



UNFPA ESAROL Luis Tatio

2gether4SRHR Mid-Term Review Report

2018 – 2020



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Acknowledgements

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Acronyms

AGYW	Adolescent girls and young women	PEPFAR	(U.S.) President's Emergency Plan for AIDS Relief
ARV	Antiretrovirals (for HIV)	PLHIV	People living with HIV
AYFS	Adolescent youth-friendly services	PMTCT	Prevention of mother-to-child transmission (of HIV)
CAC	Comprehensive abortion care	REC	Regional Economic Communities
CSO	Civil society organisation	RMNCAH	Reproductive, maternal, new-born, child and adolescent health
CSW	Commission on the Status of Women	RMNCAH&N	Reproductive, maternal, new-born, child and adolescent health and nutrition
EAC	East African Community	SAC	Safe abortion care
eMTCT	Elimination of mother-to-child transmission (of HIV)	SADC	Southern African Development Community
ESA	Eastern and Southern Africa	SDG	Sustainable Development Goal
FSW	Female sex worker	SGBV	Sexual and gender-based violence
GBV	Gender-based violence	SRH	Sexual and reproductive health
HIV	Human Immunodeficiency Virus	SRHR	Sexual and reproductive health and rights
HMIS	Health Management Information System	TB	Tuberculosis
HSR	Health Situation Room	ToP	Termination of pregnancy
ICASA	International Conference on AIDS in Sub-Saharan Africa	UHC	Universal health coverage
ICPD	International Conference on Population and Development	UN	United Nations
LGBTQI	Lesbian, gay, bi-sexual, transgender, queer and intersex (persons)	UNAIDS	Joint United Nations Programme on HIV/AIDS
MoF	Ministry of Finance	UNDAF	United Nations Development Assistance Framework
MoH	Ministry of Health	UNFPA	United Nations Population Fund
MTR	Mid-term review	UNICEF	United Nations Children's Fund
NGO	Non-governmental organisation	WBOT	Ward-based outreach teams
NSP	National Strategic Plan	WHO	World Health Organization
PAC	Post-abortion care		
PAP	Pan-African Parliament		

01

Background

2gether4SRHR is a joint United Nations (UN) regional programme that combines the efforts of UNAIDS, UNFPA, UNICEF and WHO to improve the sexual and reproductive health and rights (SRHR) of all people in Eastern and Southern Africa (ESA), particularly adolescent girls, young people, and key populations (KP). The Programme aims to fast-track the attainment of the 2030 targets of Sustainable Development Goal (SDG) 3, improve the health and well-being for all at all ages, and SDG 5, achieve gender equality and empower all women and girls.



The design and implementation of 2gether4SRHR are grounded in the International Conference on Population and Development (ICPD) Programme of Action and the Sustainable Development Goals (SDG).¹ The ICPD confirms that reproductive rights and empowering women and girls are fundamental to the development and individual well-being of all people, defines sexual and reproductive health (SRH) as including physical, emotional, mental and social wellbeing, and defines the package of integrated SRHR services to be provided. The SDGs recognize that, while important gains have been achieved globally in meeting SRH needs, there are persistent inequalities both within and between countries, and therefore commit to leave no-one behind. SDGs 3 and 5 define a series of SRHR global targets to ensure universal access to SRHR by 2030, eliminating all forms of violence and harmful practices. 2gether4SRHR is further informed by the *Lancet-Guttmacher Commission Report on Sexual and Reproductive Health and Rights*.² The Commission expands upon the definition and package of services as defined by the ICPD and proposes a comprehensive definition of SRHR that emphasizes that

“achieving sexual and reproductive health relies on realizing sexual and reproductive rights.”

Finally, the Programme reflects the priorities established by the Government of Sweden in its regional strategy on SRHR in Sub-Saharan Africa that aims to strengthen and advance SRHR across the continent.³

The ESA region has achieved significant gains in improving SRH and HIV prevention and treatment. At the inception of 2gether4SRHR, the maternal mortality rate in ESA was 384 per 100,000 live births (2018), a significant decline from 494/100,000 (2010)⁴. At the same time, increases in the number of pregnant women with HIV on treatment resulted in mother-to-child transmission (MTCT) of HIV declining from 18 per cent (2010) to 9 per cent (2018).

● ESARO Region



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9%
(2018)

¹ https://www.unfpa.org/sites/default/files/pub-pdf/ICPD_beyond2014_EN.pdf

² <https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights>

³ <https://www.government.se/information-material/2018/11/swedens-work-on-global-health--implementing-the-2030-agenda/>

⁴ <https://data.unicef.org/topic/maternal-health/maternal-mortality/>

Background

However, critical gaps must be addressed if countries are to achieve the SDGs. Sixteen countries have maternal mortality rates above 310/100,000, and HIV accounts for 10 per cent of all maternal deaths. The region has the highest rate of new HIV infections, accounting for almost 50 per cent of all new infections globally. In ESA, 30 per cent of all new HIV infections occur among adolescent girls and young women (AGYW) (15-24 years); each week, approximately 4,500 AGYW are newly infected with HIV.⁵ An estimated 1.9 million children and adolescents (0-19 years) are living with HIV, requiring lifelong retention in treatment.⁶ AGYW are also at high risk of early and unplanned pregnancy; in several countries, 1 in 4 women in ESA aged 20-24 years have given birth before the age of 18.⁷ Unmet need for family planning is approximately 25 per cent.⁸ Key populations and their sexual partners represent 62 per cent of new adult HIV infections globally.⁹ At the same time, sexual and gender-based violence (SGBV) remains at unacceptable levels; in several ESA countries, one in four adult women has experienced SGBV in her lifetime. The Joint UN has prioritized these inter-related, multiple concerns, with a specific focus on reducing vulnerabilities so that no one is left behind.

2gether4SRHR (also referred to as “the Programme”) is regional in scope, working in partnership with Regional Economic Communities (RECs), regional parliamentary forums, human rights institutions, civil society organisations (CSOs), networks of people living with HIV (PLHIV), adolescents and young people, men who have sex with men, lesbian, gay, bisexual, transgender, queer and intersex persons (LGBTQI) and sex workers. It supports public policy and programmatic interventions in ten countries (Botswana, Eswatini, Kenya, Lesotho, Malawi, South Africa, Namibia, Uganda, Zambia and Zimbabwe) to test models and document lessons that can be amplified across the region (*see Annex I for Programme Matrix*). The Programme is committed to addressing inequalities and discrimination and achieving the following:

- All people are able to exercise their sexual and reproductive health and rights.
- Reduced unmet need for family planning and unplanned pregnancies.

- Increased knowledge of, and access to, integrated SRHR, HIV, SGBV services, and prevention and response to SGBV.
- HIV prevention, including reducing new HIV infections among children, while improving access to HIV testing, supporting initiation and adherence to treatment, and preventing HIV-related deaths.
- Improved access to safe abortion services to the full extent of the law possible and post-abortion care (PAC).
- Reduced maternal morbidity and mortality.

The primary objectives of 2gether4SRHR are to support countries in the ESA region to:

- 1 Create an enabling legal and policy environment** by 2021 that empowers all people to exercise their SRH rights and access quality integrated services.
- 2 Scale up the provision of client-centred quality assured integrated and sustainable SRHR, HIV, SGBV services** by 2021, which meets 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, by 2021.**
- 4 Amplify the lessons learnt** from the implementation of the Joint UN Regional Programme to strengthen integrated SRHR, HIV, SGBV services for all people, in particular among adolescent girls, young people and key populations in the ESA region, by 2021.

5 UNAIDS 2020 Estimates. <https://www.unaids.org/en/resources/documents/2020/unaids-data>

6 Ibid.

7 Demographic and health surveys. <https://dhsprogram.com/data/>

8 <https://esaro.unfpa.org/en/topics/family-planning>

9 https://www.unaids.org/en/resources/presscentre/featurestories/2020/september/20200928_new-hiv-infections-increasingly-among-key-populations

Eastern and Southern Africa Region



Critical gaps must be addressed if countries are to achieve the SDGs

→ Sixteen countries have maternal mortality rates above 310/100,000, and HIV accounts for 10 per cent of all maternal deaths.

↓
Highest rate of new HIV infections, accounting for almost **50%** of all new infections globally



↓
30 percent of all new HIV infections occur among adolescent girls and young women



↓
approximately 4,500 AGYW are newly infected with HIV each week



→ **1.9 million** children and adolescents (0-19 years) are living with HIV requiring lifelong retention in treatment



→ AGYW are also at high risk of early and unintended pregnancy



→ **1 in 4 women** aged 20-24 years have given birth before the age of 18

↓
Unmet need for family planning is approximately **25%**



→ Key populations and their sexual partners represent

62% of new adult HIV infections globally



02

Mid-term review purpose and methodology

This Mid-term review (MTR) covered the first half of implementation of the joint programme, the period of January 2018 to December 2019. The purpose of the MTR was to:

- Determine the extent to which the Programme is on track to meet its objectives, identify successes and challenges, and recommend modifications to strengthen programme implementation.
- Identify emerging promising practices that can be documented and replicated.
- Assess the extent to which the Programme is “Delivering as One” and identify opportunities for strengthening collaboration.

The MTR was comprised of a desktop review and key informant interviews at regional level and in the ten implementation countries. Key programmatic

documents and individual country MTR reports were reviewed to determine whether the programme is on track in meeting its objectives, identify gaps and challenges, and propose recommendations for the way forward. The 15 key informant interviews included stakeholders from ministries of health, CSOs and UN country teams to gain their perceptions and feedback on programme implementation and emerging promising practices.

The MTR was designed to measure programme implementation progress and provide direction for future programme implementation. Although the MTR report does not include a comparison between baseline and mid-term data, it does offer insights and lessons learned on the effectiveness of programme implementation. Future Programme implementation will build upon these insights, address the opportunities and gaps identified during the MTR, and continue documenting and amplifying lessons learned.

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Findings

The MTR confirmed that, during the first half of programme implementation, significant progress was made across all four objectives. The first year focused on putting in place programme management and oversight mechanisms, establishing the necessary legal, policy and strategic frameworks to support programme implementation, formalizing partnerships, and conducting a range of studies to identify areas for programme implementation. These frameworks and study results extended beyond the 2gether4SRHR programme as they established a blueprint for multi-lateral support to regional bodies and national governments to jointly strengthen SRHR in the region. Progress in the second year was particularly evident in strengthening the policy and legal environment and capacity building to deliver quality, integrated SRH, HIV, SGBV services.

»» Objective 1

Create an enabling legal and policy environment

Significant progress has been made by the Programme to create an enabling legal and policy environment at regional and country level that advances demand for and access to integrated SRHR, HIV, SGBV services. 2gether4SRHR successfully partnered with regional governmental and civil society bodies to convene policy and decision makers to develop regional legal frameworks, policies, strategies and accountability mechanisms. These mechanisms are aligned with global and continental frameworks and have contributed to strengthened national laws, policies, strategies and accountability on SRHR. Regional and country level coordinating forums provided platforms for policy makers to review and finalise key SRHR frameworks for adoption by ministries, review progress made, exchange lessons learned and share emerging promising practices.

While impressive progress was made, consultative processes for the adoption of legal, policy and strategic frameworks are protracted and will require continued efforts. Similarly, advocacy for sustainable domestic and international funding for quality, integrated SRHR, HIV, SGBV service delivery requires persistency and will continue during the second half of the Programme.

 **Output 1.1**
Creating an enabling environment

2gether4SRHR strengthened the focus on and supported or accelerated the development of a critical number of laws and policies as well as regional SRHR frameworks.

The Programme supported developing and updating the **SADC SRHR Strategy, SADC SRHR scorecard and the completion of the SADC SRHR Baseline Scorecard**. A Technical Working Group, led by South Africa, Namibia and Eswatini and including the SADC Secretariat, UNAIDS, UNFPA, UNICEF, WHO, UNESCO, She Decides and Southern African CSOs, oversaw the development of the Strategy. A technical consultation was convened with Ministries of Health, Gender and Youth to finalise the Strategy and Scorecard. In November 2018, SADC Ministers of Health approved the updated SRHR Strategy for the SADC Region (2019 – 2030) and Scorecard. The SRHR Strategy and Scorecard are intended to accelerate and track progress in relation to the SDGs, the ICPD Programme of Action, the Maputo Protocol and the Maputo Plan of Action and is informed by the most current thinking on SRHR

Findings

as defined by the *Lancet-Guttman Commission Report on Accelerating Progress: SRHR for All*, and the Manifesto of the global SheDecides movement.

The Baseline Scorecard was completed in 2019 and validated by 15 of the 16 Member States. Data for the scorecard will be collected every 2 years until 2030 to track progress in meeting the SDGs. The baseline scorecard established the foundation for advocacy for the harmonization of indicators across countries, incorporating indicators relating to GBV, STIs and safe abortion care, and standardizing disaggregation by age and gender in national health information systems. The SADC SRHR Scorecard was used by WHO as a basis for the development of an integrated SRHR scorecard presented to the WHO Council of Ministers in 2019. Botswana, Eswatini, Lesotho, Zambia and Zimbabwe have incorporated the indicators of the SADC Scorecard into their national reporting tools.

The Programme supported convening the Southern Africa Development Community (SADC) **Regional Consultative Meeting on Strengthening Programming among Key Populations**. The meeting brought together representatives from Ministries of Health (MoH), National AIDS Councils, UN partners and civil society to identify the barriers to scaling up effective programmes, and to strategize how to address those barriers and accelerate progress. Participants identified emerging examples of good practices targeting KPs in SADC countries and agreed that while progress had been made in meeting the needs of KPs, some populations were continuing to be left behind, particularly transgender people, prisoners and people with disabilities. Also, participants acknowledged that no country had a national guide for KPs, and an extraordinary effort was required for countries to reach HIV targets of 90 per cent coverage rate by 2020.

In accordance with the Global Coalition Roadmap and the SADC KP Strategy, the Programme supported the SADC parliamentary forum to develop **a regional package of minimum standards for the protection of SRHR for key populations in the SADC region**. The minimum standards provide guidance and support to Parliamentarians across SADC to promote interventions at parliamentary and constituency levels for the protection of SRHR for key populations and ensure that all individuals in Member States achieve their right to health.

The Programme also supported the SADC Secretariat to convene a SADC Senior Officials Meeting on HIV prevention, develop a **guide to HIV prevention programmes for adolescent girls, young women and their sexual partners** and develop a regional adaptation of the UNAIDS Global Prevention Coalition scorecard that tracks progress across five pillars of HIV prevention. The guide and scorecard provide SADC Member States with guidance on evidence-based HIV combination prevention interventions and a methodology for measuring progress in meeting HIV prevention targets.

The Programme organised a **SADC Commission on the Status of Women (CSW) side panel and engagement with the African Union**. A rapid assessment to ascertain progress in SADC member states to implement the CSW resolution 60/2 on the Status of Women, the Girl Child and HIV was completed. Final conclusions for CSW63 to strongly reflect HIV was agreed on. Further work is ongoing (in collaboration with UN Women) to take stock of country actions against the agreed SADC indicators for implementation of CSW resolution 60/2. 2gether4SRHR provided further support to developing position papers by the African Union and SADC on CSW60/2 and a Youth Call for Action on AGYW and SRHR.

Technical assistance to the East African Community (EAC) resulted in a **joint regional Ministerial Commitment** to fast-track the unfinished business of the International Conference on Population and Development Programme of Action and inputs into updating the **EAC RMNCAH Scorecard**. The EAC was supported to finalize a study and develop a synthesis report on the integration of SRHR in the EAC region. Country findings were presented at the EAC meeting of SRHR, HIV, TB and STI managers and a satellite meeting at the International Conference on AIDS in Sub-Saharan Africa (ICASA) on the evidence of SRHR integration. Study findings informed a draft of EAC minimum standards for integration.

2gether4SRHR also collaborated with the East African Legislative Assembly and a consortium of civil society partners on developing the **EAC SRHR Bill** that, if passed, will further expand SRHR across the EAC member states.

With Programme support and guidance, EAC and SADC convened regional parliamentary forums which examined ways to fast-track the achievement of global, continental and regional commitments, considered emerging issues related to SRHR, identified areas of joint action, and shared promising practices across countries. For example, 2gether4SRHR supported the **Pan African Parliament (PAP) to develop a resolution on the role of parliamentarians in the realization of the right to health**. The resolution stated that Parliamentarians would advocate for the fulfilment of the Abuja targets to ensure sustainable financing for health and ratify human rights treaties and conventions relating to health, including the Maputo Declaration. Parliamentarians committed themselves to promote free access to high-quality, low-cost, pre-qualified antiretrovirals (ARVs), anti-TB and anti-malarial drugs, test kits, consumables, vaccines, diagnostics and essential medicines, and to promote the enactment of laws that explicitly criminalize all forms of violence against women and girls, including sexual violence, forced sterilization of women and girls living with HIV, forced and early marriage and female genital mutilation. The resolution was disseminated to all countries; Kenya, Namibia, South Sudan, Tanzania, Uganda and Zambia adopted the recommendations and developed action plans.

Support to **PAP to convene a workshop on HIV** resulted in enhanced capacity and renewed commitment of 33 Pan African Parliamentarians, as well as the President of the National AIDS Assembly, the President of the Senate and the President of the AIDS Commission, to address legal barriers for key populations and young people to access services.

A **regional initiative on youth-led accountability** was initiated in line with the SADC Parliamentary Forum Youth Development Programme targeting young parliamentarians and youth activists from the HIV/SRHR movement. Outcomes included a resolution adopted by the SADC PF Plenary Assembly on strengthening youth-led accountability in the SADC region, a Youth Commitment selected for presentation at the ICPD, and an intergenerational dialogue between young and senior Parliamentary Members and development partners on critical issues and needed actions for youth SRHR.

At country level, support was provided to develop or revise legal, policy and strategic frameworks aligned with global, continental and regional commitments and frameworks on HIV, SRHR, and SGBV. These laws,

policies, strategies and guidelines underscore the importance of ensuring a supportive environment that addresses critical issues related to SRHR, HIV, and SGBV. For example, legislation on domestic violence, strategic plans, and guidelines on clinical services for SGBV strengthened both prevention and mitigation of SGBV. Women's health, including reduced maternal mortality, access to contraceptives, HIV testing and linkage to treatment services was directly impacted by laws and guidelines on termination of pregnancy and comprehensive abortion care, including post-abortion care. (See Annex II for a list of policy-related documents).

2gether4SRHR also supported national and subnational **multi-sectoral coordinating bodies** to plan, implement, and monitor the scale up of quality-assured, integrated SRHR, HIV, SGBV services. In doing so, the Programme facilitated dialogue and capacity building with key decision makers such as Parliamentarians, Ministries of Health, and CSOs on SRHR issues, and **leveraged** 2gether4SRHR work to create broader programmes.

Specific regional support to countries led to the following results:

- **Emergency response mechanisms for LGBTQI** persons, including legal aid, medical care, and relocation costs. For example, a UNAIDS partner rapidly provided food, shelter, medical care and psychosocial support to 16 people working for a Ugandan LGBTQI organization who were arrested by police and subjected to forced anal examinations. This work informed the formation of a larger (core-funded) **UNAIDS Emergency Support Plan** that allows UNAIDS to respond quickly in human rights crises in the region, resulting in emergency support in Kenya and Malawi.
- **High-level advocacy visits** to several countries in the region raised awareness on SGBV, HIV prevention among AGYW, sustainable financing and efficiency (including Global Fund and PEPFAR implementation), SRHR integration, quality of and access to services, HIV, SRHR and SGBV in humanitarian settings, and the importance of generating and using data for programming and financing.

One important result was the Government of Tanzania's decision to **reduce the age of consent for HIV testing**, expanding access to testing for vulnerable adolescents and young people.

- Two out of the three planned values clarification workshops took place; the first on key issues relating to SRHR sensitised 2gether4SRHR country teams on balancing personal beliefs and values with their professional duties. The second was an internal UNFPA regional office workshop that sensitised all staff on the core mandate of UNFPA in relation to working with key populations and abortion.
- Implementation of regional frameworks for AGYW rights and social justice was supported with the **roll out of the Gender Reporting Oversight Model** in six SADC countries.
- The East Africa Trans Health and Advocacy Network conducted **research on transgender people's access to health in East Africa** (five countries). The findings included: high HIV prevalence, high rates of denial of services due to being transgender, inability to access gender reaffirming surgery, and high levels of sex work. With Programme support, the Network also collaborated with the African Sex Worker Alliance to gather evidence on sex workers' access to SRHR, HIV, mental health and other health services. Results were presented at the an ICASA 2019 pre-conference on "Keeping Leaders Accountable," focusing on communities left behind.
- A **regional consultation with 11 National Human Rights Institutions (NHRIs)** to share good practices on promoting rights of PLHIV, KPs, young people and vulnerable groups led to strengthened accountability for domestication of commitments made by NHRIs at global and regional level. The consultation also led to the development of Country Roadmaps and revitalization of networks of key stakeholders, including civil society, PLHIV, KP, LGBTQI persons, young people and human rights advocates.

Output 1.2

Increase funding from domestic and international sources

Regional and country-level advocacy heightened attention on the need for increased regional, domestic and international resources for SRHR.

The Programme supported the EAC to develop a **resource mobilization strategy for Universal Health Coverage** that advocates for increased domestic and international investments for SRHR, HIV and SGBV services. In addition, the Programme supported **SADC to validate the sustainable financing monitoring framework for Health** at the extraordinary SADC ministerial meeting in Namibia.

A desk review on **sustainable funding** in SADC supported finalization of regional sustainable financing frameworks that will guide countries on resource mobilization. The desk review explored the extent to which national SRHR related strategies, plans and budget allocations reflect the needs of adolescents and youth in Malawi, South Africa, Uganda, Zambia and Zimbabwe. The draft report included lessons learned from costing, budgeting and financing adolescent and youth SRH services. In addition, technical assistance was provided to countries in developing adolescent SRHR strategies and plans, costing and developing investment cases, and reviewing the quality and use of the costing studies.

A **high-level communique** was adopted during a Pan-African Parliament high-level meeting (discussed under Output 1.1), underscoring the need for increased domestic financing for health and HIV.

Technical support to six countries resulted in National Strategic Plans that include **financing for integrated HIV, SRHR, and SGBV services**. Technical support to five countries for Global Fund funding requests resulted in grant implementation with participation from CSOs and partners working on integrated service delivery.

At country level, the Programme also supported research, forecasting and costing studies, and advocacy meetings that engaged MoHs, Ministries of Finance (MoF) and Parliamentarians in increasing, unlocking and leveraging domestic and international investments in SRHR. For example, 2gether4SRHR supported National AIDS Spending Assessments and fiscal space analysis in Lesotho, Uganda, Zambia and Zimbabwe

and expenditure analysis, resource tracking studies and investment case studies in Lesotho, Malawi and Zambia. Across all countries, findings were used to generate dialogue between governments, CSOs, the

private sector, faith-based organisations and community leaders on increasing domestic investments in SRHR, HIV and SGBV services.

»» Objective 2

Support national scale up of client-centred quality-assured integrated and sustainable SRHR, HIV and SGBV services

The provision of SRHR, HIV, and SGBV services was strengthened through regional and national technical assistance, capacity development, scaled up delivery of quality integrated SRHR services, and production and use of high quality SRHR, HIV and SGBV data and information.

Output 2.1

Increased national and regional capacity

Prior to launching capacity building efforts, 2gether4SRHR supported numerous assessments that examined policy environments to scale up integrated services, identified national and regional capacity gaps and informed capacity building plans. For example, the Programme commissioned **SRHR assessments for women living with HIV** based on Global SRHR Guidelines and promoted utilization of results for advocacy in national level CSO consultations. Assessments were also undertaken at facility-level to determine readiness to provide integrated services. Findings informed capacity building, including providing technical assistance to countries to develop, update and deliver training curricula and job aides, all of which reflect global and regional guidance, norms and standards. Service delivery was further strengthened through supportive supervision and mentorship focused on meeting quality standards.

During the reporting period, the regional interagency working group provided on-going technical assistance to countries, including Joint Missions (Lesotho, Malawi, and Zambia), convening the Regional Programme

Steering Committee where countries exchanged information on promising practices and lessons learned, and convening regional workshops that encouraged countries to develop national roadmaps to strengthen the provision of integrated services.

Working regionally provided a supportive environment for advocacy with countries to address key and neglected areas of SRHR, whether through regional level trainings or by connecting countries with international best practices.

A regional approach to expanding quality comprehensive post-abortion care and post-abortion contraception. 2gether4SRHR, led by UNFPA and WHO, convened a workshop in Zambia where 48 health professionals, including obstetricians and gynaecologists, from Botswana, Eswatini, Lesotho, Malawi, Namibia, Uganda, Zambia and Zimbabwe to receive training on post-abortion care and contraception. Global partners were identified to provide technical assistance to countries, drawing on existing curricula. Throughout the workshop, health workers reflected on social norms and individual attitudes and competencies. Participants gained knowledge and skills on reducing injury and deaths from complications of abortions (i.e., incomplete or unsafe.) Qualified as Trainers, participants developed roadmaps on working with Ministries of Health to increase access to PAC and SAC within their countries. This resulted in expanded investments across all eight countries in strengthening country-level activities.

Findings

Delivering comprehensive SRHR services requires investments in strengthening health-care worker capacity. Training curricula, manuals and job-aides for health care providers (doctors, nurses, midwives and community health care workers), reflecting national policies and guidelines, were taken to scale through cascading national training of trainers and in-service training programmes. These capacity building efforts provided an opportunity to update and sensitize practicing health-care providers on the latest norms and standards and to improve the quality of information, care and support provided to clients.

In the first half of the Programme, nine countries supported Ministries of Health to review and/or develop training curricula on service integration (3); comprehensive and post-abortion care (1), adolescents and youth (2), GBV (3); family planning (2) and PMTCT (2).

Longer-term sustainability has been supported by investing in capacity building efforts for the next

generation of health-care providers. Four countries have successfully integrated SRHR-related issues into the pre-service training curricula of schools of nursing and midwives. These include: Eswatini (AFYS), Lesotho (Curriculum for Advanced Midwifery and Public Health Nursing and Neonatology), Uganda (Integration of SGBV and VAC clinical guidelines), and Zimbabwe (Integrated SRHR, HIV and GBV services).

Having a trained cadre of health-care providers that are equipped to deliver an integrated package of SRHR services requires investments in building and updating the skills of existing health-care workers. By the end of 2019, countries had invested in strengthening the capacity of **7,193** health-care workers in targeted districts and health facilities (selection during the Programme's Inception Phase). These training activities drew on existing national in-service training curricula and /or the curricula of selected partners who have expertise in a particular area where national curricula may not exist. Table One provides an overview of the training undertaken during the period 2018 – 2019.

Table 1. Country-level training activities 2018-2019

Countries N=10	Integration N=10	CAC/PAC including VCAT N=7	AFYS N=3	GBV N=6	KPs N=2	FP N=2
Botswana	326	20	0	0	0	0
Eswatini	1500	30	283	120	25	0
Kenya	99	0	0	28	0	0
Lesotho	30	0	0	30	0	0
Malawi	45	46	0	190	0	0
Namibia	0	48	0	0	0	178
South Africa	85	33	0	0	60	48
Uganda	80	265	48	240	0	0
Zambia	360		121	60	0	0
Zimbabwe	2645	150	0	0	0	0
Total	5170	592	452	668	85	226

Box 1:
Increased Access to SGBV Services in Zambia

Zambia expanded access to SGBV services thanks to 2gether4SRHR advocacy with the legal system to broaden the range of health professionals who can testify in SGBV cases. As a result, testimony is no longer restricted to medical doctors. Clinical capacity also increased as sixty nurses and clinical officers were trained in specimen collection for SGBV services.

While significant progress was made in strengthening both in and pre-service training and building the skills of health care workers, there remains a need to determine the extent to which the different training curricula promote an integrated package of services aligned with global and regional norms and standards and incorporates the needs of vulnerable populations, including adolescents and young people, key populations (LGBTQI, FSWs) and those living with disabilities. The development of training curricula by the countries will provide the foundation for the development of regional training programmes that could be adapted by others or used through online training platforms.

(See Annex III for detailed capacity building achievements, including assessments undertaken, training and other activities).

 **Output 2.2**

Quality integrated SRHR/HIV and SGBV services scaled up

Programme support to countries to take promising practices to scale resulted in increased coverage and reach and improved integration of service delivery, particularly keeping in mind “leave no one behind.”

During the reporting period, different modalities were used to support integrated SRHR services, based on national priorities and programmes. Regional level support included technical assistance on the approaches, modalities, and linkages to existing tools,

resources, and training materials. Joint missions drew upon the combined technical expertise of the four agencies at the regional level to strengthen national level implementation. Regional entities facilitated south-south exchanges by linking countries working on similar initiatives and facilitating cross-country learning through study visits. Scale up at facility level focused on improving service quality and delivering an integrated package of services, while scale up at community level focused on locating vulnerable populations and linking them to services. Increased safe and post-abortion care and strengthened referral pathways for SGBV services were particularly notable. However, further efforts need to concentrate on reaching the most vulnerable populations, including AGYW, young mothers, FSWs and their partners, LGBTQI and integrating SGBV into SRH/HIV platforms.

Lessons learned from models piloted during the Linkages Programme and OHTA formed the basis for scale up of integrated services Linkages and OHTA countries and provided insights for other countries engaged in scaling up the provision of integrated services. For example:

- **Botswana** used three models of integration (Kiosk, Supermarket and Mall) to scale up the provision of integrated services from 54 to 123 sites in 12 districts.
- **Eswatini** strengthened the national provision of integrated services with a focus on SGBV, safe abortion care and integration of FP into HIV services. A training of trainers addressed health care worker norms and attitudes using the values clarification approach. The provision of FP in HIV service delivery points was further strengthened through regional orientations of health care workers on the national SGBV guidelines.
- **Lesotho** scaled up the provision of integrated services in all ten districts, including 18 hospitals. District profiles and assessments on the state of RMNCAH, HIV and SGBV were conducted to inform scale up plans. The integration assessment highlighted the need to strengthen the integration of SGBV services, and identified challenges related to client and health care provider confidentiality. The quality-of-care assessment created awareness of the factors contributing to poor health care and recommended that investments be made in strengthening health care worker capacity, in particular around childbirth.

Findings

- **Malawi** initiated an assessment on the integration of SRHR, HIV and SGBV in health facilities that is to be completed in 2020 and will be used to inform scale up of integrated services. As part of its efforts to strengthen comprehensive abortion care, reproductive health commodities were procured. Technical support was provided to the integrated RMNCAH&N review report, and quality integrated SRHR, HIV, SGBV services were expanded for pregnant and breastfeeding adolescents.
- **South Africa** is supporting 37 facilities (20 in the Eastern Cape and 17 in KwaZulu-Natal) to strengthen integration with the Ideal Clinic initiative. Client flow maps were developed and client referral pathways strengthened to improve screening for cervical cancer and fast track clients accessing family planning. Job aids and Logbooks were developed to support the implementation of the minimum package of SRHR/HIV services. Technical support was provided to the facilities on meeting the five national minimum AYFS standards, and linkages strengthened between the health facilities and surrounding schools. This led to improved compliance by health facilities, with 23 of the facilities exceeding the 80 per cent score mark, improved collection of data by age, sex and service, and an estimated 20,000 young people aged 10-24 accessing SRHR services during the reported period.
- **Namibia** increased the number of sites providing integrated services using its “one room, one provider, and one package of services” approach from 7 pilot sites to 87 sites. This expansion was informed by regional scale up plans developed by stakeholders from 14 districts who participated in a national consultative meeting. Model sites are being used as centres of learning for those in the process of introducing the integrated service delivery model. Community health extension workers were trained to prepare communities for implementation of the integration of SRHR/HIV services.
- **Uganda** piloted 26 model facilities for integration with mentorship and supportive supervision provided by Regional Referral Hospitals in 8 districts. Implementation was guided by a package of standardized programme interventions, RMNCAH Point of Care guidelines and the national SRHR/RMNCAH quality improvement guidelines. The eight districts undertook a rapid assessment of their costed family planning implementation plans and a survey on the capacity to provide PAC, SGBV services and models for community engagement.
- **Zambia** conducted facility level assessments at 24 sites in four districts to determine the extent to which integrated services have been operationalized. This assessment recommended the need to strengthen client flows and the integration of SGBV services. Quality assurance and quality improvement tools were developed and tested in the 24 health facilities to improve the quality of services. This contributed towards improving client safety, clinical and health care operations and teamwork. A facility and community-based package of adolescent health care services, informed by global and regional standards, was implemented in four targeted districts.
- **Zimbabwe** undertook an assessment in 46 health facilities in 13 districts on the capacity to provide integrated client-centred SRHR, HIV, SGBV services. Recommendations included the need to strengthen service provider capacity, referral pathways, and tracking progress on integration of services. Site specific scale-up work plans were developed, and draft referral pathways elaborated. A monitoring tool was developed and sent to provinces for use in monitoring and quarterly supportive supervision. The Programme strengthened the provision of integrated SRHR/SGBV services at SGBV shelters and one-stop centres through training 148 counsellors from Victim Friendly Units, Social Welfare, Ministry of Women Affairs, and community-based clubs and organizations. This training, together with district-specific directories, strengthened the referral to clinical services for the prevention of unintended pregnancies and STIs, including HIV.

Box 2:
Modelling effective, efficient integrated services for female sex workers

Services were expanded to FSWs in Kenya and South Africa using different approaches, generating lessons that will inform scale up in other countries. The Kenyan model used a static health facility, complemented by mobile facilities and peer educators. From 2018-2019, the Programme reached 5522 FSWs. South Africa tested a low-cost model that provides an integrated package of SRH and HIV services for FSWs through government health facilities. In 2018, 3754 FSWs were reached during outreach, 181 referred for HIV testing, 178 screened for TB and 795 participated in risk reduction workshops. In 2019, the Programme expanded to 22 public health facilities in the Eastern Cape and KwaZulu-Natal, reaching more than 10,000 FSWs of whom eight in ten (84 per cent) were living with HIV.

Community-based approaches are critical in providing 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. Community health care workers are an important cadre of health care providers, providing basic services, psychosocial support, linkages and referrals.

- In **Eswatini**, the Programme scaled up community oriented SRHR, HIV, SGBV service delivery models for adolescent girls, young people, pregnant and breastfeeding women and key populations.
- **Lesotho** provided family planning and other SRHR services through community outreach activities to 1,765 women living in the catchment areas of health facilities to help prevent unintended pregnancies while support through young mentor mothers was initiated in two districts. The programme supported the updating of the Village Health Worker (VHW) Policy which will institutionalize, standardize and strengthen reporting on the work of VHWs.

- In **Malawi** the Programme supported 80 mentor mothers in areas surrounding 19 health facilities in three districts to provide psychosocial support, education and referral for pregnant and breastfeeding adolescent mothers with HIV and their immediate family. Community Based Distribution Agents were supported with commodities and training to provide family planning services and referral and linkages to other services. Cervical cancer awareness campaigns and screenings among women with HIV were undertaken. To help improve access to integrated services for adolescents living with HIV, the Programme supported a teen support line and 18 Teen Clubs, further strengthening community-facility linkages.
- In **South Africa** community maps were developed and displayed in 18 SRHR/HIV sites showing the referral pathway between the clinics, Ward Based Outreach Teams and communities. The Ward Based Outreach Teams are comprised of trained community health care workers who identify and refer clients for services that they cannot provide in the community and who follow up clients who are referred by the health care workers.
- **Zimbabwe** implemented the Young Mentor Mother Programme, a peer support model for adolescent mothers living with HIV. A service package was developed to guide the provision of integrated services to pregnant and breastfeeding adolescent and young mothers with HIV and those who are HIV negative. In 2019, 48 trained YMM led monthly support group meetings for 740 HIV positive young mothers and pregnant adolescents in 26 health facilities in five districts.

The Programme harnessed **traditional and social media** to facilitate communication and feedback from clients on their experiences on SRHR. Lesotho, Malawi, Uganda used social media, m-health and e-health solutions to engage adolescents and young people on SRHR, including monitoring and improving accountability for the delivery of quality services through regular polls. Zimbabwe used an integrated media approach that combined community radio programme and 5 U-Report polls, reaching 2250 adolescents and young people with counselling and referrals.

Box 3: Adolescents and young people

In Lesotho, adolescent corners, combined with mentorship and supportive supervision of service providers, led to more adolescents and young people receiving quality, integrated HIV/SRHR/SGBV services. In Zimbabwe, young people accessed vital information with the tap of a button, using the TuneMe App to learn about their sexual and reproductive rights and how to make informed choices about their health.

Box 4: Adolescent and young mothers with HIV

In some ESA countries, up to one of every three pregnant women with HIV is aged 15-24. Pregnant and breastfeeding ALHIV are shown to have poorer health outcomes, including lower service uptake, higher LTFU and higher mother-to-child transmission rates, when compared with adult mothers with HIV. In response to this growing evidence, 2gether4SRHR worked across the region to support countries to develop, deliver and monitor tailored integrated SRHR/HIV/SGBV packages that show promise in reaching larger numbers of vulnerable adolescent and young mothers and their partners. Young mentor mothers and community health workers are providing multi-faceted, multi-sectoral support in Lesotho, Malawi, South Africa and Zimbabwe. Programme results have been shared through webinars and a widely disseminated report, expanding South-South learning.

Early programme results show a significant impact on health outcomes. For example, in facilities in 7 districts in Zimbabwe, young mothers who were supported by Zvandiri's young mentor mothers had a viral load suppression rate of 93 per cent (compared to 47.9 per cent at population level). All infants were tested for HIV and 100 per cent were HIV negative.

For more information, see:

<https://www.unicef.org/esa/reports/addressing-needs-adolescent-young-mothers-affected-by-hiv>

(See Annex IV for detailed activities to take services to scale.)

Output 2.3: **High quality SRHR/HIV and SGBV data and information produced**

The regional monitoring and evaluation team identified 81 key indicators on SRHR, HIV and SGBV from a regional desk review and mapping of standardised indicators from programmatic documents, population-based surveys and policy sources. These indicators serve as the foundation for the Regional Strategic Information Hub that is responsible for generating and analysing data and disseminating information.

Recognizing the importance of country capacity to generate and use high quality disaggregated data on SRHR, HIV and SGBV, the Programme strengthened Health Management Information Systems (HMIS) and other national M&E systems to streamline RMNCAH and integrated SRHR, HIV and SGBV indicators and registers. At the same time, the Programme collected and analysed data to strengthen Programme performance and implementation.

With regional technical support, the Programme supported the launch of Health Situation Rooms (HSRs) in Lesotho, Malawi, Uganda, Zambia, and Zimbabwe, and enhanced capacities of HSR country technical focal points on using the data visualisation platform. An intercountry workshop was conducted on strengthening HMIS through an integrated standards-based approach to routine health facility data analysis and use.

A review of health facility data collection tools and the extent to which they are equipped to capture integrated services also took place. Several countries influenced data systems to support integrated programming. For example, in Uganda, the Programme worked with the MoH to capture integrated service delivery indicators into the HMIS.

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

With 2gether4SRHR support, a wide range of models and approaches were tested for their effectiveness in meaningfully engaging adolescent girls, young people and KPs in understanding their rights and knowing how to demand quality services. Activities focused on increasing knowledge, transferring skills, and addressing social and cultural norms that would facilitate the availability of and demand for integrated SRHR, HIV and SGBV services at regional, national and sub-national level.

Regional and country-level **networks** were strengthened to influence policy making, resource allocation, and programming. Investing in organisational strengthening and programming provided opportunities for stakeholders to expand their reach and impact, including implementing and monitoring evidence-informed SRHR interventions. Network groups included men and boys; traditional, religious and community leaders; young people; and key populations.

Adolescents and young people engagement is at the core of 2gether 4 SRHR, particularly in programme design, implementation and monitoring. For example, the Programme established the Coalition on Adolescence SRHR and HIV (CYSRA), a Ugandan-based platform that supports medical students to address the needs of PLHIV in all their diversity. CYSRA implemented a regional programme in 2019, “Enhancing young people living with HIV coordination in Eastern and Southern Africa,” that encouraged dialogue between medical students and people living with HIV,

building empathy among future medical providers for diversity.

Pregnant adolescents and young mothers gained knowledge, skills and increased access to SRHR, HIV, SGBV services through multiple approaches across countries, including media and community outreach, peer support (e.g. young mentor mothers), community health workers and tailored facility-based services.

Recognizing that **communities** offer opportunities to reach vulnerable populations outside of the formal health system, the Programme facilitated community consultations to develop a common community statement on people-centred Universal Health Coverage that encompasses HIV and SRHR needs. The Programme also led engagement with traditional, religious and community leaders to promote protective behaviours and the uptake of integrated services among adolescent girls, young people and key populations.

Access to SRH rights was further strengthened through **supporting shadow and community-based scorecards that promote social accountability**. For example, a promising practice at national level was the use of a scorecard to monitor and improve the quality of adolescent-friendly health service delivery. Shadow scorecards in Malawi and Uganda were used to sensitize communities and create demand for essential SRHR, HIV and SGBV services amongst communities.

Findings

Several countries held workshops on #UPROOT, a youth-led scorecard that tackles the root causes that put young people at risk of HIV. Young people were acknowledged as being most knowledgeable about their own situations and capable of leading discussions on the structural factors and social determinants that increase their risk and vulnerability.

Engaging men and boys

Men and boys are critical as both recipients and partners in integrated SRHR, HIV and SGBV services. Male engagement was strengthened regionally and nationally, establishing a solid foundation for future interventions.

- Disseminating and leveraging learning on male engagement from promising practices developed during the Optimizing HIV Treatment Access programme.

- Sharing successful male engagement strategies at a regional meeting with six countries at which regional and country road maps were developed.
- Supporting governments to work with networks of men and boys to address their SRHR, HIV and SGBV needs (Eswatini, Zambia).
- Using community dialogue and Boys Forums to deliver the Ministry of Health and Child Care's manual on Transformative Masculinity (Zimbabwe).
- Conducting a literature review on the latest evidence on young men and SRHR, HIV and SGBV.

»» Objective 4: Lessons from the Joint UN Programme amplified across countries

Several approaches were used to amplify lessons from the first half of the Programme, reaching global, regional and national audiences, including south-to-south learning, leveraging programmes, research and documentation.

South-to-South and collaborative learning is an integral part of all four 2gether4SRHR objectives. The Programme used multiple modalities, such as meetings, study tours, communities of practices, webinars and documentation, to share knowledge, innovation and expertise.

The Programme convened **regional and national bodies** to share lessons learned, identify gaps and achieve consensus on strengthening integrated SRHR, HIV and SGBV services. For example, several meetings provided opportunities to leverage learning and share research and promising practices, such as meetings of the Regional Programme Steering Committee, the SADC SRHR and HIV managers and the EAC RMNCAH managers. Participation in the 2019 ICASA conference showcased lessons learned on a global platform.

Annual programme management meetings brought the UN regional and country teams together to share experiences and workplans; a key outcome of which was building on each other's experiences and gaining new strategies.

Learning visits proved a valuable way to facilitate south-to-south cooperation and strengthen programming. For example:

- South Africa undertook a study tour to Botswana to look at its models of integration and subsequently applied lessons learned to programmes in the Eastern Cape and KwaZulu-Natal.
- Similarly, a delegation from Botswana visited South Africa to learn about the "She Conquers" campaign targeting AGYW, while a visit from a second Botswana delegation focused on domestication of the WHO clinical guidelines and developing a training guide for health care workers on providing integrated SRHR, HIV services for KPs.

- South Africa hosted a UNFPA and MoH Team from Eswatini focusing on HIV prevention, sex work, SGBV and adolescents and youth programmes, as well as infertility.
- Eswatini's visit to South Africa to explore comprehensive condom programming influenced Eswatini's national condom programme, as the country subsequently undertook a national condom preference study towards developing a national brand.
- Eswatini hosted a delegation from Botswana on harmonisation and rationalisation of data collection tools and registers.
- A health director from the Uganda MoH visited Namibia for health systems learning on client flow design to support integration and an interface meeting was organized in Namibia to support Uganda's efforts to implement the integration of male engagement in health facilities.

Exchange visits also strengthened capacities within countries as managers had the opportunities to learn from their peers. For example, Kenya facilitated exchange visits between implementing counties aimed at improving service delivery and increasing levels of access. Malawi supported Joint UN and government missions to three districts to facilitate district management and monitoring, and supported district integrated team officers to undertake learning visits to high-performing districts to understand the factors behind successful integration models.

Leveraging and building upon the process of the SADC Scorecard developed with support from 2gether4SRHR, the 2gether4SRHR team collaborated with the WHO Regional Office for Africa and AU to develop a **Regional SRHR scorecard**. The Regional SRHR scorecard has been finalized and published on the WHO/AFRO SRHR webpage and the ALMA RMNCAH webpage. Member States have been given access to log into the webpage and review their progress. The African Regional SRHR Score Card was harmonized with SADC Score card to limit multiple reporting and associated costs.

State of the art research was undertaken to contribute to the body of evidence on integrated HIV, SRHR and SGBV services. For example:

- A strategic partnership was established between UNICEF, Oxford University and Cape Town University to support a longitudinal study of the health and well-being of adolescents and their young children in South Africa. The study is assessing pathways to resilience among adolescent families living in adversity, including HIV-affected households. In addition to understanding what puts young parents and their children at risk, the study is identifying entry points for programming and social, health and economic support services that may improve outcomes for adolescent parents and their children.
- To further understand and address why adolescent and young mother in Malawi have poorer PMTCT outcomes than older mothers, the Programme collaborated with the Ministry of Health and research and implementing partners to conduct formative qualitative implementation research with adolescent and young mothers living with HIV. The study's findings and recommendations were published in a peer-reviewed journal¹⁰ and used to tailor a mentor mother model for adolescent and young mothers.
- In Uganda, the Programme supported an impact evaluation of the Ministry of Health's pilot group antenatal/postnatal care programme for AGYW. Designed to increase the use of SRH, HIV services and to encourage women to improve their self-care, group discussions were used to build peer support and deliver essential health information. The findings were used to inform scale up to 318 health facilities and resulted in the inclusion of group ANC and PNC in the National AGYW HIV Prevention Strategy.
- A qualitative Knowledge, Attitudes and Practices Survey was supported in Zambia that determined adolescent and young mothers' knowledge and use of SRH, HIV, SGBV services. The findings are being used to advocate for reduced barriers to services, leverage policy change, and develop a national social and behaviour change communications strategy.

¹⁰ Carbone NB, Njala J, et. al. "I would love if there was a young woman to encourage us, to ease our anxiety which we have if we were alone": Adapting the mothers2mothers mentor mother model for adolescent mothers living with HIV in Malawi. PLoS ONE 14(6): e0217693, 2019.

Findings

Knowledge management: Early in 2gether4SRHR, the regional offices, led by UNICEF, developed a communications strategy and harmonized guidance on documentation of promising and emerging practices. Despite only two years of implementation, all countries and the regional office documented and shared evidence on the efficiency, effectiveness and impact of SRHR, HIV and SGBV integration through technical meetings, conferences, webinars, peer reviewed journal articles, policy briefs and corporate UN publications. The Programme also collaborated with the U.S. Agency for International Development and Johns Hopkins University on a journal supplement published in the BioMed Journal of Public Health that shared

experiences on the provision of integrated services to the general population and key populations (<https://reproductive-health-journal.biomedcentral.com/articles/supplements/volume-16-supplement-1>). A satellite session was held with key contributors to the journal to further expand on the lessons learnt. At the country level, additional communication products included human interest stories, podcasts, videos, brochures, and photo-stories.

(See Annex IV for a select list of studies and knowledge management products.)

Challenges and risk mitigation

The Programme faced several challenges during the period of implementation, for example, gaining traction on SRHR issues such as child marriage, age of consent, LGBTQI rights, and abortion. Nonetheless, 2gether4SRHR made considerable advances in improving access to appropriate services and realization of SRH rights for vulnerable populations. Examples have already been provided on improving the policy environment and strengthening clinical capacity on abortion care. Also, Joint UN work is currently ongoing on developing a paper on age of consent. However, while progress was made in creating a regional normative framework for LGBTQI, this still needs to be translated into national frameworks and services remain inadequate, particularly in restrictive policy environments and especially for adolescents and young people. Further work also needs to be done in strengthening linkages with programmes on ending child marriage.

Fragmented data management systems, shortage or lack of data collection tools, lack of disaggregated data, and vertical data collection tools hampered the ability

to collect and use strategic information to improve integrated service delivery. The Programme has initiated plans to strengthen data collection, beginning with the review of data collection tools and indicators. Advocacy is on-going for a transition to the use of electronic data systems to improve programme implementation.

Weak health systems and service delivery challenges (inadequate commodities, equipment and infrastructure) persist. Efforts to leverage greater funding domestically and from foreign sources and to promote SRHR as part of the minimum benefit packages for UHC must continue for improvements realized to be sustained.

Environmental crises (e.g. Cyclone Idai) in several countries resulted in disruptions in planned interventions and service delivery. The four UN agencies worked closely with governments and civil society to respond to these humanitarian emergencies and ensure a continuity of SRHR, HIV and SGBV services to affected populations.

Delivering as One

The implementation of this Joint UN Regional Programme draws upon the comparative strengths and technical expertise of the four participating UN agencies to “Deliver as One” UN. The MTR was an opportunity for the UN agencies to reflect on what processes have worked well and what were the challenges, and to agree on ways to strengthen delivering as one.

The 2gether4SRHR Programme has remained a regional programme, contributing to countries acting in unison, aligned with regional strategies. At the same time, it responded **to national needs**, aligned with National Government Plans and integrated into national SRHR and/or RMNCAH &N programmes. It capitalized on **the comparative strengths of the UN** as each of the four UN agencies brought their unique skills and activities according to their specific mandates. This also resulted in **reduced duplication of activities**, showcased by joint activities.

In some instances, **country demand** led to regional work and kept expectations grounded. For example, the regional capacity building platform for comprehensive abortion care was developed following an identified need by countries for capacity building on values clarification, attitude transformation, and the clinical provision of comprehensive abortion care.

The 2gether4SRHR Programme **strengthened strategic leadership and developed synergies among UN agencies** from planning to implementation and monitoring. Annual work plan development and reporting was undertaken collectively by participating UN agencies and governments, at both country and regional levels. Regional Programme Steering Committee meetings served as important opportunities for regional and country stakeholders to address issues from a strategic perspective, share promising practices from the previous year, and establish priorities for the upcoming year. These joint efforts resulted in **delivering harmonized support to countries**.

The 2gether4SRHR budget was disbursed from the SRHR team of Sweden to UNFPA (the convening

agent). UNFPA then disbursed funds to individual agencies as planned. Although funds flowed to different agencies, annual budgets were jointly developed to **promote coherence** and joint activities resulted in **joint resource mobilisation**. This resulted in **reduced competition for funds** and synergies across programmes.

Working jointly posed some challenges, such as coping with different financial systems and human resource transitions in individual agencies. Nonetheless, through consistent consultations the UN agencies worked together to ensure implementation continuity and programme cohesiveness.

Overall, the Programme demonstrated that UN reform and joint implementation at the programme level is both possible and impactful, but there are real operational challenges that need to be addressed to further strengthen combining resources for enhanced implementation and results.

Future plans

During the first half of implementation, 2gether4SRHR made significant progress in meeting programme objectives. The remaining two years will emphasize providing regional and country-level technical assistance to translate integrated policies into action, scale up demand for and provision of service delivery, and document lessons learned and promising practices across the region. It is also important to note that this phase of the Programme will be implemented in the context of an unprecedented pandemic, COVID-19. 2gether4SRHR will prioritize adapting its plans to the pandemic, recognizing the stress the pandemic has put on already fragile health systems and the importance of sustaining the gains made in SRHR, HIV, and SGBV. Specific plans are as follows:



Objective 1. Create an enabling legal and policy environment

The Programme will continue to advocate and support the development of laws, policies and strategies as well as shifts in knowledge, attitudes and norms. This will entail supporting the translation of regional policies, strategies and frameworks into national action and identifying residual barriers, particularly in laws and policies related to domestic violence, child marriage and termination of pregnancy. In addition, support will continue to be given to domesticate regional instruments, such as the SADC Strategy and Scorecard. Support will continue to be provided to complete the Scorecard at regional and national level.

High level advocacy on SRHR, HIV and SGBV integration will continue to be prioritised, as well as on increasing and leveraging domestic and international funding and public-private partnerships for taking effective SRHR, HIV and SGBV services to scale and guaranteeing programme continuity.

To maximize the impact on legal and policy environments, 2gether 4 SRHR will collaborate more closely with other global and regional initiatives, such as the Spotlight Initiative on SGBV, Ending Child Marriage, and the Maternal Health Trust Fund.



Objective 2. Scale up provision of HIV, SRHR, SGBV services

The MTR confirmed that bringing services to scale requires continuous investment in health systems strengthening. Prioritisation in the second phase of the Programme will be to:

- Improve the quality of integrated service delivery through the establishment of a Technical Assistance Hub to ensure the provision of quality-assured technical assistance.
- Strengthen country responses through convening regional fora for countries to exchange information, experiences and develop roadmaps that can be supported through a flexible funding modality.
- Advocacy to strengthen HMIS to include better disaggregation of data, promote the use of electronic client management information

systems to ensure that no one is left behind, while continuing to monitor progress in meeting the SDG targets through using tools such as the SADC SRHR Scorecard, and the EAC RMNCAH scorecard.

- Promote differentiated models of service delivery to vulnerable community members, for example, through greater decentralization of services and community-facility linkages.
- Expand the use of technology such as e-platforms to conduct training or mHealth to reach people with information and support.



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

The Programme will build upon the achievements made in increasing knowledge and understanding of SRH rights and holding governments accountable for delivering services. These actions will include:

- Strengthening work on gender, key populations, and adolescents and young people, including amplifying their views through regional and national networks and traditional and social media.
- Developing an advocacy platform to strengthen joint advocacy on SRHR among organizations in the region.



Objective 4. Amplify lessons learned from the joint programme

To further facilitate access to lessons learned, the Programme will establish a **regional knowledge management information hub** that will be a repository for programme-related documents, best practices and human interest stories.

The MTR identified **promising practices** that have provided measurable results and reported successful outcomes and that could potentially be scaled up and/or duplicated. These promising practices will be documented during the final phase of the programme. The Programme will also explore how to engage adolescents and young people in the documentation process. An early list includes the following:

- Regional approaches to building and sustaining support for integrated HIV, SRHR and SGBV services
- Strengthening comprehensive safe abortion services
- Providing cost-effective services for FSWs, building upon the costing study undertaken in Kenya and the delivery of services in South Africa
- Innovative use of media to scale up access to information and services to young people
- Cost-efficient and effective ways to deliver services to female sex workers
- Working with boys and men as recipients and partners in integrated HIV, SRHR, SGBV services
- Regional, national and social accountability

Programme management

As the Programme enters its second phase, the regional and country teams have renewed their commitment to strengthening inter-agency implementation, particularly to ensure that the gains of the first half of the Programme are sustained as the COVID-19 pandemic continues to exact a toll on health systems and vulnerable populations. Programme management will be enhanced through the following measures:

- Strengthen programme management and oversight to enhance performance on key issues relating to SRHR. This includes establishing the Strategic Leadership Forum as a Joint UN Platform to undertake high-level political advocacy, engage on strategic SRHR-related issues in the region, and further strengthen joint action across the four UN agencies.
- Strengthen communication through initiation of a Deputy Regional Directors Platform.
- Strengthen programme implementation by building stronger linkages with technical units within the four implementing agencies, other Joint UN initiatives, and global initiatives.

Annex I. Programme Matrix

Objectives	Outputs	Programme Activities	
		Country	Region
1. Create an enabling legal and policy environment that empowers people to exercise their SRH rights and access quality integrated SRHR/HIV and SGBV services	1.1. A Strengthened policy and legal environment that enables all people to exercise their SRHR, including access to quality integrated SRHR/HIV and SGBV services	<ol style="list-style-type: none"> 1. Develop, amend and harmonize laws, policies, strategic plans, guidelines that are rights-based, link SRHR/HIV and SGBV and commit to the provision of comprehensive integrated SRHR/HIV and SGBV services. 2. Convene national and subnational multi-sectoral coordinating entities to plan, implement, and monitor the scale up quality assured integrated SRHR/HIV and SGBV services. 3. Develop national, civil society and community accountability mechanisms (e.g. self-assessment score cards, civil society score cards and community dialogues) to increase accountability and review progress to achieve the SDGs, global, continental, and regional SRHR/HIV and SGBV commitments. 4. Implement human rights recommendations related to CEDAW and the Universal Periodic Review. 5. Build the capacity of policy makers and programme managers to mainstream gender, equity and rights across policies, programme implementation, and monitoring for SRHR/HIV and SGBV, including the prevalence and consequences of unsafe abortions. 	<ol style="list-style-type: none"> 1. Support SADC and the East Africa Community (EAC) to develop harmonized regional standards on SRHR/HIV and SGBV in line with global, continental and regional commitments, and to facilitate their domestication amongst member states. 2. Support regional leadership initiatives such as the Champions for an AIDS Free Generation and the African Think Tank on HIV, Health and Social Justice to advocate with regional leadership structures and national leaders to protect SRH rights, promote the provision and uptake of quality integrated SRHR/HIV and SGBV services for all people, with a focus on adolescent girls, young people and key populations. 3. Undertake joint advocacy to address emerging human rights crisis to protect and promote the SRH rights of adolescent girls, young people and key populations and promote the uptake of quality integrated SRHR/HIV and SGBV services in the ESA region.
	1.2. Availability of funds from domestic and international sources to sustain provision of integrated quality SRHR/HIV and SGBV services	<ol style="list-style-type: none"> 1. Conduct research (e.g. expenditure analysis, resource tracking studies, and investment case studies) that can be used by civil society organizations (CSOs), private sector, faith-based organizations (FBOs) and community leaders to engage Ministries of Health, Finance and Parliamentarians to increase domestic investments in SRHR/HIV and SGBV to achieve sustainable financing and meet their commitments in the Abuja Declaration and the Quarter for HIV prevention. 	<ol style="list-style-type: none"> 1. Package and provide evidence to Regional Partners emerging from investment case studies, cost efficiency studies and other research to advocate for increased domestic and foreign investments (Global Fund, PEPFAR, World Bank among others) in integrating SRHR/HIV and SGBV.
2. Scale up the provision of client-centred quality assured integrated and sustainable SRH, HIV and SGBV services	2.1. Increased national and regional capacity to scale up quality integrated SRHR/HIV and SGBV services	<ol style="list-style-type: none"> 1. Incorporate and implement (train, mentor and monitor) SRHR/HIV and SGBV integration into national and sub-national human resource plans for HCWs, including task shifting, to ensure the provision of quality client centered integrated SRHR/HIV and SGBV services. 2. Incorporate the provision of a client centered rights based integrated SRHR/HIV and SGBV curricula into existing pre-service training curricula. 3. Develop standard curricula and train community health care workers to deliver an integrated package of SRHR/HIV and SGBV services within communities that is monitored and evaluated. 	<ol style="list-style-type: none"> 1. Develop a regional minimum standard for task shifting on SRHR/HIV and SGBV in partnership with regional partners to address the needs of adolescent girls, young people and key populations. 2. Develop/update a regional training curriculum for health care workers (HCWs) to include quality integrated SRHR/HIV and SGBV services to adolescent girls, young people and key populations linked to professional development programmes.
	2.2. Quality integrated SRHR/HIV and SGBV services scaled up.	<ol style="list-style-type: none"> 1. Assess the extent to which health facilities have integrated client centered SRHR/HIV and SGBV services, the bottlenecks to service delivery and the extent to which guidelines are used to address these. 2. Develop, implement, monitor and evaluate national scale up plans to provide quality assured integrated SRHR/HIV and SGBV services based on WHO tools and guidelines, and the regional standards for the integration of SRHR/HIV and SGBV. 	<ol style="list-style-type: none"> 1. Develop/adapt minimum standards and guidelines on the provision of rights based integrated SRHR/HIV and SGBV services for adolescent girls, young people and key populations. 2. Document and share lessons learnt and support south-south exchange visits to enable countries to learn from each other's experience on applying models of SRHR/HIV and SGBV integration. 3. Develop a regional guideline, document and share experiences from the piloting of an integrated package of SRHR/HIV and SGBV services for men with countries in the region.

Objectives	Outputs	Programme Activities	
		Country	Region
		<p>4. Develop, implement, monitor and evaluate strategies that meet the needs of pregnant adolescent girls and young women, to strengthen PMTCT, through improved monitoring and retention of mother infant pairs, and strengthen the links with family planning and HIV prevention.</p> <p>5. Strengthen national health systems to scale up the provision voluntary family planning to prevent unwanted pregnancies and to deal effectively with the complication of unsafe abortion through providing quality and safe post abortion care services.</p> <p>6. Scale-up community oriented SRHR/HIV and SGBV service delivery models for adolescent girls, young people, pregnant and breastfeeding women and key populations and strengthen the linkages between facility based health care workers and community health workers to improve follow up of pregnant and breastfeeding women and their infants, women receiving family planning, and retaining people on HIV treatment.</p> <p>7. Pilot the provision of an integrated package of SRHR/HIV and SGBV services targeting men and document lessons learnt.</p> <p>8. Empower adolescent girls, young people, and key populations to monitor and improve the accountability of the provision of integrated SRHR/HIV and SGBV services through social media/m-health and e-health platforms and the extent to which these meet their needs.</p>	
	<p>2.3. High quality SRHR/ HIV and SGBV data and information produced, analysed and used to inform evidence-based programming with adolescents, youth and key populations</p>	<p>1. Develop and coordinate a national multi-sectoral M&E system that includes national and sub-national SRHR/ HIV indicators and to analyse this data to strengthen programme performance and implementation (e.g. through national situation rooms).</p> <p>2. Provide catalytic support to strengthen country capacity to address gaps in strategic information data capturing (e.g. key populations size estimates, gender sensitive SRHR/HIV M&E) and utilization to inform programme and policy development.</p> <p>3. Produce annual updates on SRHR/HIV and SGBV to track regional and country progress in meeting national/ regional targets.</p> <p>4. Generate, analyse and use age and sex disaggregated data to strengthen community responses on SRHR/HIV and SGBV.</p>	<p>1. Develop a regional information hub to monitor progress in meeting global, continental and regional commitments for SRHR/HIV and SGBV.</p> <p>2. Develop and pilot a tool and/or register to measure the provision of integrated SRHR/HIV services at community and facility level to strengthen national health management information systems.</p> <p>3. Collect, and analyse data that is stratified by age, gender, geographic locations, socio economic groups that are inputted into the ESA regional information hub and repository to capture and generate high quality SRHR/HIV national and sub-national data that is utilized to monitor and improve programme implementation.</p>

Objectives	Outputs	Programme Activities	
		Country	Region
3. Empower all people to exercise their SRH rights, adopt protective and promotive behaviours and access quality integrated services	3. Strengthened communication, ownership and participation to create demand so that all people, but particularly adolescent girls, young people and key populations realize their rights, adopt protective and promotive behaviours, and access quality integrated SRHR/HIV and SGBV services.	<ol style="list-style-type: none"> 1. Convene traditional, religious, and community leaders to enhance their awareness on the right to health, address harmful norms and practices and advocate for protective behaviours and the uptake of integrated SRHR/HIV and SGBV services by adolescent girls, young people and key populations. 2. Convene professional associations (e.g. nursing and midwifery associations), networks representing adolescent girls, youth and key populations to identify, implement, monitor and evaluate evidence informed comprehensive packages of social and behavioural interventions (comprehensive sexuality education, community conversations, mass media, social and on-line media) that enhance their knowledge, transfer skills and mobilize communities to adopt protective and promotive behaviours, access community based services and are referred to facility based integrated SRHR/HIV and SGBV services where necessary. 3. Train CSOs, networks of young people and key populations so that they can enhance public awareness of the right to health and respond to SRH rights challenges that impede uptake and access to integrated SRHR/HIV and SGBV services. 4. Build capacity of governments to work with networks of men and boys to institutionalize programmes that address the SRHR/HIV and SGBV needs of adolescent boys and young men and to increase national investments in developing, implementing, monitoring and evaluating national programmes to engage men on SRHR/HIV and SGBV in the ESA region. 	<ol style="list-style-type: none"> 1. Document good practices that can be shared across the region on the meaningful engagement, participation and cooperation of adolescent girls, young people and key populations in designing, implementing, monitoring and evaluating programmes to strengthen the uptake of integrated SRHR/HIV and SGBV services. 2. Convene a regional meeting on male engagement to take stock of lessons learnt and good practices that can be replicated across countries.
4. Amplify the lessons learnt on the integration of SRHR, HIV and SGBV services across the region.	4.1 Lessons from the Joint UN Programme amplified across countries to scale up the provision of integrated SRHR/HIV and SGBV services.	<ol style="list-style-type: none"> 1. South-south cooperation so that countries can strengthen their efforts to provide quality integrated SRHR/HIV and SGBV services based on lessons learnt from the model countries from the Linkages Project and the 5 focus countries. 2. National communities of practice that bring together governments, civil society, the private sector to leverage and share research, learnings, and innovations emerging from the model and focus countries with existing SRHR/HIV and SGBV regional networks that are linked to the SRHR/HIV and SGBV regional information hub. 3. Share evidence of the efficiency, effectiveness and impact of SRHR/HIV and SGBV integration through webinars, peer review journal articles, policy briefs and corporate publications of UNFPA, UNICEF, WHO and UNAIDS. 4. Undertake operational research to further build on the body of evidence in relation to the efficacy and efficiency of the provision of integrated of SRHR/HIV and SGBV services and models of community engagement. 5. Undertake joint missions to countries to monitor programme implementation and progress towards achieving country-level results. 	<ol style="list-style-type: none"> 1. South-south cooperation so that countries can strengthen their efforts to provide quality integrated SRHR/HIV and SGBV services based on lessons learnt from the model countries from the Linkages Project and the 5 focus countries. 2. Regional communities of practice that bring together governments, civil society, the private sector to leverage and share research, learnings, and innovations emerging from the model and focus countries with existing SRHR/HIV and SGBV regional networks that are linked to the SRHR/HIV and SGBV regional information hub. 3. Share evidence of the efficiency, effectiveness and impact of SRHR/HIV and SGBV integration through webinars, peer review journal articles, policy briefs and corporate publications of UNFPA, UNICEF, WHO and UNAIDS. 4. Undertake operational research to further build on the body of evidence in relation to the efficacy and efficiency of the provision of integrated of SRHR/HIV and SGBV services and models of community engagement.

Annex II. Policy documents (Objective 1)

2gether4SRHR provided support to countries to develop, revise and adopt a wide range of policy-related documents, including the following:

Laws:

- The EAC SRHR Bill
- The Penal Code Amendment in Botswana
- The Domestic Violence Bill in Lesotho
- Evidence and the Indictment Acts to strengthen GBV outcomes in Uganda, and the
- Termination of Pregnancy Act in Zimbabwe

National policies:

- The National HIV Policy in Lesotho, and the
- HIV Policy to integrate SRHR/HIV/SGBV in Zambia

National strategic plans:

- RMNCAH or RMNCAH&N: Botswana, Eswatini and Lesotho
- SRHR: Kenya and Malawi;

- Condoms: Kenya and South Africa
- EMTCT: Eswatini
- National HIV Strategic Plans: Lesotho, Malawi
- GBV/SGBV/VAC: Zambia Uganda
- Adolescent Health: Zambia

Service delivery guidelines:

- Integrated Services: Eswatini, Kenya, Malawi, and Namibia
- Family Planning/Contraceptives: Malawi, Namibia, and South Africa
- SRHR: Malawi
- Adolescents: Malawi and Uganda
- SGBV: Eswatini and Namibia
- Termination of Pregnancy: South Africa
- Comprehensive Abortion Care: Zambia
- Sexually Transmitted Infections: Uganda and Zimbabwe
- Maternal Perinatal Death Surveillance and Response: Zambia
- Antenatal Care in Malawi

Annex III. Capacity-building Activities (Objective 2)

Regional and country-level assessments

1. Trend Analysis on SRHR trends in East and Southern Africa (1994 – 2018)
 2. A literature review on the SRHR needs of young boys and men (10-35 years)
 3. Two country assessments (Eswatini and Malawi) to investigate the readiness of national policies and plans to meet the SRHR needs of and mitigate SGBV for women with HIV.
 4. Strategic assessments on the provision of integrated SAC and PAC services (Botswana, Eswatini, Lesotho)
 5. Assessments, including at facility-level, on integrated HIV, SRHR and SGBV services capacity and systems, implementation and quality of care (Lesotho, Malawi, Zambia, Zimbabwe)
 6. An environmental scan to provide strategic insight into key SRHR issues and to inform the advocacy agenda and programme management (Regional, Malawi)
 7. A rapid assessment on the implementation of costed family planning implementation plans in 8 districts, a survey on the capacity to provide PAC and SGBV/VAC services in selected health facilities, and operational research on patient flows and community engagement models for delivery of HIV, SRHR and SGBV programmes (Uganda)
 8. A legal environment scan for KPs (Zimbabwe)
- Standard curriculum of community health care workers (Eswatini)
 - Curriculum for Advanced Midwifery and Public Health Nursing and Neonatology Programmes (Lesotho)
 - Post-abortion care in the nurses' syllabus (Malawi)
 - Family planning curricula (Namibia)
 - Training tools for voluntary male medical circumcision to reflect changes in national guidelines (Uganda)
 - Pre-service training curricula for health care workers on delivering client-friendly integrated SRHR, HIV and SGBV services (Zimbabwe)
 - National adolescent youth-friendly health services pre-service module for all the nursing and midwifery schools in the country (Eswatini)
 - Prevention of Mother-to-Child Transmission of HIV curriculum (Kenya)
 - Family Planning Reference manual and revision of the Antenatal Guidelines (Malawi)
 - Integrating SGBV and VAC clinical guidelines into pre-service and in-service curriculum (Uganda)
 - In-service training curriculum on integrated SRHR/HIV/SGBV module for health care workers; development of a comprehensive package of adolescent health services at facility and community level; adoption of quality assurance tools (Zambia)
 - Integration of SRHR, HIV and SGBV into Nurses' Curriculum (Zimbabwe)

Training tools and related materials

The following training curricula, tools and job aides were developed, reviewed and updated, or finalized:

- Adolescent and Young People Young People and Adolescent Peer Supporters training manual and job aides (Uganda)
- Job aides for health care workers on management of SGBV (Botswana)

Training activities

The following training took place at regional level:

1. Mobilising communities and advocates in hostile political environments for LGBTQI (20 advocates from Zimbabwe; and 36 advocates from Kenya)

2. Providing quality integrated comprehensive and post-abortion care (70 trainers in Eswatini, Malawi, and Botswana)
 3. Training in comprehensive and post-abortion care and post-abortion contraception (48 health professionals, including obstetricians and gynaecologist from Botswana, Eswatini, Lesotho, Malawi, Namibia, Uganda, Zambia, Zimbabwe)
 4. Health Situation Rooms (HSR) sub-national trainings events in Kenya and Zambia; training in development and finalisation of HSRs indicator business matrix for Malawi, Namibia, and Zimbabwe, and inclusion of RMNCAH and SRHR indicators in Kenya; national training of trainers in Malawi and Zimbabwe on dashboard design and creation
- Abortion care, including on values clarification and attitudes transformation, PAC, and ToP (Botswana, Eswatini, Malawi, Namibia, South Africa, Uganda)
 - Family Planning (Eswatini, Namibia, South Africa, Uganda, Zambia, and Zimbabwe)
 - SGBV (Eswatini, Kenya, Lesotho, Malawi, Zambia)
 - eMTCT (Zambia)
 - Gender and equity (Uganda)
 - Violence against children (Malawi)
 - Reproductive health commodity management (Uganda)

Additional training activities at country level included the following:

- Comprehensive health worker mentorship and supportive supervision (Uganda)
- SRHR, HIV and SRHR integration (Botswana, Eswatini, Kenya, Lesotho, Malawi, Namibia, South Africa, Uganda, Zambia, Zimbabwe)
- Antenatal and postnatal care and HIV services (Uganda)
- Analysis and use of data (Uganda)
- Adolescents and young people (Eswatini, Uganda, and Zambia)
- Key populations (Eswatini, South Africa).

Annex IV: Taking services to scale

All of the implementation countries achieved scale up of integrated service delivery. Examples include the following:

- **Botswana** applied three models of integration (kiosk, supermarket and mall) and increased the number of sites from 54 to 123 health facilities.
- **Eswatini**'s national roll-out focussed on SGBV, SAC, the integration of family planning into HIV services and the needs of key populations, and also supported scale-up of community-oriented service delivery models for adolescent girls and young people, pregnant and breastfeeding women, and key populations.
- **Kenya** integrated SRHR, HIV and SGBV services which are being delivered to FSWs and their clients using different models: a drop-in centre, static health clinic, mobile clinic, and peer education.
- **Lesotho** rolled-out integrated services in health facilities in five districts and scaled-up the Young Mentor Mothers Programme in two districts.
- **Malawi** intensified support to 19 health facilities in under-served areas in three districts, demonstrating strong community-facility linkages through the Young Mentor Mothers Programme, Community Based Distribution Agencies (family planning coverage), teen clubs, cervical cancer awareness, and PAC.
- In **Namibia**, the HIV/SRH integrated services model was scaled up to all 14 regions. Currently 89 health facilities are implementing SRHR and HIV integration services, following a regional scale up meeting to provide technical support to integration sites to provide quality integrated services.
- **South Africa** strengthened institutional capacity to deliver youth-friendly services through ward-based mapping, developed patient flow maps for ten pilot health facilities, and tested a low-cost FSW model that provides an integrated package of SRH and HIV services.
- **Uganda** supported 24 health facilities in eight districts to meet key gaps to enhance delivery of a quality integrated service delivery package. The Programme supported operationalisation of standard Quality Improvement approaches and Costed Implementation Plans for family planning.
- **Zambia** implemented Positive Linkages in four health facilities, providing psychosocial support and integrated SRHR and HIV services to adolescents with HIV.
- Adolescents were the focus of scale up to over 300 health facilities in **Zimbabwe**, primarily through the Young Mentor Mother programme, community radio, and the development of a package for integrated services for pregnant and breast-feeding young mothers with HIV.



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