the prepositioning of supplies as part of preparedness. This decision of the Ministers of Health provides the political mandate for the programme to further action the recommendations of the MISP Readiness Assessment.

RESULT 4: The programme strengthened the evidence-base for SRHR, HIV and GBV to be integrated into vulnerability assessment tools and coordination mechanisms across the ESA region.

Objective 4

A suite of harmonized tools

Women and adolescent girls, PLHIV, key populations, and persons with disabilities are affected disproportionately and face multiple challenges, including GBV, with the sudden and slow-onset emergencies, as well as in conflict and post-conflict situations. While these groups face various complex and varying vulnerabilities, existing standard vulnerability assessment tools do not systematically include these populations, and emergency preparedness and response programmes and policies do not adequately cater for their needs.

The programme commissioned a study on the extent to which SRH, HIV and GBV and the needs of vulnerable populations are incorporated into vulnerability assessments in Democratic Republic of Congo, Madagascar, Malawi, Mozambique, and Zimbabwe. This resulted in the production of harmonized, flexible vulnerability assessment tools that address the SRH, HIV and GBV needs of vulnerable women and girls, and a guide on how to use the harmonized tool to integrate and enhance SRH, HIV and GBV in existing vulnerability assessment tools at country and regional level.

The harmonized tools generate a view of community vulnerabilities and priorities in humanitarian emergencies by building on community information and perspectives, focusing on the needs of key populations who are vulnerable and often left behind, and covering both demand side (people's needs and priorities) and supply side (service availability). These tools were disseminated in a workshop which gathered over 55 government disaster management officials and partners from the ESA region in 2023.

Objective 4

RESULT 5: The programme identified insights to inform future programming considering the impact of climate change on GBV in the region.

Formative research on climate change and GBV: The programme supported formative research that examines the risks of climate change for intimate partner violence in Sub-Saharan Africa. Using large-scale microdata from demographic health surveys, the report shows the relevance of climatic impacts and extreme weather events for violence. The obtained empirical evidence is used as the basis for projections of future intimate partner violence prevalence in the sub-continent under different plausible climate and socioeconomic development scenarios.

The projections from the report show that socioeconomic development, enhanced climate mitigation and adaptation efforts can reduce the vulnerability and protect women and girls. Using a combination of different climate and socioeconomic development scenarios, the research highlights large differences in projected rates of intimate partner violence, depending on future climate impacts and the resilience of societies.

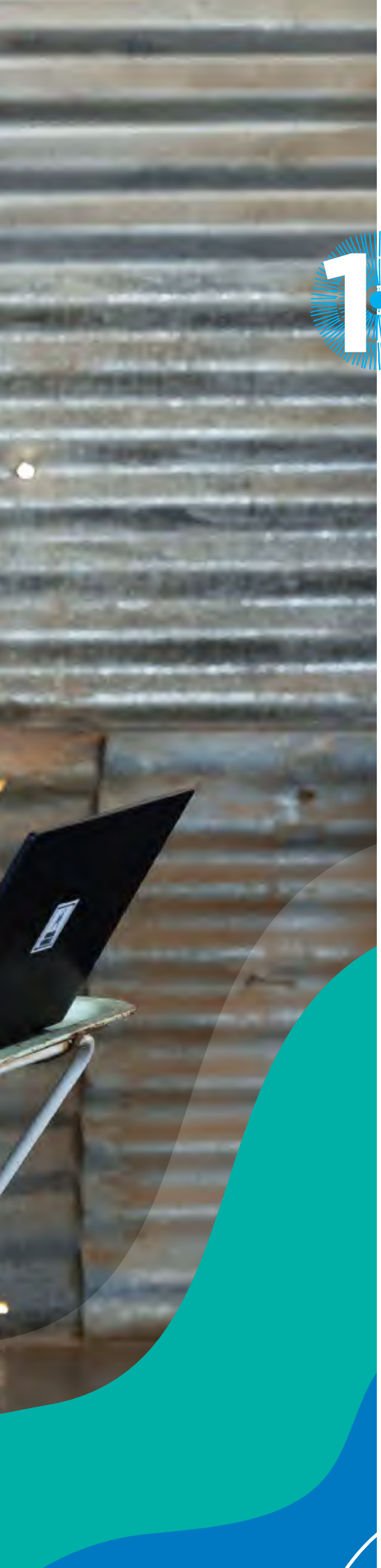
The results of the study underscore the importance of ensuring that national climate policies and relevant national gender policies incorporate adaptation measures that address the impact of climate change on women and girls not only during emergency responses where there is a heightened risk of GBV, but also in overall adaptation and socioeconomic development, including budgeted adaptation interventions and locally-led solutions. The report will be concluded and available early in 2024.

Sustainability of programme investments

The sustainability of efforts to provide SRHR services in humanitarian crises is likely due to the development of rapid response mechanisms, advocacy efforts, preparedness planning, and knowledge sharing initiatives. Lessons learned from the rapid and effective response during the COVID-19 pandemic are likely to be applied in future emergency situations. The focus on preparedness and planning, demonstrated through the harmonized vulnerability assessments and the MISP Readiness Assessments and resultant country action plans, ensures the integration of SRHR and GBV services into national disaster response plans, laying the groundwork for sustained support for SRHR in emergency settings.

Lessons learned from Phase I	Application in Phase II
Climate change, conflict and humanitarian situations are multipliers of existing SRH vulnerabilities and gender inequalities.	Phase II will provide technical assistance to the African Union and RECs to strengthen SRHR outcomes within continental and regional humanitarian and SRHR frameworks, and undertake operational research to reduce the vulnerability of various population groups in times of crisis.
Engaging national actors responsible for humanitarian response can raise awareness and strengthen prioritization and capacity for SRHR and GBV in emergency response and preparedness.	Phase II will strengthen the coordination between humanitarian and development actors, including civil society, through regional SRHR forums convened in partnership with the African Union and RECs.
Ensuring the availability of the MISP at the onset of emergencies, strengthening sustainable supply chain management procurement hubs, and distribution networks and the prepositioning of supplies, can result in a more effective and timelier SRHR response.	Phase II will advocate for a policy environment that ensures the integration of the MISP into emergency, preparedness, recovery and disaster risk reduction policies and plans, will provide technical support to the RECs for the establishment of a regional humanitarian supplies pre-positioning scheme and for capacity-building of health-care workers on the MISP.
The response to GBV in emergency settings can be enhanced through the inclusion of GBV considerations in national preparedness or contingency plans, strengthening the capacities of community networks and women's organizations to respond to GBV, and expanding training on the clinical management of rape, GBV referral pathways, and a survivor-centred approach.	Phase II will provide catalytic funding and technical assistance to countries to strengthen the implementation of the essential service package and Inter-Agency Standing Committee (IASC) guidelines for integrating GBV intervention in humanitarian actions, as well as the adoption of WHO protocols in humanitarian settings for the clinical management of rape and intimate partner violence, within the context.
Existing vulnerability assessment tools don't fully address the SRHR, HIV and GBV needs of the most vulnerable.	Phase II will strengthen regional buy-in for the integration of SRHR, HIV and GBV in vulnerability assessments through dissemination of evidence-based minimum viable products to facilitate adoption at country level, and provide catalytic and technical support to countries to implement roadmaps for undertaking vulnerability assessments that integrate SRHR, HIV and GBV and sensitize countries on their vulnerability to emergencies.
Humanitarian data systems need to be improved to ensure collection of age and sex disaggregated data which can inform timely decision-making.	Phase II will provide technical assistance and catalytic support to countries to review and strengthen data collection monitoring tools and systems during humanitarian crisis, building on the lessons learned from tracking the impact of COVID-19 on SRHR.

Photo credit © Jadwiga Figula/ UNFPA/2gether 4 SRHR



Enhancing Data and Strategic Information

The ESA region faces several challenges in collecting, managing and using SRHR data in HMIS. While some countries have made advancements in updating and digitizing health systems for more effective data capture, analysis and use (such as Eswatini); most rely on paper-based systems.

Challenges include the inadequate routine collection of key indicators, lack of disaggregated data, substantial time lapses between demographic health surveys, non-reporting from various sectors, and a lack of coordination across systems. A shortage of skilled M&E staff, limited understanding of data systems by already overburdened health-care workers, a lack of standardized protocols for data collection, and a lack of systems interoperability add to these challenges. Limited funding for digitizing systems, poor access to internet connectivity, and a lack of unique identifiers in electronic and paper-based systems further hamper the data collection process.

These challenges result in a deficit in reliable and timely SRHR data, which impedes effective decision-making at all levels of healthcare, undermining strategies to improve health outcomes and manage resources efficiently. Inadequate data makes it difficult to accurately monitor and evaluate the performance of health services, limiting opportunities for improvement and innovation, and compromising the overall quality of health-care provision in the region.

The programme contributed to a number of interventions to improve the collection, management and use of SRHR data to inform policies and improve programming, through harmonizing reporting for SRH, HIV and GBV, supporting the national M&E system by developing a comprehensive M&E framework and inclusion of SRHR indicators in HMIS; and building the capacity of subnational and health facility staff to improve data quality, reporting and utilization of health information.

Achievements in enhancing SRHR data and strategic information

Tracking and accountability against regional and national SRHR commitments and frameworks strengthened in **23 countries**

Data collection tools reviewed and improved in **10 countries**

M&E frameworks updated in **5 countries**

Collection of **integration indicators** in **8 countries**

Age and sex **disaggregated data** collection in DHIS2 enhanced in **3 countries**

Tools and job aids developed in **6 countries**

Data mentoring conducted in **11 countries**

MPDSR strengthened in **7 countries**

Innovative data collection by **communities** strengthened in **5 countries**

Reporting **tools** for community-based providers developed in **3 countries**

Population-specific data collection strengthened in **3 countries**

4 knowledge products developed

Objective 1

RESULT 1: The programme strengthened tracking and accountability against regional and national SRHR commitments and frameworks.

Regional and national scorecards: Programme investments resulted in the development of the SADC SRHR Scorecard and the updating of the EAC RMNCAH Scorecard, which allow countries to track progress towards their targets and function as accountability mechanisms (See Section 4 on Harmonization). The scorecards are useful to drive advocacy, and in all countries in the region (including those not supported by the programme) these have been used to develop reports to inform people-centred planning, prioritization and decision-making, and enhance service delivery.

The programme provided technical and financial support for the SADC Scorecard and EAC Scorecard meetings and review processes, which have provided opportunities to learn about data collection and utilization processes and challenges, and to learn from each other's successes.

Objective 2

RESULT 2: The programme strengthened comprehensive HMIS to capture relevant SRHR indicators, including demographic data, health outcomes and information on access to SRHR services thereby providing crucial information for evidence-based policy decisions.

A regional review of the countries' health information data tools: The programme undertook a review of health information data tools in the ten countries initially supported for applied learning, and benchmarked these against the SADC and the EAC Minimum Standards on SRHR. The review identified monitoring gaps relating to CAC, GBV, reproductive health cancers, and STIs.

As a result of this review, technical assistance was extended to Ministries of Health to strengthen the generation and use of high quality SRHR, HIV and GBV data and strategic information to monitor progress and inform evidence-based programming. A regional training conducted with Kenya, Lesotho, Namibia, Zambia, and Zimbabwe in September 2019 resulted in the development of national roadmaps prioritizing key actions to strengthen data capturing, reporting and use to inform evidence-based programmes.

A guideline for SRHR data collection and use is being developed under Phase II of 2gether 4 SRHR as an extension of this review, and will be used to inform country roadmaps for strengthening HMIS. The review will further inform advocacy to strengthen HMIS systems to disaggregate SRHR data, to improve reporting on the provision of integrated services, and to support the digitalization of health systems.

Strengthened national M&E frameworks: The programme supported countries to improve reporting on the provision of integrated SRHR services within their national HMIS systems through reviews of existing data capturing tools (registers), and reviews of SRHR indicators. This resulted in Botswana, Lesotho, Malawi, Uganda, and Zambia updating or developing M&E frameworks.

Harmonized reporting on these indicators has resulted in the generation of single analytical reports on SRH, HIV and GBV in Botswana and Uganda.[27] Additional interventions in Botswana, Eswatini, Lesotho, Malawi, South Africa, South Sudan, Uganda, and Zambia have resulted in alignment of the HMIS to be able to collect integrated indicators. This will contribute towards improved monitoring of the provision of the essential package of SRHR services within PHC facilities and reduce the reporting burden on health-care workers. The programme supported two learning visits for the Ministry of Health of Botswana to Eswatini and South Africa, to learn about the harmonization and rationalization of data collection and registers.

Programme investments also supported the provision of technical and financial assistance to Ministries of Health to develop national, subnational and facility-level targets to improve programme efficiency. Botswana, Uganda, and Zambia have developed targets at differentiated sub-national levels, and Lesotho developed targets at the health-facility level, informing planning and programming.

Improved age and sex disaggregated reporting: Advocacy by the programme improved disaggregated reporting for some key SRH indicators on the DHIS2 platform, and resulted in the generation of age and sex disaggregated data on adolescents' use of SRH and HIV services in Namibia, South Africa and in Zambia. This has resulted in compelling evidence to guide programming for AYP, and for women and girls.

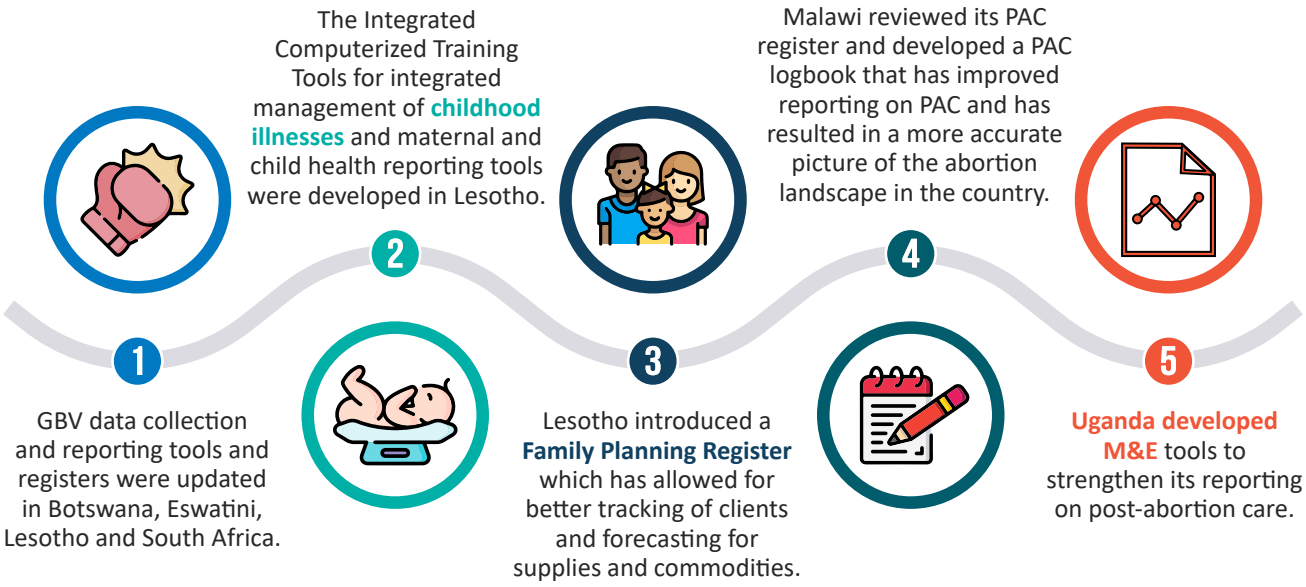
Objective 2

RESULT 3: The programme strengthened the generation of user-friendly information products from HMIS and other information systems, and to guide programming and service delivery.

The programme supported the development of tools, job-aids and capacity-building activities for health-care workers on a range of SRHR topics to enhance service-delivery; and this has included building capacity to report on services provided.

[27] A single analytical report refers to a comprehensive document that presents findings, analysis and insights from various sources to assess the status, trends and challenges in the domains of SRH, HIV and GBV.

Data collection tools: Support was provided for the development or updating of a range of useful data collection instruments. These efforts contributed to improved case finding, tracking and management; and some countries transitioned from initially unavailable data for most SRHR, HIV and GBV integration indicators, to high-quality data by the end of the programme.



Capacity-building initiatives: Capacity-building initiatives have also resulted in bottleneck analyses and a data quality assurance (DQA) report in Malawi resulting in insights to improve data quality for evidence-based reporting and programming.

Five countries (Namibia, Rwanda, Uganda, Zambia and Zimbabwe) participated in a regional virtual training to strengthen maternal and perinatal death surveillance and response (MPDSR), and capacity was also built for the MPDSR committees in Namibia. These efforts have resulted in enhanced capacity to report on MPDSR and reports on maternal death have also been generated in Lesotho and South Sudan. These efforts have resulted in a more effective response to these issues by Ministries of Health, and advocacy for the provision of quality maternal and newborn health services.

Data mentoring in 11 countries

- In partnership with IQVIA and the University of Zambia, the programme supported a data mentoring initiative with more than 30 mentees from the Ministries of Health in Eswatini, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe undergoing a 6 month mentorship to build capacity to collect, manage, analyse and report country data on PMTCT.
- This resulted in the development of country operational plans to address data gaps in their MPTCT programmes, to advance the triple elimination of HIV, syphilis and hepatitis-B.

Increased use of data at the point of service delivery: Zambia and Zimbabwe created platforms for real-time data review and visualization at district and health-facility levels, resulting in increased critical programme reviews and better use of information for decision-making at the point of data collection. In South Africa, the programme supported the development of a dashboard to provide information on the performance of facilities, the nurse-to-indicator performance ratio, stock-outs and the lack of equipment on a weekly basis; allowing facilities to respond to issues as they were reported and provide monthly updates at the subnational level.

Active surveillance, more consistent production of reports and better identification of gaps through joint intervention planning and performance tracking has improved adherence to national guidelines; and facility data was better utilized to improve commodity quantification, enabling Ministries of Health to order commodities based on estimates, and improving stock levels for family planning and maternal health.

Objective 2

RESULT 4: The programme supported advocacy efforts for the digitization of HMIS and strengthened capacity-building on DHIS2.

Advocacy and support for digitization: The programme also supported advocacy for the digitization of HMIS, and for training on the use of DHIS2, promoting digital health information management, with real-time data access, improved data quality, and streamlined reporting processes. This training has resulted in improved awareness on the types of data captured, more accurate data capturing, and has promoted the use of routine data for government departments other than Health (such as the Ministries of Gender and Education in Botswana). This has strengthened the use of data for decision-making at national, subnational and facility levels.

The programme also supported efforts to pilot the WHO digital adaptation kit[28] and digital health platforms in Kenya, Malawi and Namibia. These pilot sites will be used as model sites from which the digital adaptation kits and digital health platforms can be scaled up.

In Zambia, the programme supported the procurement of equipment (computers and software) in specific facilities, resulting in the establishment of efficient and functional electronic health management information systems; and in Zimbabwe, the adoption of the 2021-2025 eHealth/Digital Health Strategy has ensured progress with the digitization of health information.

Developing digital systems in Eswatini

Eswatini was supported to develop a digitized CMIS with unique client identifiers and records, and inter-operable systems. CMIS has the potential to reduce manpower and medicine wastage, and has reduced the burden of reporting for health-care workers, and promoted the continuum of care.

The programme has shared the experience of Eswatini of the digitized Client Management Information System (CMIS) across the region, including during SADC meetings in 2019 and 2020, and at the 2022 Regional SRHR Symposium.

Photo credit © Jadwiga Figula/ UNFPA/2gether 4 SRHR

[28] Digital adaption kits bring WHO guidelines and operational resources into a standardized format that can be more easily incorporated into digital tracking and decision support systems.

Objective 3

RESULT 5: The programme has strengthened community-led monitoring initiatives, building a sense of ownership and accountability among community members for their own health outcomes and sustained support for SRHR initiatives.

Community-led monitoring: Where communities are involved in monitoring and data collection activities, they have been empowered to actively participate in open discussions about SRHR, reducing associated social stigma and resulting in greater awareness of available services. These initiatives have included a youth-led scorecard initiative in Lesotho, community-led data collection on SRHR and food security indicators in Namibia, a youth-led monitoring programme in Tanzania, an AI-driven chat-bot in South Sudan, and the Kutabila call centre in Zimbabwe for PLHIV.

Service delivery reporting tools: Where services are provided at the community level, these have been improved through the development of reporting tools for Village Health Workers in Lesotho and Tanzania, and Community Distribution-Based Agents in Malawi. The improved reporting has resulted in greater efficiencies and enhanced effectiveness of these programmes to provide quality community-level health services.

Population-specific reporting: Efforts to capture data on the needs and health-seeking behaviours of specific populations have been supported by the programme, including strengthening the capacity of a call centre for key and vulnerable populations to monitor data related to calls, counselling, referrals, and feedback in Tanzania, resulting in improved service delivery for these populations; and the institution of a male involvement register in some facilities in eight districts in Uganda, providing useful data on men's health. A data partnership with CSOs in the Zambezi region in Namibia has strengthened community-based information systems, to provide quality data to focus on reaching the people and communities being left behind.

These initiatives have led to the identification of gaps and barriers to the uptake of services in particular areas and among specific populations, which has informed programming at the country and subnational levels. They have also strengthened community-based referral systems for improving access to services.

Sustainability of programme investments

The sustainability of efforts to gather strategic information and data on SRHR is likely due to comprehensive monitoring frameworks, enhancements to health information systems, capacity-building initiatives, digital health strategies, community-led monitoring, and peer learning advanced through the programme. The development of regional and national scorecards, monitoring frameworks and enhancements to HMIS will continue to enhance tracking and accountability against SRHR commitments. Capacity-building efforts have resulted in operational plans and advocacy for improved systems, and community-led monitoring initiatives will sustain support for SRHR initiatives. Peer learning opportunities and ongoing advocacy for digitization of health systems are likely to ensure sustained efforts to gather strategic information and data on SRHR.

Lessons learned from Phase I	Application in Phase II
There is an overall appetite for digitization in the region, and a need for digital health governance structures, strong data protection policies, and a community of practice to share lessons learned as digitalization is brought to scale. Digitization requires leadership and vision from Ministries of Health and the involvement of multiple stakeholders, and the issues of infrastructure and connectivity need to be addressed.	Phase II will develop a regional framework and a roadmap to support countries to transition to the use of digital health platforms to strengthen national health information systems.
Efforts must be made to strengthen the monitoring and reporting on all indicators, including GBV, CAC, STIs, and the provision of HPV vaccines.	Phase II will include collaboration with the African Union and RECS to advocate for the harmonization of SRHR indicators to track progress in the implementation of global, continental, and regional commitments. This includes the standardization of readiness, outcomes, and synchronizing the disaggregation of data by age.
Capacity-building, including targeted training and mentorship in data collection, quality assurance and utilization is key to improving data quality, timely reporting and data use.	Phase II will provide technical assistance and catalytic support to countries to strengthen HMIS/DHIS2 to generate, gather, analyse, and use routine health-facility data for advocacy, programme management and monitoring of progress on SRHR.

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Financial Close-Out

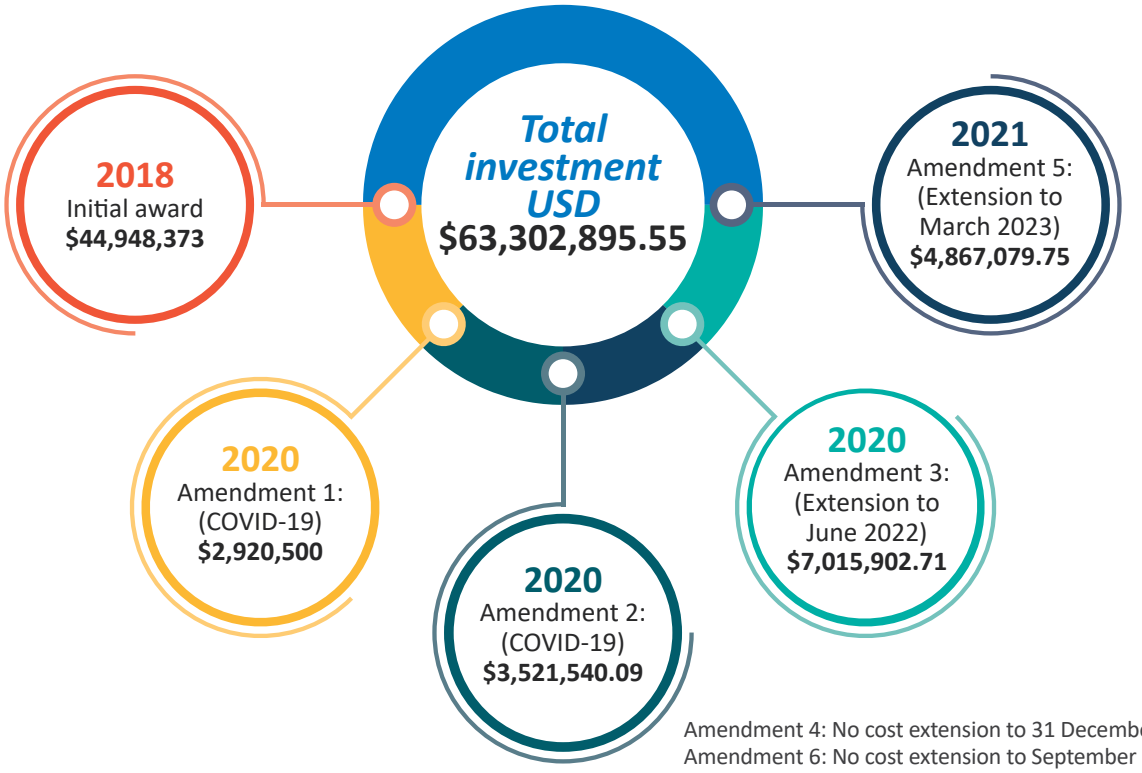
As per the provisions of the Standard Administrative Agreement (SAA) between Sweden and UNFPA, as the Administrative Agent, the final financial report for 2023 will be provided by the Administrative Agent after 31 May 2024. The final financial report for Phase I of the 2gether 4 SRHR (UZJ27) programme will be provided on 31 May 2025. Each agency is responsible for the disbursement and accounting of the financial resources received through this Joint Programme according to their own financial policies and procedures.

The SAA and the MOU also indicate that the four agencies are responsible for financial reporting against the objectives or outcomes of the programme. The annual work planning by the four agencies was done according to the objectives of the Joint Programme. It was agreed with Sweden at the inception of this programme that this requirement would be waived as the financial systems used by the agencies at the inception of the programme did not make provision to capture the expenditure by objective or outcome.

The 2023 figures should be interpreted with caution as agencies are still in the process of year-end closure. Additional expenses may yet be incurred or be recorded where expenditures, for example of goods and services accrued in 2023, may only be paid in 2024 and the payment amount may be different from the one accrued due to foreign exchange gains and losses. Furthermore, changes in the financial and operational system may have also contributed towards delays in processing certain financial transactions. For example, for UNFPA, the change to Quantum has led to delays in processing human resource transactions and these transactions are likely to only be recorded in the first quarter of 2024.

The following diagram represents the total investments by the Government of Sweden for the period 2018–2023 and the various amendments towards extending SRHR for all in ESA, through the 2gether 4 SRHR programme.

2gether 4 SRHR: investments by Regional SRHR Team 2018–2023



Amendment 4: No cost extension to 31 December 2022
Amendment 6: No cost extension to September 2023

The distribution of funds to the four partner agencies was agreed upon at the inception of the programme and approved by the Regional SRHR Team of Sweden. UNFPA was allocated a larger proportion to fulfil its role as convening agent, and WHO, as a new partner for Sweden, was allocated the lowest percentage. UNAIDS has a different proportion of the distribution of funds between regional and country offices compared to the other agencies, because unlike the other PUNOs, UNAIDS does not fund staff positions in their country offices. All personnel costs are from the regional office, which provides regional technical support to countries for the implementation of the activities.

Agencies	Distribution of funds
UNAIDS	22.22%
UNFPA	34.34%
UNICEF	26.26%
WHO	17.18%

As of 31 December 2023, the total amount of funds received from Sweden for the period 2018–2023 was US $63,302,895.55, this includes 1 per cent for the Administrative Agent and 7 per cent indirect costs. The total amount distributed to the four partner agencies was US $58,578,800.98, excluding the 7 per cent indirect cost, as these costs are still to be determined for 2023. The total expenditure is US $58,118,087.65 (excluding 7 per cent indirect costs). The remaining balance of US $459,917.76 represents 0.79 per cent of all funds received.

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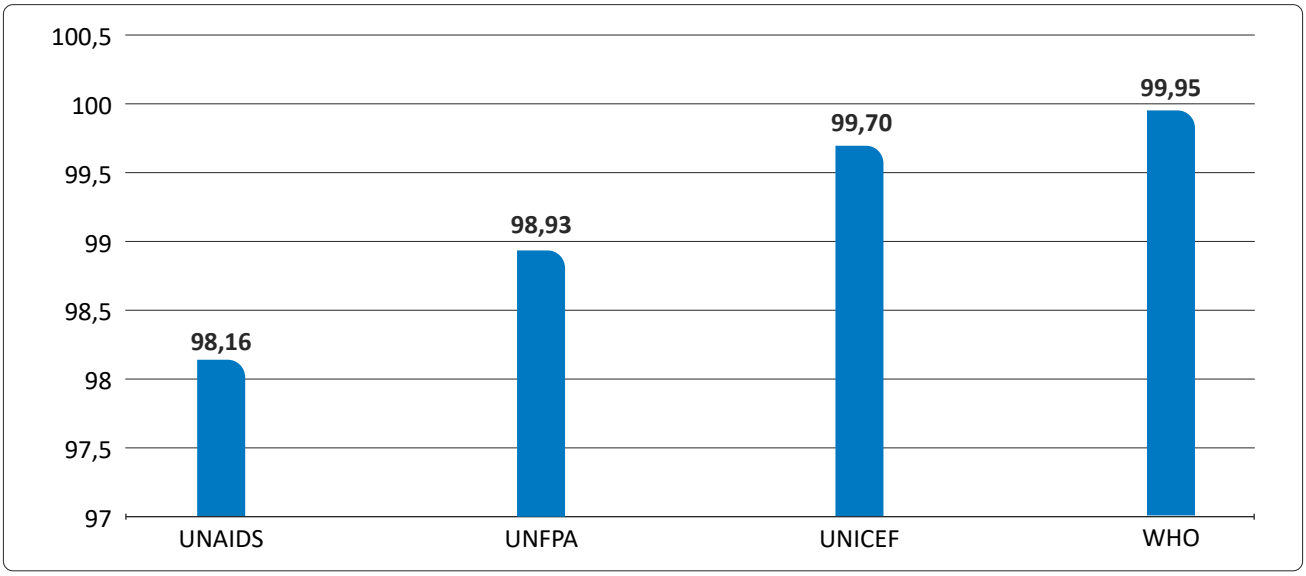
Budget implementation rate (2018-2023)								
			January to December 31 2023		2018–2023			
Regional + countries	Total income received (2018–2023) (excluding 7% IC)	Total expenditures (2018–2022) (excluding 7% IC)	Total Budget 2023	Disbursement /actual payments as of 31st December 2023)	Total Expenditures (2028–2023) excluding 7%	Budget balance	% Budget Implementation Rate (2018–2023)	Notes
Country	A	B	C	D	E	F = B – E	G = F/A	
Regional	26,611,086.58	20,532,752.67	6,078,333.91	5,649,879.08	26,182,631.75	428,454.83	98.39%	
Botswana	990,274.56	869,926.56	120,348.00	114,832.21	984,758.77	5,515.79	99.44%	
Eswatini	1,354,837.93	1,297,264.42	57,573.51	56,885.34	1,354,149.76	688.17	99.95%	
Kenya	1,108,969.26	1,083,922.26	25,047.00	23,532.00	1,107,454.26	1,515.00	99.86%	
Lesotho	4,183,593.57	4,131,386.10	52,207.47	51,428.58	4,182,814.68	778.89	99.98%	
Malawi	4,959,470.60	4,859,812.31	99,658.29	72,069.92	4,931,882.23	27,588.37	99.44%	
Namibia	1,479,959.03	1,438,343.93	41,616.10	54,848.32	1,493,192.25	–13,233.22	100.89%	
South Africa	934,447.54	887,035.54	47,412.00	25,648.00	912,683.54	21,764.00	97.67%	
Uganda	5,216,091.41	5,159,271.88	56,819.53	77,172.10	5,236,443.98	–20,352.57	100.39%	
Zambia	4,509,459.59	4,452,319.07	57,140.52	53,665.17	4,505,984.24	3,475.35	99.92%	
Zimbabwe	6,504,841.44	6,415,306.89	89,534.55	90,659.43	6,505,966.32	–1,124.88	100.02%	
South Sudan	357,775.10	314,183.10	43,592.00	41,539.00	355,722.10	2,053.00	99.43%	
Tanzania	367,198.80	344,663.55	22,535.25	19,740.22	364,403.77	2,795.03	99.24%	
Total	**58,578,005.41**	**51,786,188.28**	**6,791,818.13**	**6,331,899.37**	**58,118,087.65**	**459,917.76**	**99.21%**	

In the budget implementation table, there are three countries that have overspent in relation to programme implementation. These costs will be offset against the regional balances still available.

The graph below shows the implementation rate for each of the four participating agencies as of 31 December 2023. The implementation rate for all agencies was 99.21 per cent by 31 December 2024. UNAIDS (US $234,727.00) and UNFPA (US $215,558.49) still had balances remaining as indicated, but these may change as the financial transactions are finalized.

Implementation Rate (%) by agency 2018–2023 (31 December 2023)



The budget income and expenditure table reflects the strategic shift in the implementation modality of the programme in 2023.

In the period 2018–2022, 54.95 per cent of all predictable funding was provided to 10 countries to test and apply learnings on key areas of SRHR that were defined by each country and outlined in country programme documents developed at the inception of the programme. The table below indicates that the level of resources allocated to the countries differed by agency. This is in accordance with the agreed upon 4-year workplan and budget at the inception of the programme. Discrepancies between the regional and country allocations realized during the programme implementation period is as a result of the amendments to the agreement for COVID-19 and to extend the period of implementation, which had a stronger emphasis on regionality and the use of catalytic funding across different result areas to support programme implementation. This is indicated in the table below.

Agencies	Estimated regional 4–year programme budget (2018–2023)		Actual expenditure by region and country realized (2018–2023)	
	Regional	Country	Regional	Country
UNAIDS	63	37	72	28
UNFPA	24	76	37	63
UNICEF	27	73	38	62
WHO	80	20	38	62

Regional resources allocated by the four agencies were used to support the efforts of the programme to deliver as one. This included the funding of key personnel engaged in programme implementation across the four agencies at regional level. It allowed for effective programme management, oversight, country learning, and exchanges through the convening of statutory meetings, including the Regional Programme Steering Committee Meetings that strengthened programme implementation.

Regional resources contributed towards regional efforts to gather, collect and analyse evidence, which in turn were used at regional forums convened with the RECs and Regional Parliamentary Forums to advocate and strengthen the delivery of essential SRHR services. For example, the monitoring of the disruption to essential SRHR services during COVID-19 were used to advocate for the continuation of essential SRHR at national and regional levels. This led to governments developing guidelines and incorporating essential SRHR services into their national disaster plans, resulting in women, adolescents and young people, and key populations being able to access services and receive essential SRHR commodities to prevent unintended pregnancies, HIV infections and maternal deaths, and increasing the availability and access to contraceptive services among others. Regional resources also supported the amplification of the lessons learnt from the programme, including the documentation and dissemination of case studies, human interest stories, support to regional forums, such as ICASA, and the convening of the Regional Symposium on SRHR through which country experiences were shared, enabling countries to learn from each other and to adapt and apply those learnings in their respective countries.

Regional resources also supported RECs to develop regional frameworks against which countries could benchmark their responses, convene regional forums of programme managers to exchange country experiences, share new guidance, and to facilitate cross country learning and exchange. Technical and financial support was provided to regional parliamentarians to engage on key SRHR issues and to develop regional policy and legal frameworks to expand the rights of people to ensure their SRH and well-being. Furthermore, technical and catalytic funding was provided to countries to support emerging or key areas of SRHR.

Predictable funding was provided by all four agencies to Lesotho, Malawi, Uganda, Zambia, and Zimbabwe for the period 2018–2022. The budget allocations for Uganda and Zimbabwe were further bolstered by the awarding of the JSF that complemented existing investments, with an allocation to Uganda of USD 499,690.00 and an allocation to Zimbabwe of USD 493,350.25. This included investments across all thematic areas in the development and/or updating of national laws, policies and strategies. Strengthening of service delivery through the development of guidelines, training of health-care workers, piloting or expansion of integrated SRHR services, including for key populations, and addressing gender and social norms. The results of which have been captured under the different thematic areas depicted in this report and in the results framework.

As per the programme design, Botswana, Eswatini, Kenya, Namibia, and South Africa received funding through UNFPA, to scale up or to test models of integration based on the investments made by the European Union and Sweden through the Linkages Programme. Furthermore, South Africa and Kenya tested models of service provision for key populations that have yielded valuable insights. Namibia and Eswatini also received funding through the JSF expanding the investments in those countries to include all four of the partner agencies. While this was intended to be a 2-year investment, it was later agreed with Sweden to continue supporting efforts in these countries given environmental threats to the gains made in the provision of integrated services, and in particular for those relating to key populations.

In 2023 the programme transitioned to deepening the regional approach with funds provided to the ten countries representing only 10.45 per cent of programme resources and regional level allocations representing 89.45 per cent of programme resources. This shift in programming was to enable a regional approach with strategic and catalytic investments being expanded to countries to advance specific areas of work, for example, the Strategic Assessment on the MISP that was undertaken in all 23 countries, the Men and Boys Study conducted in five countries, and the development of the knowledge hub and regional technical assistance platforms. It is too early to say what the results of this shift in strategic approach will be, and this will be the focus on lessons learnt from Phase II of programme implementation.

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13 Conclusions

Given the challenging context for achieving SRHR, and addressing high rates of HIV and GBV in the ESA region, and with the overarching goal to enable all people, particularly adolescent girls, young people and key populations in the region to be empowered and supported to exercise their SRH rights and access quality integrated SRHR services, the 2gether 4 SRHR programme included substantial investments in reaching the four programme objectives, and has substantially changed the SRHR landscape in the region.

The outputs of the programme are reflected in the tables presented in the Appendix. The detailed outputs per country are presented in the endline data spreadsheet.

Alignment of results with programme objectives

Objective 1: Creating a legal and policy environment that empowers all people to exercise their SRHR rights and to access quality integrated SRHR, HIV and GBV services.

2gether 4 SRHR achievements: Objective 1

1 **leadership initiative** supported by the **programme**

6 regional guidance documents on SRHR, HIV and GBV integration adopted by SADC and EAC

2 accountability mechanisms to monitor regional commitments developed or supported

21 country scorecards submitted to the Annual EAC/SADC Ministers of Health Meetings

13 functional multi-sectoral coordinating mechanisms for SRHR, HIV and GBV

116 national policies, strategies and guidelines developed or reviewed

9 laws and policies that allow adolescents to access SRH services without third party authorization

8 countries supported with technical assistance to mobilize domestic and international funding to support integration

5 countries supported with technical assistance to undertake investment cases

The programme support resulted in extending the legal provisions to protect and advance SRHR in the region, with discussions on the EAC SRHR Bill, the SADC Model Law on GBV and the SADC Parliamentary Forum Minimum Standards for the Protection of Key Populations providing protections for citizens of the region. Support for advocacy and legislative processes at the country level resulted in the expansion of SRHR for AYP, greater awareness on the rights of women to access CAC services, and protection and access to services for the survivors of GBV with expanded prosecution of perpetrators of violence.

The development and updating of regional frameworks against which countries could benchmark their national SRHR responses resulted in enhanced collaboration, increased accountability and evidence-based policy-making, and it is likely that the common standards will ensure that national policies and practices meet a certain level of quality and effectiveness in addressing SRHR, HIV and GBV.

Objective 2: Scale up the provision of quality client-centred integrated services for SRHR, HIV and GBV, which meet the needs of all people.

2 gether 4 SRHR achievements: Objective 2

10 countries provided with technical support to develop training curricula for health-care workers

15 national and subnational training curricula for health-care workers that includes quality integrated SRHR, HIV and SGBV services

44,704 health-care workers in selected districts/counties trained in client-centred, integrated services

20% increase in health facilities providing integrated services in selected districts across the region

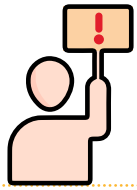
The programme investments contributed to advancing SRHR in UHC in the region, increasing the availability of strategic information and building country capacity on incorporating SRHR in UHC. These processes can guide governments to develop budgets and allocate adequate resources for SRHR services.

Through strengthening accountability and coordination at both regional and national levels and fostering a sense of shared responsibility for integrated services, the programme has also laid a strong foundation for sustainable progress on integration. Policy platforms and normative guidelines have built systemic capacity, and standardized the approach to delivering integrated services. Enhancing the capacity of countries to provide quality integrated services through training, resource allocation, and strategic planning has led to a more robust and service delivery system capable of meeting the diverse needs of clients and has facilitated easier access to essential health information and services, creating a more streamlined care pathway for individuals seeking services.

Despite the successful scale-up of integrated service delivery, more can be done to secure SRHR commodities, particularly in emergency settings.

Objective 3: Empower all people to exercise their SRH rights, adopt protective behaviours and access quality, integrated services in a timely manner.

2gether 4 SRHR achievements: Objective 3



12 countries provided with technical assistance to strengthen demand creation

59 organizations/associations/networks trained in community-facility linkages to promote demand for integrated SRHR HIV and SGBV services in focus districts/counties

By strengthening communication strategies and engaging communities, the programme has fostered ownership and participation, and effectively increased the demand for integrated SRHR, HIV and GBV services in the region. Engagements with community leaders, young people and key populations have led to a greater awareness of SRHR, and empowered people to exercise their SRH rights. While misinformation leads to attitudes that prevent some people from exercising these rights, the programme has made concerted efforts to address these through developing evidence-informed social and behavioural change communication strategies, and this has gone some way to addressing the social norms that prevent people from accessing the services they require. Sustained efforts in this regard are required to ensure that no populations are left behind.

Objective 4: Amplify the lessons learned from the implementation of the programme to strengthen SRHR, HIV and GBV services for all.

2gether 4 SRHR achievements: Objective 4

39 documented best practices/ good practices/case studies from the programme

15 regional communities or practices convened to share lessons

26 documents developed to share evidence of the efficiency, effectiveness and impact of SRHR, HIV and SGBV integration

4 joint missions conducted in countries to monitor programme implementation and progress

34 national and subnational communities or practices convened to share lessons

6 countries that have adapted lessons learned from South-South exchanges

34 non-targeted districts/ counties that applied integration lessons learned from the programme into their subnational SRHR, HIV and GBV programmes

Formative research undertaken through the programme has provided necessary evidence to guide implementation over time. While more can be done to enhance HMIS, capacity-building initiatives have effectively harnessed data to inform and refine SRHR service delivery and policy-making, have fostered community engagement and ownership in health monitoring, and promoted peer learning to strengthen evidence-based programming across the region.

The documentation and sharing of lessons learned from programme implementation at both the regional and country level have ensured that best practices are disseminated widely and has enabled other countries to replicate successful strategies, thereby amplifying the impact of the programme beyond its immediate scope. More work can be done to boost the visibility of the programme and its successes.

Sustainability and success

The principle of responsible transitioning, to ensure that SRHR continues to advance in the region, has been a guiding consideration throughout Phase I of the programme. The programme continues to be a regional flagship programme for testing and learning lessons for Joint Programming at regional level. The lessons learnt have been documented so that they can be infused into other Joint Programmes being planned or implemented.

Sustainability was ensured through aligning the programme design with the existing strategies and programmes, and work plans of the four participating agencies. The programme was able to draw upon the high-level leadership of the Regional Directors and the Deputy Regional Directors to provide strategic guidance, unblock bottlenecks in programme implementation and in support of high-level advocacy efforts. In some instances, the programme has contributed towards further strengthening, embedding and expanding the investments made in SRHR within the strategies and programmes of the agencies.

The programme drew on the technical experts of the four participating agencies, mostly funded through core resources, who were primarily responsible for programme implementation. Resources provided by the Government of Sweden were leveraged to complement and amplify investments from core and other non-core resources of all four agencies which increased the scope and scale at which interventions could be implemented. For example, the 2gether 4 SRHR programme became the delivery platform through which interventions on comprehensive abortion were implemented by both Sweden and the large anonymous donor.

Investments by Sweden went beyond just the ESA region but were also drawn on by other regions to strengthen programming. During the COVID-19 pandemic the ESA region was the first region to develop tools to monitor the impact of the pandemic globally. These tools and approaches were adopted and implemented by other regions to inform their advocacy efforts to ensure the sustainability of critical SRHR services.

Sustainability is anchored in the strategic approach of the programme at the regional level with the RECs. The programme provided technical support to the Member States of the RECs in the development of regional frameworks and peer accountability. For example, the development of the SADC SRHR Strategy and SRHR Scorecard was led by Eswatini, Namibia and South Africa and this ensured Member State leadership and regional and country ownership. Prior to the development of the strategy and scorecard, SRHR did not feature on the SADC Ministers of Health agenda. The development of the strategy and scorecard is now embedded in the work of the SADC Secretariat, with progress reported annually to Meetings of the Ministers of Health and those responsible for HIV of the SADC Member States. There has been the progressive realisation of strategy in the strategies of Member States as SRHR and RMNCAH strategies are updated.

Similarly, the development of the EAC Standards for the integration of RMNCAH/HIV were driven by the EAC, with the programme providing technical support. While the programme provided technical and financial support to the RECs for the convening of regional technical coordination platforms, meetings of Senior Officials and Ministers were covered by the RECs. The programme also brokered peer-to-peer learning between the RECs. The EAC experience was leveraged to inform the development of the SADC Scorecard, which was later extended to West and Central Africa. The experience of SADC on the development of minimum standards on SRHR integration was leveraged by the EAC.

The partnership with regional forums of parliamentarians provided a platform for engaging policy and decision makers. The SADC Model Law on GBV has become the standard against which Member States are revising and updating their national laws on GBV. While not passed, the EAC SRHR Bill provided an anchor for parliamentarians, civil society and faith-based actors to engage on SRHR issues. These dialogues and discussions would not have otherwise materialized and placed SRHR on the regional agenda in the EAC.

The provision of predictable long-term catalytic funding to the 10 participating countries was pivotal to ensuring the success of the programme, so too were programme forums through which countries were convened to share experiences of programme implementation. This peer learning and exchange enabled cross-country fertilization of ideas that strengthened programming. The national laws, policies and strategies that have been developed and approved with the support of the programme are now policy frameworks that guide programme implementation in each of the countries. Even in

instances where laws may not have been passed, documentation of lessons learnt provide insights that can inform future strategies and approaches.

The programme is also one of the only programmes that tackled the difficult topic of CAC. At the inception of the programme, no countries had included programming or earmarked any funding towards supporting the work on CAC. At the conclusion of the programme, 11 countries were engaged in sustained programming with considerable advances made in the development of policies, strategies, guidelines and the provision of integrated services. In relation to the provision of integrated services the programme successfully ensured that HIV and family planning were incorporated at CAC service delivery points. The development of data collection tools as part of national M&E systems also ensures that data will be collected on a sustained basis.

The programme successfully leveraged off the investments and lessons learnt from the UNFPA/UNAIDS Linkages Project; UNICEF Optimizing HIV Treatment Access for pregnant and breastfeeding women (OHTA) Initiative and the UNAIDS Expanded Accelerated AIDS Response towards High Level Meeting (HLM) targets and elimination commitments in the ESA Region (EAAR) funded by the European Union and Sweden. All countries were able to expand the provision of services from pilot sites to scale, especially Namibia, Botswana, Zimbabwe firmly entrenching integration of services at a national level.

Sustained investments in PMTCT have resulted in Botswana and Namibia being now firmly on the path to triple elimination. Investments in the capacity of health-care workers not only contributed towards expanding the provision of quality healthcare services, but have been shown to have a multiplier effect, with health-care workers applying the knowledge and skills gained even when they are rotated to other facilities and programmes.

Investments by Sweden in this programme was catalytic. The scale and scope of what was achieved would not have been possible without the investments by the four participating United Nations agencies and governments themselves. Funds by Sweden were bolstered by existing core and non-core resources to support programme implementation. Participating governments provided leadership, funded their personnel who led and participated in programme implementation at national, subnational and facility level and invested in the maintenance and infrastructure of facilities. Governments procured commodities and supplies, also drawing on those provided, for example, through the UNFPA supplies programme, and in the case of CAC, through a large anonymous donor. Investments were also unlocked through other funding platforms such as the Global Fund (Botswana and Namibia) to support programming in countries on HIV and AIDS, and the integration of SRHR. The unlocking of these resources has further entrenched the sustainability of programme implementation.

Throughout the process of implementation, knowledge products have been produced, lessons gained have been documented and captured as case studies, emerging practices and human-interest stories. These insights have been disseminated through the critical regional forums including regional forums of SRHR managers convened with the RECs, ICASA, and a regional SRHR symposium. This has ensured that insights and lessons learnt across 10 participating countries have been amplified across the region to the benefit of all participating agencies.

In conclusion, the programme has successfully ensured that SRHR has been placed and embedded on the regional agenda. It has expanded programming for SRHR by the four agencies, including addressing critical and areas of SRHR that are left behind. It has resulted in a truly regional partnership that has leveraged off the comparative advantage of RECs, regional forums of parliamentarians, civil society, Member States, health-care workers and communities. Investments by Sweden have been a catalyst for expanding the scope and depth of programming ensuring that the region continues to make progress towards realising the vision of the programme: that all people in East and Southern Africa are able to exercise their SRH rights, and access quality integrated SRHR services.

Continued commitments from country governments, CSOs and communities, as well as the PUNOs, donors and development partners will sustain and advance the gains made through this first phase of the programme and maximize the substantial investment from the Government of Sweden.

The regional support that will be offered through Phase II of the programme, together with catalytic funding for country programmes and for specific neglected areas of work, is likely to ensure the ongoing advancement of SRHR for the improved well-being of all people in the region.

APPENDIX: ENDLINE DATA

Objective 1: Create an enabling environment for SRHR

Output 1.1: Strengthened legal and policy environment	Baseline	Endline
OPI 1: Number of regional guidance documents on SRHR, HIV and GBV integration adopted by SADC and EAC with support of the 2gether 4 SRHR programme	0	6
OPI 2: Availability of accountability mechanisms to monitor SRHR, HIV and GBV regional commitments developed or supported by SADC and EAC with support of the 2gether 4SRHR programme	0	2
OPI 3: Number of regional leadership initiatives supported by the 2gether 4 SRHR programme to protect SRH rights, promote the provision and uptake of quality integrated SRHR, HIV and GBV services	0	1
OPI 4: Number of functional multi-sectoral coordinating mechanisms (that met at least twice a year) for SRHR, HIV and GBV	0	2
OPI 5: Number of annual scorecards aligned with SRHR/HIV and SGBV commitments submitted to the Annual EAC/SADC Ministers of Health Meeting 12	1	23
OPI 6: Number of national policies, strategies and guidelines developed/reviewed to incorporate harmonized regional standards on SRHR, HIV and GBV in line with global, continental and regional commitments	84	116
OPI 7: Number of functional multi-sectoral coordinating mechanisms (that met at least twice a year) for SRHR, HIV and GBV	12	13
OPI 8: Number of annual scorecards aligned with SRHR, HIV and GBV commitments submitted to the annual EAC/SADC Ministers of Health Meeting	0	12
OPI 9: Availability of laws and policies that allow adolescents to access SRH services without third party authorization	8	9
OPI 10: Legal status of abortion	1	1 legal 11 with restrictions

Output 1.2: Availability of funds from domestic and international sources to sustain provision of integrated quality of SRHR, HIV and GBV services	Baseline	Endline
OPI 11: Number of countries supported with technical assistance to mobilize domestic and international funding to support integration	0	8
OPI 12: Number of countries supported with technical assistance to undertake investment case	1	5
OPI 13: Total amount mobilized through multilateral and bilateral funding platforms	0	0
OCI 1: Number of countries with increased expenditure on SRHR, HIV and GBV (no data)	0	0
OCI 2: Amount current expenditure on SRHR, HIV and GBV integration (no data)	0	0

Objective 2: Scaling up integrated SRHR, HIV and GBV services

Output 2.1: Increased national and regional capacity to scale up integrated services	Baseline	Endline
OPI 14: Number of countries provided with technical support to develop training curricula for health-care workers	0	10
OPI 15: Availability of national and subnational training curricula for health-care workers that includes quality-integrated SRHR, HIV and GBV services	0	15
OPI 16: Number of health-care workers in selected districts/counties trained in client-centred, integrated services (in-service training)	0	44,704

Output 2.2: Quality integrated SRHR, HIV and GBV services scaled up	Baseline	Endline
OPI 18: Percentage of health facilities providing integrated services in selected districts	51%	71%
OPI 19: Number of users accessing e-health platforms in selected districts/counties to aid the provision of integrated SRHR, HIV and GBV services	21,558	1,001,016
OCI 3: Percentage of obstetric and gynaecological admissions due to abortion in selected districts/ counties	24%	19%
OCI 4: Percentage of clients receiving services at HIV services delivery points in selected districts/ counties that received modern family planning services	12%	11.8%
OCI 5: Percentage of clients receiving services at HIV services delivery points in selected districts/ counties that were screened for STIs	59%	56%
OCI 6: Percentage of clients accessing services at family planning service delivery points selected districts/counties that tested for HIV	37%	49%
OCI 7: Percentage of clients accessing services at family planning services delivery points in selected districts/counties that were screened for STIs	35%	45%
OCI 8: Percentage of clients accessing services at family planning services delivery points in selected districts/counties that were screened for cervical cancer	12%	18%
OCI 9: Percentage of clients attending antenatal clinics in selected districts/counties that tested for HIV	80%	93%
OCI 10: Percentage of clients attending antenatal clinics in selected districts/counties that were screened for STIs	72%	77%
OCI 11: Percentage of pregnant women living with HIV in the focus districts who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV	72%	87%
OCI 12: Number of facilities in the focus districts that provide tailored PMTCT/SRH services for pregnant adolescents and young women (<25 years)	63%	84%
OCI 13: Percentage of clients accessing GBV services at health facilities in selected districts/counties provided with full package of PEP within 72 hours of an incident	33%	63%
OCI 14: Percentage of clients accessing GBV services at health facilities in selected districts/counties that tested for HIV	51%	53%
OCI 15: Percentage of clients accessing GBV services at health facilities in selected districts/counties that were screened for STIs.	40%	64%
OCI 16: Percentage of clients receiving safe-abortion care services in selected districts/counties that tested for HIV	-	-
OCI 17: Percentage of clients receiving safe-abortion care services in selected districts/counties that received family planning services	13%	36%
OCI 18: Percentage of clients receiving safe-abortion care services in selected districts/counties that were screened for STIs	0	0
OCI 19: Percentage of clients receiving post-abortion care services in selected districts/counties that tested for HIV	35%	52%
OCI 20: Percentage of clients receiving post-abortion care services in selected districts/counties that received family planning services	40%	47%
OCI 21: Percentage of clients receiving post-abortion care services in selected districts/counties that were screened for STIs	31%	42%
OCI 22: Percentage of pregnancies reported as unintended	-	-

Objective 3: Empower all people to exercise their SRH rights, adopt protective and promotive behaviours, and access quality-integrated services

Output 3: strengthened communications, ownership and participation to create demand	Baseline	Endline
OPI 22: Number of countries provided with technical assistance to strengthen demand creation	0	12
OPI 23: Number of organizations/associations/networks trained in community-facility linkages to promote demand for integrated SRHR, HIV and GBV services in focus districts/counties	14	59

Objective 4: Amplify the lessons learnt from the implementation of the programme

Output 4: Lessons amplified across countries to scale up the provision of integrated SRHR, HIV and GBV services	Baseline	Endline
OPI 24: Number of documented best practice/good practices/case studies from the 2gether 4 SRHR programme	3	39
OPI 25: Number of regional communities or practices convened to share lessons	0	15
OPI 26: Number of documents developed to share evidence of the efficiency, effectiveness and impact of SRHR, HIV and GBV integration	2	26
OPI 27: Number of joint missions to countries to monitor programme implementation and progress towards achieving country-level results conducted	0	4
OPI 20 Percentage of non-targeted countries that applied integration lessons learned into their national SRHR, HIV and GBV programmes	0	0
OPI 29: Number of national and sub-national communities or practices convened to share lessons	2	34
OPI 30: Number of countries that have adapted lessons learnt from South-South exchanges	0	6
OPI 21: Number of non-targeted districts/counties that applied integration lessons learnt from the 2gether 4 SRHR programme into their sub-national SRHR, HIV and GBV programmes	0	34

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