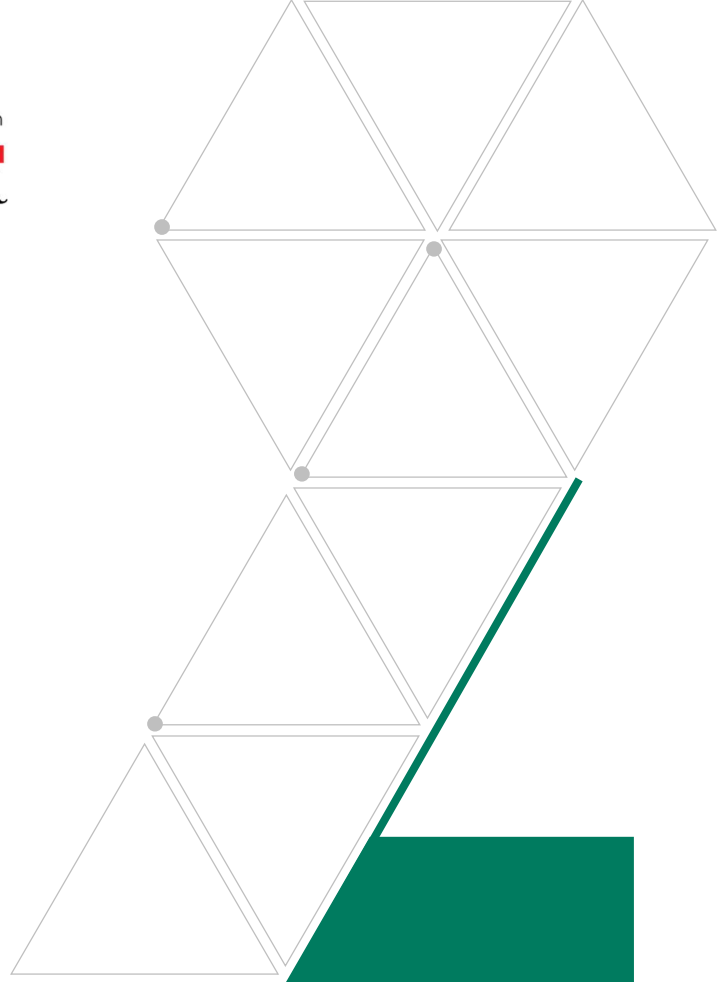




PROJECT RESULTS REPORT



PO: 7432160
Project #: P008372

TOGETHER

UNITING TOWARDS GENDER EQUALITY FOR ENJOYMENT OF WOMEN'S AND GIRLS' TOTAL HEALTH AND RIGHTS

Reporting Period
01.04.2022 - 31.03.2023

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I OUTCOMES ACHIEVED — PROGRESS ON EXPECTED OUTCOMES

1.1 ULTIMATE OUTCOME 1000

1000 Increased enjoyment of health-related rights by the most marginalized adolescent girls, women and U5 children with intersecting identities in indigenous, remote or resettlement settings in Cambodia, Kenya, Philippines and Uganda.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1000a: % of women aged 15-19 who have begun childbearing	All: 24.65% Ca: 16.44% Ke: 41.50% Ph: 4.55% Ug: 33.77%	N/A	All: 22.86 % (147/643) Ca: 23.4% (33/141) Ke: 39.18% (67/171) Ph: 6.86% (12/175) Ug: 22.44% (35/156)	All: 15.8% Ca: 12.20% Ke: 25% Ph: 2% Ug: 24%	Mobile Household Survey (MHS)
This indicator result was calculated by taking the number of women age 15-19 who answered Yes to being ever pregnant divided by the number of women aged 15-19 surveyed.					

According to the Y2 survey findings, 22.86% of women aged 15-19 have begun childbearing. Compared to the baseline result of 24.65%, this represents a slight overall reduction in the prevalence of pregnancy among adolescent girls. The reduction is specifically due to the results from Kenya and Uganda, which unfortunately was partially offset by an increase in pregnancy rates in Cambodia and the Philippines.

In Cambodia, there has been an increase in the percentage of 15-19-year-old women who have started childbearing from 16.4% at baseline to 23.4% in Y2, which is not favorable for the project outcome. This is particularly concerning as the national rate has decreased to 9.3% according to the Cambodia Demographic and Health Survey 2021-22. The survey also shows that pregnancies are more common in rural areas where the project is focused, and that the percentage of women aged 15-19 who have been pregnant decreases with increasing education levels. The rise in young women starting childbearing in Y2 is alarming. It is possible that the lack of information regarding sexual and reproductive health rights and family planning could be the reason for the rise in the proportion of young women aged 15 to 19 who have already begun having children. The project is being implemented in three phases in Cambodia. Phase I is being extended through September 2023 to catch up with the delay. The project's efforts in the community, including SRH training and campaigns, aim to reduce unintended pregnancies in Kampong Thom, Preah Vihear, and Stung Treng. Social networking and mobile awareness campaigns are being considered to reach those who cannot attend behavior change campaigns. Door-to-door education outreach was also deployed to compensate for missed training sessions, while advocacy research is being conducted to challenge cultural taboos on early marriage, family planning, and to delay childbirth in adolescent girls and young women. The project has expanded collaboration with local vocational institutions and referred young women to vocational institutions where they are supported with relevant skill training to achieve their goals and will continue to link them with training opportunities through youth groups.

In Kenya, according to the Y2 survey findings, 39.18% of women aged 15-19 began having children in Y2, which is a decrease from the initial 41.5% at the project's start. However, this figure remains very high as compared to the national average of 14.9% and the Turkana County average of 18.5%. The project's survey found that Lopur has the highest percentage of 15-19-year-old women who have begun childbearing at 52.5%, followed by Kakuma at 50.94% and Kalobeyei at 30.4%. The project's life skills and evidence-based program H&M trainings and awareness-raising messages could have contributed to

a decrease in adolescent pregnancy rates, particularly among those aged 15 to 19 years. The campaigns against early marriages and unintended pregnancies have also been effective in lowering the prevalence of pregnancy. However, over 52% of 15-19-year-old women who have begun childbearing have no formal education, highlighting the need to intensify interventions for out-of-school adolescents, particularly those who dropped out of school between the ages of 10 to 14. To aid understanding, messages aimed to reach women ages 15-19 should be tailored to their low literacy level. The project aims to provide support and increase awareness raising to these young women to delay childbearing and continue their education or seek support to enroll in tertiary institutions.

In the Philippines, there was a slight increase in the percentage of women aged 15-19 who began childbearing in Y2, with the figure standing at 6.86%, about 2 percentage points higher than the baseline rate of 4.55%. Despite a downward trend in national adolescent pregnancy rates, the Y2 results were comparable to the national average (5.4%) but almost three times higher than regional rate (2.4%). However, in some areas like Buhi and Ocampo municipalities, and among those who spoke minority languages, there was a decrease in the proportion of reported pregnancies in Y2 compared to the baseline. While this decrease was not statistically significant, it could indicate a positive impact from project activities. There was an increase in the indicator measurement for most subgroups, but there was a notable doubling of the proportion of females aged 15-19 who began childbearing among members of minority religions, recent immigrants, and residents of remote communities. This suggests the need for more targeted efforts to reach these subgroups and address their unique challenges. In Garchitorena and Siruma municipalities, where zero pregnancies were reported at baseline, there was a shift that could indicate an increase in unintended pregnancies requiring intervention, or it could be a result of increased awareness and willingness to respond truthfully to the survey question due to the project's awareness raising.

According to the Y2 survey results, 22.44% of women aged 15-19 in Uganda have started bearing children as compared to 33.77% at baseline. The district of Agago experienced the most significant decrease, dropping from 34% to 14.63%, followed by Kitgum from 42.86% to 30.19%, Lamwo from 30.56% to 20%. Unfortunately, there has been a slight increase in the number of 15- to 19-year-old women who have begun childbearing in Pader from 21.74% to 21.88%. Reports indicate that pregnancy often occurs at a young age in Uganda. World Vision's 2022 case study reveals that pregnancies spiked during the Covid-19 pandemic. Moreover, the Local Council 5 (LCV) Vice Chairperson of Pader District reported that around 85 girls aged 12 to 15 became pregnant between September and December 2022, corroborating the Y2 findings. In March 2023, during a Village Saving Loan Association (VSLA) training of Female Champion Groups (FCGs) in Omiya Anyima sub-county of the Kitgum district, unintended pregnancy was ranked among the top three issues that the community must address. The significant decrease from baseline in the percentage of women aged 15 to 19 who have begun childbearing requires further study to identify contributing factors. The effort to get females back to school after Covid and the project's coordinated initiatives to educate communities about safe motherhood, keeping children in school, and responsible parenting may have contributed to the decline. Additionally, involving local cultural, religious, and opinion leaders in addressing early marriages in the community could have reduced the prevalence of pregnancy among adolescents.

In terms of governance, the project in Cambodia collaborated with responsibility holders, primarily the government at the national and sub-national levels, to advocate for the reduction of unintended pregnancies among adolescent girls, particularly through the Project Coordination Committee (PCC) and CoLMEAL Management Committees (CMC), which are comprised of representatives from various groups of people in the community and the government departments. In terms of innovation, in Kenya, an innovative approach to implementing various awareness raising activities was used, which includes songs, dances, and drama to convey messages to peers and community members. Personal experiences are incorporated to enhance practical learning and make the sessions more relatable. In terms of Gender Equality, the project in the Philippines highlights the use of a gender-sensitive approach to address gender inequality and gender-based barriers that contribute to differences in pregnancy rates among respondents. This approach ensures that all individuals have access to reproductive health services and can make informed decisions about their reproductive health. Similarly, in Uganda, the project aims to educate both in-school and out-of-school youths aged 10-20 years in the targeted communities about 21st century skills such as negotiation, gender, SRHR, and SGBV, which improves their self-confidence when it comes to seeking, accessing, and utilizing SRHR, SGBV, and health services. Additionally, the project offers training to HC staff, CHVs, and other duty-bearers to address quality concerns at the service provision level and provide women-centred, safe, and inclusive care and counselling on SRHR and SGBV.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1000b: Proportion of women (and men) aged 15-24 years who were married or in a union before age 15 (18) years (by sex, age)	Total: <i>Before 15</i> 15-19 F: 0.87% 20-24 F: 2.26% 15-19 M: 0.34% 20-24 M: 0.53% Non-binary: 0% Total: 0.99%	N/A	Total: <i>Before 15</i> 15-19 F: 0.93% (6/644) 20-24 F: 1.15% (7/611) 15-19 M: 0.17% (1/605) 20-24 M: 1.08% (6/557) 15-24 Non-binary: 0% (0/4) Total: 0.83% (20/2423)	Total: <i>Before 15</i> 15-19 F: 0.60% 20-24 F: 1.83% 15-19 M: 0.22% 20-24M: 0.41% Total: 0.77%	Mobile Household Survey (MHS)
	<i>Before 18</i> 15-19 F: 17.22% 20-24 F: 36% 15-19 M: 3.92% 20-24 M: 9.19% Non-binary: 0% Total: 16.44%		<i>Before 18</i> 15-19 F: 18.63% (120/644) 20-24 F: 35.19% (215/611) 15-19 M: 4.46% (27/605) 20-24M: 8.8% (49/557) 15-24 Non-binary: 0% (0/4) Total: 16.96% (411/2423)	<i>Before 18</i> 15-19 F: 11.50% 20-24 F: 24.50% 15-19 M: 3.08% 20-24M: 6.54% T: 11.41% Total: 12.18%	
	Ca: <i>Before 15</i> 15-19 F: 0.69% 20-24 F: 0.69% 15-19 M: 0% 20-24 M: 0%		Ca: <i>Before 15</i> 15-19 F: 0.0% (0/141) 20-24 F: 0.71% (1/140) 15-19 M: 0% (0/144) 20-24 M: 0.0% (0/144) Total: 0.18% (1/569)	Ca: <i>Before 15</i> 15-19 F: 0.69% 20-24 F: 0.69% 15-19 M: 0% 20-24 M: 0%	
	<i>Before 18</i> 15-19 F: 18.62% 20-24 F: 40% 15-19 M: 2.07% 20-24 M: 4.83%		<i>Before 18</i> 15-19 F: 27.66% (39/141) 20-24 F: 49.29% (69/140) 15-19 M: 2.08% (3/144) 20-24 M: 4.17% (6/144) Total: 20.56% (117/569)	<i>Before 18</i> 15-19 F: 14% 20-24 F: 30% 15-19 M: 1.3% 20-24 M: 3.6%	
	Ke: <i>Before 15</i> 15-19 F: 2.72% 20-24 F: 7.64% 15-19 M: 1.38% 20-24 M: 2.14%		Ke: <i>Before 15</i> 15-19 F: 2.34% (4/171) 20-24 F: 0.56% (1/178) 15-19 M: 0.66% (1/152) 20-24 M: 1.34% (2/149) Total: 1.23% (8/652)	Ke: <i>Before 15</i> 15-19 F: 1.72% 20-24 F: 6.64% 15-19 M: 0.86% 20-24 M: 1.64%	
	<i>Before 18</i> 15-19 F: 26.53% 20-24 F: 46.53% 15-19 M: 9.66% 20-24 M: 23.57%		<i>Before 18</i> 15-19 F: 26.9% (46/171) 20-24 F: 41.57% (74/178) 15-19 M: 9.87% (15/152) 20-24 M: 16.78% (25/149) Total: 24.54% (160/652)	<i>Before 18</i> 15-19 F: 15% 20-24 F: 25% 15-19 M: 9.02% 20-24 M: 18.57%	
	Ph: <i>Before 15</i> 15-19 F: 0% 20-24 F: 0% 15-19 M: 0% 20-24 M: 0%		Ph: <i>Before 15</i> 15-19 F: 0.0% (0/175) 20-24 F: 3.27% (5/153) 15-19 M: 0.0% (0/159) 20-24 M: 3.13% (4/128) Non-binary 15-24: 0% (0/4) Total: 1.45% (9/619)	Ph: <i>Before 15</i> 15-19 F: 0% 20-24 F: 0% 15-19 M: 0% 20-24 M: 0%	
<i>Before 18</i>	<i>Before 18</i>	<i>Before 18</i>			

	15-19 F: 3.03% 20-24 F: 11.72% 15-19 M: 0% 20-24 M: 1.54% Ug: <i>Before 15</i> 15-19 F: 0% 20-24 F: 0.71% 15-19 M: 0% 20-24 M: 0% <i>Before 18</i> 15-19 F: 19.21% 20-24 F: 46.21% 15-19 M: 3.92% 20-24 M: 6.62%		15-19 F: 8.57% (15/175) 20-24 F: 10.46% (16/153) 15-19 M: 1.26% (2/159) 20-24 M: 3.13% (4/128) Non-binary 15-24: 0% (0/4) Total: 5.98% (37/619) Ug: <i>Before 15</i> 15-19 F: 1.27% (2/157) 20-24 F: 0% (0/140) 15-19 M: 0% (0/150) 20-24 M: 0% (0/136) Total: 0.34% (2/583) <i>Before 18</i> 15-19 F: 12.74% (20/157) 20-24 F: 40% (56/140) 15-19 M: 4.67% (7/150) 20-24 M: 10.29% (14/136) Total: 16.64% (97/583)	15-19 F: 2% 20-24 F: 2% 15-19 M: 0% 20-24 M: 0% Ug: <i>Before 15</i> 15-19 F: 0% 20-24 F: 0% 15-19 M: 0% 20-24 M: 0% <i>Before 18</i> 15-19 F: 15% 20-24 F: 41% 15-19 M: 2% 20-24 M: 3%	
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This indicator was calculated by:

Early marriage before 15 years old

- Women 15-19: The number of women age 15-19 who answered Yes to being ever married or entered into a union before the age of 15 years old divided by the total number of interviewed 15-19 years old women
- Women 20-24: The number of women age 20-24 who answered Yes to being ever married or entered into a union before the age of 15 years old divided by the total number of interviewed 20-24 years old women
- Men 15-19: The number of men age 15-19 who answered Yes to being ever married or entered into a union before the age of 15 years old divided by the total number of interviewed 15-19 years old men
- Men 20-24: The number of men age 20-24 who answered Yes to being ever married or entered into a union before the age of 15 years old divided by the total number of interviewed 20-24 years old men

Early marriage before 18 years old

- Women 15-19: The number of women age 15-19 who answered Yes to being ever married or entered into a union before the age of 18 years old divided by the total number of interviewed 15-19 years old women
- Women 20-24: The number of women age 20-24 who answered Yes to being ever married or entered into a union before the age of 18 years old divided by the total number of interviewed 20-24 years old women
- Men 15-19: The number of men age 15-19 who answered Yes to being ever married or entered into a union before the age of 18 years old divided by the total number of interviewed 15-19 years old men
- Men 20-24: The number of men age 20-24 who answered Yes to being ever married or entered into a union before the age of 18 years old divided by the total number of interviewed 20-24 years old men

The Year 2 survey reveals that 0.83% of women and men aged 15 to 24 were married or in a union before the age of 15, while 16.96% were married or in a union before turning 18. The result for those who were married before turning 15 indicates a slight decrease from the previous baseline with 0.99% and a slight increase for those married before 18 with 16.44% at baseline.

Data from Cambodia indicate that no 15-19-year-old women or men were married or in a union before they turn 15 as compared to the baseline data, which indicated that 0.69% of 15-19-year-old women were married or in a union at baseline. While no 20-to-24-year-old males have reported being married before the age of 15, 0.71% of women have been married or in a union which showed a similar result at baseline with 0.69%. However, data revealed that 27.66% of 15-19-year-old women reported being married or in a relationship before the age of 18, which represented a significant increase from the recorded baseline of 18.62%. The result for males aged 15 to 19 almost remained unchanged from 2.07% at baseline to 2.08% in Y2. In Y2, the data for males aged 20 to 24 showed a decline from the baseline rate of 4.83% to 4.17%. However, the data for females aged 20 to 24 have significantly increased from 40% at baseline to 49.29%. Historically, Cambodian traditions permitted marriages at 14, but this was changed to 16 to increase the family labor force and procreation. Poverty, cultural attitudes, engaging in sexual activity, and other factors may contribute to early marriage, particularly for women who are

often expected to marry and have children. To address this issue, the project will continue to work with support structures such as the Commune Committee for Women and Children (CCWC), the Commune Council (CC) facilitator, Youth Champions, and the Village Health Support Group. Additionally, the production and dissemination of behavior-changing materials like videos, songs, and banners will be encouraged. Future research should also focus on identifying the key factors that contribute to early marriage and strategies for assisting vulnerable adolescent females, particularly those living in remote or indigenous communities.

In Kenya, the survey reveals that 2.34% of women and 0.66% of men aged 15 to 19 were married or in a union before the age of 15, which represents a minor decline from the baseline figures of 2.72% and 1.32%, respectively. In addition, 0.56% of women and 1.34% of men aged 20-24 were married or in a relationship before the age of 15, compared to 7.64% and 2.14% at baseline, indicating a decline in early marriage. Additionally, 26.90% of women and 9.87% of men aged 15-19 were married or in a union before the age of 18, indicating an insignificant rise from the baseline proportion of 26.53% of women and 9.66% of men who reported being married or in a union before the age of 18. In the age group of 20 to 24 years, 41.57% of women and 16.78% of men were married before the age of 18, representing a decrease from the baseline proportions of 46.53% of women and 23.57% of men who reported being married or in a union. The decrease in early marriages and unions among women and men aged 15-24 years can be attributed to various efforts by the project, including life skills training, Program H&M training, and awareness campaigns in the project target areas. Through these initiatives, project staff, life skills educators, champions, and local leaders have raised awareness about the negative impact of early marriages and unintended pregnancies on adolescent girls and boys. As a result, many young people may have chosen to pursue career opportunities and higher education instead of getting married early. Moreover, ongoing awareness programs on tapping available opportunities and education mentorship programs have also contributed to this positive change. To further reduce early marriage in Kenya, the project will focus on engaging male champion groups to target boys and men as agents of change in the community. By advocating for a more equitable, healthy, and delayed marriage of girls, they can help intensify efforts to reach more men and boys. Additionally, the project will include more women aged 15-24 years in community engagement campaigns aimed at reducing the rate of unintended pregnancy and early marriage.

In the Philippines, no 15-19-year-old women or men have reported being married or in union prior to the age of 15. However, 3.27 % of 20- to 24-year-old females are married or in union, which is an increase from the baseline figure of zero. Similarly, 3.13 % of men aged 20 to 24 reported an increase from zero at the beginning of the project. In addition, 8.57 % of 15-19-year-old women and 1.26 % of 15-19-year-old men have reported being married before the age of 18, indicating an increase from the baseline of 3.03 % for women and zero percent for men. In Y2, the percentage of 20-24-year-old females slightly decreased from 11.72 to 10.46%. Males aged 20-24 who reported being married or in a union before the age of 18 increased from 1.54% in baseline to 3.13 % in Y2. To achieve the EOP target, the project is continuously fostering an environment that respects and protects the rights of women and girls and promoting their meaningful participation and leadership through the REFLECT and WASH sessions. By organizing male champion groups, the project also engages men and boys as allies and agents of change in promoting gender equality and preventing early marriage and unions.

The Y2 survey results in Uganda revealed that 1.27 % of females aged 15 to 19 reported being married or in union before the age of 15, a rise from zero at baseline. The zero recorded in Y2 for females aged 20 to 24 indicates an improvement from the baseline value of 0.71 %. Males aged 15-19 and 20-24 continue to have a zero as their result at baseline and Y2. 12.74% of females aged 15-19 have reported being married before the age of 18, a decrease from the reported baseline value of 19.21%. However, 4.67 % of males aged 15 to 19 reported being married prior to reaching the age of 18, a slight rise from 3.92 % at baseline. In addition, 40% of 20-24-year-old women have reported being married or in union before the age of 18, a decrease from the baseline value of 46.21 %. In contrast, there was an increase among men aged 20-24, who reported 10.29% in Y2 compared to 6.2% at baseline. The decrease in early marriage can be attributed to the project's efforts to involve local cultural and religious leaders in addressing the socio-cultural factors that promote early marriage. The project also educates boys and girls, both in and out of school, about safety, life skills, and empowerment to say no to unwanted sex, which can lead to unintended pregnancy and early marriage. Additionally, promoting equal access to education, especially for girls, can delay the initiation of sexual relationships and childbirth, which addresses early marriage. To achieve the EOP target, the project will continue to work through the Village Health Teams (VHTs) to engage the community in initiatives such as increased youth participation, sports activities, and engaging men and women together to avoid a "women project" bias. The project will also support health units to increase health service access through outreaches and engage stakeholders to advocate for the operationalization of draft policies, including the Sexuality Education Guidelines for out-of-school youth, the School Health Policy, the National SRHR policy, and the Adolescent health policy, as well as the

SRH/HIV/GBV Integration strategy. Finally, the project will strengthen the sensitization of local leaders and engage more men in addressing the challenge of child marriage.

1.2 INTERMEDIATE OUTCOME 1100

1100 Increased equitable use of health services (sexual and reproductive health, SGBV-health services) by the most vulnerable adolescent girls and women rights holders living in indigenous, remote or resettlement settings of target areas.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1100a: # of pre-natal care check-ups or other interactions (e.g. required vitamin supplementation, etc.) received by adolescent girls and women from targeted local health care providers (by age) FIAP KPI: HN3 1120a	Total: 101,074 <20: 21,531 >=20: 79,543 Cam: 35,265 <20: 8,982 >=20: 26,283 Ke: 720 <20: 299 >=20: 421 Ph: 2,097 <20: 241 >=20: 1,856 Ug: 62,992 <20: 12,009 >=20: 50,983 NOTE: THIS DATA WAS COLLECTED IN Y2	N/A	Total: 101,046 <20: 21,598 >=20: 79,448 Cam: 34,953 <20: 9,014 >=20: 25,939 Ke: 1,004 <20: 334 >=20: 670 Ph: 2,097 <20: 241 >=20: 1,856 Ug: 62,992 <20: 12,009 >=20: 50,983	N/A	Records Review
This indicator was calculated by obtaining numbers from the following health records of health facilities that the IPs are supporting: <ul style="list-style-type: none"> • Cambodia: (HC1 HO2 page 5) Check Total (1+2+3+4+5+....) [explanation: total number of visits by women for ANC] • Kenya: (MOH 405 and 711) # of pregnant women who attended at least one ANC visit during pregnancy • Philippines: FHSIS Form, Section B.1 (No. of women who gave birth with at least 4 prenatal check-ups), B.2 (No. of pregnant women assessed of their nutritional status during the 1st trimester) • Uganda: (HMIS Form 105) AN05: Total ANC contacts/visits (new clients + re-visits) Disaggregated by age					

In Y2, a total of 101,046 pre-natal care checkups or other interactions have been provided to adolescent girls and women by targeted local health care providers across the 4 implementing countries. The result indicates a slight decline from the reported visits of 101,074 at baseline. The results of Y2 for the Philippines and Uganda serve as the baseline.

In Cambodia, local health care providers have provided 35,265 pre-natal care check-ups and interactions to adolescent girls and women. Out of these, 8,982 check-ups were conducted for adolescents aged below 20, while 26,283 were conducted for those aged 20 and above. The project included activities such as promoting nutrition care through Learning Through Play (LTP) and Making Mealtimes Matter (MMM), providing baby friendly kits and encouraging at least four ANC visits before delivery. . The project also facilitated sessions on SRHR and GBV with female and male youth, parents and caregivers, drama in schools, night shows, shopping booth campaigns, and advocacy campaigns to reduce unintended pregnancies. The project aims to reduce the number of pregnancies among women under 20 and increase ANC overall, thus increasing ANC

with pregnancies for those equal to and over 20 years. To achieve this, the project will continue to intensify its efforts to train adolescent girls, boys, women, and men in SRHR and SGBV. In addition, nutrition education for parents, caregivers, and health professionals will be supported.

Local healthcare providers in Kenya have provided 1,004 pre-natal care checkups and interactions to adolescent girls and women. The number of visits increases with the age group, with women aged 20-24 conducting the most visits at 670, while girls aged 10-19 conducting 334 visits. Unfortunately, many adolescents are hesitant to visit ANC clinics due to poor attitudes and behaviors of some older pregnant women and healthcare providers, unfavorable opening hours of health facilities, lack of specific rooms or spaces for adolescents, and inadequate privacy and confidentiality. To improve access to services, reducing waiting times and creating specific rooms and youth-friendly spaces for pregnant adolescents were deemed important steps. To ensure progress on this indicator, the project will expedite the operations of youth centers and spaces catering to pregnant adolescents, women, and girls.

A total of 2,097 pre-natal care checkups and other services to adolescent girls and women have been provided by local healthcare providers in the Philippines. However, the percentage of pre-natal care uptake varies greatly among different municipalities. Buhi has the highest uptake rate at 54.46%, followed by Caramoan at 40.36%, Ocampo at 39.84%, and Garchitorena at 36.79% as compared to the eligible population (as identified by health facilities). Siruma has the lowest rate at 34.60%. Overall, only 44.76% of eligible females have received pre-natal care. Linking these results to the results of outcome indicator 1120a (Access to SRHR, SGBV and health-related services), the low uptake could be attributed to the top four reasons for not accessing SRHR services: long distance or unavailability of transportation, inconvenient hours of healthcare facilities, perceived cost of services, and insufficient awareness of location and services offered. To address barriers in accessing SRHR services in the Philippines, one of the Gender Equality Strategy actions focuses on establishing a sustainable Community-based Transport System (ComBaT) to support access to referral and confidential health services for adolescent girls and women, serving as a bridge between the community and the health facility. Additionally, 'Info Tours' will be implemented to increase awareness of location and services, and to educate individuals on the process of accessing prenatal care. The project should prioritize the implementation of ComBaT and Info Tours to improve the uptake of prenatal care services.

In Uganda, 62,992 pre-natal care checkups and other interactions with adolescent girls and women have been provided by local health care providers. Of these visits, 12,009 were by women under 20 years old, while 50,983 were by those aged 20 and above. The majority of visits were made by women aged 25-49, accounting for 42.95%, followed by those aged 20-24 and 15-19 at 37.84% and 19.01%, respectively. In order to increase uptake in Y3, the project will continue to facilitate training sessions on SRHR in schools and communities, targeting adolescent girls, boys, women, and men.

In efforts to foster gender equality, participants in sensitization sessions in Kenya were consulted on the timing and location of household and ANC visits. Health facilities have been strategically located to bring services closer to the community through outreach programs. During these programs, healthcare workers of the same sex handle clients as much as possible to encourage the community to take advantage of ANC visits at health facilities or outreach services. During health facility visits in Uganda, both female and male clients of health services were treated with respect and dignity. Pregnant and lactating mothers receive first priority, as they are the most vulnerable. To uphold human rights in Kenya, CHVs and HCWs emphasize the importance of patient confidentiality during training sessions. This is to ensure that patients can access ANC visits without fear of discrimination based on age, gender, level of education, geographical location, or medical information being leaked to the public.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1100b: # of cases of SGBV responded to by targeted health care providers, law enforcement and social work providers (by age, if available)	Total: 991 Cam: TBD Ke: 9 0-9yrs: 0 10-17yrs: 1 18-49yrs: 7	N/A	Total: 1,025 Cam: TBD Ke: 43 0-9yrs: 1 10-17yrs: 9 18-49yrs: 27	N/A	Records Review

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
	50+yrs:1 Ph: 86 0-9yrs: 2 10-14yrs: 17 15-19yrs: 31 20-49yrs: 32 50+ yrs: 4 Ug: 896 F: 587 0-28 days F: 0 29 days - 4 y/o F: 7 5-9 y/o F: 19 10-19 F: 148 20+ F: 413 M: 309 0-28 days M: 0 29 days - 4y/o M:6 5-9 y/o M: 16 10-19 M: 105 20+ M: 182 NOTE: THIS DATA WAS COLLECTED IN Y2		50+yrs: 6 Ph: 86 0-9yrs: 2 10-14yrs: 17 15-19yrs: 31 20-49yrs: 32 50+yrs: 4 Ug: 896 F: 587 0-28 days F: 0 29 days - 4 y/o F: 7 5-9 y/o F: 19 10-19 F: 148 20+ F: 413 M: 309 0-28 days M: 0 29 days - 4y/o M:6 5-9 y/o M: 16 10-19 M: 105 20+ M: 182		
<p>This indicator was calculated by obtaining numbers from the following records of health/service provider facilities that the IPs are supporting:</p> <p>Ca: Ca: HC1/HO2 "Page 1 row 138 (6.1 Violence against women and children)</p> <p>Ke: MOH 711, MOH 363 # of SGBV survivors completed PEP; # of SGBV survivors who received ECP</p> <p>Ph: Service provider records of # of SGBV cases (DSWD, PNP, and RHU)</p> <p>Ug: (HMIS Form 105) IN03: # of injuries due to gender-based violence; MC01: Abortions due to GBV</p> <p>Disaggregated by age, if available</p>					

A total of 1,025 cases of SGBV have been responded to by targeted health care providers, law enforcement, and social work providers in Kenya, the Philippines, and Uganda. The baseline values for the Philippines and Uganda were also used as the Y2 figures. Considering the Y2 result for Kenya, the number of SGBV cases responded to has increased from 9 at baseline to 43 in Y2.

There was no data collected this year in Cambodia regarding SGBV as it was not recorded in the HC1/H02 report from the Health Centre or Referral Hospital. The project team is advocating for the inclusion of SGBV information in the HC1/H02 records and will be reported in Y3.

In Kenya, 43 cases of SGBV were addressed by targeted healthcare, law enforcement, and social work providers. Out of these cases, 1 was between the ages of 0-9, 9 were between 10-17, 27 were between 18-45, and 6 were 50 years or older. There were no requests for Emergency Contraceptive Pills (ECP) or Post-Exposure Prophylaxis (PEP). This could be attributed to reporting challenges brought about by the low capacity of healthcare workers on reporting or the lack of availability of reporting tools. To address this issue, the project aims to highlight the significance of reporting and reporting tools during healthcare worker trainings.

In the Philippines, healthcare providers, law enforcement, and social work providers have responded to a total of 86 cases of SGBV (85 females, 1 non-binary). Ocampo recorded the highest number of cases at 34, followed by Caramoan with 22

cases, Buhi with 14, and Garchitorena and Siruma with the lowest at 8 cases each. However, only Ocampo was able to meet the criteria for providing safe, gender-responsive, quality, inclusive, respectful, and youth-friendly SGBV related services to adolescent girls and women according to the Facility Assessment on adequate GBV care (1200b). The high number of reported cases may be due to the existing reporting mechanisms, level of awareness and education on SGBV, and availability of resources. The age group with the highest number of reported cases is 20-49 with 32 cases, followed by 15-19 age group with 31 cases. The project aims to increase reporting through BCC efforts targeting these age groups and the establishment of help centers. To achieve this, the project needs to speed up on establishing ComBaT, facilitating Info Tours, and improving health facilities on GBV support services (Output 1211).

In Uganda, healthcare providers, law enforcement, and social work providers responded to a total of 896 SGBV cases. Among the survivors seeking treatment, 66% were females (587) and 34% were males (309). Most cases involved adults aged 20 and above with 595 cases, followed by adolescents between 10-19 years old with 253 cases. Unfortunately, women of all ages continue to make up the majority of SGBV survivors. This is consistent with statistics compiled by the Uganda Bureau of Statistics, which were quoted by Canadians Physicians for Aid and Relief (CPAR) in 2022 which reveal that 97% of women in greater northern Uganda have experienced physical or sexual violence since the age of 15.

As part of the GES, in Cambodia, health care providers are undergoing counseling skills training focusing on gender-sensitive, inclusive, non-discriminatory, respectful, confidential, private, and high-quality care. Meanwhile, in the Philippines and Uganda, the project is collaborating with the local communities to enhance Help Centers. These centers are equipped with adolescent-friendly resources such as tents, balls, television sets, dividers, tables, and chairs as well as counseling, psychosocial support, and referral skills to address SRHR, SGBV, and unintended pregnancy. In Cambodia and the Philippines, the project is conducting behavior change communication initiatives to raise awareness on SGBV. The community members who report SGBV cases in Uganda are treated with respect, dignity, and confidentiality, as a result of the training of the service providers. Sensitization trainings on SGBV in Kenya are guided by key human rights principles to ensure the full enjoyment of human rights for all, including the right to be protected against SGBV. The project is also working with the government and local authorities in Cambodia and the Philippines to promote governance and uphold human rights. Counseling skills training is being provided to police, village security groups, and other duty-bearers to better respond to GBV cases in the community.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1100c: # of visits for family planning services (Sex, Age) Source: FIAP HN1 1120d	Total: 91,522 F: 80,899 M: 10,623 Cam: 51,357 F: 50,739 M: 618 <20: 4,469 F: 4,410 M: 59 >=20: 46,888 F: 46,329 M: 559 Ke: 1,430 F: 10-14yrs: 0 F: 15-19yrs: 224 F: 20-24yrs: 633 F: 25+years: 573 Ph: 6,786 F: 6,786 10-14 F: 5 15-19 F: 537	N/A	Total: 87,688 F: 77,216 M: 10,472 Cam: 47,419 F: 46,952 M: 467 <20: 4,801 F: 4,753 M: 48 >=20: 42,618 F: 42,199 M: 419 Ke: 1,534 F: 1,534 10-14F: 24 15-19F: 225 20-24F: 627 25+F: 658 Ph: 6,786 F: 6,786 10-14 F: 5 15-19 F: 537	N/A	Records Review

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
	20-49 F: 6244 Ug: 31,949 F: 21,944 <15 F: 31 15-19 F: 3332 20-24 F: 7967 25-49 F: 10450 50+ F: 164 M: 10,005 <15 M: 9 15-19 M: 1722 20-24 M: 5322 25-49 M: 2807 50+ M: 145 NOTE: THIS DATA WAS COLLECTED IN Y2		20-49 F: 6244 Ug: 31,949 F: 21,944 <15 F: 31 15-19 F: 3332 20-24 F: 7967 25-49 F: 10450 50+ F: 164 M: 10,005 <15 M: 9 15-19 M: 1722 20-24 M: 5322 25-49 M: 2807 50+ Male 145		
<p>This indicator was calculated by obtaining numbers from the following records of health/service provider facilities that the IPs are supporting:</p> <p>Ca: (HC1 HO2 page 7) Total number of visits to avail birth spacing services Ke: (MOH 512) # of women of reproductive age receiving FP commodities Ph: FHSIS Form, Section A2, Col. 3&4 (Acceptors of FP Method) Ug: (HMIS Form 105) FP01 to FP20: Family planning methods (age vs type of user): <15, 15-19, 20-24, 25-49, 50+; new users and revisits)</p> <p>Disaggregated by age and sex</p>					

As of the reporting period, 87,688 visits for family planning services have occurred in all 4 implementing countries. The baseline figures also serve as the Y2 results for Philippines and Uganda. Combining the results for Cambodia and Kenya, Y2 data of 48,953 indicates a decline compared to the baseline of 52,787.

In Cambodia, there have been 47,419 visits for family planning services (46,952 females and 467 males). The reduction of 3,938 family planning visits from 51,357 at baseline to 47,419 in Y2 mainly occurred in Preah Vihear (2,098) and Stung Treang (1,719), with only 127 in Kompong Thom. Despite a slight decrease in visits, project activities that could have influenced the indicator results included facilitating sessions with female and male youth and parents and caregivers, drama, night shows, shopping booth campaigns, school video contests, etc. To prevent a decline in family planning visits, the project team is continuously following up with the HCs to better understand the variances and facilitate the training of HC staff and private care providers in youth-friendly SRH services.

There have been 1,534 visits (all female) for family planning services in Kenya. No data from male users were recorded in the MOH data sheet. Out of these visits, there were 24 individuals aged 10-14, 225 aged 15-19, 627 aged 20-24, and 658 above the age of 25. The uptake of family planning services in Turkana County remains low due to various factors such as fear of side effects, cultural beliefs, and lack of support from spouses. To address this, the project has been integrating its activity interventions with important topics such as SRHR, SGBV and other life skills. The project will also support the MOH in ensuring that they will collect data for both female and male on FP commodity use at the supported health/help facilities. The proper reporting tool will also be reemphasized to the MoH's staff as well.

Municipality	Number of Visits for Family Planning Services in the Philippines	TOTAL	Utilization Rate
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	10-14 years old	15-19 years old	20-49 years old		WRA Population Estimates	
Buhi	5	313	2976	3294	14106	23.35%
Caramoan	0	56	900	956	5582	17.13%
Garchitorena	0	55	719	774	3477	22.26%
Ocampo	0	97	1339	1436	5260	27.30%
Siruma	0	16	310	326	3625	8.99%
TOTAL	5	537	6244	6786	32051	21.17%

In the Philippines, 6,786 visits for family planning services have occurred in Y2. All were female (male population data is not currently collected by the government). Based on the table above, individuals in the 20-49 age group made the most visits for family planning services, with a total of 6,244 visits. This is not surprising, as this age group is more likely to be sexually active and in need of contraception. It is encouraging to see that women of reproductive age are utilizing SRHR services, which suggests that they are making informed decisions about their reproductive health. However, the number of visits made by individuals in the 15-19 age group was significantly lower, which could indicate a barrier to accessing family planning services and a higher risk of unintended pregnancies for adolescents. The data also shows that there are variations in the number of visits for family planning services across different municipalities. Buhi had the highest number of visits, followed by Ocampo, Caramoan, Garchitorena, and Siruma. However, when considering the WRA population estimates, Ocampo had the highest utilization rate of family planning services, followed by Buhi, Caramoan, Garchitorena, and Siruma. This suggests that there may be differences in the availability, accessibility, and awareness of family planning services across municipalities. It is worth noting that only Ocampo met the criteria for providing safe, gender responsive, quality, inclusive, respectful, and youth-friendly SRHR related services to adolescent girls and women. This indicates that the level of care provided by facilities affects the uptake of family planning services. To improve access to SRHR services, the project aims to advocate for the establishment of youth-friendly health facilities and the appropriation of budget for the improvement of facility infrastructure, as well as the procurement of SRHR supplies and commodities, through passing resolutions in the municipal councils of target municipalities.

Comparison of Family Planning visits by Females and Males by Age Category in Uganda			
Age group	Females	Males	Sub Total
<15 yrs	31	9	40
15-19 yrs	3,332	1,722	5,054
20-24 yrs	7,967	5,322	13,289
25-49 yrs	10,450	2,807	13,257
50+ yrs	164	145	309
Total	21,944	10,005	31,949

Based on the above table, in Uganda, family planning services were utilized by a total of 31,949 individuals, of which 21,944 were females and 10,005 were males. The number of these males reflected from those who accompanied their wives/partners to health facilities for family planning counselling and accessing condoms. Not surprisingly, the majority (83%) of those who accessed these services were aged between 20-49 years. Interestingly, despite the ongoing resistance, discouragement, and stigma associated with FP services among adolescents, a substantive number of adolescent boys and girls accessed such services. Adolescent girls (3,332) nearly doubled the number of boys (1,722) seeking FP services. To bridge the gap between men and women, the project will collaborate with health facilities to ensure men have access to voluntary, high-quality contraceptive information, services, and supplies. Additionally, the project will advocate for the integration of family

planning into other services, including partnerships with private sector organizations such as Marie Stopes and the Family Planning Association of Uganda, in order to increase access to FP services.

In an effort to promote gender equality, Cambodia's SRHR curriculum includes topics on fertility, birth spacing, and SRHR. The training emphasizes the issue of family planning visits, which revealed that many individuals overlook its importance. Additionally, men often view these visits as solely the responsibility of women, which places undue pressure on women and ignores the fact that family planning is a shared responsibility. Meanwhile, in Kenya, family planning services have been integrated with other education and development interventions such as life skills and SRHR trainings. However, a potential gender data gap has been identified in the Philippines where male population data is not currently collected by the Field Health Services Information System (FHSIS). This highlights the need for improved data collection and analysis with a gender perspective. In Uganda, the project is building widespread knowledge among in-school and out-of-school youths aged 10 to 20 in the targeted communities by training them in 21st century skills such as negotiation, SGBV, gender, and SRHR to increase their confidence in their ability to seek, access, and use SRHR, SGBV, and health services.

1.2.1 IMMEDIATE OUTCOME 1110

1110 Increased self-confidence of the most vulnerable adolescent girls and boys, especially those living in indigenous, remote or resettlement settings

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1110a: % and # of participating adolescent girls (compared to participating boys) with a healthy self-esteem (based on ASQ Methodology) (by sex)	<p>T: 72.52% (847/1168) F: 68.47% (393/574) M: 76.28% (447/586) Non-binary: 87.5% (7/8)</p> <p>Ca: 72.51% (211/291) F: 73.29% (107/146) M: 71.72% (104/145)</p> <p>Ke: 77.05% (225/292) F: 76.19% (112/147) M: 77.93% (113/145)</p> <p>Ph: 71.38% 202/283) F: 69.70% (92/132) M: 72.03% (103/143) Non-binary: 87.50% (7/8)</p> <p>Ug: 69.21% (209/302) F: 55.03% (82/149) M: 83.01% (127/153)</p>	<p>T: 74.18% F: 70.75% M: 77.60%</p> <p>Ca: F: 74% M: 74%</p> <p>Ke: F: 77% M: 78%</p> <p>Ph: F: 74% M: 74%</p> <p>Ug: F: 58.02% M: 84.41%</p>	<p>T: 72.78% (885/1216) F: 68.53% (429/626) M: 77.17% (453/587) Non-binary: 100% (2/2)</p> <p>Ca: 78.31% (195/249) F: 76.42% (94/123) M: 80.16% (101/126)</p> <p>Ke: 84.57% (274/324) F: 87.13% (149/171) M: 81.58% (124/152)</p> <p>Ph: 63.39% (213/336) F: 52.57% (92/175) M: 74.84% (119/159) Non-binary: 100% (2/2)</p> <p>Ug: 66.12% (203/307) F: 59.87% (94/157) M: 72.67% (109/150)</p>	<p>T: 83.06% F: 80.30% M: 85.81%</p> <p>Ca: F: 80% M: 80%</p> <p>Ke: F: 81.19% M: 83.23%</p> <p>Ph: F: 90% M: 90%</p> <p>Ug: F: 70% M: 90%</p>	Mobile Household Survey (MHS)
<p>This indicator was calculated by counting the number of adolescent girls and boys age 15-19 years old who have answered correctly x¹ out of the 8 questions divided by the total number of respondents multiplied by 100 x for Cambodia, Kenya, and the Philippines= 4 x for Uganda= 5</p> <p>Disaggregated by sex</p>					

In Y2, 68.53% of adolescent girls (compared to 77.17% of participating boys) have a healthy self-esteem (based on ASQ

¹ x is determined by the IP based on their appreciation of their context and how much do they think their interventions can affect (x is 4 for Cambodia, Kenya and the Philippines, and 5 for Uganda)

methodology). The figures indicate a slight increase, with 68.47% of girls and 76.28% of boys reporting they have healthy self-esteem at baseline.

According to the ASQ methodology, 76.42% of adolescent girls in Cambodia have a healthy self-esteem, slightly lower than the 80.16% of participating boys. However, both genders have shown an increase in healthy self-esteem in the Y2 report compared to baseline, with boys at 71.72% and girls at 73.29%. The Y2 figure indicate that boys have higher self-esteem than girls. The table below displays statements and the corresponding percentage of respondents who answered positively, categorized by gender.

Adolescent Self-esteem Questionnaire Statements (aged 15-19)		% of respondents showing positive self esteem (adjusted already for positive / negative statements)					
		Baseline Survey			Y2 Survey		
		Adolescent Girls	Adolescent Boys	Total Adolescents	Adolescent Girls	Adolescent Boys	Total Adolescents
		N=146	N=123	N=291	N=123	N=125	N=248
1	I am able to stand up for myself and what I believe in	43.2%	43.5%	43.3%	48.8%	57.6%	53.2%
2	How I feel about myself depends on what others think of me]	45.5%	52.4%	49.0%	33.3%	54.4%	44.0%
3	I feel I can be myself around other people	47.3%	24.3%	35.9%	43.6%	18.4%	31.0%
4	Overall I feel good about my abilities compared to others (e.g. at school, playing sports or socially)	69.0%	59.3%	64.1%	67.8%	44.0%	55.9%
5	If I make an innocent mistake I let it get me down	30.8%	57.2%	44.0%	47.4%	31.6%	39.5%
6	Overall I like who I am	93.2%	91.7%	92.4%	94.3%	96.8%	95.6%
7	How I feel about my body makes me feel less confident	28.8%	24.8%	26.8%	36.9%	31.7%	34.3%
8	I feel confident in myself to achieve the things I set my mind to	73.3%	84.8%	79.0%	87.8%	85.7%	86.8%

Both boys and girls showed progress in 5 out of the 8 qualifying statements. However, they made progress in different areas. Boys showed greater improvement than girls in statement #1, which is about standing up for oneself and beliefs, and statement #6, which is about overall self-liking. On the other hand, girls showed more improvement than boys in their overall self-confidence, particularly in statement #7, which is about body image affecting confidence, and statement #8, which is about being confident in achieving goals. Statement #2, which is about self-esteem being dependent on others' opinions, showed a significant drop for girls from 45.5% to 33.3%, but it remained relatively stable for boys, with an increase from 52.4% to 54.4%. For statement #5, which is about letting innocent mistakes bring down one's mood, girls improved from 30.8% to 47.4%, while boys experienced a decrease from 57.2% to 31.6%. The results indicate that societal norms tend to prevent adolescent boys and girls from participating in social interactions based on their age, which can hinder their ability to voice their opinions in social settings. Improving the self-esteem of adolescent girls is crucial, and involving local educational providers in this effort is an important step towards achieving this goal. The project will work with CCWC/CC facilitators, as well as local leaders, VHSGs and Youth Champions, to facilitate community sessions and expose youth to different events. By providing opportunities for them to learn, experience, and share their thoughts and initiatives, they will grow in their capacity and confidence. Key messages will focus on feelings, body image, and the importance of not letting others' opinions affect their self-esteem. This is especially important for adolescent girls in ethnic/minority groups and rural remote communities, who may lack social interactions with adults due to traditional customs that hinder their self-esteem.

According to statistics, in Kenya, more than 87% of adolescent girls have a healthy self-esteem, which is higher than the percentage of boys with a healthy self-esteem. Although both girls and boys have exceeded the Y2 targets with over 80% healthy self-esteem, the positive results for girls have not yet translated into a decrease in early marriages and childbearing. This is likely due to cultural beliefs and practices that present strong barriers. Therefore, it is necessary to take sustained efforts to expand targeted interventions and work with influential community members such as elders and leaders to address cultural beliefs and practices that contribute to unintended pregnancies and early marriages.

In Year 2, adolescent girls in the Philippines have a healthy self-esteem of 52.57%, while participating boys have a higher rate of 74.84%. However, the overall proportion of both genders with healthy self-esteem decreased in Y2 compared to baseline (Y2: 63.39% versus Y1: 71.38%), and this decline was statistically significant. This decrease in self-esteem, especially among females, indicates that females may be more sensitive to self-esteem issues and related factors. Project implementers and other stakeholders should take note of this concerning result in the delivery of interventions. The reversal in the direction of the desired response may indicate factors outside the project, such as messaging from social media or peer groups, influencing perceptions and overall self-esteem. Considering the qualifying questions, there was a noticeable improvement in responses during Y2 for those who feel they can confidently stand up for themselves and their beliefs. However, for the remaining qualifying questions, there was a general decline in responses in Y2 compared to the baseline, resulting in an overall decrease in self-esteem among respondents. This outcome measure is connected to the training provided to both girls and boys (Outputs 1111 and 1113). Since the results indicated that the intervention had the opposite effect of what was desired, it's important for the project team to monitor how the training is being delivered by educators during adolescent training.

In Uganda, 59.87% of adolescent girls (baseline: 55.03%) and 72.67% of participating boys (baseline: 83.01%) have a healthy self-esteem in Y2. The proportion of adolescent girls and boys with healthy self-esteem decreased from 69.21% at the beginning of the project to 66.12% in Y2. Surprisingly, this reduction was mainly due to the marked decrease in the self-esteem of boys from 83.01% to 72.67%, whereas the girls' self-esteem increased from 55.03% to 59.87%. The project team found this unexpected because the boys had consistently demonstrated higher self-esteem throughout the project, including during group discussions where they tended to dominate. However, the data from the qualifying question assessing self-esteem indicated that males generally reported higher self-esteem than females, except in response to feelings about oneself and overall satisfaction with oneself. The increase in self-esteem among adolescent girls could be attributed to their regular attendance and continued training in various skills such as sexuality education, parental effectiveness, psychosocial support, and participation in activities such as school debates and community dialogues. These activities empowered the girls to voice their opinions and participate in decision-making. On the other hand, the decrease in self-esteem among boys could be due to societal expectations that promote traditional masculinity and discourage them from participating in activities perceived as feminine. For example, one adolescent boy reported that his self-esteem was lowered after he was forced by his mother to marry at a young age. Social and cultural norms also affect the self-esteem of boys, who are viewed as strong, authoritative, and action-oriented decision-makers. When they fall short in any of these areas, their self-esteem suffers. To address these issues, the project aims to promote the formation of mixed groups of men and women to foster harmony among all family members. It will encourage both males and females to work together to build self-confidence and self-esteem in men as heads of families to avoid conflicts. When women and men come together, they can share ideas and provide support and encouragement to each other.

The project's activities promoted human rights by empowering adolescents and promoting their self-esteem through the creation of safe spaces, facilitation of communication, and provision of opportunities for capacity building. For adolescent girls and boys, groups have been established where they can engage in positive social interaction, express their emotions, and realize their health-related rights. The interventions in Kenya are centered on promoting gender equality and equitable access to opportunities and services for everyone. In the Philippines, learning content for adolescent girls and boys was adapted via REFLECT sessions and BCC efforts in the online space, addressing underlying factors that contribute to negative perceptions and increasing self-esteem. In Uganda, women were provided with financial literacy and savings and loan training to help them enhance their savings activities for economic growth. This training also aimed to boost their self-confidence, making it easier for them to overcome financial barriers when accessing sexual and reproductive health and nutrition services. Additionally, the project trained female and male teachers and educators in CSE, SGBV, SRHR to impart knowledge and influence behavior change among adolescent girls and boys.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1110b: Perception on importance to speaking up in defence of own rights	Total: N/A Ca: N/A	Total: N/A Ca: G: High B: High	Total: N/A Ca: G: High B: High	Total: N/A Ca: G: Very High B: Very High	Focus Group Discussions (FGDs)

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
related to health SRHR in interactions with educators or health care providers by youth girls, women, boys, and men.	<p>Ke: N/A</p> <p>Ph: N/A</p> <p>Ug: N/A</p>	<p>W: High M: High T: High</p> <p>Ke: G: Low B: Very high W: Very high M: Very high T: Female-High T: Male: Very High</p> <p>Ph: N/A</p> <p>Ug: N/A</p>	<p>W: High M: High T: High</p> <p>Ke: G: Very High B: Very high W: Very high M: High T: Female-High T: Male: Very High</p> <p>Ph: N/A</p> <p>Ug: G: Very High B: Very High W: Very High M: Very High T: Very High</p>	<p>W: Very High M: Very High T: Very High</p> <p>Ke: G: Very High B: Very High W: Very High M: Very High T: Very High</p> <p>Ph: G: Very High B: Very High W: Very High M: Very High T: Very High</p> <p>Ug: G: Very High B: Very High W: Very High M: Very High T: Very High</p>	

This indicator was calculated by using the rating guidance below:

A. Very High = high number of participants acknowledge the value of speaking up in defense of their own rights to a large extent, and at the same time they are able, at least on a theoretical level, to overcome the constraints to speak up

- Question 5:
 - Useful and important option: at least 90% of participants agree

AND

- In vain option: less than 10% of participants agree

AND

- The group was able to formulate positive consequence(s) of speaking up or negative consequence(s) of NOT speaking up (Question 7)

AND

- The group came up with relevant solutions and steps to overcome all the constraints to speak up (Question 8)

All the above conditions must be met to achieve the VERY HIGH rate

B. High = most participants acknowledge the value of speaking up in defense of their own rights, however, they may find it difficult to overcome the constraints to speak up

- Question 5:
 - Useful and important option: at least 70 % of participants agree

AND

- In vain option: less than 20 % of participants agree

AND

- The group was able to formulate positive consequence(s) of speaking up or negative consequence(s) of NOT speaking up (Question 7)

AND

- At the end of the training, the group came up with relevant solutions and steps to overcome at least some of the constraints to speak up (Question 8)

All the above conditions must be met to achieve the HIGH rate

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
<p>C. Low = essential part of participants does not value the importance of speaking up in defense of their own rights</p> <ul style="list-style-type: none"> • Question 5: <ul style="list-style-type: none"> - Useful and important option: at least 50 % of participants agree <p>AND</p> <ul style="list-style-type: none"> - In vain option: less than 40 % of participants agree <p>Both above conditions must be met to achieve the LOW rate</p> <p>D. Very low = most of participants do not value the importance of speaking up in defense of their own rights</p> <ul style="list-style-type: none"> • A group that did not meet the conditions to achieve ratings above. 					

The importance of speaking up in defense of own rights related to health SRHR in interactions with educators or health care providers by youth girls, women, boys, and men is perceived as High in Cambodia, Very High in Kenya and Uganda, and Important but Difficult in the Philippines.

In Cambodia, the importance of speaking up in defense of own rights related to health SRHR in interactions with educators or health care providers by youth girls, women, boys, and men is perceived as High. While most people realize the benefits of advocating for themselves, many struggle to do so due to various obstacles. Majority of the Focus Group Discussion (FGD) participants agree that speaking up is necessary to receive proper care and not miss out on potential benefits. However, some individuals may feel too shy or embarrassed to ask for what they need, or they may lack the language to express themselves effectively. Additionally, there are several cases where people have been discriminated against by service providers, leading to a fear of speaking up.

The importance of speaking up in defense of own rights related to health SRHR in interactions with educators or health care providers by youth girls, women, and boys is perceived as Very High and for men as High in Kenya. Both men and women recognize the importance of advocating for their own rights and are capable of overcoming obstacles to do so. This is especially true when it comes to sexual, reproductive, and health rights. Results from FGDs in various villages indicate that girls and boys are able to speak up for their rights, despite facing constraints. In five out of six villages, girls demonstrated a very high level of understanding and willingness to speak up for their rights, while boys scored very high in four villages and high in two. This suggests that young people of all genders are empowered to speak out against discrimination and infringement upon their health-related rights, regardless of their age, ethnicity, marital status, health, or disability. It is important to support activities that empower individuals of all genders, including girls, women, boys, and men, to become agents of change and strengthen platforms for their participation. In Kenya, the project aims to continue providing support to develop the necessary skills for individuals to voice their opinions on health rights, including childbearing and early marriage, while raising awareness among girls and boys in the community on the importance of education as a key determinant for sexual and reproductive health, particularly for girls.

In the Philippines, the importance of speaking up in defense of one's own rights related to health SRHR in interactions with educators or health care providers by youth girls, women, boys, and men is perceived as important but difficult. Currently, no training has been conducted for Output 1111 in the Philippines, therefore the results of this indicator will be based on the first of two parts, the first part is the FGDs conducted before the training and the FGDs conducted after the training. The FGD revealed that male and female participants understand the importance of speaking up and asking questions to healthcare providers and teachers. However, they also shared their concerns and fears that prevent them from doing so. Female and male participants expressed fear of being judged, ridiculed, or misunderstood when they speak up, while some are afraid of offending the healthcare provider or teacher. They also attributed their hesitation to shyness and nervousness. When asked if men or women are more vocal in speaking up for their rights, responses varied. While some female and male participants believed that women are more articulate and confident in asking questions, others felt that men are more dominant and assertive. Nonetheless, all participants agreed that both males and females should have equal opportunities to voice their opinions and concerns. The female and male participants also mentioned that some healthcare providers act as barriers as they are strict, unapproachable and do not speak the local language, making it difficult for individuals to speak up. This suggests that there may be issues with the recruitment, training, and supervision of healthcare providers, which are the government's responsibility. The fear of being judged or ridiculed when speaking up highlights the lack of trust in the healthcare system and the government's ability to protect the rights of male and female patients. This may be due to a lack

of transparency and accountability in the healthcare system, which can create a culture of fear and distrust among patients. The government needs to ensure that healthcare providers are held accountable for their actions and that young people are aware of their rights and how to report any violations. Creating a more supportive environment that encourages young people to ask questions and speak up can be achieved through better communication between healthcare providers, teachers, and their adolescent patients or students. Healthcare providers and teachers should also make an effort to be approachable and welcoming, while providing a safe space where young people can ask questions without fear of judgment or reprimand.

During post-training assessments in Uganda, it was found that both female and male youth recognize the importance of speaking up in defense of their health and SRHR rights during interactions with educators or healthcare providers as Very High. Although the initial opportunity to assess participants before training was missed, FGD discussions following the training showed that at least 90% of participants agreed on the significance of speaking up and were able to identify and overcome any constraints preventing them from doing so. Participants across all FGD groups acknowledged the value of speaking up and were able to come up with relevant solutions and steps to overcome constraints. However, the number of adolescent boys and girls in the FGDs was lower than planned due to some being at school or working in forests. The project will review the timing of activities to ensure the participation of both in and out-of-school females and males in both project activities and data collection.

Educators and teachers in Cambodia and Uganda have been equipped with knowledge and skills to effectively share SRHR information with female and male adolescents. To ensure the successful implementation of the project supported comprehensive sexuality education curriculum, the MOEYS in Cambodia has mandated training for both principals and teachers. While this may have resulted in fewer teachers being trained as the principals are now being added, it ultimately contributes to building self-confidence in adolescent girls and boys through thorough education and leadership support from the principals. As part of the project's GES, the project in Kenya and the Philippines conducted consultation with girls, boys, young women, and men to determine the best location and timing for the training. In the Philippines, every community session provides a safe and supportive environment for all adolescents, regardless of gender, to ask questions and speak up. In Uganda, the project aims to spread knowledge among in and out-of-school youths aged 10-20 years in targeted communities by training them in 21st-century skills such as negotiation, SGBV, gender, and SRHR to enhance their self-confidence in seeking, accessing, and utilizing SRHR, SGBV, and health services.

1.2.2 IMMEDIATE OUTCOMES 1120

1120 Increased access to SRHR, SGBV and health-related services for the most vulnerable adolescent girls and women, especially those in indigenous, remote or resettlement settings and/or those with special needs.

Indicators	Baseline	Y2 Target	Y2 Result ²	EOP Target	Data Collection Method
1120a: % of girls and women [as well boys and men]	Total: 33.20% 15-19 F: 35.78% 20-24 F: 31.18% 15-19 M: 34.08%	Total: 37.83 5-19 F: 40.50% 20-24 F: 35.83% 15-19 M: 38.57%	Total: 22.68% 15-19 F: 22.52% 20-24 F: 30.36% 15-19 M: 15.89%	Total: 58.40% 15-19 F: 61.55% 20-24 F: 57.80% 15-19 M: 56.88%	Mobile Household Survey (MHS)

² In Y2, we have expanded the disaggregation to include the types of services: 1) SRHR (Counselling or other services on family planning and sexual and reproductive health (such as how to have a healthy pregnancy, methods of contraception and emergency contraception, safe pregnancy abortion, etc.; Pregnancy and birth related services (such as check ups during pregnancy, assistance with birth; after-delivery check-ups monitoring of height/weight/age of the child, etc.); 2) SGBV (received any counselling what to do if you are involved in or witnessing physical, emotional, psychological, or sexual violence, including denial of resources or access to health services); 3) Nutrition counseling on nutritional food micronutrients, nutrition in pregnancy, breastfeeding, hygiene and safe drinking water. This is in response to GAC comment #65 in the PIP.

Indicators	Baseline	Y2 Target	Y2 Result ²	EOP Target	Data Collection Method
reporting access to SRHR, SGBV and health-related services	20-24 M: 31.33% Non-binary: 50% Ca: 56.65% 15-19 F: 67.21% 20-24 F: 62.75% 15-19 M: 43.06% 20-24 M: 53.47% Ke: 18.58% 15-19 F: 19.05% 20-24 F: 9.03% 15-19 M: 28.28% 20-24 M: 17.86% Ph: 32.21% 15-19 F: 39.23% 20-24 F: 34.48% 15-19 M: 27.27% 20-24 M: 26.15% Non-binary: 50% Ug: 25.46% 15-19 F: 18.67% 20-24 F: 17.86% 15-19 M: 37.5% 20-24 M: 27.15%	20-24 M: 36.40% Ca: 57.50% 15-19 F: 68% 20-24 F: 64% 15-19 M: 44% 20-24 M: 54% Ke: 20.56% 15-19 F: 21.05% 20-24 F: 11.03% 15-19 M: 30.28% 20-24 M: 19.86% Ph: 43% 15-19 F: 48% 20-24 F: 44% 15-19 M: 40% 20-24 M: 40%	20-24M: 21.54% Non-binary 15-24: 25.0% SRH: 38.43% Nutrition: 34.6% GBV: 32.45% Ca: 38.77% 15-19 F: 44.68% 20-24 F: 63.57% 15-19 M: 19.44% 20-24 M: 28.28% SRH: 76.59% Nutrition: 78.19% GBV: 77.66% Ke: 17.94% 15-19F: 14.04% 20-24F: 22.47% 15-19M: 15.79% 20-24M: 18.79% SRH: 19.4% Nutrition: 16.04% GBV: 12.73% Ph: 12.18% 15-19F: 13.14% 20-24F: 12.5% 15-19M: 7.59% 20-24M: 15.75% 15-24 Non-binary: 25.0% SRH: 22.54% Nutrition: 20.0% GBV: 20.77% Ug: 23.33% 15-19F: 22.29% 20-24F: 32.86% 15-19M: 16.0% 20-24M: 22.79% SRH: 45.53% Nutrition: 35.09% GBV: 41.8%	20-24 M: 57.38% Ca: 15-19 F: 77.20% 20-24 F: 72.20% 15-19 M: 49.50% 20-24 M: 61.50% Ke: 15-19 F: 39% 20-24 F: 29% 15-19 M: 48% 20-24 M: 38% Ph: 15-19 F: 80% 20-24 F: 80% 15-19 M: 80% 20-24 M: 80%	

This indicator was calculated by counting the number of respondents who answered:

- Have you, your partner, or your child younger than 5 years old (if applicable) received any of the following services in the past 12 months?
 - Counselling or other services on family planning and sexual and reproductive health (such as how to have a healthy pregnancy, methods of contraception and emergency contraception, safe pregnancy abortion, etc.)
 - Pregnancy and birth related services (such as check ups during pregnancy, assistance with birth; after-delivery check-ups monitoring of height/weight/age of the child, etc.)

AND

Do any of the following challenges make it harder for you or preventing you to access the sexual and reproductive health-related services?

- I haven't experienced any barrier

Indicators	Baseline	Y2 Target	Y2 Result ²	EOP Target	Data Collection Method
OR					
2.					
•					
AND					
•					
OR					
3.					
•					
AND					
•					
Divided by the total respondents multiplied by 100.					
Disaggregated by age group (15-19, 20-24), sex, and type of services (1, 2, 3 as numbered above).					

In the four implementing countries, only 22.68% of girls, women, boys, and men have reported access to SRHR, SGBV, and health-related services in Y2. This is a significant decrease from the baseline value of 33.20%. The Y2 target of 37.33% was not achieved by the project, and the Y2 results indicate a considerable decrease in female and male adolescents' reported access to SRHR, SGBV and health-related services.

In Cambodia, only 38.77% of girls, boys, women, and men access SRHR, SGBV, and health-related services in Y2 showing a decline from 56.65% at baseline. Lack of education, resources, and availability are some of the predominant issues that hinder accessing SRHR and GBV services, which are prevalent in all genders and age groups, but especially among minority groups and adolescent boys and men. Cambodian men typically do not seek medical care unless they have severe injuries or accidents due to the traditional view that SRHR and GBV services are for adolescent girls and women. Encouraging more adolescent boys and men to access proper medical care and treatment is essential in closing the ever-widening gap. The decline in accessing SRHR and other health-related services among the 15-19 grouping may have resulted from the fact that many of the villages sampled were outside of the phase I project implementation area, therefore the results were skewed and may not entirely reflect the results of project interventions. SRHR knowledge among men, especially adolescent boys, is very sparse in Cambodian society. While adolescent girls and women learn SRHR from healthcare providers and female household members, adolescent boys and men learn it from their peers, who are often just as ignorant of the issue. Distance, long wait times, and unavailability are some of the factors associated with the hinderance of access to SRHR and other health-related services for adolescent girls, boys, women and men. In order to overcome these obstacles, the results of the survey will be shared with village and commune authorities during CoLMEAL sessions. This will enable them to provide logistical options for safe and long travels for adolescent girls and women. The project will raise awareness during the CoLMEAL sessions on access issues, and the community action plans will include designating a health day where more people can be organized into a large group and transported together to health facilities. VHSOs will also be encouraged to conduct home visits, particularly in remote areas where transportation is limited. Additionally, during counseling training for HC staff and private providers, action plans will be put in place to provide youth friendly gender-responsive counseling services for patients who choose to have the same-sex counsellors, create a friendly environment and encourage repeated visits.

In Kenya, according to the Y2 survey data, only 17.94% of girls, women, boys, and men have reported access to SRHR, SGBV, and health-related services. Interestingly, more women between the ages of 20-24 (22.47%) received SRHR services in the

past 12 months compared to adolescent girls aged 15-19 (14.04%). Similarly, more men ages 20-24 (18.79%) received SRHR services compared to adolescent boys aged 15-19 (15.79%). The data suggests that fewer adolescent girls and boys are accessing these services. The majority of services received were SRHR (19.4%), followed by Nutrition (16.04%) and GBV (12.73%). However, the uptake of SRHR services remains low overall. The study identified several barriers to accessing and utilizing SRH, Nutrition, and GBV services, including long distances to health facilities, limited transport options, long waiting times, poor awareness of services and pricing. In addition, expensive services and inconvenient opening hours of the health facility also affects access to SRHR services. The project aims to overcome the obstacle of long distances by training additional healthcare workers (HCWs) and community health volunteers (CHVs) to provide services closer to the community. The project will collaborate with the Ministry of Health to ensure the availability of these services. By providing services closer to the community, out-of-pocket expenses can be minimized, including transportation costs, which can be a major barrier to accessing services. During HCW and CHV training, the project will emphasize the importance of flexible hours in health facilities. The project will also raise awareness in the community about the available SRHR and SGBV services. Additionally, the project will work at the county level to advocate for the construction of more health facilities near the communities, which will reduce the need for outreach services in the long term. By continuously collaborating with stakeholders and partners, the project will increase access to SRH and health-related information and services in the community. Furthermore, the project aims to identify and utilize untapped opportunities to promote the uptake of sexual and reproductive health and rights services. These opportunities could include venues such as churches, community gatherings, youth sports clubs, among others.

In Year 2, only 12.18% of both girls and boys, as well as women and men, in the Philippines reported having access to SRHR, SGBV, and health-related services. This was a decrease from the baseline of 32.21% for both genders aged 15-24. The decline was observed across all age and gender groups and almost all municipalities, except for Garchitorena, where there was an improvement in service attributes that made the services more accessible to the surveyed population. There are several potential explanations for the decline in services. One possibility is that services were not readily available or easily accessible to those who needed them. Additionally, the quality of services provided may not have met the expectations of those who received them. A lack of funding or personnel shortages may have also contributed to the decline. Another factor could be that the community members had lower awareness or knowledge about available services. It's also possible that the socioeconomic status of community members may have worsened over time. Finally, changes in economic, social, or political conditions in the target municipalities may have played a role. However, there has been a slight increase in the percentage of participants who reported no obstacles to their right to sexual and reproductive health services (33.83% in Y2, 32.21% at baseline). This has resulted in a decrease in reported barriers between Y2 and the initial survey. The improvements include transportation, facility operating hours, financial accessibility (including informal payments), awareness of the facility's location and available services, perceived competence and attitude of healthcare providers, and overall experience at the point of service (e.g., waiting times, privacy, cleanliness of the facility). However, it is worrying that more participants declined to answer this survey question during the Y2 survey, which suggests that they may have encountered barriers but were hesitant to provide specific responses. In Year 2, the top five barriers were long distance/unavailability of transport to the health facility (19.25%), inconvenient opening hours (13.43%), expensive services (8.13%), and insufficient awareness of the location, services, and prices (7.63%). To reach the target population by Y3, the project team will speed up the implementation of relevant efforts including Info Tours, Comprehensive Sexuality Education for children and their parents, and ComBaT. The project will also continue to engage women in income generation and savings activities. The project team will incorporate raising public awareness of service availability, location, and pricing into the existing interventions. Posting service-related information outside of the health facility (and potentially in strategic areas across the community) in a manner that can easily be understood by the target groups can be explored with local stakeholders. Project interventions are addressing the rest of the top barriers and given the delay in implementing relevant activities and achieving outputs in Y2, these indicators may improve in Y3.

The overall percentage of individuals in Uganda who reported having access to SRHR, SGBV, and health-related services decreased from 25.46% during the beginning of project implementation to 23.33% in Y2, affecting both males and females. Unfortunately, the project fell short of its Y2 goal of 30.24% of adolescent girls, boys, women, and men reporting access to these services. However, there was an improvement among females aged 15-19 from 18.67% to 22.29% in Y2, which fell just short of the Y2 target of 24.94% by 2.65%. Females aged 20-24 saw a significant improvement from baseline (17.86%) to 32.86%, exceeding the Y2 target of 24.29% by 8.57%. For males aged 15-19, reporting access to these services declined by 21.5% from 37.5% at baseline to 16% at Y2 assessment. Additionally, there was a reduction in the percentage of 20-24-year-old males from 27.15% to 22.79%. This reduction is not surprising, considering that women are deliberately targeted more

than men in the region, and more female-only groups are formed and supported by the project and other development partners. During planting, weeding, and harvest periods, community members, particularly males, relocate to farm areas, resulting in less involvement and participation in project activities. The project has identified several factors that may contribute to the decrease in accessing SRH and health-related services for male survivors of SGBV. One of the reasons is the lack of awareness among service providers of the specific needs of male survivors, as most SGBV programs are designed for women and girls who make up the majority of survivors. This can lead to reduced participation among young males whose self-confidence may still be low, especially if the service providers are not friendly. Furthermore, male survivors face social stigmatization as weak and unserious, not only from their families but also from service providers. In some cases, men who report abuse to the police stations are ridiculed for not being "man enough." Additionally, there are limited social spaces and programs for men and boys to increase awareness about the consequences of SGBV and the availability of SGBV services or programs that promote positive gender norms. To overcome barriers to accessing services, the project will implement several measures. These include engaging men and women in discussions about SRHR issues, providing support supervision and mentoring for healthcare and service providers, and ensuring all participants understand how to access services and where to report any denied services. The project aims to increase awareness in communities and follow up with boys and men to ensure they have access to SRHR and SGBV services. Social stigmatization of male survivors seeking assistance will be addressed through community awareness and sensitization. The project also intends to identify and integrate male survivors into existing trainings on case management and service provision. Providers will be trained to offer services for both boys and men in addition to girls and women. Lastly, the project will seek partnerships with other service providers and NGOs providing similar interventions to identify and bridge gaps.

In Cambodia, an innovative approach is being used to spread awareness about SRHR/GBV and health-related services through various communication strategies such as Facebook, other social media platforms, tablet viewing sessions, posters, banners, group sessions, shopping booths, night shows, and forums. These efforts are aimed at increasing access for both adolescent females and males, as well as women and men. Similarly, in the Philippines, champion groups, help centers, and community savings mechanisms (BULSA) have been set up to enhance access to SRHR and GBV services. An assessment was carried out in Uganda to identify gaps in each help center. The project was successful in providing necessary safe spaces, such as tents and edutainment equipment, like TV screens to improve the mobilization of youths to these help centers.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1120b: # of sessions with/or # of adolescent girls and boys, women and men reached with community-based family planning/sexual health services (by sex and age, if available) Source: FIAP HN1 1220a	Total: 18,125 G: 3,580 B: 2,107 W: 8,422 M: 4,016 Cam: 11,945 G: 1,169 B: 443 W: 7,228 M: 3,105 Ke: TBD Ph: 79 W: 40 M: 39 Sessions (mixed groups): 4 Ug: 6,101 G: 2,411 B: 1,664 W: 1,154 M: 872	N/A	Total: 18,125 G: 3,580 B: 2,107 W: 8,422 M: 4,016 Cam: 11,945 G: 1169 B: 443 W: 7228 M: 3105 Ke: TBD Ph: 79 W: 40 M: 39 Sessions (mixed groups): 4 Ug: 6,101 G: 2,411 B: 1,664 W: 1,154 M: 872	N/A	Records Review

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
	NOTE: THIS DATA WAS COLLECTED IN Y2				
Indicator Calculation:	<p>This indicator was calculated by obtaining numbers from the following records:</p> <ul style="list-style-type: none"> • Cambodia: CWCC records of the # of adolescent girls and boys, women and men reached with counselling and group information dissemination sessions on family planning/sexual health services • Philippines: Barangay Health Center records/RHU records of community-based sessions and participants of family planning/sexual health services • Uganda: Project records and Village Health Team records <p>Disaggregated by age and sex, if available</p>				

Multiple sessions of community-based family planning/sexual health services reaching 8,125 persons (3,580 girls, 8,422 women, 2,107 boys, and 4,016 men) have been conducted in Cambodia, the Philippines, and Uganda. The data reported for Year 2 also serve as the baseline. Data is currently unavailable in Kenya's HMIS and is scheduled to be collected by CHVs during Y3 outreach efforts.

In Cambodia, community-based family planning and sexual health sessions have been conducted for 1,169 girls, 7,228 women, 443 boys, and 3,105 men. However, the database records indicate that community-based family planning and sexual health services have reached fewer males than females. The reason behind this is that adult and adolescent males have migrated out of villages more frequently than females. To address this issue, several catch-up activities have been initiated in March to ensure equal access to key messages for males. These activities include shopping booths, night shows, and traditional contests. The effectiveness of these activities will be evaluated in Y3, and if necessary, alternative approaches will be proposed to ensure gender equality in the reach of key messages.

Over the course of 4 sessions of community-based family planning/sexual health services in the Philippines, 79 participants were reached, including 40 girls and women, and 39 boys and men. Unfortunately, COVID-19 pandemic-related movement restrictions and lockdowns made it difficult for individuals to attend these important services. As the pandemic overwhelmed health facilities with Covid-19 vaccination efforts, other health services, including family planning and sexual health services, suffered. Furthermore, some barangays reported missing records, especially those that were in the possession of Health Care Workers who have either resigned or been reassigned to other municipalities. The absence of disaggregated data on sex and age indicates that different populations' unique needs may not be receiving the attention they require, potentially leading to inefficiencies and missed opportunities in service delivery and perpetuating inequalities in health services access. To improve data collection and address gaps in service delivery, it's important to provide training on using standardized tools and disaggregating data by sex and age. This includes refreshing the training of Barangay Local Government Unit officials and Community Health Workers, as well as incorporating it into the orientation of new officials and CHWs. The project plans to integrate this training into Policy Development training sessions for BLGU officials (Output 1311).

In Uganda, 6,101 (with 2,411 girls, 1,154 women, 1,664 boys, and 872 men) participants were reached with community-based family planning/sexual health services. Despite efforts to promote youth access to reproductive services and educate service providers on providing these services, many adolescents still face obstacles when trying to access them. For example, girls had struggled to access family planning and sexual health services due to domestic responsibilities that limit their sexual knowledge and awareness of available services. Additionally, negative cultural attitudes towards premarital sex can cause feelings of shyness and shame, while fear of parental disapproval and lack of confidentiality among service providers can create barriers to accessing public sexual and reproductive health services. Economic and geographic factors can also contribute to limited accessibility, along with a shortage of youth-friendly health clinics. To address these issues and ensure that adolescents receive critical SRHR information, the project aims to increase the number of schools participating in the project activities and reach out to out-of-school youth through their parents, educators, and peers. Volunteers will be incentivized to work with youth, reducing attrition rates and ensuring effective delivery of information.

Males access family planning services less often than females since they believe it to be solely a female responsibility. To combat this in Cambodia, the project aims to share messages with males through various channels, such as when they return home from work or through social media platforms, with the help of responsible parties, the health sector, and local authorities. In terms of governance, the health facility assessment tool was utilized to aid targeted health facilities in the Philippines to develop action plans that prioritize the provision of family planning and sexual health services, despite limited funding and resources from the Local Government Unit. In Uganda, the project focused on improving the quality of care provided by training healthcare staff, community health volunteers, and other duty-bearers on women-centered, safe, and inclusive care and counseling. The training covered topics such as responding to sexual and gender-based violence (SGBV), preventing and treating sexually transmitted infections (STIs). To ensure quality care for SGBV survivors, the training utilized the minimum care quality assurance tool to enhance the capacity of healthcare staff and volunteers to respond to patients more effectively and with greater sensitivity.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
<p>1120c: # of sessions with/or # of adolescent girls and boys, women and men reached with community-based health services SGBV-related (by sex and age)</p> <p>Source: FIAP HN3 1210a</p>	<p>T: 10,577 G: 2,991 B: 2,251 W: 3,061 M: 2,274</p> <p>Cam: 5,571 Girls: 1,120 Boys: 995 F: 1,966 M: 1490</p> <p>Ke: TBD</p> <p>Ph: 8 G: 1 B: 1 W: 5 M: 1 Sessions (mixed groups): 5</p> <p>Ug: 4998 G: 1870 B: 1255 W: 1090 M: 783</p> <p>NOTE: THIS DATA WAS COLLECTED IN Y2</p>	N/A	<p>T: 10,577 G: 2,991 B: 2,251 W: 3,061 M: 2,274</p> <p>Cam: 5,571 Girls: 1,120 Boys: 995 Women: 1,966 Men: 1490</p> <p>Ke: TBD</p> <p>Ph: 8 G: 1 B: 1 W: 5 M: 1 Sessions (mixed groups): 5</p> <p>Ug: 4998 G: 1870 B: 1255 W: 1090 M: 783</p>	N/A	Records Review
<p>This indicator was calculated by obtaining numbers from the following records:</p> <ul style="list-style-type: none"> • Cambodia: CWCC records of the # of adolescent girls and boys, women and men reached with counselling and group information dissemination sessions SGBV health-related services • Philippines: Barangay Health Center records/RHU records of community-based sessions and participants of SGBV-related health services • Uganda: Project records and Village Health Team records <p>Disaggregated by age and sex</p>					

Multiple sessions of community-based health services and SGBV-related services in Y2 reached a total of 10,577 individual, 2,991 girls, 3,061 women, 2,251 boys, and 2,274 men have been conducted in Cambodia, the Philippines, and Uganda. The information reported for Year 2 also serves as the baseline figures. Data is currently unavailable in Kenya's HMIS and is scheduled to be collected by CHVs during Y3 outreach efforts.

In Cambodia, community-based health services for SGBV have been provided to 1,120 girls, 1,966 women, 995 boys, and 1,490 men. However, the project team has identified some barriers that have led to reduced attendance at CCWC-led facilitation sessions, including migration issues, unavailability of CCWC staff, and insufficient field monitoring and coaching. To address these issues, potential VHS and Youth champions could be trained and selected to lead sessions in the absence of CCWC staff. Additionally, more time can be allocated to field monitoring and coaching, and refresher or onsite training may be necessary to strengthen the facilitators' capacity.

5 sessions of community-based health services SGBV-related have been attended by 8 individuals (1 girl, 5 women, 1 boy, and 1 man) in the Philippines. According to CHWS, VAWC officers, and BLGU Officials, who provided the data, very few sessions were held due to the COVID-19 pandemic, resulting in limited mobilization. The sessions in Ocampo and Siruma were conducted in Y1 when restrictions were gradually easing. Despite an increase in SGBV incidents, particularly domestic violence, during the pandemic, the uptake of SGBV-related health services recorded in the health center was low due to mobility restrictions and fear of contracting COVID-19 in healthcare facilities. This reflects the baseline report's findings, which showed that underreporting, lack of awareness of SGBV, fear of stigma and shame, lack of trust in the justice system, economic dependence of victims on perpetrators, and limited access to service providers have contributed to the low uptake of services. The project aims to promote community-based SGBV-related health services through trained HCWs and CHWs, advocating for Local Government Units and Health Facilities' involvement in providing these services.

In Uganda, a number of community-based health services addressing SGBV-related issues have been conducted benefitting 1,870 girls, 1,090 women, 1,255 boys, and 783 men. According to the collected data, more women and adolescent girls have availed the services compared to men. This could be attributed to the project's efforts in supporting in and out-of-school AGWs by providing help centers through F+M champion groups. These champions are responsible for sharing information and facilitating access to the help centers for AGWs. The help centers are now equipped with sports equipment and a tent to ensure privacy, providing a safe space for counseling, dialogue, and education on SGBV and other health-related services. The project will continue to intensify community outreaches and health education, advocating for improved quality of health services and clinics that cater to the needs and preferences of adolescents and youth.

1.2.3 IMMEDIATE OUTCOME 1130

1130 Increased supportive mindset of men, boys women and girls, and key gate-keepers towards more equal health and rights of adolescent girls and women, especially in relation to SGBV, FGM and teenage pregnancy.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1130a: % of respondents who agree that women should freely realize their health-related rights (e.g. marriage, family planning, SRHR rights and rights commonly violated)	Total: 53.71% 15-19 F: 49.04% 20-24 F: 59.76% 15-19 M: 48.81% 20-24 M: 57.24% Non-binary: 60% Ca: 15-19 F: 63.70% 20-24 F: 82.76% 15-19 M: 70.34%	Total: 56.54% 15-19F: 52.36% 20-24F: 62.01% 15-19M: 51.78% 20-24M: 60% Ca: 15-19 F: 65% 20-24 F: 83% 15-19 M: 72%	Total: 47.17% (1143/2423) 15-19F: 43.32% (279/644) 20-24F: 54.26 (331/610) 15-19M: 40% (242/605) 20-24M: 51.61% (288/558) Non-binary 15-24: 75% (3/4) Ca: 15-19F: 70.21% (99/141) 20-24F: 74.29 (104/140)	Total: 74.06% 15-19 F: 72.50% 20-24 F: 77.50% 15-19 M: 71.25% 20-24 M: 75.00% Ca: 15-19 F: 85% 20-24 F: 90% 15-19 M: 85%	Mobile Household Survey (MHS)

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
by GBV, also including country specific context etc.) (By sex, age)	20-24 M: 86.90% Total: 75.90% Ke: 15-19 F: 29.25% 20-24 F: 33.33% 15-19 M: 11.72% 20-24 M: 19.29% Total: 23.44% Ph: 15-19 F: 71.97% 20-24 F: 70.34% 15-19 M: 74.85% 20-24 M: 73.85% Non-binary: 60% Total: 72.39% Ug: 15-19 F: 34% 20-24 F: 52.14% 15-19 M: 39.22% 20-24 M: 49.67% Total: 43.6%	20-24 M: 87% Total: 76.75% Ke: 15-19 F: 31.25% 20-24 F: 35.33% 15-19 M: 13.72% 20-24 M: 21.29% Total: 25.40 Ph: 15-19 F: 74% 20-24 F: 74% 15-19 M: 78% 20-24 M: 78% Total: 76% Ug: 15-19 F: 39.20% 20-24 F: 55.71% 15-19 M: 43.38% 20-24 M: 53.74% Total: 48%	15-19M: 66.67% (96/144) 20-24M: 83.45% (121/145) Total: 73.68% (420/570) Ke: 15-19F: 12.28% (21/171) 20-24 F: 27.68 (49/177) 15-19M: 15.79% (24/152) 20-24M: 22.15% (33/149) Total: 19.51% (127/651) Ph: 15-19 F: 61.14% (107/175) 20-24 F: 71.9% (110/153) 15-19M: 49.06% (78/159) 20-24M: 60.16% (77/128) Non-binary 15-24: 75.0% (3/4) Total: 60.58% (375/619) Ug: 15-19 F: 33.12% (52/157) 20-24 F: 48.57% (68/140) 15-19 M: 29.33% (44/150) 20-24 M: 41.91% (57/136) Total: 37.91% (221/583)	20-24 M: 90% Total: 87.50% Ke: 15-19 F: 55% 20-24 F: 60% 15-19 M: 50% 20-24 M: 50% Total: 53.75% Ph: 15-19 F: 90% 20-24 F: 90% 15-19 M: 90% 20-24 M: 90% Total: 90% Ug: 15-19 F: 60% 20-24 F: 70% 15-19 M: 60% 20-24 M: 70% Total: 65%	
<p>This indicator was calculated by counting the number of participants who answered:</p> <ol style="list-style-type: none"> Yes to "In your opinion, should a wife have an equal say in how many children to have and when than her husband?" <p>AND</p> <ol style="list-style-type: none"> No to "In your opinion, is a husband justified in hitting, beating or otherwise punishing his wife if he has a reason (as when she burns the food, argues with him, goes out without telling him, reject his requests, etc.)?" <p>AND</p> <ol style="list-style-type: none"> No to "Is a family member justified in preventing a woman from visiting a doctor or health center if he or she has a reason to do so?" <p>AND</p> <ol style="list-style-type: none"> No to "In your opinion, can a forced marriage in some cases justified?" <p>Divided by the total number of respondents multiplied by 100</p> <p>Disaggregation: Women 15-19; Women 20-24; Men 15-19; Men 20-24; Total</p>					

In the four implementing countries, 47.17 % of women and men between the ages of 15 and 24 agree that women should freely realize their health-related rights. Compared to the baseline percentage of 53.71%, the Y2 results showed a decrease of 6.54 %, falling short of the 56.54% Y2 target.

According to the survey conducted in Cambodia, 73.68% of females and males aged 15-24, believe that women should have the freedom to exercise their health-related rights. Among the 15-19 age group, 70.21% of females and 66.67% of males support that women should realize their health-related rights, indicating an increase from the baseline of 63.70% for females, but a decrease for males with 70.34% at baseline. In the 20-24 age group, 74.29% of women and 83.45% of men agreed that women should have the ability to freely realize their rights, showing a decline from the baseline results of 82.76% for women and 86.90% for men.

Y2 Survey: Perception of Gender Rights		Women 15-19	Women 20-24	Men 15-19	Men 20-24	All respondents aged 15-24	
% PROVIDING THE "CORRECT" ANSWER THAT IS ALIGNED WITH SRHR PRINCIPLES							
1	In your opinion, should a wife have an equal say in how many children to have and when than her husband? (yes = correct)	BL	79.5% (116/146)	93.1% (135/145)	82.1% (119/145)	91.7% (133/145)	86.6% (503/581)
		Y2	86.5% (122/141)	92.86% (130/140)	74.3% (107/144)	91.03% (132/145)	86.14% (491/570)
2	In your opinion, is a husband justified in hitting, beating or otherwise punishing his wife if he has a reason (as when she burns the food, argues with him, goes out without telling him, reject his requests, etc.) ? (No = correct)	BL	88.4% (129/146)	91.7% (133/145)	96.6% (140/145)	98.6% (143/145)	93.8% (545/581)
		Y2	86.5% (122/140)	86.4.7% (121/140)	95.8% (138/144)	94.4% (137/145)	90.8% (518/570)
3	Is a family member justified in preventing a woman from visiting a doctor or health center if he or she has a reason to do so? (No = correct)	BL	91.8% (134/146)	97.9% (142/145)	89.7% (130/145)	95.2% (138/145)	93.6% (544/581)
		Y2	95.1% (134/141)	96.4% (135/140)	91.6% (132/145)	97.2% (141/145)	95.09% (542/570)
4	In your opinion, can a forced marriage in some cases justified? (No = correct)	BL	92.5% (135/146)	96.6% (140/145)	95.9% (139/145)	97.9% (142/145)	95.7% (556/581)
		Y2	99.3% (140/141)	95.0% (133/140)	97.2% (140/144)	97.2% (141/145)	97.2% (554/570)

The overall result of 73.68% did not meet the project's Y2 target of 76.65%, but two of the four survey questions that comprise this indicator showed improvement compared to the baseline. Specifically, 93.6% at baseline and 95.09% in Y2 believed that a family member should not prevent women from visiting health centers, and 97.2% of respondents agreed that forced marriage cannot be justified, marking an increase from the baseline at 95.7%. However, domestic violence incidents remain common in rural areas as noted by the decrease in the percentage of those who do not agree that a husband is justified in hitting or beating his wife with a reason, with 93.8% at baseline and 90.8% in Y2. In addition, there is no change in the belief that a wife and husband should have an equal say in determining the number and timing of their children between the baseline value of 86% and the Y2 result of 86%. In order to achieve better results and meet the EOP target, the project will increase its efforts in conducting relevant activities such as health-related trainings, and facilitated sessions with parents and caregivers on topics related to sexual and reproductive health and gender-based violence. The project will involve CCWC/CC facilitators, local leaders, VHSG, and Youth Champions to facilitate sessions on GBV and discuss the underlying causes of violence against women. Additionally, research will be conducted to facilitate gender transformative action planning and raise awareness on SRHR and SGBV, advocating for women to have an equal voice and no tolerance for violence in the community.

Y2 Survey: Perception of Health Rights of Women (Kenya)	% Providing the correct response that is aligned with SRHR Principles				
	Women 15-19	Women 20-24	Men 15-19	Men 20-24	All respondents aged 15-24
1. In your opinion, should a wife have an equal say in how many children to have and when than her husband?	31.58% (54/171)	50.85% (90/177)	28.29% (43/152)	38.93% (58/149)	37.63% (245/651)
2. In your opinion, is a husband justified in hitting, beating or otherwise punishing his wife if he has a reason (as when she burns the food, argues with him, goes out without telling him, reject his requests, etc.) ?	60.82% (104/171)	72.32% (128/177)	59.87% (91/152)	73.83% (110/149)	66.82% (435/651)
3. Is a family member justified in preventing a woman from visiting a doctor or health center if he or she has a reason to do so?	73.1% (125/171)	75.71% (134/177)	80.92% (123/152)	88.59% (132/149)	79.26% (516/651)
4. In your opinion, can a forced marriage in some cases justified?	66.08% (113/171)	73.45% (130/177)	69.08% (105/152)	79.87% (119/149)	72.04% (469/651)

In Kenya, the percentage of both men and women aged 15-24 who agree that women should have the freedom to realize their health-related rights has declined from 23.44% at baseline to 19.51% in Y2. However, the results for females aged 15-19 and 20-24 showed a decrease from the baseline, from 29.25% to 12.28% and from 33.33% to 27.68%, respectively. On the other hand, the results for males showed an increase from baseline, with 15.79% for 15-19 males and 22.15% for 20-24 males, compared to 11.72% and 19.29%, respectively. Based on the responses to the underlying survey questions, it is alarming to note that only 37.63% of young women and men aged 15-24 believe that a wife should have an equal say in child-bearing decisions. In addition, only 66.82% of respondents believe that wife beating is unacceptable, while 72.04% believe that forced marriage is never justifiable. The majority of the participants (79.26%) hold the belief that a family member should not be denied access to health services if they require it. To increase this indicator and achieve the EOP target, it is critical that the project in Kenya focus its efforts on educating people about the importance of having an equal voice in deciding the number and timing of children.

Survey findings from the Philippines indicate that 60.58 % of 15- to 24-year-old women and men agree that women should freely exercise their health-related rights. However, this represents a significant decline from the baseline results of 73.39%. In addition, the Y2 target of 76% was not met during this reporting period. With the exception of 20-24-year-old females, who showed a slight increase from baseline (70.34%) to Y2 (71.9%), and non-binary individuals, who showed an increase from baseline (60%) to Y2 (75%), the percentage of 15-24 male respondents and 15-19 female respondents who agree that women should realize their health-related rights has decreased significantly from baseline. 61.14% of 15-19-year-old females, 49.06% of 15-19-year-old males, and 60.16% of 20-24-year-old males in Y2 demonstrated a significant decline compared to 71.97%, 74.85%, and 73.85%, respectively. In Y2, the proportion of women aged 15-24 who agreed that women should freely exercise their health-related rights was significantly higher than that of men aged 15-24, which may be attributed to the greater ability of female respondents to identify with the issue. Alternatively, the males surveyed may hold a more conservative view of the issue due to their perception that they will lose decision-making authority if women are able to exercise their gender-related rights. On the qualifying questions, the proportion of affirmative responses in Y2 decreased in comparison to the baseline across every question. For instance, slightly more respondents felt that a wife should not have an equal say in childbearing, and the proportion of respondents who felt that family members are justified in preventing women from visiting a healthcare provider increased by more than threefold. As corrective actions, the project will re-examine how the training and education sessions and materials indicated in Outputs 1131, 1132, and 1133 are communicated to the intended target group. The project will also investigate whether there are interest groups or sources offering counter-messages or information on various platforms. In addition, advocacy efforts among men of all ages and younger women will be strengthened.

In Uganda, the Year 2 results showed that only 37.91% of both men and women agree that women should have the freedom to exercise their health-related rights, falling short of the annual target of 48%. This also marks a decrease from the baseline of 43.76%. The Year 2 results revealed a decline from the baseline value, with 33.12% of 15-19-year-old females, 48.57% of 20-24-year-old females, 29.33% of 15-19-year-old males, and 41.91% of 20-24-year-old males, compared to the baseline results of 34%, 52.14%, 39.22%, and 49.67%, respectively. This decrease in Year 2 results could be attributed to male disapproval of family planning use by their female partners, misconceptions about family planning side effects, religious and cultural beliefs, and the view that men have the final say in family decisions, making it difficult for women to access health services without male consent. To improve these results, the project will continue to raise awareness of the importance of women's health-related rights through education sessions and engagement with cultural and religious leaders to empower the community on SRHR.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1130b: Level of support for health and health-related rights of adolescent girls and women expressed by the members of the F+M Champion Groups in selected real-life scenarios	<p>Cam: F: Low M: Low Total: Low</p> <p>Ke: F: High M: Low Total: High</p> <p>Ph: G: Low B: Low F: High M: Low Total: Low</p> <p>Ug: F: High M: High Total: High</p> <p>NOTE: THIS DATA WAS COLLECTED IN Y2</p>	N/A	<p>Cam: F: Low M: Low Total: Low</p> <p>Ke: F: High M: Low Total: High</p> <p>Ph: G: Low B: Low F: High M: Low Total: Low</p> <p>Ug: F: High M: High Total: High</p>	<p>Cam: F: High M: High Total: High</p> <p>Ke: Female: Very High Male: High Total: High</p> <p>Ph: G: High to Very High B: High to Very High F: High to Very High M: High to Very High Total: High to Very High</p> <p>Ug: F: Very High M: Very High Total: Very High</p>	Focus Group Discussions (FGDs)

This indicator was calculated by using the rating guide below:

Scenario rating guide

- Very High Level of Support = 4 points (All participants showed a very high level of support for health and health-related rights of adolescent girls and women in all the scenarios discussed)
- High Level of Support = 3 points (Most participants showed a high level of support for health and health-related rights of adolescent girls and women in most of the scenarios discussed)
- Low Level of Support = 2 points (The level of support was rather lower or hesitant, some participants showed a lower level of certainty about the rights of women and girls and how to support them.)
- Very Low Level of Support = 1 point (The level of support of most participants was very low, the discussion showed a high level of uncertainty about what the rights of women and girls are and how to support them)

Each of the 4 scenarios are rated based on the above guidance.

Average rating is then determined by getting the total points divided by 4. Overall rating guide:

- 4: Very High Level of Support
- 3-3.9: High Level of Support
- 2-2.9: Low Level of Support
- 1-1.9: Very Low Level of Support

According to the Y2 FGD results, the level of support for the health and health-related rights of adolescent girls and women expressed by the members of the F+M Champion Groups varies across the four implementing countries. Kenya and Uganda show high levels of support, while Cambodia and the Philippines exhibit low levels. This indicator uses data collected in Y2 as its baseline.

In Cambodia Y2 result showed that the level of support for the health and health-related rights of adolescent girls and women among the members of F+M Champion Groups is low. In various real-life scenarios discussed during focus group discussions, the group members expressed their thoughts, feelings, and actions related to teaching sexuality and reproduction at school, delaying childbirth until the age of 20, fear of gossip when consulting a doctor, contraception use among youth, and sexual abuse by respected community members. Additionally, SRHR issues such as shyness to seek services, health issues being considered too minor, lack of education and mental health, ignorance about SRHR, early marriage, and domestic violence were also discussed during the FGDs. The project will address the feedback obtained from focus group discussions during community sessions, events, and social media communications.

The F+M Champion Groups in Kenya were observed to express high levels of support for the health and health-related rights of adolescent girls and women in real-life scenarios. However, the level of support for males was found to be low, suggesting that they do not prioritize health-related issues. Upon further examination of the data from the FGDs, it was discovered that men lacked the necessary knowledge to inform their actions in various life scenarios. Seeking health services and privacy at health facilities were not seen as major concerns by men, and the referral system for health-related rights was unclear to many. In addition, men in Kenya tend to have poor health-seeking behavior for self-care, which can affect how they treat those in need of health services. The project aims to improve this situation by organizing training sessions for men, focusing on the referral pathway for seeking health services and the rights of patients at health facilities. Furthermore, promoting male engagement in championing health and rights within villages will also be encouraged to increase their support for health-related rights.

In the Philippines, the level of support for health and health-related rights of adolescent girls and women expressed by the members of the F+M Champion Groups in selected real-life scenarios is low. All groups support school-based sexuality and reproduction education. However, viewpoints vary on what and when to teach. All groups agreed that catcalling should be prohibited. Women's wardrobe choices may affect catcalling, but perspectives vary. All groups agree that adolescents—especially unmarried and minors—should not use contraception. The Champion Groups of Men and Adolescent Boys have voiced their concerns about gender-based violence and the limited role of women in their community. The Champion Groups of Adolescent Boys recognize the importance of respecting women and taking responsibility for their actions. This indicates that boys can become allies in promoting gender equality. Overall, the group's views reflect a conservative and traditional mindset towards sexuality and gender issues, especially when it comes to adolescent sexuality and GBV.

In Uganda, the members of F+M Champion Groups have demonstrated high support for the health and rights of adolescent girls and women in various real-life situations. This is attributed to the sensitization efforts of the project and other stakeholders, including ongoing awareness sessions and trainings on SRHR, SGBV, Program H&M, and COLMEAL in the area.

1.3 INTERMEDIATE OUTCOME 1200

1200 Improved provision of gender responsive, inclusive, respectful, and quality health services, and nutrition interventions which are environment-sensitive, by duty-bearers and responsibility holders for the most vulnerable adolescent girls, women and U5 children in target areas

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1200a: # and % of adolescent girls and	Total: 61.05% (359/588) 15-19 F: 66.67% (136/204) 20-24 F: 58.07% (223/384) SRH: 65.09% (343/527)	Total: 64.65% 15-19F: 66.85% 20-24F: 62.45% SRH: 65.30%	SRH 15-19F: 39.59% (251/634) 20-24F: 64.62% (389/602) Total: 51.78% (640/1236)	Total: 78.79% 15-19 F: 78.93% 20-24 F: 78.65% SRH: 80.14%	Mobile Household

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
women who report receiving youth-friendly SRH services including nutrition counselling SGBV related or family planning services from duty bearers (by age and type of service-nutrition vs. SRHR)	<p>Nutrition: 63.10% (183/290)</p> <p>Ca: 15-19 F: 29.63% (8/27) 20-24 F: 28% (28/100) SRH: 36.47% (31/85) Nutrition: 25% (19/76)</p> <p>Ke: 15-19 F: 75.61% (62/82) 20-24 F: 71.17% (79/111) SRH: 74.03%(134/181) Nutrition: 82.47% (80/97)</p> <p>Ph: 15-19 F: 83.33% (15/18) 20-24 F: 66.07% (37/56) SRH: 69.57% (48/69) Nutrition: 67.92% (36/53)</p> <p>Ug:</p>	<p>Nutrition: 66</p> <p>Ca: 15-19 F: 35% 20-24 F: 33% SRH: 40% Nutrition: 28%</p> <p>Ke: 15-19 F: 78% 20-24 F: 75% SRH: 78% Nutrition: 84%</p> <p>Ph: 15-19 F: 85.4% 20-24 F: 71.8% SRH: 74.2% Nutrition: 75%</p> <p>Ug:</p>	<p>GBV 15-19F: 23.31% (117/502) 20-24F: 31.28% (147/470) Total: 27.16% (264/972)</p> <p>Nutrition 15-19F: 38.37% (193/503) 20-24F: 56.29% (264/469) Total: 47.02% (457/972)</p> <p>Ca: SRH 15-19F: 34.85% (46/132) 20-24F: 69.17% (92/133) Total: 52.08% (138/265)</p> <p>GBV 15-19F: n/a 20-24F: n/a</p> <p>Nutrition 15-19F: n/a 20-24F: n/a</p> <p>Ke: SRH 15-19F: 42.11% (72/171) 20-24F: 74.72% (133/178) Total: 58.74% (205/349)</p> <p>GBV 15-19F: 21.64% (37/171) 20-24F: 34.83% (62/178) Total: 28.37% (99/349)</p> <p>Nutrition 15-19F: 32.16% (55/171) 20-24F: 59.55% (106/178) Total: 46.13% (161/349)</p> <p>Ph: SRH 15-19F: 42.29% (74/175) 20-24F: 43.71% (66/151) Total: 42.94% (140/326)</p> <p>GBV 15-19F: 32.57% (57/175) 20-24F: 32.89% (50/152) Total: 32.72% (107/327)</p> <p>Nutrition 15-19F: 38.86% (68/175) 20-24F: 42.76% (65/152) Total: 40.67% (133/327)</p> <p>Ug:</p>	<p>Nutrition: 79.99%</p> <p>Ca: 15-19F: 50.70% 20-24F: 49.60% SRH: 55.60% Nutrition: 47.50%</p> <p>Ke: 15-19 F: 90% 20-24 F: 90% SRH: 90% Nutrition: 92.47%</p> <p>Ph: 15-19 F: 95% 20-24 F: 95% SRH: 95% Nutrition: 95%</p> <p>Ug:</p>	Survey (MHS)

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
	15-19 F: 66.23% (51/177) 20-24 F: 67.52% (79/117) SRH: 67.71% (130/192) Nutrition: 75% (48/64)	15-19: 69% 20-24: 70% SRH: 69% Nutrition: 77%	SRH 15-19F: 37.82% (59/156) 20-24F: 70.0% (98/140) Total: 53.04% (157/296) GBV 15-19F: 14.74% (23/156) 20-24F: 25.0% (35/140) Total: 19.59% (58/296) Nutrition 15-19F: 44.59% (70/157) 20-24F: 66.91% (93/139) Total: 55.07% (163/296)	15-19 F: 80% 20-24 F: 80% SRH: 80% SGBV: 70% Nutrition: 85%	

This indicator was calculated by counting the number of respondents who answered:

1. SRH:

- Have you, your partner, or your child younger than 5 years old (if applicable) received any of the following services in the past 12 months?
 - o Counseling or other services on family planning and sexual and reproductive health (such as how to have a healthy pregnancy, methods of contraception and emergency contraception, safe pregnancy abortion, etc.)

OR

- o Pregnancy and birth related services (such as check ups during pregnancy, assistance with birth; after-delivery check-ups monitoring of height/weight/age of the child, etc.)

AND

Have answered positively x³⁴ out of 12 questions about youth-friendly SRH services. Disaggregated according to age-groups

2. Nutrition:

- Have you, your partner, or your child younger than 5 years old (if applicable) received any nutrition counselling (on nutritional food micronutrients, nutrition in pregnancy, breastfeeding, hygiene and safe drinking water) and nutrition services in the past 12 months?
 - o Yes

AND

Have answered positively x^{Error! Bookmark not defined.} out of 12 questions about youth-friendly SRH services. Disaggregated according to age-groups

3. SGBV

- Have you, your partner, or your child younger than 5 years old (if applicable) received any counselling what to do if you are involved in or witnessing physical, emotional, psychological, or sexual violence, including denial of resources or access to health services in the past 12 months?
 - o Yes

AND

Have answered positively x⁵ out of 12 questions about youth-friendly GBV services. Disaggregated according to age-groups

x for Cambodia, Kenya, and Philippines= 7

x for Uganda= 8

Disaggregated by age and type of service.

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⁴ x is determined by the IP based on their appreciation of their context and how much do they think their interventions can affect (x for Cambodia, Kenya, and Philippines= 7; x for Uganda= 8)

⁵ x is determined by the IP based on their appreciation of their context and how much do they think their interventions can affect (x for Cambodia, Kenya, and Philippines= 7; x for Uganda= 8)

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method

A recent survey conducted in four countries revealed that among the adolescent girls and women who participated, 51.78% (640 out of 1236) received youth-friendly sexual and reproductive health services, 47.02% (457 out of 972) received nutrition counselling, and 27.16% (264 out of 972) received services related to gender-based violence from duty bearers. Unfortunately, the results for sexual and reproductive health services and nutrition counselling have significantly declined from the baseline figures of 65.09% and 63.10%, respectively. While data on gender-based violence was not captured at baseline, future surveys will collect information on the specific types of services, including sexual and reproductive health, gender-based violence and nutrition.

Survey findings show that 52.08% (138/265) of females aged 15-24 in Cambodia have received youth-friendly SRH services. This includes 34.85% (46/132) of girls aged 15-19 and 69.17% (92/133) of females aged 20-24. This is a significant increase from the baseline value of 36.47%. However, in Y2, data on GBV and nutrition services were not reported due to a technical error, this information will be collected in Y3. To improve SRH service quality, the project will focus on addressing the three areas with the lowest satisfaction ratings from the Y2 survey. These include ensuring appointments and counseling services are not interrupted by staff or other clients, health service providers are non-judgmental towards clients and their partners, and services are youth-friendly, confidential, and non-judgmental. To encourage more people to utilize SRH and other health-related services, the project will provide youth-friendly SRHR service training to health staff and private providers and promote services through various channels like Facebook, Telegram, campaign events, and village-level sessions.

Survey data from Kenya shows that there has been a decrease in the number of females aged 15-24 receiving youth-friendly sexual and reproductive health services. Only 58.74% (205/349) of females in this age group accessed SRH services, with 42.11% (72/171) aged 15-19 and 74.72% (133/178) aged 20-24. This is a significant decline from the baseline rate of 74.03%. Additionally, youth-friendly nutrition services were accessed by only 46.13% (161/349) of female respondents, with 32.16% (55/171) aged 15-19 and 59.55% (106/178) aged 20-24, indicating a significant decrease from the previous rate of 82.47% (80/97). Furthermore, only 28.37% (99.0/349.0) of respondents reported accessing youth-friendly GBV-related services, with 21.64% (37/171) aged 15-19 and 34.83% (62/178) aged 20-24. The number of those receiving youth friendly SRHR services declined due to the prolonged drought which saw several families focus on the search for water and food for the family over seeking health care services. Also, there was a reduction in outreach services supported by partner NGOs supporting outreach services hence these households probably never accessed due to distance. Lastly, not many healthcare workers and CHVs were trained on SGBV services and thus were not able to provide GBV-related services. To address this issue and improve access to SRH, nutrition, and GBV services, the project will intensify its activities in all targeted villages in Turkana West sub-county. This will include focused sensitization targeting females aged 15-19, with counseling on SRHR, SGBV, and nutrition. The project will also increase communication channels to reach more people in the target communities.

Among the surveyed individuals in the Philippines, it was found that 42.94% (140/326) of females aged 15-24 reported receiving youth-friendly SRH services which include 42.29% (74/175) of females aged 15-19 and 43.71% (66/151) of females aged 20-24. However, this is a significant decline from the baseline of 69.57% (48/69). Regarding nutrition services, 40.67% (133/327) of female respondents including 38.86% (68/175) of females aged 15-19 and 42.76% (65/152) of females aged 20-24 reported receiving youth-friendly services from duty bearers. Unfortunately, this is a decrease from the reported baseline value of 67.92% (36/53). Additionally, only 32.72% (107/327) of females reported accessing youth-friendly GBV services, including 32.57% (57/175) of females aged 15-19 and 32.89% (50/152) of females aged 20-24. However, the Y2 data may not be comparable to the baseline figures due to the change in the questionnaire structure and calculation to include disaggregation by service. According to the survey results, less than half of the participants had access to youth-friendly SRH, GBV, and nutrition services. Upon reviewing the responses, it was found that the reasons for this include frequent disruptions during appointments, inadequate service availability, and judgemental and non-youth-friendly service provision. To address these, the project aims to identify CHWs who require Adolescent Job Aid and Reproductive Health Care training to improve youth-friendly service provision and patient satisfaction. Furthermore, the project aims to strengthen its advocacy efforts for gender equality and the rights of adolescent girls and young women at the local government level. This includes advocating for policies and legislation that enable easier access to SRH services, nutrition counselling, and GBV services.

In Uganda, survey results indicate a decrease in the number of females receiving youth-friendly SRH services, with 53.04% (157/296) reporting access. Of these, 37.82% (59/156) were aged 15-19, and 70.0% (98/140) were aged 20-24. This marks a decline from the 67.71% (130/192) recorded at baseline. Additionally, 55.07% (163/296) of female respondents were able to access youth-friendly nutrition services, including 44.59% (70/157) aged 15-19 and 66.91% (93/139) aged 20-24, indicating a decline from 75% (48/64) reported at baseline. However, only 19.59% (58/296) of women reported receiving youth-friendly GBV-related services from duty bearers, including 14.74% (23/156) aged 15-19 and 25% (35/140) aged 20-24. The survey revealed some areas that need improvement, specifically, managing interruptions during appointments and overcoming negative perceptions such as being non-judgemental and non-youth-friendly during service delivery. To achieve this, the project seeks to educate service providers on how to be non-interruptive and non-judgmental during service provision. In addition, the project will monitor the use of tents provided to help centers to ensure that they contribute to privacy and make service points more youth-friendly.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1200b: % and # of supported facilities that provide safe, gender responsive, quality, inclusive, respectful, and youth-friendly SRHR and SGBV related services to adolescent girls and women (by type of service)	<p>Total: SRH: 67.24% (39/58) GBV: 60.34% (35/58)</p> <p>Ca: SRH: 73.33% (33/45) GBV: 71.11% (32/45)</p> <p>Ke: SRH: 62.5% (5/8) GBV: 25% (2/8)</p> <p>Ph: SRH: 20% (1/5) GBV: 20% (1/5)</p> <p>Ug: SRH: N/A GBV: N/A</p> <p>NOTE: THIS DATA WAS COLLECTED IN Y2</p>	<p>Total: SRH: N/A GBV: N/A</p> <p>Ca: SRH: N/A GBV: N/A</p> <p>Ke: SRH: N/A GBV: N/A</p> <p>Ph: SRH: N/A GBV: N/A</p> <p>Ug: SRH: N/A GBV: N/A</p>	<p>Total: SRH: 67.24% (39/58) GBV: 60.34% (35/58)</p> <p>Ca: SRH: 73.33% (33/45) GBV: 71.11% (32/45)</p> <p>Ke: SRH: 62.5% (5/8) GBV: 25% (2/8)</p> <p>Ph: SRH: 20% (1/5) GBV: 20% (1/5)</p> <p>Ug: SRH: N/A GBV: N/A</p>	<p>Total: SRH: TBD GBV: TBD</p> <p>Ca: SRH: 80% (36/45) GBV: 75.55% (34/45)</p> <p>Ke: SRH: 80% (6/8) GBV: 80% (6/8)</p> <p>Ph: SRH: 80% (4/5) GBV: 80% (4/5)</p> <p>Ug: SRH: N/A GBV: N/A</p>	Health Facility Assessment (Checklist)
<p>Indicator Calculation: Facilities providing SRHR care: Counting the number of health facilities that have been positively assessed on x⁶ of the 30⁷ qualifiers</p> <p>Facilities providing SGBV care: Counting the number of health facilities that have been positively assessed on x⁶ of the 49⁷ qualifiers</p> <p>Disaggregated by type of service.</p>					

In Cambodia, Kenya, and the Philippines, 67.24% (39 out of 58) of facilities are offering appropriate SRHR care, while 60.34% (35 out of 58) of facilities are providing sufficient SGBV care. It is important to mention that the initial data collection was carried out in Y2, which also serves as the baseline. Data from Uganda will be presented in Y3.

⁶ x is determined by the IP based on their appreciation of their context and how much do they think their interventions can affect
⁷ this varies from one IP to another, total number of qualifiers are determined by the IPs based on what applies to their context

Data from Cambodia reveals that 33 out of 45 facilities (75.56%) are offering safe, gender-responsive, quality, inclusive, and youth-friendly SRHR care services, while 32 out of 45 facilities (71.11%) are providing safe, gender-responsive, quality, inclusive, and youth-friendly GBV services. To assure the quality of the service, the HCs operation will be evaluated using standard health facility assessment questionnaires to determine what has been completed and what is in the planning stages. Continued capacity building to these HCs remains one of the priorities covered.

Meanwhile, in Kenya, only 5 out of 8 facilities (62.50%) were found to provide adequate SRHR services, and 2 out of 8 facilities (25%) offer safe, gender-responsive, quality, inclusive, and youth-friendly services. Further analysis of these facilities indicates that most of them specialize in SRHR, with limited GBV services, which could explain the low reporting rates of GBV cases. Therefore, priority must be given to these underperforming facilities, and they must be supported to provide women-centered, youth-friendly, and inclusive services to increase access to SGBV services. The project will also arrange capacity-building programs for healthcare staff at these facilities to enhance the quality of their services.

In the Philippines, the project assessment found that only 20% (1/5) of them are providing adequate care for both SRHR and SGBV. The facility in the municipality of Ocampo stood out as the only one that met the criteria for SRHR and SGBV care. The other facilities faced challenges that hindered them from providing safe, gender-responsive, and high-quality SRHR and SGBV services, such as shortages of commodities and repair needs. Healthcare workers also mentioned other issues like a lack of privacy and space for consultation and counseling, as well as transportation difficulties for patients from remote areas. To improve the situation and achieve the EOP target, municipalities that did not meet the criteria will receive support. Health facilities will revisit action plans they developed during the assessment regarding the shortage of commodities and facility repairs during RTDs.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1200c: % of children 6–23 months of age who received a minimum acceptable diet in the past 24 hours (by sex and age)	<p>All: 5.57%</p> <p>Ca: 12.79%</p> <p>Ke: 1.32%</p> <p>Ph: 15.38%</p>	<p>All: G: 13% B: 13% T: 13%</p> <p>Ca: G: 14% B: 14%</p> <p>Ke: G: 2% B: 2%</p> <p>Ph: G: 30% B: 30%</p>	<p>All: 6-8G: 0% (0/41) 9-23G: 13.11% (16/122) G: 9.82% (16/163) 6-8B: 2.44% (1/41) 9-23B: 10% (11/110) B: 7.95% (12/151) Total: 8.92% (28/314)</p> <p>Ca: 6-8G: 0.0% (0/11) 9-23G: 33.33% (11/33) G: 25% (11/44) 6-8B: 14.29% (1/7) 9-23B: 21.95% (9/41) B: 20.83% (10/48) Total: 22.83% (21/92)</p> <p>Ke: 6-8G: 0.0% (0/15) 9-23G: 2.94% (1/34) G: 2.04% (1/49) 6-8B: 0.0% (0/17) 9-23B: 0.0% (0/40) B: 0% (0/57) Total: 0.94% (1/106)</p> <p>Ph: 6-8G: 0.0% (0/1) 9-23G: 16.67% (3/18) G: 15.79 (3/19)</p>	<p>All: G: 38.13% B: 38.13%</p> <p>Ca: Girls: 20.50% Boys: 20.50% 6-8 G: 5% 6-8 B: 20% 9-23 G: 25% 9-23 B: 25% T: 20.5%</p> <p>Ke: Girls: 22% Boys: 22%</p> <p>Ph: Girls: 80% Boys: 80%</p>	Mobile Household Survey (MHS)

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
	Ug: 1.22%	Ug: G: 6% B: 6%	6-8B: 0.0% (0/1) 9-23B: 14.29% (1/7) B: 12.5% (1/8) Total: 14.81% (4/27) Ug: 6-8G: 0.0% (0/14) 9-23G: 2.7% (1/37) G: 1.96% (1/51) 6-8B: 0.0% (0/16) 9-23B: 4.55% (1/22) B: 2.63% (1/38) Total: 2.25% (2/89)	Ug: Girls: 30% Boys: 30%	
<p>This indicator was calculated by</p> <p>Breastfed children: A breastfed child is considered to have a Minimum Acceptable Diet if the child:</p> <ol style="list-style-type: none"> Met the Minimum Meal Frequency (MMF) for breastfed children. <ul style="list-style-type: none"> 6-8 months old: 2 or more feeding during the previous day and night 9-23 months old: 3 or more feeding during the previous day and night Met the Minimum Dietary Diversity <ul style="list-style-type: none"> 6-8 months and 9-23 months old: during the previous day and night consumed meals consisting of at least 5 of the 8 food groups not counting "breast milk". <p>Non-breastfed children: A non-breastfed child is considered to have a Minimum Acceptable Diet if the child:</p> <ol style="list-style-type: none"> Met the Minimum Meal Frequency for non-breastfed children. <ul style="list-style-type: none"> 6-8 months and 9-23 months old: 4 or more feeding during the previous day and night Met the Minimum Dietary Diversity <ul style="list-style-type: none"> 6-8 months and 9-23 months old: during the previous day and night consumed meals consisting of at least 5 of the 8 food groups not counting the food group "dairy products." During the previous day and night, have had milk feedings (this includes infant formula / milk / yogurt). <p>To calculate the indicator's value:</p> <ol style="list-style-type: none"> Count the number of children who have satisfied the conditions above and divided by the total number of children Disaggregate according to: <ul style="list-style-type: none"> 6-8 months girls 6-8 months boys 9-23 months girls 9-23 months boys 					

According to a recent survey conducted among the four implementing countries, only 8.92% of children between 6-23 months of age had a minimum acceptable diet (MAD) in the 24 hours prior to the survey. While this is a 3.35% increase from the baseline value of 5.57%, it still falls short of the 13% Y2 target. The baseline data did not include information on age and sex, but age and sex-disaggregated data will be collected going forward. It should be noted that MAD is a composite indicator based on minimum dietary diversity (MDD) and minimum meal frequency (MMF), which means that a child must meet both requirements to be counted under the indicator.

Based on survey findings from Cambodia, only 22.83% (21/92) of children aged 6-23 months received a minimum acceptable diet within the 24-hour period before the survey, as compared to the baseline data of 12.79%. Among the 6-8 months age group, no girls and only 14.29% (1/7) of boys received a minimum acceptable diet. Only 33.33% (11/33) of girls and 21.95% (9/41) of boys aged 9-23 months met the minimum acceptable diet within a 24-hour period. The project has achieved its Y2 target of 14%. However, the primary reason most children aged 6-23 months did not meet the minimum dietary standards was due to their lack of dietary diversity. To ensure continued improvement, the project will be disseminating key messages that promote simple feeding practices that caregivers can easily implement. Caregivers will also be educated on how to

accurately report the food groups and understand the changes they are making. The project will also facilitate further nutritional education and promote kitchen gardens alongside the MMM group facilitated sessions.

The Y2 survey results in Kenya show that only 0.94% (1/106) of children aged 6-23 months have received a minimum acceptable diet in the past 24 hours before the survey. This figure has decreased from the baseline of 1.32% and falls short of the Y2 target of 2%. No girls and boys aged 6-8 months and boys aged 9-23 months have received a minimum acceptable diet. Only 2.94% (1/34) of girls aged 9-23 months have met the minimum acceptable diet requirement. The primary reason why most children did not achieve MAD is their inability to access diverse dietary options. To address this, the project should focus on promoting interventions that encourage food diversity production such as kitchen gardening or changing behavior. Information sharing through the positive deviance model to raise awareness about proper breastfeeding and complementary feeding practices among women with children aged 6-23 months could also improve results and help achieve the EOP target. Moreover, the project team will engage with stakeholders to discuss the findings and develop a comprehensive joint plan of action that involves both duty bearers and rights holders.

Based on survey findings in the Philippines, only 14.81% (4/27) of children aged 6-23 months received a minimum acceptable diet in the 24 hours prior to the survey. This shows a slight decrease from the previous baseline of 15.38%. However, the proportion of children who received a minimum acceptable diet was higher among those aged 9-23 months, with 16.67% (3/18) of girls and 14.29% (1/7) of boys meeting the criteria, compared to 0% for both genders in the 6-8 month age range. The survey results indicate that the project did not meet its Y2 target of 30%, and to improve, the project should focus on providing training on nutrition counseling for health providers and educators. In addition, engaging with stakeholders who have expertise in food security could help improve access to and availability of food in the community. Finally, it may be necessary to reconsider the sampling technique for the survey to increase the sample size for this indicator.

According to the Y2 survey results in Uganda, only 2.25% (2/89) of children aged 6-23 months received a minimum acceptable diet in the 24 hours prior to the survey. Though this showed an increase from the baseline of 1.22%, it falls 3.75% short of the Y2 target. Not a single girl or boy between 6-8 months received MAD, while only 2.7% (1/37) of girls and 4.55% (1/22) of boys aged 9-23 months did. The low percentage could be attributed to food scarcity, lack of parental care, child neglect due to gender-based violence, and poverty. To improve the nutrition of children, the project will focus on enhancing nutrition counseling services for adolescent girls and women. The project will also provide nutrition and kitchen gardening training to villages, and train mothers and caregivers in creating and running income-generating activities to improve their households' access to health and nutrition services. ToTs will receive training and cooking demonstrations to identify and prepare appropriate foods for children aged 6-23 months, and incentives will be provided to encourage them to reach more parents and caregivers with nutrition messages.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1200d: # of men and women receiving nutrition counselling (e.g. early initiation of breastfeeding, timely introduction of complementary foods, continued breastfeeding for 2 years and beyond, etc. done through group sessions like mothers' class or individual sessions like peer-to-peer counseling)	Total: 74,930 F: 68,742 M: 6188 Ca: 11,962 F: 5,852 M: 6110 Ke: TBD Ph: 190 F: 112 M: 78 Ug: 62,778 F: 62,778 M: 0	N/A	Total: 66,487 F: 64,589 M: 1,898 Ca: 3,519 F: 1699 M: 1,820 Ke: TBD Ph: 190 F: 112 M: 78 Ug: 62,778 F: 62,778 M: 0	N/A	Records Review

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
Source: FIAP HN2 1220	NOTE: THIS DATA WAS COLLECTED IN Y2				
<p>This indicator was calculated by obtaining numbers from the following records:</p> <ul style="list-style-type: none"> • Cambodia: HC1/HO2 "Page 3 row 17 ([0-59 months ក្មេងៗ] Total children enrolled in care programs to treat acute malnutrition (no complications) [0-59 months]) • Kenya: Project records • Philippines: Barangay Health Center/Municipal Nutrition Action Officer records on nutrition counseling sessions participants • Uganda: (HMIS Form 105) AN42: Pregnant women who received counselling; MA21: Mothers received nutrition counselling <p>Disaggregated by age and sex</p>					

According to data obtained from government facilities, a total of 66,487 individuals (comprising of 64,589 females and 1,898 males) are receiving nutrition counselling in Cambodia, the Philippines, and Uganda. For the Philippines and Uganda, the information collected in Y2 is being treated as the baseline data due to data availability. The data on individuals receiving nutrition counselling in Kenya will be included in the Y3 report.

Government data from Cambodia shows that 3,519 individuals have received nutrition counselling, with 1699 of them being females and 1820 males. This is in comparison to the baseline data which indicated that a total of 11,962 individuals (5,852 females and 6,110 males) received nutrition counseling. The Y2 result has declined mainly due to two primary factors. One is that the government was not able to input the data into the system during the reporting period. Second, it was reported that parents/couples chose to go to the provincial health facilities and other private clinics as they perceive these are better in providing quality of services. However, the project's intervention on nutrition counseling has not yet been implemented by Health Centre Staff, and therefore the results have not been influenced by the project. To address these two factors, the project will collaborate with the MOH and strengthen its collaboration in order to ensure that the data is input on-time and it is available for use. The project also has already committed to working with midwives and health centers to integrate activities using LTP, MMM, and effective parenting sessions in their nutrition counselling with fathers and mothers in the targeted communities. Finally, the project will provide incentives (baby kits) to all parents who come regularly to health centers for pregnancy and nutrition counselling and deliver their babies. Any significant changes will be thoroughly investigated and included in the next report. It is worth noting that while mothers are typically the ones who access nutrition counseling, they sometimes do not receive sufficient counseling due to time constraints. To address this issue, the project will utilize various platforms, including group sessions, campaigns, events, and social media channels, to educate both women and men on nutrition.

Government records in the Philippines show that 190 individuals have received nutrition counseling, with 112 females and 78 males participants. The data suggests that there may be disparities in access to and utilization of nutrition counseling services between genders, and that overall, the percentage of the population receiving nutrition counseling is low across all target municipalities. This may indicate potential barriers for males in accessing nutrition counselling, or a lack of awareness among males about its importance. Unfortunately, the effectiveness of nutrition counseling services for different age groups cannot be determined due to the lack of age disaggregation in the data. To improve these results, it is recommended that training be provided on standardized data collection tools, ensuring that data is disaggregated by age and gender to identify and address gaps in service delivery. Refresher training for Barangay Local Government Unit officials and Community Health Workers, as well as incorporating training in the orientation of new officials and CHWs, could help accomplish this. This training could also be integrated into the Policy Development training for BLGU officials.

According to government data data from Uganda, nutrition counselling is not provided to any males, while the total number of participants comprises of 62,778 females. This is mainly because men do not usually accompany their wives to ANC and immunization clinics where nutrition counselling is usually provided. Additionally, patriarchal community values and norms that affect gender roles hinder male involvement in MCH, and there is low sensitization on male involvement by health workers. Moreover, health workers are inadequately trained to provide male-friendly services to mobilize men. To improve this situation, the project aims to integrate nutrition into social protection and Sexual and Gender-Based Violence prevention activities, encourage male participation in nutrition counselling sessions at health facilities, and specifically

target males with nutrition counselling. The project will also continue community sensitization, particularly for men, and involve community and religious leaders, as well as men themselves, in designing and managing male involvement interventions.

1.3.1 IMMEDIATE OUTCOME 1210

1210 Increased capacity of health and social service workers to deliver or refer to safe, inclusive, respectful, SRHR, SGBV and health-related services for the most vulnerable adolescent girls and women

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1210a: # and % of supported health care providers and community health workers with the minimum defined knowledge on provision of inclusive, women-centred, youth-friendly SRHR and/or SGBV services (by sex)	<p>Total: 5.98% (45/752) F: 5.29% (34/643) M: 11.11% (11/99) Non-Binary: 0% (0/10)</p> <p>Ca: F: 7.14% (3/42) M: 13.33% (4/30) T: 9.72% (7/72)</p> <p>Ke: F: 66.67% (8/12) M: 50.00% (6/12) T: 58.33% (14/24)</p> <p>Ph: F: 4.18% (23/550) M: 33.33% (1/3) Non-Binary: 0% (0/10) Total: 4.26% (24/563)</p> <p>Ug: F: 0% (0/39) M: 0% (0/54) T: 0% (0/93)</p> <p>NOTE: THIS DATA WAS COLLECTED IN Y2</p>	<p>Total: 70.26% (163/232) F: 70.29% (97/138) M: 70.21% (66/94) Non-Binary: 0%</p> <p>Ca: F: 88.10% (37/42) M: 80.00% (24/30) T: 84.72% (61/72)</p> <p>Ke: F: 80% (48/60) M: 80% (32/40) T: 80% (80/100)</p> <p>Ph: F: N/A M: N/A T: N/A</p> <p>Ug: F: 33.33% (12/36) M: 41.67% (10/24) Total: 36.67% (22/60)</p>	<p>Total: 13.16% (99/752) F: 8.56% (54/631) M: 40.54% (45/111) Non-Binary: 0% (0/10)</p> <p>Ca: F: 90.48% (38/42) M: 76.67% (23/30) T: 84.72% (61/72)</p> <p>Ke: F: 66.67% (8/12) M: 50.00% (6/12) T: 58.33% (14/24)</p> <p>Ph: F: 4.18% (23/550) M: 33.33% (1/3) Non-Binary: 0% (0/10) Total: 4.26% (24/563)</p> <p>Ug: F: 0% (0/39) M: 0% (0/54) T: 0% (0/93)</p>	<p>Total: 80.25% F: 81.5% M: 79.25 Non-Binary: 80%</p> <p>Ca: F: 96% M: 87% T: 91.5</p> <p>Ke: F: 80% M: 80% T: 80%</p> <p>Ph: F: 80% M: 80% Non-Binary: 80% Total: 80%</p> <p>Ug: F: 70% M: 70% T: 70%</p>	Survey with Health Care Workers and community health workers
<p>This indicator was calculated by</p> <ul style="list-style-type: none"> • Cambodia: counting respondents who have answered correctly 16 of the 20 questions divided by the total number of respondents • Kenya: counting respondents who have answered correctly 8 of the 11 questions divided by the total number of respondents • Philippines: counting respondents who have answered correctly 14 of the 19 questions divided by the total number of respondents • Uganda: counting respondents who have answered correctly 14 of the 19 questions divided by the total number of respondents <p>Disaggregated by sex</p>					

Based on the data collected in the four implementing countries, it was found that 54 out of 631 women (8.56%) and 45 out of 111 men (40.54%) who received support as healthcare providers and community health workers have the minimum required knowledge for providing inclusive, women-centered, youth-friendly SRHR and/or SGBV services. This is an

improvement from the baseline data, which showed that only 34 out of 643 women (5.29%) and 11 out of 99 men (11.11%) had the minimum knowledge. However, the Y2 targets of 70.29% for women and 70.21% for men were not reached. It should be noted that except for Cambodia, the Y2 results are also considered as baseline data for Kenya, the Philippines, and Uganda.

In Cambodia, survey findings show that 90.48% (38/42) of female and 76.67% (23/30) of male healthcare providers and community health workers have the minimum required knowledge on providing inclusive, women-centered, youth-friendly SRHR and/or SGBV services. This is a significant improvement from the baseline data which showed that only 7.14% (3/42) of women and 13.33% (4/30) of men had the minimum knowledge. To continue improving these results and reach the EOP target, the project will collaborate with MOH/MOI to develop a training curriculum for healthcare staff and private providers on migrant health policy and guidelines that can be implemented in their own health facilities. Additionally, PHD will provide training on SRHR Youth Friendly services, and MOH and the Transcultural Psychosocial Organization (TPO) will work together to strengthen Youth Friendly Counseling service skills. The project will also collaborate with duty bearers from PHD, TPO, and HC to review and adapt TPO curriculums in Counseling Skills to meet the specific needs of the project's target beneficiaries. Finally, a social platform has been set up for sharing, coaching, and follow-up action plans.

In Kenya, the data shows that only 66.67% (8 out of 12) of women and 50.00% (6 out of 12) of men among health care providers and community health workers have the minimum required knowledge in providing inclusive, women-centered, youth-friendly SRHR and/or SGBV services. To improve the results, the focus will be on strengthening the training of healthcare workers who deal with SRHR issues at the facility. The training will emphasize the importance of women-centered, safe, and inclusive care, particularly for men, and the provision of youth-friendly service and structures.

According to data from the Philippines, only 4.18% of women (23 out of 550) and 33.33% of men (1 out of 3) among healthcare providers and community health workers have the minimum required knowledge on providing inclusive, women-centered, youth-friendly SRHR and/or SGBV services. This indicates a significant gap in knowledge among HCWs and CHWs, which highlights the need for more training and education. To address this issue, the project will conduct monitoring and supervised learning among CHWs, provide learning materials and IECs to CHWs, and disseminate key messages on inclusive, women-centered, and youth-friendly SRHR and SGBV services in barangay health facilities.

Survey results from Uganda show that healthcare providers and community health workers lack the necessary knowledge for providing inclusive, women-centered, youth-friendly SRHR and/or SGBV services. In a survey conducted among them, they did not provide the required number of correct responses, resulting in a 0 score for this indicator in the reporting period. To improve this situation, the project will increase supportive supervision, mentoring, and coaching for healthcare workers to ensure they understand the concepts and can put them into practice. The project will also prioritize promoting inclusive, youth-friendly services and ensuring that services are centered around women.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1210b: # and % of supported health care providers and community health workers who consider a newly discovered case of GBV a medical emergency	<p>Total: TBD</p> <p>Ca: TBD</p> <p>Ke: F: 36.36% (4/11) M: 46.15% (6/13) T: 41.67% (10/24)</p> <p>Ph: F: 4.92% (27/549) M: 0% (0/4)</p>	<p>Total: TBD</p> <p>Ca: TBD</p> <p>Ke: F: N/A M: N/A T: N/A</p> <p>Ph: F: 40% M: 40% T: 40%</p>	<p>Total: 9.47% (64/676) F: 6.68% (40/599) M: 35.82% (24/67) Non-Binary: 0% (0/10)</p> <p>Ca: N/A</p> <p>Ke: F: 36.36% (4/11) M: 46.15% (6/13) T: 41.67% (10/24)</p> <p>Ph: F: 4.92% (27/549) M: 0% (0/4) Non-binary: 0% (0/10)</p>	<p>Total: TBD</p> <p>Ca: TBD</p> <p>Ke: F: 80% M: 80% T: 80%</p> <p>Ph: F: 80% M: 75% Non-binary: 80%</p>	Survey with Health Care Workers and community health workers

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
	Non-Binary: 0% (0/10) T: 4.80% (27/563) Ug: F: 0% M: 0% T: 0% NOTE: THIS DATA WAS COLLECTED IN Y2	Ug: F: 32% (12/36) M: 43% (10/24) T: 38% (33/60)	T: 4.80% (27/563) Ug: F: 23.08% (9/39) M: 36.00% (18/50) T: 30.34% (27/89)	T: 80% Ug: F: 70% M: 70% T: 70%	

This indicator was calculated by

- Cambodia: counting respondents who have answered correctly 4 of the 6 questions divided by the total number of respondents
- Kenya: counting respondents who have answered correctly 7 of the 9 questions divided by the total number of respondents
- Philippines: count the number of respondents who have answered Yes to the question "Do you consider a newly discovered case of GBV a medical emergency?" AND have provided 75% correct responses to the follow-up question (depending on the profession) divided by the total number of respondents
 - Physician - 6 out of 8 responses
 - Nurses and other health care workers - 4 out of 5 responses
 - Community health workers - 4 out of 5 responses
- Uganda: count the number of respondents who have answered Yes to the question "Do you consider a newly discovered case of GBV a medical emergency?" AND have provided at least 4 correct responses to the follow-up question divided by the total number of respondents

Disaggregated by sex

According to the latest survey, 9.47% (64 out of 676) of health care providers and community health workers, including 6.68% (40/599) of women and 35.82% (24/67) of men, perceive the recently discovered GBV case as a medical emergency. The Y2 results for Kenya and the Philippines served as the baseline data, while the data for Cambodia is yet to be available until Y3.

Survey findings in Kenya indicate that a significant number of healthcare providers and community health workers do not consider newly discovered cases of gender-based violence (GBV) as medical emergencies. Among the surveyed individuals, only 36.36% of women and 46.15% of men viewed GBV as a medical emergency. This discrepancy between male and female healthcare providers could potentially impact the handling of GBV cases within the community. The survey also identified that some female healthcare workers struggle with identifying the pre-referral process for clients, while men had difficulty identifying standard operating procedures for emergency post-rape care services. The barriers to addressing these issues include community interference, lack of tools, and insufficient follow-up from management. To improve the situation, the project will provide training that emphasizes standard operating procedures for emergency post-rape care for male healthcare workers and pre-referral processes for female healthcare workers, helping all staff to treat newly discovered GBV cases as emergencies.

In the Philippines, 4.92% (27/549) of women of supported health care providers and community health workers consider newly identified cases of GBV to be medical emergencies. This indicates a considerable gap in the ability of HWCs and CHWs to deliver or refer safe, inclusive, and respectful SRHR, SGBV, and health-related services to the most vulnerable adolescent girls and women experiencing GBV. During the survey, the majority of CHWs had not yet received training in Adolescent Job Assistance (AJA) and Reproductive Health (RH) Care. To help improve the result, the project will conduct monitoring and supervised learning among CHWs and provide learning materials and IECs to CHWs and barangay health facilities with key messages on inclusive, women-centered, and youth-friendly SRHR and SGBV services.

In Uganda, only 23.08% (9/39) of women and 36% (27/88) of men health care providers and community health workers consider a newly discovered case of GBV a medical emergency, indicating that the Y2 targets of 32% for women and 43% for men were not met. As corrective actions, the project will ensure that the key messages are not only internalized but also implemented; it will also continue to sensitize and intensify the supportive supervision of health workers.

1.3.2 IMMEDIATE OUTCOME 1220

1220 Increased capacity of caregivers, health care workers and educators to support nutrition, hygiene and sanitation for the most vulnerable adolescent girls, women and children U5

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1220a: % of target caregivers able to identify the minimum of essential nutrition practices for pregnant/lactating women and U5 children (by sex, age)	<p>Total: 45.63% 15-19 F: 45.18% 20-24 F: 50.60% 15-19 M: 38.97% 20-24 M: 41.80% Non-binary: 33.33%</p> <p>Ca: 15-19 F: 32.43% 20-24 F: 43.75% 15-19 M: 29.95% 20-24 M: 40.35% Total: 38.93%</p> <p>Ke: 15-19 F: 21.67% 20-24 F: 33.06% 15-19 M: 22.22% 20-24 M: 19.81% Total: 25.37%</p> <p>Ph: 15-19 F: 38.46% 20-24 F: 52.36% 15-19 M: 31.82% 20-24 M: 36.84% Total: 44.03%</p> <p>Ug: 15-19 F: 80.33% 20-24 F: 77.67% 15-19 M: 80.65% 20-24 M: 75.68% Total: 77.78%</p>	<p>Total: 50% 15-19 F: 49.49% 20-24 F: 54.74% 15-19 M: 47.02% 20-24 M: 48.74%</p> <p>Ca: 15-19F: 35% 20-24F: 45% 15-19M: 35% 20-24M: 45% Total: 40%</p> <p>Ke: 15-19 F : 30.70% 20-24 F: 35.80% 15-19 M : 28.55% 20-24 M: 25.40% Total: 30.11%</p> <p>Ph: 15-19 F: 50% 20-24 F: 58% 15-19 M: 42% 20-24 M: 46% Total: 49%</p> <p>Ug: 15-19 F: 82.26% 20-24 F: 80.14% 15-19 M: 82.52% 20-24 M: 78.54% Total: 80.87%</p>	<p>Total: 72.83% (689/946) 15-19F: 66.83% (139/208) 20-24F: 80.35% (319/397) 15-19M: 54.37% (56/103) 20-24M: 73.53% (175/238)</p> <p>Ca: 15-19F: 48.78% (20/41) 20-24F: 69.79% (67/96) 15-19M: 34.88% (15/43) 20-24M: 59.42% (41/69) Total: 57.43% (143/249)</p> <p>Ke: 15-19 F: 69.84% (44/63) 20-24 F: 70.25% (85/121) 15-19 M: 61.9% (13/21) 20-24 M: 74.12% (63/85) Total: 70.69% (205/290)</p> <p>Ph: 15-19 F: 58.06% (36/62) 20-24 F: 84.42% (65/77) 15-19 M: 47.37% (9/19) 20-24 M: 75.0% (12/16) Total: 70.11% (122/174)</p> <p>Ug: 15-19 F: 92.86% (39/42) 20-24 F: 99.03% (102/103) 15-19 M: 95.0% (19/20) 20-24 M: 86.76% (59/68) Total: 93.99% (219/233)</p>	<p>Total: 83.75% 15-19 F: 83.75% 20-24 F: 83.75% 15-19 M: 83.75% 20-24 M: 83.75%</p> <p>Ca: 15-19 F: 65% 20-24 F: 65% 15-19 M: 65% 20-24 M: 65%</p> <p>Ke: 15-19 F: 90% 20-24 F: 90% 15-19 M: 90% 20-24 M: 90%</p> <p>Ph: 15-19 F: 90% 20-24 F: 90% 15-19 M: 90% 20-24 M: 90%</p> <p>Ug: 15-19 F: 90% 20-24 F: 90% 15-19 M: 90% 20-24 M: 90%</p>	Mobile Household Survey (MHS)

This indicator was calculated by counting the number of respondents who have answered correctly all of the questions:

1. What is the first food a newborn baby should receive?
2. In your opinion, what food should be given to a child in the first six months after birth?
3. In your opinion, which foods or types of food if any can be given to the child between 6 months and 2 years of age to assure the child is well nourished?
4. What would you recommend to your neighbour to feed their child between 6 months and 5 years to keep the child well nourished?
5. In your opinion, which of these advices should be followed by expecting mothers and breastfeeding women?

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
Divided by the total number of respondents multiplied by 100					
Disaggregation: Women 15-19; Women 20-24; Men 15-19; Men 20-24;					

According to the most recent survey, 72.83% of individuals who identify as women, men, or non-binary caregivers between the ages of 15 and 24 possess knowledge about the minimum essential nutrition practices for pregnant or lactating women and children under 5 years of age. These results signify a substantial improvement from the previous baseline of 45.63% and exceed the Y2 goal of 50%.

In Cambodia, more than half of the males and females aged 15-24 have knowledge of the minimum essential nutrition practices for pregnant/lactating women and children under the age of five. The percentage of people with this knowledge has increased from 38.93% to 57.43%. In the age group of 15-19 years, 48.78% of females and 34.88% of males are aware of these practices, which is an improvement from the baseline percentages of 32.43% and 28.95%, respectively. In the 20-24 age group, 69.79% of females and 59.42% of males can identify the essential nutrition practices, which is a significant increase from the baseline percentages of 43.75% and 40.35%, respectively. The project has successfully achieved all of Cambodia's Y2 targets. To meet the EOP target, the project will continue to collaborate with PHD officers to provide nutrition counseling skills to HC midwives. This will enable them to provide nutrition counseling to pregnant, lactating women, and children under five on healthy food, breastfeeding, and feeding habits, thereby increasing parental knowledge. Additionally, once the primary nutrition interventions are implemented, it is anticipated that more caregivers will have a greater understanding of the essential nutrition actions.

The Y2 results in Kenya show a large improvement in the knowledge of minimum essential nutrition practices for pregnant/lactating women and U5 children among both genders aged 15 to 24. 70.69% of men and women in this age bracket are now aware of these practices, compared to a baseline of just 25.37%. Particularly noteworthy is the increase in awareness among 15 to 19-year-olds, where 69.84% of females and 61.90% of males have identified minimum essential nutritional practices, as opposed to only 21.67% and 22.22% at baseline. Among ages 20 to 24, 70.25% of women and 74.12% of men can identify these practices, up from the baseline of 33.06% and 19.81%, respectively. All Year 2 targets were met. The project aims to continue educating caregivers, especially men, to ensure further improvement and achievement of the EOP target.

Year 2 data from the Philippines shows that more young females and males aged 15 to 24 are able to identify the essential nutritional practices for pregnant and lactating women, as well as for children under age 5. The figures have increased from a baseline of 44.03% to 70.11%, indicating significant progress. In the 15-19 age group, 58.06% of females and 47.37% of males can identify the minimum essential nutrition practices, compared to the baseline figures of 38.46% and 31.82%, respectively. Meanwhile, in the 20-24 age group, 84.42% of females and 75.00% of males can also identify these practices, representing a significant increase from the baseline proportions of 52.63% of females and 36.84% of males. The interventions under Outputs 1221, 1222, 1223, and 1224 may have been effective in achieving these results. It is also worth noting that this indicator's topic is less sensitive than those of SRH and GBV, making it easier for people to absorb the information shared during training and educational activities.

According to the Y2 survey results in Uganda, a significant increase has been observed in the percentage of women and men aged between 15 to 24 who can identify the minimum essential nutritional practices for pregnant/lactating women and U5 children. The new figure stands at 93.99%, as compared to the baseline figure of 77.78%. Similarly, young people aged between 15-19 years have shown notable improvement in awareness, with 92.86% of females and 95.00% of males being able to identify the minimum essential nutritional practices, compared to 80.33% and 80.65% respectively, at the baseline. Moreover, 99.03% of 20-24-year-old women and 86.76% of 20-24-year-old men are now aware of the minimum essential nutritional practices for pregnant/lactating women and U5 children, which is an increase from the baseline of 77.67% for women and 75.68% for men. It should be noted that women aged 20-24 play a significant role in their communities, particularly in terms of childbearing and family nutrition. They may have been particularly motivated to learn and retain

information that would benefit their families. In addition, there are several factors that may have contributed to the impressive results, including nutrition and health education sessions offered at health facilities, as well as WASH trainings and sessions provided by other NGOs. The project aims to increase awareness of nutrition in communities by intensifying health education and training programs. Trained ToTs, Health Care Workers, and Community Health Care Workers will work together to achieve this goal. In Y3, additional IEC materials will be distributed to increase the availability of nutrition information. Health workers will also receive support to integrate nutrition education into other health services, such as immunization and ANC, as well as public gatherings.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1220b: % of target community health care providers able to identify the minimum of essential nutrition practices for pregnant/lactating women and U5 children (by sex)	Total: 86.52% (321/371) F: 86.92% (319/367) M: 50% (2/4) Ca: TBD Ke: TBD Ph: F: 86.92% (319/367) M: 50% (2/4) Total: 86.52% (321/371) Ug: TBD NOTE: THIS DATA WAS COLLECTED IN Y2	Total: 88% F: 88% M: 88% Ca: N/A Ke: N/A Ph: F: 88% M: 88% Total: 88% Ug: N/A	Total: 86.52% (321/371) F: 86.92% (319/367) M: 50% (2/4) Ca: N/A Ke: N/A Ph: F: 86.92% (319/367) M: 50% (2/4) Total: 86.52% (321/371) Ug: N/A	Total: TBD Ca: F: 78% M: 78% Total: 78% Ke: TBD Ph: F: 95% M: 100% Total: 95% Ug: 85%	Survey with Health Care Workers
This indicator was calculated by: <ul style="list-style-type: none"> • Cambodia: counting respondents who have answered correctly 9 of the 17 questions divided by the total number of respondents • Kenya: counting respondents who have answered correctly 5 of the 8 questions divided by the total number of respondents • Philippines: counting respondents who have answered correctly 5 of the 5 questions divided by the total number of respondents • Uganda: counting respondents who have answered correctly 5 of the 5 questions divided by the total number of respondents Disaggregated by sex.					

According to the recent survey, 86.52% of target community healthcare providers are able to identify the minimum essential nutrition practices for pregnant/lactating women and U5 children. Among the 4 implementing countries, only the Philippines was able to contribute to this outcome. The Y2 results will serve as the baseline for the Philippines while data for Cambodia, Kenya, and Uganda will be collected in Y3.

In Cambodia, the training of trainers for CCWCs, VHSGs, and youth champions have started in March 2023, but the village sessions have not yet begun as the first communes have just completed the SRHR/GBV sessions. The first community to receive these sessions will be able to start in May 2023. The process began with training midwives at Health Centres in March 2023 on essential nutrition practices (LTP/MMM) for pregnant and lactating women. The trainings for community health care providers (VHSG and CCWC) and youth champions are scheduled for Q1Y3.

In the Philippines, 86.52% of CHWs who responded to the Y2 survey were able to correctly identify the minimum essential nutrition practices for pregnant/lactating women (PLW) and children under the age of five. The majority of respondents (367 out of 371) were female CHWs. According to the data, CHWs have a strong understanding of essential nutrition practices, particularly nutrition for newborns, children under the age of five, and pregnant/lactating women. However, there are areas in which their knowledge may be lacking, such as exclusive breastfeeding and supplementation for U2. All male respondents were able to identify the correct neonatal nutrition, U5 nutrition, and PLW nutrition practices. However, because they were unable to identify the correct nutrition practices for exclusive lactation and complementary feeding for U2, they were unable to satisfy the indicator. The Y2 result indicates that CHWs possess an adequate level of knowledge and understanding regarding essential nutrition practices even though the training for health care providers has not yet started. As new evidence and guidelines emerge in maternal-child health, ongoing training, and support will be crucial for maintaining their current knowledge.

In Cambodia, IECs materials, such as calendars, posters, banners, songs, and videos, in accordance with a behavior change model for groups of individuals, are produced in order to prompt a change in behavior. In efforts to foster gender equality, the Philippines included female CHWs in leadership and decision-making positions throughout the training modules, this ensures that female CHWs participated in action planning and were given the opportunity to lead training sessions and mentor male counterparts. The training modules included activities and exercises that challenged gender norms and stereotypes associated with health and nutrition practices and promoted more equitable gender roles and responsibilities in caregiving and domestic decision-making.

1.4 INTERMEDIATE OUTCOME 1300

1300 Increased agency of community leaders, educators, CHWs, women's organizations, adolescents and their parents/caregivers to carry out community-led, evidence-based, multi-sectoral actions in reducing structural barriers preventing realization of SRH rights by the most vulnerable adolescent girls and women in target areas.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1300a: # and % of targeted communities accomplished at least one key goal from their action plan that addresses unintended pregnancies, SGBV (CEFM, FGM, etc.) within the past 12 months	Total: 0 Ca: 0 Ke: 0 Ph: 0 Ug: 0	Total: 15/16 (93.75%) Ca: 0 Ke: 0 Ph: 5/6 (83.33%) Ug: 10/10 (100%)	Total: 1/16 (6.25%) Ca: 0 Ke: 0 Ph: 0/6 (0%) Ug: 1/10 (10%)	Total: 146/149 (97.99%) Ca: 71/71 (100%) Ke: 20/20 (100%) Ph: 15/18 (83.33%) Ug: 40/40 (100%)	Records Review
Indicator Calculation:	This indicator was calculated by counting the number of target communities that have reached the target for any one indicator of its community goal or any outcome in their community theory of change divided by the total number of communities where CoLMEAL is implemented.				

As of reporting period, 1/16 (6.25%) of targeted communities have accomplished at least one key goal from their action plan that addresses unintended pregnancies, SGBV (CEFM, FGM, etc.) within the past 12 months.

It has been reported that in Cambodia, the majority of CMCs have not completed their training modules, and as a result, none of the community action plans have been implemented by the end of Y2. However, it has been noted that a few CMCs

and grassroots organizations are scheduled to initiate the action plan in Q1Y3, and an update on the status of this indicator will be provided in the next report.

In the Philippines, the Y2 target for indicator 1300a was not achieved as none of the 6 communities managed to accomplish at least one main goal from their action plan, which addresses unintended pregnancies, SGBV (CEFM, FGM, etc.), within the last 12 months. The government is already executing some of the actions outlined in the CAPs of specific barangays as part of their ongoing programs. The project will provide regular updates on the progress made toward the desired outcomes and indicators, and the CMEALCs will oversee these activities. The iterative nature of CoLMEAL has significantly impacted the outcome, as it allows for continuous improvement and adjustment of strategies to meet the community's needs better. While most of the 1300 output activities are ongoing, there has been a delay in Output 1313 (Community Action Grants), since the staff is currently in the process of learning about this output. In order to achieve the key goals of the action plan, the CAG plays a critical role. However, due to delays, there is lack of progress in this indicator. To facilitate the CAG process, it is necessary to involve additional staff members and ensure extensive participation of Field Officers in implementing the activities. As a result, Field Officers will be assigned to support the CoLMEAL officer in this process.

As of reporting period, one of the ten CMCs in Uganda accomplished two critical goals from their action plans. These goals included enhancing the economic status of families and instituting a by-law to address unintended pregnancies, SGBV (CEFM, FMG, etc.). It takes a substantial amount of time to form and train CMCs, since Uganda is implementing CoLMEAL for the first time, which resulted in a low yield of the target value due to the time taken to comprehend and operationalize the concept. However, the communities were still able to create action plans and form CMEALCs, even though only a few of the ten CoLMEAL groups completed the six training steps under the CoLMEAL approach. Kumele Wicere, one of the project communities, was able to request agricultural tools from Kijani Forestry Company to improve income generation through farming, thus enhancing their ability to pay for education fees and reducing school dropouts, which is one of their key objectives in addressing unintended pregnancies. They also drafted by-laws on unintended pregnancies pending approval from the Sub-County level. To effectively implement CoLMEAL in Uganda, the CoLMEAL Advisor from Salanga conducted face-to-face training in April 2023 for the CoLMEAL Officer, MEAL Assistant, Project Manager, and other field personnel to enhance their knowledge of the CoLMEAL approach. The acquired knowledge and skills will be disseminated to selected ToTs in the various sub-counties to strengthen their capacity for training and supervision.

The project is working towards promoting gender equality in Cambodia by supporting gender transformative CoLMEAL action plans to address community-specific causes of SGBV and barriers to service provision. Meanwhile, in Uganda, the project is engaging cultural, opinion, political, and religious leaders to support CMCs in advocacy and their health and rights action plans to prevent SGBV and unintended pregnancy. The project is also encouraging communities to ensure the inclusion of females and other marginalized groups in important community decision-making bodies. CMCs are receiving CoLMEAL training to identify community-specific barriers to preventing and responding to SGBV and unintended pregnancy. This includes community-led identification of barriers, analysis of why they exist, developing a theory of change desired, and developing a community action plan.

To enhance the implementation of CoLMEAL in Cambodia and Uganda, the project recommends decreasing the number of target groups and planned CAGs. Reducing the groups and CAGs from 71 to 24 in Cambodia and in Uganda, from 40 to 18, will enable the project to concentrate on developing the capacity of each group, leading to greater sustainability. Additionally, providing more funding to the CAG will benefit the communities by enabling the groups to utilize the funds more effectively and create a positive impact in the selected CoLMEAL communities. A decrease in the number of target groups will allow the team to evaluate if the CoLMEAL principles are being implemented effectively, ensuring the quality of the established groups.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1300b: % of targeted community-based groups and networks who implemented at least one advocacy campaign / activity for increased action	Total: 0%	Total: 58%	Total: 12%	All: 77%	Records Review
	Ca: 0%	Ca: 36%	Ca: 11% (8/71)	Ca: 100%	
	Ke: 0%	Ke: 0	Ke: 0	Ke: 50%	
	Ph: 0%	Ph: 80%	Ph: 13% (12/94)	Ph: 80%	

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
of government agencies and parents/caregivers to address unintended pregnancies, CEFM, SGBV, FGM	Ug: 0%	Ug: 0	Ug: 0	Ug: 78%	
This indicator was calculated by counting the number of community-based groups and networks that have on-going or have completed at least one advocacy campaign divided by the total number of advocacy groups/networks supported by the project.					

In Y2, 12% of targeted community-based groups and networks implemented at least one advocacy campaign/activity for increased action of government agencies and parents/caregivers to address unintended pregnancies, CEFM, SGBV, and FGM in Cambodia and the Philippines.

Out of the 71 Community Management Committees (CMCs) in Cambodia, only 11% or 8 were able to effectively communicate the issues and action plans identified in the CoLMEAL process during district-level mass events or campaigns. To address this, the project team will work closely with CMCs and CoLMEAL committees from each commune or association to share community issues and challenges with duty bearers and lawmakers during district campaigns or events.

In barangays across the Philippines that have implemented CoLMEAL, 12 out of 94 (13%) community-based organizations and networks supported by the project have launched advocacy campaigns or activities to promote increased action by government agencies and parents/caregivers in addressing unintended pregnancies and GBV. In six barangays, the CMCs and CoLMEALs successfully conducted mobilization campaigns attended by community leaders, officials, opinion leaders, and other stakeholders. CMCs/CoLMEALs presented their TOCs and CAPs to the local government council to advocate for support on data collection and request assistance in achieving community objectives. As a result of these campaigns, the Pinitan barangay council incorporated a portion of the CAP into their Annual Investment Plan and developed a policy (barangay resolution) to prevent unintended pregnancies and SGBV. The grassroots women's organizations or Community Support Groups trained in organizational management are yet to implement advocacy campaigns or activities. The delay in implementing Output 1313 (Community Action Grants) has hindered progress on this indicator.

The project in Kenya and Uganda did not anticipate that any of the formed CMCs or grassroots women's organizations would have been able to implement any advocacy campaigns by the end of the year Y2, as they would still be undergoing trainings to develop the required capacity.

Efforts to promote gender equality in Cambodia involve supporting gender transformative CoLMEAL action plans that tackle community-specific causes of SGBV and barriers to service provision. Similarly, grassroots women's organizations in Uganda were supported to design their own gender transformative advocacy campaigns on SRHR and SGBV. This support involved training on developing advocacy plans and facilitating effective and gender transformative campaigns that challenge gender norms and roles affecting women's SRHR, address the root causes of SRH and SGBV issues, and promote shared access to resources and decision-making. Consultations were also held with members of Women's and Girls' organizations to ensure that sensitization activities are held at convenient and safe times and venues, with necessary support, such as childcare, provided. Additionally, nursing mothers were allowed to bring their babies in the sessions. As part of the innovative approach of CoLMEAL, in the Philippines, community-based groups in barangays implementing CoLMEAL are fully aware of the primary goals of the CAP and TOC developed by the CMCs through community validation sessions that consider the needs and perspectives of all genders.

1.4.1 IMMEDIATE OUTCOME 1310

1310 Increased capacity of community groups to lead the design, implementation and MEAL processes that address teenage pregnancies, SGBV, CEFM, FGM

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1310a: # and % of community group members who are able to monitor and reflect on the impact of community actions aiming towards addressing unintended pregnancies, SGBV including CEFM and FGM (by sex, age)	Total: 0 Ca: 0 Ke: 0 Ph: 0 Ug: 0	Total: 39/48 (81.25%) Ca: 0 Ke: 0 Ph: 39/48 (81.25%) Ug: 0	Total: 0% Ca: 0/358 (0%) Ke: 0/100 (0%) Ph: 0/48 (0%) Ug: 0/110 (0%)	All: 995/1142(87%) Ca: 358/358 (100%) Ke: 100/200 (50%) Ph: 117/144 (81.25%) Ug: 420/440 (95%)	Records review of attendance sheets, which are collected upon the conduct of the monitoring and reflection exercises where ADRA will have the participants fill-in attendance sheets
<p>This indicator was calculated by counting the number of CoLMEAL Committee members who have participated in the measuring of progress at the output level and towards community goal AND have participated in the drawing of lessons from past actions to inform present and future actions to meet the community goal divided by the total number of CoLMEAL Committee members.</p> <p>Disaggregated by sex and age group</p>					

Across the 4 implementing countries, no community group members were able to monitor and reflect yet on the impact of community actions aiming towards addressing unintended pregnancies, SGBV including CEFM, and FGM.

The members of the CoLMEAL committee in Cambodia have completed their training and reflected on their progress so far. However, they have not begun implementing Community Action, and therefore, no monitoring activities have been carried out yet. To ensure the success of the project, the team has developed a Phase 1 catch-up plan and a Phase 1 rollout plan, reviewing efficiencies for Year 3. The CoLMEAL staff will document the adaptive guideline, which will be evaluated further during the summit of Salanga's CoLMEAL focal person in Q1Y3. Moreover, the project is planning to train the field staff, followed by coaching and mentoring until they can conduct CoLMEAL sessions independently. The team is preparing to conduct a review of the entire CoLMEAL cycle to ensure a smooth process and introduce Community Action Plans earlier.

The CoLMEAL committee in Kenya is currently undergoing training on data collection, analysis, and presentation.

The community group members in the Philippines have yet to assess the effectiveness of their efforts to reduce unintended pregnancies. While 2 barangays have completed collecting baseline data, the others have not yet started. Setting targets for the indicators developed by CMEALCs has not been done yet, so monitoring and reflection cannot take place during the reporting period. To facilitate the CAG process, the Field Officers will require additional support from other staff members.

In Uganda, monitoring and reflecting on the impact of community actions are planned upon the completion of the training for all the CoLMEAL steps. However, the training for all 10 CMEALCS groups is still ongoing.

Efforts to support the environment in Cambodia involve limiting the use of materials and refreshments that could harm the environment during training sessions. A team is established to manage hygiene and environmental concerns before, during, and after activities. The Community Action Plan has been integrated with the commune investment plan in an innovative approach to implementing CoLMEAL by CMC members. In the Philippines, 18 community members (16 females, 1 male, and 1 non-binary) received training on community-led MEL to promote gender equality. The training reached a diverse group of participants, including members of the LGBTQIA+ community, which is encouraging. However, only one male participated out of the 18, which may indicate a potential gender disparity in participation.

1.4.2 IMMEDIATE OUTCOME 1320

1320 Increased capacity of grassroots women's and girls' rights organizations to advocate for health-related services for the most vulnerable adolescent girls, women and children

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1320a: # of grassroots women organizations with developed advocacy plan for specific SRHR topics	Total: 0 Ca: 0 Ke: 0 Ph: 0 Ug: 0	Total: 27 Ca: 1 Ke: 0 Ph: 25 Ug: 1	Total: 2 Ca: 1 Ke: 0 Ph: 0 Ug: 1	Total: 107 Ca: 1 Ke: 21 Ph: 76 Ug: 9	Records Review
<p>This indicator was calculated by counting the total number of grassroots women organizations that have developed an advocacy plan with clear steps, timeline, responsible individuals, budget requirements to advocate for health-related services.</p>					

As of the reporting period, 2 grassroots women's organizations in Cambodia and Uganda have developed advocacy plans for specific SRHR topics. However, grassroots women's organizations in Kenya and the Philippines are yet to create their advocacy plans, thus, the annual target of 27 was not achieved this reporting period.

In Cambodia, the project collaborated with the Cambodia Organization for Women's Support (COWS) to conduct research on family planning, unintended pregnancy, and early marriage. They analyzed the findings and created a presentation to showcase the results. The project coordinated with COWS to present the research results to decision-makers at various levels, including provincial ProTWGH (provincial technical working group on health) and PCC meetings, district Women's Day events, and commune council and health center staff meetings. The presentation was also given to a middle school and a men's Reflect group session at the local level. COWS was trained by the project to prepare a written advocacy plan, which met the target for Y2. However, the project management team will provide further assistance to improve the current advocacy plan by updating plans for advocacy conducted to date and providing coaching to COWS in preparing advocacy plans for each specific SRHR topic chosen based on their research.

During the reporting period in the Philippines, 188 members of grassroots women's organizations received training on organizational management. However, none of the organizations have created their advocacy plan yet, as they lack experience in this area. Previously, they mostly implemented activities initiated by Local Government Units that focused on livelihood. To address this gap, the project will offer mentorship to organizations that completed the organizational management training. Additionally, future training batches will include the development of an advocacy plan as an output.

In Uganda, although grassroots women's organizations have received training on developing advocacy and strategic plans, only Center of Hope for Vulnerable Women and Children has completed their advocacy plan. Others are near completion with clear steps on how to operationalize them. The Center for Hope for Vulnerable Women and Children will lead their advocacy plan implementation while those near to completion will continue to be supported by the project.

In order to promote gender equality, women's organizations in Cambodia were provided with gender-sensitive training and support in research techniques, result analysis, and advocacy plan development, with the Do No Harm principle guiding all processes. To help empower women in the Philippines, they received training in organizational management, but they still need to create their advocacy plans. These organizations must receive the resources and support necessary to develop their advocacy plans, including mentorship. In Uganda, organizations were trained in gender-transformative advocacy campaigns on SRHR and SGBV, as well as the development of advocacy plans. These campaigns addressed gender norms and roles

affecting women's SRHR, the fundamental causes of SRH and SGBV issues, women's and men's shared access to and control over resources and decision-making, and the availability, accessibility, and quality of SRH and SGBV response systems.

Indicators	Baseline	Y2 Target	Y2 Result	EOP Target	Data Collection Method
1320b: Level of confidence among representatives of grassroots women's organizations that they can effectively advocate for specific SRHR topics	Ca: High Ke: TBD Ph: Very High Ug: High	Ca: High Ke: N/A Ph: High to Very High Ug: High	Ca: High Ke: N/A Ph: Very High Ug: High	Cam: Very High Ke: High Ph: High to Very High Ug: Very High	KII
<p>This indicator was calculated by:</p> <ol style="list-style-type: none"> Getting the total score (1 for very low, 2 for low, 3 for high, 4 for very high) from 10 confidence areas Getting the average score by dividing the total score by 10 Average score is then matched based on this scale: <ul style="list-style-type: none"> 0.0 – 0.9 for very low 1.0 – 1.9 for low 2.0 – 2.9 for high 3.0 – 4.0 for very high <p>The key informants self-rated their level of confidence in the following 10 confidence areas:</p> <ul style="list-style-type: none"> Knowledge on policies/laws related to sexual and reproductive health rights, protection rights (against GBV, CEFM, FGM) Knowledge on effective advocacy – its principles, purpose, processes, tools Knowledge on the magnitude, severity, causes and effects of SRH and GBV issues such as early/unwanted pregnancies, early marriage, rape, sex work, domestic violence Knowledge on the needs and rights of right-holders (adolescents 15-19, women 19+) Knowledge on the mandates, priorities, and capacities of specific duty-bearers (local government, government agencies, special bodies/taskforce, uniformed personnel, etc) Knowledge on the responsibilities, priorities and capacities of the responsibility holders (parents, caregivers) Skill in developing key advocacy messages for duty-bearers and responsibility holders Skill in delivering key advocacy messages and engaging in dialogues with government officials, parents to advocate for an agenda Skill in documenting the dialogue between the right-holders and duty-bearers Skill in drawing lessons from past advocacies and applying those to future advocacy campaign/activity 					

Based on KII findings, grassroots women's organizations in three implementing countries have varying levels of confidence in their ability to advocate effectively for specific SRHR issues. The confidence levels of grassroots women's organizations in Cambodia and Uganda are high, while those in the Philippines are very high. The results indicate that each country has met its Y2 target. Except for Cambodia, the Y2 results for the Philippines and Uganda also serve as the baseline. In Kenya, the activities contributing to this Outcome indicator are scheduled for Y3.

In Cambodia, the local partner COWS reported a high level of confidence that they can effectively advocate for SRHR topics. The baseline and Y2 results were collected in March 2023. The baseline data was gathered by asking COWS to rate their confidence levels before attending project advocacy trainings, while the Y2 data was assessed by asking respondents to rate their confidence levels after completing the training and advocacy actions. It is possible that COWS' confidence levels were enhanced through participation in project activities conducted before March 2023 such as training on research methodology/protocols, questionnaire development, data collection and analysis, report writing, and more. The first research for advocacy focused on early marriage and unintended pregnancy. COWS staff were then taught how to use research results in advocacy platforms at the duty bearer's level. As a result, COWS was able to conduct this advocacy campaign and received support from duty bearers. Throughout the project's duration, the project will enhance the local

partner's ability to effectively advocate for SRHR topics by refining the advocacy plan to be more precise and targeted. This will serve to further improve their confidence in the advocacy process.

In the Philippines, an interview with 10 representatives from grassroots women's organizations revealed a high level of self-confidence in their ability to effectively advocate for specific SRHR topics. However, based on feedback from members and officers of these organizations, further support is needed to enhance their confidence levels. This can be achieved through additional training and seminars, increased access to knowledge and resources, and more frequent community meetings and sessions. It is clear that knowledge and skill development play a crucial role in boosting confidence, both for individuals and for the organization as a whole. By providing opportunities for training and networking, as well as a supportive environment, these women's organizations can be empowered to effectively advocate for SRHR issues. To facilitate this, the project will actively engage with trained grassroots women's organizations to help them create advocacy plans.

Based on the results of the KII in Uganda, it is evident that representatives of 5 grassroots women's organizations have a high level of confidence in their ability to advocate for specific SRHR topics. This rating is expected as these organizations have undergone capacity building in several areas such as advocacy, financial and program sustainability, human resource management, and community mobilization, among others. They were also linked to better established, experienced and renowned organizations regionally and nationally. However, three grassroots organizations selected from among the CMCs did not participate in the interview. The nonparticipation of the 3 CMCs during the interview may indicate that their level of confidence is still uncertain due to their newness, and lack of funding for their activities and operational offices. This is expected to change over time as their capacity is enhanced, they can access small grants, and their skills are practiced. To ensure that the CMCs are capable of fulfilling their roles and responsibilities in advocating for SRHR and addressing SGBV with confidence, the project will continue nurturing them and strengthening the more established organizations.

2 STORIES OF CHANGE

Please see *Appendix 3 - Stories of Change*.

3 REACH

Target population Group	Type of Beneficiary Group	Targeted Individuals Cambodia	Targeted Individuals Kenya	Targeted Individuals Philippines	Targeted Individuals Uganda	TOTAL
Girls (age 0 - 4)	Beneficiary	1,175	579	0	0	1,754
Boys (age 0 - 4)	Beneficiary	1,175	425	0	0	1,600
Girls (age 5 - 9)	Beneficiary	0	621	0	0	621
Boys (age 5 - 9)	Beneficiary	0	475	0	0	475
Adolescent girls (age 10-14)	Beneficiary	6,512	5,221	5,404	4,528	21,665
Adolescent girls (age 15-19)	Beneficiary	5,116	4,379	5,404	13,585	28,484
Women (age 20-24)	Beneficiary	9,634	2,120	3,213	4,528	19,495
Women (age 25-49)	Beneficiary	7,427	5,117	3,213	906	16,663
Women (age 49+)	Beneficiary	827	2,063	2,142	454	5,486
Adolescent boys (10-14)	Beneficiary	3,961	1,316	2,316	2,264	9,857
Adolescent boys (15-19)	Beneficiary	3,112	1,384	2,316	6,792	13,604
Men (age 20-24)	Beneficiary	5,493	82	1,377	2,264	9,216

Men (age 25-49)	Beneficiary	6,194	179	1,377	453	8,203
Men (age 49+)	Beneficiary	791	39	918	226	1,974
Total Direct Beneficiaries		51,417	24,000	27,680	36,000	139,097

NOTE: The table above includes an update to the number of targeted beneficiaries that was proposed in the latest AWP submission.

4 DESIGN CHANGES

4.1 CHANGES TO THE THEORY OF CHANGE (TOC)

No changes have been made to the ToC within the Reporting Period since the submission of the PIP.

4.2 CHANGES TO THE LOGIC MODEL (LM)

No changes have been made to the LM within the Reporting Period since the submission of the PIP.

4.3 CHANGES TO THE PERFORMANCE MEASUREMENT FRAMEWORK (PMF)

With the submission of the Y3 AWP, a number of changes have been proposed to the PMF. Kindly see the **TOGETHER – Annual Work Plan – Year 3 – CONSOLIDATED** document that was submitted on Feb 15, 2023 for the details.

In addition, following a comprehensive review of the project's outcomes and outputs, further changes to the PMF are being proposed. Please refer to the following table:

Ind. Code	Current Approved Indicator in PMF (with target)	Proposed change to Indicator (and target)	Description and reason for change
New 1000c		To add a new indicator at the Ultimate Outcome level: Proportion of women (15-24) who make their own decisions regarding contraceptive use and reproductive health care.	While the other two indicators at the Ultimate Outcome level are specifically targeting positive change happening in a narrow group of people with a high need for support (people with unintended pregnancies and early/forced marriages), there are many other people, who have a chance to experience the positive change at the Ultimate Outcome level (enjoyment of health and health-related rights), simply by accessing the services improved by the project and also as a result of the project helping to tackle some of the socio-cultural norms and barriers, that prevented them from enjoying their health and rights in the

			past. Therefore, we are proposing this new indicator that will help to measure and articulate the positive change on a broader group of directly targeted people.
1300a	<p># and % of targeted communities accomplished at least one key goal from their action plan that addresses unintended pregnancies, SGBV (CEFM, FGM, etc.) within the past 12 months</p> <p>Cambodia EOP Target: 71</p> <p>Uganda EOP Target: 40</p>	<p># and % of targeted communities accomplished at least one key goal from their action plan that addresses unintended pregnancies, SGBV (CEFM, FGM, etc.) within the past 12 months</p> <p>Cambodia New EOP Target: 24</p> <p>Uganda New EOP Target: 18</p>	<p>By gaining a better understanding of the CoLMEAL process, the team has decided to reduce the number of targets. This will allow the project to focus on enhancing the capacity of each group, leading to improved sustainability. The team can also evaluate the effective implementation of CoLMEAL principles and ensure the quality of the established groups and their outputs.</p>
1310a	<p># and % of community group members who are able to monitor and reflect on the impact of community actions aiming towards addressing unintended pregnancies, SGBV including CEFM and FGM (by sex, age)</p> <p>Cambodia EOP Target: 358/358 (100%)</p> <p>Uganda EOP Target: 420/440 (95%)</p>	<p># and % of community group members who are able to monitor and reflect on the impact of community actions aiming towards addressing unintended pregnancies, SGBV including CEFM and FGM (by sex, age)</p> <p>Cambodia New EOP Target: 120/216 (56%)</p> <p>Uganda New EOP Target: 188/198 (95%)</p>	<p>As a result of gaining a greater understanding of the CoLMEAL process, the team has decided to reduce the number of target communities; correspondingly, fewer community group members will be trained. This will allow the project to focus on enhancing the capacity of each group, leading to improved sustainability. The team can also evaluate the effective implementation of CoLMEAL principles and ensure the quality of the established groups and their outputs.</p>
1311a	<p># Community leaders, officials, opinion leaders and other stakeholders who attended health and rights focused mobilization campaigns (by sex)</p> <p>Cambodia EOP Target: 74 (34F/ 40M)</p>	<p># Community leaders, officials, opinion leaders and other stakeholders who attended health and rights focused mobilization campaigns (by sex)</p> <p>Cambodia New EOP Target: 59 (27F/32M)</p>	<p>The project has decided to lower the target for community leaders, officials, opinion leaders, and other stakeholders who are members of the Project Coordination Committee, attending health and rights focused mobilization campaigns after reviewing the year 2 activities and results and reflecting on the engagement with the PCC.</p>
1312a	<p># of community groups (female, male, mixed) completing group Action Plan addressing SGBV, unintended pregnancies or sex work, in inclusive process</p> <p>Cambodia EOP Target: 71</p> <p>Uganda EOP Target: 40</p>	<p># of community groups (female, male, mixed) completing group Action Plan addressing SGBV, unintended pregnancies or sex work, in inclusive process</p> <p>Cambodia New EOP Target: 24</p> <p>Uganda New EOP Target: 18</p>	<p>By gaining a better understanding of the CoLMEAL process, the team has decided to reduce the number of targets. This will allow the project to focus on enhancing the capacity of each group, leading to improved sustainability. The team can also evaluate the effective implementation of CoLMEAL principles and ensure the quality of the established groups and their outputs.</p>

1313a	<p># of Community Action Grants distributed to community groups (by group leader's ' sex)</p> <p>Cambodia EOP Target: 71</p> <p>Uganda EOP Target: 40</p>	<p># of Community Action Grants distributed to community groups (by group leader's ' sex)</p> <p>Cambodia New EOP Target: 24</p> <p>Uganda New EOP Target: 18</p>	<p>CoLMEAL is a new approach to both Cambodia and Uganda. Initially, the project team was quite excited about it and put the stakes high. After undergoing the CoLMEAL training in preparation of its roll-out, both teams understood it better and realized the level of engagement it requires in terms of time and resources. This has led to the proposed changes aimed at ensuring that its implementation is smooth and sustainable. As a result of this action, the project will focus on enhancing the capacity of each group, leading to improved sustainability. The team can also evaluate the effective implementation of CoLMEAL principles and ensure the quality of the established groups and their outputs.</p> <p>Additionally, providing more funding to the groups implementing community actions will benefit the target communities by allowing them to utilize the funds more efficiently and have a positive impact on the communities.</p>
1314a	<p># of community group members provided with training on community-led MEL (by group members' sex)</p> <p>Cambodia EOP Target: 496 (248F/ 248M)</p> <p>Uganda EOP Target: 440 (160F/280M)</p>	<p># of community group members provided with training on community-led MEL (by group members' sex)</p> <p>Cambodia New EOP Target: 168 (50F/118M)</p> <p>Uganda New EOP Target: 198 (72F/126M)</p>	<p>By gaining a better understanding of the CoLMEAL process, the team has decided to reduce the number of targets. This will allow the project to focus on enhancing the capacity of each group, leading to improved sustainability. The team can also evaluate the effective implementation of CoLMEAL principles and ensure the quality of the established groups and their outputs.</p>

5 LESSONS LEARNED AND ACTIONS TAKEN

5.1 AREAS FOR IMPROVEMENT

Area for Improvement	Recommended Actions
Cambodia	
<p>Management of field data collection among management team was limited which hindered accelerating activities that fall behind the target</p>	<ul style="list-style-type: none"> • Produce tools to summarize the data collected from field team members and to be able to track activities progress . • Require each activity holder to record data and report to their supervisor on a regular basis (at least quarterly).

Planned activities were repeatedly delayed	<ul style="list-style-type: none"> • Monthly review of the Master DIP and catch-up plan to avoid delay. Include catchup plan in the monthly implementation plan of field staff. • For those activities that require involvement from the external stakeholder, a schedule is required to be made ahead with an appropriate amount of time.
Management of workload, staff assignment and shared responsibilities was limited.	<ul style="list-style-type: none"> • Hold staff accountable by setting clear designation of responsibilities among technical staff for hosting community events, engaging with government, provide capacity building to partners and staff. • To strengthen the capacity of APMs and team supervisors so that they will be able to make decisions /direct team more independently but abide by the necessary policies and regulations.
Participants complete required number of training topic facilitation was very low	<ul style="list-style-type: none"> • Conduct further analysis on how to reach youth participants. The team will be prepared to take specific actions after the analysis findings.
Kenya	
Training of the life skills to community level	<ul style="list-style-type: none"> • Conduct a refresher training for educators using teach back methodology to help sharpen the facilitation skills.
Philippines	
Regular communication and coordination with LGUs	<ul style="list-style-type: none"> • Ensure that all concerned departments and officials are properly informed and engaged in project activities by keeping regular communications with them, including sharing project updates and progress.
Strengthening of monitoring and reporting mechanisms	<ul style="list-style-type: none"> • Strengthen the monitoring and reporting mechanisms to ensure the timely and accurate updating of project-related information and data. This includes setting a regular schedule for providing copies of reports to concerned parties.
Promotion and engagement in project activities	<ul style="list-style-type: none"> • Increase promotion and engagement in project activities to maximize participation and increase household partner engagement. This includes mobilizing community officers to promote project activities and utilizing social media platforms to disseminate information.
Expanding coverage for AMN radio and AMN's Facebook.	<ul style="list-style-type: none"> • Gradually switch to video podcasts through Facebook live streaming. Create more interactive content focused on the target audience's interests, needs, and concerns promoting equal health-related rights and the rights of adolescent girls and women
Simplifying ColMEAL facilitation to shorten training time	<ul style="list-style-type: none"> • Explore alternative strategies to enhance participants' understanding of complex concepts, such as using 90% visuals during training.
Engaging men and reducing attendant absence	<ul style="list-style-type: none"> • Intensify community awareness of gender equality and role sharing. Promote peer support, such as male spouses or friends encouraging their partners or friends to participate.
Uganda	
Community outreach using radio programs.	<ul style="list-style-type: none"> • The project will intensify the use of radio to reach more adolescent, women, and girls in remote areas.
Incentives	<ul style="list-style-type: none"> • In the future, the project should include more incentives for the volunteers to motivate them to support project interventions at the community level.
Improving monitoring and analysis of implementations	<ul style="list-style-type: none"> • The project will ensure that activity data is uploaded into Kinaki on time and on a regular basis in order to allow project management to conduct regular analysis and track progresses.

5.2 BEST PRACTICES AND LESSONS LEARNED

The project identified the following best practices and lessons learned during the reporting period:

Best Practices
Cambodia
<ul style="list-style-type: none"> By developing selection criteria and guidelines at the start of the project, the project was able to select qualified youth champions to lead and share knowledge to their youth groups members after attending the leadership/facilitation skills training. When developing the curriculums and IEC key messages, the project required a link to the result of baseline report and Gender Analysis so that the activities address can appropriately address the root causes recommended by the Gender Analysis. Engagement with duty bearers from government partners to prepare training curriculums for trainings to HCs, CCWCs, VHSGs and youth champions ensures that these curriculums will be sustainable since there are guidelines/training curriculums required from the government sectors.
Kenya
<ul style="list-style-type: none"> When conducting proper consultations with adolescent, women and girls, they feel that valued and respected because of being consulted on the timing and venue of the project training and meetings. Sex-segregated training of male and female champions such as the gender synchronized approach Program H&M allows girls and boys to freely express themselves on sensitive topics such sexuality issues and SRHR. Engage with local religious leaders, CHVs and teachers as ToT leads to increase access to health care services.
Philippines
<ul style="list-style-type: none"> Open communication, involvement of field assistants in every field activity, and creating CoSuG Group Chats for proper and easy coordination help ensure that all stakeholders are informed and involved in the project. Monitoring output progress and regular follow-up are important practices that help the project team evaluate the activities and make necessary adjustments. Adaptive management, flexibility in work schedule & tasks, and delegation of tasks ensure that the project team can adjust to changing circumstances and respond to unexpected challenges.
Uganda
<ul style="list-style-type: none"> Pre-approval of quarterly work plans, budgets and procurement increases efficiency and burn rate of the project Legal services for survivors of SGBV are lacking in the project area. The project is actively seeking partnerships with organizations within the districts that can provide some legal support to the survivors.

Lessons learned
Cambodia
<ul style="list-style-type: none"> Some activities planned during the National Election in 2022 were on-hold due to sensitivity (conflict with election campaign) of field engagement. For the commune election in 2023, the project has replaced field

activities with setting new offices, designing training curriculum and providing orientation to staff on Y3 implementation in order to avoid conflicting field schedule during the election campaign.

- Completing the activity report on a regular weekly basis remains ineffective. The project has set up a tracking list and followed-up for those who are late in sending in the data.
- Staff and CMC members would still need ongoing mentoring and support for COLMEAL activities. Therefore, ongoing capacity building and mentoring for CMCs and staff were beneficial.
- When planned activities with government partners cannot be completed as scheduled due to the government's working priorities, the management team and specialists must review the schedules with government partners promptly to reschedule appropriate dates.
- There was an error in data collection focusing on nutrition and GBV. The lesson learned for this is to ensure to have a printed paper version of the questionnaire during field testing of the questionnaire and compare to what will be asked in the Kobo.

Kenya

- Working closely with the government and religious leaders enhances partnership, sustainability and enhances service delivery. Frequent consultation with county or sub-county officers boosts project's supports.

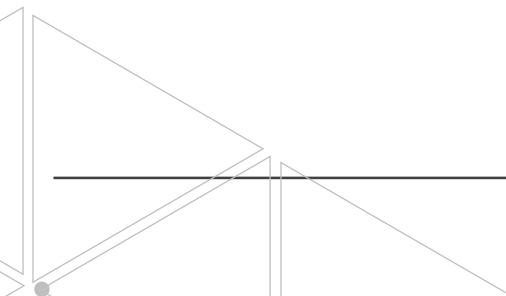
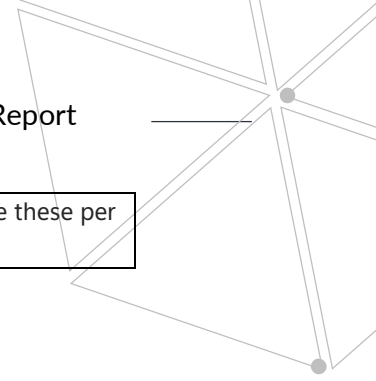
Philippines

- Following up with project participants one day before the event takes place. Personal invites can also be sent to identify all the participants in the training/community sessions for better attendance.
- In ColMEAL, staff must ensure that the deeper root causes are identified in the problem tree and are addressed in the TOC. The facilitator must trigger the realization of the participants to recognize these causes and to identify interventions in addressing those root causes.
- The REFLECT facilitators need to master the content and the effective use of materials for the session to be truly meaningful and engaging.
- Outputs are interrelated, and therefore, the design of activities needs to be approached as a package and not as independent activities. This will make planning and coordination activities with partner government agencies and other organizations much more productive.
- Since students are now going back to face-to-face classes, the participants of the succeeding batches of youth champions should no longer be students to avoid dropouts and maximize the output from the training.
- Community members are more motivated to attend sessions, and parents are more likely to allow adolescents to participate in REFLECT if they receive rice or school supplies instead of serving snacks.
- When conducting the VAWC and BCPC training, more time should be allotted to discuss the provisions of RA 9262 since this is the law that most BLGU officials and VAWC Officers are unfamiliar with.
- To help CMEALC & CMCs be recognized by the community, there should be increased ColMEAL visibility through shirts and IDs. Working in pairs or smaller groups allows for peer coaching and open learning.
- Since the project will rely on HMIS data and barangay records, there should be an intervention in capacitating BLGU officials and community health workers on record-keeping and data management.
- A better way to record feedback and complaints should be devised since the current channel/method is not utilized by project staff.

Uganda

- Integration of activities with other partners reduces costs, including transport, on the project
- Early identification of suppliers increases efficiency of conducting project businesses.

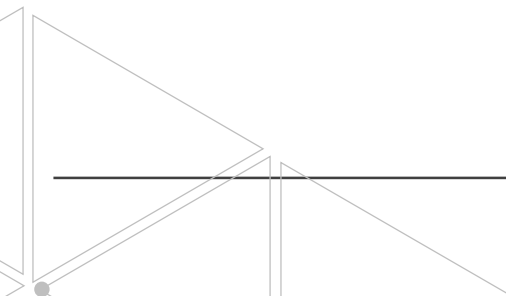
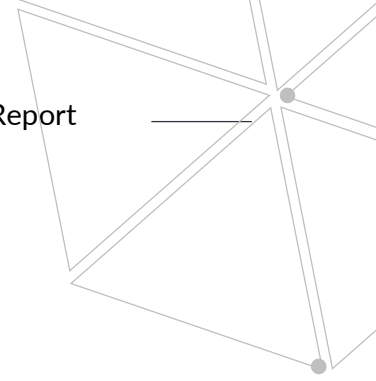
- Writing Concept notes for each field activity consumes a lot of time. The team will try to prepare these per quarter to enable them have adequate time for more strategic operations

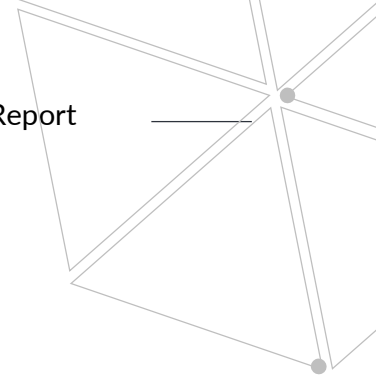


6 APPENDICES

Appendix 2 – Outcome Reporting Worksheet – TOGETHER ORW – Year 2 - CONSOLIDATED

Appendix 3 – Stories of Change





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