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<th>Full Form</th>
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<td>AfriYAN</td>
<td>African Youth and Adolescents Network</td>
</tr>
<tr>
<td>AGAG</td>
<td>Africa Grantmakers’ Affinity Group</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>AMSHeR</td>
<td>African Men for Sexual Health and Rights</td>
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<tr>
<td>APM</td>
<td>Annual Partners’ Meeting</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>AU</td>
<td>African Union</td>
</tr>
<tr>
<td>AUC</td>
<td>African Union Commission</td>
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<tr>
<td>CAG</td>
<td>Community Action Group</td>
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<td>CATS</td>
<td>Community Adolescent Treatment Supporters</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
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<td>CCM</td>
<td>Country Coordination Mechanism (Global Fund)</td>
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<td>CEDAW</td>
<td>Convention on the Elimination of Discrimination Against Women</td>
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<td>CEDEP</td>
<td>Centre for the Development of People (Malawi)</td>
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<td>CHESA</td>
<td>Community Health Education Services and Advocacy</td>
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<td>CHW</td>
<td>Community Health Workers</td>
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<td>CMSS</td>
<td>Community Mobilisation and Systems Strengthening</td>
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<td>CRVS</td>
<td>Civil Registration and Vital Statistics</td>
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<td>CSE</td>
<td>Comprehensive Sexuality Education</td>
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<td>CSK</td>
<td>Comprehensive Sexuality Knowledge</td>
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<td>CSO</td>
<td>Civil Society Organisations</td>
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<td>CSTL</td>
<td>Caring and Support for Teaching and Learning (framework)</td>
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<td>Donor Co-ordinating Committee</td>
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<td>DHAT</td>
<td>Disability HIV/AIDS Trust</td>
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<td>DMSS</td>
<td>District Mobilisation and Systems Strengthening</td>
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<td>DU</td>
<td>Drug User</td>
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<tr>
<td>EAC</td>
<td>East African Community</td>
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<tr>
<td>EANNASO</td>
<td>Eastern Africa National Networks of AIDS Service Organisations</td>
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<td>ERA</td>
<td>Evaluation Research Agency</td>
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<td>ESA</td>
<td>Eastern and Southern Africa</td>
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<tr>
<td>EWEC</td>
<td>Every Woman, Every Child (commonly known as the Global Strategy)</td>
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<tr>
<td>FARCO</td>
<td>Finance, Audit and Risk Committee</td>
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<td>GALZ</td>
<td>Gays and Lesbians of Zimbabwe</td>
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<tr>
<td>GBV</td>
<td>Gender-Based Violence</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GT</td>
<td>Gender Transformative (mapping, programming etc.)</td>
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<tr>
<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<tr>
<td>HHS</td>
<td>Happy Healthy and Safe</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HLM</td>
<td>High Level Meeting (UN)</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<tr>
<td>IBP</td>
<td>Implementing Best Practice Initiative</td>
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<td>ICP</td>
<td>International Co-operating Partners</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IDU</td>
<td>Injecting Drug User</td>
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<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
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<td>INGO</td>
<td>International Non-Governmental Organisations</td>
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<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bi-sexual, Transgender and Intersex</td>
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<tr>
<td>LICO</td>
<td>Life Concern Organisation</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
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<td>MEFADA</td>
<td>Methadone Family Against Drug Abuse (Tanzania)</td>
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<tr>
<td>MNCH</td>
<td>Maternal, New-born and Child Health</td>
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<td>MoHCC</td>
<td>Ministry of Health and Child Care (Zimbabwe)</td>
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<td>MoPSE</td>
<td>Ministry of Primary and Secondary Education (Zimbabwe)</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
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<tr>
<td>MWAGCD</td>
<td>Ministry of Women Affairs, Gender and Community Development (Zimbabwe)</td>
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<tr>
<td>NAC</td>
<td>National AIDS Council</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>NHS</td>
<td>National Health Structures (Zambia)</td>
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<td>PCIMIS</td>
<td>Partner Contracts and Management Information System</td>
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<tr>
<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
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<tr>
<td>PMF</td>
<td>Performance Monitoring Framework</td>
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<tr>
<td>PMNCH</td>
<td>Partnership for Maternal, Newborn and Child Health</td>
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<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<tr>
<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
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<td>PWD</td>
<td>People with Disabilities</td>
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<td>RAANGO</td>
<td>Regional African AIDS Non-Government Organisations (Forum)</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<tr>
<td>SAT</td>
<td>Southern African AIDS Trust</td>
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<tr>
<td>SDC</td>
<td>Swiss Agency for Development and Co-operation</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<tr>
<td>SEK</td>
<td>Swedish Krona</td>
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<tr>
<td>SIDA</td>
<td>Swedish International Development Cooperation Agency</td>
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<td>SRGBV</td>
<td>School-Related Gender Based Violence (framework)</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>TALC</td>
<td>Treatment Advocacy and Literacy Campaign</td>
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<td>Tanzania Media Women’s Association</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNFPA</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UPR</td>
<td>Universal Periodical Review</td>
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<td>USA</td>
<td>United States of America</td>
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<td>USG</td>
<td>United States Government</td>
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<td>VDCs</td>
<td>Village Development Committees</td>
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<td>VFU</td>
<td>Victim Friendly Unit (Zimbabwe)</td>
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<td>VIAC</td>
<td>Visual Inspection with Acetic Acid and Camera/Cervicography</td>
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<td>WAR</td>
<td>Women Against Rape (Botswana)</td>
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<td>YFHS</td>
<td>Youth-Friendly Health Services</td>
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<td>YFS</td>
<td>Youth-Friendly Service</td>
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<td>YHHS</td>
<td>Young Happy Healthy and Safe</td>
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EXECUTIVE SUMMARY

In the last year during which SAT implemented the workplan in line with our strategy, we have also been asking ourselves several key strategic questions that have had an impact on how we have delivered. The questions have been:

- Regarding SRHR, what are the proper responses of civil society in a seemingly post-progressive world?
- What will ‘move the needle’ on SRHR systems - policies, discourse and practice in eastern and southern Africa?
- What, practically, can gender equality mean for SRHR in the region, and SRHR for gender equality?
- What opportunities are opened by the 163-month SDG window for both gender equality and SRHR in Africa?
- Given the multiple failures but also the success of advocacy, what should future models for progressive influence be in this region?
- What does it mean to move from being a programmatic organisation to a catalytic organisation?

Each question has multiple sub-questions and, of course, multiple answers. Question 2 is perhaps the key – as well as the most vexing - question for SAT. This year we have striven to answer it in practice, while not straying too far from our agreed strategy and our delivery commitments. We anticipate that answering these questions more fully and in ways less restrained by the past will constitute the core of our impending update of our 2016 - 2021 strategy required by both Sida and SDC.

As we worked to deliver better systems changes within our existing strategy, the balance of partnerships – both in SAT’s sub-granting portfolio, as well as strategic partnerships - has begun to change.

At continental and regional levels SAT collaborated, and or supported collaborations, in several ways with governments or member state bodies.

At African Union level, SAT has played a strong conceptual and supportive role in establishing the AU Civil Society Reference Group for Ending Child Marriage (see ‘Ending child marriage’ section). In the Eastern and Southern Africa (ESA) region, SAT has been liaising with UNESCO and a number of ministries of Education in attempts to establish a new normative framework for dealing with school-related gender-based violence (SRGBV). Collaboration is underway with UNESCO on community-driven materials for this. In the same region, SAT has supported AfriYAN to represent itself and SAT on the ESA Commitment Civil Society Committee. We are in close co-operation with UNESCO on current and future support to the committee. And in East Africa, SAT supported EANNASO to work on eradicating child marriages in the EAC region - and also to draft the East Africa Sexual and Reproductive Health Rights Bill.

At a global level SAT continued to work with strategic partners such as UNAIDS, UNICEF, UNFPA, and UNESCO. SAT joined the Partnership for Maternal, Newborn and Child Health (PMNCH) and organised for best practice governance training for the two youth members elected onto the PMNCH Global Board. Our contribution to the UNAIDS global dialogue on funding for communities is given in Annexure M. The SAT Executive Director is the International Co-Chair of Track E of the International AIDS Conference 2018.

By the beginning of the year, SAT had brought together its work in innovative models for strengthened SRHR interventions for girls, adolescents and young women into what become called ‘the big five’. During this last year this concept further focused into what is now being called ‘The Girl Plan(also for boys)’. The concept of pulling disparate SRHR interventions or enabling interventions together into one plan has been to emphasise for all constituents the inter-connectedness of the interventions. It also ensures that one or two favoured interventions are not focussed on to the detriment of others.

At the beginning of the year we naively thought that the community push to work with schools as sites of access for adolescents would simply extend our community innovation work. It didn’t work out like that for a number of reasons, and the year has been an instructive one on navigating the politics of working with new...
sectors. Despite these problems, **37 SAT partners worked with approximately 308 schools** in five countries. We also worked regionally with groups of teachers, principals, pupils, and with UNESCO.

A key lesson learned this year, both in schools and in communities, has been that **boys are often ignored** in programming and SAT work now focuses on both boys and girls.

At regional level, SAT worked with principals, teachers, CBOs and pupils to **develop school plans and materials in two areas**: tracking school retention through pupil wellness tracking, and tracking school re-admissions. By the end of the 2016/17, SAT and its partners had worked with 396 schools (compared with the target of only 60 schools) in implementing the **re-admission programme**. We are also in the innovation stages of our involvement with headmen in changing attitudes and practices towards keeping girls, but also boys, in safe schools.

The concept of **wellness registers** for all pupils emerged this year, following an ease with the possibility that vulnerability registers might raise stigma. SAT has begun sourcing both hardware and software resources to support the testing of this concept in schools in the new year. A very large-scale multi-million Rand potential digital solution was seen in South Africa that could be used across the region, but the several millions of rand required to adapt this from recording academic progress to recording wellness was out of SAT’s budgets.

In supporting menstrual health, SAT partners in 18 communities provided some **5,827 girls** with over **25,000 re-usable sanitary pads**. In addition, groundwork was laid for a community-based **social entrepreneurship model** to manufacture sanitary pads.

Due to regional resources already allocated to CSE in the ESA Commitment, the strategy area of **comprehensive sexuality knowledge** was a lower priority for SAT regarding innovation in SRHR – with SAT intending to focus on two areas outside of the mainstream, namely on-line resources for MSM, and resources for HIV-positive adolescents. The repressions of LGBTI communities in Tanzania led to our withdrawing from the plan around MSM, as it had a very high probability of being seen as “promoting homosexuality” and thus exacerbating the crisis not just in Tanzania but also across the region.

We introduced into the workings of the **Civil Society Support Group to the ESA Commitment** the concept of CSK materials for positive adolescents. At community level some **11,933 adolescents** were reached with CSK materials on Positive Adolescence.

**Increasing adolescent access to SRHR services** remained perhaps the largest SAT challenge of the year, as it was for SRHR in the region. By the yearend, the feedback we had received led us to list five key barriers to adolescents’ accessing SRHR services – characterised as getting to (the distance barrier); getting in (the legal barrier); getting seen (the out-of-pocket/poverty barrier); getting heard (the staff attitude barrier); and getting helped (the services and commodities barrier).

**Youth-friendly services (YFS)** were mapped in two countries and 22 SAT partners monitored young people’s access to YFS and HCT. A total of 147,251 young people aged 15-24 **accessed youth-friendly services (including information)** through SAT partner support. Partner interventions in youth-friendly corners reached 41,082 young people in Zambia and 13,827 in Zimbabwe. In Botswana, SAT developed and launched **TeenWyze**, a mobile app for youth providing information, including about services. As a result of using the app to map 17 YFS clinics operated by both government and NGOs, young people can now geo-locate services using the app.

In 2016/17, **HCT services** were accessed by 64,446 young women and 52,126 young men. These figures were well below the targets SAT had set for the year, given a number of factors which included shortages of test kits in countries, as well as partners reporting that the expanded responsibilities set for them in The Girl Plan (also for boys) meant that same-size grants and targets proved unrealistic. SAT managed to **increase legal access** to modern contraceptives for young people in three SAT countries - Malawi (13%), Zambia (53%) and Zimbabwe (36%). After a lengthy project undertaken in collaboration with **20 law firms globally** (who provide pro bono services brokered by the Thompson Reuters Foundation), SAT reviewed the age of consent laws in 22 countries. Arising from this research, SAT is making **five key recommendations regionally** that will become the basis for advocacy.
Across the SAT countries, 1,232 community dialogues were held with traditional authorities, the police and community members to promote awareness around GBV and the importance of reporting cases for remedial measures. A total of 5,461 individuals were provided with services related to GBV including counselling, safe houses and legal support. All SAT partners are increasing their reach on GBV messaging - with one SAT partner in Tanzania receiving over 50,000 feedback messages on social platforms following three TV talk shows (which reach 3.6 million listeners).

SAT innovations included supporting 12 partners to promote awareness of, and referrals to, cervical cancer screening. A total of 8,120 women were screened and 167 treated with cryotherapy. SAT also supported the Government of Zimbabwe to administer 8,660 Human Papilloma Virus vaccines for children in the Kwekwe District.

Due to there not being large sums of money to invest and to interest key actors at district levels, the initial range of planned district-level activities was too disparate to act as a sufficient 'hook' to interest them. In order to better ‘package’ the offer, SAT began to drive the idea of working collaboratively on The Girl Plan (also for boys) at district level. Although conversations were initiated during the year, a series of planning meetings to finalise full district and cross-district learning took place early in the following year.

Youth hubs were established within SAT offices in Botswana, Malawi, Zambia and Zimbabwe as well as at the SAT regional office. Substantial activity took place in the hubs (one receiving up to 50 young visitors a day), but alignment between the hubs, and message quality have arisen as issues to be addressed urgently in the new year.

In order to promote inclusive services, SAT supported programming which worked with LGBTI communities, sex workers, drug users and people with disabilities.

Programming to end child marriage was focused mostly at a continental level. SAT applied for, and became a member of, the ten-person African Union Commission (AUC) Civil Society Reference Group for Ending Child Marriage, which has enabled us to strengthen the voice of girls and the community in the AU End Child Marriage Campaign. On the SDG 5 networks, SAT laid the ground work in Malawi, Zambia and Zimbabwe for the establishment of steering teams, networks and partnerships to advance the work around gender equality and empowerment of all women and girls.

Data was the weakest delivery area for SAT in 2016/17. While large amounts of data continued to be collected, the complementary piloting of technology, and aggregation of data upwards into useful collections from which analysis could take place, did not happen. The causes for this slow uptake were understood to be primarily linked to (1) not having existing relationships in new sectors which are a prerequisite for more formal data collection; (2) the shift to electronic data collection (from a paper-based one) shutting down previously accessible sources; and (3) governments becoming nervous when civil society asks for data even data in the public domain.

While expanded in 2016 to technically cover the entire ESA region, the Regional Health Data xChange was not populated with data during the year. In our 2017/18 workplan SAT has plans to catch up on outstanding data collection and use with technology. A re-admissions tracking tool was developed for pilot schools and this will be further developed and tested in 2017. In Tanzania SAT’s partner working with drug users will continue to track the use of harm reduction services. Cervical cancer-positive women screened and treated were tracked on a unique user level, but due to complications with follow-up screening, no technology was piloted in 2016/17.

Although not anticipated, it appears that the two greatest SAT-supported users of data in 2017 will be youth hub activists and district managers.

The rest of this report reviews in substantial detail delivery of the SAT annual workplan.
SECTION A: CONTEXT

A summary of the changed context over the last year at a regional level is given here. A up-to-date situational analysis of factors relating to The Girl Plan (also for boys) is given as Annexure B.

Women’s, Children’s and Adolescents’ Health

There are two global developments that are worth noting as context.

The global initiative on Every Woman, Every Child (EWEC) (commonly known as the Global Strategy) has still not impacted ESA in ways that are obvious from an outsider’s perspective. With the ascension of a new UN Secretary General, it is not immediately apparent how much of the force of the UN will remain behind this initiative.

Secondly, immediately after the US election, it appeared as if there were only five or six progressive countries left in the global leadership of SRHR. It suddenly seems as if we are living in a post-progressive world. Whereas once we spoke of a backlash by conservative forces against SRHR, now it appears as if progressive support for SRHR may be the backlash against a world largely opposed to reproductive rights and sexual rights.

The re-issuing of the Global Gag Rule by the White House and the subsequent #SheDecides initiative may be a turning point in rallying a number of countries back towards better support of SRHR. Nevertheless, this will not diminish hardcore opposition to rights within Africa, Eastern Europe, Russia, parts of the Far East, the Middle East, and a number of international agencies. The culture wars of the USA have gone global and progress made at Cairo, Beijing, the ICPDs, and even the SDGs signings since 1990, may now be endangered.

This may partly be a result of the unipolar world of the 1990s and 2000s that was dominated by the USA and had a dominant western liberal ethos of rights. The world, having decidedly moved back to a multi-polar political era, may have tipped a reaction against a perception of a Western agenda. This may partly be the much-discussed phenomenon of revolts against perceived elites and establishments. If the rights agenda in SRHR is seen as an agenda of the UN or elites in the West at a time when the UN is increasingly rejected or scoffed at by resurgent nationalisms, and ‘the establishment’ has become a target for revolt in many places, then the rights agenda may suffer the same fate.

This is not to rarefy discussion to an abstract level but rather to consider bigger and perhaps less visible themes to take practical action. If global forums involving SRHR are in danger of becoming toxic, then what actions need to be taken to work on this? Can regional work in Africa, for example, change patterns at global levels? If not, can work within the ESA region focus on implementation of rights despite higher-level rhetoric? And of course, what resources are required to do so?

What scope do the SDGs – particularly 3 and 5 - have in the next 165 months to ‘permit’ programming and advocacy for change? Regarding the #SheDecides initiative, it remains to be seen how much money is recycled, relabelled or real; how much will come to the South; and how much will end up with civil societies? Also, to what extent will #SheDecides manage to integrate with other important initiatives such as EWEC and the SDGs, rather than become a new silo?
New Thinking on Comprehensive and Resilient Systems for Health

2017 has been designated by the African Union as the year of harnessing the Demographic Dividend through investments in the youth. The majority of sub-Saharan Africa is, however, heading for demographic disaster rather than dividend.

Many sub-Saharan countries are already facing substantial youth bulges in the composition of their population and they have some of the highest fertility rates in the world which, if unaltered, will see populations rising at rates like these between 2015 and 2050: Malawi, 16 million to 42 million; Tanzania, 53 million to 137 million; Zambia, 16 million to 42 million; Zimbabwe, 15 million to 29 million. Of the SAT countries, only two are even set to achieve the pre-condition for the demographic dividend: South Africa, climbing from 54 million to 65 million in that time; and Botswana, climbing from 2.2 million to 3.4 million.

With increases like these on the same available land area, with the same or less access to drinking water, potentially less arable land available due to global warming, and services and GDP increasing at a far slower rate than the population, it will be impossible to achieve the SDGs - and improbable to even maintain the human development index achieved thus far by 2017. Fertility reduction has become one of the key pre-requisites for national development. It is not only an SRHR issue but a development issue.

The danger of this realisation is that the world has a dark and shameful history of 'population control', legislating away parents’ rights to decide on having children and forcing and coercing sterilisation. Even in less dramatic responses, the danger of turning women and young people into subjects that must be ‘made’ to have less children through a command-and-control style national plan is a real one.

Advocacy is required to address fertility reduction in the region, as are democratic and rights-based approaches to do so. Keeping girls in safe schools for longer, reducing gender-based violence (GBV), and increasing the sexual and reproductive health knowledge of young people have been factors across the world. Gender equality and the ability of adolescents and young people to access health services are also factors. But, perhaps, it is the increased access to modern contraceptives and women making choices about their own reproductive health that have turned the tide.

There are many barriers to adolescents around the globe - the majority of citizens in many countries – to access SRH services. Distance from services, lack of transport, lack of available commodities, poverty, inherited beliefs, harmful practices, and hostile staff attitudes can all be barriers to access. But only one barrier is self-inflicted by countries - and this barrier could disappear tomorrow, creating massive access for adolescents. It is the barrier of legal restrictions on adolescents’ access to SRH health services. The majority of countries in the region have placed arbitrary legal barriers to adolescent access by creating policies or laws providing for a number of parental consent and other restrictions which prevent adolescents from initiating their own health care.

These barriers might be summed up as:

1. Getting The distance barrier
2. Getting in The legal barrier
3. Getting seen The out-of-pocket/poverty barrier
4. Getting heard The staff attitude barrier
5. Getting helped The services and commodities barrier.

All of these barriers need solutions - and civil society can and must play a role. This is part of the resilient, inclusive, and equitable new systems for health.
New questions need to be dialogued at a regional level as to whether and how regional structures play a constructive and progressive role in positive change in health. Given the unhelpful role of the Africa block in global SRHR, it remains to be seen how useful the African Union Commission (AUC) will be in SRHR. The answer is probably a nuanced one as some aspects of ‘safer’ subjects like maternal health will be well supported, while others like adolescent contraception and sexual rights will not be. There is no doubt that the ‘majesty’ of the concept of the African Union does hold normative power. An example is how quickly the AUC has managed to ‘normalise’ the push to raise marriage ages to 18. On what other issues this can be harnessed and through what labyrinth of channels remains work in progress.

Other organs to consider are the Southern African Development Community (SADC) and East African Community (EAC). Efficiency, return on resource and a focus on investments, normative influence, and other factors need further dialogue within civil society. They also deserve dialogue between international co-operating partners who have convening powers due to budget or larger relations and civil society organisations (CSOs) who are often shut out of the structures.

**Gender Equality and the Empowerment of Women and Girls**

The most notable contextual factor in gender equality over the last 12 months is that almost nothing has happened in gender equality over the last 12 months at a regional level.

A key question for the next few years is to what extent SDG 5 can become a rallying call that opens a window of opportunity to create an urgency for action on gender equality. There are 165 months to go until 2030 at the time this report was written. If the kind of urgency that was created around the AIDS response can be created around the gender agenda, then perhaps some momentum can be created in the region.

It is noted that Sweden and Switzerland are well developed along the gender equality pathway and it may be that both are well placed to lead by example, sharing and exchanging with the region.
SECTION B: FOUR PROGRAMME RESULT AREAS FOR THE YEAR

RESULT AREA 1: INNOVATIVE MODELS - FOR STRENGTHENED SRHR INTERVENTIONS

SAT continues to innovate in areas of SRHR with two main aims:

- to seek innovative solutions to SRHR issues that have the potential to be replicated or scaled up to country levels, and from there across the region; and

- to seek innovative solutions that have the potential to create tools or models for, or to problematise country/local level implementation of, Africa-wide/national policies.

At the beginning of the year SAT listed ‘the big five’ SRHR intervention areas for girls, adolescents and young women in the Annual Workplan. In discussions with stakeholders during the year, these coalesced into what is now being called ‘The Girl Plan(also for boys)’. The concept of pulling disparate SRHR interventions or enabling interventions together into one plan has been to emphasise for all constituents the inter-connectedness of the interventions, and to avoid one or two favoured interventions being taken up to the neglect or even detriment of others.

As the year has ended, the concept of The Girl Plan(also for boys) is as follows.
Preparing for schools programming

At the beginning of the year we naively thought that the community push to work with schools as sites of access for adolescents would simply extend our community innovation work. It didn’t work like that for a number of reasons.

SAT community partners have long-standing relationships with both the people and the organisations/institutions with which they work. Our directive to expand this required an unforeseen level of building new relationships that proved more difficult than either we, or the partners, could have foreseen. Even where local relationships were not too difficult to build, the district level and national dynamics of beginning to work with an entirely new ministry – Education – proved complex. We noted local partnership difficulties by mid-year and worked with partners to improve these - not anticipating larger dynamics of inter-sectoral work.

That being said the list of schools accessed through SAT partners - in Annexure C - is not inconsiderable being 308 schools accessed through 37 partners in 5 countries. This work was done in 23 districts - and over 29,660 students were reached in Botswana and Zimbabwe.

In terms of outcomes, in 2016/17 SAT worked to ensure that

- girls, adolescents and young women were readmitted to school after pregnancy; and
- gender-based violence (GBV) plans were implemented in schools.

More generally, schools were also identified as sites of engagement for the following areas of work, which are reported below:

- promoting menstrual hygiene in schools and availability of sanitary pads;
- keeping girls in safe schools (including the by-laws project); and
- comprehensive sexuality knowledge – particularly comprehensive sexuality education (CSE).

After working with teachers, pupils, principals and community-based organisations (CBOs) from across the region, SAT developed a number of draft materials which collectively made up a ‘caring school’ approach to community/school SRHR and SRHR-enabling work (see the poster below).
Even this concept was fraught with politics, however, as numerous different frameworks already existed. SADC has the Caring and Support for Teaching and Learning (CSTL) framework; UNESCO has a School-Related Gender-Based Violence (SRGBV) framework, and several countries in ESA have their own unique frameworks. In dialogue with communities, the one common complaint was that most of these frameworks are very complicated for communities to understand and relate to, and fairly exclusionary in how they impact on community participation.

From a community perspective the caring school is a concept that allows for simplified partnerships between civil society and schools in support of the rights and sexual and reproductive health of adolescents. It nudges schools towards co-operating with communities in eight areas:

1. school-related gender-based violence (SRGBV);
2. sexuality education;
3. supporting community plans to end child marriage;
4. developing plans for pupil access to SRH services;
5. becoming a menstrual health-friendly zone for girls;
6. working smarter to re-admit and re-integrate returning pupils after dropping out;
7. creating a culture of gender equality; and
8. mutual respect between boys and girls.

The idea is that none of these commitments from schools should be over and above existing policies, and none should require prohibitive external resources that cannot be sourced from the immediate surrounding community.

Various materials linked to the ‘caring schools approach’ are described in relevant sections of this report.

At regional level, a significant lesson learned this year has been that boys are often ignored during attempts to keep adolescents in school. Because boys do not get pregnant, and tend not to be required to help at home with domestic or agricultural work, programmes do not focus on them. Dropout rates for boys in secondary school across the region are also abysmal, however, with reasons including, inter alia, poverty, violence, abuse, and drug use. As programmes often ignore boys, all SAT work now focuses on both boys and girls.

Promoting menstrual hygiene in schools and availability of sanitary pads

SAT planned to

- conduct desktop research, in collaboration with the global IBP Initiative, to assess good practice community-led approaches to the supply of menstrual hygiene commodities; and

- map menstrual hygiene issues affecting girls in SAT’s partners’ schools as well as menstrual hygiene facilities and infrastructure.

Based on the findings of the desktop research and community mapping, SAT intended to develop a social entrepreneurship model that it would pilot in targeted SAT communities.

Specifically, SAT intended to ensure that three SAT communities would be providing girls and young women (10-24) with increased access to affordable pads.

SAT’s intention to conduct desktop research was not realised, following a prolonged membership application process with the IBP Initiative. This remains in progress.
In Zimbabwe, SAT mapped menstrual hygiene issues affecting girls and menstrual hygiene facilities and infrastructure in partners’ schools. Due to other competing priorities, SAT postponed mapping these in Malawi and Zambia and this may be done in the next workplan, if deemed necessary to supplement findings from the Zimbabwe mapping exercise.

That being the case, SAT focused away from research and towards the other components of the year plan, particularly the production and provision of sanitary pads.

The production of sanitary pads has contributed to ensuring that girls and young women (10-24) have increased access to affordable pads in 18 communities, exceeding the workplan target of this taking place in three SAT communities. A total of 5,827 girls were provided with 25,676 re-usable sanitary pads. For example in two sites in Zambia’s eastern cluster, SAT provided 160 girls from disadvantaged families with re-usable sanitary pads.

In assessing all of this work SAT has recognised large differences between sites and quality issues. Swift measures have been implemented to benchmark products against the Zimbabwe standards authority quality guidelines and to organise study visits between SAT partners.

The social entrepreneurship model - which entailed producing sanitary pads - was successfully piloted in targeted SAT communities.

- During 2016/17 SAT secured the intellectual property rights to manufacture re-usable sanitary pads in Zimbabwe - and certification by the International Standards Organisation has been applied for.

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3 This was six communities in Zimbabwe, nine in Malawi and three in Zambia.
• CHIEDZA, a SAT partner in Zimbabwe, initially trained ten volunteers to produce re-usable sanitary pads using domestic machines. By December 2016, a total of 6,855 pads had been produced and distributed to 1,301 girls. In response to a plan by CHIEDZA, SAT purchased five industrial sewing machines and materials, so that they could increase production to 20,000 re-usable pads for sale in communities at a cost of US$4.50 per girl per year. This has made pads more affordable for girls and created 27 jobs (absorbing the ten volunteers). CHIEDZA also leveraged off the concept and the equipment in order to build a mini-community factory, with additional support from USAID.

• In Malawi SAT procured 9 sewing machines and is in the process of training 15 people in two communities to produce re-usable sanitary pads.

• Whilst in Zambia SAT supported two organisations that produced and distributed 1,821 sanitary pads to 779 girls during the reporting period. In addition, SAT procured four industrial machines to upscale production of re-usable sanitary pads in Zambia.

In this financial year, SAT has also:

• supported partners in addressing myths and misconceptions surrounding menstruation, including working with traditional leaders and initiation counsellors;

• provided girls with menstrual health information and engaged boys to end harassment of menstruating girls;

• supported partners in enabling mother groups to counsel school-going girls and train them in menstrual hygiene; and

• supported the construction of change rooms for girls in schools.

Building better awareness in schools is central to the regional thrust regarding menstrual health. In consultation and collaboration with teachers, principals, pupils and CBOs, SAT and its partners developed draft materials and criteria for a menstrual health-friendly school. In the next year these materials will be revised through a collaboration between SAT and UNESCO Regional, and avenues for field testing them across the region will be sought.

In addition SAT is exploring with the Girl Guides Association (Africa Region) towards including a ‘badge’ in menstrual health. It is also working with SAT youth hubs to assess economic and social implications of having sanitary wear exempted from tax.
Keeping girls in safe schools

In 2016/17, SAT planned to do the following:

1. To work with adolescents and young people to develop templates for school plans for keeping girls in school and re-admission of young mothers (as well as GBV prevention, SRHR access, and menstrual hygiene support) – in the context of promoting the whole school-based approach to SRHR. These plans would be piloted in collaborative schools and supported and monitored.

2. To track school retention in target schools by mapping enrolment and retention figures in partners’ collaborating schools (noting age, sex and grade).

3. To track school re-admission target schools by mapping in partners’ collaborating schools the extent to which girls who fall pregnant while at school are re-admitted after they give birth.

Both sets of tracked data (2 and 3) would be added to the Data xChange.

Specifically, SAT aimed to ensure that:

- 30% of girls in the target areas were re-admitted after pregnancy; and
- 60 schools implemented the re-admission programme, in support of health interventions innovated

Challenges of programming at school level (mentioned above) prevented work on a scale that had been envisaged. For example the policy in Zimbabwe is that NGOs should not work in schools but through the relevant government departments. Recognising this, SAT partners are using the multi-sectoral approach involving government ministries to reach out to the intended goals. This process is susceptible to bureaucracy, however, and has had a substantial impact on access and timing.

At regional level, SAT has worked with principals, teachers, CBOs and pupils to develop school plans and materials in two areas: tracking school retention through pupil wellness tracking, and tracking school re-admissions.

By the end of the 2016/17, SAT and its partners had worked with 396 schools (compared with the target of only 60 schools) in implementing the re-admission programme (see more below).

Tracking school retention

While SAT did not map enrolment and retention figures in schools as intended, SAT supported partners with funding and technical assistance to enable them to deliver interventions that would retain more girls in schools. These included:

- intensifying collaboration with teachers, school management committees, parents’ teacher associations and, most importantly, traditional leaders to ensure that girls in schools have safe learning environments;
- working with mother and father groups to give motivational talks at schools regarding the importance of education;
- providing amenities to ensure menstruating girls can go to school safely;
- forming school health clubs that focused on young people-led health education in schools e.g. 30% of the SAT Zambia partners operated school-based clubs that served as platforms for promoting safe spaces for girls;
- partnering with health facilities to offer regular school-based health talks and services;
- conducting dialogues with stakeholders to support the re-admission of girls to schools; and
- providing psycho-social counselling for girls to enable their return to school after giving birth.

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4 This section integrates three sub-sections: Promote the whole school-based approach to SRHR, Track school retention in target schools, Track school re-admission in target schools.
5 Nominator: # of girls readmitted after pregnancy in target area/ denominator: # of girl pupils that fall pregnant in school in the target area.
SAT also worked with affected communities and other partners towards strengthening safety nets that would assist vulnerable pupils who dropped out of school due to failure to pay fees or lack of school-related resources.

In one of the Zambian communities served by partner organisation Petauke NZP+, 20 pupils dropped out of school before writing examinations in 2015. However, following sensitisation meetings in which Petauke NZP+ focused on headmen and teachers, there was a reduction in school dropout. In addition, all 27 pupils who registered to sit for Grade 7 examinations in 2016 did so, 19 of whom qualified for Grade 8.

An example is Ezra Njobvu, headman of Kalunguzya Village under Chief Nyamphande in Zambia, who is known to support girls going back to school – and opposes early marriage, recognising the dangers these pose to young girls.

Asked why this is so, he testified that he had seen ‘a lot of deaths in my village of girls who were stopping school and [who] entered into early marriages at the age of 12 to 15 years’. Many had divorced ‘with only two children and are now keeping the children without their fathers’. He added that he had been ‘one of the victims’ as he had lost his 13 year-old daughter because of early marriage and early childbirth: ‘After delivery (by caesarean section) she got sick and we thought she was bewitched - but after her death and after learning, it’s when I realised that the girl was still young’.

Headman Ezra Njobvu wants his village to develop and feels that it is not doing so ‘because a lot of youth are just peasant farmers and didn’t have any other plans of developing the village’. He has seen the importance of having people in the community ‘who are educated’ – and that being informed enables people to make choices that promote the wellbeing of families and the community, including and especially young girls.

Innovation
The concept of vulnerability registers were the initial result of dialogues with school stakeholders which focussed on identifying pupils’ vulnerability before they dropped out school. These registers would link with key local welfare agencies to ensure that no child slipped through the cracks between various systems.

It became clear as conversations progressed, however, that
• stigma could be attached to being designated ‘vulnerable’ in a school; and
• focusing only on specific aspects of vulnerability could allow other factors to go unnoticed.

This shifted the approach towards tracking the wellness of all pupils against a set of basic minimal wellness points, rather than only those who were considered vulnerable. Base data about a pupil would constitute a unique record which, kept in parallel to the academic one, would track their wellness.

While this needs further work and dialogue in the new year, in particular with UNESCO, points discussed included CRVS\(^6\); guardianship of a child; child-headed households; weight and nutrition; hearing and eyesight; disability; disclosed HIV\(^7\); HIV treatment; disclosed parenthood by a pupil; disclosed childhood marriage; and even distance and routes to school. SAT has begun sourcing both hardware and software resources to support the testing of this concept in schools in the new year.

\(^6\) CRVS = civil registration and vital statistics.

\(^7\) The concept of ‘disclosed’ used here refers to a school carefully asking parents whether they wish to register any of these factors. Privacy issues and stigma and discrimination are very real problems here but many argued that in a small community many of these factors are known anyway.
Tracking school re-admission in target schools

In 2016/17, 422 girls in SAT target areas in Zambia and Zimbabwe were re-admitted to school, 252 of these having left due to forced or early marriage.

### Girls in SAT target areas re-admitted to school

<table>
<thead>
<tr>
<th>SAT Malawi target areas</th>
<th>TOTAL NO. OF GIRLS RE-ADMITTED</th>
<th>NO. OF GIRLS RE-ADMITTED AFTER EARLY MARRIAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>info to ff</td>
<td>info to ff</td>
</tr>
<tr>
<td>SAT Zambia target areas</td>
<td>235</td>
<td>235</td>
</tr>
<tr>
<td>SAT Zimbabwe target areas</td>
<td>197</td>
<td>17</td>
</tr>
<tr>
<td>TOTAL</td>
<td>TOTALS TO FF</td>
<td>TOTALS TO FF</td>
</tr>
</tbody>
</table>

Tracking dropouts and re-admissions has included

- supporting partner organisations to track pupils who drop out including, where possible, working with schools to ensure that there is good school retention; and
- the on-going development of an effective follow-up and tracking system to be consistently implemented by schools in collaboration with SAT partners – particularly as some girls opt to go to different school or study centres where their backgrounds are not known.

Through SAT partner organisations, **15% of young mothers returned to schools after pregnancy** which is half of the 30% SAT aimed to have re-admitted.

SAT country offices explained this as follows:

- In Zimbabwe, the re-admission policy was in its early stages of implementation as it was only enacted in 2016. SAT partners are in the process of developing tracking tools for schools to use to identify school dropouts so they can be followed up. They found that some girls who they tracked were not eager to return to school due to stigma, discrimination and embarrassment associated with their pregnancy.

- There are a number of factors that relate to, or inhibit, school re-entry in Zambia. These include guardians’ inability to meet the schools’ financial/resource requirements, as well as girls’ uncertainty about returning to the same school environment, following pregnancy.

- In Malawi the targets were not met as some of the girls were still pregnant or still had very young babies, and some had relocated to an area outside the partner catchment area.

### Innovation

In the course of this work, two unforeseen and surprising issues became clear.

Firstly, SAT had assumed that everyone agreed that re-admissions were crucial to adolescents, as well as to communities and to the larger education system. This seemed evident, as all countries in which we work have re-admission policies based more or less on globally-accepted good practice.

During our work with key stakeholders, however, it became clear that teachers, parents and community members often opposed re-admission on various grounds. These include a desire to punish adolescents who have ‘done wrong’ by, for example, becoming pregnant or using drugs; as well as a fear that ‘returnees’ would ‘spread the wrong’ by, for example, encouraging other girls to get pregnant or have sex or persuading other pupils to use drugs, or physically endangering them.

This led to the development of simple draft SBCC materials which **argue the case for re-admissions**. In addition, SAT has developed draft school re-admission plan templates working regionally with principals, teachers, pupils and CBOs.

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8 This is 20% in Malawi, 9.3% in Zimbabwe and 10% in Zambia.
9 Social and Behaviour Change Communication
Secondly, and more starkly, and as noted above, we learned or realised that boys are often ignored in attempts to keep adolescents in schools, and that programmes do not focus on them. In reality significant numbers of boys also drop out of schools. All materials and planning tools developed regionally took account of this factor.

Traditional Authority Kachindamoto, a woman traditional leader in Dedza district of Malawi, rescued 600 adolescents from child marriages (400 girls and 200 boys). She dismissed four chiefs under her jurisdiction who had given consent to the marriages of girls – and only reinstated them after they had dissolved the marriages and ensured that the girls went back to school.

Overall, SAT designs its programmes to innovate community- and district-level interventions that will practically retain more girls in schools as safe spaces, and thus demonstrate pathways to achieve what are, mostly, already existing policies. We also seek to work with policy makers on school retention for girls, HIV prevention, gender equality (SDG 5) and national development. In this way SAT seeks to create viable models for civil society support in this area that can be shared and can impact on regional thinking about this key gender equality issue.

Local by-laws project

In 2016/17, SAT planned to
• work with its partners to map local by-laws aimed at promoting SRHR and gender equality; and
• use a gender transformative lens to evaluate these by-laws for good and bad practices, and to share these findings among SAT partners.

The by-laws aimed at promoting SRHR and gender equality are listed in Annexure D. These comprise ten in Malawi, five in Zambia and 17 in Zimbabwe. In Malawi, for example, 85% of traditional leaders in SAT target areas have functional by-laws in place and in two areas, community-level task forces (led by the traditional authorities) have been established to deal with issues around child marriage, school dropouts and teen pregnancies.

While these by-laws will be evaluated for good and bad practice in the next financial year, during the current reporting period they were used to impact positively at a community level, dealing with issues such as school retention, ending child marriage, teenage pregnancy, promoting giving birth at health facilities and preventing violence against women and children.

Two key SAT programme areas in which by-laws have evidently been helpful, are keeping girls in safe schools and ending child marriage.
Keeping girls in safe schools

- As noted above, some traditional leadership in Malawi have used by-laws to ensure that every child is in school.
- Similar by-laws have been passed by community leadership in Zimbabwe - promoting attendance at school by all children, irrespective of gender. These include by-laws that children whose school fees have not been paid should not be excluded but rather that schools should engage with caregivers and parents to explore ways in which they could be paid.
- By-laws regulating the closure of bottle stores, nights clubs and bars at stipulated times were also developed by SAT partners in Zimbabwe - and we are working with community leaders and SAT partners in Malawi - thereby contributing to ensuring safe schools.

Ending child marriage

- At least 75% of SAT partners in Zambia have implemented community-level initiatives to end child marriage.
- 42% of communities serviced by SAT partners in Zambia established community action groups, which included community leaders, to address early marriage. This has resulted in increased reporting to authorities of child marriage and some partners recorded having ‘retrieved’ girls from early marriages.
- In three target communities in Zimbabwe, by-laws were established to ban child marriage, with some requiring that any household with a child marriage should be reported to the local leaders. In these communities, a referral system of reporting has been designed with the support of childcare workers to ensure reporting of child marriages.
- In Malawi the Kachila Youth Initiative worked with traditional leaders to encourage them to advocate for the end of child marriages and to increase school retention, especially for girls.

Ending Child Marriages

While efforts to end child marriages should be reported here (under Result Area 1) given the conceptualisation of The Girl Plan (also for boys), we have followed the layout of the workplan. ‘Ending child marriages’ is thus reported under Result Area 3: ‘Supportive Environments for Women’s Rights & Wellbeing Health’.
Accessing comprehensive sexuality knowledge materials

**Facilitate and increase the availability of CSK materials for key populations**

Due to extensive support to comprehensive sexuality education (CSE) generally and the resources already allocated to CSE in the ESA Commitment, this area tended to be a lower priority for SAT regarding innovation in SRHR. SAT therefore intended to focus on two areas outside of the mainstream, namely on-line resources for MSM\(^{10}\), and resources for HIV-positive adolescents.

In 2016/17, SAT planned to work with CHESA in Tanzania (as well as with several SAT partners who were leading on positive adolescent health) to develop CSK supplementary materials for specific target groups, namely men who have sex with men (MSM) and HIV-positive adolescents. The intention was to distribute and use MSM materials via LGBTI organisations, rather than for use in schools.

Specifically, SAT planned to ensure that there was an increase in CSK on Positive Adolescence, such that by the end of 2016/17

- 10,000 adolescents would have been reached with CSK materials on Positive Adolescence; and
- 150 outlets would be distributing the CSK materials for Positive Adolescents.

In addition:

- 1 set of CSK materials on Positive Adolescence were to be developed.

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**Men who have Sex with Men (MSM)**

The repression of LGBTI communities in Tanzania led to our withdrawing from the plan around MSM, as it had a very high probability of being seen as ‘promoting homosexuality’ and thus exacerbating the crisis for LGBTI communities in the country. (This is reported on more fully under in Result Area 2 ‘Expanding access and inclusivity: LGBTI’ below).

**Positive Adolescents\(^{11}\)**

In terms of meeting the targets in 2016/17 for CSK materials on Positive Adolescence:

- 11,933 adolescents were reached with CSK materials, exceeding the target of 10,000; and
- 482 outlets distributed these CSK materials, exceeding the target of 150 outlets.

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\(^{10}\) MSM = Men who have Sex with Men

\(^{11}\) Adolescents has been very clear that they wish to distinguish between ‘positive adolescence’ meaning living your adolescence in a positive way while HIV positive, and ‘positive adolescents’ meaning adolescents living with HIV. They are clear that materials should be developed for the former that will also be useful to teachers, parents, friends and positive adolescents themselves.
In addition SAT and partners began to develop materials to be used to provide CSK among adolescents living with HIV/AIDS. These were workshopped regionally towards the end of the year with positive-living adolescents and a structure for materials was designed that will provide the basis in the new year for more detailed materials design in collaboration with several other regional partners.

Recognising that CSK materials for positive adolescents is a substantial issue requiring systems-scale interventions across the region, however, we also introduced the concept into the workings of the Civil Society Support Group to the ESA Commitment (which advises UNESCO on the ESA Commitment, that in turn advises governments). The intention is to introduce, or support the adoption of, the need for materials on positive adolescence into the 22 member states of the ESA Commitment.

**Facilitate and increase the availability of CSK materials in schools**

SAT planned to develop - and distribute - three sets of CSK materials:

1. **basic school materials on gender equity** which SAT would design and develop with community partners and gender experts for distribution in SAT partner communities;

2. the existing **Happy Healthy Safe materials** used in Zambia and Swaziland which SAT would review to make them more widely available to selected partners with school collaborations; and

3. **CSK materials for parents** which SAT would develop in consultation with parents and young people, including HIV-positive adolescents, to tailor make them to their needs.

To ensure increased availability, SAT aimed to disseminate **CSK materials in at least 150 sites** through all partner schools plus other possible outlets such as the internet and at events.

In terms of **developing materials**

- SAT produced basic school materials on gender equity and these include the school plan to end child violence, poster and fact sheet to end child violence.

- While the Happy Healthy and Safe (HHS) materials were sourced from Young Happy Health and Safe partner in Zambia, the process of reviewing and adapting them into CSK materials for schools had not been finalised at the time of reporting.

- SAT began the process to develop CSK materials for parents and this will be completed in the coming year.

Although SAT partners faced challenges with ministries of Education in accessing schools to distribute CSK materials, SAT partners innovated at local level to explore ways of promoting CSK.

In Zimbabwe:

- 1 out-of-school session and 9 in-school sessions were held in communities, reaching 765 youth (305 males and 460 females) with CSK information;

- 5 CSE outreach programmes were held, encouraging 5,593 adolescents to access comprehensive services and health facilities;

- 261 young people were reached with peer-led SRHR information (including through learning tools like film) through the Community Adolescent Treatment Supporters (CATS);

- 58 teachers from 26 schools were trained as peer educators to disseminate information to people living with HIV (PLHIV) and refer them for SRH services; and

- 5 support group meetings were conducted reaching 304 adolescents (186 males and 118 females).

And in Zambia, SAT partners worked with schools to implement CSE as part of government policy as a stepping stone to CSK programming, plans and processes to finalise CSK materials that address the needs of adolescent living with HIV.
Promoting adolescent access to youth-friendly services\(^\text{12}\)

In 2016/17, SAT planned to improve data on the availability and use of youth-friendly services (YFS), through

1. mapping the availability of YFS in two SAT countries on the Data xChange, such that all YFS sites in one country had been mapped;
2. advocating with other SAT country governments and non-SAT countries to do the same;
3. supporting 10 partners to monitor access of young people to YFS and HCT\(^\text{13}\);
4. improving the quality of data collected on adolescent service use through community mapping exercises (with particular focus on PMTCT\(^\text{14}\), HCT, MNCH\(^\text{15}\), facility birth delivery, modern contraception and GBV services for adolescent health) – for use in school-based planning for SRHR access, and in community dialogues; and
5. developing an app to gather user feedback on experiences of services, to be piloted in Tanzania and Kenya.

Specifically, SAT planned to ensure that adolescents and young women accessed services, especially HCT and contraception, such that by the end of 2016/17:

- 10,000 young men and women aged 15-24 would have accessed youth-friendly SRH services in the outreach area;
- 250,000 young women and 180,000 young men aged 15-24 in the outreach areas would have accessed HCT - and would know their status;
- 40% of young people in the target areas would have reported having accessed legal modern contraceptives; and
- planning to increase legal access to modern contraceptives for young people would have been implemented in 3 districts in 3 SAT countries.

Data

SAT began the year committed to mapping on the Data xChange the availability of youth-friendly services (YFS) in two SAT countries and advocating with other SAT country governments and non-SAT countries to do the same. We also committed to work with a technology partner to pilot user feedback on experiences with services, by developing a user feedback App for piloting in Tanzania and Kenya.

To report on the second commitment first, the tensions and growing inaccessibility in Tanzania during the LGBTI crisis and the attendant attack on NGOs made approaching the government on this project not a viable option. Since the Kenya component was premised on building on the Tanzanian field-testing this too did not occur. In the absence of the very highest level of political support for a feedback project (ministerial or presidential), the potential political fallout makes it strategically unviable. Avenues are being sought to find such support, but they remain tenuous.

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\(^{12}\) This section integrates two sub-sections: Youth-friendly Services and Promote Adolescent Access to Services

\(^{13}\) HCT = HIV counselling and testing

\(^{14}\) PMTCT = prevention of mother-to-child transmission

\(^{15}\) MNCH = maternal, newborn and child health
Youth-friendly services were mapped in two countries as per the workplan – Malawi and Zimbabwe. These are given in Annexure E and summarised in the table below. (While SAT Zambia has not yet mapped youth-friendly services, a list from the Ministry of Health shows there are 1,590 youth-friendly services in the country.)

The list of youth-friendly corners supported by SAT partners is given in Annexure F – again summarised below.

Youth-friendly services and corners

<table>
<thead>
<tr>
<th>SAT OFFICE</th>
<th>YOUTH-FRIENDLY SERVICES MAPPED BY SAT</th>
<th>NO. OF YOUTH FRIENDLY CORNERS SUPPORTED BY SAT PARTNERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malawi</td>
<td>517</td>
<td>26</td>
</tr>
<tr>
<td>Zambia</td>
<td>to be mapped in 2017/18</td>
<td>22</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>356</td>
<td>25</td>
</tr>
</tbody>
</table>

Access to, and uptake of, youth-friendly health services

SAT supported 22 partners to monitor young people’s access to YFS and HCT, up from the targeted 10 partners.

As given in Annexure F, the number of youth reached through partners’ interventions in the youth-friendly corners were as follows:

Youth reached through youth-friendly corners supported by SAT partners

<table>
<thead>
<tr>
<th>SAT OFFICE</th>
<th>NO. OF YOUTH REACHED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malawi</td>
<td>31,629</td>
</tr>
<tr>
<td>Zambia</td>
<td>47,255</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>13,827</td>
</tr>
<tr>
<td>TOTAL</td>
<td>92,711</td>
</tr>
</tbody>
</table>
As we cannot identify those who, as a result of SAT partners, use the youth-friendly services (largely offered through state-run clinics), we do not have statistics for these services. That being said, an evaluation study revealed that only about a third (31%) of young people in Malawi had heard about youth-friendly health services, and only 13% of young people had ever used them, despite 75% to 100% of clinics being considered youth-friendly.

In 2016/17, a total of 147,251 young people aged 15-24 accessed youth-friendly services (including information) offered through SAT support\(^\text{16}\), exceeding SAT’s target of 10,000 during this period. Country offices attributed this success as follows:

- Services were increasingly taken to the people through outreach programmes as well as offering services at sporting galas organised by the partners. Higher numbers of youth could have been reached, however, were it not for the shortage of testing kits.
- In Zambia, partners were increasingly engaging with youth-friendly services, both as service providers and with regard to demand generation.
- More youth-friendly sexual and reproductive health service points were established in Malawian partners’ catchment areas.

Examples of newly-customised services for youth included:

- four support groups for adolescents and young PLHIV were established in Zambia, to provide personal support and promote adherence; and
- clinic days for adolescents were established in four health facilities, providing opportunities for about 10 children and youth per clinic to address health issues specific to them when collecting their medicines.

Youth-friendly corners were increasingly being revived through which SRH services were accessed. This included young people providing services to their peers such as counselling, HIV testing, screening for sexually transmitted infections (STIs), pregnancy testing, contraception and male medical circumcision, as well as providing referrals to nearest health facilities.

Youth participated in providing youth-friendly services in other settings too, including:

- counselling services as part of ART clinics for adolescents and young people; and
- delivering ART services within health facilities in Zambia through a SAT partner Treatment Advocacy and Literacy Campaign (TALC).

In Zambia the participation of young people in delivering health services through another SAT partner, Young Happy Healthy and Safe (YHHS) resulted in a 33% increase in condoms accessed by young people.

Overall, it remains unsatisfactory that young people who are the majority of citizens in all SAT countries, and indeed in Eastern and Southern Africa, are marginalised in youth-friendly corners or in infrequent adolescent-friendly days. What is needed, rather, is high-powered political support to conceptualise what a national health service reoriented entirely towards young people would look like. It is unlikely that SAT, by itself, has either the convening power or the resources to bring this about.

**Creating demand**

Youth also participated in promoting uptake, generating demand and creating awareness of service availability and access. For example in Zimbabwe,

- SAT worked with 3,700 young leaders to form Youth Accountability Boards to spearhead the mobilisation of young people to seek and access services in health, education and social protection; and
- in-school peer educators referred 468 adolescents to services that included HCT, family planning and emergency contraception.

\(^\text{16}\) Botswana 101; Malawi 68,715; Zambia 41,082; and Zimbabwe 37,353.
In addition, SAT, working through its partners,

- created awareness of where specific youth-friendly SRH services could be accessed;
- made referrals to such services; and
- collaborated with health facilities in providing health services to community members.

For example, in Botswana, SAT developed and launched TeenWyze, a mobile app for youth which provides a secure and youth-friendly platform that facilitates access to SRH services. SAT mapping of 17 YFS clinics operated by both government and NGOs and young people can now geo-locate services using Teenwyze.

**Youth participation**

Across the region, interventions promoting youth participation in increasing access to HIV and SRH services included young people participating in fora identifying youth-friendly services. For example:

- 81 adolescents from two districts in Malawi assisted in identifying key aspects of services they would like, as well as how they would like the information to be communicated. This also contributed to planning the SAT Youth Hub in Malawi (reported on below).
- In Zambia, 16 young people participated in a national stakeholder consultation on Gender and Adolescent Participation in National Health Structures (NHS). The outcomes included the identification of opportunities and strategies for improving adolescent participation in NHS and interventions geared towards improving adolescent health. For example the Chisomo Community Programme established three community youth hubs to increase access to information as well as to link young people to health care service providers.

**Accessing HCT services**

HCT services were accessed by 64,446 young women (lower than the target of 250,000) and 52,126 young men (lower than the target of 180,000). There was a sense from the country offices (and their partners) that the targets had been set unreasonably high, especially given the increasing shortages of test kits in their countries. They commented as follows:

- SAT partners in Zambia observed that the targets were unrealistic given past trends, capacity and resources available such as testing kits, grant sizes, etc. They indicated again this year that the lack of testing kits and reagents was contributing to reduced numbers of people accessing HCT services.
- In Malawi the environment was not conducive and health facilities did not have enough testing kits, despite creation of demand by partners.
- In Zimbabwe, SAT partners reported that a shortage of test kits prevented them from making testing more widely available. In addition the reduction of the number of partners with whom SAT works also reduced the possible reach.

**Accessing contraception**

Ensuring access to legal modern contraception was also not as successful as planned:

- 30% of young people in the SAT target areas\(^\text{17}\) reported having accessed legal modern contraceptives, less than the 40% targeted.
- SAT implemented plans to increase legal access to modern contraceptives for young people in one SAT country – namely Zimbabwe – not three districts in three countries.

SAT gave the following reasons for reaching fewer young people than targeted:

- Where there are no youth-friendly corners or outreach programmes, shyness prevents young Zimbabweans from accessing contraceptives in health facilities, preferring to buy them from shops if they have the money (which means numbers are not recorded); failing which they simply do not use them.
- In Malawi a general shortage of contraceptive materials led to the reduced access by young people therefore only 13% were reached.

\(^\text{17}\) Malawi (13%), Zambia (41%) and Zimbabwe (36%)
While targets were not reached, access to modern legal contraceptives was nonetheless reported to have increased through SAT’s partners undertaking community efforts ranging from demand generation, making referrals and actual service provision.\(^{18}\)

**In Zimbabwe** 36% of young people were reached in target areas through youth-friendly centres and through integrated health youth outreach programmes among other interventions. For example:

- 11,991 youth accessed information and modern contraception services from six youth-friendly centres that were established in clinics where SAT Zimbabwe partners worked. These clinics have seen an increased uptake in modern contraception services and are key hubs for information dissemination.
- 15,987 adolescents were given family planning and modern contraception information and 1,829 adolescents accessed family planning services through 22 integrated health outreach programmes in hard-to-reach areas.

**In Zambia**, SAT partners were more successful, reaching 41% of young people in the target area. However, more than 50% of the partners achieved targets above 40% through supporting, or working closely with, youth-friendly services to increase access to modern contraception – with some partners engaging in service-based collaborations to deliver services closer to communities. In addition, SAT partners increased demand generation activities. As a result, there was a marked increase in the quantities of condoms distributed and accessed and the number of points at which they were distributed. For example in the community served by Young Happy Healthy and Safe (YHHS), a 33% increase in condom distribution was recorded in the reporting period.

### Barriers to access

Globally there are many barriers to adolescents - the majority of citizens in most countries in the region – accessing SRH services. These might perhaps be summed up as:

- **Getting to** The distance barrier
- **Getting in** The legal barrier
- **Getting seen** The out-of-pocket/poverty barrier
- **Getting heard** The staff attitude barrier
- **Getting helped** The services and commodities barrier

The large scale of these problems and the small contribution possible by one, or even a collaboration of, civil society organisations makes this perhaps one of the least satisfying areas of SAT work this year and across the region in general.

After a lengthy project undertaken in collaboration with 20 law firms globally who provide pro bono services brokered by the Thompson Reuters Foundation, SAT has reviewed the age of consent laws in 22 countries.\(^{19}\)

The range of countries was chosen to highlight a spread of geography; cultures; development status; ‘non-achievement’, ‘in-transition’ and ‘achievement’ of the demographic dividend; and adolescent health outcomes. The report is given in Annexure G.

In addition, SAT and UNICEF also undertook an Ethical, Cultural and Social review in nine countries (seven being from the 22 countries above, plus two others - Uganda and Philippines) to look at ethical cultural and social barriers impacting adolescent access to health and services including SRH services.

\(^{18}\) Modern contraception accessed included condoms, oral contraception, injectables, and, in some cases, implants. By far, condoms were the most popular contraception that young people accessed.

\(^{19}\) Botswana, Kenya, Ivory Coast, Malawi, Morocco, Nigeria, South Africa, Tanzania, Zambia, Zimbabwe, Swaziland, Brazil, Jamaica, India, Indonesia, Thailand, Vietnam, Canada, England and Wales, France, Sweden, and Ukraine
From the wide range of data and analysis, a few game-changing recommendations seem to suggest themselves for advocacy and further work:

1. De-sexualize SRH services and treat them as we would any other health system access.
2. Base both access and restriction decisions on child and adolescent development, competence and maturity to make decisions about their own health.
3. Do not make the age of sexual consent older than 16 years, and do not distinguish between young men and young women.
4. Have in place provisions regarding statutory rape to protect adolescents from predatory older adults.
5. Put in place ‘close in age’ exceptions to the age of sexual consent so that young adolescents having consensual sex with one another do not have to go to jail – a travesty overwhelmingly affecting young men aged 13-16 years.

Work was also begun regionally within the framework of the caring school concept (see above) on promoting school-centred, though not school-based, access to SRH services. Principals, teachers, pupils and CBOs drafted a planning tool allowing pupil-led ‘School SRHR Access Planning’. Given the significant sensitivities regarding this area, more political consultation has to be done, including with UNESCO regionally and with Education ministries in SAT countries.

**Combatting gender-based violence**

Although initiatives relating to gender-based violence were located in various sections of the workplan, we have reported on most of them here.

In 2016/17, SAT planned to do **GBV prevention work in schools**:

1. SAT would facilitate the development of the **GBV planning tool**, among other things, as part of Preparations for Schools Programming.
2. SAT planned to work with adolescents and young people to **develop templates for school plans for GBV prevention** (as well as keeping girls in school, re-admission of young mothers, SRHR access and menstrual hygiene support) – as part of promoting the ‘whole school’-based approach to SRHR. These would then be piloted, supported and monitored in collaborative schools. Specifically, SAT planned to ensure that **30% of schools in the target area had implemented plans focusing on GBV**.

In 2016/17, SAT also planned to work with **technology for safer environments**:

1. In Malawi SAT would develop and implement a mobile phone app to **support sex workers in reporting violence or harassment** and in accessing health services.
2. In Botswana a community-based mobile solution for **monitoring GBV case reporting, survivor support, case management and monitoring** (based on the iMonitor+) was to be developed in collaboration with the NGO Women Against Rape (WAR) and the Botswana Police Service.

**Schools**

During 2016/17, SAT focused on using schools as sites to reduce GBV, innovate local solutions to making contexts safer for girls, and develop and model a GBV referral system in Botswana. The thinking behind using schools as sites to reduce GBV is that they contain very large numbers of young people whose values and habits developed in school have the opportunity of influencing siblings and families as well as informing their own behaviour in the future as citizens and parents.

SAT partners’ approaches to addressing GBV in schools included mobilising pupils in various ways against GBV, and involving teachers, especially the guidance and counselling department, to identify cases and link students to services.
Country offices reported that 62% of target schools in their areas implemented plans focusing on GBV – double the target of 30%. In addition:

- In Botswana, 2,101 students (1,134 girls, 967 boys) were reached through peer education about GBV in five secondary schools in Maun. This was through Student Against Rape (SAR) clubs, established by SAT in collaboration with Women Against Rape (WAR). SAR clubs conduct weekly GBV prevention and life skills sessions with the support of guidance and counselling teachers. In addition four secondary schools have established SAR clubs at ‘adopted’ primary schools in their areas, to create safe schools for girls.

- In Zambia, Young Happy Health and Safe (YHHS) involved surrounding communities in establishing an enabling environment to address, among others, school-based GBV.

- In Zimbabwe, SAT partners reached 1,063 school students (369 males and 704 females) and sensitised 5 teachers within 8 schools as planned, using dramas and debates on teen-dating violence to conduct GBV dialogues and SRHR activities.

- A further 202 Zimbabwean pupils received information aimed at empowering them to report GBV cases and to fight GBV in the community - through 6 awareness campaigns.

- 259 cases of emotional abuse, 14 cases of physical abuse and 6 of sexual abuse were reported through the whistle blowing system in 9 Zimbabwean schools where youth were trained as peer educators to support whistleblowing on GBV cases, offer referrals and linkages to support for survivors, and disseminate information on GBV.

SAT worked regionally with principals, teachers, pupils and CBOs to develop school-based plan templates and materials opposing violence against children (1 and 2 above). Although still in their development phases, these materials are now being integrated into the ESA regional rollout of the global UNESCO school-related GBV (SRGBV) strategy - and in collaboration with UNESCO the materials will be taken forward and field-tested variously across the SADC region with ministries of Education.

Reducing acceptance of GBV in communities

SAT partners worked with communities in the region to contribute to creating local cultures that promote non-violence, relationships based on equality, and individuals who take a personal and public stand against abuse. This was done mainly through engaging the general public, community members, leaders, religious leaders, other NGOs, health care and social service providers - enrolling them as advocates, community activists, and encouraging them to form community GBV action groups.

SAT partners conducted structured community dialogues within communities to discuss GBV-related issues (e.g. exploring GBV and its forms, the legal environment, the social and other drivers of GBV) and to explore ways in which communities could reduce GBV. Across Botswana, Malawi, Zimbabwe and Zambia, 1,232 community dialogues were held with traditional authorities, the police, and community members to promote awareness around GBV and the importance of reporting cases for remedial measures.

Youth Peer Educators in Bolero  
Community mobilisation in Zimbabwe
The community dialogues resulted in Community Action Groups (CAGs) being formed to act as links between the community and various GBV service providers, as well as to mobilise the communities for action to prevent GBV. CAGs comprise community members, community-based paralegals, the police, schools, and health services. The presence of active CAGs in each SAT country has resulted in increased reporting of GBV cases across the region and has helped in providing counselling services and referrals for survivors of GBV. They have also provided a platform for community leaders to act and speak out against GBV. Across SAT countries, a total of 5,461 individuals were provided with services including counselling, safe houses and legal support.

SAT partners used both mainstream and social media to engage communities on GBV prevention in both Botswana and Tanzania.

- In Tanzania, SAT partner TAMWA conducted three radio talk shows for communities to dialogue on GBV, during which rape and its effects on survivors, legal support and counselling for GBV survivors were discussed. From the radio station’s 3.6 million listeners, 50,000 feedback messages were received on social platforms and through text messages.

- In Botswana, SAT ran a social media campaign to engage communities regarding the drivers of GBV, as well as to gauge social acceptance of GBV. A provocative teaser posted on Facebook elicited significant disapproval, suggesting high levels of ‘zero tolerance to GBV’ especially among youth aged 18 – 24 years. (See article in Annexure H.)

Piloting cervical cancer-led integrated health screening

In 2016/17, SAT planned to

- map cervical cancer services in all SAT countries on the Data xChange; and
- conduct a baseline survey on cervical cancer services among selected SAT partners.
- evaluate the existing integrated screening outreach project in Zimbabwe and good practice recorded and reported.
- initiate three new sites in this reporting period.

Due to a number of interlinked implementation challenges - including a lack of transparency regarding data and collaboration with ministries - SAT could not fulfil its 2016/17 activities to map cervical cancer services in all SAT countries as planned. We also did not succeed in conducting a baseline survey on cervical cancer services among selected SAT partners, as the 2015/16 mapping information was moved into the 2016/17 programming activities.

SAT evaluated the screening projects in Zimbabwe and Malawi. Through these interventions we raised the demand for, and supported the delivery of, cervical cancer screening services - as a result of which three new sites were initiated in this reporting period.
Evaluations

Zimbabwe

SAT commissioned Singizi Consulting to undertake an evaluation of the Zimbabwe cervical cancer outreach project (given in Annexure I). Key questions for the evaluation focused on the project’s relative success in terms of its objectives and on what adjustments would be necessary to replicate the project elsewhere.

The main finding was that the community outreach programme, incorporating VIAC\(^2\), was largely viable, particularly as it was located within the government’s policies on both providing integrated care and decentralising health service provision. In addition, cervical cancer screening has proved to be a powerful entry point into effective SRHR education and programming.

In summary, the evaluation found:

- The critical step of engaging with the local authorities was done effectively, as the groundwork was complete when the testing equipment arrived.
- There are low-tech ways of doing effective screening, as pioneered during these SAT-supported outreaches in under-resourced areas.
- The limited number, and pressurised, staff at the facilities resulted in limiting the number of VIAC screenings possible.
- The ideal composition of outreach teams comprised ten people being a doctor, three VIAC nurses, an HIV Rapid Testing and Counselling nurse, a nurse to do syphilis and other STIs screening and treatment, an EPI and family planning nurse, an ultra-sonographer/radiographer, a data capturer and a general assistant.
- There was little or no systematic case management evident during the evaluation of the VIAC programme at the Kwekwe or Silobela/Nyoni sites – and treatment management in Zimbabwe healthcare provision is generally the responsibility of the patient.
- Outreach visits created awareness about basic health issues and have been critical to enhancing access to other health services.
- The project provided a good gateway for education on personal hygiene and methods of care, as screenings provided valuable insights into unorthodox and unhealthy self-administered ‘cleaning’ practices.
- The cost of biopsies at the government pathology department was between $40 and $70. SAT Zimbabwe was making efforts to cover the costs where required.

The evaluation recommended that:

- increased collaboration among stakeholders would ensure integrated outreach services were offered and resources would be saved; and
- the project should treat 100% of screened women, as this was not the case when the evaluation was conducted.
- All the women screened were later followed up and have since been treated.

\(^2\) Visual Inspection with Acetic Acid and Camera/Cervicography
Malawi

The Malawian evaluation is given in Annexure J. It describes the intervention by Life Concern Organisation (LICO) who, supported by SAT, piloted the implementation of cervical cancer awareness and screening services project. The project aimed to promote early diagnosis and treatment of cervical cancer via community outreach and health facility referrals. LICO piloted the project in five health facilities in Rumphi district (namely Rumphi district hospital, Mhuju rural hospital, Bolero rural hospital, Mzokoto health centre and Katowo health centre).

LICO trained eight nurses in the ‘screen and treat’ approach – and procured a Cryotherapy machine for Rumphi hospital to be used for treating women who had been diagnosed with cervical cancer.

In the four months from January to May 2016, 2,035 women were screened for cervical cancer (compared with 11 women screened in the previous five months). Of these, 209 women were diagnosed with gynaecological problems and were treated the current reporting period; 13 were referred for cryotherapy treatment and were treated, while 7 with advanced cervical cancer were referred to Mzuzu Central Hospital. In addition, 19,030 people were reached with information on cervical cancer through outreach and awareness campaigns.

The report concludes that ‘LICO appears to be providing high quality first-level cervical cancer information sharing and screening, and without LICO intervention, there would be no access to cervical cancer screening at all in the area serviced by LICO. There are limits to how much treatment can be offered, given the lack of resources.’

Recommendations included that if SAT Malawi supports other community-based partners to run similar projects in the future, it actively encourages ‘learning amongst peers’ using the LICO experience – adding that ‘there is also invaluable experience amongst other NGOs operating in this sphere in Malawi (noting especially SOS Children’s Villages’).

Demand and supply

In 2016/17, SAT innovations included supporting 12 partners to promote awareness of, and referrals to, cervical cancer screening. A total of 8,120 women were screened and 167 treated with cryotherapy.21

Two models were used for service delivery:

- outreach – as in Zimbabwe where services were taken to the people; and
- in-reach – as in Malawi where SAT supported clinics22 with equipment and created awareness and demand.

A third model is to pressurise for the supply of services through raising local demand – although there are ethical considerations in this. While national activism for services can be supported through local community action, non-delivery after raising awareness and expectations is not good practice. For example, in Zambia although mobilisation efforts at community level created demand, in some cases there were no or only limited cervical cancer screening services available.

And finally, in 2016/17, SAT complemented government efforts by supporting the administration of 8,660 human papilloma virus (HPV) vaccines for children in the Kwekwe District. Given the effectiveness of the HPV vaccination, these cervical cancer services targeted at girls should become a priority.
Lessons learned

Importantly the lessons learned were as follows:

- Don’t create demand at local level without supply.
- Task shifting – from doctors to nurses and from nurses to community health workers (CHWs) – can significantly increase access to screening and treatment. The shortage of trained health personnel to do cervical cancer screening provides an opportunity for advocacy to ensure that resources are made available to make screening accessible.
- Screening and basic treatment can be done locally by CHWs/ nurses, and in local clinics by nurses with a Leep machine – reducing the dominant current practice of referring women to hospitals, which entails costs to the household and risks loss-to-follow-up.
- HPV vaccines should be administered to children as part of their standard vaccination regimen.
- Testing men for prostate cancer could be equally considered.

RESULT AREA 2: COMPREHENSIVE, EQUITABLE AND INCLUSIVE SYSTEMS FOR HEALTH

SAT’s work here has continued to focus on the horizontal component of SRHR - namely that of supporting resilient systems for equitable and inclusive health. At the beginning of the year we had intended to focus on two aspects within this result area, namely:

- the community and civil society’s contributions to systems for health; and
- increasing the participation of women and young people in systems as planners and leaders and not just as beneficiaries.

Modelling collaboration between government and civil society

Regarding greater participation of civil society in systems for health, SAT aimed to have;

- 15 formalised agreements between civil society and government to improve SRHR delivery.

More specifically in 2016/17, SAT would have

- supported 50 young people (in their capacity) to participate in systems for health;
- facilitated 15 events, processes or structures where SAT advocated for the role and sustainability of civil society in systems for health;
- ensured 40 communities had implemented the Community Mobilisation and Systems Strengthening (CMSS) and that 3 districts had implemented the District Mobilisation and Systems Strengthening (DMSS)
During the period under review, SAT country offices and partners worked collaboratively with their respective governments, particularly within SAT’s ‘Big Five’ Intervention areas - namely gender-based violence, keeping girls in safe schools; comprehensive sexuality knowledge; preventing child/early marriages; and access to SRH services.

While SAT has collaborated with a range of government departments and agencies, most of these efforts have been without formalised agreements.

In Malawi:
- SAT partners improved their collaboration and networking initiatives with other civil society organisations and with government at different levels.
- Key government organisations included the Ministry of Health and Population*, and the Ministry of Education at district levels.
- At community level, SAT partners worked with health centres and clinics and with primary education advisors, head teachers and teachers in both primary and secondary schools.
- SAT partners also established working partnerships with other parts of government, in their own right.  

In Zambia:
- Collaboration with strategic partners was based on mutual interest and was not guided by signed Memoranda of Understandings (MOUs).
- In the period under review SAT worked with various government ministries and departments e.g. with the Ministry of Chiefs and Traditional Affairs in engaging traditional leaders to address GBV and early marriages; with the Ministry of Health under the Adolescent Technical Working Group (with SAT supporting one of its meetings and facilitating the dissemination of the adolescent-friendly health guidelines in the Eastern Province).
- SAT was also part of the team that worked with government representatives and other CSOs in drafting the country’s Adolescent Health Strategy and the National AIDS Strategic Framework 2017-21.
- At sub-national levels, SAT partners collaborated closely with, primarily, ministries of Health and General Education to deliver community programmes in health facilities and schools. While again most of the collaboration was not guided by MOUs, two SAT partners had formalised their engagement with Ministry of Health at district levels through MOUs, authorising them to use spaces provided by the Ministry in delivering services for adolescents.

In Zimbabwe:
- SAT Zimbabwe strengthened its partnerships with various stakeholders, including the government: namely with the Ministry of Health and Child Care (MoHCC), Ministry of Women Affairs, Gender and Community Development (MWAGCD), Ministry of Primary and Secondary Education (MoPSE), Ministry of Youth, Victim Friendly Unit (VFU) and National AIDS Council (NAC).
- SAT also worked with two UN agencies, namely UNDP and UNFPA. These partnerships complement government efforts in offering better quality and affordable services. Some of the benefits included accompanying partners to mobile outreach clinics, providing cervical cancer screening, HTC and HPV immunisation (mentioned elsewhere in this report).
- Government ministries also helped with SRHR and family planning information dissemination and with censuring perpetrators of GBV.

SAT will also develop stronger collaborative arrangements with like-minded civil society organisations to strengthen their voice towards more collaborative action towards positive systems change.

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* Within the Malawian Ministry of Health, key sections included the HTC office, District YFHS Co-ordinator, the District Nursing Office, the District ART Office, for technical support and facilitating training.

* For instance, in Malawi CEDEP (Centre for the Development of People) works with the Ministry of Justice and Ministry of Gender, being a member of the national task force for the International Covenant on Civil and Political Rights, Universal Periodical Review (UPR), African Commission on Human Rights and Convention on the Elimination of Discrimination Against Women (CEDAW). It is also represented at the CCM level. CEDEP is also represented in the development of the Global Fund Proposal for the 2020 and also in the COP18 through stakeholder engagements.
In terms of quantifying these interactions, then, SAT **achieved the following** in relation to the targets set:

- **1,347** young people - rather than the 50 proposed – were supported to participate in systems for health;
- of the **15** formalised agreements that were to be made between civil society and governments, SAT managed to formalise **11**.
- **Events, processes or structures where SAT advocated for the role and sustainability of civil society in systems for health were facilitated** was another indicator - much like those for gender equality advocacy activities - where we battled to distinguish between events called, led, funded, or even just participated in by civil society on the one hand, and specific discreet events on the other hand. The impossibility of distinguishing these led to misleading reporting, with only **3** events being recorded in this category rather than the scores if not hundreds that should have qualified. This indicator issue of multi vs discreet purpose events is being urgently addressed.
- **25** communities had fully implemented the CMSS (rather than the **40** aimed for) while no districts had implemented the DMSS due to reasons covered in the description of the district project,. District level implementation of the DMSS is now planned for the next annual workplan period.
- maps for data xChange were produced in **10** districts in one country (Zimbabwe), compared with the target of **6** districts in **3** countries; and
- the SAT database was established - but only in Malawi on which data from the community and district mappings were captured and stored.

At continental and regional levels SAT collaborated, and/or supported collaborations, with governments or member state bodies in several ways.

- At **African Union** level, SAT has played a strong conceptual and supportive role in establishing the AU Civil Society Reference Group for Ending Child Marriage (see ‘Ending child marriage’ section).
- In the **ESA region** SAT has been liaising with UNESCO and a number of ministries of Education in attempts to establish a new normative framework for dealing with school-related gender-based violence (SRGBV). Collaboration is underway with UNESCO on community-driven materials for this.
- In the same region, SAT has supported AfriYAN to represent itself and SAT on the ESA Commitment Civil Society Committee. We are in close co-operation with UNESCO on current and future support to the committee.
- And in **East Africa**, SAT supported EANNASO to work on eradicating child marriages in the EAC region and also to draft the East Africa Sexual and Reproductive Health Rights Bill.

A significant failure during this period has been to make any breakthrough with **SADC**. Despite several attempts to liaise and dialogue on CSO collaboration, no entry point was found during this year.

### District projects

At district level, SAT planned to

- recruit **3 district partners**, one each in Zimbabwe, Zambia and Malawi;
- support districts to **increase youth and women participation** in health planning and monitoring;
- work with district health leaders and use the SAT gender transformative community-mapping tool to **develop Gender Transformative District-mapping and programming tools**;
- support **3 districts** to **promote legal access to modern contraceptives** and to implement **youth-friendly approaches service** access;
- work with district health management in one district to develop a **client feedback tool** for district use.
District partners

SAT recruited six districts as partners – two in each country - being more than the three required, namely:

- Malawi – Rumphi and Lilongwe
- Zambia - Lusaka and Chipata
- Zimbabwe – Mutasa and Insiza
In the course of conversations with districts during the year it became clear that without being able to produce large sums of money to interest the districts in collaboration, the initial range of district-level activities planned was too disparate to act as a sufficient ‘hook’ to interest them. In addition, both Zambia and Malawi are in the process of de-centralization, and both the politics as well as the practicalities of these exercises proved a substantial hindrance to implementation.

In order to better ‘package’ the offer, SAT began to drive the idea of working collaboratively on The Girl Plan\(\text{(also for boys)}\) at district level, with district leaders and managers.

The usefulness of using The Girl Plan\(\text{(also for boys)}\) is that it necessitates drawing in all SRHR actors at district level including Health, Education, Social Development, Police and Justice, District Commissioners/Administrators, as well as NGOs, faith-based organisation and churches, and young people themselves. Initial conversations during the year culminated (only early in the following year) in a series of planning meetings to finalise full district and cross-district learning.

### Increased participation of women and young people in systems for health leadership

With regards to promoting the **institutionalised participation of women and young people in health at local, district, national and regional levels**, SAT’s aims were as follows:

**Women:**
- 33% of SAT communities to have established a **mechanism for participation of women** in governance for health;
- 3 SAT districts across 3 countries to have had **meaningful participation by women** in district health governance.

**Young people**
- 33% of SAT communities to have established a **mechanism for participation of young people** in systems for health;
- 3 districts across 3 countries to have had **meaningful participation by a young person** who had been nominated by civil society;
- facilitated a **regional youth structure** to interact on a regular basis with SADC on SRHR.

SAT largely achieved - and sometimes exceeded - these targets, as follows:

**Women:**
- 30% of SAT communities established a mechanism for participation of women in health governance – only slightly shy of the 33% target.
- 7 SAT districts across 2 countries reported meaningful participation by women in district health governance – totalling more than the proposed target of 3 districts across 3 countries.

**Young people**
- 43% of SAT communities have established mechanisms for participation of young people in systems for health - higher than the target of 33%.
- 5 districts across 3 countries have had meaningful participation by a young person nominated by civil society - higher than the target of 3 districts in 3 countries.
- No regional youth structures were established to interact on a regular basis with SADC on SRHR.
Gender transformative district mapping tool

The Gender transformative district mapping tool was not completed. Intense interest was showed during the year by District Commissioners/Administrators but, once again, difficulties were experienced in accessing data. Finally, after the end of the reporting period, the agreement by all 6 districts to work with SAT on the development of a Girl Plan, should lead to a rapid catch-up in this area in the new year.

Delivery of SRH services

With regards to the delivery of SRH services, SAT’s aims were as follows:

- to support 3 districts to promote legal access to modern contraceptives and to implement youth-friendly approaches service access;
- to work with district health management in one district to develop a client feedback tool for district use.

SAT’s support to the provision of legal access to modern contraceptives and implementation of youth-friendly approaches to services has been reported under ‘Promoting adolescent access to youth-friendly services’ in Result Area 1 above.

Client feedback

Again as reported above under ‘Promoting adolescent access to youth-friendly services’, SAT did not develop a client feedback tool, given the repression in Tanzania. SAT therefore could not work with district health management in one district to implement it.

Community health database

SAT had planned to work with a technology partner to develop and populate a database of community-collected data on SRHR. However during the year no suitable system was found that combined sufficient user-friendly and affordable technology with the data requirements. We were gradually made aware that the level of sophistication that we sought was a ‘computer gaming’ level and substantially out of our price range. To address this, SAT has subsequently engaged other organisations to work on the design at a reasonable cost, delivering expected results. This is an activity for the coming year.

During this period we have continued to store data using SAT’s Partner Contracts and Management Information Systems (PCMIS) and monitoring and evaluation (M&E) systems. While these are sufficient for SAT’s use, they remain insufficient for widespread community use.

Youth hubs

In 2016/17, SAT planned to open and host youth hubs for adolescent and young people’s health activism in spaces within SAT offices in Johannesburg, Harare, Lusaka, Lilongwe and Gaborone. The hubs would have computers, internet connections and workshop materials and would be open to negotiated NGOs, CBOs and youth activists.

In Botswana, SAT intended to host a group of youth activists, bloggers and social media activists to facilitate youth participation in the national health discourse towards ensuring that they are active players in the health system and not merely beneficiaries. These activists were to be provided with space, internet and other facilities to enable their participation.

Youth hubs were established within SAT country offices in Botswana, Zambia and Zimbabwe as well as at the SAT regional office in Johannesburg (annual reports for which are given in Annexure K). Malawi is in the final stages of establishing their youth hub, and their report (also in Annexure K) describes a range of organisational activities that will provide a strong basis for their youth hub. SAT Tanzania is in the early stages of establishing their youth hub.
Activities

Youth hubs are attracting large numbers of young people – e.g. in the Zambian youth hub there are up to 50 people per day. Annexure L gives an overview of the activities in each hub. These include youth hub partner and stakeholder consultation meetings, debates and training on SRHR, among others.

Those participating in youth hubs have identified co-ordinators and facilitators among themselves and run programmes for their peers, addressing a range of SRHR-related topics such as prevention of HIV and STIs, prevention of unintended pregnancies, correct and consistent condom use, contraception and other issues of concern to young people.

The Botswana youth hub has made a video of their interviews with policy makers regarding SRHR issues affecting youth - and through the development of Facebook pages and WhatsApp groups, SAT has become visible on social media.

The existence of youth hubs has encouraged some SAT partner organisations to establish youth clubs along similar lines, benefitting the youth in communities in which they operate, including those who are HIV positive.

In order that youth hubs remain relatively focussed and do not try to meet all the expressed needs, it may be helpful to have clear guidelines regarding the parameters of their scope of operation.

Participation in fora

Members of youth hubs have participated in various national and regional fora – for example,

- national youth forums and activities related to International Woman’s Day (8 March 2017);
- 29th African Union Summit on ‘Harnessing the demographic dividend through investment in youth’; and
- national SRHR and health meetings in the respective SAT countries.

Because youth hubs grew organically, and because of the energy and passion of young people, a range of activities and somewhat disparate foci have emerged. This is a concern for regional results and impact and for quality control of messaging. SAT’s new Regional SRHR & Advocacy Officer has been tasked to align the hubs for better regional results.

Access and inclusivity (leave no-one behind)

In order to promote inclusive services, SAT addresses issues facing LGBTI, sex workers, drug users and people with disabilities (PWDs) – many of whom risk discrimination and less than optimal access to suitable services.
LGBTI

SAT works towards reducing exclusion and discrimination of LGBTI by fostering more inclusive systems in the region generally - through advocacy and collaboration in global and regional structures and forums for LGBTI.

To this end, SAT planned to

- create working examples of how to promote inclusion at the local level, by supporting one national organisation; and
- contract another partner to produce CSE materials aimed at MSM.

Promote inclusion at the local level

SAT supported African Men for Sexual Health and Rights (AMSheR), comprising some 18 MSM organisations, in order to create working examples of how to promote inclusion at the local level.

SAT also supported MSM organisations in Malawi and Zambia to conduct health worker training, as well as increase their capacity to programme for their health. The support to LGBTI programming in these two countries has resulted in

- strong relationships between the Human Rights Commissions, the National AIDS Councils (NACs) and the general health system;
- the inclusion of transgendered persons in Malawi’s National SRHR and HIV Integration Strategy, 2015-2020, following SAT’s support to partners’ engagement with multiple relevant government institutions; and
- the development of minimum organisational capacity standards for key population organisations in Zambia.

In addition

- Malawi recorded a rare victory in getting the Malawi Broadcasting Co-operation to air a SAT partner-produced video documentary on being intersex.
- The increased partner capacity in Malawi and the existing service providers’ directory has facilitated LGBTI persons’ access to services.
- A total of 2,599 LGBTI persons accessed SRHR information through outreach activities in Malawi while 2,194 LGBTI persons were referred to health facilities to access SRH services.

In Zimbabwe, SAT has conducted limited interventions targeting LGBTI. However, SAT partnered with UNDP to procure lubricants and condoms for MSM for distribution nationally by Gays and Lesbians of Zimbabwe (GALZ).

The persecution of LGBTI communities and organisations in Tanzania has resulted in the postponement of partnerships and has led to SAT cancelling the production of CSE materials aimed at MSM which were due to be produced by CHESA. In efforts to mitigate the impact of this persecution, SAT participated in a crisis committee comprising UN organisations, LGBTI community members and allies. SAT liaised extensively with groups in and out of Tanzania to channel information and acted as a conduit for funding, liaising with Tanzanian-based SAT partner EANNASO which was identified by the local LGBTI community following a long supportive relationship with them.
 Continentally and globally

SAT collaborated with key population civil society representatives in supporting LGBTI rights during a contentious UNAIDS Programme Co-ordinating Board meeting (attended by the SAT Executive Director in June 2016). And in the lead up to the UN High Level Meeting (HLM), SAT worked with an international coalition of civil society organisations to strategise how to re-include 22 key population organisations which had been excluded by UN member states from attending the HLM in New York. Ultimately all excluded organisations did attend, following a technical route around the exclusions – and SAT supported the attendance of AMSHeR, one of the ‘excluded’ organisations.

Sex workers

SAT works with sex workers and their allies in pursuit of systems for health that are inclusive and serve all people without distinction.

SAT believes that the health of sex workers is best led by sex workers themselves, either in their own organisations or leading programmes within other organisations. As such, SAT planned to recruit a new sex worker organisation and strengthen the work of existing partners to ensure that sex workers have access to contraceptives and services - such as HIV self-testing, pre- and post-exposure prophylaxis (PrEP and PEP) - as well as to initiatives focussing on reducing gender-based violence associated with sex work.

SAT partners are working with sex worker leaders, not only because they co-ordinate other sex workers but because they tend to be less mobile and therefore accessible. (A major challenge in sex work programming over this period has been the low numbers of sex workers reached. The occupationally-driven difficulties of reaching sex workers often seems to discourage community-based programmes from working with them).

During the year under review,

- one sex worker partner organisation was recruited;
- suitable programming with two existing partners continued to include interventions on HIV prevention and STIs, promotion of access to SRH services and antiretroviral therapy (ART) adherence;
- work towards female sex workers’ access to integrated non-discriminatory HIV and SRH services was facilitated;
- the capacity of a female sex worker organisation in Malawi was strengthened through developing their strategic plans and constitutions, towards registering their organisation;
- training in human rights was provided to female sex workers in Malawi; and
- in Zambia training materials for sex workers were developed and piloted.

For some time in Malawi, sex workers have been struggling to form a national association to support one another, this being complicated by considerable politics. Much work in the reporting period has been spent on overcoming this. To share best practices and issues relating to accessing SRH services, SAT facilitated an exchange visit between female sex worker organisations in Malawi and Zambia.

While SAT had intended to develop and implement a mobile phone app in Malawi to support sex workers in reporting violence or harassment and in accessing health services, this was not possible. (This is reported under ‘Technology for safer environments’ in Result Area 3.)
Drug users

In 2016/17, SAT planned to establish two partnerships to undertake work relating to drug abuse, focusing on the formation of a technical working group as well as community level interventions.

In 2016/17, SAT formed a partnership with the Methadone Family Against Drug Abuse (MEFADA), a small CBO working with young people who use drugs in Dar es Salaam, Tanzania. The second intended partnership - with Tanzanian Drugs Control Council - could not proceed following the organisation’s being disbanded and replaced by the Drug Control Authority with new leadership.

A mapping process to identify issues for drug users, including injecting drug users (IDUs) - undertaken by MEFADA with SAT’s support - revealed that 250,000 youth engaged in drug use, of whom 120,000 - 180,000 were in Dar es Salaam. One of the challenges identified was their limited access to SRH services, including HIV and SRH services.

As a result, SAT’s partnership with MEFADA was redefined to focus on increasing the number of drug users and sex workers accessing SRH services. This included, since 1 October 2016, the use of unique identifier data to track drug users as they accessed different services.

To supplement the community mapping, MEFADA conducted community dialogues and a sensitisation meeting attended by 20 service providers from government and civil society organisations that ran programmes and provided services to DUs. As a result, MEFADA observed a slight increase in service providers’ awareness of DUs rights to health services, including access to HCT, condoms and IEC materials. Between January and March 2017, of the 1,942 people who accessed HCT services, there were 46 IDUs (2%) 481 non-IDUs (25%) and 1,415 non-drug users (73%). In addition, 470 people (24%) were referred for further treatment for methadone, STIs and HIV.

People With Disabilities (P WDs)

In 2016/17 SAT planned to work closely with Disability HIV/AIDS Trust (DHAT) - a regional organisation working on HIV, SRHR and disability - to impact regionally on the disabled community’s access to SRHR in support of equitable and inclusive health.

Over the past few years, SAT’s perception has been of declining participation of DHAT in SRHR and HIV programming regionally and of minimal measurable impact at a regional level. During the reporting period, SAT twice rejected DHAT’s annual workplans as being too weak and unfocused. As little progress had been made in the first six months of the reporting period, SAT engaged a consultant to work with DHAT to develop a new strategy, implementation plan and Performance Monitoring Framework (PMF).

As DHAT has been almost entirely dependent on SAT for funding, SAT resolved that continued support would depend on their raising other funding and achieving significant regional results. As they have not managed to do so, SAT will fund DHAT for only another six months in the new year, after which we will cease funding.

At country level, the Global Fund grant enabled SAT Zimbabwe to train health workers in Mashonaland West and Central provinces, to sensitise them to the health needs and challenges of people with disabilities.

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26 The partner organisation notes that these data need to be updated through mapping since they are obtained from the census and relatively old studies. For example McCurdy SA, Williams ML, Kilonzo GP, Ross MW, Leshabari MT. 2005. Heroin and HIV risk in Dar es Salaam, Tanzania: Youth hangouts, mageto and injecting practices. AIDS Care, June 2005; 17(Supplement 1): S65_/S76. This article cites a 2004 source: ‘Social workers in Dar es Salaam estimate that there are approximately 200,000 to 250,000 drug users in this city of approximately 3 million.’

27 IEC = Information Education and Communication

28 MEFADA observed during the intervention that there was an insufficient supply of health kits for Community Outreach Workers.

29 Through the SAT support, Methadone was considered a redeemer among IDUs, especially those who were HIV positive, as it tended to reduce dependence and injecting related risk behaviour. Counselling on the new transmission ways remained an essential component to drug users. Going forward, MEFADA started efforts to integrate HTC, STIs and family planning.
RESULT AREA 3: SUPPORTIVE ENVIRONMENTS FOR WOMEN’S RIGHTS AND WELLBEING HEALTH

Ending child marriages

SAT planned to contribute to an improved environment where women and girls can realise their rights and wellbeing. A socio-ecological approach would inform programming to reduce child marriages and other forms of gender-based violence.

More specifically SAT planned to ensure that there was increased community action on eliminating early marriage such that by the end of 2016/17, 30% of SAT communities would have implemented plans on eliminating early marriage.

At country level, 37% of SAT communities had implemented plans on eliminating early marriage, compared with the target of 30%. This was achieved through working with traditional leaders, by promulgating protective by-laws and by mitigating girls leaving school, among others – as follows.

At community and district levels, SAT partners continued to work with traditional leaders on innovations aimed at preventing child marriages as well as on ‘return’ measures. These innovations included developing registers of by-laws that address early and forced child marriages and other areas of SAT interest that were passed by various communities – the list of which that is in Annexure D. In Malawi, for example, over 85% of traditional leaders in SAT communities have developed by-laws to end child marriages.

In Karonga District of Malawi, a task force comprising eight chiefs was formed to take the lead in campaigning against early and forced marriages and violence to women and children across all 24 village development committees (VDCs) in the district.

In Zimbabwe a community referral system was designed with the help of child care workers so that any child marriage is reported to local leadership. SAT partners trained the case care workers as well as conducted community awareness so that all cases of child marriages are reported to the local leadership.

In Zambia, SAT procured and distributed bicycles to 60 traditional leaders to enable them to mobilise communities and follow up on child marriage cases. This also contributed to the establishment of community action groups to address early marriages in 42% of communities serviced by partner organisations.

SAT procured 60 bicycles distributed to traditional leaders in Zambia
Varied forms of sanctions were imposed on Zambian parents who were involved in cases of early child marriages.

In one community, for example, a traditional leader dissolved the marriage, returned the girl to school and required the couple to clean a health facility for a period of one month.

In another community, school-based action groups on early marriages were established. SAT Zambia intends to follow up this initiative to determine its impact on child marriages in the area.

School retention as mitigation for early marriage

As keeping girls in schools is thought to minimise chances of child marriage, SAT Zimbabwe enabled partners to provide small start-up capital for communities to run income generating projects - proceeds from which would assist households who are unable to pay school fees/levies or buy uniforms. In this way SAT provided 126 pupils (53 boys and 73 girls) with educational assistance, whilst 198 pupils (91 boys and 107 girls) paid school levies. A further 84 pupils (32 boys and 52 girls) bought school uniforms using proceeds from chicken and goat pass-on schemes. This was done to ensure that girl children remain in schools as communities tend to prioritise the boy child.

Across SAT countries, over 200 girls were returned from early and forced marriages and 131 of these were re-enrolled into school.

In Malawi, SAT facilitated training of 20 members of a child protection committee, conducted by a Child Justice Magistrate. The training, which addressed the Marriage Act and Child Care, Protection and Justice Act, enhanced their capacity to handle cases affecting young people and law enforcement with respect to girls’ re-admission to school and to prevent child marriages.

Lessons learned

The child marriage issue remains highly controversial amidst religious and traditional beliefs and requires careful and sensitive messaging. Some important lessons learned in this area are as follows:

Messaging on ending child marriage can very easily go wrong and be appropriated for ‘moral regeneration’ reasons. In an example in the field we saw messaging that, with equal weight, said ‘sex is evil’; ‘contraception is evil’ and ‘child marriage is evil’. This type of messaging risks elevating the issue of ending child marriage to a moral or religious crusade with all the potential attendant rejection of public health principles and comprehensive sexuality education. It also poses the very real danger that if we are opposed to child marriage because it is evil, we do not have to face the complexities of the drivers of child marriage.

In exercises to uncover the systemic reasons for child marriage, SAT identified the following drivers as key:

- **Poverty** - families literally sell off girls into marriage.
- **Dropping out of school** - significantly also due to poverty, leaving school means girls very quickly become pregnant which often leads to marriage.
- **Pregnancy** - pregnancy leads to marriage, almost immediately. Not only is this a cultural issue, but is linked to a lack of CSE knowledge and access to modern contraception.
- **Culture** - a cultural rupture is required when child marriage has been acceptable for years.
- **Aspiration** - girls themselves want to follow a well-trodden, familiar and acceptable path to womanhood.

Lastly we learnt that while ending child marriage interventions primarily focus on girls and young women, there is need to address boys in programming - for instance, as secondary targets to address some of the traditional beliefs that may reinforce patriarchy in boys and young men.
Regional and continental initiatives
SAT applied for, and became a member of, the ten-person African Union Commission (AUC) Civil Society Reference Group for Ending Child Marriage, which has enabled us to strengthen the voice of girls and the community in the AU End Child Marriage Campaign.

SAT’s good relationship with the AU Goodwill Ambassador on Ending Child Marriages also enabled SAT and partners to benefit from regular dialogue and interaction on child marriage. In collaboration with the Ambassador and the Rosario Memorial Trust (Zimbabwe) SAT supported the participation of three adolescent girls in the launch of the AU’s 2017 year of ‘Harnessing the Demographic Dividend through Investments in Youth’. They have since played an active role at country and regional levels as ‘End Child Marriage’ advocates.

SDG 5 networks
SAT planned to work with other relevant organisations to share information and to collaborate on programming and advocacy related to gender equity and SDG 5. This year the focus was to be on linking with organisations in Zimbabwe, Zambia and Malawi, analysing the SDG indicators as they come out, dialoguing with governments and advocating on national plans.

In 2016/17 SAT planned to establish an SDG 5 network in one country.

SAT attempted to leverage its legitimacy and credibility in SRHR programming to take a small-scale convening position around SDG 5. SAT’s core message was the need to prioritise programming and resource allocation to support women and girls for the achievement of SDG 5 by 2030. We also emphasised that gender equality and SRHR are co-dependent issues and there cannot be universal access to SRHR without gender equality, just as there cannot be the achievement of SDG 5 without universal access to SRHR.

Regarding the SDG 5 networks, SAT laid the ground work for the establishment of steering teams, networks and partnerships in Malawi, Zambia and Zimbabwe to advance the work around gender equality and empowerment of all women and girls. SAT’s key engagements included the following:

- Participation at the African Union Health Experts Meeting in April 2016 where the revised Maputo Plan of Action was reviewed and recommended to the Ministers Meeting in Geneva. SAT’s input was around civil society collaboration with governments and on attempting to get menstrual health written into the Plan, as this is a key SRHR issue. The menstrual health agenda was accepted in an experts working group but unfortunately was later removed from the document.

- The establishment of a steering committee for SDG 5 in Malawi following a meeting with gender experts and representatives of NAC, the Ministry of Health, and four UN agencies (UNFPA, UNAIDS, UN Women and UNESCO). This committee has been linked to the Graca Machel Trust, SAT Paralegal Expert work and Girls Not Brides Initiatives that work on promoting gender equality and women empowerment;

- Participation in the ‘Women Deliver’ Conference in Copenhagen, which included two members of the SAT senior management team and two young people from the AfriYAN Executive Committee. The conference provided a forum to understand the global landscape with regard to broader programming for women beyond HIV and even SRHR.

- In Botswana, SAT partnered with the International Working Group on Women and Sport to host the HeForShe Campaign as part of the 2017 International Women’s Day commemoration.

- The Botswana youth hub produced a video promoting gender equality and women empowerment messages to young people offered by prominent local women. The video was posted on the Botswana youth hub Facebook page to ensure good coverage. In the first three weeks (by 31 March 2017), the video reached 1,964 people, attracted 590 views and 67 reactions and 14 ‘shares’.

- In Zambia, SAT supported 50 women from partner organisations, who joined other civil society organisations, government ministries, parastatals and private companies in observing the International Women’s Day under the theme ‘Promoting inclusiveness in economic participation as a means of attaining sustainable development’.
• On International Women’s Day SAT promoted messages supporting women and girls empowerment on social media as well as in advertisements in the press in Botswana, Malawi, Tanzania, Zambia and Zimbabwe.

Gender transformative programming

As a follow-up step to gender transformative (GT) mapping, SAT planned to include work and good practice into gender transformative programming guidelines that would be used to guide all SAT-funded programming.

In 2016/17, using the GT guidelines SAT intended to support 20 communities and 1 district in making their programmes more gender responsive.

SAT commissioned a study to develop Gender Transformative Programme Guidelines – which proposed various approaches, including the use of gender audits and gender analysis tools to better understand the underlying personal, social and structural factors that contribute to an issue. While the Guidelines will be disseminated among partners in all five SAT programme countries (with dialogues on gender transformation being extended beyond SAT partners) they are currently being finalised after a long period of development. We were therefore not able to support districts or communities in gender transformative programming.
During the reporting period, SAT continued to support 27 communities in two countries - Malawi (12) and Zambia (15) - to continue working with data from gender transformative community mapping.

**Women’s access to sexual and reproductive rights and justice**

SAT planned to facilitate the training of **women paralegals in three districts** in support of increasing access to sexual and reproductive rights and to justice more broadly. A SAT partner in each country would manage the paralegals and link their work with national legal organisations.

More specifically, SAT proposed that by the end of 2016/17,
- 15 paralegals would have been trained
- there would be one women paralegal network operating.

SAT commissioned a desk review on women’s access to justice, including paralegal services available in Botswana, Malawi, South Africa, Tanzania, Zambia and Zimbabwe. This was completed in the last quarter of the reporting period, and the report is being consulted and revised into an action plan for the new year.

In compliance with the target set, SAT Malawi entered into a partnership with CARER to work with paralegals to address human rights issues, including GBV and LGBTI-related issues. A total of 75 paralegals from two districts - including 12 sex workers and 4 MSM representatives - were trained. The paralegals will contribute to addressing injustices and GBV in the country.

At regional level, SAT was invited to provide civil society inputs to the EAC SRHR Bill by joining the Regional Task Force hosted by a SAT partner EANNASO. The main aim of the Task Force is to develop a road map to promote a conducive legal environment to address SRHR within the EAC partner states.

**Gender transformative schools materials**

SAT planned to work with community partners and gender experts to design and develop **basic school materials on gender equity** for distribution in SAT partner communities.

The difficulties of working in education have been described above in this report.

A number of draft materials have nonetheless been produced:
- school SRHR access plans;
- CSE materials on positive adolescence;
- ending child marriage plans;
- school-based anti-GBV plans;
- school-based menstrual health criteria; and
- school re-admission plans.

All of these templates attempt to use a gender transformative lens in their development. However, SAT had contemplated the production of more explicit gender equality materials. These were not able to be produced.
Technology for safer environments

SAT planned to

- develop a system for monitoring GBV reporting in Botswana in collaboration with NGOs and the Botswana Police Service; and
- develop and implement a mobile phone app in Malawi to support sex workers in reporting violence or harassment and in accessing health services.

Significant progress was made in Botswana in the development of various technology-based applications for reporting, monitoring and accessing health services. SAT intends, where feasible, to use these experiences to inform the development of applications in other countries. Applications developed include

- a community-based mobile solution to report gender-based violence;
- connected referral systems to promote co-ordinated service delivery; and
- TeenWyze - a youth-friendly information platform.

A community-based mobile solution to report gender-based violence

A cell phone app to support GBV reporting was piloted in Botswana, implemented by local partners, Women Against Rape (WAR) and the Botswana Student Network in Maun and Gaborone respectively. It is based on the iMonitor+ product and was developed by Dure Technologies.

The freely available app enables community members to both report an incident in real time (with geo-tagging so that police and other authorities will have all the information needed to follow up) and monitor GBV cases. WAR responds to all incoming reports and provides both immediate support, referral and follow-up. As the project unfolds police, health care providers, teachers, social welfare officers, and judicial officers will also be trained to use the dashboard to track their follow-up and performance.

The tool reduces duplication and record-keeping through enabling sharing of data between service providers and improves individual and community-level monitoring.

A television advertisement and an animated video have been developed and students at several tertiary institutions mobilised to download and use the app for reporting GBV. Increased reporting of cases is expected, depending on user experience, responses to dummy alerts, and appropriate messaging. In Maun, where there has been SAT-supported GBV programming for over a year, there has been a 24% increase in GBV case reporting from 415 cases in 2015 to 514 in 2016.

Promoting co-ordinated service delivery through connected referral systems

While not in the workplan, SAT supported WAR to work with USAID and the Government of Botswana to develop a GBV Referral Information System that responds to GBV cases. This complements the GBV reporting app, as it links clients to relevant services, ensuring there is complete referral, collaboration and networking among stakeholders (such as education, administrative of justice, health, law enforcement, NGOs and social services).

Simplifying the flow of information between service providers enhances stakeholder collaboration and multi-sector co-ordination, ultimately increasing access to comprehensive, quality service for GBV survivors.
TeenWyze - a youth-friendly information platform

TeenWyze is a secure and youth-friendly platform providing sexual and reproductive health information and which facilitates access to SRH services. It has been linked with three clinics based in tertiary institutions, such as the University of Botswana Clinic, and one youth-friendly community clinic (Botswana Family Welfare Association). Initially available on Android, by the end of the reporting period it had over 750 signed users.

This mobile app was developed in partnership with the Development Advance Institute, and has been successfully tested and published on Google Play Store under the licence of Southern African AIDS Trust. SAT has been working with the developers and the Botswana Student Network – which has 78,000 members - to improve the App and increase the uptake. The new revamped App, is available for downloading at https://play.google.com/store/apps/details?id=com.flussbinario.teenwyze&hl=en.

Mobile app to support sex workers in reporting violence or harassment

The mobile app to support sex workers report violence or harassment and to access health services was not developed, due to unforeseen start-up difficulties in working in this sector.

It is hoped that lessons and experiences from Botswana (above) could be adapted for development of this app in the coming year.
RESULT AREA 4:
DATA REVOLUTION FOR HEALTH

In 2016/17, SAT planned to drive demand for
• new formats of data and updated mechanisms for more timely reporting and sharing of information;
• more relevant data and usage of information;
• more open access; and
• data that is more user-friendly to non-traditional data consumers.

The plan was to expand the emergent Data xChange to cover all of Eastern and Southern Africa, focussing particularly on populating the xChange with relevant data. Significant advocacy and support was to be aimed at and given to health leaders in districts, and at national level to use the maps.

SAT planned to establish systems and upload data through
• establishing a SAT database;
• developing a component on gender data to enable these data to be captured and used in the data xChange; and
• piloting a Unique Identification Code system with selected partners in four programme areas, namely cervical cancer programmes, harm reduction programmes, re-admission of girl mothers to school; and SRH community services.

In terms of the collecting and using data/health maps, SAT planned to ensure that
• data from community and district mappings was captured and stored in the database (and see table below);
• xChange maps were produced for 6 districts in at least 3 countries, to increase the availability of data;
• six districts across Zambia, Zimbabwe and Malawi were supported to manage and utilise district data – including supporting the capacity strengthening of partners and communities in how to use the data;
• 100 civil society members were registered to use the health map;
• 20 government officials were registered to use the health map;
• the staff of 5 international agencies were registered to use the health map;
• 10 measurable dialogues were held at which the health maps were used, as part of promoting the use of health and gender data; and
• 1 measurable dialogue was held at which civil society and government made use of SAT’s health maps as part of ongoing civil society/government fora for data on gender and health.

SAT also aimed to work with data regionally in order to
• support links in the minds of policy makers between gender equality (SDG 5), SRHR and national developments;
• encourage and increase the use of data regionally to monitor delivery of commitments at member state level; and
• enhance civil society collaboration in systems for health.
To this end SAT planned to ensure that:

- preparatory work was conducted to establish a Coalition on Women and Data at regional level in the ESA region;
- the capacity of 10 partners was strengthened to use data for gender and health; and
- 3 country parliamentary standing committees across 3 countries were supported to use data from the Data Xchange.

As data is a cross-cutting issue, the table below indicates where data has appeared elsewhere in this report.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>IN SECTION IN THIS REPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Map the availability of YFS in two SAT countries on the Data XChange, such that all YFS sites in one country had been mapped</td>
<td>Promoting adolescent access to youth-friendly services</td>
</tr>
<tr>
<td>Map cervical cancer services in all SAT countries on the Data XChange</td>
<td>Piloting cervical cancer-led integrated health screening</td>
</tr>
<tr>
<td>Track school retention in target schools by mapping enrolment and retention figures in partners’ collaborating schools (noting age, sex and grade).</td>
<td>Keeping girls in safe schools</td>
</tr>
<tr>
<td>Track school re-admission target schools by mapping in partners’ collaborating schools the extent to which girls who fall pregnant while at school are re-admitted after they give birth.</td>
<td></td>
</tr>
</tbody>
</table>

Both sets of tracked data would be added to the Data Xchange.

Summary of achievements

Data was the weakest delivery area for SAT in 2016/17. While large amounts of data continued to be collected, the complementary piloting of technology, and aggregation of data upwards into useful collections from which analysis could take place, did not happen.

SAT has planned steps in its 2017/18 workplan to mitigate the issues which have hampered this work (described below) - to catch up on outstanding data collection and use with technology. The appointment in February 2017 of the Regional Data Manager has already enlivened the data projects and infrastructure processes in the last quarter of the financial year – and his plans for catching up on data delivery projects and of mitigating problems experienced in 2016 has been approved by SAT management.

Lessons and observations

Reviews of the challenges and failures relating to data collection at community, country and regional levels have resulted in three major learnings from this period which will inform our plans for delivery in the next year. The three learnings are as follows:

1. **That established relationships are a prerequisite for formal data collection.** This was learned when, for the first time, SAT entered schools more systematically and tried to collect information to which we had previously only had informal access.

While data from schools, clinics and other local sources had been willingly given to SAT partners when this was deemed to be for the partner’s use and for improving local programming, this changed when it became clear that the intention was to formalise and analyse the data, and as the formats for requesting information became more structured. Partners began to fear that their data would be reported in ways that might cause difficulties for them – and their willingness to collaborate decreased substantially.
2. Linked to the first learning, that partners who were willing to open registers, attendance books, and other forms of source data when the recording was paper-based, baulked when discussions began on using electronic formats.

3. That governments get nervous when civil societies ask for data - even when this is public data.

Two broader issues relating to data also became evident. The first is that there is substantial misreporting on a wide range of issues at local level. For example, schools cover up GBV cases and dropouts due to pregnancy as they do not want a bad reputation; police stations lose GBV reports; and families request police stations to lose GBV reports after being paid to do so.

Secondly, countries in the region are grappling with larger and opposing currents in data. On the one hand there is an attempt to control data and to pass legislation that hinders, or in fact punishes, open use of data – while on the other, there are UN influences which, under the banner of the data revolution, are attempting to bring 21st century thinking and more open sharing of data to the region.

Both Malawi and Zambia are currently engaged in national processes to adapt their data systems, with Zambia implementing a new multi-source data feed-in to national systems under the Central Statistical Office. The implementation of these new systems appears to have led to a reluctance among bureaucrats to take actions too far in advance of the emerging systems. Under pressure from District Commissioners and Administrators late in the last quarter, however agreements are emerging with the Central Statistical Offices of Malawi and Zambia for the better provision of access to data in 2017.

The Regional Health Data xChange

Expanded in 2016 to technically cover the entire ESA region, the Regional Health Data xChange remained relatively underutilised and devoid of data during the year. This has a negative knock-on effect on advocacy for data use and on use of data, including data on gender.

SAT liaised during the year with Data2X at the United Nations Foundation on global trends in data on women and girls and on the emerging framework for SDG 5. This included a visit to the Foundation attached to ICPD participation in New York in early 2017.
Piloting the use of unique identification codes

Schools
In 2016/17, SAT tracked schoolgirls who dropped out due to pregnancy. The lack of formal agreements in the education sector and of access to referrals again made tracking their health much more difficult, although this was done by a number of local partners. Formal agreements here are exceedingly difficult to reach as the data involves individual identities that all ministries are very reluctant to give to civil society organisations.

Even at the relatively low levels of data tracked in 2016, however, it became clear that a major gap was tracking boys who dropped out – and who returned. This will be corrected for in 2017.

In the last quarter of the year a tracking tool was developed as a part of re-admissions support for pilot schools and this will be further developed and tested in 2017.

Drug users
In Tanzania, as described in the ‘leave no one behind’ section of this report, SAT’s partner working with drug users will continue to track users of harm reduction services.

Women screened for cervical cancer
Both SAT-supported sites for cervical cancer - in Zimbabwe and in Malawi - had substantial difficulties tracking women who had been screened to ensure that 100% of them received treatment. The attention paid to ensuring 100% treatment meant that almost no time was given to developing a technical system for tracking. This work will resume in 2017 in Zimbabwe and Malawi at site level and in Tanzania at a national level.

Contributing to ‘small data’ for SRHR and health
SAT will continue supporting communities to collect, curate, and utilise gender transformative community mapping data relevant to health.

The district project was very slow in getting started, given the difficulty of working with bureaucracies, resulting in efforts in 2016/17 being focused on getting started rather than on data. The district data maps will be further developed and used by piloting districts in 2017.

Focusing on traditionally neglected data constituencies
For data on women and girls the initial meetings on SDG 5 have been described above and interested stakeholders will be brought together a number of times in 2017 to focus on monitoring SDG 5 indicators.

Data on people who use drugs and on sex workers are dealt with above in the report in the respective sections.

Become an information intermediary, making information available in new, user-friendly forms
In 2016, youth-friendly service sites were captured on the Regional Health Data xChange. In 2017, this data will be used in dialogues on expanding adolescents’ access to services. See above in ‘Adolescent access to services’.
Supporting and developing communities of data users

The **TeenWyze application** for mobile phones in Botswana has been reported above.

The capacity to use data for gender and health was strengthened among 12 partners in two countries, slightly exceeding the target of 10 partners.

Although not anticipated, it appears that the two greatest SAT-supported users of data in 2017 will be **youth hub activists** on the one hand, and **district managers** on the other hand.

SAT Partnerships

The SAT strategy for 2016-2021 identifies partnerships as key to the success of the strategy. As SAT has focused increasingly on regional results, the balance of partners – both in SAT’s sub-granting portfolio, as well as strategic partners – has begun to change. The sections below give a little more detail of these changes, and the SAT Annual Workplan for 2017/18 makes recommendations for further changes.

The 2016/17 workplan proposed that SAT ensures that dialogues take place in the region – such that

- 1 key SRHR issue had been **discussed at EAC and/or SADC structure** as a result of SAT’s influence, in order to inform policy dialogue in EAC and/or SADC on key women- and adolescents-focused SRHR issues; and
- **10 measurable dialogues on gender equity** had been facilitated by SAT and SAT partners to increase the visibility of, and discourse on, gender equity issues at local, national, regional levels.

While one key SRHR issue was discussed at **EAC** (the draft SRHR Bill), no issues could be raised with SADC or at **SADC** level. The issue of ending child marriage was also taken up at African Union level.

With regard to the **dialogues on gender issues**, a definitional problem arose in reporting. All dialogues supported by SAT partners or hosted by SAT dealt with gender equality issues: the components of The Girl Plan (also for boys) all deal with gender equality, as do the three other SAT result areas. However, a fear of ‘double-reporting’ led to the statistics of all dialogues being captured in other areas of SAT reporting leading to a nil reporting in this area. Discussions are underway on how to capture this in the next year to avoid the same problem.

SAT Regional partners

The need to change the focus of partnerships yet again to aim for SRHR systems entrepreneurship at a regional level has been dealt with in the introduction to this report. In short, SAT aims to work with, and to track more closely, the work of the African Union Commission with regard to SRHR and gender equality, and to seek partners who will help to ‘move the needle’ with regard to positive SRHR changes in the region.

In our portfolio, SAT worked with four partners - namely AfriYAN, EANNASO, AMSHeR and DHAT – the choice of partners being informed by SAT’s pivoted strategy which prioritises the ‘Big Five’ areas (keeping girls in safe schools; gender-based violence; comprehensive sexuality education; elimination of child marriages and increased access to SRH services).

During this year these regional partners delivered as follows:

**African Youth and Adolescents Network (AfriYAN), (ESA region)**, a civil society organisation of young people for young people, has become a centre of youth activism on SRHR and HIV. As it is still relatively unstructured organisationally, however, SAT has worked to strengthen its organisational form as well as its programmatic work in systems representation strengthening and advocacy. To this end, in 2016/17 SAT supported AfriYAN in their SRHR advocacy activities that included participation at both global and regional platforms – like the International AIDS Conference, ‘Women Deliver’ Conference and ‘#SheDecides’ among others.
In addition, SAT assisted AfriYAN with managing a US$25,000 grant from HIVOS (for the #90Days of Consent project implemented in Malawi, Zambia and Zimbabwe), and hosted a regional administrator in the SAT office in Johannesburg.

Programmatically though, during 2016/17 AfriYAN (ESA region) did not perform as well as SAT expected. Lessons have been learned from this weak performance. SAT held back for much of the year, not wanting to take a role we have previously accused others of taking - namely an overly directing, prescriptive and patronising one. The result of this hesitance, however, was a frustratingly slow process to develop a strategy that, when eventually produced, appeared to hark back to some of the forms of organisation of the AIDS network years which have subsequently proved not to work well, either for delivery or for survival. Only in the last quarter of the year did SAT intervene more forcefully to set some conditions for our acceptance of a strategy and a workplan.

Part of our internal analysis of the problems underlying this slow progress, is that AfriYAN has only one administrator funded by SAT and hosted in the SAT regional office in Johannesburg. There are no professional staff members to carry out either planning or programming, and Executive Committee members are either full-time staff of other civil society organisations, or unemployed and desperately seeking employment or income. SAT is consulting with AfriYAN and UNFPA regarding how to avoid this situation going forward.

**Eastern Africa National Networks of AIDS Service Organisations (EANNASO)** is a regional network covering the EAC region. SAT works with EANNASO to increase collaboration between southern and eastern African NGOs on SAT’s four strategy result areas. In particular, SAT partnered with EANNASO to work on eradicating child marriages in the EAC region and also to draft the East Africa Sexual and Reproductive Health Rights Bill which provides the legal framework for matters relating to sexual and reproductive health, to protect children, adolescents and young persons from sexual abuse and other forms of exploitation.

**African Men for Sexual Health and Rights (AMSHeR)** is an established Africa-wide MSM organisation working with an extensive range of LGBTI NGOs. The inclusion of MSM in regional and national programming for SRHR and HIV remains controversial and largely marginalised. In 2016/17, SAT supported AMSHeR to create working examples of how to promote inclusion at the local level. SAT supported AMSHeR in its advocacy work to provide a voice for the LGBTI community at international fora such as the International AIDS Conference. In addition, we also supported the organisation in systems strengthening and capacity building.

**Disability HIV & AIDS Trust (DHAT)** has struggled to make significant impact on SRHR and disability at a regional level and remains almost entirely dependent on SAT for funding. SAT resolved, and informed DHAT, that we would cease to support DHAT should they fail to raise other funding and achieve significant regional results. As they have not managed to do so, SAT will fund DHAT for only another six months in the new year, after which we will cease providing funding.

**The Regional African AIDS NGOs Forum (RAANGO)**, as the name indicates, is a regional forum of what used to be the key civil society HIV players, all of whom now also focus on SRHR and integration. This forum has been beset with a lack of funding and the almost impossible task of collaboration in a climate of dwindling resources, which perhaps invariably has led to narrower organisational foci. Our perception is that, discourse to the contrary, many of the organisations still focus largely on HIV and AIDS. In our estimation it is no longer useful to attempt to resurrect this forum.
Changes in the partnership strategy at country levels

Once again the need for changes has been addressed in the introduction of this report. With a widened scope of concern regarding SRHR and the ‘packaging’ of this into The Girl Plan (also for boys), SAT has begun to liaise with new strategic partners at country level. These include ministries dealing with Justice, Education, Women, and Social Welfare; police services; and, in pilot districts, district-level leaders and administrators. In addition, civil society groups dealing with gender equality and women’s access to health have been approached and have participated in SAT activities.

What become clear during the year was that two new sets of strategic partners would be required to make significant progress in SRHR – religious leaders and traditional leaders, with a focus on the latter as they have real power through district and chieftainship structures.

With regard to sub-granting partners in countries, SAT began the 2016/17 financial year with a deliberately reduced portfolio of 36 partners at country level, down from 57 partners the previous year. This was again due to a shift in resources towards greater emphasis on regional results and on dialogue and advocacy regionally rather than on programming, as in the past. An increase, rather than a shift, in focus has been on-going for some years now, and has included an outward expansion of thinking and working from SAT community partners, to partners of partners. In most cases these have been health facilities with which SAT partners have partnered (see list of clinics in Annexure N) – but increasingly these are also schools, police stations, and local and district administrations.

Continental work

SAT continues to engage at a continental level, in the interests of influencing SRHR-related issues.

- As noted above under the section on ‘Ending child marriages’, SAT joined the ten-person AUC Civil Society Reference Group Committee for Ending Child Marriage.

- SAT supported the participation of three adolescent girls in the launch of the AU’s 2017 year of ‘Harnessing the Demographic Dividend through Investments in Youth’ through collaborating with the AU Goodwill Ambassador on Ending Child Marriages and the Rozario Memorial Trust (Zimbabwe). These young women have since played an active role at country and regional levels as ‘End Child Marriage’ advocates.

- The appointment of a new Head of the Youth Division of the AUC saw a revitalisation in the second half of the year – focussing on the AUC declaration of 2017 as a year to invest in the ‘demographic dividend’.

- SAT participated at an Eastern and Southern Africa Regional Workshop organised by the AU and UNFPA - to discuss a concept note on Harmonising the Legal Environment for Adolescents SRH, with a focus on CSE and gender issues.

- SAT became a member of the Civil Society Organisations committee of the East and Southern Africa (ESA) Commitment and sponsored AfriYAN’s similar participation.

- SAT joined the Africa Grantmakers’ Affinity Group (AGAG), a network of funders with a mission to promote robust, effective and responsive philanthropy benefiting Africa. SAT participated at the AGAG 2017 on ‘ - with a view to promoting philanthropic investment in SRHR in the region.

Global Work

- SAT continued to work with strategic partners such as UNAIDS, UNICEF, UNFPA, and UNESCO.

- SAT joined the Partnership for Maternal, Newborn and Child Health (PMNCH), a multi-stakeholder platform to increase the engagement, alignment and accountability of partners and support successful implementation of the Global Strategy for Women, Children and Adolescents Health. In addition, SAT organised for best practice governance training for the two youth members elected onto the PMNCH Global Board.
• In 2017, SAT joined the Menstrual Hygiene Day Alliance, a global platform bringing together non-profit organisations, government agencies, the private sector, the media and individuals to promote menstrual hygiene management. SAT participated in the preparations for the 2017 Menstrual Hygiene Day on 28 May.

• SAT’s contribution to the UNAIDS global dialogue on funding for communities is given in Annexure N.

• The SAT Executive Director is the International Co-Chair of Track E of the International AIDS Conference 2018.³⁰

**Resource Mobilisation**

SAT spent much of the first three months of 2016 developing a pivoted strategy ahead of submitting a new funding extension agreement to SIDA. This was concluded at the beginning of the reporting period. The funding extension of SEK 23 million per year was awarded for two years.

For the rest of the reporting period, SAT focused on two large proposals, smaller grants and contracts.

A consortium involving SAT, AMSHeR and Stellenbosch University submitted a proposal for Human Rights for Key Populations to United States Government (USG). The proposal was for a total of $10 million over 4 years, working with partners across 15 African countries. Although initial indications before the Trump Administration appeared positive (the regional consortium was contacted by USG to discuss the proposal via Skype), there has been no further communication. It is assumed that the initiative disappeared altogether under the new USA administration or that it was granted only to USA INGOs who lobbied vociferously that too much funding was heading to the global South and away from the USA. SAT also participated in a country-level consortium in Zambia that submitted a separate proposal.

In Malawi SAT successfully applied for, and was awarded, a grant of $1.2 million from ActionAid, to undertake an MSM key population project running from December 2016 to December 2017. In addition, SAT Malawi secured funding of US$1,642 million from the Global Fund through ActionAID and 156,733 Euros from the Federal Republic of Germany.

In Zimbabwe, SAT submitted a concept note for funding to Family Health International (FHI360) who had invited SAT to join a consortium for a project in that country. In addition, SAT Zimbabwe participated in the PATA Promising Practice Survey in adolescent HIV Treatment and Care Programme and was awarded an appreciation fee of US$5,000.

In Zambia, SAT submitted a Concept Note to the European Union titled ‘Amplifying Voice – Dignity and Inclusive Health for All’ targeting female sex worker and LGBTI organisations. The concept note was approved to proceed to the proposal development stage.

Lastly SAT commissioned a desk review to map existing funding streams into Africa for gender programming - and, in particular, current or potential funding pipelines for women’s health and rights in Southern Africa.

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³⁰ Track E: Implementation Research, Economics, Systems and Synergies with other Health and Development Sectors
SECTION C: MONITORING AND EVALUATION

Enacting the pivoted strategy

During this reporting period, SAT held Annual Partners’ Meetings (APM) in Malawi, Zambia and Zimbabwe at which partners were consulted and updated on SAT’s pivoted strategy – and, following feedback meetings, to share key highlights; to initiate conversations with stakeholders about the strategy and its implementation; and to secure stakeholder perspectives on it. These dialogues were fed into the partner M&E training.

Key activities:

- With support from the Evaluation Research Agency (ERA) at Stellenbosch University, new methods of reporting data and programming were developed using Google spread sheets.
- Indicators were included in **partner contracts**.
- **Quarterly reports** have been instituted and are being submitted.
- SAT convened M&E training workshops in Malawi, Zambia and Zimbabwe for partner organisations and country offices to establish and explain the **electronic data-uploading mechanism** for partners. The workshops were supported by facilitators from Stellenbosch University and attended by 36 participants from SAT partners.
- At the time of reporting the inclusion of partner organisations on the platform of the SAT **PCMIS system** was in progress, with specifications for an expanded scope of work agreed with the PCMIS developers.
- SAT developed **relevant data collection tools** to be used by partners – e.g. the Services Tracker, the Event Tracker, and the Cervical Cancer Tracker. This was done with support from ERA; this was followed by training of partners in Botswana, Malawi, Zambia and Zimbabwe, on the use of these tools.
- The **reporting template** for verification visits and the annual and semi-annual reporting templates were also amended and aligned to the new pivoted strategy.

Monitoring visits

The following monitoring visits took place:

Country offices proceeded with their **partner verification visits** as follows;

- In **Botswana**, SAT conducted both financial and programmatic monitoring visits to WAR in November 2016. The visits were very fruitful and verified the programmatic work being implemented on the ground. Three wards which conducted community dialogues on GBV and other SRHR issues were visited, as well as a school.
- In **Malawi**, SAT conducted seven verification visits to its partners.
- In **Tanzania**, SAT conducted two partner-monitoring visits to TAMWA and MEFADA, that included both programming and finance.
- In **Zambia**, 16 programme and financial verification visits were conducted. Six of the verification visits were combined with donor/partner field visits. The remaining nine visits scheduled for the last quarter were overtaken by urgent imperatives of the regional planning for The Girl Plan(also for boys) imposed on the country office by SAT Regional Office. They have been re-scheduled for the first quarter of the new year.
- In **Zimbabwe**, all 10 SAT partners were visited in 2016/17. No major negative findings were observed.
SECTION D: BUDGET

Finances

The analysis that follows is based on SAT's unaudited Annual Financial statements for the Financial Year ended 31st March 2017.

Overview

SAT's total JFA expenditure for 2016/17 was $4,474,602 which represents an execution rate of 90% of budget for the 2016/17 financial year. This was a higher rate than 2015/16 (execution rate 87%); but is a little disappointing in a context where there was sufficient funding available to have achieved a higher rate.

SAT received all the different tranches of JFA income that were budgeted for 2016/17. The main reason for the actual income received being slightly less than budget in Table 1 below, was that the Swedish Krona continued to depreciate against the US Dollar, and therefore the SEK 23 million contributed by SIDA in 2016/17 only translated to $2,632,606 and not $2,750,722 as budgeted. The effect of this was offset somewhat by the fact that the final audited amount of JFA funds brought forward at the start of the year was higher than had been estimated at the time of submitting last year's Annual Report ($908,398 compared to $869,200).

SAT JFA Income Received compared to Budget FY 2017

<table>
<thead>
<tr>
<th>BUDGET DESCRIPTION</th>
<th>TOTAL JFA BUDGET</th>
<th>ACTUAL JFA RECEIVED</th>
<th>DATE RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance of Funds Brought Forward</td>
<td>$ 869,200 USD</td>
<td>$ 908,398 USD</td>
<td>Audited</td>
</tr>
<tr>
<td>Swedish International Development Agency (SIDA)</td>
<td>SEK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st Tranche 2016/17</td>
<td>13,000,000 USD</td>
<td>$ 1,554,756 USD</td>
<td>1 June 2016</td>
</tr>
<tr>
<td>2nd Tranche 2016/17</td>
<td>10,000,000 USD</td>
<td>$ 1,077,850 USD</td>
<td>28 Nov 2016</td>
</tr>
<tr>
<td>Swiss Development Cooperation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st Tranche 2016/17</td>
<td>$ 1,000,000 USD</td>
<td>$ 1,000,000 USD</td>
<td>19 Aug 2016</td>
</tr>
<tr>
<td>2nd Tranche 2016/17</td>
<td>$ 1,000,000 USD</td>
<td>$ 1,000,000 USD</td>
<td>1 Feb 2017</td>
</tr>
<tr>
<td>Total Income Available</td>
<td>$ 5,619,922 USD</td>
<td>$ 5,541,004 USD</td>
<td></td>
</tr>
</tbody>
</table>

As SAT continued to submit its required reports on time and to a satisfactory standard, international cooperating partners were able to release the funding tranches in good time and the effect was that SAT did not experience any cash flow constraints in 2016/17. Graph 1 below shows that SAT’s quarterly expenditure patterns in 2016/17 followed a very similar pattern to 2015/16, albeit at reduced levels.

Table above reflects that the second SDC tranche was received quite late (1 February 2017) but this was due to problems experienced between the banks involved in making the transfer itself, SDC had approved the release in mid-December 2016. It is hoped that the bank issues have now been resolved and will not affect future transfers.
JFA funding continues to provide the bulk of SAT’s funds each year. This is however supplemented by individual project funding from other donors at a national level. Table below provides a summary of the ‘non-JFA’ funding received and expended in FY 2017.

Non JFA Income and Expenditure FY 2017

<table>
<thead>
<tr>
<th>OTHER DONORS 1 APRIL - 31 MARCH 2017</th>
<th>SAT Malawi USD</th>
<th>SAT Regional USD</th>
<th>SAT Zambia USD</th>
<th>SAT Zimbabwe USD</th>
<th>TOTAL USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grants Received (Incl Funds b/fwd)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>International AIDS Alliance</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 25,786</td>
<td>$ -</td>
<td>$ 25,786</td>
</tr>
<tr>
<td>DFID</td>
<td>$ 163,084</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 163,084</td>
</tr>
<tr>
<td>Global Fund (SSR)</td>
<td>$ 783,271</td>
<td>$ 36,456</td>
<td>$ -</td>
<td>$ 342,303</td>
<td>$ 1,162,029</td>
</tr>
<tr>
<td>Global Fund (ZNNP+)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 43,486</td>
<td>$ 43,486</td>
</tr>
<tr>
<td>GIZ</td>
<td>$ 48,324</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 48,324</td>
</tr>
<tr>
<td>IPM</td>
<td>$ 36,182</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 3,209</td>
<td>$ 39,391</td>
</tr>
<tr>
<td>PACF</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 199,235</td>
<td>$ 6,435</td>
<td>$ 205,670</td>
</tr>
<tr>
<td>TSE</td>
<td>$ 2,703</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 2,703</td>
</tr>
<tr>
<td>UNDP</td>
<td>$ 9,305</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 9,305</td>
</tr>
<tr>
<td>UNICEF</td>
<td>$ -</td>
<td>$ 79,323</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 79,323</td>
</tr>
<tr>
<td>TOTAL INCOME</td>
<td>$ 1,042,870</td>
<td>$ 115,779</td>
<td>$ 225,021</td>
<td>$ 395,433</td>
<td>$ 1,779,102</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YTD Expenditure</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>International AIDS Alliance</td>
<td>$ (157,421)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (157,421)</td>
</tr>
<tr>
<td>DFID</td>
<td>$ (2,703)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (2,703)</td>
</tr>
<tr>
<td>Global Fund (SSR)</td>
<td>$ (756,466)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (369,015)</td>
<td>$ (1,125,482)</td>
</tr>
<tr>
<td>Global Fund (ZNNP+)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (54,572)</td>
<td>$ (54,572)</td>
</tr>
<tr>
<td>GIZ</td>
<td>$ (48,477)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (48,477)</td>
</tr>
<tr>
<td>IPM</td>
<td>$ (41,506)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (17,246)</td>
<td>$ (58,752)</td>
</tr>
<tr>
<td>PACF</td>
<td>$ (25,487)</td>
<td>$ -</td>
<td>$ (145,596)</td>
<td>$ (25,487)</td>
<td>$ (171,083)</td>
</tr>
<tr>
<td>TSE</td>
<td>$ (5,063)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (5,063)</td>
</tr>
<tr>
<td>UNDP</td>
<td>$ (9,307)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (9,307)</td>
</tr>
<tr>
<td>UNICEF</td>
<td>$ -</td>
<td>$ (63,849)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (63,849)</td>
</tr>
<tr>
<td>TOTAL EXPENDITURE</td>
<td>$ (1,000,994)</td>
<td>$ (63,849)</td>
<td>$ (153,663)</td>
<td>$ (466,320)</td>
<td>$ (1,684,827)</td>
</tr>
</tbody>
</table>

Comparison of Quarterly Expenditure between FY 2017 and FY 2016

Comparison of Quarterly Expenditure between FY 2017 and FY 2016
The Performance of Regional Currencies against the US Dollar

Local currencies fared much better against the US Dollar in 2016/17 than has been the case for several years. Three of the SAT countries, namely South Africa, Zambia and Botswana, actually strengthened against the Dollar and although the Malawi Kwacha and the Tanzanian Shilling continued to weaken, the rate of their decline slowed considerably. Sadly this improved performance was not so much due to inherent strengthening of the economies in the region, but more related to Dollar weakness.

Due to the fact that all SAT staff salaries are now pegged in Dollars, the stronger local currencies did not have any adverse effect on the salary budget for the year.

How SAT local currencies fared against the US Dollar in 2015/16

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>BOTSWANA</th>
<th>MALAWI</th>
<th>SOUTH AFRICA</th>
<th>TANZANIA</th>
<th>ZAMBIA</th>
<th>ZIMBABWE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currency</td>
<td>BWP</td>
<td>MWK</td>
<td>ZAR</td>
<td>TZS</td>
<td>ZMW</td>
<td>USD</td>
</tr>
<tr>
<td>31 Mar 2016</td>
<td>10.81</td>
<td>674.21</td>
<td>14.82</td>
<td>2,140</td>
<td>11.19</td>
<td>1</td>
</tr>
<tr>
<td>31 Mar 2017</td>
<td>10.30</td>
<td>722.17</td>
<td>13.40</td>
<td>2,193</td>
<td>9.13</td>
<td>1</td>
</tr>
<tr>
<td>%age change</td>
<td>+5%</td>
<td>-7%</td>
<td>+10%</td>
<td>-2%</td>
<td>+18%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Note:
A positive percentage indicates the local currency strengthened compared to the US Dollar

A negative percentage indicates the local currency weakened compared to the US Dollar

The total expenditure for the year of $4,474,602 (as per Table 3) is calculated by converting the annual expenditure in each local currency to US Dollars, using the respective country’s average exchange rate for the year. In a changed environment where some local currencies are now strengthening this implies that there should be an overall exchange rate gain reported in the consolidated financial statements for 2016/17.

An estimate of how much this will be is given by the rough calculation below:

<table>
<thead>
<tr>
<th>REF</th>
<th>USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Income available (in actual Dollars received)</td>
<td>$ 5,541,004</td>
</tr>
<tr>
<td>Less: Total expenditure (at average exchange rate for the year)</td>
<td>($ 4,474,602)</td>
</tr>
<tr>
<td>Exchange Rate Gain (estimated)</td>
<td>$ 128,491</td>
</tr>
<tr>
<td>Estimated balance of Funds in hand at year end (at year end exchange rates)</td>
<td>$ 1,194,893</td>
</tr>
</tbody>
</table>

Table: SAT JFA Income received compared to budget FY 2017
Table: SAT consolidated Expenditure Statement 2016-2017
Audits

This was the fourth year where all of the external audits of SAT offices were conducted by a single firm – KPMG. KPMG have again been appointed to conduct the audits for the year ending 31 March 2017. This will be the fifth and final year, as FARCO has agreed that the SAT audit will go out to tender early in 2018. KPMG will be permitted to submit a proposal, along with other firms, but it will be a competitive process and KPMG will only continue in office should they be adjudged to offer the best and most competitive service going forward.

For the first three years of having a single auditing firm, each country office was left to negotiate the timing of their audit with their local KPMG firm. The theory here was that all the audit fieldwork would be conducted at roughly the same time (during mid-May to early June) and that therefore all of the financial statements and audit management letters would be complete and ready for review by FARCO well before the end of July, and it should be a comfortable process for SAT to be able finalise and submit everything by the final deadline of 30 September.

However in practice this proved not to be the case. By the time FARCO met at the end of July, invariably there was at least one office (usually a different office each year) that had run into a particular problem, such as a previously unforeseen technical issue with IFRS, that meant their audit had been delayed or prolonged and this would then in turn affect other processes and the final submission for the whole of SAT.

For the 2015/16 audit it was decided to try a new approach - to stagger the audits such that Regional Office finance would have a chance to get involved in the preparation and conduct of each separate country office audit. This proved very successful.

- Firstly, Regional Office became aware of any technical problems on the ground much earlier than before and was able to take the necessary steps to address them with KPMG at the time the particular audit was still taking place.
- Secondly there was a marked reduction in the number of new audit management points raised and a big improvement in the number of previous points satisfactorily addressed. This was due to improved preparation before the auditors commenced their fieldwork.
- Thirdly it was possible to achieve better consistency in the way particular technical financial matters were addressed and disclosed across all the SAT financial statements (the treatment of Deferred Income was a good example).
- Last, but not least, for the first time in four years SAT finally succeeded in submitting ALL of the individual country financial statements and audit management letters on time by 30 September 2016.

Given this success, the plan for the 2016/17 audits is also to stagger them.

Once the individual audits have been finalised this still leaves the preparation of the consolidated financial statements, work on which does not start until there are final audited numbers for each of the individual offices. Sadly in FY2016 SAT was badly let down by the service provider responsible for formatting of the final statements after they have been audited. This meant that the 2015/16 consolidated statements were not produced on time. Suffice to say the service provider in question will no longer be involved in the 2016/17 SAT audits.
Financial Report

Below is the financial expenditure report for the period 1 April 2016 to 31 March 2017. The report only covers grants received under the Joint Financing Agreement (JFA), all figures are in US Dollars.

### SAT Consolidated Expenditure Statement 2016 – 2017

<table>
<thead>
<tr>
<th>Details: -</th>
<th>Actual Exp</th>
<th>Budget</th>
<th>Variance</th>
<th>Execution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.0 PROGRAMMING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Human Resources (CTC)</td>
<td>1,752,991</td>
<td>1,770,042</td>
<td>(17,051.25)</td>
<td>99%</td>
</tr>
<tr>
<td>1.2 Staff Development</td>
<td>18,940</td>
<td>25,000</td>
<td>(6,059.80)</td>
<td>76%</td>
</tr>
<tr>
<td>1.3 Technical Support Services</td>
<td>59,370</td>
<td>60,000</td>
<td>(629.90)</td>
<td>99%</td>
</tr>
<tr>
<td>1.4.1 Staff Travel &amp; Accommodation</td>
<td>82,348</td>
<td>137,000</td>
<td>(54,652.38)</td>
<td>60%</td>
</tr>
<tr>
<td>1.4.2 Conferences</td>
<td>83,218</td>
<td>128,000</td>
<td>(44,782.42)</td>
<td>65%</td>
</tr>
<tr>
<td>1.5.1 Partner Learning &amp; Development</td>
<td>464,896</td>
<td>506,260</td>
<td>(41,363.85)</td>
<td>92%</td>
</tr>
<tr>
<td>1.5.2 Partner Programming Grants</td>
<td>751,247</td>
<td>1,085,000</td>
<td>(333,753.39)</td>
<td>69%</td>
</tr>
<tr>
<td>1.6.1 Partner Programme &amp; Plans</td>
<td>146,245</td>
<td>211,000</td>
<td>(64,755.47)</td>
<td>69%</td>
</tr>
<tr>
<td><strong>TOTAL PROGRAMMING</strong></td>
<td>3,590,065</td>
<td>4,139,302</td>
<td>(549,236.81)</td>
<td>87%</td>
</tr>
<tr>
<td><strong>2.0 GOVERNANCE &amp; ADVISORY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Annual Audit</td>
<td>89,238</td>
<td>88,000</td>
<td>1,238.45</td>
<td>101%</td>
</tr>
<tr>
<td>2.2 SAT Board</td>
<td>10,829</td>
<td>20,000</td>
<td>(9,170.54)</td>
<td>54%</td>
</tr>
<tr>
<td><strong>Total Governance &amp; Advisory</strong></td>
<td>112,406</td>
<td>133,000</td>
<td>(20,594.00)</td>
<td>85%</td>
</tr>
<tr>
<td><strong>3.0 CAPITAL EXPENDITURE (excl IT)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 Furniture</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>3.2 Equipment</td>
<td>29,479</td>
<td>13,000</td>
<td>16,479.00</td>
<td>227%</td>
</tr>
<tr>
<td><strong>Total Capital Expenditure</strong></td>
<td>29,479</td>
<td>13,000</td>
<td>16,479.00</td>
<td>227%</td>
</tr>
<tr>
<td><strong>4.0 INDIRECT PROGRAMME SUPPORT &amp; ADMINISTRATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Human Resources (CTC)</td>
<td>256,548</td>
<td>233,986</td>
<td>22,562.01</td>
<td>110%</td>
</tr>
<tr>
<td>4.3 Consultant Services</td>
<td>22,029</td>
<td>22,500</td>
<td>(471.15)</td>
<td>98%</td>
</tr>
<tr>
<td><strong>Total Indirect Program Costs</strong></td>
<td>742,652</td>
<td>695,486</td>
<td>47,165.80</td>
<td>107%</td>
</tr>
<tr>
<td><strong>TOTAL EXPENDITURE</strong></td>
<td>4,474,602</td>
<td>4,980,788</td>
<td>(506,186.01)</td>
<td>90%</td>
</tr>
</tbody>
</table>
Country Spend

The 2016/7 Financial Year expenditure is shown in Graph 2 below. Although this shows that some 60% of funding was spent in countries, it should be borne in mind that much of that spend was on advocacy within regional thrusts, or on innovations within regional programmes such as the youth hubs or school related gender based violence, in line with SAT’s regional programming, focus and interventions.

SAT Country Office Expenditure in the 2016/17 Financial Year

The Regional Office still consumes the largest portion of the ‘pie’, This stood at 39% in the 2016/17 financial year, but is likely to go up over the next three years as SAT increases targeted spend for greater regional impact.

The very targeted and focused contributions in Botswana and Tanzania, where community level innovations are not part of the country contributions to the regional strategy, is reflected in the very much smaller budgets of both countries.

SAT Botswana managed two highly innovative and technically sophisticated projects with Women Against Rape and a national youth organisation in 2016/17. In order to support these, two staff, a country director and a youth intern were in place. SAT Tanzania with its contribution to the region on Drug use and SRHR/HIV; Girl Plan focus linked to SDG5; GBV; and youth hub focus was supported by only two staff by the end of the year – the country programme officer, and an administration assistant.

The following graph focusses on the actual expenditure recorded against budget for each of the SAT offices covered by the JFA for 2016/17. A detailed explanation of budget variances by line item follows in the detailed expenditure variance analysis.

Execution of Budgets by Country Offices in the 2014/15 Financial Year
The three large country office SAT Malawi, SAT Zambia and SAT Zimbabwe were all very close to operating at 100% of their budget estimates, with execution rates of 101%, 98% and 95% respectively.

SAT Botswana and SAT Tanzania executed lower level execution rates due largely to severe controls exercised by the regional office as they initiated new strategies.

The Regional Office only achieved an execution rate of 83%. Several reasons, dealt with in the narrative report, speak to this lower than expected rate. SAT’s project with 6 districts across the region took right up until the end of the year to get fully on track, due to various bureaucratic hurdles. The consequence of this is that a large expenditure planned out of the current year’s budget, will now effectively only occur at the beginning of the next financial year. Significant elements of the influence/new advocacy strategy, particularly some of the materials development together with portions of the Tanzania budget were also unavoidably delayed and are actually being implemented in April-May 2017.

**Detailed Expenditure Variance Analysis**

In 2016/17 approximately 80% of SAT expenditure went towards programming expenditure, 17% to programme support and the balance to strengthening governance and advisory systems and capital expenditure. See graph below:

![Expenditure Categories 2016/17 Financial Year](image)

The pie graph shows that 80% of SAT resources were directed towards programming. This is 1% less than the previous year and there was a corresponding increase of 1% in the proportion of resources directed to indirect programme support (administration).

It is important to point out that this was not due to any increase in actual expenditure on administration, in fact administration expenditure dropped from $760,888 in FY 2016 to $742,652 in FY 2017. The percentage change arises from the fact that, in a context of a lower overall spend, administration costs did not decline quite as fast as programme costs. This situation will reverse in 2017/18 where there is a larger budget of $5.3 million.

---

31 Programming is used in the broad sense here and incudes policy work, advocacy and dialogue.
The graph following shows a detailed comparison between FY2016 and FY 2015 of actual expenditure on each budget line item.

**Comparison of Actual Expenditure by Line Items FY 2017 vs FY 2016**

A detailed explanation of expenditure variances, using the line items from the Consolidated Statement of Expenditure, now follows:

1.0 PROGRAMMING

FY 2017 Actual Spend $3,590,065 (87% Execution)
FY 2016 Actual Spend $3,944,275 (85% Execution)

SAT achieved a budget execution rate of 87% for programming activities in 2016/17. This was higher than the execution rate for the previous year, but in the context of a reduced budget this still meant that actual expenditure on programming was $354,210 less than 2015/16.

1.1 Programme Salaries

FY 2017 Actual Spend $1,752,991 (99% Execution)
FY 2016 Actual Spend $1,691,601 (92% Execution)

Actual expenditure on programme salaries for FY 2017 was higher than the previous year due to the retrenchment packages that were paid to staff who were made redundant during the year.

The following staff were retrenched in 2016/17:

- **Regional Office**: Manager: Country Support - effective 31 Dec 2016
  Programme Officer: Partner Capacity Building – effective 31 Dec 2016
- **SAT Tanzania**: Country Accountant – effective 30 September 2016
- **SAT Malawi**: Finance Monitoring & Compliance Officer (FMCO) – effective 31 Dec 2016
- **SAT Zambia**: Finance Monitoring & Compliance Officer (FMCO) – effective 31 Dec 2016
  Assistant Accountant – effective 31 December 2016
- **SAT Zimbabwe**: Finance Monitoring & Compliance Officer (FMCO) – effective 30 June 2017
The rationale for the retrenchments was two-fold, firstly to reduce the staff overhead budget in line with the overall reduction in the JFA budget from approximately $6 million per annum to $5 million per annum in recent years, and secondly to align the staffing structure to better deliver on changed strategic priorities.

In this latter regard new regional positions have been created and filled as follows:
- Data Manager appointed with effect 1 February 2017
- Regional Women’s Rights & Health Manager appointed with effect 1 April 2017
- Regional SRHR & Advocacy Officer appointed with effect 1 May 2017

All SAT staff, with the exception of the Executive Director and the Chief Operating Officer, were awarded Cost of Living (COLA) increases with effect from 1 December 2016. The COLA percentage was different for each country, in line with SAT Board’s policy that recognises that each country experiences unique inflationary and other economic factors.

The actual COLA percentages awarded were as follows:

<table>
<thead>
<tr>
<th>SAT Office</th>
<th>COLA Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Office (South Africa)</td>
<td>6%</td>
</tr>
<tr>
<td>SAT Botswana</td>
<td>3%</td>
</tr>
<tr>
<td>SAT Malawi</td>
<td>4%</td>
</tr>
<tr>
<td>SAT Tanzania</td>
<td>3%</td>
</tr>
<tr>
<td>SAT Zambia</td>
<td>6%</td>
</tr>
<tr>
<td>SAT Zimbabwe</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Cost of Living Increases (COLA) awarded to the different SAT Offices in FY 2017**

**1.2 & 4.2 Staff Development & Recruitment**
- FY 2017 Actual Spend $18,940 (76% Execution)
- FY 2016 Actual Spend $38,295 (96% Execution)

The above figures combine the Staff Development expenditure for both line item 1.2 and 4.2, and also include recruitment costs.

The majority of staff development/training initiatives were aimed at programme staff from all SAT offices with a view of increasing standards of programming support.

Total SAT expenditure on staff development for FY 2017 was considerably less than in previous years. Recruitment costs were also low.

**1.3 Technical Support Services**
- FY 2017 Actual Spend $59,370 (99% Execution)
- FY 2016 Actual Spend $73,209 (86% Execution)

SAT again was able to reduce expenditure on outside technical assistance in FY2017. During the year SAT engaged expert external assistance in the following areas:

- Oversight and moderation of the performance review process
- Development and support of PCMIS (Partner Contract Management Information System)
- An overview of the new King IV Governance principles
- Market review of salaries and pay scales for finance staff
- Initial work towards a long term sustainability strategy for SAT
- Professional assistance with the various staff retrenchment processes
1.4.1 Conferences & Staff Travel & Accom.
FY 2017 Actual Spend $165,565 (62% Execution)
FY 2016 Actual Spend $204,698 (99% Execution)

The figures above combine the actual expenditure and budgets for both 1.4.1. Staff Travel and Accommodation and 1.4.2 Conferences. The combination reflects the money spent on transport, accommodation, registration fees and per diems for staff attending workshops, meetings and conferences both locally and internationally. It includes both SAT organised meetings (such as when staff from the country offices come to Johannesburg for meetings, training and briefings or when regional staff visit country offices to attend meetings and give advice and support) and external conferences and workshops organised by third parties.

Total expenditure for the year on travel and conferences was almost $40,000 less compared to the previous year.

Expenditure on international conferences included the following:

- April 2016 Meeting of the AU Technical committee in Addis Ababa attended by the ED, COO and two youth representatives
- May 2016 ‘Women in Development” Conference in Copenhagen attended by the ED, COO and two youth representatives
- June 2016 UNAIDS PCB meeting in Geneva attended by the ED.
- June 2016 FD and COO visit the International AIDS Alliance in Brighton UK to learn about improving technical and operational systems
- July 2016 International AIDS conference in Durban attended by Country Directors, programme officers and selected SAT partners from all SAT countries
- November 2016 ED and COO visit strategic Alliance partners in Canada as follow up to SAT submission to Canada’s international aid review and to regain SAT visibility in Canada towards resource mobilization.
- Dec 2016 UNAIDS PCB meeting in Geneva attended by the ED.
- Jan 2017 three young women from Malawi, Zambia and Zimbabwe respectively, sponsored to attend AU Young Women’s pre-summit consultation in Addis Ababa
- March 2017 UN SDG 5 meeting in Washington D.C. attended by SAT youth representative

1.5.1 Partner Learning & Development
FY 2017 Actual Spend $464,896 (92% Execution)
FY 2016 Actual Spend $451,873 (71% Execution)

This category includes the planned support, capacity building, training initiatives etc that SAT gives to all partners during the course of the year. The costs of annual partner meetings (which was formerly a separate line item) and the costs of annual partner external audits (which are held back from partner grants) are also included here.

A particular highlight of 2016/17 was the launch of youth hubs at every SAT office. The idea of a youth hub is that the SAT office provides a dedicated space for youth where young activists can get together and discuss relevant issues, research information and communicate with peer networks online. SAT also occasionally provides support for youth representatives to attend certain meetings and functions where these are properly motivated and in line with agreed objectives.
The expenditure in FY 2017 was actually slightly higher than FY 2016 and included the following:

Region

Regional Office  Support for two partner representatives and one youth representative per country to attend the Durban International AIDS conference, also the costs of running an information booth and holding a side event at the conference. Regional Office Youth Hub activities including employment of a full time AFRIYAN coordinator from the beginning of 2017. ‘Line of credit’ support to AMSHER (SAT has ceased direct granting until there is satisfactory evidence of proper financial management and controls)

Botswana  Youth Hub and ‘i-monitor’ activities

Malawi  Annual Partner meeting (5 days) held in June 2016 with representatives from all partner organisations. Various ad hoc activities throughout the year including events involving youth, women, MSM and paralegals

Zambia  Annual Partner meeting (5 days) held in May 2016 with representatives from all partner organisations. Various ad hoc activities throughout the year including events involving youth (such as running an information workshop at a sports festival on World AIDS Day), traditional leaders, sex workers and also the costs of field visits prior to the DCC meeting held at the Swedish Embassy Lusaka in September 2016.

Zimbabwe  Annual Partner meeting (3 days) held in August 2016 with representatives from all partner organisations. Zimbabwe youth hub activities.

1.5.2 Partner Programming Grants

FY 2017 Actual Spend $751,247 (69% Execution)
FY 2016 Actual Spend $1,058,887 (83% Execution)

The figures for 2016/17 show an under-spend of about $333,000 on Partner grants. This is mainly a reflection of the strategic shift in priorities as SAT moves resources away from partners who solely focus on local community issues, to partners that are able to exert influence at national and regional level. There were also some practical issues as explained below.

The main under-spend were at the Regional office (Actual expenditure was $133,000 compared to budget of $300,000), SAT Tanzania (Actual expenditure was $19,500 compared to budget of $100,000) and SAT Zimbabwe (Actual expenditure was $163,500 compared to budget of $205,000).

At the regional office the budget envisaged support to DHAT (regional organisation supporting disabled people living with HIV/AIDS); AMSHER (regional organisation supporting Men’s sexual health); AFRIYAN a regional youth network and EANNASO (regional SRHR organisation operating mainly in East Africa). Of these, contracts were entered into with DHAT and EANNASO, whilst support for AMSHER and AFRIYAN was provided directly and is included under Partner Learning and Development (above). Direct support to AMSHER was less than had been budgeted as the organisation received substantial support from other funders and did not require much from SAT. Direct support to AFRIYAN only commenced quite late in the year, after a lengthy process to find and appoint a suitable full time coordinator. AFRIYAN is a loose informal network and SAT’s intention is to help it build a proper organisational structure and substance, but at a pace that is appropriate to its circumstances. During the year SAT assisted AFRIYAN to obtain and satisfactorily complete its first ever external grant, amounting to $37,000.

In Tanzania the budget had envisaged a swift sign on with four or five new partners before 31 March 2017. As events turned out it was only possible to commence agreements with two new partners (an organisation promoting women’s issues in the media and an organisation specialising in issues for people using drugs). The slow progress is a reflection of the capacity issues in the SAT Tanzania office.

The under-spend in SAT Zimbabwe is primarily a reflection of the decision made during the year to drop a partner before entering into a renewal of contract, due to the partner’s persistent failure to supply required information and reports in a timely manner.

The budget plans for partner contracts in the remaining SAT offices were largely achieved.
Publications

FY 2017 Actual Spend $ 0 (0% Execution)
FY 2016 Actual Spend $6,913 (29% Execution)

A decision was taken in 2016/17 not to budget for publications as a separate line item. It was felt that ‘publications’ as a category is quite restrictive in an age of many different media forms by which one can communicate information to target audiences. It was therefore considered more appropriate to include any printed media under the overall umbrella of ‘Communications and Advocacy’ (below).

1.6.2 Communications & Advocacy

FY 2017 Actual Spend $146,245 (69% Execution)
FY 2016 Actual Spend $58,570 (96% Execution)

As part of the pivoted strategy SAT is committed to placing greater emphasis on advocacy efforts at regional and national levels. There was therefore a large increase in both the budget and spend in this category.

A regional three day advocacy workshop was held in Johannesburg in September 2016 which was attended by 36 participants from across the region and representatives of international NGOs. In focussed on SAT’s key advocacy priorities of

4. Age of Consent for adolescent access to SRHR
5. Prevention of child marriages
6. Menstrual health support for girls and young women

A decision to move to some new ‘non-traditional’ modes of advocacy (see narrative report) meant more background dialogues and connecting with points of influence in ministries, UN agencies and civil society. This took longer than we had envisaged, and as the dialogues happened, the immediate results were requests for materials to begin a series of influence interventions (new advocacy). Although these processes began well within the financial year, many of the products went into long production and consultation cycles, a result of which was large payments being delayed into the next financial year.

At a further planning workshop for SAT Country Directors and Programme Officers held in Johannesburg in February 2017 detailed plans were agreed for advocacy and communications programmes for each of the country offices going forward. This programme is being rolled out at the time of writing with meetings and workshops being held by each country on the subject of SDG 5 (Achievement of Gender Equality for Women and Girls).

1.6.3 Information and Communication Technology

FY 2017 Actual Spend $51,687 (140% Execution)
FY 2016 Actual Spend $65,998 (99% Execution)

The expenditure on this item includes: renewal of licenses, computer software, anti-virus, 3G cards, hosted emails, internet connectivity, remote back-ups and cloud based server, and purchases of peripherals and hardware.

During the year the transition of the accounting and payroll systems to a cloud based server was completed. A web based back up system has also been implemented for all SAT laptops, such that all important data on the machine is automatically backed whenever the user connects to the internet. These actions have significantly improved the ability of regional office to access data in a timely manner and have improved data security whilst reducing the risk of data loss for all users.

Reliable and fast internet connectivity has long been an issue for some of the country offices and during the year it was decided to upgrade the internet ‘packages’ for both the Malawi and Zambia offices. This was expensive and resulted in large unbudgeted overspends at these two offices ($12,000 overspent by SAT Malawi and $6,000 overspent by SAT Zambia). This was unfortunate but very necessary. The looming overspend was brought to donors attention in the semi-annual report sent out in October 2016.

No major purchases of hardware were made in 2016/17 but it should be noted that the laptops purchased in April 2014 were three years old by March 2017, so SAT has budgeted to replace about one third of these in the 2017/18 financial year.
   FY 2017 Actual Spend $124,119 (99% Execution)
   FY 2016 Actual Spend $263,757 (82% Execution)

At regional level a further contract was entered into with Stellenbosch University to support the continued improvement of SAT’s M&E systems. This included separate partner capacity workshops run by Stellenbosch University facilitators for each of the three large SAT countries. Three ‘once off’ evaluations were conducted, by a different consultant, for specific SAT supported programmes identified in Malawi, Zambia and Zimbabwe respectively.

M&E expenditure also includes the costs of the regular SAT programme and finance monitoring visits to partners in the field. Monitoring visits were carried out as planned by all offices.

1.8 Strategic Information Management & Planning
   FY 2017 Actual Spend $55,005 (100% Execution)
   FY 2016 Actual Spend $40,152 (45% Execution)

This includes the travel and accommodations costs for country directors and others attending Senior Management Team meetings at Regional Office, held on a quarterly basis.

2.0 GOVERNANCE AND ADVISORY
   FY 2017 Actual Spend $112,406 (85% Execution)
   FY 2016 Actual Spend $129,625 (100% Execution)

2.1 Annual Audit
   FY 2017 Actual Spend $89,238 (101% Execution)
   FY 2016 Actual Spend $99,365 (113% Execution)

The audits were conducted as planned and no additional audit work was necessary (see also Section 6.3 Audits above).

2.2 SAT Board
   FY 2017 Actual Spend $10,829 (54% Execution)
   FY 2016 Actual Spend $16,810 (84% Execution)

As required in terms of its charter, there were two full meetings of the Board during the year (in June 2016 and November 2016). The Board’s Finance sub-committee FARCO met quarterly, on four separate occasions.

In June 2016 five Board members resigned and three new Board members were appointed. The retiring members had all served for a number of years, and so this was an agreed and planned process to make way for ‘new blood’. SAT is still looking for a further two Board members with specific skills to complement and deepen the existing skill set on the Board.

The expenditure in this category reflects just transport, accommodation and venue costs for holding the Board and FARCO meetings, as all external Board members serve on a strictly voluntary, non-remunerated basis. The under-spend is due to fewer members being present at the December Board meeting and the fact that two of the three new members happen to be Johannesburg based.
2.3 Country Advisory Committees
FY 2017 Actual Spend $12,338 (49% Execution)
FY 2016 Actual Spend $13,449 (61% Execution)

The three larger country offices were all able to hold the requisite number of Country Advisory Committee meetings, all of which are also attended by either the Executive Director or the Chief Operations Officer. The two smaller country offices (Botswana and Tanzania) only held one meeting each, due to capacity constraints. There is usually an under-spend on this category because the budget always envisages full attendance of all members at all meetings, and this rarely happens in practice.

3.0 CAPITAL EXPENDITURE
FY 2017 Actual Spend $29,479 (227% Execution)
FY 2016 Actual Spend $11,704 (47% Execution)

The large overspend here was due to the need to purchase equipment, laptops and furniture for the ‘Youth Hubs’ which were instituted at all SAT offices during the course of 2016/17 (see also 1.4.1 Partner Learning and Development above). This was not foreseen at the time of the 2016/17 budget preparation exercise, but was communicated to donors at the time the decision was made and subsequently reported in the Semi Annual report sent to donors in October 2016.

4.0 INDIRECT PROGRAMME SUPPORT AND ADMINISTRATION
FY 2017 Actual Spend $742,652 (107% Execution)
FY 2016 Actual Spend $760,888 (96% Execution)

SAT achieved a reduction in the actual Year on Year expenditure in this category – total expenditure dropped by about $18,000 comparing FY 2016 to FY 2015 although, as shown by Graph 4 above the proportion this represents of total budget spend in 2016/17 has risen.

4.1 Human Resources (CTC)
FY 2017 Actual Spend $256,548 (110% Execution)
FY 2016 Actual Spend $257,046 (79% Execution)

The over-spend on administration salaries was caused by delays in implementing the redundancies of the Accountant in Tanzania and the Assistant Accountant in Zambia. Both of these had originally been planned to take place early in the year, but ultimately it was decided to retain the two individuals concerned until after the audits were complete. This resulted in smoother and better audit processes with both entities.

4.2 Staff Development
FY 2017 Actual Spend $nil (0% Execution)
FY 2016 Actual Spend $9,677 (129% Execution)

This item has already been discussed in conjunction with 1.2 Staff Development (above).

4.3 Consultant Services
FY 2017 Actual Spend $22,029 (98% Execution)
FY 2016 Actual Spend $22,796 (101% Execution)

The budget for this item is intended to provide for expenditure that may be necessary for any ad-hoc assistance in HR or finance matters management may require when a particular situation arises that is beyond the expertise of in house staff. It also includes regular monthly fees payable to the external provider of SAT’s fraud and corruption hotline, Pastel accounting system support, VIP payroll support and a small monthly retainer to a specialist agency that provides ad hoc advice on HR matters.

4.4 Office Running Costs
FY 2017 Actual Spend $451,403 (110% Execution)
FY 2016 Actual Spend $457,482 (108% Execution)
In general the types of costs included under this heading (items such as office rent, stationery, equipment leases, telephone line rentals etc) are fixed by nature. This means that they tend to remain fairly constant whether there are high or low levels of programmatic activity and should, barring the unforeseen, be reasonably close to the levels budgeted each year.

The main reason that SAT was unable to achieve greater savings than the approximately $5,000 difference between Office Running costs for FY 2017 compared to FY 2016 shown above, was a budget overrun of approximately $16,000 on the SAT Tanzania budget. The original budget had envisaged a significant ‘downsizing’ for SAT Tanzania including moving out of the existing premises to a much smaller office. However this needed a re-think when the decision was made to launch ‘Youth Hubs’. SAT would be able to build on some thriving youth activism in Dar es Salaam, and Tanzania’s existing offices had space for a separate Youth Hub area, but it would have been impossible in a small office, so management decided to stay in the larger premises.

4.5 Vehicle maintenance costs

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<th>FY 2017 Actual Spend</th>
<th>FY 2016 Actual Spend</th>
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<td></td>
<td>$12,672 (55% Execution)</td>
<td>$13,888 (93% Execution)</td>
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The above category only reflects the ‘admin portion’ of vehicle running costs i.e. for when vehicles are used for deliveries/messages etc around the office and not for field trips to partners, which form part of the M&E expenditure.

As highlighted in the Semi Annual report, SAT Malawi’s vehicles have reached an age where there are serious and repeated problems, leading to expensive repairs and meaning there were times in 2016/17 when the office was unable to make field trips. The purchase of a good quality reliable low mileage 4x4 has been budgeted for in 2017/18.
SECTION E: SAT’S ORGANISATIONAL SUPPORT TO DELIVERY

E1: SAT Governance and Management

In June 2016 SAT began the process of revamping the composition of the Board in line with King III Good Governance Practice. This saw the departure of five existing members and the arrival of four new members, who brought with them governance skills and experiences - such as finance and risk management, legal expertise, and programmatic experience in SRHR and related issues. At the time of writing, efforts were in progress to recruit one more member with private sector experience.

With respect to Board meetings and country-level Advisory Committee meetings, these were held as planned.

SAT also implemented structural changes that resulted in a leaner finance team and new skills and experiences being injected into the programme team. Seven positions were retrenched across our SAT Offices. In addition the position of the Regional Finance Monitoring and Compliance Officer was upgraded to that of Regional Grants Manager, whilst two new middle management positions (Data Manager and Regional Manager: Women’s Rights & Health) were created and filled. Lastly by the end of the reporting period, recruitment for a Regional SRHR and Advocacy Officer was completed with the successful candidate will start in May 2017.

An improved performance appraisal system was piloted during the year and all SAT offices are expected to be on track during 2017-18 to fully implement the system.

In addition to the above governance and management measures, SAT also held Annual Partner Meetings (APMs) in Malawi, Zambia and Zimbabwe. These were used to formally launch the SAT pivoted strategy to partners and stakeholders and to promote networking and collaboration with service providers and other stakeholders. The major outcome from the APMs was the partners’ and stakeholders’ buy-in to SAT’s pivoted strategy.

In September 2016, representatives from SIDA, SDC and senior personnel from the Zambian Ministries of Health and Gender, undertook field visits to seven SAT partners in Zambia. In their feedback to the Donor Co-ordinating Committee (DCC) meeting which was held in the aftermath of the field visits, SIDA and SDC expressed their satisfaction with the work of five of the partners visited and raised some concerns about two of the partners. In response SAT engaged NZP+ to discuss HIV Prevention messages (especially in schools) and advised that these should be comprehensive, namely, ABC, and should not emphasize abstinence only, in order to allow a broader choice of HIV prevention interventions.

With respect to YHHS, SAT engaged an independent consultant (SINGIZI) to assess YHHS performance and the evaluation report notes that YHHS adheres to the values that underpin SAT work, namely, inclusiveness, dignity and rights and gender equality. The report further notes that YHHS ‘has achieved some significant gains in relation to the provision of SRH and HIV prevention information and services to young girls and boys through comprehensive sexuality and life skills education…’. On that basis, the Evaluators recommended that “SAT should continue to work with the organisation but reflect the concerns raised so that greater awareness of these risks is created”.

The International Co-operating Partners (ICP) expressed their support for the involvement in these visits of high profile persons from the Ministries of Health and Gender as government involvement is regarded as a key factor to upscaling and sustainability of interventions.

The ICPs’ collective observations of the field visits and recommendations comprised 13 observations and 8 recommendations identifying issues that need improvement, emphasis or special consideration in order to strengthen and increase the effectiveness of SAT-supported interventions.
**E2: SAT Budgeting, Financial Management and Audits**

The individual statutory audits of each SAT office were all completed and submitted to the donors by the end of Q2 (30 September 2016). In response, the donors submitted their questions on issues arising from the audits, and these were addressed. SAT also prepared the consolidated financial statements that were submitted by the end of November 2016. Both SIDA and SDC were able to release their next disbursements after being satisfied with the respective audits and consolidated financial statements.

Complementary to the audit processes, the Internal Audit Plan was implemented as per plan and reports were submitted to the Finance, Audit and Risk Committee (FARCO) for their review. Collective reviews were conducted in the offices of SAT Zambia, Zimbabwe and Malawi – covering governance, financial, human resource, programming, and information technology - to assess whether processes are working in line with the organisation’s policies and objectives. All areas that were reviewed were found to be in order and this was further supported by audits conducted on an annual basis. Recommendations made were registered, and their implementation tracked.

**E3: SAT PCMIS, Risk Management and Anti -Corruption**

During the reporting period, SAT conducted further training for both regional and country-level staff in the use of the PCMIS system. General outcomes of the training indicate improved use of the PCMIS, as evidenced by the efficiency and better handling of the contracting process and regular updates within the system compared to previous period.

SAT also made changes to the PCMIS system, introducing an additional module - namely Partner Audit, Monitoring Point Tracking Registers - to partner contracts. The feature facilitates timeous and effective monitoring implementation of audit, risk and compliance recommendations to implementing partners. Its use will be fully implemented in 2017/18. SAT hopes to further introduce more features to the system that will include new contracts layout, indicators, data capturing and summary budgets are in the process of being updated in the system.

An ad hoc review on compliance with the policy on delegation of authority was conducted in June 2016 as requested by SAT’s FARCO. This resulted in further improvements regarding the approval levels at country offices and the monthly cash advance approval process at regional office.

Quarterly updates of the Audit Point Tracking Register - which regularly monitors progress on external and internal audit-related recommendations - were submitted to the donors, SAT Board, FARCO and management, as was the Disallowable Fund Tracking Register. No new cases have been reported since April 2016.

SAT’s Head of Internal Audit is a member of the panel which receives notifications/ tip-offs of any irregularities, fraudulent or corruption cases that may be anonymously reported by any staff member or the public through SAT’s Anti-Corruption Hotline. The hotline is administered by an external service provider. This is a standing reporting item on FARCO’s quarterly meetings; and no new cases have been reported on the hotline since April 2016.

In line with contractual requirements, SAT partners conducted individual external audits on grants received from SAT and reports were submitted. The opinions on all audits were satisfactory, indicating that partners are managing their finances properly and that they have good governance structures in place.

**E4: Sexual Harassment**

SAT planned to collaborate with other civil society organisations to propagate a wider culture to fight sexual assault and to develop systems and mechanisms for mutual support. Although a draft for collaboration is in place, time constraints by all parties meant that more formalised collaboration agreements had to be delayed to the 2017/18 year.

The review outlined draft recommendations for SAT consideration and these will be presented as a part of a realigned funding strategy focusing on SRHR within a Women’s Rights & Health paradigm.
# Annexures

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