EMPOWERING WOMEN AND GIRLS TO REALIZE THEIR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN SOUTH AFRICA

Programme results from three districts for the period 2019-2024

A UNFPA-UNICEF Joint Programme

UNFPA

unicef
for every child

In partnership with Canada

ACKNOWLEDGEMENTS
AND VOTE OF THANKS

On behalf of the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF) Joint Programme, we extend our deepest gratitude and appreciation to Global Affairs Canada for their generous funding and unwavering support for our project focused on Empowering Women and Girls to Realize their Sexual and Reproductive Health and Rights in South Africa. This project has been a cornerstone of our efforts to promote gender equality and enhance the lives of young women.

We would also like to acknowledge the tireless efforts of the Government of South Africa, our implementing partners, local organisations, community leaders, volunteers, and young people who have worked diligently on the ground to bring this project to life. Your dedication, passion, and collaboration have been pivotal in reaching our goals and making a tangible difference in the lives of many adolescent girls and young women.

@UNICEF South Africa/2023/Moultrie

PROGRAMMATIC OVERVIEW

UNFPA-UNICEF Joint Programme: *Empowering Women and Girls to Realize their Sexual and Reproductive Health and Rights in South Africa*

Programme Title & Project Number	Country, Locality(s), Priority Area(s) / Strategic Results
• **Programme Title:** UNFPA-UNICEF Joint Programme Empowering Women and Girls to Realize their Sexual and Reproductive Health and Rights in South Africa. **MPTF Office Reference Number:** *N.A.*	***Country/Region:*** South Africa, with a focus on three districts: uThukela district, in the province of KwaZulu-Natal; and Alfred Nzo and Nelson Mandela Bay districts, in the province of Eastern Cape. ***Priority area/ strategic results*** United Nations Sustainable Development Cooperation Framework (UNSDCF) 2020-2025 for South Africa, Pillar 2- Human capital and social transformation.

Participating Organization(s)	Implementing Partners
• United Nations Population Fund (UNFPA) - Administrative Agent • United Nations Fund for Children (UNICEF)	**National Counterparts:** the National Department for Social Development, the National Department for Health, the National Department for Women, Youth and Persons with Disabilities, and Provincial and District Governments. **Implementing Partners:** see list in Annex VIII

Programme/Project Cost (US$) 5,500,000 CAD	Programme Duration
• Total approved budget as per project (approx. 4.2 million USD) MPTF /JP Contribution: Government Contribution *(if applicable)* - Other Contributions (donors) *(if applicable)* - **TOTAL:** 5,500,000 CAD	**Overall Duration (months):** 54 months **Start Date:** 05 September 2019 **Original End Date:** 05 September 2023 **Current End Date:** 05 March 2024

Programme Assessment/Review/Mid-Term Eval.	Report Submitted By
Assessment/Review - *if applicable please attach* Yes (No) Mid-Term Evaluation Report – *if applicable please attach* Yes (No)	• **Name:** Siziwe Jongizulu, • **Title:** Gender M&E Analyst • **UNFPA South Africa** Email address: jongizulu@unfpa.org

TABLE OF CONTENTS

LIST OF ACRONYMS

AGYW	Adolescent Girls and Young Women
ABYM	Adolescent Boys and Young Men
AYFS	Adolescent and Youth Friendly Services
COVID-19	Coronavirus Disease, formerly referred to as the 2019 novel coronavirus
COGTA	Department of Cooperative Governance and Traditional Affairs
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organizations
CTOP	Choice on Termination of Pregnancy
DDM	District Development Model (partnership UN and Government of South Africa)
DoH	Department of Health
DSD	Department for Social Development
DWYPD	Department of Women, Youth and Persons with Disabilities
EC	Eastern Cape (Province of the Republic of South Africa)
GAC	Global Affairs Canada
GBV	Gender-Based Violence
GBVF	Gender-Based Violence and Femicide
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council of South Africa
JP	Joint Programme
KZN	KwaZulu-Natal (Province of the Republic of South Africa)
GY M&E	Monitoring and Evaluation
NSP on GBVF	National Strategic Plan on Gender-Based Violence and Femicide
PDSA	Plan, Do, Study, and Act
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-based Violence
SRHR	Sexual and Reproductive Health and Rights
UNDG	United Nations Development Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework

FIGURES

ANNEXES

PART 1
EXECUTIVE SUMMARY

Empowering Women and Girls to Realize their Sexual and Reproductive Health and Rights in South Africa is a UNFPA-UNICEF Joint Programme designed to improve the sexual and reproductive health and rights (SRHR) and reduce sexual and gender-based violence (SGBV) among vulnerable adolescent girls and young women (AGYW) living in in the Alfred Nzo District Municipality, Nelson Mandela Bay Metropolitan Municipality, and uThukela District Municipality in South Africa. Since its inception in September 2019, the Joint Programme has supported the increased use of and access to quality sexual and reproductive health (SRH) services and improved HIV and SGBV prevention and response services. Additionally, it has contributed to a decrease in the discriminatory and harmful practices and attitudes that perpetuate and validate sexual and gender-based violence against women and girls in these districts. This was achieved through high-impact interventions providing vulnerable young people between the ages of 15 and 24 with accurate information through various multimedia platforms and engaging key community actors, including parents, community leaders, faith-based organizations and civil society groups, to amplify their supportive role.

The three districts – two in the Eastern Cape province and one in the KwaZulu-Natal province (KZN) – had been severely affected by COVID-19 and climate challenges. Four hundred and thirty-five people had lost their lives, and 17,700 families had been displaced, creating a humanitarian challenge and heightening the vulnerability of adolescents and youth, who were at risk of being left further behind as a result. During the period of support, the Joint Programme facilitated solidarity among key players and affected populations, enhancing the resilience and rights of adolescent girls and young women during times of crisis. The Joint Programme also provided targeted support to the most vulnerable girls in shelters in two of the three Joint Programme districts.

Final field visit mission, uThukela district KZN

Crucially, the Joint Programme helped to strengthen health and social services systems for the provision of integrated SRH/HIV/GBV adolescent and youth services and bolstered coordination between various sectors in the region. This was achieved by supporting national-level ownership, aligning with national systems and managing for results while strengthening mutual accountability. The Joint Programme strengthened the provision of integrated SRHR/HIV/GBV services within the youth zones thus playing a vital role in promoting the health and well-being of adolescents and young people, contributing to healthier communities and brighter futures. SRHR/HIV/GBV integrated dashboards to support the government in tracking its achievements and analysing bottlenecks have been designed and rolled out in KwaZulu-Natal and are currently being adjusted for use in the Eastern Cape.

As a result of the Joint Programme, the *Plan, Do, Study, and Act (PDSA)* model was established and has subsequently been approved by the KwaZulu-Natal Provincial Legislature on SRH/HIV/GBV integration. This integration model has been effectively scaled up to Ugu and eThekwini districts within the Joint Programme period. This is a key milestone for the Joint Programme in KwaZulu-Natal as the PDSA model is a proven methodology to facilitate the integration of SRH/HIV/SGBV services and improve the quality of service within the existing health system constraints. Additionally, the *Izigodi model* on community engagement for SRH/HIV/GBV has also been piloted in KwaZulu-Natal to coordinate and engage key community actors.

In the Nelson Mandela Bay Metropolitan Municipality in the Eastern Cape, the Joint Programme worked with the Gender-Based Violence Forum, supported by the Office of the Premier, which serves as a multisectoral platform bringing together government and civil society stakeholders to address GBV comprehensively. The Joint Programme helped strengthen the role played by traditional leaders in decreasing discriminatory and harmful practices and attitudes that perpetuate and validate SGBV against women and girls by engaging young men in traditional initiation spaces on sexual and reproductive health in the province. Traditional Leaders are still playing this role in the Eastern Cape, reaching additional districts beyond those earmarked by the Joint Programme. Additionally, social behaviour change programmes aimed at AGYW and the broader public have cumulatively reached over one million people, disseminating critical information on SRHR and challenging gender norms that perpetuate SGBV in the targeted districts.

PART 2
INTRODUCTION

UNFPA and UNICEF's Joint Programme, **Empowering Women and Girls to Realize their Sexual Reproductive Health and Rights in South Africa**, was launched in late 2019 to improve sexual and reproductive health and rights (SRHR) and reduce sexual and gender-based violence (SGBV) among vulnerable adolescent girls and young women in three districts across two provinces of South Africa. The districts supported are Alfred Nzo and Nelson Mandela Bay in the Eastern Cape and uThukela in KwaZulu-Natal. These districts have youthful populations (15-34 years) as follows: Alfred Nzo, 34 per cent; uThukela 35 per cent; and Nelson Mandela Bay, 32 per cent, as of 2022[1] as well as having the highest national poverty headcount ratio (the percentage of the population living below the national poverty line) and a high burden of disease. In addition, the three districts have reported poorer progress on selected SRHR indicators, including teenage pregnancy and HIV. To address such challenges, the Joint Programme was designed around two main outcome areas:

i. Increased availability and use of quality sexual and reproductive health (SRH), HIV and SGBV prevention and response services free of bias and discrimination for/by the most vulnerable and marginalized adolescent girls and young women (AGYW) in the selected districts.

ii. Decreased discriminatory and harmful practices and attitudes that perpetuate and validate SGBV against women and girls and act as barriers to SRHR within targeted households and communities in the selected districts.

The Joint Programme strived to bridge the gap between policy formulation and actual implementation by involving social cluster departments and stakeholders in health, education, and social services at the district level. The programme identified services and exemplary practices, evaluated existing gaps, and identified bottlenecks and barriers hindering effective SRH service provision. The programme prioritized policy advocacy at upstream levels while cascading and testing implementation at subnational levels. It emphasized community engagement and integration pathways at the district level for SRH, HIV, and GBV services, particularly focusing on adolescents and youth aged 15–24. This targeted approach to service delivery is supported by key community actors. This report provides results for the Joint Programme for the four-year period, 01 September 2019 to 05 March 2023.

[1] *Census Report Statistics South Africa 2022*

@ UNFPA uThukela district concluding remarks during the final visit mission - Rapid Response Teams in action

PART 3
PROGRAMME GOVERNANCE

The Joint Programme utilized guidance provided by the United Nations Development Group (UNDG)[2] on the governance of the Joint Programme, with UNFPA serving as the convening agent. Each agency was responsible for its own financial and programmatic accountability according to its respective agency rules and procedures. As the convening agent, UNFPA was responsible for in-country i) programmatic coordination, including coordinating and compiling annual work plans and narrative reports, ii) monitoring of annual targets, participating in the National Steering Committee meetings convened by the National Government, iii) reporting back to the National Steering Committee on progress made.

3.1 Programme Steering Committee

In accordance with UNDG Guidance, a national coordinating entity (the National Steering Committee) was formed to facilitate collaboration between participating UN organizations and the host government for the implementation of this Joint Programme. The National Programme Steering Committee was the highest decision-making body overseeing the implementation of this Joint Programme. Its key functions included i) supporting the resolution of strategic barriers and risks to programme implementation. ii) approving/rejecting changes to the project that may impact on timelines and budget, iii) overseeing programme implementation, including approving work plans, budgets and annual reports, iv) facilitating the sharing of information, lessons learned and emerging practices, and v) using influence and authority to identify opportunities to strengthen the project and mobilize additional resources to achieve outcomes.

3.2 Programme Technical Working Group

The interagency Technical Working Group (TWG) was composed of technical experts drawn from the two participating UN agencies that worked together to oversee the implementation of the Joint Programme. The TWG was responsible for i) overseeing programme implementation and reporting on progress made, ii) developing joint work plans, budgets and annual reports to deliver as one; iii) identifying opportunities for joint advocacy to support the goals and objectives of the project; iv) identifying lessons learned that can be documented and amplified nationally/regionally, v) participating in the development of joint knowledge products.

3.3 Institutional Arrangements

The UNFPA/UNICEF Joint Programme, funded by Global Affairs Canada, was implemented with the support of the civil society sector and the participation of adolescent and youth key community actors and the Government of South Africa. The programme targeted three districts: Alfred Nzo and Nelson Mandela Bay in the Eastern Cape and uThukela in KwaZulu-Natal. Both UNFPA and UNICEF have footprints across these districts with developed partnerships. The programme leveraged these existing strong partnerships, ongoing UNFPA/UNICEF projects programme and existing coordination mechanisms in these districts.

3.4 Programme Monitoring and Reporting

Quarterly meetings with Global Affairs Canada added an additional layer of accountability for the Joint Programme and ensured quarterly feedback on progress and the immediate resolution of challenges.

[2] *United Nations Development Group (UNDG) 2022*

@ UNFPA uThukela district concluding remarks during the final visit mission - Rapid Response Teams in action

PART 4
PROGRAMME RESULTS AND ACHIEVEMENTS

4.1 Ultimate Outcome 1000. Improved sexual and reproductive health and rights and reduction of sexual and gender-based violence among vulnerable adolescent girls and young women aged 15–24

Ultimate Outcome 1000 indicator aims to achieve improved sexual and reproductive health and rights (SRHR) and a reduction in sexual and gender-based violence (SGBV) among vulnerable adolescent girls and young women (AGYW) aged 15-24. The following are the indicators:

1000-1. Number of incidents of gender-based violence (GBV) reported

The South African Police Service (SAPS) collects and maintains data on reported cases of GBV, including sexual assault, domestic violence, and intimate partner violence. This data is often included in annual crime statistics reports released by SAPS. However, obtaining district-level data from SAPS and Thuthuzela Care Centre has been difficult. The District Health Information System (DHIS)[3] provides a proxy indicator for measuring the extent of sexual GBV, i.e. *New Sexual Assault Cases at Health Facilities.*

New sexual assault cases seen at a health facility

The DHIS (District Health Information System) *New Sexual Assault Cases at Health Facilities* indicator refers to the number of reported cases of sexual assault that are documented by health facilities within a specified period.[4] While the data specifically focuses on sexual assault cases, it is a significant aspect of GBV measurement as it provides insight into the prevalence and patterns of sexual violence within a given population or geographic area. Below are the trends on this indicator for the period 2020-2023.

A positive trend towards addressing SGBV within the communities

Proxy data on GBV suggests a growing willingness within communities to speak out against gender-based

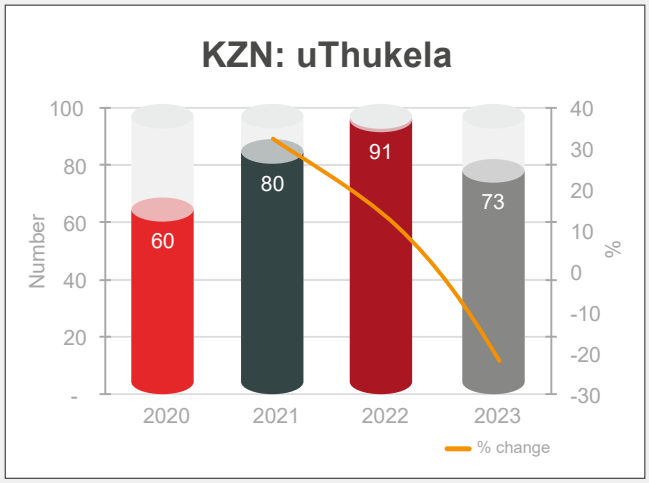
[3] *District Health Information System South Africa*
[4] *Office of the Global AIDS Coordinator (OGAC), 2019. PEPFAR Monitoring, Evaluation and Reporting Indicator Reference Guide Version 2.4*

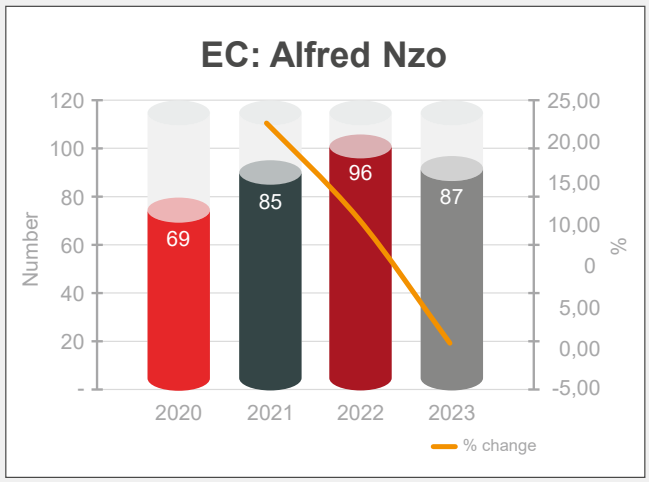
violence and address the issue in the three districts. This indicator suggests a positive trend towards addressing SGBV within the communities. From 2020 to 2023, there has been a notable rise in reported cases of sexual assault at health facilities in the Alfred Nzo and Nelson Mandela Bay districts of the Eastern Cape, with noticeable fluctuations in the number of reported cases from year to year. Factors contributing to this increase may include improved awareness and reporting mechanisms, increased trust in health-care providers, and enhanced efforts to address stigma surrounding sexual assault. The trends are consistent with the Joint Programme-supported study on cultural practices and rites of passage for adolescent girls in the three districts (2023),[5] which reports positive observations about community responses to combat *ukuthwala*, a form of abduction that involves kidnapping a girl or a young woman by a man and his friends or peers with the intention of compelling the girl or young woman's family to agree to marriage, that may lead to non-consensual sexual activities. A significant increase in reported cases related to these harmful practices suggests a growing willingness within the communities to speak out against and address the issue.

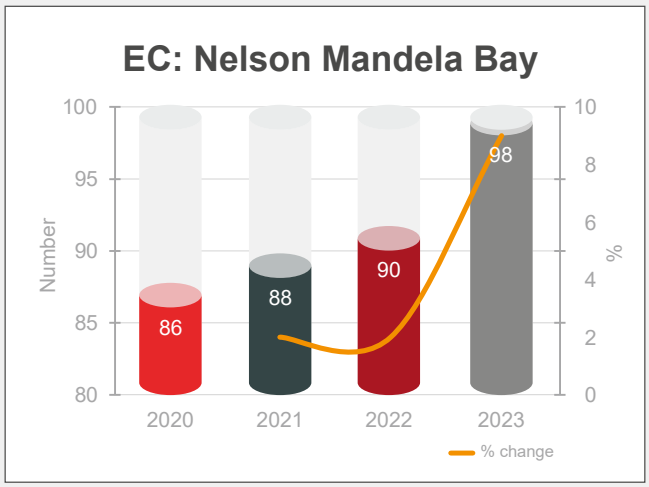
Qualitative results from uThukela emphasized the crucial role of local leadership, which includes the men's sector, in eliminating harmful practices and integrating sexual and reproductive health (SRH) considerations. Men stressed the collective responsibility of men to challenge negative behaviours and advocate for positive change within their communities. In Nelson Mandela Bay, the Gender-Based Violence Forum serves as a multisectoral platform, bringing together government and civil society stakeholders to address GBV comprehensively.

A facilitator leads a session with children in Alfred Nzo, Eastern Cape

Figure 1: New Sexual Assault Cases at Health Facilities in the Three Districts







Source: District Health Information Systems

The decrease in reported sexual assaults at health facilities in Alfred Nzo and uThukela between 2020 and 23, as well as the increase in reported cases in Nelson Mandela Bay Metro, both point to a greater awareness of the need to address SGBV comprehensively through the facilitation of social change behaviour that inspires communities to challenge negative behaviour.

[5] *Cultural Practices and rites of passage adolescent girls go through in the three districts 2023 Human Sciences Research Council*

1000-2. HIV incidence rate among AGYW by age group

The second prioritized indicator under this outcome is the HIV incidence rate among AGYW by age group. The HIV incidence rate focuses on new infections and prevention strategies, while HIV prevalence provides a broader picture of the overall burden of HIV within a population, including both new and existing cases. Both indicators are crucial for understanding and addressing the complex dynamics of HIV in public health planning and intervention. The following data from the Naomi model 6 provides HIV rates among adolescent girls and young women (AGYW) aged 15-24, by district, from 2019 (baseline year) to 2023, for every 1,000 individuals.[6] Overall, the data indicates a general decreasing trend in HIV incidence rates among AGYW across all districts from 2020 to 2023. This decline may reflect the effectiveness of HIV prevention and treatment efforts, including increased access to HIV testing, antiretroviral therapy, and sexual health education programmes.

Alfred Nzo District Municipality, Eastern Cape	In 2019 (baseline), there was a relatively high HIV incidence rate among AGYW, at 2.1 per 1,000 individuals. By 2020, this rate notably decreased to 1.65, indicating a positive trend in HIV prevention efforts. The decline persisted in 2021, dropping the incidence rate to 1.54. In 2022, another decrease to 1.36 reflects continued efforts to reduce HIV transmission. By 2023, the HIV incidence rate further dropped to 1.31, suggesting ongoing progress in HIV prevention and care initiatives within the district.
Nelson Mandela Bay Metropolitan Municipality, Eastern Cape	In 2019, the HIV incidence rate among AGYW in the Nelson Mandela Bay district was lower than that in Alfred Nzo, at 1.16. By 2020, this rate decreased to 0.92, indicating some improvement in HIV prevention efforts within the district. Throughout 2021, the incidence rate remained relatively stable, hovering around 0.86. Although there was a slight increase to 0.92 in 2022, the rate remained lower compared to the baseline year, indicating sustained efforts in HIV prevention. By 2023, the HIV incidence rate decreased slightly to 0.89, suggesting ongoing efforts to combat HIV transmission within the Nelson Mandela Bay metro.
uThukela District Municipality, KwaZulu-Natal	In 2019, the uThukela district revealed the highest HIV incidence rate in the three districts among AGYW, standing at 2.75. By 2020, this rate significantly decreased to 1.56, signifying substantial progress in HIV prevention efforts within the district. The declining trend persisted in 2021, with the incidence rate further decreasing to 1.40. In 2022, another notable decrease to 1.27 reflects sustained efforts to reduce HIV transmission. By 2023, the HIV incidence rate further dropped to 1.15, indicating continued progress in HIV prevention and care initiatives within the uThukela district.

@UNICEF South Africa/2023/Moultrie

[6] *South Africa District HIV Estimates accessed at https://www.hivdata.org.za*

The declining trend in HIV incidence rate among AGYW (15-24) is in line with an overall decrease nationally.

1000-3. Delivery rate in facilities under age 18 by district

This indicator refers to the number of childbirths or deliveries that occur in health-care facilities specifically for females aged 10–19 years.[7]

The biggest increase is observed between 2021 and 2022, which could be ascribed to the impact of COVID-19. By 2023, there had been a significant decline in delivery rates across the three districts.

Alfred Nzo District Municipality	There was a gradual increase in deliveries in health facilities among individuals aged 10–19 years from July to December 2020 (1,607) to January to December 2021 (3,254). However, there was a slight decrease in deliveries in 2022 (2,990) compared to the previous year. Further, there was a notable decrease in deliveries from January to September 2023 (2,080) compared to the previous years. Notwithstanding a pattern of fluctuation, an overall decrease was observed from 2022 to 2023.
Nelson Mandela Bay Metropolitan Municipality	Like Alfred Nzo, there was an increase in deliveries in health facilities from July to December 2020 (868) to January to December 2021 (2,074). However, there was a decrease in deliveries in 2022 (1,912) compared to the previous year. Additionally, there was a further decrease in deliveries from January to September 2023 (1,529) compared to the previous years. The trend in Nelson Mandela Bay mirrors that of Alfred Nzo, with an overall decrease observed from 2022 to 2023.
uThukela District Municipality	uThukela had a similar pattern to Alfred Nzo and Nelson Mandela Bay, with an increase in deliveries in health facilities from July to December 2020 (1,297) to January to December 2021 (2,527). However, there were fewer deliveries in 2022 (2,395) compared to the previous year. Like the other districts, there was a further decrease in deliveries from January to September 2023 (1,647) compared to the previous years.

A declining trend in deliveries by females aged 10 to 19 years could be indicative of various factors, such as changes in teenage pregnancy rates, access to contraception, and education and awareness programmes.

1000-4. The proportion of women, girls, men and boys reporting that SGBV is not acceptable under any circumstances by gender, age and district

For this indicator, the programme was unable to measure comparative data over the years to analyse the trend of the proportion of those reporting that SGBV is not acceptable. Hence, the quoted data below are provided as a snapshot of the surveyed beneficiaries' perceptions.

In 2023, community actors in three districts demonstrated increased awareness and willingness (81-83 per cent) to prevent SGBV, emphasizing zero tolerance for such acts. In the uThukela district, men's sector focus group discussions underscore the rejection of GBV among men. This reflects a collective effort to address knowledge gaps and ensure comprehensive support for all individuals. Additionally, 89 per cent of U-report[8] respondents (UNICEF's flagship digital platform that enables two-way communication with adolescents and youth on specific areas that impact children) in Eastern Cape and KwaZulu-Natal reject justifying partner beating, indicating widespread acknowledgement that violence in relationships is unacceptable.

[7] *District Health Information System South Africa*
[8] *U-Report accessible at www.https://sa.ureport.in/opinion/6876/*

4.2 Intermediate Outcome 1100: Increased availability and use of quality sexual and reproductive health, HIV and SGBV prevention and response services free of bias and discrimination for/by the most vulnerable

Summary of 1100 results

Below is a selection of indicators to demonstrate progress made in this outcome; overall the three districts performed well and progressively improved after the challenge of COVID-19. A significant increase was observed in the number of adolescents and youth accessing integrated services across the three districts over the Joint Programme period. A positive trend has been observed across the three districts that achieved the targets set for output 1100. There is evidence of increased availability and utilization of sexual and reproductive health, HIV, and SGBV services at the end of the four-year period.[9]

1100-1 Proportion of health facilities in 3 districts meeting the 5 minimum quality standards on adolescent and youth-friendly sexual and reproductive health and services

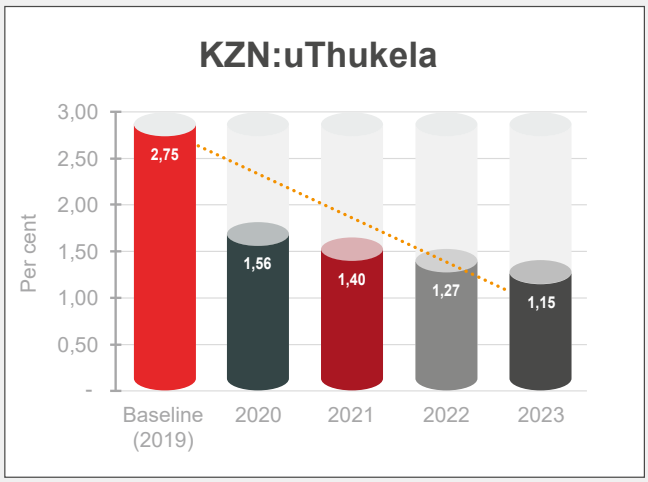
At the start of the programme in 2019, 29 per cent of the health facilities were meeting the five minimum standards, and by the end of 2023, 95 per cent of the health facilities in three targeted districts were meeting the five minimum quality standards on adolescent and youth-friendly sexual and reproductive health and SGBV services. This resulted in an increase in the number of adolescents and youth accessing integrated AYFS services in health facilities in the three districts by 2023 (end of the project), with a particular increase in the number of young people accessing the health facility for contraceptive services and HIV tests. This could be attributed to demand generation in the community and improved referral mechanisms supported through the Joint Programme.

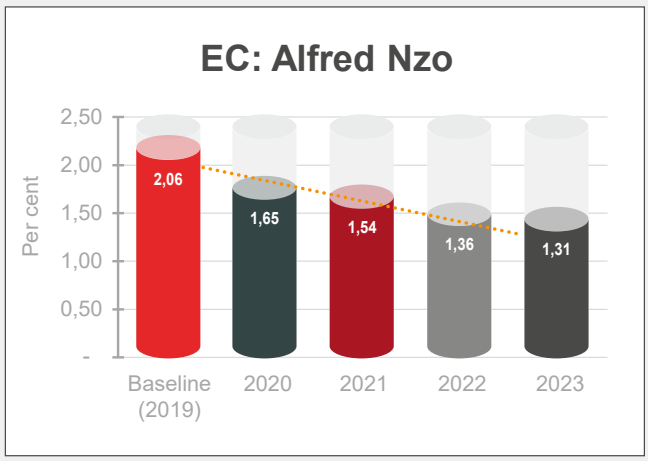
Good progress is observed on the indicator number of HIV-positive young women taking or accessing antiretroviral medication. DHIS proxy data for clients receiving ART15+ was used and weighted with the StatsSA 15–24 years provincial proportions, respectively. The data provides insights into the number of HIV-positive young women (aged 15–24) accessing antiretroviral medication in health facilities across three districts over the four-year period from 2020 to 2023. Overall, these trends indicate positive outcomes in terms of both treatment retention and HIV prevention efforts across the three districts, highlighting the effectiveness of interventions aimed at improving access to antiretroviral therapy and reducing HIV prevalence among young people aged 15–24.

Among the trends observed is the decreasing trend in HIV incidence rates. The following data from the Naomi model[9] provides HIV rates among adolescent girls and

[9] *South Africa District HIV Estimates.* https://www.hivdata.org.za/

Figure 2: Decreasing Trend in HIV Incidence Rates Among Females, Aged 15–24 Years. Source: Naomi estimates calibrated to Thembisa 4.6 outputs





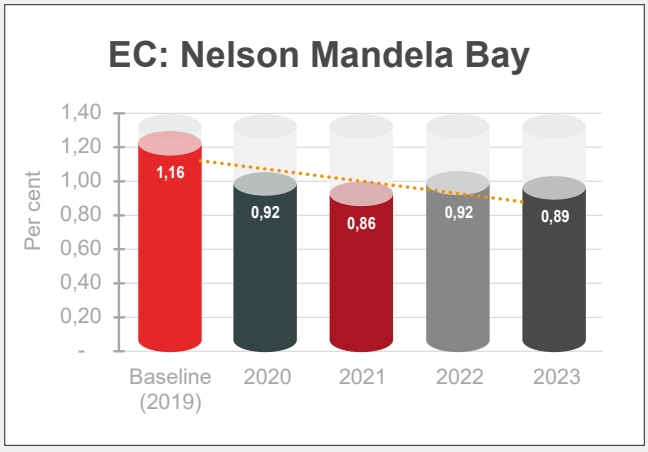
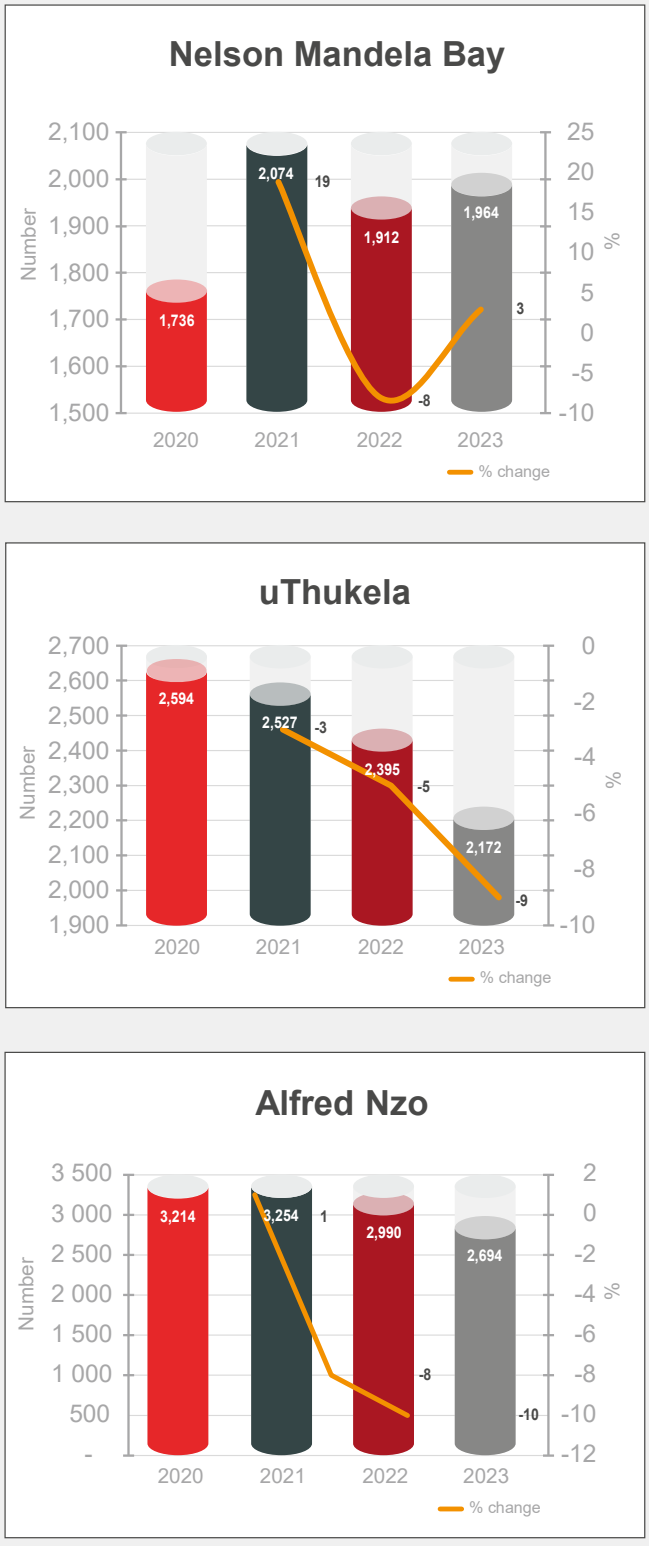


Figure 3: Deliveries by Females Aged 10–19 at Health Facilities.



Source: District Health Information Systems

young women (AGYW) aged 15–24 by district from 2019 (baseline year) to 2023 for every 100 individuals. Overall, the data indicates a general decreasing trend in HIV incidence rates among AGYW aged 15–24 years across all districts from 2020 to 2023. This decreasing trend aligns with national HIV estimates as per the South African National HIV Prevalence, Incidence, Behaviour and Communication Survey (SABSSM) VI.[10] The positive progress in HIV prevention efforts, facilitated by UNFPA technical support, indicates the effectiveness of the Joint Programme interventions in reducing HIV transmission. These efforts have led to increased access to HIV testing, treatment, and prevention services, along with education on safe sexual practices.

The number of young women and girls using or having access to a range of modern contraceptives in health facilities in the three districts. This indicator refers to the number of childbirths or deliveries that occur in healthcare facilities for females aged 10–19 years. A gradual increase in the number of babies delivered to girls and young women in this age group during COVID-19 was observed. In all three districts, there was an initial increase in the number of deliveries in health facilities among individuals aged 10–19 years from 2020 to 2021. However, this trend was followed by a decrease in deliveries in 2022 and in 2023 across all districts. Overall, an overall decrease in deliveries from 2022 to 2023 is evident in each district.

The proportion of respondents who demonstrate knowledge of SHR, prevention of GBV and, more specifically, knowledge and awareness of safe sex practices in three districts. The proportion of respondents demonstrating knowledge of sexual and reproductive health, prevention of GBV, and safe sex practices in the three districts is not explicitly provided at the end of the project. However, the Joint Programme managed to engage adolescents and youth, men and boys, as well as key community actors, in GBV prevention and SRH information. Pre- and post-tests indicate increased knowledge and awareness of safe sex practices across the three districts, specifically among comprehensive sexuality education (CSE), HIV, and GBV knowledge enhancement workshops with 1,000 (out-of-school youth) in at least three higher education institutions (TVETs). A total of 911 youths (335 females and 576 males) were reached. With youth in higher education, spikes in GBV cases reported to the campus counsellor occurred when students abused alcohol, causing them to engage in risky behaviour.

Qualitative Information from Focus Groups[11] indicates that the dissemination of knowledge on sexual reproductive health has been insufficient among men. Furthermore, the men's sector in Okhahlamba firmly condemns and disassociates itself from men who perpetrate acts of GBV, underscoring their

[10] *Ramlagan, S., The sixth South African national HIV prevalence, incidence, and behaviour survey (SABSSM VI): 20 years of strategic HIV and public health data*
[11] *KwaZulu-Natal Christian Council, 2023*

commitment to combating such harmful behaviours within the community. The men believe that addressing and remedying the numerous cases of gender-based violence and femicide is a matter of urgency. These results demonstrate the men's sector's knowledge of SHR and the prevention of GBV.

In 2020, a baseline assessment aimed at gauging youth satisfaction regarding sexual and reproductive health and rights information and services was undertaken.[12] In 2023, the Joint Programme conducted a rapid qualitative assessment in the uThukela district. It showed significant knowledge of SRHR among adolescents, indicative of the effectiveness of the Joint Programme in this region.

The U-report 2023 poll shows a high level of awareness of sexual reproductive rights in the Eastern Cape and KwaZulu-Natal, with 83 per cent and 82 per cent of respondents demonstrating knowledge of SRH, respectively. These relatively high levels of awareness could suggest positive progress in promoting knowledge about SRHR, prevention of gender-based violence, and safe sex practices within these districts.

1100-2. Number of vulnerable AGYW referred to multisectoral services through a strengthened referral system

Over the four-year programme period, the number of referrals for vulnerable AGYW has increased. The Joint Programme played a crucial role in increasing referrals to multisectoral services by investing in strengthening referral mechanisms between social services and health as well as other sectors such as education and community service providers. This has enhanced the availability and utilization of quality sexual and reproductive health, HIV, and sexual and gender-based violence prevention and response services.

The Joint Programme strengthened the district-level coordination mechanism and the District Directors, who had all the contacts for referral points. The district-level service directory was developed and is currently being used among district partners. The TWG has advocated that government print more copies for community partners and make electronic copies available at the district and facility levels.

In Nelson Mandela Bay, Sonke Gender Justice referred 1,268 AGYW to multisectoral services across the three districts, which surpassed the initial target of 1,000. A further 449 vulnerable adolescent girls and young women were referred by these trained social services professionals (SSPs) to multisectoral services for various services. Doxa Youth Programme has trained 63 staff from community-based organizations on referral pathways in Alfred Nzo and Nelson Mandela Bay, resulting in 187 referrals to health facilities. Additionally, in uThukela, the KwaZulu-Natal Christian Council facilitated 4,402 referrals for SRH, family planning, sexually transmitted infections, HIV testing services, TB screening, psychosocial support, and gender-based violence.

1100-3. Number of AGYW accessing integrated AYFS services in health facilities in the three districts

In Alfred Nzo, 10,278 individuals aged 10–19 and 18,436 individuals aged 20–24 accessed integrated SRHR, HIV, and GBV services during the reporting period, surpassing the target of 20,000.

1100-4. The proportion of respondents who demonstrate knowledge of SHR, prevention of GBV and, more specifically, knowledge and awareness of safe sex practices in three districts

The programme was unable to measure comparative data to analyse trends in the proportion of respondents who demonstrate knowledge and awareness of safe sex practices. Pre- and post-tests showed an increase in knowledge levels across the three districts in 2022, which was directly attributed to the Joint Programme's targeted youth engagements, which used community-level platforms and tailored messaging to ensure widespread outreach. Baseline data was collected through qualitative methods, and further engagements utilizing multimedia platforms as well as community engagements led to improved knowledge levels.

An increased number of adolescents and youth accessed integrated services across the three districts over the Joint Programme period

@UNICEF South Africa/2023/Moultrie

[12] *Rapid Qualitative Assessment of Youth Satisfaction on the Uptake of SRHR Information and Services from Supported Clinics. Accessible at https://www.tandfonline.com/doi/full/10.1080/02673843.2020.1831558*

4.3 Intermediate Outcome 1200: Decreased discriminatory and harmful practices and attitudes that perpetuate and validate sexual and gender-based violence against women and girls within targeted households and communities

1200-1 The number of women and girls, men and boys demonstrating positive attitudes towards ending SGBV through GAC-funded projects

The Joint Programme has reached over one million girls, boys, women, and men with social behaviour change programmes in three target districts. However, "demonstrating a positive attitude" could not be measured with a year-to-year comparison over the programme period. Baseline information is taken from the Focus Group discussions held during the KAP study. While this was collected in a qualitative manner, significant improvement is observed.

In the Eastern Cape, the Joint Programme observed a positive change among traditional leaders: the manual that was developed has been utilized to engage various men and young men in traditional male circumcision spaces.[13] The Joint Programme translated this manual into a local language (isiXhosa) to enable easy understanding and application. A focus on training the trainers has enabled the province to maintain a core group that moves around applying the content in traditional male circumcision communities, reaching 350 young men in total in one district. This manual has been positioned to change attitudes and harmful masculinities of young men in traditional male circumcision spaces. While this is an investment made by the Joint Programme, trainers continue to disseminate this information beyond the targeted period. The Joint Programme has conducted dialogue with adolescent boys and young men and received 261 pledges out of 353 participants (74 per cent). It found that despite many boys having been raised by single mothers, they still developed the notion that women should be submissive to men. Through constructive dialogues and posing critical questions related to sexual reproductive health and GBV, the Joint Programme was able to gain trust and buy-in from boys and young men to be an agent of change in SGBV.

In KwaZulu-Natal, the Joint Programme has invested in the engagement of key actors (traditional leaders, the religious sector, parents, traditional healers and young people). The facility-level data is analysed and simplified to engage communities on the challenges faced by young women because of discrimination and harmful practices. As a result of this evidence-informed engagement, a KwaZulu-Natal-specific community model known as *Izigodi* has transpired. The *izigodi* has been presented on various advocacy platforms as a promising model for engaging communities on their challenges. The *Izigodi* model has fostered community-driven solutions in addressing SRH/HIV issues, addressing GBV root causes through community

@UNICEF South Africa/2023/Moultrie

[13] *Life Skills Manual for GBVF/SRHR and HIV Prevention - Joint Programme tool*

dialogues, and involving professionals with expertise in health - care and social work. This has received endorsement at the highest levels from the House of Traditional Leaders and the King of the Zulu nation, Silo samaBandla, King Misuzulu Sinqobile kaZwelithini,

A demonstration of knowledge on SRH and the prevention of GBV was evident, with 75 percent of men and adolescent boys actively engaging in SGBV response through community programmes. A total of 1,656 women, girls, men and boys were reached, and 139 pledges were made to support initiatives to improve sexual and reproductive health, prevent HIV, and stop GBV. Among these individuals, 498 boys and 805 girls (62 per cent) have shown a willingness to engage actively and positively in initiatives aimed at tackling SRH, HIV, and GBV. Their commitment reflects a growing awareness and understanding of the importance of these issues, particularly among the youth demographic. In addition, 50 per cent of women and girls have exhibited positive attitudes towards ending SGBV within their communities.

Community dialogues successfully engaged 521 community leaders and 200 learners, reaching a total of 28,714 AGYW in Alfred Nzo. As a result, 162 men (31 per cent) signed a pledge to actively speak out against GBV, indicating a growing momentum within the community to tackle these issues.

School-based dialogues

The Joint Programme mapping exercise showed that adolescents are exposed to various challenges, including early sexual debut, sexual assaults, and harmful cultural practices such as ukuthwala. A series of educational events in the three districts focusing on various aspects of SRHR events collectively engaged 12,200 students, providing them with essential knowledge and resources to make informed decisions regarding their sexual and reproductive health, over and above the 10,000 target. Through intergenerational dialogue, 1,126 parents who participated in multisectoral dialogues expressed appreciation for these dialogues, which equipped them to play a more supportive parenting role. These dialogues provided a platform for diverse voices and perspectives to converge, fostering an inclusive environment for addressing SRHR, HIV, and gender-related issues.

4.4. Immediate Outcome 1110: Improved institutional capacity of health and social services in the three targeted districts to provide quality, age-appropriate SRHR, HIV and SGBV services, including information, education and counselling to AGYW

1110-1. Number of targeted, trained health-care and social services professionals demonstrating an increased capacity to deliver AYFS and SGBV services

Over four years, 3,642 health-care workers were trained on SRHR and GBV, and 3,580 were certified competent, representing a 98 per cent increase in knowledge and skills demonstrated by the trained nurses in the provision of integrated SRHR and GBV services. In addition to uThukela, KwaZulu-Natal also managed to scale up training for health workers in Ugu and eThekwini. All three Joint Programme districts underwent extensive training and mentoring on SRH, GBV, and the utilization of job aids, reaching 42 doctors, 3,315 professional nurses, 237 facility managers / operational managers, and 48 pharmacists. Challenges in the Nelson Mandela Bay Metro led to fewer health-care professionals being reached. Follow-up mentoring continued to get 100 per cent of these categories competent, ensuring that theory and practice are aligned.

Additionally, 105 social service professionals (SSPs) were trained on SRHR, HIV, and GBV issues, with 95 per cent of the trained SSPs indicating that their capacity to provide quality, age appropriateness and non-discriminatory services had improved either to a great extent or to some extent.

1110-2. The number of adolescents and youths satisfied with AYFS services

Client exit interviews revealed a notable increase in client satisfaction with the services received. During

School dialogues in session

Source: Soul City Institute, 2023

Parents' advocacy sessions at Tabhane High Ward 8, Bergville, Okhahlamba Local Municipality

Source: KwaZulu-Natal Christian Council, 2023

August and September 2023, a feedback session with 121 young people revealed that 85 per cent of respondents were satisfied with the service they received, while 15 per cent expressed dissatisfaction, primarily focusing on concerns related to the clinic's infrastructure.

The U-report also indicates high levels of satisfaction with the quality of services in KwaZulu-Natal (89 per cent) and the Eastern Cape (93 per cent).[14] The programme's success, as self-reported by AGYW at the Provincial level, reflects its relevance and effectiveness in improving the quality of services provided, which contribute to better SRHR, HIV, and SGBV outcomes for adolescents and youth in the community.

4.5. Immediate Outcome 1120: Increased capacity of the health and social services data management systems (including production of disaggregated data) to inform policy-making, planning, implementation, monitoring, and scale-up pilot models to the provincial and national level

1120-1: Number of new programme initiatives/ models integrated into national or subnational policies and plans

Two models are currently being integrated into subnational plans: the SRH/HIV/GBV integration model and the *Izigodi* model. The Kwa-Zulu-Natal legislature has endorsed the SRH/HIV/GBV integration model, which has been supported by the Joint Programme. This is the highest level of political support and has led to the integration of the model into subnational policy in KwaZulu-Natal and has been scaled up into two additional districts,[15] eThekwini and Ugu districts by the Government. The high level of political support and willingness to scale up to all the districts in KwaZulu-Natal is a testament to the positive impact of the Joint Programme in this province.

The *Izigodi* model[16] has been endorsed by traditional and religious leaders at the highest level in KwaZulu-Natal as the best model to engage communities on SRH/HIV/GBV. These engagements have continued beyond the Joint Programme period.

Up to 70 per cent more health facilities are using improved age- and sex-disaggregated data. At the start, baseline studies showed that only 20 per cent of facilities were collecting this data. This success has been achieved by building on other efforts like the UNFPA's Safeguard Young People Programme, which is being implemented in at least two Joint Programme districts. KwaZulu-Natal uses the dashboard to provide quality service provisions for adolescent girls and young women in health facilities.

Remarkable progress has been observed in KwaZulu-Natal with an integrated dashboard designed and finalized. The provincial Department of Social Development has ownership of the tool and conducted follow-up training in March 2024. Okhahlamba, a local municipality in the uThukela district, is the first to bring the dashboard to full utilization. While progress has been slower in the Eastern Cape, a draft dashboard has incorporated performance indicators from existing provincial plans. Advocacy on the dashboard continues beyond the Joint Programme at the provincial level and has the potential for immediate provincial scale-up because of location and advocacy at the midstream/ provincial level.

1120-2: Proportion of health facilities using improved data (age- and sex-disaggregated) or dashboard for quality service provisions for adolescent girls and young women

Across all three districts, the indicator performed below expectations due to challenges in obtaining age- and sex-disaggregated data and implementing a quality service dashboard for adolescent girls and young women. In uThukela, data was disaggregated at 29 out of 37 facilities, while in Nelson Mandela Bay, the introduction of an age column in the primary health care (PHC) register is expected to improve data accuracy. However, both initiatives faced obstacles such as delayed or non-submission of data and restricted access to clinics for mentorship on adolescent and

@UNICEF South Africa/2023/Moultrie

[14] *October 2023. U-report survey, 1,177 responded out of 1,191 polled. Available at https://sa.ureport.in/opinion/6632/*
[15] *PDSA model of SRH/HIV/GBV Integration Guide*
[16] *UNFPA_KZNCC Mid Term Report_28 Sept 2023 Updated.doc*

youth-friendly services (AYFS). Addressing these challenges requires providing training and support to clinics and implementing regular monitoring to ensure data submission.

The data reported from the three districts in KZN shows that 60 out of 67 clinics successfully reported the AYFS disaggregated data using the instituted reporting tool, which is an improvement at the end of the project compared to previous years.

4.6. Immediate Outcome 1210: Increased capacity of community actors (such as parents, adolescent girls and young women, and networks) to become social change agents for responsive and comprehensive SGBV, SRHR and HIV services and gender equity work in the targeted districts

1210-1: Proportion of community actors engaged in the activities at the key districts who report awareness and willingness to act to prevent GBV and harmful practices

During the Joint Programming period, efforts to engage communities in preventing GBV and harmful practices in Nelson Mandela Bay and Alfred Nzo districts exceeded expectations. The target of 1,000 community actors was surpassed, with 1,138 actively participating and demonstrating readiness to combat GBV. In Alfred Nzo, uThukela and Nelson Mandela Bay, a notable 81 per cent of 544 community actors reported their awareness and willingness to combat GBV and harmful practices, with an additional 162 individuals vowing to *"never commit nor support gender-based violence"*.

GAC-funded partners (Soul City, loveLife, KwaZulu-Natal Christian Council, Kwambele Social Marketing, and Doxa Youth Programme) completed 15 advocacy and public engagement activities that enabled young people to access accurate SRHR, HIV and GBV information across all three districts. Examples of those engagements include YENA (Young Educated Normative Adolescent) events targeted at adolescents and youth via Kwambele Social Marketing and dialogue with boys and men by Doxa Youth Programme, which aims to shift social norm changes related to toxic masculinity. Overall, all three districts surpassed their target of 12 engagements by year four, delivering 27 advocacy and public engagement activities in total. A combination of platforms was used to deliver targeted information on sexual and reproductive health and rights, HIV management and prevention, and GBV to reach the target audiences.

Community radio:	Sonke Gender Justice's campaigns reached some 600,000 people across three districts, while Kwambele Social Marketing reached 436,000 people through the #iNkunzi Radio Campaign. The eight-episode story aired on local radio stations in uThukela, Nelson Mandela Bay and Alfred Nzo, portrayed families dealing with relationships, sexuality, violence, alcohol, sharing of resources and responsibilities, and parenting. These included a mix of successful community radio stations, such as Alfred Nzo Community Radio, with a substantial listenership of 132,000, and national broadcasters, such as KZN's Ukhozi FM, with a listenership of 7,680,000.
Social media:	Through four short video narratives, Kwambele reached 12,351 young people through social media campaigns. Additionally, on social media platforms, especially Facebook, Alfred Nzo Community Radio has amassed 27,243 followers and reached an impressive 1,822,231 individuals.
Roadshows:	On a roadshow across uThukela, 231 boys and youth were introduced to condom usage as a dual prevention method for HIV and STI. Designed to demonstrate competencies in the correct and consistent use of condoms and impart knowledge through quizzes, demonstrations, and discussions, it proved to be a major success.
Webinar:	In 2022, the Joint Programme hosted a webinar on statutory rape, reaching 1,078,283 viewers on Facebook and 2,828 on Instagram. This outreach exceeded the number of followers on both platforms, indicating significant engagement and interest in the topic.

1210-2: Number of women's rights organizations and networks (international and local) advancing SRHR that receive direct GAC support or that receive support from GAC-funded partners. (Key GAC Performance Indicator for Advocacy and Public Engagement)

Women's rights organizations, Soul City, KwaZulu-Natal Christian Council and Mthombo Wempilo are among the organizations that received support directly from the Joint Programme. In uThukela, the Women's Development Committee plays a vital role in empowering and uplifting women, focusing on gender equality and addressing various women's health, education, economic, and social issues.

4.7. Outputs achievements under Immediate Outcome 1110

1111. Mapping of all health and social sector stakeholders (including facility assessment) at the district level providing SRHR, HIV and SGBV services to AGYW conducted

A mapping report was finalized as the initial deliverable of the Joint Programme.[17] This report enabled a better understanding of all health and social services stakeholders, including those at the community level in each district.

1112: District coordination mechanisms to produce implementation plans, monitor progress and provide oversight, including on referral pathways established

The Joint Programme strengthened district coordination mechanisms in two of the three districts, namely Nelson Mandela Bay and uThukela district. Alfred Nzo continued to lag behind in coordination mechanisms at the district level. However, the stakeholders were engaged through the provincial-level mechanisms. Throughout the Joint Programme period, Alfred Nzo struggled with staff attrition at management and technical level. This hampered the Joint Programme district coordination. Both Nelson Mandela Bay and uThukela districts had excellent coordination mechanisms and produced multisectoral plans and oversight for the Joint Programme. Nelson Mandela Bay utilized existing multisectoral district-level mechanisms and strengthened the focus on adolescents and youth aged 15–24 years, bringing diverse partners to the table. uThukela district tapped into existing district structures and strengthened the Joint Programme focus, producing an Okhahlamba multisectoral plan.

1113: Health and social service professionals' capacity strengthened in using approved national tools

Before the Joint Programme, various initiatives focusing on adolescent and youth programming as well as strengthening the provision of adolescent and youth-integrated SRH and HIV in the health sector had been implemented in at least two Joint Programme districts. The Joint Programme helped strengthen these efforts while also placing a stronger emphasis on GBV integration. The Joint Programme also built on the strong foundation laid by the regional Safeguard Young People Programme (SYP), now in its third phase in Alfred Nzo and uThukela, as well as the regional 2gether 4 SRHR Programme in those two districts. As a result of all these various efforts, at least 900 health-care providers had already received training and systems strengthening prior to the Joint Programme intervention. However, these interventions had poor SGBV integration, and this is where the Joint Programme had the biggest impact.

Face-to-face training was prioritized immediately after COVID-19 to address prevailing gaps, especially with regard to better integration of GBV into ongoing SRH/HIV initiatives as a means of strengthening the health sector response to the National Strategic Plan on Gender-Based Violence and Femicide (NSP-GBVF). An

@UNICEF South Africa/2023/Moultrie

[17] *Southern Hemisphere Situation Analysis Report, 2021 Adolescent Health Rights - Mapping and Situation Analysis | Southern Hemisphere*

initial hybrid policy advocacy session was organized with national-level counterparts, reaching 45 health-care providers. The follow-up mentoring for health facilities ensured further strengthening of the SRH/HIV/GBV integration such that by the end of the project, 98 per cent of health providers had been reached. Through Sonke Gender Justice, 105 social service professionals were trained across the three districts on the integrated service provision of SRH, HIV and GBV. Post-training surveys showed that 95 per cent of the SSPs who attended demonstrated increased knowledge and capacity.

4.8. Outputs achievements under Immediate Outcome 1120

1121. Review of existing data management systems, tools, and processes for evidence-based generation, use and monitoring enhanced

Government systems rely on diverse data collection tools and management systems such as DHIS and Tier.Net. At the facility level, tick registers and input forms are prevalent. Nevertheless, numerous facilities struggle with ineffective data management systems, particularly electronic records, and disaggregation. This issue extends beyond the jurisdiction of the Joint Programme. In the uThukela district, data-reporting initiatives covered 29 out of 37 facilities, but 8 facilities discontinued them due to staffing shortages.

An integrated SRH/HIV and GBV dashboard has been designed in two targeted provinces in collaboration with relevant government departments. The two dashboard designs have taken different development paths based on the provinces' needs.

1122: Knowledge and skills of district health teams and district social services professionals on evidence-based SGBV, SRH and HIV programming improved through tools and dashboards to be developed/ refined

Both health and social services professionals have improved their knowledge and skills in the utilization of data tools for evidence generation and informed decision-making. By the end of the programme, 92 relevant government officials from the Department of Health (DoH) and the Department of Social Development (DSD), as well as health and social service professionals, had been trained on data collection and how to use the dashboard following three capacity-building workshops.

1123. Use of developed district-level SGBV, SRH, and HIV dashboard institutionalized

As part of the Joint Programme, UNICEF supported the development of an integrated HIV, SRH, and GBV dashboard in collaboration with DSD in KwaZulu-Natal and the Eastern Cape to strengthen data management systems and to improve decision-making. The dashboard has data at district and facility levels and has been adapted by DSD in the uThukela district and operationalized.[18] However, it has not been operationalized in the Eastern Cape, although all outcome-level data is available for the province.

1124. Documentation of good practice on district-level SRH, HIV and SGBV for provincial and national scale-up produced

Advocacy briefs and human interest stories on good practice have been produced across the three districts, and these are utilized for district-level advocacy on SRH, HIV and SGBV. This investment will be utilized beyond the Joint Programme period. They include:

- Story of Change: Young Girl Makes a Mark in the Clinic Committee (Youth Leadership) (Umthombo, 2023)
- Story of Change: Access to CTOP Service (Umthombo, 2023)
- Story of Change: Contraception Helps Nandipha Realise her Dream (Umthombo, 2023)
- Manuscript - Effectiveness of the Plan, Do, Study, and Act (PDSA) model of SRH/HIV/SGBV integration at selected facilities in selected districts of KwaZulu-Natal
- Selected advocacy briefs

@UNICEF South Africa/2023/Moultrie

[18] *UNFPA_UNICEF JOINT PROGRAMME DASHBOARD, EC and KZN 24_04_2024_FINAL.xlsx*

4.9. Outputs achievements under Immediate Outcome 1210

1211. Desktop situational analysis of knowledge, attitudes and behaviour of AGYW and community actors about SRHR, HIV and SGBV conducted

A situational analysis was conducted to assess the knowledge, attitudes, and behaviour of adolescent girls and young women and community actors regarding sexual and reproductive health and rights, HIV, and sexual and gender-based violence was conducted in 2020 to inform the programme.

1212. Core reference and oversight structure, inclusive of AGYW and community representatives, established

A core reference group and oversight structure were not separately established; however, this structure was integrated into the coordination forum, which included adolescents, youth, and community leaders.

1213. Targeted community interventions led by community actors (faith-based organizations, traditional leadership structures, parents, community-based organizations, women-led organizations, and men and boys' institutions) to challenge prevailing harmful gender norms that increase HIV exposure and reinforce SRHR and build positive attitudes to end SGBV implemented

Kwambele Social Marketing has led four YENA (Young Educated Normative Adolescent) events to provide accurate and factual information about SRHR in an objective and reassuring way for young people. The event was designed to support Health Education Rights (#HER) and focused on introducing #HER's four teaching sessions devoted to menstrual hygiene, pregnancy and pregnancy prevention, self-esteem, and decision-making. The event included a community mobilization component with outreach and a service delivery mechanism for condom distribution, HIV/AIDS screening/testing, and referral, implemented in collaboration with other programme partners such as loveLife, DoH, and Sonke Gender Justice. During four events, 810 AGYW participated in the sessions.

Doxa Youth Programme organized six community events across three districts that attracted 1,158 community actors. These events included boys' assemblies, intergenerational community dialogue for women and men, and school-based campaigns to prevent teen pregnancy. In particular, for the boys' assemblies, boys discussed the negative impact of violence against girls and women while promoting HIV prevention led by boys and men. Medical male circumcision was promoted, and the consistent use of condoms as a mechanism to prevent HIV infection was discussed.

Two hundred manuals were distributed to empower individuals with the knowledge and tools needed to challenge harmful gender norms and effectively address and prevent SGBV within their communities. Furthermore, a Life Skills Manual for traditional male initiates was developed for the Eastern Cape House of Traditional Leaders. The training of 521 gatekeepers and community communicators, including traditional leaders, political leaders, faith-based leaders, and influential individuals, has fostered a community-wide commitment to combating SGBV in KwaZulu-Natal. As a result, traditional leaders have pledged to address SRHR and GBV issues during community meetings and Imbizos, demonstrating a significant step towards addressing these critical issues at the grassroots level. Two of the three districts have developed an action plan for community-based interventions addressing social norms contributing to SGBV.

1214. Information and knowledge of AGYW, through social behaviour change on women and girls' human rights, SGBV and SRHR issues and gender equality increased

Eighty per cent of targeted adolescents and youth have increased knowledge of women's and girl's human rights, sexual and gender-based violence and SRHR and gender equality. The Joint Programme played a pivotal role in enhancing information and knowledge among AGYW by supporting the establishment of seven AGYW clubs with 510 girls in the Eastern Cape (Alfred Nzo and Nelson Mandela Bay) and eight new AGYW-targeted clubs and safe spaces in KwaZulu-Natal. These spaces were strategically set up both within schools and outside of the school environment. The dialogues significantly contributed to increasing information and knowledge about SRHR, HIV and GBV among adolescent girls and young women. These dialogues successfully engaged 200 learners (120 girls and 80 boys) and reached out to 120 parents in Nelson Mandela Bay.

As illustrated in section 4.1 Ultimate Outcome 1000, the number of babies delivered to individuals aged 10–19 in 2022 and 2023 in each district decreased overall compared to the prior two years.

Good practice at district level SRH, HIV and SGBV

The following stories were developed to illustrate good practice:

- Story of Change: Young Girl Makes a Mark in the Clinic Committee (Youth Leadership) (Umthombo, 2023)
- Story of Change: Access to CTOP Service (Umthombo, 2023) Annex VI
- Story of Change: Contraception Helps Nandipha Realise her Dream (Umthombo, 2023)

PART 5
LESSONS LEARNED

The Joint Programme provided an opportunity to reach a mix of rural, urban and semi-urban areas with different needs. It incorporated unique socio-cultural dynamics in diverse target areas and took different approaches based on the province and district. While the programme closely coordinated with provincial focal points, closer engagement with district-level technical focal points in the design phase could have enhanced ownership and created a bottom-up conduit to address issues at provincial and national levels. The Performance Management Framework could also have been more robust and rigorous, especially for behaviour and norm change indicators where there is a lack of baseline data for effective year-to-year comparison of the target area. The common tool to measure the attitude change across multiple partners engaged in the programme could also improve the attitude and behaviour change across the three target areas. Despite improved services and a social behaviour change programme, AGYW still report stigma and discrimination as the main barrier to accessing integrated SRHR/HIV and SGBV services. Information campaigns and confidential online platforms should be explored with digital service providers in future interventions. Intentional efforts should also have been made to institutionalize the programme within the government structure at the design stage to create stronger alignment with provincial and national government plans and programmes, although this improved during the implementation phase. Stakeholder engagement was key throughout the programme, and future interventions must engage extended stakeholders who were missing from this programme implementation, such as the Department of Basic Education, the South African Police Service, the National Prosecuting Authority, as well as the economic sector for prevention and empowerment of AGYW.

PART 6
WAY FORWARD

The next-generation Joint Programme should align with ongoing governmental programme priorities. It is recommended that it deepen its intervention within the current three target districts and broaden it to include other districts within the two target provinces.

By building on the successes in the existing target districts, the next phase of the programme can institutionalize standard operating procedures for referrals among health and social development utilizing the directories of services. Institutional capacity building can be extended to equip school-based health workers and learner support educators to reach out to the learners on SRHR, HIV/AIDS, GBV, and mental health.

Community-based engagement is still required to reduce stigma and discrimination, and future programmes can design evidence-based social behaviour change programmes informed by the evidence generated over the past four years. Adolescent peer-to-peer mentorship and youth leadership should be promoted, and adolescent boys and young men should not be left behind in discussions around SRHR, HIV and GBV. This was a particular recommendation from AGYW, who wanted to have an equally informed counterpart. Digital engagement with adolescents and young people through the B-wise platform was recommended, as young people use the confidential online platform to gain knowledge and interact with others. It is also recommended that the parenting programme be scaled up based on good evidence to indicate that a positive relationship between parents and adolescents fosters healthy choices among adolescent girls and boys.

Institutionalization and scale-up of best practices such as SRHR, HIV, and GBV, as well as integrated service provision to other districts, should be promoted. Where these key stakeholders are engaged, the programme's results are scalable using government resources. A functional government-led Technical Working Group should be institutionalized as part of the new programme supported by UNFPA and UNICEF to align its overall programme direction with existing national priorities, such as efforts to reduce teenage pregnancy.

The next phase of the project will also focus more on the sustainability of key interventions through strengthening community stakeholders and engaging government institutions aligned with UNFPA and UNICEF country programme priorities.

LIST OF
REPORTS CONSULTED

Adolescent Health Rights - Mapping and Situation Analysis | Southern Hemisphere.

Health Education Rights Performance Report: Kwambele October 2022–February 2023

KwaZulu-Natal Christian Council (KZNCC): Midterm Report on piloting the Izigodi Model in uThukela District, Okhahlamba Local Municipality Izigodi Zase Ward 8 through Policy and Advocacy Dialogue and Action Research

loveLife Progress Report: June-September 2023

loveLife: Promoting access to adolescent and youth friendly information and health services for integrated Sexual and Reproductive Health and Rights (SRHR), HIV and GBV services for vulnerable adolescents and youth in eThekwini Metro, Ugu and uThukela districts in KwaZulu Natal

loveLife uThukela Project Final Report: July--December 2020

MenCare 5050 Plus Project Review – December 2023

Optidel: Final Report- Technical Assistance on SRSH, HIV and GBV Integration Model. implementation of High Impact Interventions with an Exit Strategy - December 2023

Rapid Qualitative Assessment of Youth Satisfaction on the Uptake of SRHR Information and Services from Supported Clinics in uThukela

Six Community Events on SRHR reported by Doxa Youth programme

Soul City Institute social media and radio campaign on sexual reproductive health rights, GBVF: January 2023

Umthombo Annual Report 2023

ANNEX I

Performance Monitoring Framework (2020-2024) Version (May 2024)[1]

EXPECTED RESULTS (from logical model)	INDICATORS (environmental sustainability and gender equality where possible)	BASELINE	TARGETS (Include time range if possible) Year 1 2020	Year 2 2021	Year 3 2022	Year 4 2023	Final Year 2024	DATA SOURCES	DATA COLLECTION METHODS	FREQUENCY	RESPONSIBILITY
1000. Improved sexual and reproductive health and rights and reduction of sexual and gender-based violence (SGBV) among vulnerable adolescent girls and young women (AWYG) ages 15-24	**Ultimate Outcome** **N.B. Indication of agency in parentheses indicates responsibility for reporting (and not accountability/sole responsibility for results). At the ultimate outcome level, the project is responsible for *contributing* to results/targets.**										
	Number of incidents of GBV reported - by district - by type of violence - by age, if available Proxy: New sexual assault seen in health facility	Number of sexual offences registered in Q3 2020: 1,762 in Eastern Cape; 2,029 in KwaZulu-Natal. No district or age disaggregation	Alfred Nzo: 69 Nelson Mandela: 86 uThukela: 60	Alfred Nzo: 85 Nelson Mandela: 88 uThukela: 80	Alfred Nzo: 96 Nelson Mandela: 90 uThukela: 91	Alfred Nzo: 87 Nelson Mandela: 98 uThukela: 73	Alfred Nzo: Nelson Mandela: uThukela:	SAPS quarterly reports (main source; however, no disaggregation by district or age)	Data review	Quarterly reports from SAPS	UNFPA and UNICEF
	HIV incidence rate among AGYW - by district - by age group	Alfred Nzo: 2.1 Nelson Mandela: 1.16 uThukela: 2.75	Alfred Nzo: 1.65 Nelson Mandela: 0.92 uThukela: 1.56	Alfred Nzo: 1.54 Nelson Mandela: 0.86 uThukela: 1.40	Alfred Nzo: 1.36 Nelson Mandela: 0.92 uThukela: 1.27	Alfred Nzo:1.31 Nelson Mandela: 0.89 uThukela: 1.15		Annual estimate by DoH (DoH plans to release this on an annual basis)	Data review	Yearly	DoH / UNICEF
	Delivery rate in facilities under age 18 by district (%)	Alfred Nzo: 24.6 Nelson Mandela: 9.7 uThukela: 18.6	Alfred Nzo: 24.6 Nelson Mandela: 9.7 uThukela: 18.6	Alfred Nzo: 24.5 Nelson Mandela: 11 uThukela: 19.1	Alfred Nzo: 22 Nelson Mandela: 17.4 uThukela: 18.6	Alfred Nzo: 21 Nelson Mandela: 13.2 uThukela: 21.6		District Health Information System (DHIS)	Data review	Yearly	District health team / UNFPA
	Proportion of women and girls, men and boys reporting that SGBV is not acceptable under any circumstance - by gender and age - by district	Lack of comparative data	10% improvement from the baseline		Pol 1: 480 AGYW: Nelson Mandela: 256 uThukela: 150 Alfred Nzo: 74	20% improvement from Year 2 81-83% of community actors demonstrated increased awareness and willingness to prevent SGBV		Baseline and end-line survey	Survey in the three targeted districts	Pre- and post - intervention	UNFPA and UNICEF

[1] *This version reflects final progress made on the Joint Programme*

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*

EXPECTED RESULTS (from logical model)	INDICATORS (environmental sustainability and gender equality where possible)	BASELINE	TARGETS (Include time range if possible) Year 1 2020	Year 2 2021	Year 3 2022	Year 4 2023	Final Year 2024	DATA SOURCES	DATA COLLECTION METHODS	FREQUENCY	RESPONSIBILITY
Intermediate Outcome											
1100. Increased availability and use of quality sexual and reproductive health, HIV and SGBV prevention and response services free of bias and discrimination for/by the most vulnerable and marginalized AGYW in Nelson Mandela, Alfred Nzo and uThukela districts in South Africa	Proportion of health facilities in 3 districts meeting the 5 minimum quality standards on adolescent and youth-friendly sexual and reproductive health and services	29% of facilities meeting the 5 minimum AYFS standards in the 3 priority districts	Target 5% more Actual: 35% 9 in Alfred Nzo 10 new facilities in Nelson Mandela, baseline conducted 17 facilities in uThukela	50%	July-September 2022 Alfred Nzo: 74 Nelson Mandela:48 uThukela: 37	95% of the health facilities are meeting the 5 minimum AYFS standards		Rapid facility assessment report, project progress report, end-project assessment	Facility assessment to be conducted, end-project assessment report	Annually	DoH/ UNFPA
	Number of AGYW accessing integrated AYFS services in health facilities in the three districts, disaggregated by age, gender and type of service	Alfred Nzo: 62,706 adolescents (10-19) accessed PHC Nelson Mandela: 33,102 adolescents (10-19) accessed PHC uThukela: 45,155 adolescents (10-19) accessed PHC No gender or type of service disaggregation available	Alfred Nzo: 3,214 Nelson Mandela: 1,736 uThukela: 2,594	Alfred Nzo: 28,390 Nelson Mandela: 2,074 uThukela: 2,527	Alfred Nzo: 26,509 Nelson Mandela: 27,461 uThukela: 2,395	Alfred Nzo: 28,714 Nelson Mandela: 1,529 uThukela: 1,647		Rapid facility assessment report, project progress report, end-project assessment	Health Facility records, IP Reports	Annually	DoH/ UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible)					**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
			Year 1 2020	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**				
Intermediate Outcome *cond.*											
1100. Increased availability and use of quality sexual and reproductive health, HIV and SGBV prevention and response services free of bias and discrimination for/by the most vulnerable and marginalized AGYW in Nelson Mandela, Alfred Nzo and uThukela districts in South Africa	Number of vulnerable AGYW referred to multi-sectoral services system in a year	0	Alfred Nzo (2021 Q3): • 78 cases AGYW 15-24 referred by DoH to DSD Nelson Mandela (2021 Q3): • data is being collected uThukela (2021 Q3): • data is being collected	Alfred Nzo: 78	Alfred Nzo (2022): • 100 (10-19) AGYW referred to TOP • 362 Sexual Assault referred Nelson Mandela (2022): • 100 (10-19) AGYW referred to TOP • 486 sexual assault referred uThukela (2022): • 114 (10-19) AGYW referred to TOP • 277 sexual assault referred	uThukela: 2,999 Nelson Mandela:150 Alfred Nzo: 150 Disaggregated by service		Health and Social Development Information Management System	Data Review	Yearly	DSD/DoH/ UNICEF and UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible)					**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
			Year 1 2020	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**				
Intermediate Outcome *cond.*											
1100. Increased availability and use of quality sexual and reproductive health, HIV and SGBV prevention and response services free of bias and discrimination for/by the most vulnerable and marginalized AGYW in Nelson Mandela, Alfred Nzo and uThukela districts in South Africa	Proportion of respondents who demonstrate knowledge on SHR, prevention of GBV and, more specifically, knowledge and awareness on safe sex practices in 3 districts; - by gender and age - by district - by education level - by parity	To be established B-Wise app can potentially inform baseline survey: measure knowledge awareness on safe sex practices	KAP Survey youth engagements showed limited knowledge of SRHR over the JP period. several multi-media and community outreach to young people showed improved knowledge levels (Soul City and, Kwambhele)		Workshop for 45 of the AYFS champions, 3x AYH district managers, 5x loveLife, 1x PDoH. The evaluation showed participants gained a lot of knowledge from the training uThukela (Escourt -Wembezi): 71 male youths were able to show competencies in correct and consistent use of condoms and gained knowledge	3,527 (99.3%) participants were reached from a target of 3,550 and had increased knowledge to make informed choices on uptake of AYFS health services loveLife end of Project Report, 2023). Qualitative data shows that they were utilizing services in clinics more, and making healthy choices regarding SRH (loveLife qualitative interviews) The men's sector in Okhahlamba firmly condemns and disassociates itself from acts of GBV, underscoring their commitment to combatting such harmful behaviours within the community		Baseline and end of project survey	Questionnaire to collect information among participating girls, women, men and boys	At beginning and end of the project	UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible)					**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
			Year 1 2020	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**				
Intermediate Outcome *cond.*											
1200: Decreased discriminatory and harmful practices and attitudes that perpetuate and validate SGBV against women and girls within targeted households and communities in Nelson Mandela, Alfred Nzo and uThukela: districts in South Africa	Number of women and girls, men and boys, demonstrating positive attitudes towards ending SGBV through GAC-funded **projects (Key GAC Performance Indicator - SGBV)**	Baseline data collection to be conducted Command Centre	Target to be set after the baseline assessment		Alfred Nzo: 350 uThukela: 1,656 with 139 pledges	Alfred Nzo 28,714 with 162 pledges Nelson Mandela: 261 pledges 763 signed pledges: AGYW 510 ABYM 253 (Doxa)		U-Report Facebook Twitter Other multimedia activities	Data analysis of U-Report polls	Yearly	UNICEF/ UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible) **Year 1 2020**	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**	**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
IMMEDIATE OUTCOMES											
1110. Improved institutional capacity of health and social services in the 3-targeted districts to provide quality age-appropriate SRHR, HIV and SGBV services, inclusive of information, education and counselling to AGYW	Number of targeted health-care and social services professionals trained that demonstrate increased capacity to deliver AYFS and SGBV services - category of professionals Revised the HCW target for 3 districts to 500 based on realistic figures	Pre and post-assessments were conducted online	HCW Target: 200 Achieved: Alfred Nzo: • A total of 65 HCWs (55F & 10 m) Nelson Mandela: • A total of 52 HCWs in Nelson Mandela (47 F, 2 m and 3 F medical Drs) An overall total of 117 HCWs in the EC Province. uThukela District: • A total of 30 HCWs were reached in uThukela Achieved: 147		Alfred Nzo 2022: • A total of 146 HCW Nelson Mandela 2022: • A total of 69 HCWs • Total HCWs 215 (90 F nurses, 16 M nurses, 10 Drs • 32 social services professionals	End of the JP 3,163 health services providers 73 social services professionals	A total of 3,642 HCW of which 3,580 demonstrated increased capacity at the end of the 4 years 105 social service professionals at the end of the 4 years demonstrated increased capacity (Alfred Nzo: 61 Nelson Mandela: 22 uThukela: 22)	Post-training assessment to be conducted online	Online polls to be held during the training sessions	Per training	DoH/ UNFPA/ UNICEF

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible)					**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
			Year 1 2020	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**				
IMMEDIATE OUTCOMES *cond.*											
1200: Decreased discriminatory and harmful practices and attitudes that perpetuate and validate SGBV against women and girls within targeted households and communities in Nelson Mandela, Alfred Nzo and uThukela: districts in South Africa	Proportion of adolescents and youth satisfied with AYFS services				85% of the respondents within the youth zones were satisfied with AYFS services. U-Report 89% satisfaction in KZN and 93% satisfaction in Eastern Cape			Beginning assessment and end-project assessment	Client exit interview as part of the end-project assessment	End of project cycle	DoH/ UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible)					**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
			Year 1 2020	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**				
IMMEDIATE OUTCOMES *cond.*											
1120. Increased capacity of the health and social services data management systems (including production of disaggregated data) to inform policymaking, planning, implementation, monitoring, and scale-up pilot models at the provincial and national level	Number of new programme initiatives/ models integrated into national or sub-national policies and plans	0	Not applicable		Not applicable	2 initiatives /models: SRH/HIV/GBV integration and the Izigodi model	Integrated dashboard adopted in KZN	Project reports, national and sub-national government decisions and plans	Desk review	Once-off (at the end of the project)	UNFPA/ UNICEF
	Proportion of health facilities using improved data (age- and sex-disaggregated) or dashboard for quality service provisions for adolescent girls and young women - by districts	-	-	-	-	uThukela: data disaggregation in 29 out of 37 health facilities				Yearly	DoH/ UNFPA/ UNICEF

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible)					**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
			Year 1 2020	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**				
IMMEDIATE OUTCOMES *cond.*											
1210 Increased capacity of community actors (parents, adolescent girls and young women, networks, etc.) to become social change agents for responsive and comprehensive SGBV, SRHR and HIV services and gender equity work in the targeted districts	Proportion of community actors engaged in the activities at the key districts who report awareness and willingness to act to prevent GBV and harmful practices	To be collected ahead of the activities	Soul City has conducted 9 sensitization workshops in KZN during this year and 9 in Eastern Cape by end of December 2021. The pre and post-workshop assessments have been applied to all participants. KwaZulu-Natal Christian Council has reached 135 on GBV prevention and harmful practices		An additional 520 community actors were engaged in 2022	544 community actors reported awareness and willingness to act, 162 individuals committed to never support nor commit GBV 331 key gatekeepers engaged in MenCare Parent Programme Plus through community dialogues: Alfred Nzo: 220 Nelson Mandela: 54 uThukela: 57		Project reports	Project documents, attendance registers	Yearly	UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible)					**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
			Year 1 2020	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**				
IMMEDIATE OUTCOMES *cond.*											
1120. Increased capacity of the health and social services data management systems (including production of disaggregated data) to inform policymaking, planning, implementation, monitoring, and scale-up pilot models at the provincial and national level	Number of women's rights organizations and networks (international and local) advancing SRHR that receive direct GAC support or that receive support from GAC-funded partners. (Key **GAC Performance Indicator for Advocacy and Public Engagement)**		3 women's rights organizations advancing SRHR receive support from JP (Soul City; Mthombo; KZNCC)	3 women's rights organizations advancing SRHR receive support from JP (Soul City; Mthombo; KZNCC)	3 women's rights organizations advancing SRHR receive support from JP (Soul City; Mthombo; KZNCC)	3 women's rights organizations advancing SRHR receive support from JP (Soul City; Mthombo; KZNCC)		Project reports	Project documents, attendance registers	Yearly	UNFPA
OUTPUTS: ***Mapping of all health and social sector stakeholders at district level on quality, age-appropriateness free of bias and discriminatory practices SRHR, HIV and SGBV services to AGYW conducted***											
1111. Mapping of all health and social sector stakeholders (including facility assessment) at district level providing SRHR, HIV and SGBV services to AGYW conducted	Availability of the report of mapping done in the three targeted districts	Not available	Available mapping report		Mapping concluded	Available		Mapping report	Desktop review	Once off (at the beginning of the project)	UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible) **Year 1 2020**	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**	**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
OUTPUTS: ***Mapping of all health and social sector stakeholders at district level on quality, age-appropriateness free of bias and discriminatory practices SRHR, HIV and SGBV services to AGYW conducted*** *cond.*											
1112: District coordination mechanisms to produce implementation plans, monitor progress and provide oversight, including on referral pathways established	Number of multisectoral plans produced Proportion of activities in the plans implemented	0	KZN: NSP-GBVF Implementation Plan developed and finalized in 2020 - 2021 EC: NSP-GBVF EC developed in 2020- 2021 implementation commenced		Okhahlamba multisectoral plan 65% activities implemented focusing on GBV prevention and response	Nelson Mandela Bay GBV Forum Implementation Plan (2023)		Meeting minutes	Desk review	Once-off (at the beginning of the project)	UNFPA
1113: Health and social service professionals' capacity strengthened in using approved national tools	Number of health professionals trained in 3 districts: - Trainers through ToT - Doctors - Nurses (roll-out) - Facility managers Number of health- care providers trained in SRHR services through GAC-funded projects. **(Key GAC Performance Indicator – SRH Services)**		Alfred Nzo: A total of 65 HCW (55F & 10 m) A total of 52 HCW (47 F, 2 m and 3 F medical Drs) An overall total of 117 Health Care Workers in the EC Province uThukela: Data being collected		• Alfred Nzo 2022: 146 HCW • Nelson Mandela 2022: 69 HCW • Total HCWs 215: 90 F nurses 16 M nurses 10 Drs • 32 SSPs	3,642 health-care providers trained at the end of the project		Pre and post-training assessment conducted		Per training	District health teams/ UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*

EXPECTED RESULTS (from logical model)	INDICATORS (environmental sustainability and gender equality where possible)	BASELINE	TARGETS (Include time range if possible) Year 1 2020	Year 2 2021	Year 3 2022	Year 4 2023	Final Year 2024	DATA SOURCES	DATA COLLECTION METHODS	FREQUENCY	RESPONSIBILITY
OUTPUTS: ***Mapping of all health and social sector stakeholders at district level on quality, age-appropriateness free of bias and discriminatory practices SRHR, HIV and SGBV services to AGYW conducted cond.***											
1113: Health and social service professionals' capacity strengthened in using approved national tools	Proportion of social services professionals and community health workers trained on youth-friendly services	0	40%		60% 27% of social services professionals have been trained on youth-friendly services	105 social services professionals trained at the end of the project (Alfred Nzo: 61 Nelson Mandela: 22 uThukela: 22)		Project report, training reports	Record keeping/desk review	Yearly	District health teams/ UNFPA/ UNICEF
1121. Review of existing data management systems, tools and processes for evidence-base generation, use and monitoring enhanced	Availability of data management systems, tools/ processes that increase efficiency	Not available	Not available	Not available	The dashboard has been developed and supported across the three districts. The functionality was tested in uThukela in 2022	Dashboard in uThukela district is functional		Action plan	Desk review	Yearly	UNICEF
1122: Knowledge and skills of district health teams and district social services professionals on evidence-based SGBV, SRH and HIV programming improved through tools and dashboards to be developed/ refined	Availability of the functioning integrated dashboards on SGBV, SRH and HIV in all three districts	Not available	Not available		The dashboard has been developed and supported across the three districts. The functionality was tested in uThukela in 2022 EC Province: All Provincial Directors had a session with UNICEF and UNFPA on the dashboard	KZN: 92 Health and social services professionals were trained on the dashboard		Dashboard	Desk review, field visits	Annually	UNICEF

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible)					**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
			Year 1 2020	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**				
OUTPUTS: ***Mapping of all health and social sector stakeholders at district level on quality, age-appropriateness free of bias and discriminatory practices SRHR, HIV and SGBV services to AGYW conducted*** *cond.*											
1122: Knowledge and skills of district health teams and district social services professionals on evidence-based SGBV, SRH and HIV programming improved through tools and dashboards to be developed/ refined	Number of district health team members and district social service professionals trained and using the dashboards (to be disaggregated by the district)	0	12 (2 district health team members and 2 district social service professionals from 3 districts)		EC Province: All Provincial Directors had a session with UNICEF and UNFPA on the dashboard	KZN: 92 Health and social services professionals were trained on the Dashboard		Project report	Record keeping/desk review	Annually	UNICEF
1123. Use of developed District level SGBV, SRH, and HIV dashboard institutionalized	Number of district coordination meetings where the review of data from dashboards is included in the agenda	0	0		6 KZN 3 Quarterly district coordinations were held. EC 3 Quarterly Provincial coordination meetings were held	Integrated SRH/HIV/ GBV Dashboard developed and functional in KZN	2 Coordination meetings held in EC	Agenda for the meeting	Desk review/ field visit	Yearly	UNICEF

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible)					**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
			Year 1 2020	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**				
OUTPUTS: ***Mapping of all health and social sector stakeholders at district level on quality, age-appropriateness free of bias and discriminatory practices SRHR, HIV and SGBV services to AGYW conducted*** *cond.*											
1124. Documentation of good practice on district-level SRH, HIV and SGBV for provincial and national scale-up produced	Number of documents produced on the good practice at district levels re SRH, HIV and SGBV	0			3 KZN Newsletter SRH/HIV/GBV integration stories U-Report documentation	Good practices Stories of Change attached		Documents	Desk review	Yearly	UNICEF/ UNFPA
1211. Desktop situation analysis of knowledge, attitudes and behaviour of AGYW and community actors about SRHR, HIV and SGBV conducted	Availability of situation analysis report on knowledge, attitudes and behaviour of AGYW and community actors about SRHR, HIV and SGBV	Not available	Situation analysis report available		Available (KAP study)	Not applicable		Situation analysis report	Desk review	Situation analysis report available	UNICEF
1212. Core reference and oversight structure, inclusive of AGYW and community representatives established	Existence of district-level core reference and oversight structure for SRHR, HIV and SGBV	Integrated into the coordination forum			In existence (established) Incorporated in the District Coordination Fora	In existence (fully functioning)		Terms of Reference	Desk review, field visits	Yearly	UNICEF/ UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible)					**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
			Year 1 2020	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**				
OUTPUTS 1213: ***Targeted community interventions led by community actors (FBOs, traditional leadership structures, parents, CBOs, women-led organizations and men and boys institutions) to challenge prevailing harmful gender norms and build positive attitudes to end SGBV implemented***											
1213: Support implementation of the 2019 National Strategic Plan on Gender-Based Violence and Femicide	Action plan for the community-based interventions addressing social norms developed	2019 National Strategic Plan on Gender-Based Violence and Femicide	Mapping and situation analysis on community interventions addressing social norms and action plan NSP Implementation Plans and M&E tools developed in 2021, in 2022 implementation is taking place		Situation analysis report ready	none		Situation analysis report and Action plan	Desktop review	Annually	UNICEF/ UNFPA
	Training manual for community actors on SRHR and SGBV developed	2019 National Strategic Plan on Gender-Based Violence and Femicide	Life Skills Manual for traditional male initiates was developed in partnership with the EC House of Traditional Leaders		Life Skills Manual for traditional male initiates is available	Workshops conducted with key local stakeholders on SRHR and SGBV (Train the Trainer) in the identified districts		Reports	Data analysis evaluation forms	Quarterly	UNICEF/ UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*

EXPECTED RESULTS (from logical model)	INDICATORS (environmental sustainability and gender equality where possible)	BASELINE	TARGETS (Include time range if possible) Year 1 2020	Year 2 2021	Year 3 2022	Year 4 2023	Final Year 2024	DATA SOURCES	DATA COLLECTION METHODS	FREQUENCY	RESPONSIBILITY
OUTPUTS 1213: ***Targeted community interventions led by community actors (FBOs, traditional leadership structures, parents, CBOs, women-led organizations and men and boys institutions) to challenge prevailing harmful gender norms and build positive attitudes to end SGBV implemented cond.***											
1213: Support implementation of the 2019 National Strategic Plan on Gender-Based Violence and Femicide	Number of sustained media campaigns on SRHR, HIV, SGBV and COVID targeting AGYW through the media (SABC, TV) and other channels	0	Community radio was utilized to disseminate messaging about SRH, HIV and GBV in the three districts; • Social media (Facebook, Twitter) was utilized to disseminate social media cards and messaging on the Joint Programme • Newspapers (IOL and Mail and Guardian) were utilized to disseminate opinion pieces and articles on the JP focus areas and approach; • TV was utilized to disseminate key messaging on the Joint Programme on the occasion of the International Day of the Girl Child		• Community radio was utilized to disseminate messaging about SRH, HIV and GBV in the three districts; • Social media (Facebook, Twitter) was utilized to disseminate social media cards and messaging on the Joint Programme; • Mail and Guardian is being contracted to disseminate key messaging on the Joint Programme on the occasion of the International Day of the Girl Child in Eastern Cape Province #iNkunzi Radio Campaign by Kwambele reached 436, 000 over 8 episodes covering teenage pregnancy and GBV	Approximately 600,000 (listenership) were reached through community radio stations, with messages about GBV, SRHR and HIV (MenCare 5050 Plus Project). Impact assessment evaluation on the awareness campaigns		Reports Evaluation report	Media reports and data analysis	Quarterly for the campaigns and once-off for the evaluation	UNICEF/ UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible) **Year 1 2020**	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**	**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
OUTPUTS 1214: ***Increased Information and knowledge of AGYW, through social behaviour change on women and girls' human rights, SGBV and SRHR issues and gender equality***											
	Proportion of targeted AGYW with increased knowledge on women and girls' human rights, SGBV and SRHR issues and gender equality	Baseline data collection to be conducted	2,817 young people reached with CSE content		25%	50%		U-Report Facebook Twitter Other multimedia activities	Data analysis of U-Report polls	Yearly	UNICEF (U-Report) UNFPA (collection of data before activities)
1214. Communi-cation, information and support for the Implementation of the sanitary Dignity Framework and COVID-19 response through sector awareness	Number of campaigns conducted to create awareness on social behaviour change, SGBV, SRHR and gender equality	3 (Southern Hemisphere, Soul City, She Conquers and Mmapho)	2 Soul City Campaigns: First campaign focused on HIV, SRHR, GBVF and COVID-19 for AGYW and was conducted through social media and webinars		2 Soul City Campaigns: First campaign focused on HIV, SRHR, GBVF and COVID-19 for AGYW; conducted through social media and webinars; #iNkunzi Radio Campaign by Kwambele reached 436,000 people with 8 episodes covering teenage pregnancy, GBV, SRHR YENA (Young Educated Normative Adolescent) Events were hosted by Kwambele, reaching 820 adolescents and youth through educational sessions	3 initiatives conducted on social behaviour change, SGBV, SRHR and gender equality in Institutions of Higher and Further Education and training DOXA conducted 6 campaigns across 3 districts: 3 in Alfred Nzo - 2 school events targeting adolescents on HIV/ reproductive health, 1 community dialogue to discuss barriers to access AYFS 2 in Nelson Mandela Bay 1 intergenerational dialogue on SRHR and 1 Adolescent and Youth Friendly Service 1 in uThukela Boys' assembly focusing on GBV and HIV		Reports on the events	Data analysis	Quarterly	UNICEF/ UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible)					**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
			Year 1 2020	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**				
OUTPUTS 1214: ***Increased Information and knowledge of AGYW, through social behaviour change on women and girls' human rights, SGBV and SRHR issues and gender equality cond.***											
					4 initiatives (1 per quarter) conducted on social behaviour change, SGBV, SRHR and gender equality in schools	8 initiatives (2 per quarter) conducted on social behaviour change, SGBV, SRHR and gender equality in schools		Reports on the events	Data analysis	Quarterly	UNICEF/ UNFPA
1214. Communi-cation, information and support for the Implementation of the sanitary Dignity Framework and COVID-19 response through sector awareness	Number of communication platforms (radio/ digital/outdoor/ TV/print) utilized to promote awareness on social behaviour change, SGBV, SRHR and gender equality	0	4 communication platforms utilized: • Community radio was utilized to disseminate messaging about SRH, HIV and GBV in the three districts • Social media (Facebook, Twitter) was utilized to disseminate social media cards and messaging on the Joint Programme		4 communication platforms utilized: • Community radio was utilized to disseminate messaging about SRH, HIV and GBV in the three districts • Social media (Facebook, Twitter) was utilized to disseminate social media cards and messaging on the Joint Programme	At least 10 media mentions (radio/ digital/outdoor/TV/ print) utilized to promote awareness on social behaviour change, SGBV, SRHR and gender equality		Media Reports Facebook Twitter Other multimedia activities	Data analysis	Quarterly	UNICEF/ UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible)					**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
			Year 1 2020	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**				
OUTPUTS 1214: ***Increased Information and knowledge of AGYW, through social behaviour change on women and girls' human rights, SGBV and SRHR issues and gender equality cond.***											
1214. Communi-cation, information and support for the Implementation of the sanitary Dignity Framework and COVID-19 response through sector awareness			• Newspapers (IOL and Mail and Guardian) were utilized to disseminate opinion pieces and articles on the JP focus areas and approach • TV was utilized to disseminate key messaging on the Joint Programme on the occasion of the International Day of the Girl Child		• Mail and Guardian was utilized to disseminate opinion pieces and articles on the JP focus areas and approach						

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible) **Year 1 2020**	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**	**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
OUTPUTS 1214: ***Increased Information and knowledge of AGYW, through social behaviour change on women and girls' human rights, SGBV and SRHR issues and gender equality cond.***											
	Number of AGYW targeted clubs and safe spaces supported in school and out of school to play an effective role in SGBV prevention protection	0	This might not be feasible for 2020 due to the impact of the COVID-19 regulations and the suspension of co-curricular activities in schools		Activity completed through the conduction of the SH Study	Support the establishment of (8) AGYW-targeted new clubs and safe spaces in school and out of school as support structures for SGBV prevention and protection		Activity reports and financial reports on transfers to clubs and safe spaces	Data analysis and financial statements	Quarterly	UNICEF/ UNFPA
1214. Communi-cation, information and support for the Implementation of the sanitary Dignity Framework and COVID-19 response through sector awareness	Number of beneficiaries in shelters and communities receiving sanitary dignity packs to promote menstrual health and hygiene during COVID-19	0	3,000 girls to be reached (1,000 per district) through the pilot, ending in March 2022	3,000 targeted stakeholder consultation conducted in May 2022, followed by data collection. Distribution of dignity kits consisting of disposable sanitary pads, reusable sanitary pads, IEC materials, and a hot water bottle started in August 2022, as well as awareness raising with learners.1,479 learners have been reached with this programme	Discontinued			List of beneficiaries in DSD shelters and higher health (2020) List of girls reached with sanitary dignity packs	Reports and pictures of the distribution activities	Bi-annually	UNFPA

Performance Monitoring Framework (2020-2024) Version (May 2024) *contd.*											
EXPECTED RESULTS (from logical model)	**INDICATORS** (environmental sustainability and gender equality where possible)	**BASELINE**	**TARGETS** (Include time range if possible) **Year 1 2020**	**Year 2 2021**	**Year 3 2022**	**Year 4 2023**	**Final Year 2024**	**DATA SOURCES**	**DATA COLLECTION METHODS**	**FREQUENCY**	**RESPONSIBILITY**
OUTPUTS 1214: ***Increased Information and knowledge of AGYW, through social behaviour change on women and girls' human rights, SGBV and SRHR issues and gender equality cond.***											
1214. Communi-cation, information and support for the Implementation of the sanitary Dignity Framework and COVID-19 response through sector awareness	Number of beneficiaries receiving personal protective equipment (PPE) in DSD shelters and higher health	0	KZN: Traditional Authorities 20,000 sanitary pads 2,000 buckets 756 (5L) sanitizer 5,000 bars of soap EC: 2,256 sanitary pads 904 bars of soap	Information on SRH, HIV, and GBV information and referrals at 40 high-volume shelters as well as 2,000 dignity kits are being provided. Each kit contains a blanket, SABS-approved sanitary pad, soap and female cotton underwear in varying sizes, with labelling of items. The kits include a message to create awareness of GBV and relevant contact numbers for reporting or obtaining information on the closest available GBV services	0 Procurement and distribution of personal protective equipment for DSD shelters and higher health Discontinued			List of beneficiaries in DSD shelters and higher health	Reports	Twice a year	UNFPA

ANNEX II

A report on the effectiveness of the Plan, Do, Study, and Act (PDSA) model of SRH/ HIV/SGBV integration at selected facilities in selected districts in KwaZulu-Natal

Executive Summary

Human immunodeficiency virus (HIV) and sexual and reproductive health and rights (SRHR) service integration aims to maximize collective outcomes and is based on the need to offer comprehensive and integrated services that include treatment for survivors of sexual and gender-based violence (SGBV). This project aimed to develop, implement, and document the effectiveness of the Plan, Do, Study, and Act (PDSA) model of SRH/HIV/SGBV integration at selected facilities in selected districts in KwaZulu-Natal.

The intervention was rolled out in four phases between 2017 and 2022 as follows: baseline assessment, the pilot phase in five facilities, documentation of the effectiveness of the model phase in 12 facilities, and scale-up from 12 to 53 facilities across uThukela, eThekwini, and Ugu districts in KwaZulu-Natal. The implementation involves mainly on-site training, developing and using job aids, routine data-tracking tables, and monthly dashboards, which were used as tools.

Despite the challenges posed by the series of lockdowns and a 20 per cent drop in headcount in the 12 facilities during COVID-19, the intervention yielded significant positive outcomes. Subdermal implants increased from 150 to 954, the average couple-year protection rate went from 13.3 per cent to 25.9 per cent, and the number of IUCDs inserted rose from 87 to 135. One hundred and fifteen professional nurses (PN) were trained, representing 75 per cent of the total number of PNs. The intervention was scaled up to 53 facilities in three districts in September 2021. The support contributed about 28 per cent of the overall district total in eThekwini, 34 per cent in Ugu and 46 per cent in uThukela by March 2022.

Overall, the SRH/HIV/SGBV integration model has proven to be effective. However, it is crucial to emphasize that its success hinges on provincial, district, and facility ownership. For a successful scale-up, the province must continue to expand the intervention to other districts, underscoring the urgency and importance of this task.

1. INTRODUCTION

In South Africa, the foundation of service integration at primary health care (PHC) facilities is enshrined in the Ideal Clinic model. An Ideal Clinic has good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes, and sufficient bulk supplies. It uses applicable clinical policies, protocols, and guidelines and harnesses partner and stakeholder support (Ideal Clinic South Africa, 2021). An Ideal Clinic also works with other government ministries, departments, agencies, the private sector, and non-governmental organizations to address the social determinants of health.

Integrated Clinical Services Management (ICSM) is a central pillar of health service delivery within the Ideal Clinic model. ICSM aims to respond to the growing burden of chronic diseases in South Africa efficiently and cost-effectively. Therefore, the model reorganizes health service delivery in facilities into four broad streams: acute illness, chronic disease, maternal and child health, and health support services. This phased out the previously existing multiple streams comprising acute minor illness, antenatal care, antiretroviral therapy (ART), chronic non-communicable disease (CND), child health curative, doctor visit, family planning, human immunodeficiency virus, counselling, and testing (HCT), immunization, tuberculosis (TB), well-baby clinic, dressings/injections, and others (Egbuie et al., 2018).

The ICSM approach aims to reduce the poor quality of care and patient outcomes, eliminating multiple patient visits, multiple patient files, and polypharmacy (NDOH, 2019). With the Ideal Clinic model intervention, patients should receive consultation for all illness complaints from the same health-care worker once in a consulting room, rather than having to go from one to another if additional services are needed. Integrated health services refers to the organization and management of health services so that people get the care they need, when they need it, in user-friendly ways, achieve the desired results and provide value for money (WHO, 2009).

A case for SRH and HIV integration

The connections between HIV and sexual and reproductive health and rights (SRHR) are well-established, especially as HIV is predominantly sexually transmitted or associated with pregnancy, childbirth, and breastfeeding (UNFPA et al., 2013). Similarly, sexually transmitted infections (STIs) can increase the risk of HIV acquisition and transmission (WHO, 2007). People living with HIV have specific SRHR needs, including but not

limited to the prevention of mother-to-child transmission of HIV, which requires an integrated service delivery response. Establishing linkages between SRHR and HIV has had demonstrable health and wellness benefits (Kennedy et al., 2010). Some benefits include better treatment outcomes, improved quality of care, better use of scarce human resources, and the potential for reduced HIV-related stigma and discrimination (Hopkins et al., 2017). Strengthening SRH and HIV integration as a vital part of the ICSM implementation benefits South Africa.

Sexual and reproductive health and rights (SRHR) and HIV service integration aim to maximize collective outcomes and is based on the need to offer comprehensive and integrated services (UNFPA et al., 2014). When these services are integrated with sexual and gender-based violence (SGBV) — a structural driver of HIV and tuberculosis (TB), the leading cause of death among the people living with HIV in South Africa — it creates a potent synergy towards the attainment of the healthy populace.

The KwaZulu-Natal and Eastern Cape Provincial Department of Health (NDoH), with the support of the United Nations Population Fund (UNFPA), commissioned the assessments of the status of SRH/HIV and SGBV integration and implementation in 10 health facilities in Alfred Nzo, OR Tambo, and uThukela Districts. This assessment led to the development of the District Implementation Plan (DIP), the job aid, and the minimum care package at service streams that will facilitate SRH/HIV and SGBV integration at the facility level. OPTIDEL was appointed as a technical partner to implement and document a Plan, Do, Study, and Act (PDSA) model of SRH/HIV/SGBV integration in a phased scale-up from five facilities in one district (uThukela) to 53 facilities in three districts (uThukela, Ugu and eThekwini) of KwaZulu-Natal. Furthermore, a closeout phase was implemented to entrench sustainability and ownership by the province.

The project's scope covered three aspects: building capacity through training and mentorship, ensuring sustainability and institutionalization, and the 3Ds—data use, documentation, and dissemination.

2. METHODOLOGY

Implementation phases

The intervention was rolled out in four stages, ending with a closeout.

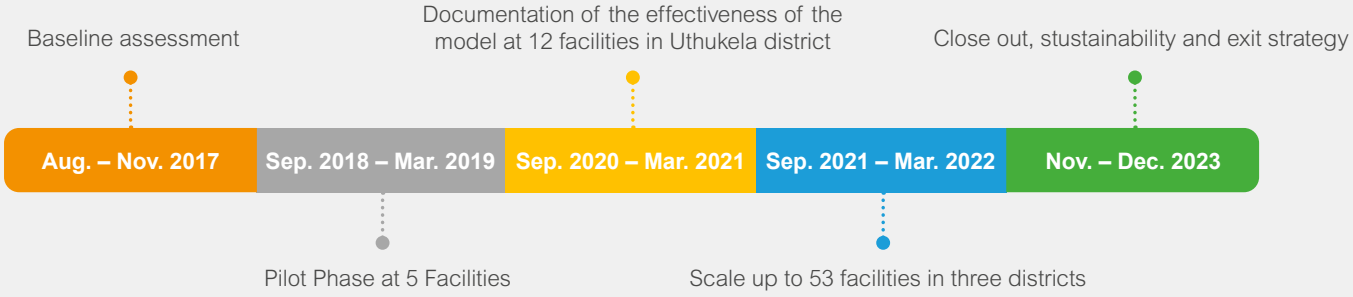


Figure 1: Phases of intervention implementation

Baseline assessment of SRH/HIV/SGBV/TB integration

OPTIDEL conducted baseline assessments of 10 identified facilities in 2017 to establish the national status of SRHR/HIV linkages at the policy and systems level. It collected baseline data through the District Health Management Information System (DHMIS) on defined SRHR/HIV integration indicators. This assessment indicated the health facility's readiness to integrate SRHR and HIV services and assessed uptake and possible barriers to integration of services.

Main constraints in offering integrated SRH/HIV services

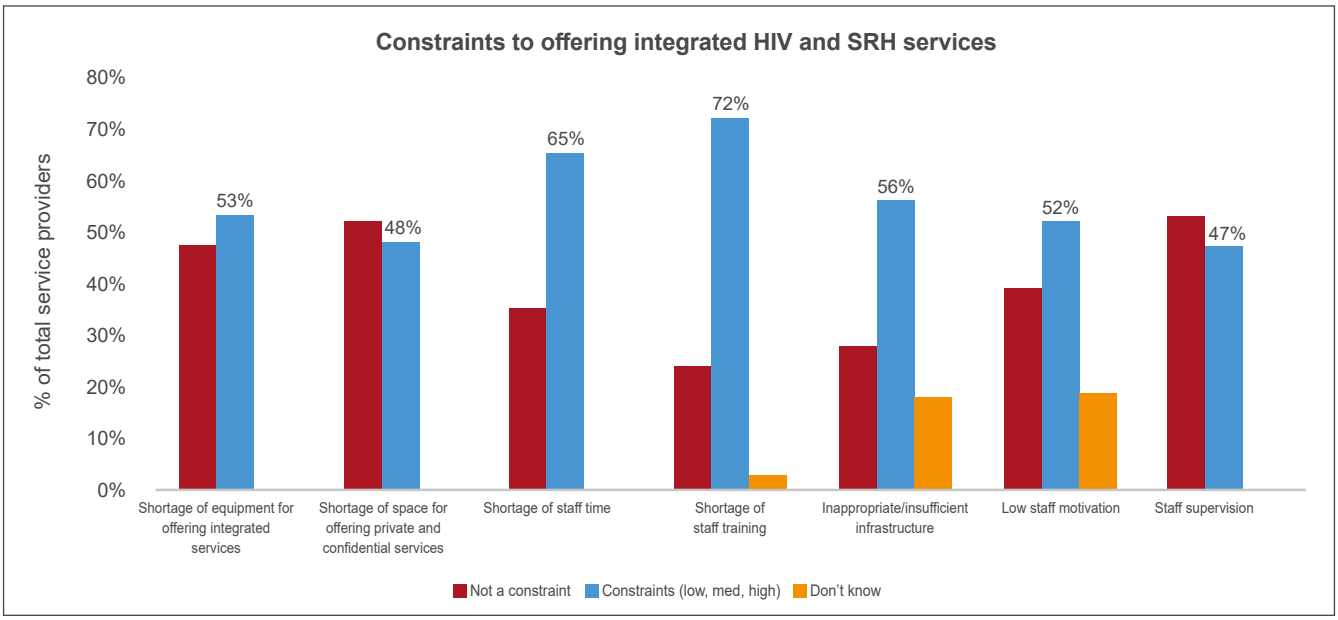


Figure 2: Constrains to offering integrated HIV and SRH services

The following recommendations were made from the assessments.

1. The Department of Health (DoH), with the support of partners, should develop a minimum package of services that can strengthen integration at the facility level. This package can be complemented by designing job aids that can practically guide integration at the three existing service streams or entry points: maternal, child and newborn, minor ailments and chronic. This minimum package of services should take into cognizance the low integration of SGBV, prevention and management of post-abortion services, psychosocial support, AYFS, and key population.
2. The DoH and partners should address the training gap that emerged strongly from the study. Addressing the current training inadequacies requires an innovative approach that extends beyond the organization of training workshops and strengthens in-service training, mentorship, and supportive supervision. The content and guide of this capacity-building support should address facility-specific factors that affect integration.
3. The facility managers and team of the 10 assessed facilities should re-evaluate the patient flow process to optimize the opportunities and mitigate the weaknesses of their facilities to provide integrated services. This approach should aim to reduce waiting time and improve the quality of service and staff efficiency. It is also critical to mitigate the infrastructural challenges and for the facility team to own the product of the re-evaluation.
4. As part of the facility re-evaluation process, the team needs to identify opportunities for integration at all facility entry points.
5. Use the re-evaluation process described above as an opportunity to encourage team building among staff members to support any service point needing help at any time due to high patient load.
6. Stakeholders should emphasize that integration should not be seen as a consulting room process. It must start from the point of entry into facilities and through the patient flow to optimize the opportunity at every service point. In addition, the process of successful referrals and linkages to appropriate care should be emphasized.
7. Establish a sensitive communication strategy as part of introducing the new approach. The health education platform at the facility level should be used to educate patients on the benefits of integrating SRH and HIV services.

In summary, the assessment showed that **providing a minimum package for service integration** and linkages, **appropriately building the capacity of service providers, and exploring the potential of the existing community structures** can prevent some missed opportunities from occurring. Therefore, these findings informed the implementation of the UNFPA SRH/HIV/SGBV Integration project by OPTIDEL using the PDSA Model.

After the assessment, inception activities commenced, forming part of the intervention rollout in 2018. The pilot phase occurred in five facilities in the uThukela district

of KwaZulu-Natal from September 2018 to March 2019. The district selected these facilities based on their performances and patient volume. The approach also informed the subsequent phases, such as scaling up to 12 and 53 facilities across uThukela, eTthekwini, and Ugu districts in KwaZulu-Natal.

Implementation model

OPTIDEL adapted the Plan, Do, Study, and Act (PDSA) model to implement the SRH/HIV/SGBV integration (Figure 3). The model was modified to address contextual issues at the facility level.

As a guiding principle, it was important that this model did not create another parallel system but worked within the ideal clinic structure, integrating into the existing nerve centre meeting. It also recognizes the unique nature of the individual clinic and devises a targeted approach centred on instituting in-house training and flexi-training time, not taking people out of the duty posts, engendering ownership by district and facility staff, and using the dashboard to entrench accountability and effective supervision.

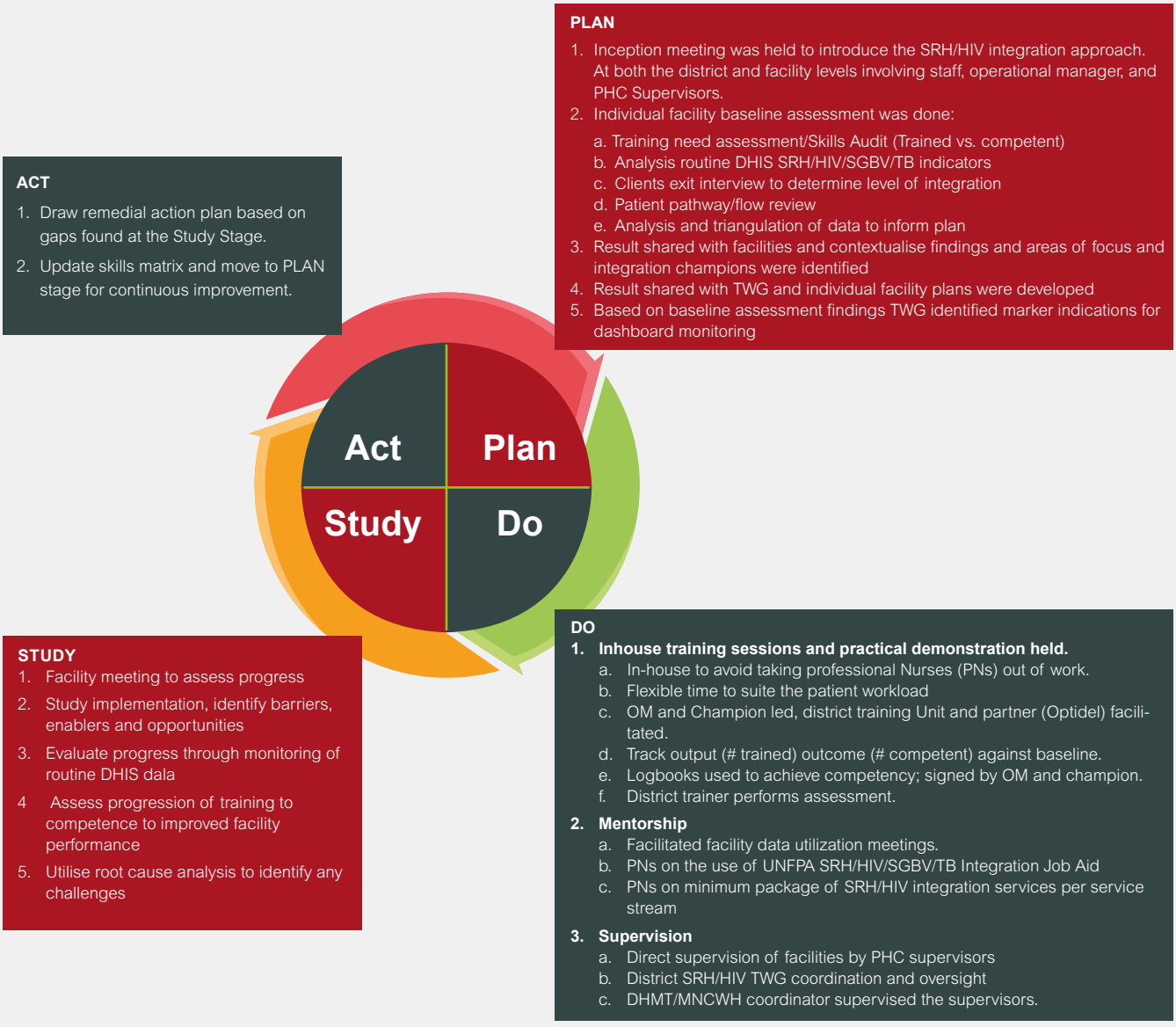


Figure 3: PDSA model of SRH/HIV/GBV integration

The model was used to target specific gaps identified based on the facilities' performance against selected tracker indicators at the district level. OPTIDEL's district technical advisors/mentors continually engaged in mentorship and in-house capacity development to strengthen the SRH/HIV/SGBV integration within/across the Ideal Clinic service streams in the facilities.

In principle:

- The project's sole aim is to improve the integrated SRH/HIV/SGBV service provision **within existing health system constraints**.
- The project does not aim to solve perennial health system issues such as infrastructure and staff shortages.
- The project does not aim to form any parallel system but to facilitate the integration of services and improve the quality of service.

After the pilot, there was a scale-up and documentation of the effectiveness model in 12 facilities.

The following approach was adopted to monitor the performance of interventions of the model:

Actions taken to integrate SRH/HIV and SGBV

1. Provincial and district ownership ensured

✓ Induction meeting with the province and district focal persons
✓ Agreement on implementation approach and indicators

2. Sensitization training for PHC supervisors and facility managers:

✓ Introduction of project scope, principles and approach
✓ Introduction of the package of services for different service delivery streams
✓ Introduction of job aids

3. Facility baseline and end-line data collection and analysis

a) Selected marker indicators from DMHIS as per the sample below
   ✓ Couple-year protection rate and family planning methods
   ✓ Cervical cancer screening
   ✓ Deliveries 10-19 years
   ✓ Sexual assault: new cases
   ✓ Sexual assault: under 12 years
   ✓ HIV testing (index testing and prep initiation)
   ✓ TB screening
   ✓ Facility headcount

b) Training needs assessment/skills audits were conducted at baseline to identify possible gaps to be prioritized and addressed.

c) Patient service integration survey to get the service beneficiaries' perspective

4. Training of health-care workers on SRH/HIV/SGBV integration

5. Dissemination of the model of integration and institutionalization

Tools used for the interventions

The following tools were used to ensure implementation success:

a) **SRH/HIV/SGBV integration job aids were used at the three service delivery points**

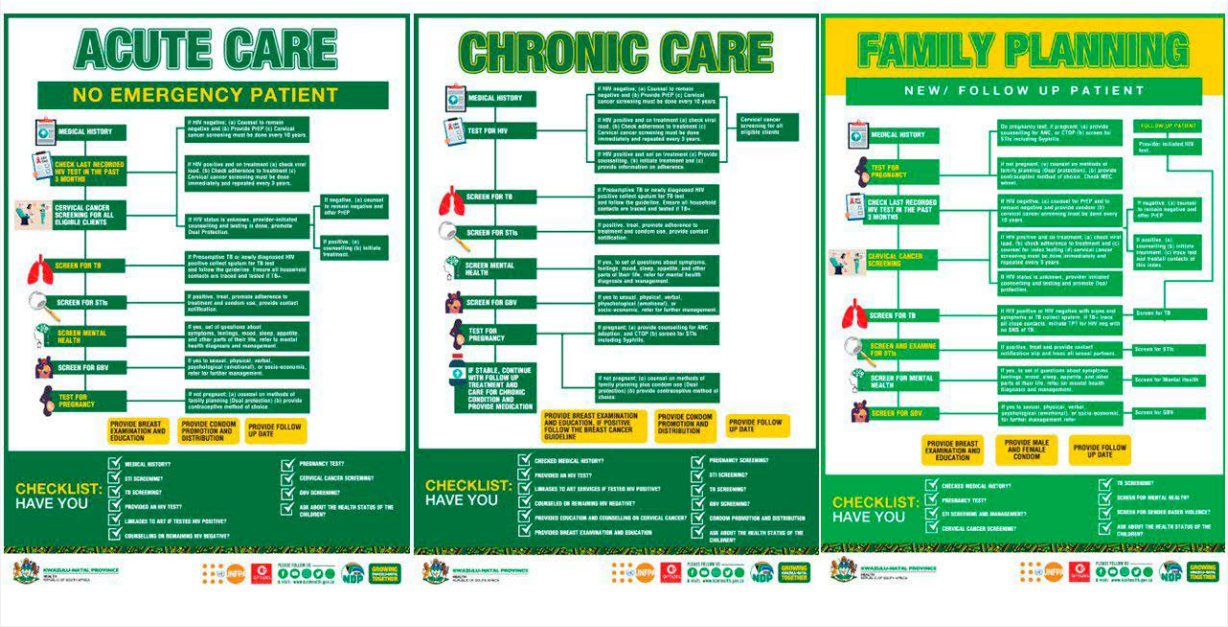


Figure 4: Sample job aids for health workers

b) Routine data tracking tables

The progress of selected indicators was monitored across the three districts using data tracking tables. The tracking tables helped develop the dashboard as an early warning tool and for supportive supervision.

c) Monthly dashboard

The monthly dashboard facilitated the prioritization of facilities for targeted supportive supervision and mentorship. The colour coding reflects the performance at a glance. As per the example below, green indicates the target is achieved, orange indicates making progress or borderline performance, and red indicates not achieved. The dashboard analysis also triangulates the number of professional nurses in the facility, which helps to estimate the average performance per indicator per professional nurse in a month. Furthermore, it helps assess the available capacity to implement the interventions. On the use of the dashboard (see sample dashboard in Figure 5), a district manager said: "We are encouraged by the monthly dashboard indicator that OPTIDEL sent to us, as it encourages our facilities to do well."

IUCD Insertion Feb 2022 - Dashboard

Facility	Number of PNs	Total IUCD Inserted	Nurse to IUCD Insertion	Number of PNs trained	Number of PNs competent
AE Haviland Memorial Clinic	12	0	12 PNs carried out 0 IUCD insertions in 1 month (12:0)	8	3
Bergville Clinic	7	11	7 PNs carried out 11 IUCD insertions in 1 month (7:11)	5	3
Dukuza Clinic	6	2	6 PNs carried out 2 IUCD insertions in 1 month (6:2)	1	1
Ekuvukeni Clinic	10	0	10 PNs carried out 0 IUCD insertions in 1 month (10:0)	0	0
Emmaus Gateway Clinic	6	4	6 PNs carried out 4 IUCD insertions in 1 month (6:4)	0	0
Ezakheni 2 Clinic	6	1	6 PNs carried out 1 IUCD insertions in 1 month (6:1)	4	2
Injisuthi Clinic	17	40	17 PNs carried out 40 IUCD insertions in 1 month (17:40)	8	2
Ncibidwane Clinic	12	6	12 PNs carried out 6 IUCD insertions in 1 month (12:6)	8	1
Ntabamhlope Clinic	19	5	19 PNs carried out 5 IUCD insertions in 1 month (19:5)	8	4
Oliviershoek Clinic	11	6	11 PNs carried out 6 IUCD insertions in 1 month (11:6)	5	1
St Chads CHC	39	7	39 PNs carried out 7 IUCD insertions in 1 month (39:7)	21	13
Steadville Clinic	8	5	8 PNs carried out 5 IUCD insertions in 1 month (8:5)	3	1
Walton Clinic	7	7	7 PNs carried out 7 IUCD insertions in 1 month (1:1)	3	3
Watersmeet Clinic	6	5	6 PNs carried out 5 IUCD insertions in 1 month (6:5)	3	3
Wembezi Clinic	12	20	12 PNs carried out 20 IUCD insertions in 1 month (12:20)	5	5

Dashboard Summary Feb 2022

Indicators	Best Performing Facilities	Least Performing Facilities	Notes/Intervention
IUCD Insertion	• Bergville Clinic • Emmaus Gateway Clinic • Injisuthi Clinic • Ncibidwane Clinic • Oliviershoek Clinic • Steadville Clinic • Walton Clinic • Watersmeet Clinic • Wembezi Clinic	• AE Haviland Memorial Clinic • Ekuvukeni Clinic • Ezakheni 2 Clinic • Ntabamhlope Clinic • St Chads CHC	• Injisuthi, Wembezi and Bergville Clinics did exceptionally well. • Only x5 Facilities performed poorly and its facilities that have this trend. • Ekuvukeni Clinic still has a challenge with renovations and the plan is for them to move back to the clinic since there are great challenges with the service provider. • AE Haviland Clinic is always least performing and the reason the team mention is the environment and attitude of deep rural community otherwise they try to market the product without winning. • Ezakheni2 Clinic managed to insert x1 IUCD compared to a zero last month. • Poor performing Facilities will be supported frequently and monitored closely in March.

Figure 5: Sample dashboard

3. RESULTS

OPTIDEL implemented the proof of concept and documented the effectiveness of implementation using the above methods at 12 facilities in the uThukela district of KwaZulu-Natal.

The summary of the proof-of-concept result indicated that performance in the 12 project sites had improved despite the series of lockdowns and a 20 per cent drop in headcount during COVID-19. See Figure 6 below:

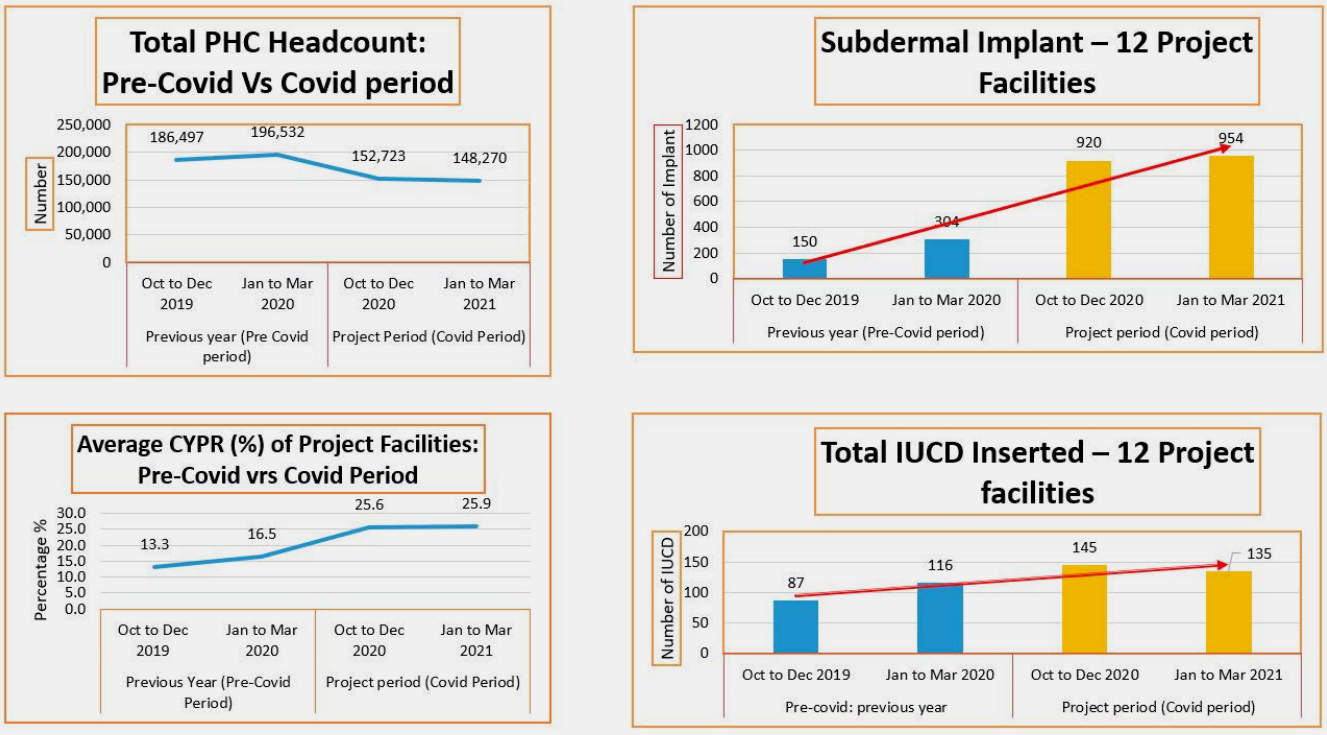


Figure 6: Project performance

Compared to the pre-COVID-19 era, there was a sharp drop in the uptake of short-acting contraceptives and an increase in the uptake of long-acting reversible contraceptives (LARC). However, further evaluation is needed because this could indicate clients' avoidance of short-acting methods that required frequent attendance at facilities during COVID-19.

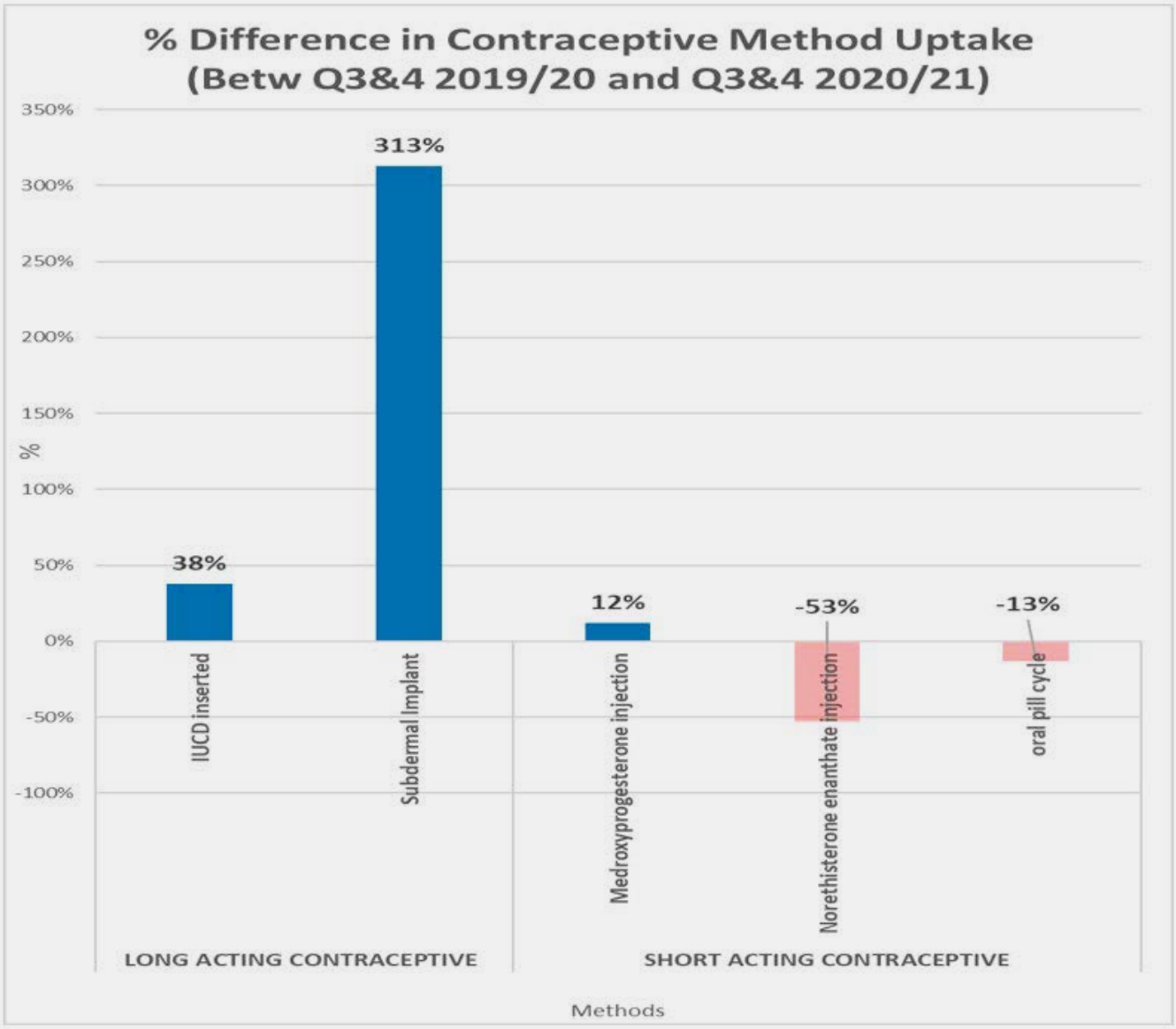


Figure 7: Percentage difference in contraceptive method uptake before and during COVID-19

Other indicators:

a) **Training data:** The project adhered to its principle of implementing in-house capacity development and competency improvement. Overall, due to OPTIDEL's technical mentorship and the series of demonstration sessions within the facilities, the proportion of professional nurses who were trained and reported competent at the end of the project significantly improved compared with the baseline.

   For the first time, the project introduced the concept of on-site SGBV training to the KZN facilities, which trained 115 professional nurses (75 per cent of total PNs) in the 12 facilities over this period. Hence, it improved the index of suspicion and early first responders' intervention in GBV issues.

Table 1: Results of training conducted

	Beginning of project Sept 2020			End of Project March 2021		
Indicator	Total Number of professional Nurses at Baseline	Total Number Trained at baseline (% of Total PNs trained)	Total Number that reported Competent at baseline (% of Total PNs competent)	Total Number of PN at the end of project	Total Number Trained at the end of the project (% of Total PNs trained)	Total Number competent at the end of the project (% of Total PNs competent)
IUCD	129	44 (34%)	24 (19%)	153	97 (63%)	58 (38%)
Implanon		71 (55%)	57 (44%)		124 (81%)	114 (75%)
Cervical Cancer Screening		119 (92%)	119 (92%)		149 (97%)	147(96%)
GBV (SGBV)		12 (9%)	10 (8)		115 (75%)	115 (75%)

b) **Cervical cancer screening:** The indicator showed a significant increase in the number of cervical cancer screenings performed during OPTIDEL's intervention period (October 2020 to March 2021) compared with the preceding six months before the intervention (April 2020 to September 2020).

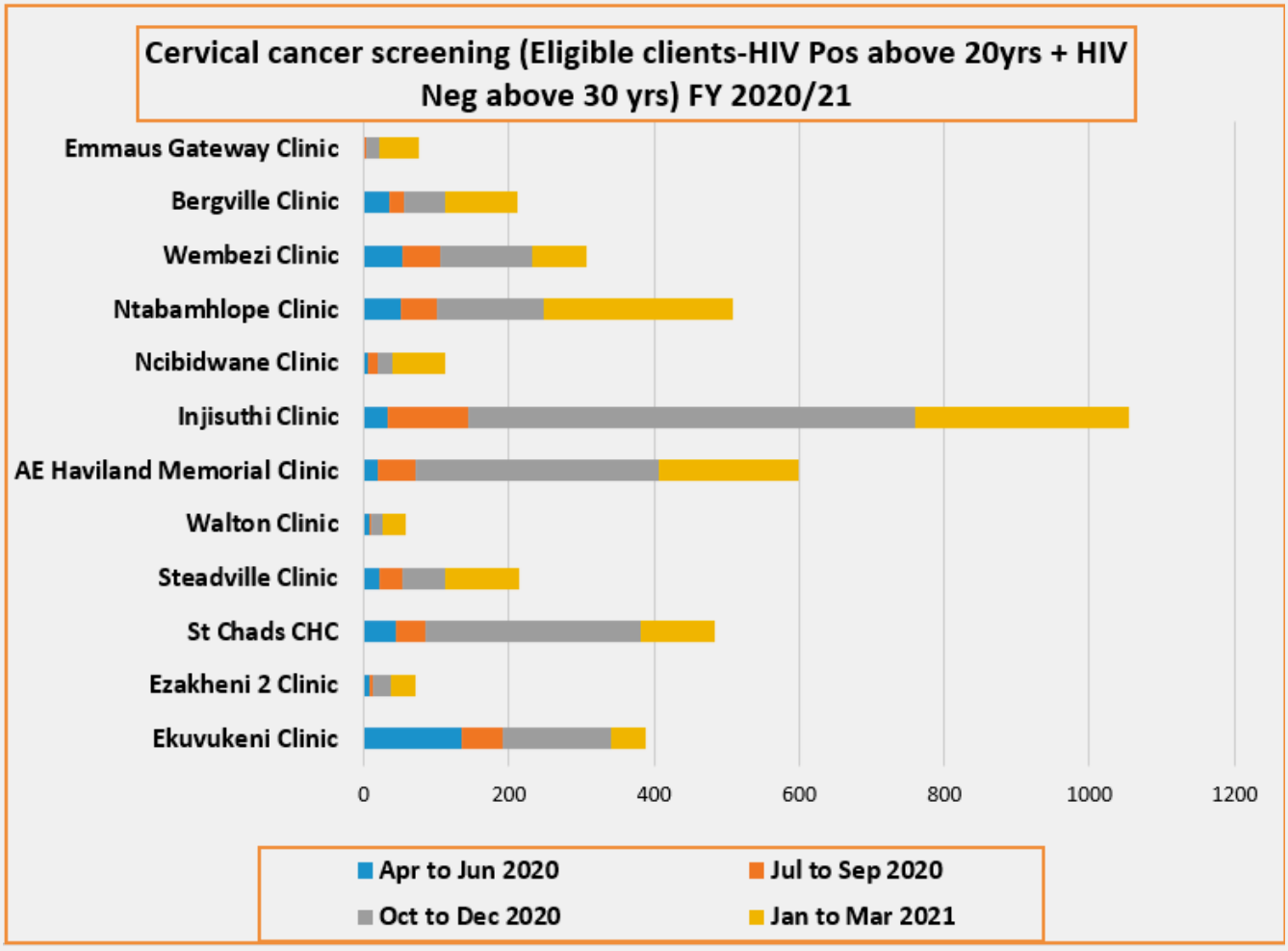


Figure 8: Quarterly cervical cancer screenings conducted in the 2021 financial year

c) **The client exit interview:** The survey indicated that clients received more services at the end of the project cycle than at the baseline. At baseline, clients reported receiving an average of one additional service apart from the one they came for. However, after the interventions, clients said they received three other services in addition to the one they came for.

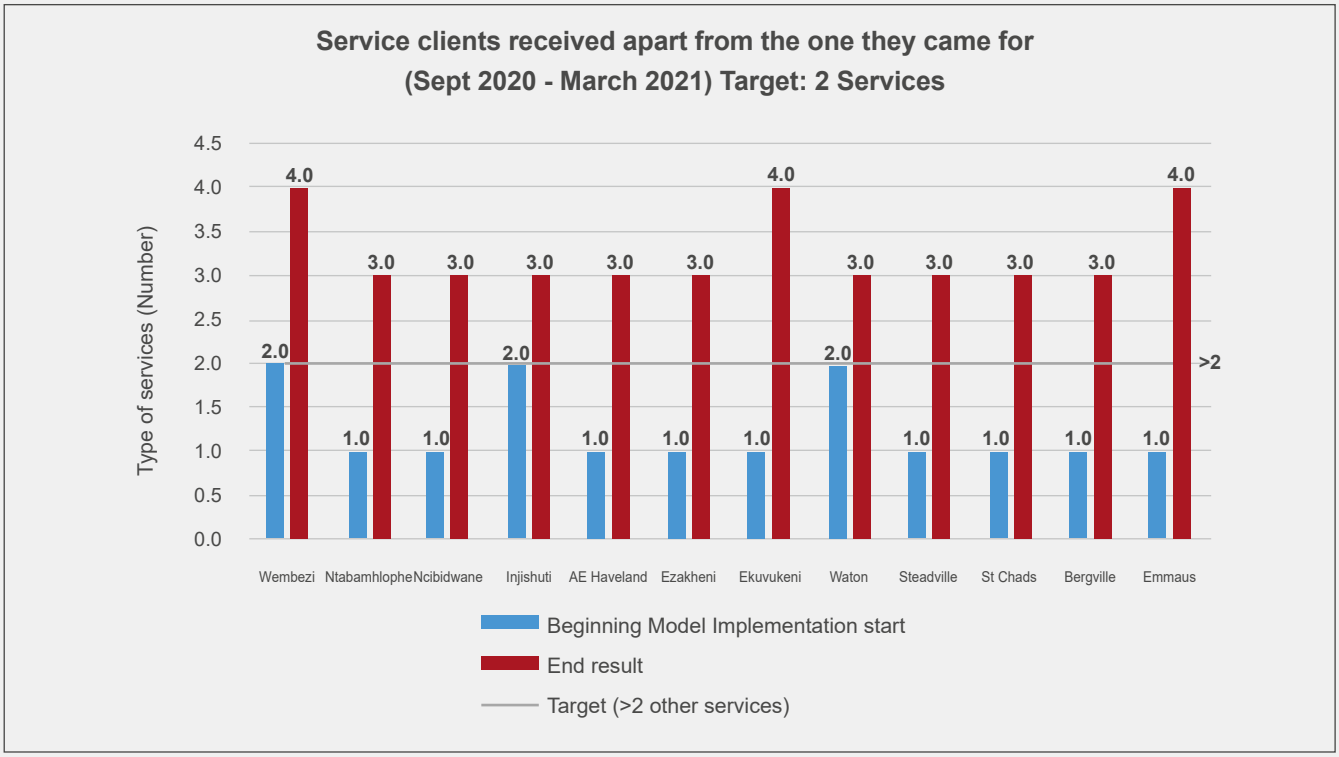


Figure 9: Services received by clients apart from the one they came for

d) **TB symptoms five years and above screening:** Fewer patients over five years of age were screened for TB during COVID-19.

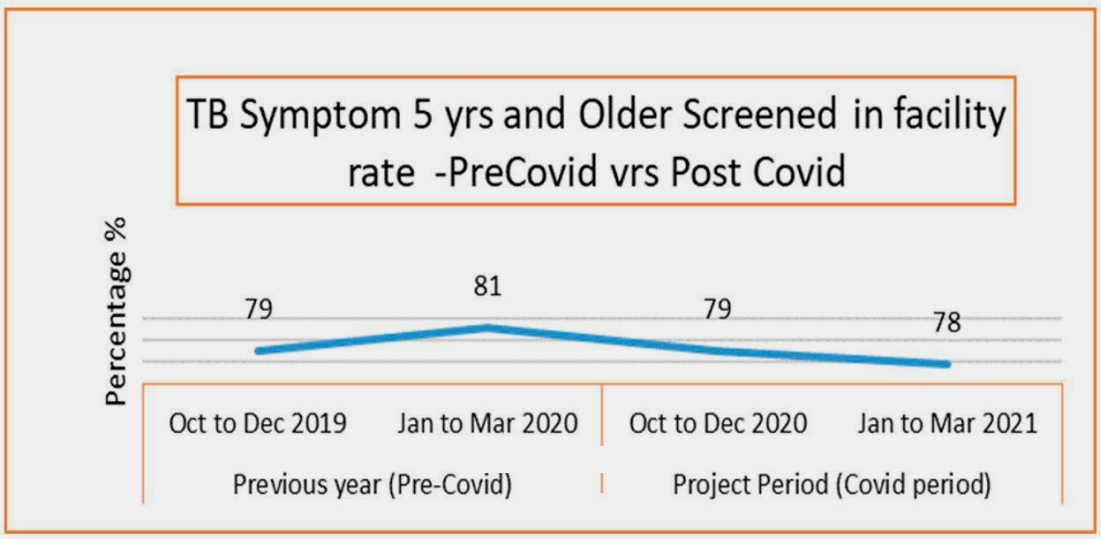


Figure 10: TB symptom screening for patients five years and older pre- and during COVID-19.

The successful proof of concept resulted in a further scale-up to 53 low-performing facilities in three districts. The intervention further improved the performance of the marker indicators. However, this did not translate to district-level improvement because of the low facility coverage, especially in eThekwini and Ugu, where the project only lasted six months before closing out. UNFPA/OPTIDEL support contributed about 28 per cent of the overall district total in eThekwini, 34 per cent in Ugu, and 46 per cent in uThukela.

Out of the three districts, the uThukela support, although episodic with about six months of implementation gaps, covered nearly 50 per cent (46 per cent) of the district facilities. The district took ownership and used the tools to support all the district facilities beyond the OPTIDEL-supported ones. This could be one of the reasons behind uThukela's consistent improvement over time, as highlighted below.

uThukela consistently reduced the "Delivery in 10-19 years in facility rate - per cent" indicator from FY2020 to 2022 (Table 2). The same applies to the "Couple year protection rate" and "Cervical cancer screening coverage" (Table 3).

Table 2: Trends in teenage and adolescent pregnancy

	Apr 2020 to Mar 2021				Apr 2021 to Mar 2022				Apr 2022 to Mar 2023			
	Delivery 10-14 years in facility	Delivery 15-19 years in facility	Delivery in facility sum	Delivery 10-19 years in facility rate %	Delivery 10-14 years in facility	Delivery 15-19 years in facility	Delivery in facility sum	Delivery in 10-19 years in facility rate%	Delivery 10-14 years in facility	Delivery 15-19 years in facility	Delivery in facility sum	Delivery in 10-19 years in facility rate %
eThekwini	216	8,427	68,286	12.7	291	8,408	69,870	12.5	194	8,309	69,954	12.2
Ugu	60	2,511	14,226	18.1	85	2,531	14,654	17.9	57	2,464	14,023	18
uThukela	36	2,573	13,531	19.3	68	2,409	13,510	18.3	56	2,307	13,258	17.8

Table 3: Trends in couple-year protection rates and cervical screenings

	Couple-year protection rate			Cervical cancer screening coverage		
District	Apr 2020 to Mar 2021	Apr 2021 to Mar 2022	Apr 2022 to Mar 2023	Apr 2020 to Mar 2021	Apr 2021 to Mar 2022	Apr 2022 to Mar 2023
eThekwini	41.7	51.4	48.5	31.5	48.8	53.6
Ugu	43.8	55.6	53.9	42.7	53.7	68.1
uThukela	**66.1**	**66.1**	**73.3**	**58.2**	**93.6**	**97.3**

4. KEY CHALLENGES

OPAs with all interventions, several challenges were encountered during the implementation period. These included:

1. The COVID-19 pandemic disrupted services and made project implementation difficult.
2. The pandemic also affected the supply chain and logistics management systems, leading to a stock-out of long-acting reversible contraceptives (implants) and other commodities.
3. Apart from the HIV testing services (HTS) registers, no source registers comprehensively promote SRH/HIV/SGBV integration, hence the use of marker indicators and client exit surveys. The evaluation of integration through routinely collected data from Ideal Clinic service points is not consistent and accurate in many cases.
4. Due to funding and contract issues, OPTIDEL projects are implemented for an average of six months a year, leaving wide gaps without implementation. This limited the project's ability to maximize its effectiveness.
5. Increased implementation costs due to inflation and COVID-19 almost halted the project.

5. LESSON LEARNED

This project showed definitively that:

- Strengthening the provincial and district oversight is critical.
- Strengthening the quality of supervision enhances functional and effective implementation.
- Ensuring ownership by facilities facilitates sustainability.

Three promising practices were identified:

- Strengthening the health system to achieve person-centred and coordinated care.
- Improving the interface among health workers, clients, and other stakeholders.
- Strengthening access to education and information, data collation tools, and monitoring processes.

Other lessons from the field

Having dedicated SRH champions, making cervical screening part of the HIV treatment routine, and using the opportunity to talk to clients about family planning options while they are having their vital signs monitored also led to an increase in overall SRH delivery.

Selection of champions

After SRH training and mentorship, the facilities selected their SRH champions. The selection boosted the individual's morale and self-esteem, and they developed a sense of ownership of the programme. The champions confidently monitored the SRH indicator and related activities. This motivated their peers to focus more on the SRH indicators, leading to overall SRH performance improvement. In some facilities, champions were assigned to be the SRH custodians and provide mentorship services to support their facility's satellite clinics.

Integrating cervical cancer screening as part of the routine HIV treatment initiation

During mentoring and coaching sessions, one recommendation was that facilities should include cervical cancer screening as part of routine HIV treatment initiation and management. There were performance indicator improvements in the facilities that implemented that recommendation. This was replicated in other facilities, which also showed improvement.

Providing family planning education at vital signs stations

Family planning information was provided to individuals at the vital signs station, helping ensure that clients were already informed about family planning choices by the time they reached the consulting room. The information recorded on the client exit interview showed that the total number of services the client received was more than the number of services the client came for, with a significant number of women receiving family planning information. However, more evaluation is needed to know the effect on service integration.

6. CONCLUSION AND RECOMMENDATIONS

Based on the overall success of the intervention, the following recommendations have been made:

- The SRH/HIV/SGBV integration models should continue to be scaled up across KwaZulu-Natal.
- The approach and lessons learned should be used to scale up the intervention to other health facilities using the existing tools, especially job aids.
- The South Africa National Department of Health should consider adopting the KZN model and scaling its implementation nationally.
- There is a need to develop or adopt SRH/HIV/SGBV integration indicators as part of routine monitoring datasets at all levels that can be monitored and reported by each facility.
- There is also a need to mitigate facility-level human resources and infrastructure challenges, including investment in technology to enable ease of communication and access to virtual and in-house training.
- Implementers and funders should ensure the intervention's sustainability and provide ongoing supervision, technical support, and monitoring of the health facilities transitioning off OPTIDEL's technical support intervention.
- Finally, we recommend provincial and national ownership to facilitate scale-up.

References

Egbujie, B. A., Grimwood, A., Mothibi-Wabafor, E. C., Fatti, G., Tshabalala, A. M. E. T., Allie, S., Vilakazi, G., & Oyebanji, O. (2018). Impact of 'Ideal Clinic' implementation on patient waiting time in primary healthcare clinics in KwaZulu-Natal Province, South Africa: A before-and-after evaluation. *South African Medical Journal*, *108*(4), 311-318. https://dx.doi.org/10.7196/samj.2018.v108i4.12583

Human Sciences Research Council (HSRC). (2018). *The Fifth South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017*. Pretoria: HSRC Press.

Ideal Clinic South Africa. (2023). Retrieved December 18, 2023, from https://www.idealhealthfacility.org.za/

National Department of Health (NDoH). (2019). *Integrated Clinical Service Management Manual*. Retrieved March 12, 2021, from https://www.knowledgehub.org.za/system/files/elibdownloads/2019-07/Integrated%2520Clinical%2520Services%2520Management%2520%2520Manual%25205th%2520June%2520FINAL.pdf

South African National AIDS Council (SANAC). (2017). *National Strategic Plan 2017-2022*. Pretoria: SANAC.

Statistics South Africa. (2017). *Mid-Year Population Estimates 2017*. Retrieved April 11, 2021, from http://www.statssa.gov.za/

World Health Organization. (2009). *Making Health Systems Work: Integrated Health Services: What and Why*. Geneva: World Health Organization.

ANNEX III

POLICY BRIEF

Comprehensive Sexual and Reproductive Health Services: Findings in the Eastern Cape and KwaZulu-Natal Provinces in South Africa

Empowering Futures: Unveiling Paths to Holistic Health

Source: https://www.ippf.org/sites/default/files/2023-01/edited_tanya.jpg

February 2024

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immune deficiency syndrome
ABYM	Adolescent boys and young men
AGYM	Adolescent girls and young women
ARV	Antiretroviral drug
CBO	Community-based organization
CoGTA	Department of Cooperative Governance and Traditional Affairs
CSO	Civil society organization
DoH	Department of Health
DSD	Department of Social Development
FGD	Focus group discussion
GBV	Gender-based violence
HIV	Human immunodeficiency virus
IPV	Intimate partner violence
KAP	Knowledge, attitudes and practices
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual and non-heterosexuals
NGO	Non-governmental organization
NSP-GBVF	National Strategic Plan on Gender-Based Violence and Femicide
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
SAPS	South African Police Service
SGBV	Sexual and gender-based violence
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TCC	Thuthuzela Care Centre
UNFPA	United Nations Population Fund
UNICEF	The United Nations Children's Fund

INTRODUCTION

Adolescent girls and young women (AGYW) in the Eastern Cape and KwaZulu-Natal provinces are disproportionately impacted by health and social challenges. If unaddressed, these challenges could further exacerbate poverty, poor education, gender inequality and unemployability among this population group. The mapping of comprehensive sexual reproductive health (SRH), including human immunodeficiency virus (HIV) and gender-based violence (GBV) prevalence in Nelson Mandela Metro and Alfred Nzo (Eastern Cape) and uThukela Districts (KwaZulu-Natal), revealed concerning findings with key community informed recommendations.

In 2019, the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF) began implementing a Canadian-funded programme titled ***Empowering Women and Girls to Realize their Sexual and Reproductive Health and Rights in South Africa***. The Joint Programme was designed to achieve two outcomes:

- Increase availability and use (by adolescent girls and young women) of quality SRH, HIV and SGBV prevention and response services free of bias and discrimination in three key districts: Alfred Nzo and Nelson Mandela in Eastern Cape and uThukela in KwaZulu-Natal.
- Decrease discriminatory and harmful practices and attitudes that perpetuate and validate SGBV against AGYW and act as barriers to SRHR.

The programme is in line with the National Development Plan priorities to create a safer South Africa and ensure a healthy life for all. It specifically works with district-level service providers and communities to ensure that vulnerable AGYW (ages 15–24) are empowered to enjoy their SRHR and live free from coercion, discrimination and violence. The programme is also in line with and supports the localization of the South Africa National Strategic Plan for Gender-Based Violence and Femicide and the generation and utilization of strategic evidence to inform policies and programmes.

This policy brief summates the findings of the baseline mapping of services and knowledge, attitudes and practices (KAP) situation analysis done within the scope of implementing the Joint Programme. The primary focus of the analysis was to determine the depth and scope of GBV, SRHR, and HIV service delivery within the health and social sectors for AGYW in the three pilot districts of the Joint Programme in South Africa.

Background

In South Africa, adolescent girls and young women (AGYW) face disproportionate vulnerability, contending with alarmingly high levels of gender-based violence (GBV), a crisis exacerbated by gross underreporting owing to institutional shortcomings and various other factors.[1] This perpetuates a cycle of adverse outcomes, including heightened intimate partner violence (IPV), unintended pregnancies, and rampant sexually transmitted infections (STIs), all contributing to poor sexual reproductive health outcomes. Despite being a policy-enabling nation with progressive legislation, the translation of these laws into effective service implementation remains elusive, leaving AGYW's health needs largely unaddressed. This gap is further widened by a complex web of social, cultural, political, and economic disparities, driving the prevalence of HIV and GBV among AGYW. Tackling these entrenched issues necessitates a comprehensive, coordinated approach, engaging stakeholders across society, including parents, community members, educators, and policymakers. Such collective action is imperative to empower adolescents, ensuring their realization of sexual and reproductive health (SRH) rights and broader human rights.

Key International, Regional and National Legal Frameworks

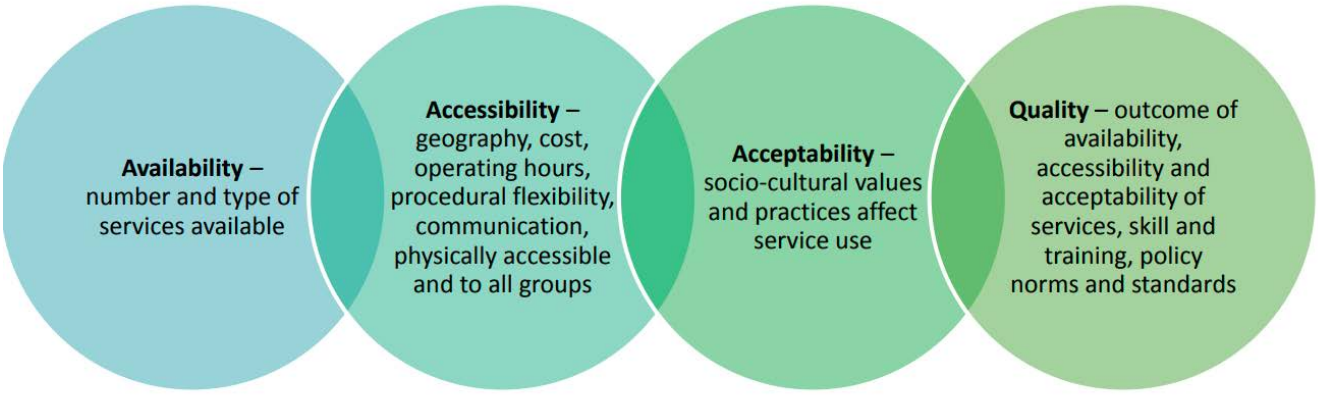
Some prominent global conventions signed by South Africa include the following:

- United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979)
- Convention on the Rights of the Child (1989)
- Convention on the Rights of Persons with Disabilities (2006)

Essentially, legally binding provisions that are laid down in these agreements have helped the South African government to be accountable for their responses to domestic violence, SRHR, forced marriage and a host of other abuses against AGYW. South Africa has made considerable contributions during international conferences. South Africa has an excellent and extensive legislative framework for protecting the rights of women and children and has made significant advancements in the fight against GBV. As such, effort should be made to ensure the effective implementation of existing ones. Adequate funds need to be directed towards combating GBV. A well-coordinated multisectoral national approach and strategy bringing together the government, civil society organizations (CSOs), non-governmental organisations (NGOs), and the private sector is crucial to the development and implementation of a clear roadmap towards combating GBV in South Africa. The South African legislative framework is unique, as it has legislated separately on several SRH services, and introduced a few protective public policy measures to safeguard their ability to make SRH decisions.

Key Findings

The main findings are presented within the AAAQ APPROACH conceptual framework as explained in the diagram below:



[1] *Naeemah Abrahams and others, "Intimate Partner Femicide in South Africa in 1999 and 2009", PLoS Med 10(4): e1001412. (2013)*

1. Availability of SRHR & HIV Services to AGYW

The Eastern Cape and KwaZulu-Natal provinces of South Africa have implemented a robust network of SRHR services that are also integral to promoting individuals' well-being and autonomy. This section explores the available SRHR services in ensuring access to comprehensive health care, reproductive rights, and gender equality.

1.1. Comprehensive Sexuality Education and Behaviour Change Interventions

Health Facilities

Nurses, who are often the frontline health-care providers, offer limited information about the range of services available to prevent pregnancy, sexually transmitted infections (STIs), and HIV. Particularly concerning is the lack of information provided on crucial services like contraception, comprehensive termination of pregnancy (CTOP), and pre-exposure prophylaxis (PrEP).

Schools – Life Orientation

The findings reveal a concerning gap in the provision of sexual and reproductive health and rights education. Only four out of nine adolescent girls and young women participating in Focus Group Discussions reported receiving SRHR/HIV education at school. Moreover, the Integrated School Health Programme (ISHP) appears to be largely inactive in schools. Resistance from schools towards implementing SRHR programmes is noted, indicating a significant barrier to comprehensive sexuality education. Community-level education and behaviour change interventions are not widespread, further limiting access to vital information.

Access to sexual and reproductive health and rights (SRHR) services in the targeted districts is hampered by various systemic obstacles. While health-care facilities and schools play a role, the availability of SRHR services remained limited, with only eight organizations offering such support across two districts, excluding Alfred Nzo. This gap in service provision underscored the necessity for external assistance. The Canadian-funded Joint Programme has been instrumental in bridging this gap, significantly enhancing the availability and accessibility of SRHR services in the region. By investing in the recruitment and training of additional social workers and expanding the provision of comprehensive life skills and psychosocial support, particularly tailored to AGYW, the programme has addressed critical gaps in the existing infrastructure. Moreover, the Canadian funding has facilitated the integration of preventive measures for GBV and enhanced decision-making support for AGYW, empowering them to navigate complex socioeconomic challenges. While biomedical services like HIV counselling, STI screening, and condom distribution are more prevalent, the introduction of services related to breast cancer prevention among AGYW represents a notable stride forward. Through the Joint Programme, youth now report increased access to vital screenings such as pap smears and breast examinations at health-care facilities, underscoring the tangible impact of the Canadian investment on SRHR outcomes in the region.

Maternal, Perinatal, and Newborn Health

Maternal, perinatal, and newborn health clinics primarily focus on child growth monitoring and the prevention of mother-to-child transmission of HIV. Hospitals are tasked with treating pregnancy-related complications, highlighting a division of labour between health-care facilities to address the multifaceted needs of AGYW during pregnancy and childbirth.

These findings underscore the significant gaps and challenges in accessing comprehensive SRHR services for AGYW. From limited information provision in health-care facilities to resistance towards SRHR education in schools and systemic barriers beyond, addressing these challenges requires a multisectoral approach. Efforts should prioritize comprehensive education, capacity-building for service providers, and addressing socioeconomic determinants to ensure equitable access to SRHR services for AGYW.

1.2. GBV Services for AGYW Survivors

Social Services

The Department of Social Development (DSD) plays a crucial role in funding shelters for GBV survivors across the Eastern Cape and KwaZulu-Natal. In the Eastern Cape, 16 shelters run by non-governmental organizations (NGOs) and 146 White Door Centres of Hope provide refuge and support. Similarly, in KwaZulu-Natal, the DSD funds 20 shelters and 16 White Door Centres of Hope. These shelters serve as safe havens for survivors of GBV, offering essential support and resources.

Prevention Programmes

Efforts to prevent GBV extend beyond shelters, with the DSD and NGOs implementing education and awareness campaigns. These programmes include GBV education initiatives and door-to-door awareness campaigns to educate communities and raise awareness about GBV. Community dialogues have emerged as an effective prevention approach, facilitating open discussions on GBV issues. Notably, the KwaZulu-Natal Christian Council (KZNCC) spearheaded a seven-month project, engaging faith-based and traditional leaders to create awareness and conduct community dialogues on GBV.

Justice and Policing Services

In terms of justice and policing services, victim-friendly rooms (VFRs) and first responder counselling services are available at South African Police Service (SAPS) stations across the project sites. For instance, there are 12 SAPS stations in Alfred Nzo, 17 in Nelson Mandela Bay Metro, and 16 in uThukela District, equipped with VFRs and Family Violence, Child Protection, and Sexual Offences (FCS) Units. Although precise data on the total number of VFRs and FCS Units is unavailable, their presence underscores efforts to provide supportive environments for GBV survivors.

Additionally, Court Preparation Officers (CPOs) operate in both provinces, providing crucial support to survivors navigating the legal system.

Integrated Services

Thuthuzela Care Centres (TCCs), coordinated by the National Prosecuting Authority's Sexual Offences and Community Affairs (SOCA) Unit, offer integrated services to GBV survivors. These centres provide a comprehensive range of services, including initial reception of the victim, medical examination, treatment for pregnancy and sexually transmitted infections (STIs), refreshments and clothing, transportation, and referrals for follow-up support. The existence of TCCs reflects a coordinated effort to provide holistic support to survivors of GBV, integrating medical, legal, and psychosocial services under one roof.

These findings highlight the multifaceted approach taken to address GBV, encompassing support services, prevention initiatives, and justice and policing efforts. While significant strides have been made in providing support and resources to GBV survivors, ongoing collaboration and investment in these services are essential to ensure comprehensive and effective responses to GBV in the Eastern Cape and KwaZulu-Natal.

2. Accessibility Of GBV, SRHR and HIV Services

Challenges Faced by Marginalized Groups

Marginalized communities, including LGBTQIA+ AGYW and sex workers, encounter discrimination from both law enforcement and health professionals. Limited access to inclusive transportation and health-care facilities further exacerbates their vulnerability. Undocumented migrants face additional hurdles, as they are unable to access services without proper identification.

Impact of COVID-19 on Access and Availability

The COVID-19 pandemic significantly disrupted the accessibility and availability of GBV, SRHR, and HIV services. Campaigns and awareness initiatives suffered due to restrictions on physical gatherings. Counselling services transitioned to telephonic sessions, while essential facilities like White Door Centres were forced to close. Regulations limiting the number of people in health-care settings affected access to contraceptives, ARVs, and PrEP, particularly in areas like Nelson Mandela Bay and uThukela.

Barriers to Accessibility

Limited knowledge and information about GBV, contraceptives, CTOP, and PreP among AGYW pose significant barriers. Geographical and financial obstacles, especially in rural areas, make accessing services challenging due to distance and transportation costs. In Nelson Mandela Bay, the threat of gang violence further complicates travel safety. Mobile clinic services are inconsistently provided, leaving many without essential care. School-going AGYW face additional hurdles, as they often miss clinic hours or find services closed by the time they are available.

Acceptability of services is hindered by stigma, discrimination, and confidentiality concerns. Cultural, traditional, and religious beliefs within communities also deter AGYW from seeking assistance, perpetuating the cycle of underutilization of available services.

Addressing the accessibility challenges in GBV, SRHR, and HIV services requires a multifaceted approach that acknowledges and addresses the specific needs of marginalized groups. Efforts to combat discrimination, improve transportation infrastructure, and enhance awareness are essential. Moreover, adapting services to the realities of the COVID-19 legacy and overcoming barriers related to knowledge, geography, and cultural norms are critical to ensuring equitable access to essential services for all individuals, regardless of their background or circumstances.

3. Quality of Services for AGYW

Clinic Services

AGYW face numerous challenges within clinic settings, including long waiting times, limited youth-friendly spaces, and inadequate privacy. Nurses' attitudes are often described as apathetic and judgmental, exacerbating discomfort and discouraging adolescent girls and young women from seeking care. Moreover, police response to GBV is perceived as inadequate, with issues often not treated seriously, further undermining trust in institutions. Privacy concerns persist for GBV survivors, sex workers, and transgender women, with reports of further assault by police officers across districts. Social workers are often overburdened and impatient, limiting their effectiveness.

Quality of GBV, SRHR, and HIV Services to AGYW

The absence of clear quality standards across various sectors, including police, justice, schools, and social development, raises concerns about service consistency and effectiveness. Staff shortages are prevalent, leading to overloaded health promotion teams and health-care workers who struggle to meet demand. While some initiatives like iloveLife.mobi incorporate feedback mechanisms, funding limitations constrain service delivery. Additionally, the lack of integrated referral systems and clear pathways complicates the process of addressing GBV cases effectively.

Integration of Services

At the clinic level, integration remains uneven, with HIV services being more well-integrated compared to GBV and SRHR services. Routine screening for GBV is lacking, leading to undetected cases. While clinics have information for referrals, the absence of clear pathways and protocols hampers effective follow-up. NGOs often have well-defined referral processes, facilitating integration between SRHR, GBV, and HIV services, but counter-referrals and follow-up remain challenges. Coordination structures, though established, face issues like poor attendance, accountability mechanisms, and interdepartmental coordination, hindering a comprehensive multisectoral response.

Making services acceptable to AGYW necessitates comprehensive reforms across various sectors. Efforts should focus on improving clinic environments, enhancing staff attitudes, and strengthening privacy protections. Clear quality standards, adequate staffing, and sustainable funding are imperative for effective service delivery. Moreover, fostering integration between different service providers and establishing robust coordination structures are essential for a cohesive response to the diverse needs of AGYW. Ultimately, ensuring acceptability requires addressing immediate challenges as well as fostering a culture of respect, inclusivity, and responsiveness within service delivery systems.

Understanding Knowledge, Attitudes, and Practices regarding SRH, HIV, and GBV Services

In 2020/2021, a baseline mapping study and a knowledge, attitudes, and practices desktop review were conducted to inform the programme's implementation.

Key guiding questions in this analysis are:

a) What is the attitude of community actors (health workers, police, justice) towards AGYW seeking GBV and SRH services?

b) What do AGYW and community actors classify as violence (physical, emotional, cyberbullying, femicide, financial, etc.)?

c) What are the attitudes of the police or justice system towards the victims of GBV, and how do attitudes impact on reporting.

Exploring the perceptions and practices of various stakeholders, from government officials to caregivers and community leaders, sheds light on critical factors influencing the accessibility and acceptability of services for adolescent girls and young women (AGYW) and adolescent boys and young men (ABYM). Here's an in-depth analysis:

1. Knowledge of SRH, HIV, GBV Service Providers

While government clinical staff demonstrate good knowledge of HIV services, gaps persist in understanding modern contraceptives and cervical screening, particularly among police personnel. This disparity can hinder effective support and response to GBV cases.

2. Attitudes and Practices by Government and CSOs Towards AGYW Seeking Services

Negative attitudes and practices are observed, including resistance to working in remote areas, breaches of confidentiality, and judgmental behaviour towards AGYW seeking contraception or termination of pregnancy (TOP). Vulnerable groups like sex workers and LGBTQIA+ individuals face mistreatment in clinics, highlighting systemic discrimination.

3. Knowledge of Caregivers on HIV, SRH, and GBV

Caregivers exhibit varying levels of knowledge across regions, with disparities in understanding HIV prevention methods and GBV definitions. While some caregivers demonstrate awareness of available services, others lack crucial information, affecting the support they can provide to AGYW and ABYM.

4. Attitudes and Practices by Broader Community on SRH, HIV & GBV

The broader community's response to GBV is concerning, with instances of condoning or perpetrating violence, including reports of rape by traditional healers and inadequate involvement of religious leaders. Political leaders and teachers' unions are implicated in covering up GBV cases, indicating systemic challenges.

5. Knowledge of AGYW & ABYM on SRH and GBV

AGYW and ABYM exhibit varying levels of understanding regarding SRH and GBV, including misconceptions about teenage pregnancy, TOP, and HIV transmission. While some demonstrate awareness of preventive measures, others hold misconceptions, which can influence their behaviour and decision-making.

6. Attitudes of AGYW & ABYM on SRHR and GBV

Perceptions vary widely among AGYW and ABYM regarding teenage pregnancy, TOP, consent in intimate relationships, and conceiving with HIV. While some advocate for informed decision-making and consent, others hold stigmatizing views or lack awareness of their rights and options.

Addressing the gaps in knowledge, attitudes, and practices surrounding SRH, HIV, and GBV requires a multifaceted approach involving comprehensive education, training, and community engagement. Efforts should focus on promoting accurate information, combating stigma and discrimination, and empowering service providers and users to ensure equitable access to quality care and support for AGYW and ABYM. Collaboration between government, civil society, and community stakeholders is essential to address systemic challenges and foster a culture of respect, inclusivity, and accountability within communities.

Key Recommendations for Improving SRH, Including HIV and GBV Services

Addressing the complex challenges surrounding SRH, HIV, and GBV requires a multifaceted approach. Here are key recommendations derived from the study:

1. Ecological Systems Approach:

- Strengthen alternative access points for SRH services, including mobile clinics and school-based programmes.

- Focus on capacity strengthening, particularly in GBV response and youth-centred approaches.
- Promote service integration to enhance efficiency and effectiveness.

2. Addressing Institutional and Cultural Barriers:

- Target institutional barriers like staffing shortages and management practices.
- Foster open SRHR conversations by addressing cultural norms and improving communication dynamics between caregivers and AGYW.
- Engage community leaders actively, including traditional leaders, healers, and religious figures.

3. Strengthening School Health Programmes:

- Enhance the Integrated School Health Programme and Life Orientation curriculum in schools.
- Provide support to school management teams and capacity strengthening for life orientation teachers.

4. Expansion of Services:

- Expand access to essential services such as PrEP, ART, contraceptives, and sanitary products.
- Conduct awareness campaigns to increase knowledge about available services.

5. Capacity Strengthening of Service Providers:

- Provide high-quality capacity-strengthening support to service providers, focusing on AGYW.
- Collaborate with organizations experienced in training health-care staff and educators.
- Incorporate wellness programmes and psychosocial support for those working with GBV survivors.

6. Strengthening Rural Outreach:

- Establish mobile clinics and telehealth initiatives to reach underserved rural communities.

7. Comprehensive Youth Programmes:

- Develop targeted SRH and HIV prevention programmes for adolescents and youths.
- Establish youth-friendly clinics with trained staff and tailored services.

8. Integration of GBV Services:

- Implement holistic approaches by integrating GBV services with existing SRH programmes.
- Enhance training for health-care providers to address survivors' multifaceted needs.

9. Health Workforce Development:

- Invest in comprehensive capacity development that includes well planned training programmes, strategies and guidance on bi-directional referrals and the optimum use of community level resource lists, plus incentives to retain skilled health-care professionals and the overall service workforce.
- Provide ongoing capacity-building initiatives for staff handling GBV cases.

10. Community Awareness Campaigns:

- Launch targeted campaigns using diverse media channels.
- Collaborate with community leaders, schools, and local organizations for grassroots initiatives.

11. Adolescent-Friendly Spaces:

- Create safe and confidential spaces within health-care facilities.
- Involve youths in the design and implementation of services.

12. Monitoring and Evaluation:

- Implement robust monitoring and evaluation systems.
- Regularly review and update policies based on community needs and challenges.
- These recommendations, when implemented effectively with the support of UNICEF, UNFPA, and local stakeholders, will contribute to a more comprehensive and accessible health-care system, ultimately improving the well-being of individuals and communities in the Eastern Cape and KwaZulu-Natal.

Conclusion

Addressing the complex challenges of SRH, HIV, and GBV in the Eastern Cape and KwaZulu-Natal requires a comprehensive approach. Through targeted interventions, including capacity strengthening, service expansion, and community engagement, we can bridge institutional and cultural barriers, ensuring equitable access to vital health-care services. Collaborative efforts between UNICEF, UNFPA, and local stakeholders are pivotal in implementing these recommendations effectively. By prioritizing the well-being of individuals and communities, we can create a more inclusive and accessible health-care system, fostering positive outcomes and improving the overall health outcomes in these regions.

DISCLAIMER

*This policy brief is for the Canadian-funded **Empowering Women and Girls to Realize their Sexual and Reproductive Health and Rights in South Africa** Joint Programme that is implemented by the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF). The Joint Programme covers the period 2019 to 2023 and focuses on strengthening district-level health and social services systems and supports communities to enable adolescent girls and young women (AGYW) to realize their sexual reproductive health and rights (SRHR) as well as prevent and address sexual and gender-based violence (SGBV), in the Alfred Nzo and Nelson Mandela districts of the Eastern Cape and the uThukela district in KwaZulu-Natal.*

ANNEX IV

Ward-Based Rapid Response Teams: An Emerging Good Practice Model for Addressing GBVF in South Africa

Gender-based violence and femicide (GBVF) pose significant challenges globally, affecting over a third of women worldwide with documented repercussions for reproductive, maternal, adolescent, and mental health. In sub-Saharan Africa, including third-world settings, there is a pronounced prevalence of gender-based violence and femicide (GBVF), necessitating urgent and effective responses. This article proposes drawing on similar successful strategies globally for the implementation of Ward-Based Rapid Response Teams (RRTs) to combat GBVF in South Africa. It emphasizes the importance of multisectoral, multi-stakeholder collaboration, incorporating screening and referral protocols within grassroots structures across all wards. Drawing from South Africa's successful grassroots-level multidisciplinary service delivery models currently operational within the broader health strategy, this model emphasizes community mobilization, collaboration among government departments, and integrated service delivery to empower local communities and address the complex challenges associated with GBVF. This article proposes the establishment of Ward-Based Rapid Response Teams (RRTs) as an effective intervention strategy and an emerging Good Practice Model to reduce and eliminate gender-based violence and femicide (GBVF) incidence at a national level.

In particular, it explores the efficacy of implementing Ward-Based Rapid Response Teams (WRRTs) within the grassroots structures of all municipal wards in South Africa to create a comprehensive response strategy to GBVF within existing socialcultural and health frameworks.

GLOBAL CONTEXT

Numerous studies globally have highlighted the prevalence of GBVF and its profound impact on women's health, both physically and mentally. A substantial body of evidence supports the assertion that GBVF is a pressing concern in various parts of the world, with implications for reproductive health, maternal well-being, and the mental health of survivors (World Health Organization, 2013). Acknowledging the global nature of GBVF, this proposed model draws inspiration from successful strategies employed in diverse regions to address this pervasive issue.

Local Challenges: In sub-Saharan Africa, including third-world settings, the challenge of GBVF is exacerbated by resource limitations and a lack of effective solutions. Localized responses are crucial in navigating the complex socio-cultural contexts that influence the prevalence of SGBV in these regions (Dunkle et al., 2004). This model seeks to address these challenges by proposing the establishment of Ward-Based RRTs, which can effectively respond to GBVF within the specific sociocultural nuances of South Africa.

An Emerging Good Practice Model: This article advocates for the establishment of Ward-Based RRTs as an emerging good practice model. The model is built on the principles of multisectoral and multi-stakeholder collaboration. Similar strategies have demonstrated success in addressing GBVF in various global contexts (Jewkes et al., 2008). By integrating screening and referral protocols into grassroots structures across all wards, the model aims to enhance survivor detection and access to comprehensive services, aligning with global evidence that supports the effectiveness of such approaches (Ellsberg et al., 2008).

This case study examines the emerging good practice of implementing the Ward-Based Rapid Response Teams (WRRT) strategy as a comprehensive approach to combat GBVF, aligning with the key criteria set forth by the World Health Organization (WHO).

KEY CRITERIA FROM WHO:

1. **Community Engagement and Participation:** (*Reference:* WHO. (2018). Community engagement: A practical guide for the World Health Organization, Geneva: World Health Organization).
   - *Description:* The WRRT model underscores the significance of engaging and empowering community members to actively participate in preventing and addressing GBVF. This involves leveraging awareness campaigns, community dialogues, and grassroots initiatives to foster gender equality, challenge harmful norms, and encourage bystander intervention.
   - Key features:
     - WRRTs have a core function to engage and empower community members to actively participate in preventing and addressing GBVF. Community leaders, Civil society Organizations, and War Room members form part of the WRRT structure.
     - WRRTs have an advocacy role that proposes the use of awareness campaigns, community dialogues, and grassroots initiatives to promote gender equality, challenge harmful norms, and encourage bystander intervention.
     - The model actively encourages the involvement of men and boys in GBVF prevention efforts both within the WRRT structures, as well as through targeted advocacy and screening initiatives in the homes, schools, community organizations and workplaces. Promoting positive masculinity, addressing harmful social norms, and providing platforms for advocacy contribute to gender equality and respectful relationships.
     - Engaging young people through school-based programmes, youth groups, and mentorship initiatives is a crucial objective of this strategy.
2. **Inter-Agency Collaboration:** (*Reference:* WHO. (2017). Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers. Geneva: World Health Organization).
   - *Description:* The heart of the WRRT model is a multisector, multi-stakeholder structure that fosters collaboration among various agencies, ensuring a coordinated and integrated response to GBVF. It is composed of representatives from 12 government departments (representing all sectors), as well as civil society organizations and community leadership, including traditional leaders. Protocols for information-sharing and joint initiatives are established to enhance the efficiency of the response. Its primary engine is designed to:
     - Drive collaboration and networking among various stakeholders involved in GBVF prevention and response.
     - Facilitate partnerships with relevant government departments, NGOs, community-based organizations, and other service providers to create a coordinated and integrated approach to addressing GBVF at the ward level.

- Work with different stakeholders to ensure that the community-based resources such as shelters for GBVF survivors are adequately equipped.

(i) Guidelines from the NSP state the following: "the active engagement of communities, including women, children and LGBTQIA+ persons in recognition of women's self-agency and own choices to end GBV and to promote survivors' access to services coordinated, intersectoral and integrated service provision specifically, in relation to housing, education, local government and economic development support, care and debriefing for all service providers, as integral for their own well-being whilst contributing to limiting any forms of secondary victimisation". (National Strategic Plan Gender-Based Violence and Femicide 11 March 2020).

3. **Survivor-Centric Approach:** (*Reference:* WHO. (2019). Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. Geneva: World Health Organization).

- *Description:* In alignment with WHO guidelines, the WRRT model prioritizes a survivor-centric approach. Trauma-informed care and counselling services are integrated into the response, ensuring the safety and well-being of survivors. A survivor-centric approach ensures that the needs and well-being of survivors guide the response mechanism. (National Strategic Plan Gender-Based Violence and Femicide 11 March 2020) which advocates the following guidelines for WRRTs:

- To ensure that every survivor of GBV has access to appropriate and sensitive response, care and support that facilitates immediate containment, medium to long term healing, and agency towards reclaiming their bodies, mental and physical health, well-being, and lives.

- The overall focus is two-fold: strengthening services and systems and improving relationships between stakeholders whilst building and bolstering resilience through harnessing the capacity of institutions, households and communities to play important roles in responding to and supporting survivors.

- All survivors should be able to access care and support services to reduce the impact of GBV **24 hours a day and seven days a week.**

- A survivor and child-centred approach to the provision of services must be applied in the provision of:

(ii) a holistic, comprehensive, consistent, confidential, equal, and equitable quality service responsive to the diverse needs of women across ages, sexual and gender diversities, including the need to provide support to their children;

(iii) a standardised core package of services by trained, skilled, compassionate, and competent staff which includes access to health and mental care, appropriate after-care services and referrals/feedback systems.

- In working towards a whole of society approach, it seeks to change the current bias that favours perpetrators to a survivor-centric approach in order to:

(i) provide a platform for survivors to express and raise their voices, thereby breaking the silence;

(ii) reduce femicide, promote norms and standards for the protection of women and girls;

(iii) provide the opportunity for integration, support and referrals (aftercare); and

(iv) promote standardization of services, and ensure that services are legislated and reflect a caring society." (National Strategic Plan Gender-Based Violence and Femicide 11 March 2020).

4. **Data Collection and Analysis:** (*Reference:* WHO. (2017). Putting women first: Ethical and safety recommendations for research on domestic violence against women. Geneva: World Health Organization).

- *Description:* The WRRT strategy seeks to employ a secure and confidential data collection system. Integral to its operation is the intention for regular analysis of collected data to help identify trends, hotspots, and gaps in service provision, aligning with WHO's emphasis on evidence-based decision-making.

- *To this end electronic data collection, reporting, and performance appraisal tools have been crafted and are pending approval and legislative compliance.*

5. **Capacity Building:** (*Reference:* WHO. (2018). Strengthening health system responses to gender-based violence in Eastern Europe and Central Asia. Geneva: World Health Organization.)

- *Description:* Capacity building serves as a foundational pillar within the framework of the Ward-Based Rapid Response Team (WRRT) strategy. The initiation of the programme and the establishment of WRRT structures across the province adopted the cascade model for capacity building. This approach led to the comprehensive training of 170 Master Trainers specifically designated for the three targeted districts currently undergoing pilot implementation. The role assigned to these Master Trainers encompassed the activation of WRRTs within their assigned wards, along with the empowerment of WRRT members through the provision of essential knowledge, information, resources, and skills. This empowerment is aimed at optimizing their functionality within the defined scope of work. Furthermore, the Master Trainers assumed responsibility for post-activation mentoring and continual capacity building, focusing on a diverse set of skills cascades.
- The skill cascades incorporated into the capacity-building initiative include:
  - **Working Effectively within Diverse Teams:** Emphasizing the importance of collaborative and inclusive team dynamics.
  - **Administrative Skills:** Equipping WRRT members with organizational and administrative competencies.
  - **Roles and Responsibilities of WRRT Office Bearers (Chairperson/Secretariat):** Clarifying the distinct functions and obligations of WRRT leadership roles.
  - **Report Writing Skills:** Enhancing proficiency in generating clear and concise reports.
  - **Electronic Data Collection/Capturing/Analysis Skills:** Providing expertise in utilizing electronic tools for efficient data management.
  - **Crisis Intervention Skills and Referral Protocols:** Training for effective response in crisis situations and the appropriate referral procedures.
  - **Basic Lay Counselling and Victim/Survivor Support:** Instilling foundational skills for providing support to victims and survivors.
  - **Communication Skills for Survivor Interaction:** Teaching effective communication strategies to engage with survivors.
  - **Case Management and Reporting Skills:** Enhancing competencies in managing cases and accurately documenting reports.
  - **Community Advocacy and Group Management:** Developing skills for community advocacy and effective group facilitation.
  - **Diversity Management:** Working with Key Population Groups: Promoting understanding and effective engagement with diverse population groups.
  - **Care of the Caregivers:** Recognizing the importance of self-care and well-being for those involved in caregiving roles.
  - **Stress Management and Self-Care:** Providing strategies for managing stress and prioritizing self-care.
  - **Regular Training Sessions on GBVF Dynamics, Trauma-Informed Care, and Legal Protocols:** Ensuring continual education on the evolving dynamics of GBVF, trauma-informed care practices, and the latest legal protocols.
- In adopting the cascade model for capacity building, the WRRT strategy not only endeavours to enhance the immediate skills of Master Trainers but also aims at the sustainable empowerment of WRRT members through ongoing mentorship and skilsl development across a diverse spectrum of critical competencies.

IN SUMMARY

The implementation of Ward-Based Rapid Response Teams exemplifies an emerging good practice in combating GBVF, aligning with key criteria outlined by the World Health Organization. This model not only engages the community but also fosters collaboration among various sectors, ensuring a survivor-centric, data-driven, and legally supported response to GBVF. This emerging good practice represents a comprehensive and adaptable model for combating GBVF at the community level. As the strategy evolves, ongoing evaluation and refinement will ensure its sustained effectiveness and relevance. As we navigate the complexities of this pervasive issue, the WBRR strategy offers a promising avenue for effective, community-based intervention.

WAY FORWARD: THE CURRENT SOUTH AFRICAN CONTEXT

For the WRRT to deliver its mandate in South Africa, the following is critical:

- The coordination of GBVF is the responsibility of the central offices at government level i.e. the Presidency: Department of Women Children, and People With Disability (at National level), Offices of the Premier: Office on the Status of Women (at Provincial level) and Mayors' Offices: Special Programmes (at local level).
  - At all these levels, there should be a multisectoral committee (including civil society), chaired by the Gender Focal Point or GBVF responsible person at that level.
  - Capacity building of these committees is essential. They need to meet on a regular basis monthly during these initial stages of implementation, and when all systems are in place, quarterly meetings will suffice.
- The Mandate lies within the scope of practice of different departments/sectors, with:
  - the Department of Social Development (DSD) assuming the lead and providing social support;

- Department of Health (DoH) responsible for clinical and health services and psychological support;
- South African Police Services (SAPS) and Department of Justice (DoJ) responsible for safety and security and prosecution of perpetrators;
- DARLD and DEDTEA responsible for economic empowerment and food security;
- SRAC for physical health and well-being;
- CoGTA for traditional and cultural support and integrated planning for the implementation of the PIP and MDIPs.

• Key roles and responsibilities of District/Local Municipalities in supporting and enhancing the effectiveness of Ward-based GBVF RRTs include:

- Leadership and Coordination:

1. Provide leadership and coordination to the Ward-based GBVF RRTs within their jurisdiction.
2. Establish and oversee the WRRTs, ensuring that they are functioning effectively and aligned to the overall objectives and strategies of the municipality.
3. Mainstream or integrate likeminded structures such as Ward AIDS Committees, Women's Forums, LGBTQIA+ Sector, Disability Forum and sector.

• Resource Allocation and Support:

1. Ensure that the Gender Focal Person is vetted to be able to work with GBVF programmes.
2. Allocate resources, including funding, personnel, and infrastructure, to support the functioning of Ward-based GBVF RRTs.
3. Ensure that the WRRTs have the necessary resources to carry out their activities, such as training and capacity-building programmes, community outreach initiatives, and awareness campaigns.
4. Ensure that the GBVF work is mainstreamed at a local level within other programmes such as HIV and AIDS, DDM, Operation Sukuma Sakhe structures and strategic plans.

• Capacity Building:

1. Facilitate capacity-building programmes for WRRT members as detailed above.
2. Work closely with other stakeholders, such as government departments, civil society organizations, and community leaders, to provide policy or other relevant updates, targeted training based on identified needs, and knowledge-sharing opportunities to WRRT members.

• Collaboration and Networking:

1. Promote collaboration and networking among various stakeholders involved in GBVF prevention and response.
2. Facilitate partnerships with relevant government departments, NGOs, community-based organizations, and other service providers to create a coordinated and integrated approach to addressing GBVF at the ward level.
3. Work with different stakeholders to ensure that the community-based GBVF referral points (including shelters such as White Door Centres) have adequate resources in the form of clothing for victims, food and privacy, and security.

• Data Collection and Monitoring:

1. Collect and analyse data related to GBVF incidents and the functioning of Ward-based RRTs.
2. Ensure that reliable data is gathered on reported cases, interventions, and outcomes to inform decision-making, monitor progress, and evaluate the effectiveness of the RRTs' activities.

• Policy Development and Implementation:

1. Contribute to the development and implementation of policies, Guidelines, and Protocols to guide the operations of Ward-based GBVF RRTs. These policies may include:
   - Standard Operating Procedures for case management,
   - Protocols for collaboration with other stakeholders, and
   - Guidelines for survivor support and referral pathways.
   (NB. Advocacy on the role of traditional courts needs urgent attention so that there are clear guidelines. Communities need to know that even if they prefer to report to the traditional courts they could also report to the civil courts).
2. Work closely with relevant government departments and community stakeholders to ensure the effective implementation of these policies.

• Community Engagement, Awareness and advocacy:

1. Engage with the community to raise awareness about GBVF and the existence of WRRTs (protecting the members of the WRRT from perpetrators that are in powerful positions).
2. Advocate for community participation, and reporting of incidents (supporting and protecting victims who have reported their cases so that they do not withdraw fearing reprisals from perpetrators and their families).
3. Facilitate community dialogues, awareness campaigns, and educational programmes to address the underlying causes of GBVF and foster a culture of gender equality and respect (this includes ensuring that the traditional ways of solving GBVF are not accepted).
4. Engage the community in offering their homes as White Door Centres and ensure the protection of such homes.

• Monitoring and Evaluation:

1. Monitor the performance and impact of Ward-based GBVF RRTs.

2. Conduct regular evaluations to assess the effectiveness of interventions,
3. Identify gaps or challenges.
4. Provide feedback for continuous improvement.

In summary, district/local municipalities have a critical role in providing leadership to support the functioning of Ward-based GBVF RRTs through leadership, resource allocation, capacity building, collaboration, data collection, policy development, community engagement, and monitoring. Their involvement is essential for creating an enabling environment that supports effective GBVF prevention and response efforts at the local level.

Albeit still in a pilot phase, the WRRT Model adheres to the criteria outlined below, used as a global benchmark to identify emerging good practice. The criteria were developed by The Organisation for Economic Co-operation and Development (OECD), an international organization that works to build better policies for better lives (OECD library).

Relevance: The intervention by the Ward-Based Rapid Response Teams (WBRR) is highly relevant to preventing the scourge of Gender-Based Violence and Femicide (GBVF). By establishing community-level response teams, the intervention addresses the immediate needs of survivors, provides a rapid and coordinated reaction to incidents, and involves the community in combating GBVF. It aligns with the urgent need for localized, efficient, and community-driven responses to GBVF.

Coherence: The intervention demonstrates a high level of coherence by aligning with the specific needs of the community. The cascade model of capacity building, the involvement of Master Trainers, and the focus on diverse skills cascades contribute to a coherent strategy. The intervention recognizes the complex and multifaceted nature of GBVF and responds with a comprehensive and integrated approach, ensuring a well-fitted response to the identified challenges.

Effectiveness: The model exhibits significant potential for effectiveness. By training Master Trainers and establishing WRRT structures, the intervention creates a mechanism for rapid and informed responses to GBVF incidents. The focus on skills cascades, community engagement, and survivor-centric approaches enhances the effectiveness of the intervention. The model's ability to activate WRRTs, capacitate members, and provide ongoing mentoring aligns with its objectives and enhances its capacity to achieve them.

Efficiency: The utilization of the cascade model for capacity building demonstrates efficiency in the use of resources. By training a cadre of Master Trainers who, in turn, train WRRT members, the intervention optimizes the use of resources. This approach ensures that expertise is disseminated widely and efficiently within the targeted districts, enhancing the overall efficiency of the intervention.

Impact: The intervention has the potential to make a substantial difference in the response to GBVF. Through the activation of WRRTs, community engagement, and the empowerment of individuals with diverse skills, the intervention aims to have a direct impact on the prevention, response, and support mechanisms related to GBVF. The focus on comprehensive training and community advocacy indicates a commitment to creating a lasting impact on communities affected by GBVF.

Sustainability: The sustainability of the intervention is promising. The emphasis on training Master Trainers and building local capacity ensures that the knowledge and skills are embedded within the community. Ongoing mentoring and capacity building contribute to the sustainability of the model by creating a system where expertise is continually developed and passed on. This approach enhances the likelihood that the benefits of the intervention will endure over time.

In summary, the Ward-Based Rapid Response Teams' proposed response to GBVF demonstrates strong alignment with the identified needs, coherence in its design, potential for effectiveness, efficiency in resource utilization, the capacity to make a meaningful impact, and promising sustainability for lasting benefits.

CONCLUSION

In conclusion, the proposed Ward-Based RRT model, inspired by successful strategies globally, offers a comprehensive and contextually relevant approach to combat GBVF in South Africa. The integration of screening and referral protocols within grassroots structures demonstrates a commitment to improving survivor detection and access to essential services. By drawing on the successes observed in diverse regions, this model aspires to contribute to the global conversation on effective strategies to address the urgent issue of GBVF.

References

- World Health Organization. (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.
- Dunkle, K. L., Jewkes, R. K., Brown, H. C., Gray, G. E., McIntryre, J. A., & Harlow, S. D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa.
- Jewkes, R., Nduna, M., Levin, J., Jama, N., Dunkle, K., Khuzwayo, N., ... & Duvvury, N. (2008). A cluster randomized-controlled trial to determine the effectiveness of Stepping Stones in preventing HIV infections and promoting safer sexual behaviour amongst youth in the rural Eastern Cape, South Africa: trial design, methods and baseline findings.
- Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., Garcia-Moreno, C., & WHO Multi-country Study on Women's Health and Domestic Violence against Women Study Team. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study
- Belcher, B. and M. Palenberg (2018), "Outcomes and Impacts of Development Interventions", American Journal of Evaluation, Vol. 39/4, pp. 478-495, https://doi.org/10.1177/1098214018765698.
- Evaluation of Health Initiatives (2009-2020), Italian Ministry of Foreign Affairs and International Cooperation, http://www.oecd.org/derec/italy/evaluation-report-of-health-initiatives-in-Bolivia-2009_2020.pdf
- Hallman, K. et al. (2018), Girl Empower Impact Evaluation: Mentoring and Cash Transfer Intervention to Promote Adolescent Wellbeing in Liberia, International Rescue Committee, https://www.rescue.org/sites/default/files/document/4346/girlempowerimpactevaluation-finalreport.pdf
- (https://www.oecd-ilibrary.org/sites/c249f611-en/index.html?itemId=/content/component/c249f611-en)
- https://www.gov.za/documents/other/national-strategic-plan-gender-based-violence-and-femicide-11-mar-2020), 2023)

ANNEX V

Advocacy and Policy Dialogues in uThukula and Alfred Nzo

Alfred Nzo: Partnering with Community Radio to Promote Condom Use

UNFPA partnered with the Alfred Nzo Community Radio Station in the Eastern Cape in a campaign to promote condom use. The radio package included two adverts boosted by eight interview slots focusing on sexual and reproductive health and rights (SRHR). Alfred Nzo Community Radio has a broad reach in the Eastern Cape, with a listenership of some 1,322,000, making it an effective community-based platform to encourage behaviour change. The ads were flighted between July and October 2020 and remain relevant.

The objective was to promote condom usage as a dual prevention method for HIV and sexually transmitted infections (STIs). While condoms are freely available at government clinics, new cases of STIs and HIV in the area remain stubbornly high.

In a study among South African youths aged 15–24, 52 per cent used a condom at their last sexual encounter, while only 33 per cent reported consistent condom use—defined as always using condoms with their most recent sexual partner.

The campaign targeted boys aged 12 and above, based on clinic data from 2022 showing that fewer boys were accessing clinic services and engaging in health prevention. It emphasised the many advantages of using condoms during sex, specifically preventing unwanted pregnancies and HIV/AIDS. It also addressed the unlawful practice of stealthing. This is the act of surreptitiously removing a condom before or during sex without the consent of the partner; a practice that deprives female partners of their rights to sexual and bodily autonomy and their right to control their sexual and reproductive choices. As such, it violates several civil and criminal laws, and young girls and women were urged to exercise their right to report it.

During the various events and focus group discussions, youth cited difficulties in accessing condoms and a lack of support from parents and teachers as among the main reasons for the poor uptake in condom use. Boys also lacked knowledge of contraceptive methods. Following the events, youth in their early 20s were able to demonstrate competencies in the correct and consistent use of condoms and proved knowledgeable about the benefits of using condoms.

When it comes to accessing condoms, many schools are opposed to the idea of distributing government-issued (free) condoms and only those schools with designated School Support Agents are permitted to stock condoms. Additionally, commercially bought condoms are expensive and beyond the reach of most young people. As part of the debate, young people suggested that taxis could carry condoms and make them accessible at taxi stops. Taxi operators expressed support for the project and subsequently received sensitization and education on contraceptives and HIV prevention methods before being linked to the nearest clinics to form part of clinic committee teams.

Youth were also engaged around the economic and social benefits of preventing STIs and HIV, as well as the positive impact on young girls being able to complete their schooling and not having to drop out due to an unplanned pregnancy.

Izigodi Model: Using Indigenous Knowledge Forums to Promote SRHR

In June 2023, UNFPA began working with community leaders in Okhahlamba, a local municipality in the uThukela district, to pilot the *Izigodi* model, an innovative approach that equips local leadership with the knowledge and skills to become champions of change in their communities. This village model seeks to incorporate and work with traditional structures to effect behaviour change that will have a positive impact on SRHR, resulting in fewer teenage pregnancies, the prevention of HIV, and a reduction in SGBV and other harmful practices.

The *Izigodi* model is being trialled for use in geographically remote communities with limited access to basic municipal services and inadequate information on how to prevent HIV and GBV and promote SRHR. Using biomedical data to get buy-in and support from community leadership, church leaders, and other stakeholders, the Izigodi model leverages local assets and indigenous knowledge systems to develop sustainable solutions. This not only addresses complex community issues but also revitalizes positive values, ethics, principles, and practices within rural, semi-urban, and farm villages.

The *Izigodi* model operates within a territorial unit that includes several *Imizi* (homesteads) under the leadership of a headman (*induna yesigodi*) who maintains order and administers justice in his village. This model recognizes the crucial role of key community stakeholders such as the *Isiqongo*, who provide leadership and guidance in preserving cultural values; the Igonso, the leader of all the young men in the village; the *Umgogodla*, the village's wise men, who offer insights on matters requiring careful consideration and cultural sensitivity; and the *Abashikishisi*—deputies to the *Igonso*. Each stakeholder plays a unique role in the functioning of the model, ensuring its success.

It is proving to be a highly effective platform for bringing all stakeholders—including professionals with expertise in health care and social work and GBV survivors—together to address deep-rooted health and societal challenges. It enjoys support at the highest political levels in the province.

The pilot programme is equipping community leaders, local indunas and the men's sector with the insight and data for positive SRH&R outcomes by resourcing and harnessing the power of local and indigenous knowledge, SRHR has received a significant boost in these communities. The now fully local leadership is on board with the need to drive social and behavioural change that will empower generations of women and girls.

ANNEX VI
A STORY OF CHANGE

Reopening of CTOP Services in Alfred Nzo District

In 2018, UNFPA began an initiative to revive CTOP services in the Alfred Nzo district of the Eastern Cape to help local women and girls who – following the cessation of these services in Alfred Nzo – were obliged to travel long distances to seek a safe, legal termination of pregnancy. In addition to the cost and inconvenience to the clients, it also strained the resources of CTOP services in neighbouring districts. To start the process of reopening the dormant facilities, UNFPA held a debriefing workshop for the providers to clarify values and understand what it would take to revive the service. Out of this emerged the need for a separate engagement with pharmacists and facility/operational management to address the feelings of isolation and overall lack of support experienced by the providers, many of whom felt highly conflicted, which led to burnout and impacted morale. Following a series of engagements with all stakeholders, the Department of Health purchased the necessary equipment and supplies to resume the service, and new and existing providers underwent further training to be able to re-open all the facilities in the region. As a result, 348 girls and women accessed the services in the three months from October to December 2022, 58 of whom were between the ages of 11 and 19. This initiative forms part of the broader implementation of the Strategic Plan on Ending Gender-Based Violence and Femicide and strengthening collective responses.

ANNEX VII

HUMAN INTEREST STORIES FROM OPTIDEL:

#1: Came to treat STI but also informed of LARC

"I am Imbali [not her real name] a 17-year-old child …. doing Grade 12 this year; I am still waiting for results. I want to be a teacher.

I am studying. Since I was born, my mother has been attending this clinic (Injisuthi) for ANC and Immunization, but in 2021, I came to treat STI, and the Sister treated me and explained to me about the importance of family planning and using condoms and discussed with me the different types of family planning methods and I chose IUCD, she explained side effects and advised me to come after 7 days for insertion.

I would never change that method because I want to study further; she inserted it in 2021 when I was doing Grade 10.

I'm happy with the method even in 2026, I will insert it again.

The service is good. I came for STI treatment, and the nurse was able to offer me family planning without judging me and also condoms".

#2: Missed information on LARC

Miss KwaMashu aged 27 and single, originally from Flagstaff in Eastern Cape, currently resides at Richmond farm in the KwaMashu area. She sought postnatal care at KwaMashu CHC after delivering on the 7th of December 2023. She mentioned she had been on Depo Provera, an injectable contraceptive initiated at Lancer's clinic. She was not informed about Long-Acting Reversible Contraceptives (LARCs). Her employment as a domestic worker posed difficulties in adhering to the three-month visits, resulting in unintended pregnancy due to her defaulting on the contraceptive schedule. The situation led to her experiencing depression as the pregnancy was unplanned.

During her delivery, she had early labour at the local level 2 hospital and was assessed on admission. However, a subsequent assessment in the morning revealed no fetal heartbeat, leading to the delivery of a Fresh Still Born (FSB). She continually expressed the distressing emotions associated with the unfortunate event.

The visit on the interview day was focused on postnatal care for the baby. She expressed regret at not having been informed about LARCs earlier, as it would have been a suitable contraceptive option given her circumstances. Despite the challenging experience, she acknowledged receiving excellent care during delivery and would wish to deliver at KwaMashu CHC in the future.

3: GBV: A key driver of teenage pregnancy and HIV

A 16-year-old female student visited the clinic accompanied by an adult female. The purpose of her visit was to undergo a pregnancy test, which yielded a negative result. Counselling was provided, and when asked about her plans, given her non-pregnant status and school attendance, she expressed her interest in contraception.

During the consultation and counselling and the use of Job Aid tools, when probing for emotional or psychological stressors, it was revealed that the accompanying adult was not the client's mother or legal guardian but rather the mother of the client's boyfriend. The client had informed her boyfriend that she was pregnant almost six months prior to deter him from pressuring her to conceive. The boyfriend, wishing to become a father, insisted on accompanying her to the clinic alongside his mother as the client's abdomen hadn't shown signs of growth.

Upon further investigation, it was disclosed that the client did not desire a child, especially since she was still in school. Her deception about the pregnancy was solely to deter her boyfriend's persistent pressure. The boyfriend's mother, aware of her 21-year-old son's desire for parenthood and cognizant of their lack of financial readiness, attempted to discourage him from his decision, recognizing the client's young age and educational pursuits.

The consulting nurse recognized both the accompanying adult female, a client who collects ART from the clinic, and the boyfriend (the adult female's son), also an ART client who is virally unsuppressed. The boyfriend's mother opposed her son's wish for fatherhood due to the girlfriend's young age and educational commitments. She supported the girl's choice to opt for contraception.

Further inquiry into the living arrangements revealed that the 16-year-old girl does not reside with her boyfriend. Additionally, the fact that the boyfriend's mother, rather than the client's legal guardian, accompanied her to the clinic raised questions. The screening for emotional or psychological stressors unveiled instances of physical abuse suffered by both the client and the boyfriend's mother at the hands of the boyfriend, who exhibits violent behaviour and intimidates them, even resorting to gun threats to get his way.

The mother is fearful of her son and struggles to ensure his adherence to antiretroviral treatment. She also supports the client during clinic visits, recognizing her as her son's girlfriend and seeking to provide her with the care and support she cannot extend to her violent son. Notably, the boyfriend was vertically infected with HIV at birth, potentially contributing to his aggression and hostility towards his mother and, subsequently, his girlfriend.

This case highlights the critical importance of integrating HIV/SRH/GBV services. It underscores how the level of the situation, particularly concerning abuse and complex relationships, might remain unexplored without comprehensive SGBV screening.

ANNEX VIII

Joint Programme Implementing Partners:

- Clowns Without Borders SA (https://cwbsa.org/)
- Doxa Youth programme (https://www.facebook.com/doxayp/)
- KwaMbele (https://kwambele.co.za)
- loveLife (https://lovelife.org.za)
- Optidel (https://optidel.org)
- Sonke Gender Justice (https://genderjustice.org.za/)
- Soul City Institute (https://www.soulcity.org.za)
- Teddy Bear Foundation (https://teddybearfoundation.org.za/)
- Wildflower (https://wildflowerprojects.co.za)

ANNEX IX

UNFPA/UNICEF JOINT PROGRAMME

Empowering Women and Girls to Realize their SRHR in South Africa

Donor: Global Affairs Canada

Full-Programme Workplan (Updated May 2021)[1]

[1] *This workplan has been updated to include: the provisions and activities completed in Year Zero (COVID-19 reprogramming year and additional allocation of 1M CAD); the specific targets to be met in the current year of implementation; the indication of activities budgeted and not budgeted; and the roles and responsibilities annex, outlining how the agencies have agreed to distribute the coordination of the activities and responsibilities.*

Programme Output 1110: Improved institutional capacity of health and social services professionals in the 3-targeted districts to provide quality age-appropriate SRHR, HIV and SGBV services, inclusive of information, education and counselling to AGYW free of bias and discriminatory practices

Performance Indicators & Targets	• Availability of the report of mapping done in the three-targeted districts (2021 target: report available) • Number of multi sectoral plans produced (2021 target: 3 plans) • Proportion of activities in the plans implemented (2021 target: 40% activities implemented) • Number of health professionals trained in 3 districts: Trainers through ToT, Doctors, Nurses (roll-out), Facility managers: (2021 target: 190 Trainers, 300 Doctors, 2000 Nurses, 100 Facility Managers) • Proportion of social services professionals and community health workers trained on youth friendly services

Activity Code	Activity Description	Lead Agency & budget holder		Y0 2020 (COVID)	Y1 2021	Y2 2022	Y3 2023
		UNFPA	UNICEF				
1111.1	**Mapping of all health and social sector stakeholders at district levels SRHR, HIV and SGBV services to AGYW conducted** - Technical support to conduct the mapping exercise. - Mapping and desktop analysis of what exists and what UNFPA and UNICEF are currently doing in the three districts (Health and Social Services). - Workshop for target setting and identification of bottlenecks. - Produce a draft district directory (in Excel format).		X	✓	✓		
1111.2	**Use mapping report to produce district directory of SGBV, SRHR and HIV services** - Dissemination and validation by the District Coordination Fora in the three districts. - Establish linkages with other SRH, SBV, LGBTIQ, initiatives. - Test out the directory with health, social services, AGYW and other stakeholders. - Design a user-friendly version of the district directory and print. - Integrate part of the district directory information in other platforms including the B-wise app.				✓		
1112.1	**District coordinating mechanism and referral pathways established** - Convene biannual provincial inter-sectoral meetings. - Leverage existing quarterly district coordination fora in all the districts to monitor progress on progress on implementation. - Produce 3 multi-sectoral plans for strengthening district-level inter-sectoral coordination structures. - Share tools on referrals that could be helpful and adopted as good practice by districts. - Use the district coordination fora to advocate for more disaggregated and better data for AGYW and referrals between services. Include community structures in planning, implementation, and monitoring of district plans. - Include community structures in planning, implementation, and monitoring of district plans.	(in uThukela and Alfred Nzo)	X (in Nelson Mandela)	✓	✓	✓	✓

Programme Output 1110: Improved institutional capacity of health and social services professionals in the 3-targeted districts to provide quality age-appropriate SRHR, HIV and SGBV services, inclusive of information, education and counselling to AGYW free of bias and discriminatory practices *contd.*							
Activity Code	**Activity Description**	**Lead Agency & budget holder**		**Y0 2020 (COVID)**	**Y1 2021**	**Y2 2022**	**Y3 2023**
		UNFPA	**UNICEF**				
1112.2	**Alignment of district plans and programmes to national policy and programmes** - Advocacy at policy level (build on GBV NSP opportunities). - Design and print district policy briefs GBV and NSP for integration and alignment with district health plans - draft policy briefs to be tabled and discussed within the District Coordination Fora. At least 1 brief to indicate findings of the mapping of services; 1 brief to indicate data gaps; other briefs to be defined as the Joint Programme develops. - Support and influence the provincial roll-out of the GBV NSP. - Technical working group to continue discussions on tools and standards to apply for service provision. - Use GBVF NSP to advocate and integrate elements in the district plans, capacitate ommunities, monitor implementation.		X	✓	✓	✓	✓
1112.	**Convene quarterly district coordination fora to monitor progress on referrals and district implementation**		X		✓	✓	✓
1113.1	**Health (UNFPA) and social service (UNICEF) professionals'case management capacity to provide SRHR, HIV and SGBV services strengthened** - UNFPA and UNICEF to harmonize the standards for case management and integration between services. - Technical consultant or IPs to facilitate capacity building workshops for health and social services professionals in all three districts. - Ongoing mentorship in line with the outcomes of the mapping, baseline study report and situational desktopreview (UNFPA for Health and UNICEF for Social Services). - Documenting human interest stories from the trainings and interviewing HCW and SS providers that can serve asrole models (IPs and/or comms).		X	✓	✓	✓	✓

Programme Output 1110: Improved institutional capacity of health and social services professionals in the 3-targeted districts to provide quality age-appropriate SRHR, HIV and SGBV services, inclusive of information, education and counselling to AGYW free of bias and discriminatory practices *contd.*							
Activity Code	**Activity Description**	**Lead Agency & budget holder**		**Y0 2020 (COVID)**	**Y1 2021**	**Y2 2022**	**Y3 2023**
		UNFPA	**UNICEF**				
1113.2 1113.3 1113.4	**Integrated and mentorship for the delivery of quality SGBV, SRH, and HIV prevention and response including the use of AYFP manual, AY policy, Clinical Handbook on Health care for women subjected to intimate partner or sexual violence by UN Women, WHO and UNFPA** - UNFPA responsible for: provision of technical supportto planning, monitor implementation, provide quality assurance and reporting for implementation to service providersfor implementation of integrated services; - UNICEF responsible for: provision of technical supportto planning, monitor implementation, provide quality assurance and reporting for community actors, Higher Education institutions, Civil Society Organizations (CSO) on integrated community services delivery. **Part of IPs work plan:** - Capacity building, ongoing support as well as datacollection for health and social service professionals on prevention and early intervention package of care, including multi-sectoral referral pathways, and provision of core packages of services the targeted districts. - Rolling out of the social work administrative standards and tools for social services professionals, which will include tracking of referrals to health care services.		X	✓ (UNICEF only)	✓	✓	✓

Programme Output 1120: Increased capacity of the health and social services data management systems (including production of disaggregated and gender -sensitive data) to inform policy making, planning, implementation, monitoring on SRHR, HIV and SGBV free of bias and discrimination and scale up pilot models to the provincial and national level

Performance Indicators & Targets	• Availability of data management systems, tools/ processes that increase efficiency (target for 2022) • Availability of the functioning integrated dashboards on SGBV, SRH and HIV in all three districts (target for 2022) • Number of district health team members and district social service professionals trained and using the dashboards (to be disaggregated by the district) (2021 target: TBD - final target: 12) • Number of the district coordination meetings where the review of data from dashboards is included in the agenda (2021 target: 6 meetings) • Number of documents produced on the good practice on district level SRH, HIV and SGBV on data management tools (2021 target: 3 documents)

Activity Code	Activity Description	Lead Agency & budget holder		Y0 2020 (COVID)	Y1 2021	Y2 2022	Y3 2023
		UNFPA	UNICEF				
1121.1	**Review of existing data management systems, tools and processes** - Mapping exercise for health and social services data management systems, tools and processes (DHIS, Social Services Data System). - Identify gaps and challenges for strengthening to inform planning and implementation.			✓ (UNICEF only)	✓ (UNICEF only)		
1122.1	**Development of dashboards, using district disaggregated data and review of existing processes to address gaps, ensure integrated evidence-based implementation and monitoring** - District validation meeting of mapping results. - Technical support on data management, development and use of dashboards. - Capacity building workshops and training. - District data review sessions for all stakeholders and programme implementers. - On-going mentoring on the developed dashboards.			✓	✓	✓	✓
1122.2	**Revise existing tools using new innovative technologies for improved quality SRH, HIV and GBV services** - Technical support to facilitate use of new technologies. - Integration of mHealth innovative solutions. - Training of staff on the tools. - Purchase of devices and adaptation of B-wise app	(only year 3)		✓	✓	✓	✓

Programme Output 1120: Increased capacity of the health and social services data management systems (including production of disaggregated and gender -sensitive data) to inform policy making, planning, implementation, monitoring on SRHR, HIV and SGBV free of bias and discrimination and scale up pilot models to the provincial and national level *contd.*							
Activity Code	**Activity Description**	**Lead Agency & budget holder**		**Y0 2020 (COVID)**	**Y1 2021**	**Y2 2022**	**Y3 2023**
		UNFPA	**UNICEF**				
1122.3	**Capacity building for various levels of end – users on the tools and dashboards** - Providing ongoing mentoring on the use of the developed dashboards for health and social services management of SGBV, SRH and HIV service delivery. - Monitor referrals and district implementation of dashboards. - Document human interest stories from the trainings and interview providers that can serve as role models.		(budgeted under 1113.3)	✓	✓	✓	✓
1124.1	**Identify national level structures and processes for high-level advocacy building on district level results and lessons learned, coordination, and reporting to structures such as SANAC AGYW technical team, She Conquers programme and the GBV NSP technical team** - Identify national level structures and processes for high-level advocacy building on district level results and lessons learned and reporting. - Dissemination of lessons learned and good practices at district, provincial and national level for possible scale up.				✓	✓	✓
1124.2 **1124.3**	**Collate quarterly district reports and human-interest stories for documentation of good practices** - Collate quarterly district reports and human-interest stories for documentation of good practices.			✓	✓	✓	✓
1124.3	**Knowledge sharing and dissemination of good practice for scale up at district, provincial and national levels.** - Convene a Symposium.					✓	

Programme Output: 1210: Increased capacity of community actors (parents, adolescent girls and young women, networks, etc.) to promote women and girls HR, SRHR, prevent SGBV and advocate with decision makers for comprehensive SGBV, SRHR and HIV services and gender equity work in the targeted districts

Performance Indicators & Targets	• Availability of situation analysis report (2021 target: available) • Existence of district-level core reference and oversight structure for SRHR, HIV and SGBV (2021 target: existing and functioning) • Training manual for community actors on SRHR and SGBV developed (2021 target: manual completed) • Number of sustained media campaigns on SRHR, HIV, SGBV and COVID targeting AGYW through the media (SABC, TV) and other channels (2021 target: 6 campaigns) • Number of beneficiaries in shelters and communities receiving sanitary dignity packs to promote menstrual health and hygiene during COVID- 19 (2021 target: 2,000 to be reached with continuous intervention over 6 months) • Availability of the action plan for the community-based interventions addressing social norms (2021 target: not applicable, initiative has to be fully functioning in year 3) • Proportion of targeted AGYW with increased knowledge on women and girls' human rights, SGBV and SRHR and gender equality (2021 target: 25%) • Number of campaigns conducted to create awareness on social behaviour change, SGBV, SRHR and gender equality (2021 target: 2 initiatives) • Number of communication platforms (radio/digital/outdoor/TV/print) utilised to promote awareness on social behaviour change, SGBV, SRHR and gender equality (2021 target: at least 6 media mentions)

Activity Code	Activity Description	Lead Agency & budget holder		Y0 2020 (COVID)	Y1 2021	Y2 2022	Y3 2023
		UNFPA	UNICEF				
1211.1 1211.2	**Commission a desktop situational analysis of knowledge, attitudes and behaviour of community actors concerning SRHR and SGBV to better understand the context and environment. Development of relevant content and training materials, toolkits and resources for community actors in relation to SRHR and SGBV also using the Essential services package for women and girls subject to violence by UN Women, UNFPA, WHO, UNDP and UNODC** - Development of Analysis of IPV among Youth (with HSRC). - Development of relevant content and training materials, toolkits and resources for community actors in relation to SRHR and SGBV. - Layout and printing of materials. - Adaptation of National guidelines for community-based interventions. - Workshop with key local stakeholders, development of the toolkit and facilitators guide, development and production of the support material. - Support for various key community SGBV structures.			✓	✓		

Programme Output: 1210: Increased capacity of community actors (parents, adolescent girls and young women, networks, etc.) to promote women and girls HR, SRHR, prevent SGBV and advocate with decision makers for comprehensive SGBV, SRHR and HIV services and gender equity work in the targeted districts *contd.*							
Activity Code	**Activity Description**	**Lead Agency & budget holder**		**Y0 2020 (COVID)**	**Y1 2021**	**Y2 2022**	**Y3 2023**
		UNFPA	**UNICEF**				
1212.1 1212.2	**(Not budgeted) Identify relevant community representatives and key stakeholders to set up a core reference and oversightstructure established at district level. Convene quarterly communitycore group reference meetings on prevention and response** - District coordination fora to include core reference and oversight structure, including AGYW			✓	✓	✓	✓
1213.1 1213.2	**Provide support for various key community SGBV structures (Traditional leaders and faith-based organizations, community-based institutions) to play an effective role on awareness, advocacy andto serve as change agents on gender equality SGBV prevention /protection, including IPV and rape.** **UNICEF: Awareness creation** - Support community-based actors to play an advocacyrole and be change agents - Create awareness campaigns through the media (SABC, TV) and other channels - Training session for adoption of National guidelinesfor community based interventions - Document human interest stories from the sessions and interview community actors that can serve as role models **Engagement of young men and boys (budgeted together with 1213.1)** - Technical support through Implementing Partners - Capacity building workshops on gender equality and GBV prevention/protection - Engage role models (celebrities) to fight GBV			✓	✓	✓	✓
1213.3	**Conduct capacity-building workshops for community actors to serve as change agents on gender equality SGBV prevention /protection, including IPV and rape** - Capacity building workshops conducted by Implementing Partners across 3 districts including implementation support of behaviour change programmes (Sinovuyo Teens and MenCare): capacity building workshops, supervision, monitoring and reporting (@ R1,500,000 per IP x 3 districts in 3 years)				✓	✓	✓

Programme Output: 1210: Increased capacity of community actors (parents, adolescent girls and young women, networks, etc.) to promote women and girls HR, SRHR, prevent SGBV and advocate with decision makers for comprehensive SGBV, SRHR and HIV services and gender equity work in the targeted districts *contd.*							
Activity Code	**Activity Description**	**Lead Agency & budget holder**		**Y0 2020 (COVID)**	**Y1 2021**	**Y2 2022**	**Y3 2023**
		UNFPA	**UNICEF**				
1214.1 1214.2	**Targeted AGYW sensitization and social behaviour change in schools, Further Education Training centres, Universities and relevant youth institutions addressing GBV and social norms that limit girls and women's control over their bodies and their rights to equality.** - Appointment of an implementing partner for provision of technical support for delivery of quality integrated SBCC and community based interventions - Roll out community/university radio social behaviour change communication and social media programme supported by interpersonal communication addressing GBV and social norms that limit girls and women's control over their bodies and their rights to equality.			✓	✓	✓	✓
1214.3	**Support established AGYW targeted clubs and safe spaces in school and out of school to play an effective role on SGBV prevention /protection.** - Activity has no budget and the technical work included in the KAP Analysis instead.			✓			
Additional Activity - COVID support	**Support Implementation of the Sanitary Dignity Framework (MHM) in the context of COVID-19** - Distribution of sanitary pads connected to MHM interventions in the key districts (2020 onwards) - Provision of PPEs for key sectors in the context of COVID-19 outbreak (2020 only)			✓	✓	✓	✓

Annex - Detailed roles and responsibilities in the Joint Programme

Roles	Responsibilities	Agency
Convening Agency (CA)		
	• Coordinates the Joint Programme, coordinates and compiles annual work plans and narrative reports, coordinates monitoring of annual targets, calls and reports on Steering Committee meetings, facilitates audits and evaluation, and reports back to the Steering Committee; may be involved in resource mobilization • Involved in day-to-day coordination, but does not hold any financial or programmatic accountability	UNFPA
Administrative Agent (AA)		
	• Receives donor contributions, disburses funds to Participating UN Organizations based on Steering Committee instructions, and consolidates periodic financial reports and final financial report.	UNFPA
Participating UN Agencies (PUNOs)		
	• UN organizations that participate in the Joint Programme. • Operate in accordance with their own regulations, rules, directives and procedures • Assume full programmatic and financial accountability for funds disbursed by the AA	UNICEF & UNFPA
Overall Technical Responsibility on Health Services training		
	• Implements and oversees all the activities related to health/training and mentorship of health professionals. • Hire/oversee partners working on improvement of health services in all three districts. • Report back to the TWG on a monthly basis for overall coordination.	UNFPA
Overall Technical Responsibility on Social Services		
	• Implements and oversees all the activities related to social protection/training and mentorship of social services professionals. • Hire/oversee partners working on improvement of social services in all three districts. • Report back to the TWG on a monthly basis for overall coordination.	UNFPA
Joint Technical Responsibility on GBV		
	• Joint technical support and oversight of GBV at National, Provincial and District Levels. • Development and adaptation of UN Standards and Guidelines to the country and local contexts. • Report back to the TWG on a monthly basis for overall coordination.	UNICEF & UNFPA

Annex - Detailed roles and responsibilities in the Joint Programme *contd.*

Roles	Responsibilities	Agency
District of u81Thukela- Programmatic Coordination		
	• Coordinate and monitor progress of partners and work on the ground, ensuring smooth implementation. • Liaise with district authorities and stakeholders, conveying the value and contribution of the Joint Programme and capturing their perceptions and needs; • Convene and document the District Coordination Meetings, and ensure the follow-up actions are implemented and reported on. • Report back to the TWG on a monthly basis for overall coordination.	UNFPA
District of Alfred Nzo- Programmatic Coordination		
	• Coordinate and monitor progress of partners and work on the ground, ensuring smooth implementation; • Liaise with district authorities and stakeholders, conveying the value and contribution of the Joint Programme and capturing their perceptions and needs; • Convene and document the District Coordination Meetings, and ensure the follow-up actions are implemented and reported on. • Report back to the TWG on a monthly basis for overall coordination.	UNFPA
District of Nelson Mandela Metro - Programmatic Coordination		
	• Coordinate and monitor progress of partners and work on the ground, ensuring smooth implementation; • Liaise with district authorities and stakeholders, conveying the value and contribution of the Joint Programme and capturing their perceptions and needs; • Convene and document the District Coordination Meetings, and ensure the follow-up actions are implemented and reported on. • Report back to the TWG on a monthly basis for overall coordination.	UNFPA

ANNEX X

UNFPA/UNICEF Joint Programme
Empowering Women and Girls to Realize their SRHR in South Africa
Donor: Global Affairs Canada

Full-Programme Indicative Budget & Distribution Plan (Updated May 2021*)
in Canadian Dollars (CAD)

Activity Code	Activity Description	Lead Agency & Budget Holder	Indicative Budget in CAD							
			Y0 2020 COVID-19		Y1 2021		Y2 2022		Y2 2022	
			UNFPA	UNICEF	UNFPA	UNICEF	UNFPA	UNICEF	UNFPA	UNICEF
1111.1	Mapping of all health and social sector stakeholders at district levels SRHR, HIV and SGBV services to AGYW conducted	UNICEF	$14 951,00	$58 441,00	$-	$58 441,00	$-	$-	$-	$-
1111.2	Use mapping report to produce district directory of SGBV, SRHR and HIV services	UNFPA	$24 820,65	$-		$-	$-	$-	$-	$-
1112.1	District coordinating mechanism and referral pathways established	Both	$-	$-	$30 955,58	$-	$22 223,97	$-	$-	$-
1112.2	Alignment of district plans and programmes to national policy and programmes	Both	$20 000,00	$-	$56 608,00	$-	$8 304,00	$-	$-	$-
1112.3	Convene quarterly district coordination fora to monitor progress on referrals and district implementation	Both	$-	$-	$27 464,42	$-	$42 029,33	$-	$-	$-
1113.1	Health (UNFPA) and social service (UNICEF) professionals' case management capacity to provide SRHR, HIV and SGBV services strengthened	Both	$-	$41 348,00	$30 956,66	$82 696,00	$15 478,33	$47 848,00	$-	$-
1113.2 1113.3 1113.4	Integrated and mentorship for the delivery of quality SGBV, SRH, and HIV prevention and response including the use of AYFP manual, AY policy, Clinical Handbook on Health care for women subjected to intimate partner or sexual violence by UN Women, WHO and UNFPA	Both	$-	$150 000,00	$128 116,66	$66 087,50	$64 058,33	$66 087,50	$-	$-
1121.1	Review of existing data management systems, tools and processes	Both	$-	$-	$16 609,00	$-	$-	$-	$-	$-
1122.1	Development of dashboards, using district disaggregated data and review of existing processes to address gaps, ensure integrated evidence-based implementation and monitoring.	UNICEF	$-	$-	$-	$33 771,00	$-	$-	$-	$-

Activity Code	Activity Description	Lead Agency & Budget Holder	Indicative Budget in CAD							
			Y0 2020 COVID-19		Y1 2021		Y2 2022		Y2 2022	
			UNFPA	UNICEF	UNFPA	UNICEF	UNFPA	UNICEF	UNFPA	UNICEF
1122.2	Revise existing tools using new innovative technologies for improved quality SRH, HIV and GBV services	Both	$-	$-	$-	$30 000,00	$24 913,00	$7 647,00	$-	$-
1122.3	Capacity building for various levels of end –users on the tools and dashboards	UNICEF	$-	$-	$-	$-	$-	$-	$-	$-
1124.1	Identify national level structures and processes for high-level advocacy building on district level results and lessons learned, coordination, and reporting to structures such as SANAC AGYW technical team, She Conquers programme and the GBV NSP technical team.	UNFPA	$-	$-	$43 159,32	$-	$21 579,66	$-	$-	$-
1124.2 1124.3	Collate quarterly district reports and human-interest stories for documentation of good practices	UNICEF	$-	$-	$-	$13 287,00	$-	$6 643,50	$-	$5 755,93
1124.3	Knowledge sharing and dissemination of good practice for scale up at district, provincial and national levels.	UNFPA	$-	$-	$-	$-	$41 672,00	$-	$-	$-
1211.1	Commission a desktop situational analysis of knowledge, attitudes and behaviour of community actors concerning SRHR and SGBV to better understand the context and environment.	UNICEF	$-	$59 653,00	$-	$59 653,00	$-	$-	$-	$-
1211.2	Development of relevant content and training materials, toolkits and resources for community actors in relation to SRHR and SGBV also using the Essential services package for women and girls subject to violence by UN Women, UNFPA, WHO, UNDP and UNODC.	UNFPA	$100 000,00	$-	$152 522,00	$-	$-	$-	$-	$-
1212.1 1212.2	(Not budgeted) Identify relevant community representatives and key stakeholders to set up a core reference and oversight structure established at district level. Convene quarterly community core group reference meetings on prevention and response.	Both	$-	$-	$-	$-	$-	$-	$-	$-
1213.1 1213.2	Provide support for various key community SGBV structures (Traditional leaders and faith-based organizations, community-based institutions) to play an effective role on awareness, advocacy and to serve as change agents on gender equality SGBV prevention / protection, including IPV and rape.	UNICEF	$100 000,00	$15 000,00	$-	$125 110,00	$-	$125 109,00	$-	$-

Activity Code	Activity Description	Lead Agency & Budget Holder	Indicative Budget in CAD							
			Y0 2020 COVID-19		Y1 2021		Y2 2022		Y2 2022	
			UNFPA	UNICEF	UNFPA	UNICEF	UNFPA	UNICEF	UNFPA	UNICEF
1213.3	Conduct capacity-building workshops for community actors to serve as change agents on gender equality SGBV prevention /protection, including IPV and rape	UNICEF	$-	$-	$-	$91 739,66	$-	$183 479,32	$-	$-
1214.1 1214.2	Targeted AGYW sensitization and social behaviour change in schools, Further Education Training centres, Universities and relevant youth institutions addressing GBV and social norms that limit girls and women's control over their bodies and their rights to equality.	UNFPA	$-	$-	$56 793,24	$-	$90 073,00	$-	$-	$-
1214.3	(Not budgeted) Support established AGYW targeted clubs and safe spaces in school and out of school to play an effective role on SGBV prevention /protection.	UNICEF	$-	$-	$-	$-	$-	$-	$-	$-
New - COVID	Support Implementation of the Sanitary Dignity Framework (MHM) in the context of COVID-19	UNFPA	$214 000,00	$-	$184 650,00	$-	$-	$-	$-	$-
Total programmable amounts			**$473 771,65**	**$324 442,00**	**$727 834,88**	**$560 785,16**	**$330 331,62**	**$436 814,32**	**$-**	**$5 755,93**
			$798 213,65		**$1 288 620,04**		**$767 145,94**		**$5 755,93**	
			Programmable Y0 COVID		**Programmable Y1 2021**		**Programmable Y2 2022**		**Programmable Y3 2023**	

Summary	Y0 COVID 2020	Y1 2021	Y2 2022	Y3 2023
Programmable	$798 213,65	$1 288 620,04	$767 145,94	$5 755,93
Management UNFPA & UNICEF	$127 020,00	$1 046 522,00	$530 819,00	$524 922,00
Overhead Costs (both agencies, 7% over Programmable + Management)	$64 766,36	$163 459,94	$90 857,55	$37 147,46
AA Costs (UNFPA, 1% over tranche total)	$10 000,00	$24 986,02	$14 028,51	$5 735,61
Overall Total	**$1 000 000,00**	**$2 523 588,00**	**$1 402 851,00**	**$573 561,00**

Summary	COVID-19 Tranche (2020)	1st Tranche	2nd Tranche	3rd Tranche	
UNICEF Tranche	$393 776,05	$1 066 271,22	$700 504,73	$239 270,12	
UNFPA Tranche	$596 223,95	$1 432 330,76	$688 317,75	$328 555,27	
AA Costs (UNFPA, 1% over tranche total)	$10 000,00	$24 986,02	$14 028,51	$5 735,61	
Overall Total	**$1 000 000,00**	**$2 523 588,00**	**$1 402 851,00**	**$573 561,00**	
	1 000 000,00	2 523 588,00	1 402 851,00	573 561,00	5 500 000,00

*All amounts are listed in Canadian Dollars (CAD). This version of the budget brings together the original Joint Programme tranches together with the COVID-19 budget provisions that were added in 2020. Due to some activities having been carried out in the Year Zero (2020) of the Joint Programme, the budget lines for the remaining years have been in some cases revised to avoid duplication of costs, as well as to allocate resources for priority areas that emerged after COVID. The budget distribution between activities was slightly adjusted to contemplate the current scenario and challenges/areas of focus


UNFPA


unicef
for every child


In partnership with
Canada