SEPTEMBER 2021

MIDTERM EVALUATION REPORT

Sexual Health and Empowerment (SHE) Project

SHE
SEXUAL HEALTH & EMPOWERMENT

OXFAM

Global Affairs Canada
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DIsclaimer

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Photo credit: SIKAP (2021)

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Abbreviations and Acronyms

AMDF	Al-Mujadilah Development Foundation (now Al-Mujaadilah Women's Association)
AMWA	Al-Mujaadilah Women's Association
BARMM	Bangsamoro Autonomous Region in Muslim Mindanao
CAT4SRHR	Capacity Assessment Tool for Sexual and Reproductive Health and Rights
COVID-19	Coronavirus disease 2019
CSO	Civil Society Organization
DMSFI	Davao Medical School Foundation Inc.
DOH	Department of Health
DSWD	Department of Social Welfare and Development
FPOP	Family Planning Organization of the Philippines
Friendly Care	Friendly Care Foundation
GAC	Global Affairs Canada
GIDA	Geographically Isolated and Disadvantaged or Depressed Areas
GBV	Gender-based Violence
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IEC	Information, Education and Communication
KATROPA	Kalalakihang Tapat sa Responsibilidad at Obligasyon sa Pamilya
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning
LGU	Local Government Unit
MEAL	Monitoring, Evaluation, Accountability and Learning
MEL	Monitoring, Evaluation, and Learning
MIDAS	Mayon Integrated Development Alternatives and Services
MTE	Midterm Evaluation
OECD	Organization for Economic Cooperation and Development
OiPh	Oxfam in the Philippines
PCT	Project Coordination Team
PCW	Philippine Commission on Women
PIP	Project Implementation Plan
PKKK	Pambansang Koalisyon ng Kababaihan sa Kanayunan
PLI	Partners Learning Interaction
PMF	Performance Measurement Framework
POPCOM	Commission of Population and Development
PSA	Philippines Statistics Authority
RHU	Rural Health Unit
SOGIE	Sexual Orientation, Gender Identity, and Gender Expression
SIKAP	Sibog Katawhan Alangsa Paglambo
SHE	Sexual Health and Empowerment
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
UnYPhil-Women	United Youth of the Philippines- Women
UPCWGS	University of the Philippines Center for Women and Gender Studies
VAWC	Violence Against Women and Children
WGNRR	Women's Global Network for Reproductive Rights
WRA	Women of Reproductive Age
WRO	Women's Rights Organizations

EXECUTIVE SUMMARY

The Sexual Health and Empowerment (SHE) Project is funded by Global Affairs Canada (GAC) and managed by Oxfam Canada as the Partner Affiliate in collaboration with Oxfam in the Philippines (OiPh). The SHE Project seeks to empower women and girls to secure their Sexual and Reproductive Health and Rights (SRHR) in six disadvantaged and conflict-affected regions of the Philippines (Bicol, Eastern Visayas, Zamboanga Peninsula, Northern Mindanao, Caraga, and Bangsamoro Autonomous Region of Muslim Mindanao (BARMM)). It aims to (1) improve knowledge and awareness of SRHR, particularly among women and girls, including the prevention of gender-based violence (GBV); (2) strengthen health systems and community structures to deliver rights-based, comprehensive Sexual and Reproductive Health (SRH) information and services; and (3) improve the effectiveness and capacity of women's rights organizations (WROs) and women's movements to advance SRHR and prevent GBV. Its Theory of Change is supported by two pillars and twelve partners who in turn implement the project. Pillar 1 involves multi-stakeholder engagement of rights holders to support gender responsive and youth friendly SRH information and services. Pillar 2 builds on the strengthened capacities of its partners and allies to leverage influence and policy advocacy on SRHR related laws and policies.

The midterm evaluation (MTE) aims to assess the continued relevance of the SHE Project and the progress made towards achieving its planned outcomes. Specifically, the MTE will provide the project with a basis for identifying appropriate actions to: (a) address issues or problems in implementation, and (b) reinforce initiatives that demonstrate the potential for greater impact.

The rest of the executive summary covers the findings and recommendations, whereas the best practices and lessons learned are covered in the main body of the report.

FINDINGS

PROJECT DESIGN The data showed that the outcomes, outputs, and activities scheduled during the period captured were either completed, on schedule to be completed, or to be implemented. Any project lags were rectified by catch up plans – meaning these were agreed to be rescheduled or transferred to Year 2.

1.**Changes to the Project Assumptions, Strategies, and Drivers:** The partners compared the assumptions against local conditions that the SHE Project underwent, as well as the key findings from the Performance Measurement Framework (PMF) and the drivers of change. Admittedly, local conditions have changed due to COVID-19 but the MTE team assessed that the SHE Project's Logic Model, Theory of Change, and assumptions remained unchanged from project inception to Year 3 of reporting.

2. **Pivot in Terms of Approaches to the Strategies due to COVID-19.** Partners shifted either partially or fully to digital platforms due to Inter-Agency Task Force for the Management of Emerging Infectious Diseases restrictions on mobility and public assembly. This came with a steep learning curve for all partners in adjusting to asynchronous learning. [1]


Photo credit: PKKK (2021)

3. **Common Understanding of SRHR Concepts Among Project Implementers.** There were no irreconcilable differences or challenging cases found by the MTE team. During the Partners Learning Interaction (PLI), the partners discussed how to arrive at a collective understanding of SHRH within the project itself. This would reflect both the diversity in terms of mandates, technical know-how, and field experience of SHE partners, and the fact that some partners came on board after the project inception.
4. **SHE Partners' Understanding of the Project Design.** There were no noted irreconcilable differences or disagreements among the partners when it came to the project design, PMF, and Theory of Change, but the experiences shared were certainly rich in how SRHR was successfully adopted in the project areas.

IMPLEMENTATION The MTE team found no notable or intractable challenges to the project implementation.

1. **Application of Feminist Principles.** The MTE team observed how concepts such as anti-sexism, women's autonomy, choice, and empowerment were applied in the strategies and activities of the SHE Project, given the diverse contexts of the project sites. This was evident in Jhpiego's implementation, when it trained its regional coordinators on Gender Transformation for Health, and all key staff on gender and health perspectives. This had a two-fold effect – it aided in the roll out of gender training activities and awareness of gender responsiveness spilled over to the workplace.
2. **Inclusion of SRHR Concepts and Women's Rights Dimensions in Information, Education, and Communication (IEC) Materials.** Discussions with the partners revealed that they developed and utilized their own IEC and training materials. The partners subjected these materials to quality assurance then reviewed and adapted them to SHE activities to ensure gender sensitivity and responsiveness. An example of this is when partners working in mostly Muslim areas engage with credible Muslim religious leaders as writers and champions to educate the community on SRHR and GBV principles.
3. **Involvement and Strategies of Different Levels of Stakeholders.** There was a noted progression or "leveling up" -- from promoting the project and increasing awareness about SRHR issues, to largely getting their commitment to, and active participation in project activities. Women's Global Network for Reproductive Rights (WGNRR), for example, saw strategic entry points for stakeholder engagement by providing learning opportunities for WROs, advocacy groups, and organizations working with young people on the fundamentals of SRHR.
4. **Collaboration and Complementarity.** The partners all had a courteous professional relationship with each other. It was evident not just in the partners' reports or the notes of the coordination meetings (Project Coordination Team), but especially in observations during the PLI. This cordial relationship was further seen in the elements of communication, coordination, shared schedules, and technical expertise.

CAT4SRHR Oxfam supported the partners' institutional development, which in turn helped significantly in how the partners implemented the interventions.

1. **Progress of Partners.** Partners had a positive view of the Capacity Assessment Tool for Sexual and Reproductive Health and Rights (CAT4SRHR) workshop and its ongoing process in positively affecting their organizations in a sustainable way
2. **Extent of How Far the CAT4SRHR has Achieved its Objectives.** The partners gave an average modal score of 7[1] for the project, and for the partners in both pillars. The partners justified this during discussions by pointing out that there were still pending activities and transitional factors to consider in their own organization. This was particularly applicable to organizations that joined the project at a later stage. It is important to note that while partners appreciate the immense value of the CAT4SRHR (this came out in the self-assessment questionnaires), they were still realistic in their respective achievements and progress. In addition to this, the partners cited the unprecedented circumstances brought on by the COVID-19 pandemic for the low rating.

MEL The Monitoring, Evaluation, and Learning (MEL) systems followed the iterative learning process of continuous self-improvement of Oxfam. It was cited as significant in guiding the direction of activities, especially during the first year of COVID-19. It helped the partners successfully pivot and capture changes.

1. **Assessment of the Strengths of MEL as Applied in the Project Sites.** Partners were well-guided on the application of quantitative data collection and collation through online platforms, which made data management easier. Quantitative indicators were clear, and time bound. The PMF was a very efficient way to generate quantitative sex and age-disaggregated data required in the output indicators, as noted by the MTE team. The variances were easily identified, and corrective measurements were proposed. Collaboration between partners went beyond stakeholder engagement and technical expertise. One example is how Jhpiego shares its access to municipal level data to Mayon Integrated Development Alternatives and Services (MIDAS), which does not have its own baseline data on disaggregated sex and age groups.
2. **Effectiveness of MEL Systems in Capturing Gender Sensitive Data.** Partners agreed that sex- and age-disaggregated data on SRHR were adequately captured by the project's MEL system, and consciously applied by partners. The MTE team, however, noted that there was no explicit quantitative indicator on capturing data on GBV, but some indicators capture outputs related to GBV which allows for further improvement.
3. **Use of Project Monitoring Processes and Activities as an Effective Management Tool.** The PMF was cited as a strong project management tool which still has room for improvement, particularly along the lines of data privacy protection, as not all partners have a system and process in place.
4. **How Learning Is Documented and Communications Systems Improved.** Overall, learnings were documented and disseminated to project intermediaries and drivers of change through creative forms. Stories and lessons generated from the project were shared and converted into more palatable formats like infographics, video shorts, photo essays, and policy briefs. Pivoting research data into easy-to-understand content made it easier to disseminate information to various groups and individuals. This offered, and continues to offer, an opportunity for partners to learn from each other.

[1] The Self-Assessment Questionnaire or Tool has a score rating system of 1 to 10, with 10 being the highest.

RECOMMENDATIONS

The recommendation portion of the MTE report focused on what areas to continue and what to do more of. There were no reflections on what to do less of. This validated the conclusion of the findings – that there were no intractable issues that forced a change or a change in direction, but rather a need to deepen how strategies and approaches can be further improved. This section draws not only from the MTE findings and analysis, but also from relevant recommendations of various data sources, principally from SHE documents reviewed.

DESIGN

1. Continue Doing
   - The finding that there has been no change in the assumptions, Theory of Change, and results framework despite external conditions confirmed that the design of the SHE Project went through an intensive consultation process with partners. This ethos of placing partners in the "driver's seat" is commendable and should be continued.

1. Do More Of
   - Provide a continuous and systematic solid grounding on the project context and content to ensure that everyone is on the same page
   - Identify and/or map out and intensify the adaptation of good practices, strategies and protocols, where applicable
   - Assess how the issue of unpaid work of carers can be addressed. It was determined in the key findings that household tasks and priorities limited the participant engagement in activities, as explained in the main body of the report. This can provide a collaborative opportunity with partners and their allies, or addressed as an issue to help strengthen the research-advocacy link. This recommendation is more extensively discussed in the MEL section.

IMPLEMENTATION

1. Continue Doing
   - Provide flexibility in making adaptative adjustments during implementation.
   - Support resource sharing among partners and continue to encourage a systematic process that cultivates such an environment. There were potential opportunities for collaboration such as research and competencies that can be learned from each other, like advocacy through social media. One example would be collaborative research on exploring the link between SRHR and livelihoods.
   - The active and sustained involvement of judiciously selected peer educators, local partners, and community leaders was crucial to sustain project benefits and successes and promote project sustainability. One example of this is the contribution of Indigenous Peoples' leaders in reaching out to remote and conservative communities, and how to empower staff to discuss sensitive topics.

2. Do More of
   - Work through and with allies and among partners to address community level queries on Sexual Orientation, Gender Identity, and Gender Expression (SOGIE) issues, including related issues such as metal health and body dysmorphia.
   - Strengthen the links between grassroots advocacy and national efforts. A more systematic and purposive strengthening of such efforts to ensure that advocacy impact is reinforced would be helpful. An area to explore would be the increase of male involvement, and the integration of a bolder and clearer power perspective to the role men and boys. Facilitating the process with the Commission of Population and Development's (POPCOM's) Kalalakihang Tapat sa Responsibilidad at Obligasyon sa Pamilya (KATROPA) and the Department of Social Welfare and Development's (DSWD's) Empowerment and Reaffirmation of Paternal Abilities Training programs and bringing them to the grassroots level is another opportunity.

- Embark on concerted action to ensure that Teenage Pregnancy and GBV are top priorities when working with and through partners and allies.
- Ensure that project communities have access to a systematic and well organized SRHR and Gender Transformative Products, such as localized IEC materials, guidance on how to communicate SOGIE issues, and contacts of allies. This will complement the awareness raising and capacity building activities provided.

CAT4SRHR

1. Continue Doing
   - Build on online learning endeavors to anticipate hybrid working arrangements in the new normal. Some work has already been done in terms of blended learning (i.e., synchronous, and asynchronous sessions) by some partners and can be shared with others.
   - There is a need for continuing assessment of the partners' level of implementation of their action plans, including weak areas that need improvement. Oxfam could provide guidance and technical support for a shared template and process, including an indicator to gauge improvement and status by end-of-project.

2. Do More Of
   - Refresher sessions for continuous professional development and improvement. It would be advantageous to partners to have regular but short, invigorating refresher sessions to upgrade their technical competencies. This would empower them and help effectively implement Project Partnership Agreements within their institutions. Outside of their institutions, the partners can be drivers in their areas of change and cascade the capacity to their covered community influencers and leaders.
   - Systematic Quality Assurance processes of SHE Training/Outputs to be put in place to ensure consistency of content. The end view is for the project partners and intermediaries to gain and present coherent but strategically effective knowledge and communication products. This means all materials share a similar strategy and are based on human rights frameworks, even as each partner creates Information, Education and Communication (IEC) materials in their local languages for their specific contexts.[1]
   - Skills development for all partners on techniques and good practices on advocacy and policy influencing. This is best done with Local Government Units (LGUs) to help influence their plans and social accountability approaches. An example of this is the work done by partners in Bicol and BARMM where technical support is provided to LGUs, and plans are in place to assess existing Gender and Development Plans respectively.
   - Project teams mentoring of the partner organizations on the technicalities and various aspects of running an effective program, given the intensified pace of project activities that have yet to be delivered.

MEL

1. Continue Doing
   - Use of the PMF tool as it was consistently raised by the partners as a solid and reliable project management tool.
   - Continued guidance from Oxfam on reporting and documentation to capture qualitative information from different beneficiary groups.
   - Conduct of Data Quality Assessments to ensure proper recording of project outputs.

2. Do More Of
   - Assess if resilient sensitive pathways on MEL that have been informally practiced by partners can be documented. If not, Oxfam's Framework for Resilient Development can provide a practical guide if seen as relevant by the MEL practitioners among the partners and Oxfam.
   - Continuously check the activities' contribution to the Theory of Change as an additional process to track changes. This will require frequent learning loops and can be embedded into the Project Coordination Teams (PCTs) or in dialogues with partners to cover two aspects: learning by doing and putting learning into practice.
   - Potentially form a technical working group of SHE MEL officers who meet outside of PCT meetings facilitated by Oxfam to optimize the expertise of partners. One of the issues to start to collaborate on would be an explicit indicator on GBV data, though partners agree that gender sensitive and age-appropriate data on SRHR are adequately captured. Optimization of partners' competencies could also include closer collaboration between WGNRR and the University of the Philippines Center for Women and Gender Studies (UPCWGS), because in Pillar 2, UPCWGS is assigned a research role whereas WGNRR is the policy advocacy link.
   - Enhance the tools of Qualitative data such as the impact story outline. There is a need to revisit the outline to ensure that minimum basic information is completed, and users can easily fill up the form. Journaling methods and the use of "rolling" stories or qualitative panel data[2] strategies can be examined.
   - Invest in IT capacities and digital tools that aid in reporting new technological innovations. Partners and Oxfam can investigate this potential.
   - Strengthen the policy research link. An example is intensifying WGNRR and UPCGWS' collaboration especially on the national advocacy for SRHR, ensuring that the policies needed are advocated for. This could lead towards strengthening or amending existing laws, legislation, and ordinances for women's rights. New laws and policies can also be passed with the support of legislative studies. On a related issue[1], there is also a need to strengthen the monitoring of policy change and implementation since this is a continuing and iterative process. Oxfam could provide the technical assistance.
   - Ensure that all partners have a system in place for data privacy protection. Data protection was already raised in the Oxfam pulse survey training, and some partners do have a Data Privacy Officer, but not all partners have the same resources. There is also no unified process that the partners can agree on.
   - Improve the accessibility and user-ability of the online SHE Resources Hub. The hub should be open to SHE partners, and later on to its allies for sustainability. This allows for a wider audience to access resources based on lived-in experiences, and contextualized to either fit the needs of the audience, or act as guidance notes in the development of knowledge products.
   - Improve the PCT to accommodate the partners' needs on a systematic learning and reflection activity. This can take the form of "brown-bag sessions" or encourage cross learning sessions among partners. This peer learning activity can be considered "Magaan pero malaman" (translation: light but substantive), with learning outcomes in mind but leaving adequate space and time for discussions.
   - Plan Early for a Robust End line Study and Project Evaluation. While this is already scheduled in the PMF, it would be helpful to initiate thinking among partners as early as now.

[2] Longitudinal qualitative panels are instrumental in observing changes in consumer behavior when affected by life changes.

INITIATIVES DEMONSTRATING POTENTIAL FOR GREATER IMPACT

- Oxfam is in a prime position to further lead as a thought leader-facilitator for the SHE Project, given the reach of its resources, networks, and experiences. With the headway it has made, Oxfam needs to continue to anticipate the needs of the project vis-à-vis policy and other external changes.
- Multi-stakeholder involvement and engagement is a key skill of all SHE partners. There is a wealth of stories and experiences shared that attests to this. It is important to ensure that multiplier agents such as influencers, LGUs, rural health units (RHUs), implementing partners, and the beneficiaries themselves are appropriately identified. Their roles as multipliers should be determined as well as if such groups are within the spheres of influence by partners.
- Activities under CAT4SRHR will not only continue to impact not just the project integrity and robustness of the organization's institutional development and governance, but also lead to robust SRHR programming.
- Built-in sustainability mechanisms need to be continuously updated, especially those with LGUs and RHUs as they can have maximum impact after the project life. Experience shows that project gains can be sustained if the LGUs incorporate it into their development priorities with funding allocation. The Gender and Development fund is one clear funding source but not the only one. Forward planning that is part of the sustainability plans proactively anticipate the Mandanas[3] ruling affirmed by the Supreme Court. The Mandanas ruling strengthened decentralization, and a result, social service delivery was improved. Actively influencing budget allocations for SRH activities can help to address longer-term structural reforms.

CONCLUSION

The SHE Project has all the essential elements to influence and promote key learnings, further in-depth research, and strengthen policies on gender and SRHR. The project can assure that the mid-term reflection and review reap the benefits of careful and intentional planning and strategic selection of partners. These two form the keystones that allow SHE to thrive as it has, to learn more of itself and the deep value and legacy its partnership model can bring to gender and SRHR. From here on, it will be necessary to strengthen the MEL processes so its Theory of Change continues to be relevant and anticipate the project needs and adjustments, given policy changes in the horizon and the elections in May 2022.

[3] As a result of the Mandanas versus Ochoa Ruling by the Supreme Court in 2018 and 2019 (G.R. No. 199802, July 3, 2018 and April 10, 2019), the Internal Revenue Allotment are programmed to increase by 55 percent in the 2022 budget, reaching Php1.08 trillion or 4.8 percent of the country's gross domestic product compared to 3.5 percent of GDP in 2021.


Photo credit: Inmiego (2021)

1. INTRODUCTION

The Sexual Health and Empowerment (SHE) project is a five-year engagement of the Global Affairs Canada (GAC) in partnership with Oxfam Canada. It is also in collaboration with Oxfam in the Philippines (OiPh), and twelve (12) other local women's rights organizations (WROs)[4] , civil society organizations (CSOs,) and international partners in the Philippines. The project seeks to empower women and girls to secure their Sexual and Reproductive Health and Rights (SRHR) in six (6) disadvantaged and conflict-affected regions of the country. Its objectives are to (a) improve knowledge and awareness of SRHR, particularly among women and girls, including the prevention of gender-based violence (GBV); (b) strengthen health systems and community structures to deliver rights-based, comprehensive Sexual and Reproductive Health (SRH) information and services; and (c) improve the effectiveness and capacity of WROs and women's movements to advance SRHR and prevent GBV.

The project's two (2) pillars are interconnected through an integrated and multi-faceted socio-economic approach in its Theory of Change:

- Pillar 1: Engaging rights holders, community members, and health care practitioners to support gender-responsive and youth-friendly SRHR information and services, and promote positive gender and sexuality-related norms, which improve health-seeking behavior; and
- Pillar 2: Building knowledge and strengthening the capacity of WROs, institutions, and alliances to influence and advance the full implementation of SRHR-related laws, policies, and programs.

A midterm evaluation (MTE) was conducted to assess the project's continued relevance of interventions and its progress towards achieving its planned outcomes. Specifically, the MTE will provide the project with a basis for identifying appropriate actions to: (a) address issues or problems in implementation, and (b) reinforce initiatives that demonstrate the potential for greater impact. Implementing partners engaged in the implementation of these MTE are as follows:

[4] Tarbilang Foundation was not included in the MTE as it ended their engagement with the SHE Project in 2021. This is reflected in Table 1 and explained further in the Methodology section

Table 1. List of Current SHE Implementing Partners

PILLAR 1: Responsible for delivering activities in the target provinces and municipalities	
MIDAS	Mayon Integrated Development Alternatives and Services Bicol provinces: Masbate, Sorsogon
FPOP	Family Planning Organization of the Philippines Samar provinces: Northern Samar, Samar
PKKK	Pambansang Koalisyon ng Kababaihansa Kanayunan Zamboanga provinces: Zamboanga Del Sur, Zamboanga Sibugay N. Mindanao provinces: Bukidnon, Misamis Occidental
AMDF	Al-Mujadilah Development Foundation (now AMWA) BARMM: Lanao Del Sur
SIKAP	Sibog Katawhan Alang sa Paglambo Caraga provinces: Agusan Del Norte, Surigao Del Sur
UnYPhil Women	United Youth of the Philippines Women BARMM: Maguindanao
Jhpiego	Johns Hopkins Program for International Education in Gynecology & Obstetrics Provinces: All catchment sites of Pillar 1
PILLAR 2: Grantees generate research and knowledge, advocacy, influence laws and policies	
DMSFI	Davao Medical School Foundation Inc.
Friendly Care	Friendly Care Foundation
UPCWGS	University of the Philippines Center for Women and Gender Studies
WGNRR	Women's Global Network for Reproductive Rights

1.1. OBJECTIVES OF THE MIDTERM EVALUATION

The MTE was conducted for the SHE Project to assess its continued relevance towards prevailing SRHR disparities in the project regions and provide an opportunity to make modifications to ensure the achievement of the project outcomes. The MTE provided a basis for identifying appropriate actions to: (a) address issues or problems in implementation, and (b) reinforce initiatives that demonstrate the potential for greater impact. The MTE focused on assessing the assumptions, strategies, and drivers of the Theory of Change as described in the SHE Project Implementation Plan. Specifically, the aims were to:

1. Assess whether the project's assumptions described in the Theory of Change are holding true in the new context.
2. Assess whether the project's strategies, as described in the Theory of Change, are still effective in the new context.
3. Identify any obstacles that are hindering quality or implementation, and recommend practicable solutions that can be implemented during the remainder of the project.
4. Identify lessons learned and examples of best practices in SRHR from project partners; and
5. Facilitate cross-partner exchange of experiences and learnings.

1.2. COUNTRY CONTEXT

Since March 2020, major cities and provinces in the Philippines have been in various stages of community quarantine with regulated non-essential travel to prevent the spread of Coronavirus disease 2019 (COVID-19) infection within communities. The Department of Health (DOH) and Commission of Population and Development (PopCom)[5] reported that routine healthcare systems were disrupted due to the prioritization of COVID-19 services. This was a main challenge in accessing SRHR services, reinforced by additional barriers such as lack of finances and transport, the closure of clinics, restricted movements, and fear of infection. Furthermore, implementers of the Responsible Parenthood and Reproductive Health Law faced challenges heightened by the COVID-19 pandemic, such as: 1) insufficient human resource for full implementation of essential health services due to reassignment of health staff to COVID-19 response; 2) limited access to basic health services, due to restricted operating hours, conversion of some facilities as dedicated COVID-19 hospitals, and limitations in transportation; 3) misconceptions and fears on immunization, family planning side effects, and HIV/AIDS stigma among its users due to lack of or poor counseling; 4) increased barriers to healthcare-seeking behaviors due to mobility restrictions and fear of contracting COVID-19; and 5) record-keeping, surveillance and reporting measures were hampered as existing resources were tapped to perform COVID-19-related tasks. While the government itself emphasized the continued delivery of essential reproductive health services including maternal health care[6], the failure to address the weaknesses of the healthcare system as a whole and to systematically implement reproductive health-related policies has led to the deprivation of SRHR services among women. In response, WROs and CSOs have repeatedly asserted that women's access to essential SRHR information and services remains critical in responding to COVID-19.

[5] DOH and PopCom, 2021. Annual Report 2020: Responsible Parenthood and Reproductive Health Act of 2012. Manila, Philippines.
[6] As per Department Circulation 2020-0167: Continuous Provision of Essential Health Services During the COVID-19 Epidemic; Department Memorandum 2020-0222: Guidelines on the Continuous Provision of Family Planning Services during Enhanced Community Quarantine following the COVID-19 Pandemic

Even with the expressed support of the current government for SRHR programs and services before the pandemic, the Responsible Parenthood and Reproductive Health Law continuously faced major hurdles and delays in its full implementation. Yearly budget cuts on the Family Health and Responsible Parenthood programs (PhP4.27 billion in 2017 to PhP2.03 billion in 2020)[7] further reduced the delivery of SRHR services, particularly for low-income women who need it most. Comprehensive sexuality education, which is one of the law's provisions, remained shelved with the Department of Education at the expense of young people being deprived of making informed choices about their sexual health and well-being, with teachers yet to be trained on how to best deliver age specific modules. Meanwhile, increasing rates of HIV/AIDS, teenage pregnancies, and maternal mortality were alarming, with existing government programs deemed unsuccessful in curbing teen pregnancy. PopCom had to urge President Rodrigo Duterte to declare adolescent pregnancy a "national emergency" [8] . Poverty, the lack of comprehensive sexuality education in and out of schools, poor access to sexual and reproductive healthcare, sexual and GBV, sex trafficking, and forced marriages were seen as the major drivers of teenage pregnancy.

Key barriers such as low awareness of SRHR, limited decision-making power among women and girls, societal norms and values on SRHR, policy related issues such as criminalization of abortion, and restricted parental consent requirements on access to SRHR services were identified [9,10,11,12] as further contributing to elevating teenage pregnancy to a "national emergency."

1.3. OVERVIEW OF PROJECT REGIONS IN NUMBERS

The disparities in SRHR and elevated levels of GBV are evident in the country's Geographically Isolated and Disadvantaged Areas (GIDAs), many of which are conflict-affected or disaster-prone. Teenage pregnancy rates, for example, are higher in rural versus urban areas. The percentage of adolescent women aged 15-19 who have begun childbearing is at 10% in rural areas, and as high as 15% in Northern Mindanao, as opposed to 7% in urban areas [13]. Within GIDA are compounded issues such as income insecurity, loss of livelihood, and lack of land rights and land disputes, which exacerbate women's and girls' vulnerability and ability to influence health outcomes. Evidence across a broad range of SRHR and GBV indicators in the project regions in the Philippines showed that women and girls faced numerous challenges in exercising SRHR even before the COVID-19 pandemic. Table 2 shows some SRHR and GBV indicators in the project regions.

Based on the Philippine Statistics Authority (PSA) report, the government sector is the most popular channel to access modern contraception. Barangay Health Stations serve twenty five percent (25%) of modern contraceptive users, with government hospitals (17%) and rural or urban health centers (12%) also prominent. By region, the unmet need for family planning of women is highest in Zamboanga Peninsula (25%). Women's reported experiences with violence inflicted by a partner varies widely by region.For example, seven percent (7%) of married women in the BARMM reported experiencing physical, sexual, or emotional violence committed by their last partner, compared to fifty two percent (52%) of ever-married women in Caraga who responded to the PSA survey. The report indicated that all forms of violence generally declined with increasing household wealth.

[7] DOH and PopCom, 2021. Annual Report 2020: Responsible Parenthood and Reproductive Health Act of 2012. Manila, Philippines.
[8] http://popcom.gov.ph/popcom-clarifies-moral-decadence-among-youth-not-the-reason-for-rise-in-teen-pregnancies/
[9] Oxfam, 2019. SHE Project Implementation Plan. Oxfam, Canada.
[10] Nagari, M. et. al., 2019. Opportunities Lost: Barriers to Increasing the Use of Effective Contraception in the Philippines, PLoS ONE 14(7).
[11] Devine, A. et. Al., 2017. Freedom to Go Where I Want: Improving Access to Sexual and Reproductive Health for Women with Disabilities in the Philippines. Reproductive Health Matters 25(50).
[12] Valerio, K and Parvez Butt, A., 2020. Intersecting Injustices: The links between social norms, access to sexual and reproductive health and rights, and violence against women and girls. Oxfam, Canada.
[13] PSA and ICF. 2018. Key Findings from the Philippines National Demographic and Health Survey 2017. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF.

Table 2. SRHR and GBV Indicators in 6 Project Regions in the Philippines

SRHR and GBV indicators Women (aged 15-49) Adolescents (aged 15-19)	Bicol	Eastern Visayas	Zamboanga Peninsula	Northern Mindanao	Caraga	BARMM	Whole Philippines
% Adolescent who have had live birth	4.0	5.1	6.8	11.6	5.7	6.8	7.0
% Women who use any method of contraceptives	51.3	58.8	49.5	53.5	54.8	26.0	54.3
Injectables	4.6	6.1	5.6	3.5	5.8	5.6	5.0
Implants	0.9	2.0	2.3	0.7	0.4	0.6	1.1
Pill	18.6	18.6	21.9	22.5	25.1	9.7	20.9
IUD	1.3	5.4	5.5	10.4	8.4	1.2	3.5
Male condom	2.3	1.7	1.9	1.7	1.4	0.2	1.7
Withdrawal	14.3	14.0	3.1	4.8	4.4	6.3	10.3
% of women demand for family planning	72.6	74.9	74.1	71.3	72.6	44.0	70.9
% of women with unmet need for FP	21.3	16	24.6	17.8	17.8	17.8	16.7
% Received antenatal care from skilled provider at least once	96.2	98.8	88.7	94.2	95.0	68.6	93.8
% Received pre-natal care	92.9	89.9	63.1	68.6	73.4	63.6	86.1
% of adolescent with knowledge about HIV	16.1	17.9	17.3	14.3	25.0	14.2	20.2
% of women who experienced abuse	43.3	43.2	43.4	22.6	51.8	6.7	26.4

Source: PSA and ICF, 2018.[14]

[14] PSA and ICF. 2018. Philippines National Demographic and Health Survey 2017: Key Indicators. Quezon City, Philippines, and Rockville, Maryland, USA: PSA and ICF.

2. METHODOLOGY

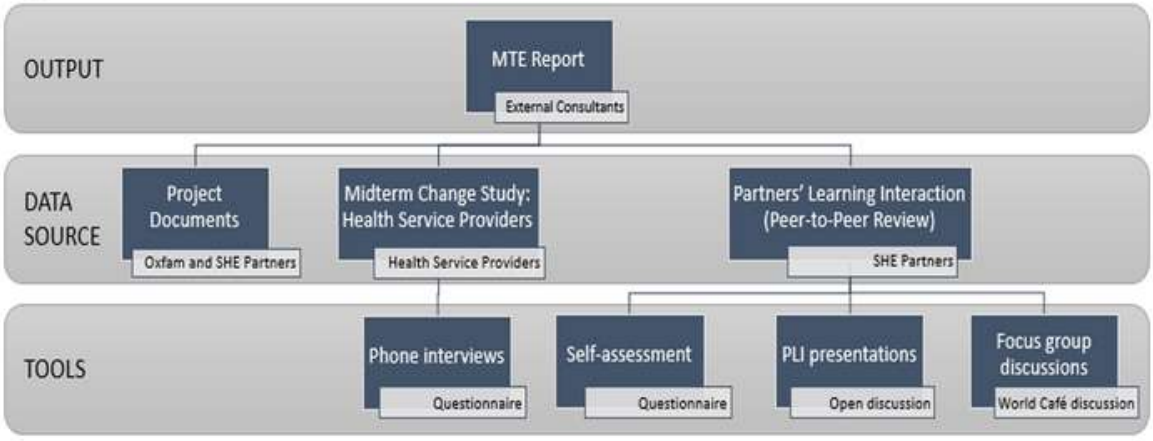
The MTE investigated all initiatives of the eleven (11) project partners (Pillar 1 - AMDF now known as AMWA, FPOP, Jhpiego, MIDAS, PKKK, SIKAP, UnYPhil-Women; Pillar 2 - DMSFI, Friendly Care, UPCWGS, WGNRR) to gain a broader picture and deeper understanding of the overall project management process and implementation.

Four (4) major areas of focus identified by Oxfam Canada for the MTE covering are (i) project design; (2) implementation; (3) capacity assessment; and (4) monitoring and learning. Key questions under each area were developed to guide the MTE process and analysis. The Feminist Principles to Monitoring, Evaluation, Accountability, and Learning of Oxfam and GAC's Results-Based Management methodology both required that project activities are designed, planned, and implemented using a participatory approach. Hence, the key questions were reviewed in consultation with OiPH and the project partners before data collection.

2.1. DATA COLLECTION AND ANALYSIS

The data collection tools used to gather the data requirements for this MTE included: (1) a desk review of relevant project documents available as of MTE period (August 2018 to August 2021); (2) midterm change study of health service providers in project sites; and (3) a peer-to-peer review process[15] (Partners Learning Interaction or PLI) including a self-assessment[16] questionnaire completed by each SHE partner (see Figure 1 for data source and data collection tools used for the MTE).

Figure 1. Data Sources and Data Collection Tools of the MTE



Desk Review The document review[17] was done at the early stage of the MTE utilizing internal project documents (e.g. Annual Reports, Baseline Report, etc **(see Annex 1 for list of documents reviewed).** The document review determined if implementation of the project reflected project outcomes and helped guide other data collection tools for the MTE. A data collection form was prepared to summarize data to help compile and analyze evaluation findings.

[15] OECD, 2003. Peer Review: An OECD Tool for Cooperation and Change. https://www.oecd-ilibrary.org/economics/peer-review_9789264099210-en-fr

[16] The self-assessment tool digs deeper and provides greater insight into how the partners have been implementing their respective parts of the SHE Project.

[17] CDC, 2018. Data Collection Methods for Evaluation: Document Review. https://www.cdc.gov/healthyyouth/evaluation/pdf/brief18.pdf

Midterm Change Study From August to September 2021, all fifty two (52) health service providers and managers who participated in the Rural Health Units (RHUs) Assessment [18] conducted in 2020 were contacted for a semi-structured qualitative interview. Eleven (11) health service providers and managers agreed to participate in the phone interviews, in lieu of face-to-face interviews, to gauge how much they have learned from the SHE activities -- what significant changes were observed, and what else is needed to meet the expected outcome of the project. The study intended to use the Most Significant Change method [19] for evaluation with the panel data. However, data was limited due to high attrition, hence results were presented as Stories of Change [20] . Ethical guidelines in research were followed during the data collection and gender sensitive approaches were observed as well. Consent was obtained from all participants before the interview, and they were made aware that any identifying information obtained in connection with the interview will remain confidential and will be disclosed only with the subject's permission.

Partners Learning Interaction SHE partners participated in the Partners Learning Interaction (PLI) from August to September 2021 to share their experiences, hear from a cross-section of partners about how they implemented the project, and provide their perspectives on the progress of the other partners' activities. This peer-to-peer review process was chosen because it was likely to be acceptable and manageable by all partners, and because it promoted cross-partner learning. A webinar was conducted by the external consultants with Oxfam and SHE partners to discuss the PLI process and finalize the key questions of the MTE **(see Annex 2 for Guide for Partners Learning Interaction).**

Table 3. Data Collection Tools, Data Sources, Sampling, Data Analysis and Interpretation

Data Collection Tool	Data Source	Sampling/Participants	Data Analysis and Interpretation
Semi-Structured Questionnaire	Management and staff of 11 SHE partners involved in the SHE project	43 management and staff - 4 directors - 10 project manager/ coordinators - 15 project officers - 4 MEL officers - 5 Administration - 5 community officers	A questionnaire was sent out to SHE partners before the Partners Learning Interaction to collect qualitative data and was synthesized according to the key learning questions.
Presentations and Open-Discussion (3 days)	Management and staff of 11 SHE partners Oxfam Philippines	11 presentations Day 1 - 31 participants Day 2 - 40 participants Day 3 - 34 participants	Collected data during presentations of SHE partners to answer descriptive questions about the activities of the project, the various results it has had and the context in which it has been implemented.
Online Focus Group Discussions using World Cafe technique[21] (9 days)	SHE partners focal persons and staff	11 focus group discussions 52 management and staff engaged in 5 webinars and	Peer-to-peer learning and review process which focused on achievements, best practices, strategies, activities, knowledge products and challenges of the SHE partners.
Individual interviews and report review	SHE partners	11 focal persons	Focused editorial sessions of the MTE report with focal persons of the SHE partners

[18]Jhpiego and Oxfam, 2020. Rural Health Unit Assessment Report.
[19] Davies, R. & R. Dart, 2005. The 'Most Significant Change' (MSC) Technique: A Guide to Its Use.
[20] Bailey, H., 2015. Stories of Change. Institute of Development Studies, UK.
[21] This involved a structured reflective conversational process to facilitate open discussion and link ideas. The small groups (like in coffee tables) discuss in response to a set of questions. The guide questions are predetermined and focused on the specific objectives of the review. The technique provides a small, safer, and focused space for implementing partners to share their experiences, perspectives, concerns and insights. The feedback/review forms will allow for collection of confidential comments and suggestions not mentioned during the discussions. (http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/)

Each of the SHE partners nominated a focal person from their organization to facilitate the activities and act as reviewers. Focal persons from two partners carried out the review on a third partner within their pillar group. Since Jhpiego works in all project sites, it participated in all reviews for Pillar 1 partners. Four (4) stages of the PLI followed **(see Table 3 for the data collection tools used during the four stages).** Activities were conducted candidly and in a collegial manner, relying on mutual trust and cooperation among project partners. Exchanges in an open manner among peers facing similar challenges were valued. External consultants accompanied each evaluation process, organized meetings, stimulated discussion and worked closely with the reviewers.

Qualitative content analysis[22] was used to organize and elicit meaning from the data collected. Data are presented in key focus areas based on the key questions. A manifest analysis[23] was used to describe what the data sources say, staying close to the text to describe the visible and obvious in the text.

Deductive disclosure or internal confidentiality was practiced following the principles of research ethics[24] . This means confidentiality was strictly observed especially upon answering the self-assessment questionnaire or tool, and partners were given the opportunity to leave questions unanswered. The aim of the self-assessment tool was to dig deeper and provide greater insight into how the partners have been implementing their respective parts of the SHE in their respective pillars and project sites. The questionnaire or tool was guided by key questions adopted by the SHE Project MTE TOR document, refined and finalized in consultation with the project partners and Oxfam prior to data collection. The questionnaire or tool contained a mix of open-ended questions as well as questions requiring responses against a rating or scoring scale. **(See Annex 2 for further details)** Rating scales are utilized for their ability to allow quantitative measures to be applied to more abstract, subjective sentiments. Satisfaction, experience, perfection, and feeling were difficult to quantify, and a rating/scoring scale is useful to measure performance or effectiveness. The rating/scoring scale is measured with 1 being the lowest and 10 being the highest. The responses of the partners are taken collectively, and the average score is mentioned in the key findings section.

2.2. SCOPE

Tarbilang Foundation was not included in the MTE as it ended its engagement with the SHE Project. They were not involved in the peer-to-peer review. Their outputs for Year 1 to Year 3, however, were included in the beneficiary count.

OiPh ensured the timely availability of requisite SHE Project documents for review. This report notes that analyses for the MTE was largely derived from the Comparative Statistical Analysis of the Baseline, Pulse, and Midline Surveys[25] . The document gauges the interest of beneficiaries in the main areas of project intervention from baseline to midline.

Data collection, interviews, and surveys did not include Oxfam Canada and OiPh in the peer-to-peer review process, as agreed upon. As part of the review team, Oxfam Canada and OiPh reviewed the activity guidelines and questionnaires for approval. Evaluation of Oxfam Canada's role and management in the project was out of scope. However, it was agreed to engage them for the final evaluation.

[22] Bengtsson M, 2016. How to Plan and Prepare a Qualitative Study using Content Analysis. NursingPlus Open 2:8-14.
[23] In a manifest analysis, the researcher describes what the informants say, stays very close to the text, uses words themselves and describes the visible and obvious in the text
[24] https://www.apa.org/monitor/jan03/principles
[25] Morales, R. and Chacon, J., 2021. SHE Comparative Statistical Analysis of Baseline, Pulse and Midline Surveys. Oxfam, Canada.

The scope of what the MTE team can and cannot do is outlined in its terms of reference. As such, the key findings and evaluation reflects a facilitative approach wherein observing, reflecting, generating ideas and data during the interview process, seeking patterns, and identifying next steps and consensus building are key aspects.

2.3. LIMITATIONS

Cognizant of the threat of the highly contagious COVID-19 Delta variant in the country, restrictions and travel protocols on non-essential activities were tightened and some project areas even experienced frequent and/or extended lockdowns. All activities and data collection of the MTE were done remotely.

For the midterm change study, despite repeated follow-up to health service providers, the resulting attrition from the baseline sample is high. The Philippines was intensively rolling out COVID-19 vaccinations all over the country, and health service providers had to prioritize vaccination efforts, and setting up phone interview appointments with them proved problematic. At the same time, health service practitioners were already interviewed for the GAC semi-annual monitoring and OiPh monitoring for the annual report, hence many health service providers chose not to be interviewed again. It was clarified by Jhpiego that their refusal was due to a general assumption that they had already been interviewed for the MTE specifically, which they were not.

[19] Bengtsson M, 2016. How to Plan and Prepare a Qualitative Study using Content Analysis. NursingPlus Open 2:8-14.
[20] https://www.apa.org/monitor/jan03/principles
[21] Morales, R. and Chacon, J., 2021. SHE Comparative Statistical Analysis of Baseline, Pulse and Midline Surveys. Oxfam, Canada.

3. KEY FINDINGS

3.1. HIGHLIGHTS

The main data sources for this section are (i) the Self-Assessment Questionnaire completed by SHE partners specifically in response to the key MTE questions; (ii) PLI presentations and focus group discussions (see Annex 3 for report); (iii) combined findings culled from the SHE Project documents reviewed for the MTE (see Annex 1 for list); and (iv) findings in the Midterm Change Study: Health Service Providers (see Annex 4 for the report). The key findings highlight the 4 major sections being evaluated which were the project design, implementation, Capacity Assessment Tool for Sexual and Reproductive Health and Rights (CAT4SRHR), and monitoring, evaluation, and learning.

Based on the Performance Measurement Framework (PMF) of the Year 3 Annual Report of SHE (October 2020-March 2021), the MTE team noted that most of the outcomes, outputs, and activities scheduled during the period captured were either completed, on schedule, or to be implemented despite project lags on a few of the immediate outcomes and outputs. Delayed indicators were the following: (a) perspectives of targeted population on positive attitudes that promote women's reproductive autonomy; (b) perceptions of partners on their capacities to generate knowledge on women's rights; (c) number of WROs/networks reporting on at least two (2) improved influencing skills; and (d) total facilities that meet at least 80% of standards for youth-friendly and gender-sensitive services.

These delayed indicators were mainly due to the rescheduling of activities, and movement or transfer of some activities to Year 4 upon agreement with Oxfam. However, the MTE team highlighted the fluctuating attitudes of the target population regarding the promotion of women's autonomy where project lag was most evidenced. This co-relates to a comparative analysis done by the team on the Baseline, Pulse Survey, and Midline Survey where there was a reduction in the positive attitudes especially among men and boys, as shown in the SHRH Index indicators. The MTE team also admitted to falling short of this target in the Year 3 Annual report, although it is worthy to note that girls had far exceeded the target out of the rest of the group. While recommendations were provided in the midline and pulse surveys, it is vital to the project design to be vigilant of fluctuations from here on. The partners and Oxfam can also reexamine how its high-level stakeholder engagement can contribute to a shift in positive attitudes of SRHR and gender.

3.2. EXTENT OF HOW ACTIVITIES/OUTPUTS HAVE LED TO ACHIEVEMENTS

The Table 4 below investigates how mutually reinforcing the indicators were showing the cohesiveness of its theory of change.

INTERMEDIATE OUTCOME	IMMEDIATE OUTCOME	HIGHLIGHTED ACTIVITES AND TARGET REACH
Enhanced utilization of gender-responsive sexual and reproductive health information and services (public and private) by women of reproductive ages, adolescent girls, and boys	Increased knowledge, skills, and capacity of women, girls, and boys regarding their SRHR Improved positive attitudes modeled by women, men, girls, boys, and influencers in support of SRHR information and services Improved capacity of the public and private health systems to provide comprehensive and gender responsive SRHR information and services	• 30,699 direct beneficiaries were reached since the start of the project (58% of which were women and 19% are girls) • Staff of 11 SHE partners, 9,449 beneficiaries and health service providers were trained as change agents • 19,767 (41% of total target) people were reached through different activities conducted by SHE partners and peer educators, local community facilitators, and barangay health workers. • 27 Information, Education and Communication (IEC) materials were produced on SRHR, and social norm change for women, men, girls, boys, and influences • 253 community sensitization and mobilization conducted with influences on gender, SRHR and GBV prevention

- 17 RHUs (100% of target) assisted to create space with audio-visual privacy and record of SRHR counseling
- At the time of the assessment, 21 RHUs (124% of target) supported with three modern methods of family planning including at least 1 long-acting reversible method
- Six activities for alliance building and networking for organizations working on SRHR and GBV as indicated in Pillar 1.

KEY FINDINGS

1.Awareness-raising activities such as workshops and trainings were effective in terms of changes in knowledge and attitude among community members on GBV and SRHR. SRHR issues and concerns were discussed, misconceptions were corrected, and those with differing beliefs joined SRHR dialogues. The midline survey[26] reported an overall increase in positive attitudes toward SRHR in project sites which correlated positively with a rejection of early marriage. Girls have a higher increase in rejection of early marriage than women (**see Annex 6a for highlights of the midline survey**).

2. Stories collected from health service providers (**see Annex 4 for details of the Midterm Change Study: Health Service Providers**) trained by the project, included positive changes in individual skills and behavior toward clients which in turn had a multiplier effect on family and the community. The enhanced qualities of the trained individual included their ability to transfer basic concepts of SRHR information and existing services to other members in the family and community. The varying changes noted were enhanced knowledge and skills in family planning methods, attitudinal and behavioral change in support of SRHR information and services, enhanced self-confidence, and the ability of health service providers to influence clients. A reflective thinking process in the training brought self-awareness and introspection and helped health service providers to be

[26] Morales, R. and Chacon, J., 2021. Comparative Statistical Analysis of Baseline, Pulse and Midline Surveys. Oxfam, Canada.

comfortable in fulfilling their responsibilities as caregivers and SRHR providers, regardless of their personal beliefs. Health service providers were also certain that awareness-raising and delivery of services had benefited men and women and adolescent girls and boys in the community. The success was attributed to outreach activities that SHE supported and the continuous supply of family planning commodities. The outreach activities guaranteed access to SRH in remote areas and reduced referrals to the municipal health office for contraceptive implant services. It enabled health service providers to reach new villages or barangays and increased their visits to administrative areas. Also, health facilities were able to promote their services and provide referrals and hotlines, and this increased the uptake of services.

3. The Adolescent SRHR program in health facilities successfully expanded the scope and reach of SRHR services for adolescents. It created an enabling environment, which included confidentiality, to enhance adolescents' access to and use of SRHR services. It strengthened the capacity of health facilities to provide age appropriate, comprehensive, and scientifically accurate information and services for SRHR. For adolescents, the use of IEC materials, especially the flipcharts, were seen as highly effective in sensitizing clients. Based on data from DOH's Field Health Service Information System, twelve (12) of the twenty-one (21) municipalities covered by the SHE Project successfully reduced their teen pregnancy rate in 2020[27].

4. Counseling in a private safe space, prior to service provision, proved to be essential in terms of reinforcing women and girls' decisions. Women and girls were guided in their desire to shift methods from traditional to modern family planning, and from short to long acting or permanent methods. This facilitated an informed and well thought out decision-making process, enabling women to gradually develop self-confidence, leading to self-initiated and determined personal goals. Health service providers adopted a more client-centered approach to counseling and were finding themselves more understanding of their clients' circumstances and needs. For example, the techniques enabled them to be more sensitive and compassionate, as opposed to being judgmental, in their line of questioning. This encouraged adolescents to respond more instead of being defensive. Responses led to identify and understand if female clients were coerced by her partner, and a more empathetic stance was developed as a result. Unmet need on Family Planning services for women in the project site was reduced by 18% from 2019 to 2021 [28].

5. The technical assistance to national and local government units (LGUs) on Gender Planning and Budget, Harmonized Gender and Development Guidelines and other capability-building activities led LGUs to consciously integrate Gender and Development Plans and Budgets allocation on SRHR that included funding for reintegration program for survivors of Violence Against Women and Children (VAWC), capacity building and training, family planning programs to reduce teenage pregnancy, and logistic support for SRHR sessions organized by Sangguniang Kabataan.

6. Increased capacity among the local community facilitators and peer educators correspondingly led to increased self confidence in influencing their respective communities as far as SRHR is concerned. They were able to create an encouraging environment for the women to articulate and utilize SRHR services. The same is true among the youth peer educators. A number of them have initiated their own activities and even coordinated with other youth groups from different barangays. Empowered women and youth peer educators and facilitators have started forming their own advocacy groups for SRHR.

[27] Morales, R. and Chacon, J., 2021. Comparative Statistical Analysis of Baseline, Pulse and Midline Surveys. Oxfam, Canada.
[28] Oxfam, 2021. SHE Year 3 Annual Report. Oxfam, Canada.

INTERMEDIATE OUTCOME

Improved effectiveness of WROs to advance rights related to sexual and reproductive health and prevention of gender-based violence

IMMEDIATE OUTCOME

Technical assistance provided for improved management and coordination of SRHR and GBV prevention services

Strengthened capacity of WROs/CSOs to generate knowledge to influence policy and practice on women's rights, particularly on SRHR and GBV prevention

Improved ability of WROs and networks to promote women's rights and influence policy makers on SRHR and GBV prevention

HIGHLIGHTED ACTIVITES AND TARGET REACH

- Three (3) learning events or initiatives to support or establish a community of learning and practice
- Ten (10) advocacy strategies and 26 activities implemented for SRHR and GBV accountability improvement
- Two (2) sets of knowledge products developed for dissemination: SRHR lecture videos and module on Feminist 101
- Eleven (11) SHE partners received institutional strengthening grants

KEY FINDINGS

1.All eleven (11) SHE partners received an institutional strengthening grant and were at various stages in implementing the activities. Through the Capacity Assessment Tool for Sexual and Reproductive Health and Rights (CAT4SRHR) process, partners were able to identify the strengths and weaknesses of their organization and their capacity needs. There was positive feedback of the tools and CAT workshops and its potential impact on partner organizations. Some partners have expressed plans to continue using the methodology. The effectiveness of continuing this methodology is not captured in this report as it is still being applied. Among the projects taken up by partners, SHE is the only project that emphasized capacity building of staff to become more effective change agents for women's rights.

2. Prior to the pandemic, direct advocacy with legislators was implemented through sub-partners and regular interactions with legislators and key staff. The project was able to continue advocacy through a webcast-type event, engaging key legislators towards building them as an advocacy champion, particularly on adolescent reproductive health.

3. The project through WGNRR and its various partner CSOs and WROs developed a sign on statement in 2020 derived from multi-stakeholder consultations, mobilizing support from WROs and other organizations to demand that SRHR remain essential in the pandemic response from the governments and other response actors. As part of the International Day of Action for Women's Health campaign, the statement was sent to relevant agencies and disseminated to the media. The statement was picked up by major news outlets online. Due to the visibility of the petition accomplished by WGNRR and its partners, on May 28, 2020, the DOH released the issuance of Interim Guidelines on the Continuous Provision of Family Planning and Maternal Health Services during COVID-19 Pandemic.
4. The learning events helped participants reflect on the importance of a rights-based approach in their research design and data collection methods. As a result, three (3) organizations submitted research proposal on SRHR and GBV. Also, initial findings from research studies helped contextualize SRHR and GBV issues which were used to develop knowledge products such as infographics, and will further be integrated into IEC materials, briefers, and policy documents for both Pillar 1 and 2 advocacy and influencing activities.

Synthesized information from the table shows substantial changes have occurred and continue to occur in the areas of community norm setting, health-seeking behavior of women and girls, health service provision, and articulation and increased understanding of laws and policies in the covered communities. These are four (4) of the five (5) areas of change in the project's Theory of Change.

The fifth area of change planned for the upcoming year involves (a) continued advocacy through social media and webcast events; (b) the coordination and partnership between CSOs and WROs resulting in steadily influencing legislators and government agencies; and (c) increasing the degree of collaboration through WROs for advocacy campaigns. Activities on building advocacy, influencing skills, and implementing advocacy strategies to improve the ability of WROs and networks, and better promote women's rights and influence policymakers on SRHR and GBV prevention, have already been agreed upon and mapped out with the partners.

3.3. COMPARATIVE STATISTICAL ANALYSIS OF BASELINE, PULSE, AND MIDLINE SURVEYS

To track trends in project outcomes, three (3) population-based surveys were undertaken by the project: baseline survey (2019), pulse survey (2020) and midline survey (2021). Please **see Annex 6a** for a summary of the surveys that showed the changes in the SHE Project's outcome levels in project sites through the first three (3) years of implementation. While not part of the MTE per se, it was note-worthy to include the comparative statistical analysis study [29] conducted in July 2021. The study was conducted by an external consultant to further understand how Oxfam utilized the data to better understand its beneficiaries (**see Annex 6b for summary of the report**). The comparative statistical analysis indicated positive changes in the community after project strategies, such as awareness raising campaigns and community dialogues, were implemented. For example, partners have worked closely with influencers to address misconceptions and myths about family planning and combat early marriages. Young people were informed, through peer education sessions, about their right to decide whom and when to marry. The following positive changes in project sites were observed:

- Increase in positive attitudes in the SRHR index (respondents' feelings regarding key aspects of SRHR and related issues) was positively linked to a rejection of early marriage among girls. All age and sex groups (women, men, girls, and boys) in the project sites showed an eleven percent (11%) increase in rejection of early marriage for girls under 18 years old from the baseline to the midline survey.

[29] Morales R. and J Chacon, 2021. Comparative Statistical Analysis of Baseline, Pulse and Midterm Surveys. Oxfam, Canada.

- Increase in positive attitudes regarding sexual and reproductive health was positively linked to a better attitude towards women's reproductive autonomy (use and the choice of contraceptives) for girls from the pulse to the midline survey (1% increase). When using the "who decides the number of children a woman should have" indicator, the percentage of girls who considered it their personal decision increased (4%) from the pulse survey to the midline survey.
- For men and boys, a substantial increase (30% between the baseline and midline survey) in sexual negotiation and communication indicator implied that men and boys were openly discussing and being comfortable in talking with women and girls about sexual relations.
- There was an eleven percent (11%) increase in respondents who discussed family planning with their partners. About ninety five percent (95%) of the women who declared using contraceptive methods also consulted their partners. In the Philippines, spousal communication on family planning affects the decision on whether to continue using a method. Frequent discussion of family planning issues between husband and wife is positively associated with contraceptive use and lessened the probability of discontinuation [30].

3.4. PROJECT DESIGN KEY FINDINGS

3.4.1 CHANGES TO THE PROJECT'S ASSUMPTIONS, STRATEGIES AND DRIVERS

SHE defined their ultimate outcome as improved SRHR for women and girls in GIDA in the Philippines. This definition of the outcome suggests that changes were anticipated for women and girls, and the transformative change needed to reach the intermediate outcome includes men and boys. SHE's Theory of Change identified important assumptions, which were:

- Exposing influencers and youth to more positive gender and sexuality-related norms supported attitude and behavioral changes
- Improving women's and girls' awareness of SRHR and the availability of services will enable better access and use of these services
- Fostering leadership potential within women and adolescent girls will support shifts towards positive norms that model gender equality
- Engaging men and boys in support of SRHR/ending GBV can lead to changes in attitudes, norms, and behaviors; and mitigate the possible risk of backlash to the changes in SRHR that the project is promoting
- Improving the awareness and skills of health service providers can shift hostile attitudes and behaviors among service providers to improve quality of SRH services; and attract and maintain clients
- Improving the capacity of project partners contribute to more effective work to promote SRHR and prevent GBV
- SRHR-related projects, advocacy, and influencing are more effective if these efforts are evidence based.
- Alliance building among WROs and CSOs is integral in advancing SRHR advocacy and influencing efforts
- Full implementation and/or advancement of SRHR and GBV related laws and policies provides a more enabling context for women and girls to realize their rights

These assumptions were treated against the local conditions that the project underwent, the key findings from the PMF, and the drivers of change.

The **local conditions** have changed since the inception of the project due to COVID-19 being a once in a generation event. However, the MTE team ascertained that the SHE Project's Logic Model, Theory of Change, and assumptions remained unchanged from inception to Year 3 of reporting.

[30] Laguna, E. et al., 2020. Contraceptive Use Dynamics in the Philippines: Determinants Of Contraceptive Method Choice And Discontinuation. Population Institute University of the Philippines, Quezon City, Philippines.

Annual reviews found good reason to continue to pursue multi-pronged interventions that simultaneously addressed community norm setting, health seeking behaviors, adaptable SRHR service provision, organizational capacity, and social accountability. Project implementers and partners at all levels exerted their utmost efforts to discharge their functions and kept their commitments as drivers of change by adapting to the continuously changing situation.

The Year 2 and Year 3 annual reports detailed the pivot in terms of approaches to the strategies that the partners undertook for the COVID-19 pandemic:

A. COVID-19 Pandemic. Everyone was unprepared and forced to respond to the changing environment brought about by the COVID-19 pandemic. Below are several responses partners identified and extracted from the PLI and the annual reports which coincided with the DOH and PopCom[31] identified threats to accessibility of SRHR services:

- There were insufficient human resources for full implementation of SRHR services and activities in project sites. Many health service providers and staff of local government units (LGUs) and Philippine National Police were reassigned to prioritize COVID-19 response. This resulted in limited access to SRHR services and activities due to limited operating hours, conversion of some facilities as dedicated COVID-19 hospitals, limitations on transportation, and prohibition of group gatherings.
- Increased barriers in seeking and accessing SRHR services due to mobility restrictions and fear of contracting the COVID-19 disease were experienced everywhere.
- Due to financial stress during the pandemic, communities deprioritized SRHR needs and instead shifted their major focus, especially among men, to livelihood programs and activities.
- There were prevalent cases of violence against women and children (VAWC) during lockdown, but not all were reported due to the culture of silence in the communities the project are working on. The SHE midline survey[32] reported that only a small number of women were willing to share experiences of GBV with an interviewer.
- All partners were forced to partially or fully transition to digital platforms due to mobility and group gathering restrictions. While this was useful for the continuity of their respective project implementation and stakeholder engagement, partners noted that it affected their learning capacity and engagement as Zoom fatigue became a common issue. Limitations on the use of digital platforms included participant disengagement or loss during the workshops due to fatigue or lack of proper digital infrastructure or gadgets. The lack of human interaction in online platforms presented a challenge. People's body language and expressions were not captured, making ways of engagement difficult.

B. Derived from the partners' exchanges, the MTE team noted that all partners along with various stakeholders shifted their approach to activity delivery to address the reduced face to face interactions and mobility restrictions. These were documented as follows:

- Use of technology and internet-based applications was helpful in reaching out to conduct training activities, despite the limitations of digital platforms. Partners switched to some combination of virtual coordination with stakeholders in local communities and some activities became virtual sessions where internet access was stable with limited face-to-face interactions. These included virtual mentoring/supervision of peer educators and virtual monitoring of field activities. Several media and digital tools were utilized and depended on with increasing frequency, such as the use of social media, IEC materials, and radio programs.

[31] DOH and PopCom, 2021. Annual Report 2020: Responsible Parenthood and Reproductive Health Act of 2012. Manila, Philippines.
[32] Morales, R. and Chacon, J., 2021. SHE Comparative Statistical Analysis of Baseline, Pulse and Midline Surveys. Oxfam, Canada.

- **Reduced participant numbers and more sessions** were conducted in batches or tranches, aside from virtual activities for those that needed physical assemblies, where applicable. Larger venues were identified to maintain social distancing and hand sanitizers were provided while always maintaining local Inter Agency Task Force for the Management of Emerging and Infectious Diseases guidelines.
- **Limited facility-based activities** to avoid participants' travel and co-mingling with participants outside their municipality.
- **Hiring local consultants** to assist in the coordination with participants and local partners for research activities enabled CSO partners to remotely continue with activities despite mobility restriction.

Other external events did not change the assumptions nor the strategies essentially but imbued the project's mandate with a sense of urgency and relevance.

C. **Alarming prevalence of teenage pregnancy caused the Philippines to declare it** as a national emergency. President Duterte issued Executive Order No. 141 in June 2021, declaring the prevention of teenage pregnancies as a "national priority." [33] There was an increase in cases of unplanned teenage pregnancies in nine (9) project sites[34]. This highlighted the need to improve girls' and boys' awareness of SRHR and the availability of services. With this, several legislative reforms on teenage pregnancies, early and child and forced marriages, and amendment of the Revised Penal Code to lower the age for statutory rape were needed. It led to new bills filed by SRHR advocates in Congress, as well as local ordinances and supportive reforms on the ground.

D. **Gender Based Violence.** PopCom commissioned the Social Weather Station survey[35] , as reported on Women's Day last March 2021. The survey showed that 1 in 4 adult Filipinos committed harmful acts of various forms to women and 77 percent were violations of the Anti-VAWC[36] law, or the intimate partner-relationship category. Based on accounts of the Philippine National Police in the yearly Responsible Parenthood and Reproductive Health report, there were 19,743 recorded cases of violence against women in 2019, before the pandemic. This was reinforced by observations and feedback coming from intermediaries and influencers in the project communities which suggested that there was increased risk of violence against women and girls. Increased risk and incidence of unplanned and teenage pregnancies likewise showed a worrisome upward trend as the pandemic surged on.

E. **Unstable peace and order situation in some project areas**. Aside from the encounter between armed groups and the military in some areas, land disputes forced indigenous communities to evacuate their areas which affected the program's reach. Some SHE activities had to be done in evacuation centers.

F. **Emerging beneficiary concerns**. Newly expressed concerns in project sites including cisgender, gay, and heterosexual men experiencing body image issues, body dysmorphia, and other mental health concerns were uncovered during the participants' discussions and creation of outputs.

[33] Philippine News Agency, June 29, 2021. Addressing teenage pregnancies declared as 'national priority.' https://www.pna.gov.ph/articles/1145373
[34] Oxfam, 2021. SHE Year 3 Annual Report. Oxfam, Canada.
[35] https://www.pna.gov.ph/articles/1133079
[36] Republic Act No. 9262 entitled "An Act Defining Violence Against Women and Their Children, Providing For Protective Measures For Victims, Prescribing Penalties Therefore, And For Other Purposes"

Overall, both Pillar 1 and Pillar 2 partners experienced unforeseen challenges. Nonetheless, there was consensus among project partners that the project design more than addressed its objectives and relevance in the Philippine context as shown by the results of the self-assessments accomplished. With a modal value at 8, and no values lower than 7 on a scale of 1-10 in their respective self-assessment questionnaire or tool, the result showed that the partners found the "fit" of its pillars and the selection of intermediaries and beneficiaries as appropriate. Original assumptions of the Theory of Change remain the same, although some emerged as more urgent during the COVID-19 pandemic and others more challenging in implementation.

The MTE team examined if the **drivers faced any challenges** in achieving the planned outputs and outcomes.

- **SHE Pillar 1 and 2 Partners** SHE partners were encouraged to participate in activities organized by other partners, accomplish their own planned activities, submit reporting requirements, and attend monitoring and evaluation meetings mostly at the same time. This was seen as a project management challenge to accomplish and prioritize simultaneously. More importantly, field coordinators and project officers were still vulnerable to COVID-19 exposure, as they were the frontliners for the project, especially with new variants coming in such as the Delta and Lambda variants. Another challenge was the difficulty of capturing the attention and focus of participants and partners in online activities. Though resource persons made sure that interactive activities were included in the training design, difficulties of keeping participants engaged and ensuring that they are learning from each workshop or module was a monumental balancing act.
- **Government** The changing political scenario and new governance in BARMM delayed the deliberation and approval of the Gender and Development Code which in turn affected the timing of implementation of the partners' advocacy. The Code included provisions on the elimination of child early and forced marriages.
- **Health Service Providers** The healthcare system was overwhelmed because of the COVID-19 pandemic response. This affected the number of health service participants to activities under Intermediate Outcome, yet capacity building and coordinated activities were still delivered. The following general challenges were observed by the MTE team through the documentation review:
    - **Surface or basic understanding of SRHR**. To some health service providers (and duty bearers), SRHR was associated with family planning only. It was difficult to explain and simplify what SRHR was all about in local languages. Extensive explanations in the local context were needed to make them understand, but the health service providers usually do not have the time to fully grasp the concept, given their added responsibilities to respond to the pandemic. As a result, they did not understand the full scope of SRHR, and consequently did not give proper attention to the issues on SRHR. Remedial sessions might want to be considered depending on a rapid assessment of their knowledge.
    - **Delay in activities** led to loss in momentum among health service providers, especially since SRHR was deprioritized with the pandemic response given more importance. Such a project lag was addressed in the catch-up plan developed by Jhpiego.

The MTE team did note, however, that SHE faced different challenges in engaging beneficiaries and securing active support and participation.

Women were the main beneficiaries of the SHE project, yet participation in activities was challenged due to their multiple responsibilities around the home. They were preoccupied with household chores since most were primary caregivers and had no reliever from household responsibilities. They often brought their children along during SHE activities or were unable to join scheduled activities when they could not find relievers. Continually involving them in SHE activities was a challenge. There is an opportunity here to engage with partners on how to better address unpaid care work – GAC has a new Care guidance note[37] that the SHE Project can investigate.

[37] Canada's feminist approach to addressing unpaid and paid care work through international assistance. https://www.international.gc.ca/world-monde/issues_development-enjeux_developpement/priorities-priorites/fiap_care_work-paif_prestation_soins.aspx?lang=eng

In terms of access to SRH services during SHE activities, unequal decision-making powers within couples were observed. Women conceded they had to consult their husbands for contraceptive use, while some disclosed experiences of GBV. This was also reinforced in the results of SHE's Comparative Statistical Analysis of the Baseline, Pulse and Midline Surveys[38] **(see Annex 6a** for summary) where a sizable percentage of women who currently use any contraception method answered that they jointly decide with their husband (98% in the baseline and 97% in the midline). While unpaid care work was not directly addressed by the SHE Project although it was acknowledged as a systemic barrier, the MTE team recognized an opportunity for partners to take this on as part of their advocacy. The MTE team received the GAC guidance note[39] on how these can be applied to the project, and while it is not addressed directly during the period of the MTE, it is recommended by the team for Oxfam and its partners to investigate the issue further. The GAC document provided helpful guidance in areas such as developing evidence-based data, and suggestions such as taking an intersectional approach to assess care related inequities, acknowledge caregivers as rights-holders, and establish the responsibilities of duty bearers.

Men The COVID-19 pandemic made life economically difficult for many families in the communities. Job displacement was a problem for a lot of men, forcing them to take odd jobs that may require extended working hours compared to their previous jobs. Thus, gathering/mobilizing them in awareness raising activities was more challenging compared pre-pandemic.

Moreover, there was a segment of men-participants who lacked the enthusiasm and willingness to learn their responsibilities. This was seen in their responses and body language such as an unenthusiastic nod, side comments (i.e., "If these are the laws for women, what are the laws for men?"), or facial expressions. In discussions with project partners, it was concluded that resistance to notions of gender equality needed further[40] sensitization strategies and ramped up activities. Only through several more engagements did men become more amenable, especially when engaged with male facilitators.

This further reinforced the correlation indicated in the Comparative Statistical Analyses of the Baseline, Pulse and Midline Surveys [41]document, that men demonstrated a drop in the acceptance of women's reproductive autonomy and greater variability in attitude towards SRHR, with a drop in the pulse survey and increase in midline survey. Further analysis showed that reduction in positive attitudes among men towards women's reproductive autonomy was linked to a possible negative reaction to seeing women become empowered by having access to information about their sexual and reproductive rights[42].

Adolescents The shift in school methodologies, i.e. online and modular, caused limited participation in the project activities in some areas in Mindanao, as COVID-19 protocols were restrictive to children and adolescents. For boys, one of the main causes for the non-participation was due to helping the family in farm labor, with most livelihoods affected by the COVID-19 pandemic.
Parental consent, as per government policy, was required for minors to access contraceptives, unless the minor had been pregnant before. The requirement for parental consent limits the privacy and confidentiality rights of minors who want contraceptives, in turn severely restricting adolescents' meaningful choice of and access to contraceptives.
Girls were made to be solely responsible for contraceptive use and yet faced social stigma if they ever got pregnant. When they do get pregnant, it was observed that they had to drop out of school

[38] Morales, R. and Chacon, J., 2021. SHE Comparative Statistical Analysis of Baseline, Pulse and Midline Surveys. Oxfam, Canada.
[39] The guidance note was issued in November 2021
[40] Morales, R. and Chacon, J., 2021. SHE Comparative Statistical Analysis of Baseline, Pulse and Midline Surveys. Oxfam, Canada.
[41] Oxfam Canada noted in reviewing initial versions of the MTE report that such a reaction was anticipated in its Theory of Change
[42] Philippine Statistics Authority. 2017 Civil Registry and Vital Statistics

and more likely be engaged in early marriage compared to boys. On the other hand, there were reported case stories of teenage girls getting impregnated by much older men, which was more worrisome. The MTE team ascertains this might be a long-standing trend that needs to be addressed after the MTE phase. This has already been mentioned as early as 2017, where only 3% of the teenage pregnancies are fathered by men of the same age group [43].

The MTE team **saw no significant change in both the assumptions and strategies**. Based on the key findings however, strategies needed to be purposive in its inclusion approach when it comes to men, boys, and issues raised on beneficiary concerns. This was raised as well during the PLI activity where partners discussed the need for an inclusionary approach to engaging men and boys as well as seeking guidance on the appropriate way to respond to queries on the ground regarding on Sexual Orientation, Gender Identity, and Gender Expression (SOGIE) issues.

3.4.2 COMMON UNDERSTANDING OF SRHR CONCEPTS AMONG PROJECT IMPLEMENTERS

There were no irreconcilable differences or challenging cases found by the MTE team. During the PLI, the partners discussed how to arrive at a collective understanding of SHRH within the project itself. This was understandable given that (a) not all partners were on board simultaneously as others came onto the project after its inception; and (b) the diversity in terms of mandates and technical know-how of the organizations meant that they had their own interpretation. However, by the end of the discussion, most had a clear understanding of SRHR concepts. For some, minimal differences existed due to context. This was apparent among Muslim partners who adapted their approach depending on their respective beneficiary target groups by contextualizing Islamic principles in their SRHR advocacies.

For example, part of SHE Project advocacy was that an individual can decide alone regarding her body. However, in the Muslim context, there were aspects wherein women, specifically married women, cannot access or use contraceptives without the support and knowledge of the husband. Women who needed contraceptives would be accompanied by their husbands to consult the health worker together with the aim to ensure the safety of the woman. In the case of the project as shared by partners, differences were managed by emphasizing the Islamic context of the issue in the project areas. Partners consulted with Muslim religious leaders to ensure that SRHR concepts were presented in a culturally sensitive way.

Among SHE partners, lively discussions centered on varying SRHR views, including who the appropriate users of birth control were (one question raised was if sexually active minors counted as appropriate users); abstinence as a form of birth control versus other forms of contraceptive methods; the stance on abortion; and perspectives surrounding teenage pregnancy. Different views were discussed through online dialogues. Online dialogues also included how perspectives would be recognized considering publication and dissemination (e.g., disclaimers, logo placements, etc.). The MTE team noted the prominent level of comfort of participants in discussing these topics with each other. Partners shared that Oxfam's Gender Officer provided the perspective of Oxfam.

3.4.3 WAYS IN WHICH SRHR CONCEPTS AND DIMENSIONS OF WOMEN'S REPRODUCTIVE AND SEXUAL AUTONOMIES COMPLEMENTED EACH OTHER

The project emphasized SRHR as being an important part of the basic and universal human rights. There was a conscious effort to link women's reproductive and sexual autonomy to SRHR, with women having the right to say "no" in situations where their sexual rights were violated. In advocacy campaigns, capacity building, and communication, the messages promote, defend, and advance SRHR so that women and girls are empowered to make autonomous and informed decisions. Also, SRHR concepts were integrated through research studies, online dialogues such as Conversations through Arts, and creative workshops. Creating this environment and space of diversifying views

[43] Gender Orientation is MIDAS' activity, introducing participants to basic gender concepts so that they may better understand SRHR and GBV and its relation to gendered and power relations.

and recognition of various lived realities helped participants to be more open to their situation, experiences, thoughts, and feelings.

Beneficiaries were made aware of different services offered for SRHR and GBV in various communication pathways. At the health facilities and during outreach activities, the team noted that reproductive health services were offered such as ensuring healthy pregnancy and childbirth. Sexual health and sexuality were respectfully approached in a positive way, such as through sharing messages regarding having pleasurable and safer sexual experiences, free of coercion, discrimination, and violence. Furthermore, advocating for male involvement in health seeking behavior and family planning were encouraged so that there would be a guided understanding for their families' health.

In developing strategies, the aim was to come up with gender transformational activities where SRHR concepts and dimensions of women's reproductive and sexual autonomies complement in organizational vision, mission, core principles and institutional policies, plans, processes, systems and procedures through review and revision (if necessary) of core principles, institutional policies, plans, and manual of operations.

To summarize the section on design, there were no changes in the assumptions, drivers of change or strategies. The partners however, learned how to pivot their approach to the strategies to implement the project activities. This, however, came with a steep learning curve for all partners in adjusting to asynchronous learning, the effects of which can be taken up further in the report.

While recommended interventions from the pulse and midline surveys were helpful on how concerted effort could be undertaken to raise positive perception of target groups - an intentional and systematic integration of an intersectional lens when it comes to implementation would likewise help in understanding this further. Two (2) factors brought up by the partners during the PLI support this - to better engage with target groups, especially men and boys, and to seek appropriate messages or communication strategies to respond to queries on the ground on SOGIE and mental health issues. Given that the partners work in diverse settings, this is a relevant tool to apply. Oxfam includes this as part of its feminist approach to influencing and is framed as thus: "Ensures that no one is left behind and the poorest and most marginalized, men, women, boys and girls, are given an equal voice and opportunity to shape the future".

The MTE team also noted the camaraderie and openness of the partners during discussions. There were no noted irreconcilable differences or disagreements within the partner when it came to the project design, PMF, and Theory of Change, but the experiences shared were certainly rich in how SRHR was successfully adopted in the project areas. While the PMF showed that most activities were on-schedule or were already agreed on to be accomplished with partners, there was a need to apply concerted and intensified effort and catch up on delayed activities.

3.5. IMPLEMENTATION

The section on implementation covers four key questions agreed upon with Oxfam on how the project was implemented, given its mandate and principles.

3.5.1. APPLICATION OF FEMINIST PRINCIPLES INTO THE IMPLEMENTATION

Documentation review of partners' reports and annual reports by the MTE team noted Oxfam's feminist principles which were aligned to GAC's framework, and which guided the SHE Project. The team observed how concepts such as anti-sexism, women's autonomy, choice, and empowerment were applied in the strategies and activities of the SHE Project given the diverse contexts of the project sites. It was significant to point out that the SHE Project was able to strategically select implementing partners at the grassroots level that were well integrated into the project sites for Pillar 1 and partners with wide networks for Pillar 2. This was crucial because the design of this project placed partners in the driver's seat. They determined the type of capacity strengthening

they required to carry out the activities of the project in line with their "nothing about me without me" principle. Complemented by their creativity, persistence, openness, and experience, the SHE Project was a showcase of how feminist principles can be applied in diverse cultural societal settings as long as partners and beneficiaries were given free rein to learn from each other and allowed to do their work.

The MTE team saw how the CAT4SRHR process valued the knowledge, expertise, and experience of each member of the organizations, giving them a space to share their experience and voice out their capacity needs. Awareness raising activities were used to shift social norms and attitudes toward SRHR, gender inequality, and GBV.

As they leveraged and relied on the different strengths and strategies of partners, feminist principles were applied in diverse ways. Examples derived from the partners' reports were indicated:

- Gender Orientation [43] was the foundation of each learning activity for MIDAS emphasizing that there was no justice without gender justice and equality. This made them easy targets for red-tagging[44] , as some linked feminism to activism, especially when challenging oppressive social structures. The MTE team raised this to Oxfam as an issue to be explored further with the partners on how to proactively address the links between feminism and activism, as this may come up in the target communities.
- Feminist principles were deeply embedded with project objectives and practiced by the teams through project implementation. Oxfam's principles brought more details and practicality to FPOP's own gender inclusivity framework.
- AMDF's (now Al-Mujaadilah Women Association or AMWA) approach was to advance women's rights and prioritized women, especially the vulnerable women sectors (women of reproductive age (WRA), teenagers etc). They found discussing women leadership a challenge among participants. This was addressed this by intentionally seeking out gender champions who were respected and credible Muslim religious leaders in communities.
- UnYPhil-Women strengthened their partnership within BARMM through the Bangsamoro Women Commission and CSOs, or International Non-Government Organizations, to incrementally influence lawmakers. In the draft Bangsamoro Gender and Development Code, they lobbied for some of the provisions such as the elimination of child early and forced marriages and respecting the rights of the lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ).
- Jhpiego ensured that all its regional coordinators were trained on Gender Transformation for Health as facilitators, and all key staff on gender and health perspectives. This aided not only in the roll-out of gender training activities but also gender-responsiveness approaches spilled over to the workplace.
- Friendly Care and DMSFI of the Pillar 2 organizations did not have feminist principles as a foundation, but they planned to include these principles in their institutional policies and respective programmatic activity designs.
- As for UPCWGS, the team's core principles were already rooted in feminist theories, inclusive development, and recognition of intersectional needs and identities, and could contribute to Oxfam's approaches.
- WGNRR used a feminist lens, along with rights-based and justice framework, in addressing SRHR issues, with a particular focus on the marginalized. They shared many of Oxfam's identified feminist principles and this was most apparent in their materials and messaging. Their partners were also requested to ensure that all activities and messages were collaboratively

[43] Gender Orientation is MIDAS' activity, introducing participants to basic gender concepts so that they may better understand SRHR and GBV and its relation to gendered and power relations.
[44] The act of labelling, branding, naming and accusing individuals and/ or organizations of being left-leaning, subversives, communists or terrorists (used as) a strategy… by State agents, particularly law enforcement agencies and the military, against those perceived to be 'threats' or 'enemies of the State.

formulated to be connected to the experiences of historically, economically, socially, physically, and/or geographically marginalized populations. Organizationally, WGNRR applied feminist principles by ensuring care ethics guide expectations and dealings among the staff.

3.5.2. INCLUSION OF SHRH CONCEPTS AND WOMEN'S RIGHTS DIMENSIONS IN IEC MATERIALS, TRAINING MANUALS, AND INFLUENCING MESSAGES

Given the robustness and creativity of how its diverse partners integrated feminist principles and concepts, it was worthy to showcase the inclusion of SRHR concepts and women's rights dimension into IEC materials, training manuals, and influencing messages. Discussions with the partners revealed that they developed and utilized their own IEC and training materials. They would often use or reference publicly available training materials that they have access to from DOH, PopCom, and international organizations.

These materials underwent a quality assurance by the partners and were reviewed and adapted to SHE activities to ensure gender sensitivity and responsiveness. While this hands-on and pre-emptive approach is commended by the MTE team, they agreed with the partners during the PLI that it raised a lack of project identity and consistency. It would be helpful for partners to have some common IEC and training materials or manuals that can be recognized as SHE Project branded documents. This will further solidify the SHE SRHR advocacies among the partners.

Below are some examples of how partners included SRHR concepts in their products and materials as derived from partners' discussions and reports:

- MIDAS adjusted its training module on Gender Sensitivity to reduce the heteronormativity and binary thinking. They integrated SRHR as part of human rights in their Communications Strategy.
- PKKK tools subscribed to feminist pedagogy and popular education principles putting people, particularly women and girls, at the center of conversations. The processes encouraged them to speak, so their importance, dignity, and rights were affirmed, catalyzing them to recognize their potential to change the situation.
- Those operating in mostly Muslim areas anchored their advocacies on Islamic teachings by engaging with credible Muslim religious leaders as writers and champions to educate SRHR and GBV principles. This bolstered the confidence of staff to engage with communities on sensitive issues. IEC materials and training manuals were designed with the objective of increasing the awareness of SRHR in the context of Islam. This included GBV prevention and increased understanding of how essential SRHR services were in taking care of one's reproductive health – all of which were essential to being a good Muslim. Through AMDF's consultation with credible Muslim religious leaders, six (6) sermons or khutbah on SRHR and GBV were developed, as well as a booklet that served as an IEC material for COVID-19, SRHR, GBV, Mental Health and Referral hotlines. This booklet was reproduced and distributed to different areas along with the hygiene kits provided by Oxfam as part of its COVID-19 response. Furthermore, development of SHE Project materials were consulted with AMDF leaders to ensure key messages were in line in advancing the advocacy of the project.
- For partners who recently joined the project after its inception and yet to develop IEC and training materials, they relied (or will rely) mostly on those shared by the SHE partners or from materials shared by Oxfam resource persons/consultants.
- SRHR concepts, feminist principles, and women's rights dimensions were incorporated in the development of UPCWGS' knowledge products (i.e., production of infographics, video shorts, and policy briefs) based on the objectives, results, and conclusion of their research studies. Results were discussed and brainstormed between the core SHE team and the researchers.

- WGNRR reviewed materials as a team to ensure that they were guided by frameworks in line with their mission and mandate to connect and strengthen movements for SRHR and justice. They also reviewed their partners' materials to make sure there were no contradictions. Through partnership meetings and activities like the SRHR write shop conducted for those who contributed to Pasya ("decision" or "choice" in English) Advocazine, the team endeavored to provide space for partners and contributors to be part of the review process.

The MTE team welcomed the diversity of the materials reviewed and developed as well as the initiative of the partners. It was agreed that Oxfam would provide guidelines to facilitate the quality assurance process with partners.

3.5.3. MANAGEMENT OF IMPLEMENTATION CHALLENGES

The MTE team compiled general implementation challenges as consistently reported by partners in their documents. Most of the challenges were standard of implementation challenges and consistent with the PMF progress. It was interesting that no challenges were observed in terms of activities that involved shifting positive attitudes among boys, girls, men, and women, either in the reports of the partners or during the PLI. It showed that agreed interventions that focused on engaging men and boys was a unanimous approach to be undertaken by all partners. There were no unintended outcomes based on the discussions and reviews shared. It was more of fine-tuning approaches to project implementation.

Duplication of Efforts Given that most of the partners strategically identified had similar mandates, it was not unusual for duplicated efforts to take place especially during implementation (i.e., conduct of Enhanced Usapan of local CSO partners that were in some cases not properly coordinated with Jhpiego and the RHU). Groups were formed with various names but have similar functions (i.e., GBV Watch Group is similar to the Multidisciplinary Team of the LGU).

As a result, some activities were required to be rescheduled and managed through proper coordination with Jhpiego. Similarly, with the Multidisciplinary Team and GBV Watch Group, coordination was needed to identify how to complement each other as the Multidisciplinary Team operated on a municipal level and was often represented by national agencies, whereas GBV Watch Groups focused on barangay and purok level.

Level off on Community Expectations It was natural when engaging or mobilizing communities that there was a risk of creating expectations outside of the project's scope, such as economic and livelihood needs. Others sought forms of assistance that were beyond the scope of the project such as food relief assistance, livelihood assistance, and emergency vehicles or ambulances. Most partners were able to resolve this by leveling off on expectations at the start of project orientations and being consistent with their messaging.

Availability of health partners and service providers Given the bandwidth of health partners due to COVID – 19 and the demands on their time and skills, activities would be readjusted, and altered. Meetings replaced face-to-face visits to continue project activities while house-to-house activities replaced group gatherings. The MTE team considered that moving forward a hybrid approach can be utilized -- mix of limited face to face and virtual – this, however, was dependent on COVID -19 cases in the area and with the participants' consent.

Project Spillover Partners considered GBV and SRHR widespread issues and advocated for this in their other projects aside from SHE. UnYPhil-Women was a prime example that ensured that all its staff of different projects were familiar with the issues so that they can integrate these within their respective project advocacy (i.e GBV and SRHR issues in livelihoods, disaster response, protection related projects. While this allowed additional beneficiaries to be reached beyond the specified target numbers because of the project (i.e. spillover), the MTE team flagged this with Oxfam's monitoring and evaluation on how to consistently ensure that data on this is captured by the partners.

Budget Realignments and activity shifts Altered timelines and newly adopted methodologies due to COVID-19 resulted in budget savings that necessitated budget realignments. Shifting to online modalities, for example, allowed WGNRR to include strategies that were not originally in the plans such as creating a social media channel, creating webcasts, publishing magazines digitally, and adjusting workshop methodologies to online delivery. This included subscribing to online platforms and tools. With this, they were able to reach organizations and local government institutions outside the National Capital Region.

3.5.4. INVOLVEMENT AND STRATEGIES OF DIFFERENT LEVELS OF STAKEHOLDERS

As was on par with the project, there was increasing engagement with key stakeholders over the past three years, especially project partners in Pillar 1. Based on a review of the documentation provided on training manuals and coming from the partners' reports, this added greater depth or richness into the content of such engagement, giving better perspective to the mandate and agency of the stakeholders. There was a noted progression or "leveling up" from promoting the project and increasing awareness about SRHR issues, to largely getting their commitment to, and active participation in project activities. Field officers commented that this experience was more evident with women and girls than with men and boys, and with the public sector and community or women leaders, than with private and religious entities.

The identification of strategic partners was a compellingly successful element of the partnership model of the SHE Project. Upon documentation review, it showed that there was a mix of strong local and grassroots organizations, including those with a wide reach in terms of alliance building, and those who are competent in diversifying their strategies to reach out to different sectors and stakeholders.

Examples of this can be seen on different modalities of partnership engagement with multi-stakeholders, and this was generally based on the experiences, expertise, and depth of relationships cultivated by the organizations. Partners in BARMM, for example, participated in government processes within the Regional RH Implementing Team. Others were existing partners in local health boards and technical inter-agency meetings that contextualized advocacies to mainstream SRHR.

WGNRR saw strategic entry points for stakeholder engagement by providing learning opportunities for WROs, advocacy groups, and organizations working with young people on the fundamentals of SRHR. The SHE Project supported WGNRR's capacities, which in turn opened more opportunities to reach out and work directly with national and local organizations and institutions. They hosted a national event in partnership with the Philippine Commission on Women (PCW). This allowed both organizations the space to share advocacy priorities and through the opportunity, align their priorities with the United Nations Commission on the Status of Women. Through their webcasts and public engagement activities, they engaged with key government agencies, such as the DOH (Family Planning Program), PopCom, PCW, and Center for Gender Equality and Women's Human Rights, Commission on Human Rights of the Philippines. They also engaged with CSOs and advocates, such as Filipino Nurses United, Young Advocates for SRHR, Girls4Peace, and SHE partners from FPOP, PKKK, and the Philippine Legislators' Committee on Population and Development.

JHPIEGO's multi-stakeholder collaboration with health facilities, other SHE partners, and multiple government agencies proved to be essential in bridging information and available services to the communities. Trainings offered to health service providers resulted in improved knowledge on SRHR, positive changes on individual skills and behavior toward clients, and enhanced ability to transfer SRHR information and services to other people in the communities. Family planning outreach, awareness-raising, and delivery of services conducted by the RHUs benefited women and adolescents in the community. At least three (3) modern methods of family planning, including a long-lasting reversible method, were available in the facilities and outreach activities. According to health service providers, Jhpiego's assistance resulted in an increase in clients and a reduction in teenage pregnancy. For GBV, Jhpiego established one referral mechanism and a multi-discipline team (Social work, Philippine National Police, RHU).

Advocacy through stakeholder engagement involved the three (3) elements of self, individual, and systems advocacy. It was vital to undertake high level engagements and participate in multi-stakeholder advocacies because there was power in coming together. At the same time, it was equally relevant to determine how such achievements impact and flow down to influence its respective communities.

3.5.5. COLLABORATION AND COMPLEMENTARITY

Partners under Pillar 1 were responsible for delivering activities in their respective target provinces. Only Jhpiego provided technical leadership in all target provinces to improve the quality of health services. Partners and Jhpiego collaborated and complemented their respective activities, wherever applicable. It was evident not just in the partners' reports or the notes of the coordination meetings (Project Coordination Team), but especially during the PLI, that the partners had a courteous professional relationship with each other. These were seen in the elements of communication, coordination, shared schedules, and technical expertise.

Some partners under Pillar 2 who were brought in after the inception phase of the project were understandably looking for collaborative entry points to work with others. They saw the importance of collaboration and complementarity, especially during meetings, to synergize individual efforts in project implementation. For instance, UPCWGS supported by sharing their collaboration experience with Young Feminists Collective and Feminist Media Lab with one of the SHE partners, WGNRR, in certain online discussions.

Across Pillars, Pillar 1 partners engaged in Pillar 2 activities throughout the project. UPCWGS capacitated participants from SHE partners (FPOP, MIDAS, AMDF, PKKK, SIKAP, WGNRR and Oxfam) in their Feminist Research 101 on feminist epistemologies, research methods, and ethics. SHE partners also actively participated in WGNRR campaigns, such as the May 28 International Day of Action for Women's Health, where the partners organized their own local activities around the Day of Action. Inputs of SHE partners were also valuable in guiding WGNRR's creation of knowledge products. SHE partners were featured in WGNRR online activities such as webcasts and fora. This indicated the strength of the partnership model which sees partners mobilize in increasing frequency on shared advocacies and technical experiences, rather than being limited to being participants to another partner's events.

One can see the eventual building blocks of coalition building from this partnership model. Agendas were specific, individuals from each organization worked well together, and were also good at building bridges based on the examples cited earlier. The partners focused on setting an agenda that feeds the direct strategic needs of their organizations and simultaneously connected to the public interest or common good. The MTE team noted that the partnership acts using a variety of communication strategies and activities. There was also a coordinative system through the PCT for addressing feedback on the use of different strategies, tools, and suggestions on managing all the moving components such as key response actors or policy-related issues.

> Regular coordination of Jhpiego and FPOP proved efficient in the conduct of activities, and each complemented the work of the other, sharing different expertise needed in the conduct of different activities of the project. There was also a shared calendar of activities of both Jhpiego and FPOP with the partner government agencies to ensure a well-coordinated delivery of activities. Regular planning as part of the coordination meetings helped in the successful delivery of activities. There was also a professional culture of check and balance where both partners check on each other and provide constructive and objective criticism for improvement.

PCT meetings were used as a platform where partners for both Pillars 1 and 2 collaborated to see the bigger picture of the program status as it relates to the achievement of the intended outcomes. Partners shared project progress, plans, and best practices, and were encouraged to share knowledge and interact with each other. Participants of the PLI felt the PCT meeting was a good avenue for concerted coordination to reflect prioritization for the direction of activities. Instead of individual coordination, SHE partners collaborated as a team to reach a consensus towards a collective direction.

In conclusion, **there were no notable or intractable challenges to the project implementation**. While not seamless in working together from the onset, there was a natural progression towards collaborating and a "tightening" of partnership dynamics through shared experience and expertise. The MTE team noticed how partners answered the operational question of how technical concepts such as feminism, reproductive autonomy, and gender were applied. The partners answered by inter-relating these concepts with justice and human rights and implementing them in diverse contexts where societal norms seemingly push back against such principles. The team saw the partners' sensitivity on the ground and recognition of their own competencies and that of their peers – there was a continual embrace of sharing and self-improvement. It was important to ensure that communities' level off on expectations, especially given the economic difficulties being experienced, and expectations that any project in communities brings some economic value. At some point this must be addressed by the partners. Advocacy efforts that attempt to seek a balance between high level engagement and visibility as well as impact and influence on communities will also be a continuing point of discussion.

3.6. CAT4SRHR

Oxfam supported the partners' institutional development which in turn helped significantly in how the interventions were implemented by the partners. According to the Project Implementation Plan (PIP), the CAT4SRHR was originally developed for Oxfam's Engendering Change program and later adapted for SRHR. The tool supported partners in identifying their capacity strengthening needs, and in designing a context-specific action plan to build their own capacity.

The following section assesses the progress made and feedback from the partners themselves.

3.6.1. PROGRESS OF PARTNERS IN THE IMPLEMENTATION OF CAT4SRHR

In general, partners had a positive view of the CAT4SRHR workshop and its ongoing process in positively affecting their organizations in a sustainable way. This came out in the individual responses of the self-assessments and validated through the PLI. The CAT4SRHR process supported the partners' development and strengthened not only their own standing as an organization, but also created drivers of change. It also enabled partners to effectively discharge their pillar functions, responsibilities, and commitments.

The approach to this capacity building was expected to further result in better SRHR programs for the organization, for the SHE Project's implementation, and for other SRHR projects that the organization may also be implementing in other areas, and even beyond the project life. As assessed by the MTE team, the provision of CAT4SRHR benefited the partners in the following ways:

- The organizational capacity assessment and knowledge gap analysis were fundamental processes carried out as part of the CAT4SRHR. The partners acknowledged that these were done in a progressive manner that allowed them to better understand their organizational needs, what capacities or competencies they need to support it and in doing so, better respond to their SRHR programming.
    - Organizational capacity assessment was acknowledged as a sturdy foundation of the CAT4SRHR process to better address how to undertake SRHR programming. It allowed partners to objectively identify gaps in mainstreaming gender and SRHR in the institutional process and mechanisms. The outputs were used as a programmatic compass to see if the direction of capacity building priorities mapped out were still truly relevant and needed.
        - The process of partners identifying and agreeing to map out their capacity strengthening and designing a corresponding action plan that responded to organizational needs was also acknowledged. The process indicated knowledge gaps on what aspects of SRHR and what areas to "brush up on" and how to respond. The trainings, symposiums, and other capacity enhancement activities provided towards the partners' development were part of their responsibilities and commitments to the project. Having an embedded training officer for each partner provided a support system that helped to develop or refine existing modules to be responsive and appropriate to the actual needs and situation of target participants.

- The partners acknowledged that the CAT4SRHR strengthened the organizations' structures (e.g., hiring of staff/experts for specific needs), manual of operations with embedded SRHR (i.e., UnYPhil-Women, SIKAP, UPCWGS, DMSFI, Friendly Care), and their monitoring system. It was not a rigorous step by step process imposed onto the partners but rather a process that oriented them on how to take on what activities and which ones to prioritize. Some partners simultaneously focused on interventions such as community norm setting, adaptable SRHR service provision, organizational capacity, social accountability (i.e., responsive health service provisions, better governance, synchronized service delivery and community mobilization) and the implementation of policies to improve health-seeking behavior among beneficiary-community partners.

Overall, it enabled partners to identify institutional documents such as human resource policies, sexual harassment policies, anti-discrimination policies and development framework that needs to be revisited and improved. For some partners, reviews were ongoing with technical assistance from hired external consultants. Other partners will further collaborate on how to go about with their policies and manual revisions.

The partners were asked to what extent the CAT4SRHR tool or process, over its first years of implementation, achieved its objectives during the self-assessment rating. The partners gave an average modal score of 7[45] for the project, and for the partners in both pillars. The partners justified this during discussions by pointing out that there were still pending activities and transitional factors to consider in their own organization. This was particularly applicable to organizations that joined the project at a later stage. It is important to note that while partners appreciate the immense value of the CAT4SRHR (this came out in the self-assessment questionnaires), they were still realistic in their respective achievements and progress. In addition to this, the partners cited the unprecedented circumstances brought on by the COVID-19 pandemic for the low rating.

At the end of Year 3, a major set of planned activities were yet to be delivered (e.g., Mapping and Review of SRHR coalitions, Strategic Planning on setting up a partnership/network fund, developing a Strategy Plan for Youth Volunteerism in SRHR, Sustaining Values Clarification activities). However, there are catch-up plans in place to shift them to Year 4 and prioritize planned targets that suffered setbacks. This proactively addressed the bandwidth of staff members working on both the institutional strengthening aspect and the main SRHR programmatic activities. Sourcing of resource persons and service providers was also a challenge due to the pandemic.

To manage competing priorities, partners assessed and managed activities accordingly. Partners had constant team meetings to plan out strategies and assess which worked well for the staff, the project, and the community. Setting priorities and urgent tasks were highlighted during meetings, ensuring that each project's activities were considered. During assessment sessions, variances were identified in the deliverables to see which CAT4SRHR activities were off-track and were given attention in the periodic planning activities. This can likewise be seen in the PMF table. In organizations with lean staffing, senior staff engaged in core SHE activities took the lead in delivering the institutional strengthening activities identified in the CAT4SRHR. In addition, capacity-building workshops were scheduled on months or dates with the least core SHE activities. Some partners prioritized institutional strengthening activities where external consultants can be used to relieve senior staff.

There were no key issues highlighted that impacted on the CAT4SRHR interventions. The discussions and reports indicated how partners fine-tuned their approaches. This can be attributed to the familiarity of the partners with the process and principles of institutional building, not just with Oxfam, but with other donors. While the aim of CAT4SRHR was to strengthen the SRHR programmatic delivery of the partners, there was an opportunity here for Oxfam to offer an organizational legacy to its partners. Institutional building affects all levels of the organization and can impact positively on the integrity of its programs. This can be documented or part of the meaningful change stories towards the end of the project.

The CAT4SRHR is a platform that does not just let Oxfam offer an organizational legacy, but it also allows Oxfam to directly engage with partners as a thought leader-facilitator, given its significant global reach and wealth of technical knowledge and resources developed. It can help guide partners, proactively listen to their needs, and lead in iterative thinking and adaptive management processes. This can minimize the "donor-recipient" dichotomy and power divide that often occurs when any organization provides resources to both the recipient's programmatic delivery and its organizational development. There are significant and positive outcomes to this form of intervention design, as long as the principles of empowerment are deeply embedded and both donor and recipient are seen more as partners and agents of change.

[45] The Self Assessment Questionnaire or Tool has a score rating system of 1 to 10,with 10 being the highest.

While this issue never came up during the PLI or from reports, as non-government organization practitioners, it always helps to be sensitive to the three (3) dimensions of empowerment – self-empowerment through individual action, mutual empowerment that is interpersonal, and social empowerment in the outcomes of social action.

3.7. Monitoring, Evaluation and Learning

Oxfam invested resources into its Monitoring, Evaluation, and Learning (MEL) process. This is evident in Section 5 of the PIP document where Monitoring, Evaluation, Accountability and Learning (MEAL) approaches, tools and strategies are outlined. It drew from Oxfam Canada's experience in feminist MEAL, which endeavored to shift power in project partnerships, integrated key learnings into the MEAL strategy, methodology and process, as well as questioned how evidence is captured and who gave it meaning and relevance.

3.7.1. ASSESSMENT OF THE STRENGTHS OF MEL AS APPLIED IN THE PROJECT SITES

Periodic reports (quarterly, semi-annual, and annual reports) required by Oxfam from partners was a fundamental practice to monitor and evaluate the progress of project implementation. The templates with guiding questions facilitated the formulation of reports. Partners were well-guided on the application of quantitative data collection and collation through online platforms, which made data management easier. Quantitative indicators were clear, and time bound. The PMF was a very efficient way to generate quantitative sex and age-disaggregated data required in the output indicators, as noted by the MTE team. The variances were easily identified, and corrective measurements were proposed.

Beneficiary reach can be assessed, and double counting was checked through an output validation process to make use of the beneficiary master-list. Partners with dedicated MEL officers ensured that reporting of the project progress was organized and accurate.

The project reported at the outcome level on an annual basis starting from Year 3 of implementation, as changes were coming into fruition. This was complemented by in-depth data collection from the pulse and midline surveys. However, while the process of reporting was in place to ensure the collection of qualitative data, it will always be a natural challenge in project implementation to report on qualitative description/evidence where indicators were currently only quantitative or at the stage of accomplished activities. This is particularly applicable to partners who came on board after the project's inception.

This was evident in some partners' reports that were mostly activity-based and did not have the perspective on reporting vis-a-vis the logic model at various levels of influence. Reporting vis-à-vis the logic model and denoting various levels of influence can provide the partners with a bigger picture of what the project had achieved, and not just purely report on what was done per outcome level indicator. There was consensus on strengthening this form of reporting which in turn would need the required knowledge and skills to effectively generate qualitative information and capture project changes.

Partners further suggested including more qualitative means of assessment to appreciate change beyond numbers. The results of the peer review from partners dove-tailed with the MTE team's suggestions on strategies such as journaling, ongoing (quarterly or monthly) cell phone reflection videos with key project participants, or using outcome harvesting in annual workshops (which OiPh MEL team were already using in other projects), and collecting impact stories on a regular basis. Some partners started gathering stories of change using the project's guidance document on how to develop/write a Story of Change which can be enhanced through integration of qualitative

methodologies beyond case stories. The MTE team noted that the partner's capacity to generate qualitative data needs to be built through sharing of approaches and tools that are guided by the feminist MEL framework that would best capture significant changes obtained in the project.

Collaboration between partners went beyond stakeholder engagement and technical expertise. Some partners do not have well-established baseline data for some indicators, as there was no disaggregated data from the LGUs at the start of the project (e.g., MIDAS does not have baseline data on disaggregated sex, age groups on some indicators). To counter this, they will be supported by Jhpiego in accessing municipal-level data for evidence-based planning and reporting.

Some of the indicators were currently dependent on research-based data which are costly and hard to produce. Utilizing available data that the government has in monitoring the progress of the project was an offered option. Comparison of household survey of the project with the upcoming results of the 2022 National Demographic and Health Survey for attributable impact to the project has been confirmed by Oxfam to be utilized as a comparison point (as designed at the PIP stage of the project).

3.7.2. EFFECTIVITY OF MEL SYSTEMS IN CAPTURING GENDER SENSITIVE DATA

Partners agreed that sex- and age-disaggregated data on SRHR were adequately captured by the project's MEL system and consciously applied by partners. Partners' attendance sheets were reliable sources of sex-disaggregated data on training reach, while the Field Health Service Information System data of the health facilities and Adolescent Health and Development Program logbooks of the Adolescent Friendly Health Facilities provided additional age disaggregation for data.

The partners noted that there was no explicit quantitative indicator on capturing data on GBV, however some indicators capture outputs related to GBV.

Review of the data gathering, and consolidation process took place to note which aspects require improvement. The output validation process was done for Year 2 and ongoing for Year 3. It allowed the project to assess if the MEL systems and processes are at par with standards on sex and age disaggregation for quantitative data.

The MEL system allowed partners to regularly report on similarities and differences between men and women's experiences and viewpoints. Some partners included opinions and feedback from men and boys in the result stories incorporated into the third-year annual reports. Stories related to GBV, and LGBTQ have also emerged.

The midline survey[46] highlighted changes in the attitudes of women, girls, men, and boys on reproductive decision making and attitude about SRHR. New questions were introduced in the midline survey to assess the level of knowledge about the different contraceptive methods, and it would be useful to have these questions in future surveys that can capture gender-sensitive data and facilitate a comparative analysis about knowledge.

3.7.3. USE OF PROJECT MONITORING PROCESSES AND ACTIVITIES AS EFFECTIVE MANAGEMENT TOOL

Performance Measurement Framework As the project faced restraining factors and challenging situations, both externally and internally, the PMF underwent thorough review and updating based on findings of project monitoring systems and reports. Experience gained by project partners and other stakeholders from real, on-the-ground engagements surfaced the need to revise indicators and operational measures of outcomes and outputs (some examples are detailed in the next

[46] Morales, R. and Chacon, J., 2021. Comparative Statistical Analysis of Baseline, Pulse and Midline Surveys. Oxfam, Canada.

paragraph). Further reality checks necessitated adjustments in strategies, activities, and targets. Such changes and adjustments were made through a regular process of consultation, monitoring and documentation, and reporting and review of progress and accomplishments (**see Annex 5 for the updated PMF for the SHE Year 3 Annual Report**).

For comparability, the team noted that changes were made to baseline values of selected indicators. For instance, after the baseline survey, the project adjusted the PMF to include 10- to 14-year-old girls and boys as target reach because age of sexual consent in the Philippines is 12 years old and the baseline showed that the lowest age of first sexual encounter was 11 and the earliest age of first pregnancy was 12. Also, as Field Health Service Information System data became available, some baseline values were added, where appropriate. Oxfam is currently assessing the quality of data generated by the RHU monitoring system, and changes might still be made as needed.

Data privacy protection Not all partners have a system and process in place for data privacy protection. Some made sure all data gathering and reporting were only aggregate numbers. Staff were reminded to avoid diving into confidential information with respect to data privacy. All confidential information, as well as attendance sheets, were kept in files and would follow proper disposal come close out of the project. During the Pulse Survey training, Oxfam discussed with partners the principles of ethics, data management and protection approaches, as well as ethical and safety guidelines. Friendly Care has a Data Privacy Officer and is a member of the National Privacy Commission. Their consent forms are in place and in missions, they adopt the DOH policy on data sharing for reporting and records retention and disposal.

Project Monitoring Processes The MTE team observed how field project implementers tend to treat communities as mere sources of information during monitoring and evaluation, rather than participants and actors that can be a rich source of inputs in identifying change indicators and tracking project progress. This is not a new issue or specific to the SHE Project. The team discussed and agreed with the partners on how to consistently apply the MEAL strategies. It was agreed that an understanding of the MEL processes is not limited to the function of the MEL focal point, but a collaborative and active effort of all.

3.7.4. HOW LEARNING IS DOCUMENTED AND COMMUNICATION SYSTEMS IMPROVED

Within organizations, the MTE team noted periodic assessments through staff meetings were conducted where they shared project learnings. Sessions on different technical areas served as a guide for implementation. Cross-project knowledge sharing of successful best practices and strategies spurred on cooperation, shared vision, understanding of everyone's role in their organization, and positive externalities in other project beneficiaries.

Learnings were documented and disseminated to project intermediaries and drivers of change through creative forms. Stories and lessons generated from the project were shared and converted into more palatable formats like infographics, video shorts, photo essays, and policy briefs. Pivoting research data into easy-to-understand content made it easier to disseminate information to various groups and individuals. Other SHE partners and key stakeholders were allowed to disseminate and/or utilize said knowledge products.

Communication and advocacy used various social media platforms to share and engage with more people. However, in some cases, particularly among partners' staff, implementing staff were unaware of the research and knowledge products being initiated by other partners. There is a demand, the MTE noted, for training modules and knowledge products in local languages.

Additional findings documented by the team were:

- It was noted that the project's MEL system did not have an explicit indicator on GBV data, though partners agreed that gender-sensitive and age-appropriate data (age- and sex-disaggregated) on SRHR were adequately captured like the Field Health Service Information System, Adolescent Friendly Health Facilities and Adolescent Health and Development Program, among others. Additional review needed to be done on what other data gathering and consolidation processes could be put in place for improvement.
- Frequent learning loops embedded into the PCTs or dialogues with partners could be encouraged. This involves two (2) aspects – learning by doing: learning continuously as we implement the project and learning into action: by making decisions based on new knowledge and lessons learned; putting learning into practice to improve the program during implementation. This is nothing new for the project but can be made more systematic and integrated into processes, so much so that it becomes part of the system's way of thinking.
- Revisit the impact story outline. The team noted that the template has extensive informational requirements. For partners with dedicated MEL officers, this ensured that the stories are kept up to date with minimal data gaps. For partners with no dedicated MEL officers and where the responsibility of filling up the stories can vary from person to person each reporting period, it is necessary to keep the template flexible and ensure minimal data compliance. The team suggested the use of panel data, sometimes referred to as longitudinal data that contains observational changes. This means beneficiaries who were featured in the impact stories are revisited periodically to be able to track the changes of the project interventions.
- Use of digital and social media as an advocacy strategy can be discussed during PCTs as a form of experiential learning exchange among partners
- A focus group discussion or online dialogue on ways of easing up on copious MEL reporting is needed, given the continuous changing quarantine measures and health guidelines. Oxfam's regular monitoring activities and GAC's semi-annual monitoring activities need to be coordinated properly with partners to avoid confusion among respondents, and minimize extra workload for partners.
- Regular MEL-focused field visits from Oxfam to ensure partners are reporting accurately and the MEL system and processes are in place to ensure transparency and data quality when travel is possible. This visit could also pave the way to coach partners on areas that they need assistance on.
- PCTs were mentioned previously under CAT4SHRH as a platform where partners engage with each other. As a coordinating mechanism, the agenda focused on getting partners to work effectively together by ensuring minimal overlaps and scheduling conflicts. Partners suggested the agenda could be more intentional and focus as well on other topics such as field level learnings, challenges faced by partners, or how policy impacts on field level implementation.
- Some partners started documenting and disseminating project learning and knowledge products through the SRHR Resource Hub, especially those in local language, so different partners could evaluate them and try to adapt them to their contexts.

In conclusion, **the MEL systems followed the iterative learning process of continuous self-improvement of Oxfam.** The MTE team followed a framework of "learn better and faster curve," to understand how change happened or is happening in each context, and assessed progress in terms of capacities and programmatic delivery. This framework with the PMF helped the partners to successfully pivot and capture changes along the way of the project implementation.

It was interesting to note however, particularly on learning lessons, best and emerging practices, that the general score was 8 – yet there were ratings as low as 5 when asked to rate themselves against their own organization. This was based on the results of the self-assessments by partners on rating the project's MEL systems over a 3-year period. Evidently, there are internal organizational issues that need to be addressed, especially on qualitative data gathering and reporting, that can be taken up in the recommendations and lessons section of the report.

There was no significant need for improvements as investigated by the MTE team. Continuous fine-tuning on what is existing and consistent guidance to partners as well as easy access to support would be the next steps. An emphasis on bearing in mind what the learning outcomes are will allow for partners and Oxfam to cultivate intentional, purposive meetings, dialogues and learning events that is process oriented, rather than routine and business as usual.

4. BEST PRACTICES AND LESSONS

Sharing best practices and lessons provides significant benefits to any organization. It helps to nurture a learning culture, identifies, and fills in knowledge gaps. It also helps to generate creative and innovative ideas, acknowledges that learning is an iterative process, thereby freeing the organizations from the fear of failure. It can also enable better decision-making processes.

This section identifies what those lessons and practices in SRHR are and to what extent they were incorporated into the SHE Project. Much of the lessons and best practices were derived from the implementation aspect of the project, whereas reflections and lessons for CAT4SRHR and MEL were carried forward to the recommendation section to minimize on reiterations.

4.1. IMPLEMENTATION

4.1.1. BEST PRACTICES

Achieving SHE Project outcomes requires continued capacity-building, commitment of champions and advocates through support formation, lobbying, SRHR legislation, budgets, and planning for sustainability. In adherence with good partnership principles and localization agendas, the project did not impose specific sub-activities. It leveraged each partners' specialization and unique ways of delivery and there were best practices that can be replicated across implementing partners. Some best practices were the following:

- **The creation of synergies** between team efforts resulted in harmonized activities
- **Continuous coordination** and on-going dialogues iteratively improved on its processes, complemented with open dialogue between the partners
- **Sharing of Effective SRHR Strategies and Training Materials**. Various partners approached activities differently based on their individual capacities and experiences. The SHE project continued to create a space where different partners share effective strategies that work in various contexts, such as the PCT meetings.
- **Sustainability Built in Activities**. Some WROs/CSOs had sustainability in mind in formulating their activity strategies since the beginning. For example, conducting sustainability planning workshops and allowing stakeholders to organize themselves as advocacy groups (including men) as part of the Movement Against Violence Everywhere.
- **Leveraging off Each Other's Expertise**. It is best practice to design a partnership model in such a way that the partners leveraged off each other's expertise and experience. One such example was WGNRR's multimedia advocacy campaigns, capacity building and communication messages to promote, defend, and advance SRHR. The tools were effectively engaging, digestible, easy to understand, and had a wider reach. Monitoring reach on social media was also good practice.
- **Parent-Teen Talk Approach**. This is an engagement tool where health service providers acted as facilitators to converse with both parents and teens using PopCom's highly engaging training toolkit. It taught a good approach on how to navigate and develop attitudes, skills, and capacities of parents and children to openly talk about oft-regarded sensitive issues surrounding sexuality. As a best practice of AMDF, other partners can review and assess how it can work with their respective organizations if this can be adapted.
- **Leveraging on Existing Government Programs**. This is another example of an organization's good practice that other partners can learn from. MIDAS integrated SRHR into the regular sessions and activities of government programs, in particular the Pantawid Pamilyang Pilipino Program (4Ps) and the Sangguniang Kabataan projects (supported by the Local Youth Development Council), which ensured a wider reach to women, men, girls and boys. The 4Ps is a national program that provides social assistance (monetary support) and social development

(including family development sessions) to poor families in the country. Implementers of the 4Ps in Bicol saw the value of integrating SRHR into the monthly family development sessions of the parent groups with both women and men attendees. For the Sangguniang Kabataan projects, health has been the top priority during the pandemic. They organized Webinars on COVID-19, reproductive health, and mental health; and distributed health care kits including vitamins and contraceptives.

- **Extending Technical Expertise to LGUs**. MIDAS's expertise on local governance meant that its technical skills were requested by LGU-partners. An example of this is technical support to the Gender and Development Planning and Budgeting, Harmonized Gender and Development Goals, and other capacity building activities that will lead to SRHR mainstreaming in local plans and budgets. While other partners have had some experience on this in other projects, it would be worthwhile to investigate how MIDAS was able to achieve this and what their learnings were.
- **Concerted Efforts for Outreach**. Jhpiego's work together with partners and RHUs on outreach strategies of family planning provisions in GIDAs, where SRHR services are high in demand, would be another best practice to learn from. A huge number of family planning acceptors turned out for such events, with the majority even opting for the long-acting method of implant. As explained by a health service provider, the outreach activity allowed residents in GIDAs to avail of counseling and commodities without traveling far to health facilities, which is time consuming and costly. These also reduce congestion of clients in the hospitals (**see Annex 4 for Midterm Change Study**).
- **Creating Safe Spaces** Similarly, Jhpiego and Friendly Care created safe spaces, be it physical spaces or supportive environments. These safe spaces reinforce positive actions to clients that access their services. For example, providing a private and safe place for counseling among WRAs, coupled with a service provider they can trust, reinforced well-thought-out decisions for their contraceptive methods. It was also important to ensure that services and health products would be available.
- **Performance Accountability System** The use of the Performance Accountability System for SRHR in various locations (as this tool is not limited to certain contexts) resulted in (a) better governance support (policy, logistics, financial), (b) engagement of key stakeholders in the municipality and barangays, (c) responsive health service provision, (d) community mobilization and transformation of women leaders who become more active and self-confident in spearheading community activities (e.g. survey of WRA with unmet needs) and (e) more accountable local leaders.
- **Targeting Families on GBV Awareness**. Targeting families as an additional strategy on GBV awareness was seen not only as an effective strategy but deeply rooted in Filipino culture. This was done using an effective family conversation process to achieve a shared base of knowledge among family members. Separate facilitated conversations (Parents Conversations and Peer Education Sessions or Family Conversation) with the family, popularized by AMDF for Muslim families, can be used in other locations with the whole family having shared knowledge on SRHR.
- **Partners strove to engage multi-stakeholder involvement and participation** in various levels, like participating in the Regional RH Implementing Team in BARMM, local health boards, and inter-agency meetings, and contextualize advocacies for SRHR to make it mainstream. Partnering with different International Non-Government Organizations working in the same project area also paved the way for efficient delivery of project outputs.
    - UPCWGS is another example that collaborated with organizations and individuals with a gender and SRHR lens and grassroots experience in local communities. The collaboration, for example, with the Lunas Collective was crucial in strengthening the intersectional lens in the creative workshop design. Their analyses and nuances on identities and cultures have helped the project's creative experts craft modules pertaining not only to gender issues, but also to other intersectional identities as well. They tapped the network of UPCWGS and UPCWSFI from different programs and projects in the dissemination of knowledge products.

Public events/activities, such as the various modules of Conversations through Arts, are also used for dissemination as well as to collect requests on additional relevant information.

- There is also the advocacy of UnYPhil-Women who continued to engage in a high level, multi-sectoral advocacy with BARMM members of parliament, the Darul Ifta and the Ministry on Indigenous People, to prioritize a bill that supports the elimination of GBV in the harmful traditional and cultural practices. They actively participated and contributed to the crafting of the BARMM Gender and Development Code, and the partners hope for its passage in the BARMM parliament.

4.1.2.KEY LESSONS

During the PLI, several key lessons were discussed:

- **Experiences of partners in including men and boys** in Gender Sensitivity Trainings can help develop a bolder approach in gender transformational programming. Due to their experiences, partners were in a better position to help develop a bolder and clearer power perspective on the potential role men and boys can play in transforming gender patterns in the project areas. Men and boys, especially those occupying powerful or influential roles in communities, were routinely invited as part of the Gender Sensitivity Training approach. Experience taught partners that Gender Sensitivity Training which either included men and boys as participants, or were organized for them, were most effective, more so if facilitators were men, or male religious leaders. Partners in BARMM realized Muslim religious leaders should also be trained together with community leaders as they play a significant role in exerting moral influence in their respective communities. Partners accommodated this strategy into their capacity building activities after this important lesson. Other partners are now engaging with the Philippine National Police and male barangay leaders in monitoring GBV.
- **Activities need constant follow-through actions**. Partners can never underestimate the value of consistent follow-through actions. Peer education required follow up interactions to reinforce decisions made and implement plans to address issues and concerns (e.g., adolescent who attended Usapang Barkadahan) on SRHR advocacies in the communities. Partners closely and regularly coordinated with LGUs, both at the municipal and barangay levels, to foster a better partnership and ensure support to SRHR. Mentoring, coaching and post-activity actions were essential and cannot be discounted in terms of their usefulness and need by women and youth leaders to nurture their self-confidence.
- **Effective use of local influencers in promoting SRHR**. Many of the partners worked through local community facilitators during the pandemic to establish trust and awareness and act on SRHR issues at the barangay level. They took on the roles of leaders and organizers to draw out values and beliefs considered taboo and discuss them through an empowering conscientization approach. The success of "modeling" or" influencing" hinged on how beneficiaries perceived the positive changes on the influencers themselves. Local community facilitators acting as change agents, advocates, and champions at the local level were an established good practice, and have been invaluable during the pandemic when staff of SHE partners were restricted from visiting project sites.
- **The art of relationship building with LGUs.** Prioritization at the LGU level may be very competitive given the meager resources, numerous social development priorities, and countless development actors seeking an audience with the LGU. How a partner managed this challenge was part of their relationship building strategy. Partners always welcomed learning from others on what the appropriate persuasive messaging and "push" would be, as LGUs have their own personalities and dynamics. An example was the willingness of the BARMM LGUs to act on the complex issue of teen pregnancy with the formation of technical working groups with SRHR partners such as AMDF, which led to the implementation of needed policies and programs.

- **COVID-19 pandemic underlines the importance of readiness in GBV and SRHR responses**. Significant issues on GBV and teenage pregnancy were further compounded by the pandemic. Partners realized they could not directly address this either at the community level or advocacy through pre-pandemic means without pivoting in their approach. Lessons learned on utilizing digital platforms or a hybrid arrangement made partners realize that readiness was not just limited to responding during disasters. The pandemic showed that hybrid work arrangements or working digitally were mitigation measures that prepared partners to smoothly pivot with minimal disruption to programmatic delivery. Readiness means that there are essential ingredients in place such as basic infrastructure to implement these allocated resources, and existing competencies to engage with communities and stakeholders should an event occur. The Lunas Collective was one such example. It was a feminist inclusive chat service that ran on the compassion of volunteers – a safe online space where people seeking support related to GBV and SRHR can expect to be heard. The Lunas Collective was a partner of UPSWGS and together came up with a documentation study on GBV. Another example is Jphiego's collaboration with LGUs' multi-disciplinary teams which were trained to respond to GBV cases and appropriately refer cases in any contexts both humanitarian and development.
- **Normalization and accessibility of psychosocial support during COVID-19**. Mental health concerns among staff members and beneficiaries highlighted the importance of accessibility, normalization and availability of mental health and psychosocial support. For example, UPCWGS provided added support, including endorsing services and online discussions, to WROs to ensure that they can efficiently respond to the increasing psychosocial and legal needs of GBV survivors. It reinforced the perspective that psychosocial support and mental health is not limited to the beneficiaries of partners. It is also a responsibility to oneself.
- **Development of Catch-up plans**. The process of developing catch up plans to address project lags that were affected due to COVID-19 gave partners the opportunity to learn from each other on how best to prioritize what should be included in the next set of work plans, and how to strategize their implementation. This does not negate the partners' experience with other donors and projects, rather it contributed to the partners' learning curve on project management. An example of this was the breaking up of week-long trainings into shorter time periods (low dose high frequency)[47] .

4.2 CAT4SRHR

4.2.1. KEY LESSONS

- **Self-Assessment** Institutional strengthening through the CAT4SRHR enhanced the capacity of partner organizations, resulting in process improvements and clear outputs within a given time frame. The learning-by-doing component of capacity-building of staff (e.g., USAPAN) was an effective tool to retain technical skills.
- **Results Based Management**. Staff members' improved understanding of Results Based Management. This is evident in how the lessons acquired in the workshops were being applied or referred to during annual and mid-year planning assessment and crafting of project proposals. The learnings during the research training were also being applied in ongoing research projects.
- **Technology Use**. The capacity building activity on social media enhanced the knowledge of the senior staff on the basic guidelines in maximizing its platforms for advocacy work. Management and staff learned the importance of virtual platforms to promote and advance SRHR. It was especially helpful to those who are not digital natives. Partners improved their capacity in online advocacy work and created media accounts, which was a boon during the pandemic.

[47] LDHF is a capacity-building approach that promotes maximum retention of clinical knowledge, skills, and attitudes through short, targeted in-service simulation-based learning activities spaced over time and reinforced with structured, ongoing practice sessions at the workplace https://hms.jhpiego.org/about-us/our-approach/

- **Introduction and Use of System-Oriented Tools**. The CAT4SRHR tool is an example of this – it is used as a reference for capacity building initiatives of WROS, specifically in determining what capacity areas and topics to be addressed.
- **Mediation and Counseling**. Existing skills of members and staff on mediation pertaining to handling GBV cases was further honed. During the Enhancing Dispute Resolution and Management Processes training, participants trained on mediating contextualized conflict cases. Similarly, the Values Clarification training was extremely useful especially in leveling off on the issue of abortion. In addition, staff were now more consciously aware that their counseling does not end when a family planning method was chosen and selected. They see the impact of these conversations and counseling from the women they engage with. For Friendly Care, staff deployed in itinerant missions such as family planning are well-informed on how to use their counseling strategies. This is because they combined the theoretical learnings they gained with experience in actual counseling and engagement with WRA. Staff were consciously taking their time in their counseling sessions to promote openness, to disarm and build trust (e.g., privacy even in a plastic barriered setting), and to probe the concerns of the WRA. Attendees to their outreach activities increased and Friendly Care was asked to return to the sites and cover more barangays.
- **Knowledge of non-SHE Staff in SRHR** Significant positive and even external spillover effects of the CAT4SRHR interventions and activities were observed by staff through unreported "beneficiary reach" on the ground (e.g., non-SHE Project areas were included in the SRHR awareness activities by staff). This was attributed to the support of SHE through the skills development of its staff.
- **Proposal Writing**. CAT4SRHR strengthened the capacities of all staff of the partners in proposal writing. Though not part of project activities, partners were able to introduce the fundamentals of proposal writing to their local partners as part of skills transfer.
- **Timely update of organizational policies and procedures** ensured a smooth and effective project implementation and advocacy. Similarly, the CAT4SRHR process enabled the organizations to closely examine the significant roles of each member to ensure the organizational structure and operational procedures are being eyed with flexibility, and delivery is timely and functional. SRHR principles were embedded in organizational work. For example, for Friendly Care being new to Oxfam and the SHE Project, the CAT4SRHR was an essential first step to get the organization aligned and grounded to have a similar starting point for Friendly Care's clinics and missions.
- **The nature of power dynamics in the SHE partnership model**. This is touched upon in the section on key findings about the dichotomy of power. The provision of CAT4SRHR was important in the regular assessment of the organizational direction and priorities. It was beneficial for an organization to constantly check whether policies and procedures were still applicable and functional, how to assess the strengths and weaknesses of the organization, and how to hone it. There was consensus among partners on the benefits of the CAT4SRHR tool beyond the project. As an intervention by itself, it was an empowering process because it cultivated the growth of the staff and the institution to be dynamic and responsive. On the other hand, there was also a keen awareness of who funds what, and the underlying power dynamics this brings. It was nothing new to a partnership model like SHE. This was why partners acknowledged that coordination meetings helped to "equalize" and bring everybody to the same table with unified interests and agenda.
- **Importance of a good facilitator** of the CAT4SRHR process who not only understands the organization but is sensitive enough to ask if support was required and when to step back and give organizations the opportunity to learn.
- **Promotion of SRHR begins within the organization**. Promotion of SRHR and mainstreaming gender in an organization must have the necessary buy-in from senior leadership, codified and effective policies must be in place, and there must be an annual budget allocation. Acknowledging the need for institutionalization of SRHR and gender among its partners, the CAT4SRHR provided for a complementary institutional grant for each of its partners, and several of them are progressing in various levels of mainstreaming SRHR in their policies.

5. RECOMMENDATIONS

The recommendations section of this MTE report focused on what areas to continue more of and what to do less of (if any). This section draws not only from the MTE findings and analysis, but also from relevant recommendations of various data sources, principally from SHE documents reviewed. The partners themselves shared and/or implied recommendations from the PLI, the partners' reports, annual reports, and even from notes of the PCT meetings. The information was synthesized but references to documentation will be mentioned. Some specific recommendations from BrainTrust were also integrated in connection to the key findings.

Overall, the key findings and conclusions by the MTE team determined the SHE Project was proceeding on track, despite the challenges in the first half of its project life and project lag that impacted on positive perceptions especially of men and boys. This reflected the partners' and their respective stakeholders' adaptability, commitment, and tenacity. The progression of the project was also evident in the modifications and adjustments to the PMF and its development from how partners captured project change i.e. from activity based reporting to a shift in capturing outcomes. The implementation processes have been responsive such that catch-up plans are expected to make up for any delays.

5.1. PROJECT DESIGN

The key findings noted patterns and analyses from the reports and through partner interactions to intensify project efforts. This was a progressive pattern in any project life as it moved from the mid-term period to its conclusive end. It was also further reinforced by the fact that project activities naturally slowed due to COVID-19, as the partners pivoted to address their approach to programmatic delivery. As the country adjusted to a new normal, it was expected that activities would step up based on the PMF and the catch-up plans of partners. Further, partners shifted from activity-based to capturing emerging outcomes. There was a wealth of project experiences and reflections captured by the MTE team for the SHE Project to apply its concerted efforts to.

5.1.1. CONTINUE DOING

As indicated in the key findings, there was no change in the assumptions, Theory of Change, or results framework. This was not so much as a "continue to do" but more of a validation that the results framework and Theory of Change are sound despite external changes. It was further confirmation that the design of the SHE project went through a deliberate intensive process of consultations with partners. The SHE project may continue with this ethos of consultations and placing partners in the "driver's seat".

5.1.2. DO MORE OF

- Provide a continuous and systematic solid grounding on project context and content. SHE partners, and other drivers of change do well when the context was well rooted and grounded not only on SRHR technical content, but also on the overarching principles of human rights and social justice. This would be systematic and solid grounding that is non-static that further adapts to changes and helps to challenge presumptions. It must be continuous because there will be a presumption as the project shifts focus to implementation, that all partners at this point understand the project design. However, staff members come and go, and some partners came on board after the inception phase of the project. A continuous and adaptive grounding provides an environment where learning can thrive.

- Support wider application/adaptation of good practices, strategies, and protocols by partners across levels and areas. Partners worked in diverse rich settings. There was enough information in this phase of the project to identify commonalities that worked and apply and or adapt them systematically across all partners in the four (4) key focus areas.
- The key findings brought up the issue of unpaid care work and it mentioned that this can be a strategic entry point for research by the project. A recommendation that can be applicable to this would be exploring access to SRHR information and services, and how decision-making dynamics were affected by increased women's economic roles due to lack of livelihood opportunities (yet unpaid care work has not changed). This may not require additional costs – but more on capitalizing opportunities that come up especially during monitoring. Another suggestion would be to raise this during the PCT to assess opportunities for inter-collaboration between partners or allies. This can be linked to resource sharing and inter-collaboration expanded in the Implementation section.

5.2. IMPLEMENTATION

5.2.1 CONTINUE DOING

- Provide flexibility in making adaptive adjustments during implementation. Project management and operations need to be adaptive to shifting circumstances, especially to the still evolving pandemic that has given rise to a new normal. Online modalities cost less compared to in-person delivery, hence adjustments to budget allocations to certain activities were needed. It was recognized that timely submission of plans (AWP, annual budget, etc.) and reports (narrative and financial) was an important facilitating factor in project implementation. Assistance from, and involvement of, an Oxfam MEL officer (for partners without a dedicated MEL officer) to focus on how to use and manage the volume of reports to be accomplished, as well as mentor on MEL technical skills has been helpful. This recommendation is further expanded in the MEL section.
- Support resource sharing among partners and continue to encourage systematic processes that cultivate such an environment. The project needs to maintain its well-established working relationships with and between each partner. Joint planning, sharing schedules, providing feedback and updates, and sharing knowledge, learning and experiences were examples of go-to collaborative activities amid pandemic restrictions. Sharing knowledge products and undertaking synchronized project implementation activities in project communities were being done to the extent possible, without exposing themselves and their local partners in the communities to undue risks. This synergy was appreciated especially by partners from Pillar 2 who came on board after the inception phase of the project and evident in the examples below:
    - Appreciation of the importance of synergy contributed to the groundswell of good will and intentional cultivation of a culture of generosity and reciprocity. This was vital given the partnership model of the SHE project, where engagement was an essential ingredient. This was relevant given the amount of project lag that partners must accomplish. Stress and anxiety increased during COVID-19 as partners adjusted to depending on different modalities of working. Continuing to formally recognize this sharing and caring work ethic ensured an organized and well-coordinated delivery of activities, and a professional culture of checks and balance, where both partners checked up on each other and provided constructive and objective criticism for improvement (experienced and reinforced first-hand in the MTE PLI).
    - This same synergy extended as well to coordination work. Jhpiego and other partners must continue their regular coordination to achieve synchronization of the supply and demand generation sides. There will be great benefit if these two sides interact and work together to create synergy and multiplier effect. Inter-collaboration can be greatly encouraged.

- Strategic selection, support and participation of local partners and influencers. The active and sustained involvement of judiciously selected peer educators, local partners, and community leaders was crucial to sustain project benefits and successes, and promote project sustainability. Hence, initiatives of the stakeholders in organizing themselves and continued capacity building and accompaniment activities for SRHR advocacy groups must be encouraged and supported. Additional specific actions could include integrating SRHR discussions in family development sessions at the Municipal Social Welfare and Development Office complementing Gender and Development awareness among 4Ps beneficiaries. Partners operating in mostly Muslim areas could strongly correlate Islamic teachings and SRHR advocacies through well respected credible Muslim leaders as champions to discuss SRHR and GBV principles. The contribution of Indigenous Peoples' leaders immensely helped to reach out to remote and conservative communities. The support of indigenous and moral leaders could empower staff to discuss sensitive topics and issues.
- Multi-stakeholder involvement and participation. Department of Interior and Local Government /Government agencies' suspicious attitude or behavior towards CSOs (red tagging phenomenon) can be proactively addressed through sustained formal dialogues with LGUs and the Department of Interior and Local Government. CSOs need to continue their mitigation measures and to consistently engage through sharing of planned activities (ie. sharing of movement plans) and inviting LGUs to their activities/training. Partners have mitigation measures to address this.

5.2.2. DO MORE OF

- The key findings under the Design section took note of emerging beneficiary concerns on issues on gender, sexuality, body dysmorphia, and mental health concerns. Guidance was raised by partners on how to address such issues and in turn empower their communities and allies to do the same. Review of the PIP document indicates a project design that integrates feminist principles. Upon further review of the documents such as the PIP, intersectionality was discussed but not specifically related to issues such as body dysmorphia or mental health. In translating the Theory of Change to application of the field activities means deliberately integrating SOGIE and related mental health issues. This provides an opportunity for the SHE Project to collaborate with allies and among partners. Further related examples and suggestions are indicated below:
    - There is a generational divide in thinking about gender and this is a strategic entry point for the SHE project to explore gender with new eyes, to persuade especially men and boys to ask questions to better understand gender complexity. There was mention in the key findings under the implementation section of male participants disengaged in the training activities. It can be uncomfortable especially for those new to the "world" of gender complexity and in most cases, men were not even aware of toxic masculinity, gender's complex interrelationship between body, identity, and social gender, and how any incongruence may result in confusion and/or mental health needs.
    - The fact that partners brought this issue up spoke to their lived-in experiences in working on gender and SRHR issues in diverse communities that may have pushback against feminism, empowerment, SRHR, and gender diversity. Partners addressed these issues based on their experience and intuition. This would be a good jump-off point to contextualize and systematize what an intersectionality approach or even a process could look like. It would certainly enrich the current tools and processes being used. It may even help to further understand and fine-tune, for example, how to better shape and influence men's and boys' perspectives. Intersectionality analysis has also been applied within the context of reducing health disparities among socially disadvantaged groups.
- Strengthen the links between local or grassroots advocacy to national efforts. One of the key findings in the project's implementation was the recognition of advocacy and alliance building

accomplished by the partners, linked to multi-stakeholder engagement on the ground. A more systematic and purposive strengthening of such efforts to ensure that advocacy impact is reinforced would be helpful. Any case studies or documentation on this should be highlighted in reports.

  - Stronger advocacy efforts and Inclusion for male involvement. This was further highlighted in the design section of the key findings. Intersectionality and engagement were mentioned in the recommendations. There was consensus during the PLI on the need to highlight masculinity, and integrate a bolder and clearer power perspective to the role men and boys could play in transforming gender patterns in the project areas. Sensitization strategies and sessions could include how to increase health-seeking behavior in men, especially on family planning and antenatal care. Specific actions could include bringing in that increased knowledge and enthusiasm to the grassroots level such as peer educators, health personnel and community members, and linking them with PopCom and DSWD programs such as Empowerment and Reaffirmation of Paternal Abilities Training and KATROPA. The project could help facilitate this. The Arouse-Organize-Mobilize strategy is also another example that the project can facilitate and later be adapted for communities. IEC materials can be developed to focus on promoting active involvement of the men themselves in reproductive health issues throughout their life cycles, and the importance of their participation in reproductive decisions for women's health. Men can be very sensitive to anything perceived as an attack on masculinity and good humor is an essential ingredient in IEC efforts. Entertaining stories which can be presented in many ways are a good avenue for broaching sensitive topics and stimulating discussions.

- Family as a domain of change. This is an AMDF's strategy to target families as an additional strategy on GBV awareness, using a structured family conversation process (family members are separated and grouped after) so family members can level off on their knowledge and perceptions. It can be assessed in terms of how to adapt and use in the project areas of other partners. Family conversation was one of the strategies popularized by AMDF since 2017, and has been practiced since the implementation of community-based sessions (on mental health, SRHR, etc). This may be further shared among partners and studied as a complementary approach project-wide. However, it should not be done at the expense of activities that focus on women and girls (topics of empowerment and bodily autonomy), and not at the expense of individual activities (since family units are not always safe and they can be sites of violence, etc).
- Concerted action to contain teenage pregnancy made a top priority. The declaration of teenage pregnancy as a national priority requires urgent measures to curb its continual rise especially during the pandemic. More trained peer educators and health service providers trained on Adolescent Job Aid need to be mobilized through focused mentoring, coaching and post-activity accompaniment contributing to the current effort. For example, the use of PopCom's highly interactive module on Parent-Teen Talk is an effective strategy since it is widely accepted among this beneficiary group. Moreover, this massive roll-out of awareness raising activities will be highly effective especially with the youth target group who have emerged as advocates and resource persons of SRHR in their communities. This would go hand in hand with the dissemination of well-tailored IEC materials.
  - It would be worthwhile to assess the content of peer educator capacity building activities and how to integrate issues of intersectionality, mental health, and gender diversity. Skills could be built around informal, conversational capacities that allow for empathetic listening. Peer educators could also be trained to appropriately respond to high-risk questions and mental health concerns by ensuring that clients have access to referral services, rather than directly resolving these concerns by themselves.
- Active referrals and IEC complement the creation of more adolescent friendly health facilities. The Midterm Change Study of Health Service Providers provided all the evidence needed to

push for more adolescent friendly health facilities. To build on the achievements, a complementary approach of vigorous word-of-mouth advertising and inclusion in the IEC awareness activities to welcome communities that facilities are not only available but accessible, will help to improve utilization of health facilities. Peer educators can also actively take part in referring clients for counseling and service provision with carefully set schedules. RHUs and peer educators need to clarify their expectations and how they can contribute to the Adolescent Youth programs of the facilities. More partners can learn from Jhpiego, which encouraged the use of a referral mechanism linking communities, local agencies, peer educators, and RHUs to see changes and progress in cases, and sharing RHU information in awareness-raising and gender sensitivity sessions.

- GBV concerns front and center. Due to a culture of silence, addressing GBV and its prevention has been challenging. Aside from SRHR, capacity building on mental health issues stemming from GBV (such as suicide ideation) could be addressed more vigorously since peer educators do not have these skills, and government institutions' services are not sufficient to be able to address this. Capturing GBV experiences and stories more adequately through surveys and other ways can be difficult, and deriving good evidence for more responsive interventions requires focused attention.
    - A specific action mentioned earlier is to assess the content of the training modules of peer educators to ensure that they are empathetic to the needs of clients and be ready to automatically refer to high risk cases rather than take it on themselves.
    - Another strategy that has shown some results is the project aligning itself to existing GBV watch groups that will be accessible to survivors of GBV. These are referral systems that can further connect them to appropriate responders, service providers, and even eventual legal remedies, as needed. Likewise, complementing capacity-building activities with barangay VAWC Desk Officers and Jhpiego's Multidisciplinary Team training is another big step that could be taken project-wide.
    - Partners can deliberately build on their success in engaging with influencers, and extend to other circles of influence such as mother leaders at purok or sitio level (barangays are generally subdivided into these smaller neighborhoods or groups of families), officers of locally recognized associations of single parents, senior citizens, and transport operators and drivers, among others.
    - Additional roles with appropriate training could also be considered, e.g., referral/resupply for family planning services/commodities, and sharing of IEC materials.
- Systematic and organized SRHR- and Gender-Transformative delivery of products and services in project communities. Focal points who front-face and address queries from communities need to be trained on sensitivity, such as use of non-sexist language, and what gender transformative demeanor and gestures could look like in cultural contexts. Such capacity building can be complemented with access to SRHR and gender related products and services (such as localized IEC materials, guidance on how to communicate SOGIE issues, contacts of allies such as POPCOM and DSWD). This can further be institutionalized or widely made accessible among SHE allies in communities. SHE partners need to ensure that these resources are organized and indexed in a way that ensures that these are easily accessible, and provides for user-friendly instructions on what each knowledge product is used for. This knowledge management system will be helpful. A "script" or guide document in the local language can also aid in this. This small but specific action can result in better compliance and later, second-nature competencies. In time, the transformation would rub off on the client-beneficiaries or communities at the other end of the table/transaction.
- While not a major activity, it was brought up during the key findings on how to level off expectations with communities, especially given economic hardships because of COVID-19. A potential focus of collaborative research could be exploring the link between SRHR and livelihoods in programming, especially among the youth, and ensuring a tie up with LGUs and

line agencies in implementing simultaneous livelihood programs during dialogues with communities.

5.3 CAT4SRHR

5.3.1 CONTINUE DOING

- Building on online learning accomplishments to anticipate hybrid working arrangements in the new normal. It was observed during the PLI that this is unevenly embraced by partners – given factors such as weak connectivity or the partner not being technically savvy. Oxfam may look at how to build or strengthen implementing partners' capacities to be tech savvy with appropriate training tools. This can be part of the CAT4RHR activities that Oxfam can lead. Blended learning (i.e., synchronous, and asynchronous sessions) applied in recognition of the varying conditions (e.g., unreliable internet connectivity) have been developed by some partners and can be shared with others. This can help to prepare all partners for hybrid work arrangements, so project disruption is kept to a minimum. This can also be linked to the recommendation under the Implementation section where good practices are reviewed and adapted at a wider scale.
- Adherence to Rights-Based Capacity Building Processes. Inclusive and participatory planning and conduct of organizational development activities such as those undertaken for CAT4SRHR, facilitate or hasten buy-in and commitment to sustained practice. There is a need for continuing assessment of partners' level of implementation of their action plans, including weak areas that need improvement. Oxfam could provide guidance and technical support for a shared template and process, including an indicator to gauge improvement and status by end-of -project.

5.3.2 DO MORE OF

- Refresher sessions for continuous professional development and improvement. This may also be an opportunity to integrate content on the project context and content (mentioned in the recommendations under Project Design). There are continually new updates and introductions of concepts, experiences, theories, and perspectives on gender and SRHR. It would be advantageous to partners to have regular but short, invigorating refresher sessions. This will upgrade their technical competencies and empower them to effectively implement Project Partnership Agreements, not only within their institutions, but most especially as drivers in their areas of change. They can also cascade the capacity to their covered community influencers and leaders.
- Systematic quality assurance process of SHE training/outputs. A systematic quality assurance process can be put in place to also ensure consistency of context and content. Agreed upon steps forward will be taken on how best to utilize all the training outputs. The end view is for the project partners and intermediaries to gain and present coherent but strategically effective knowledge and communication products. This means all materials share a similar strategy and are based on human rights frameworks, even as each partner creates IEC materials in their local languages for their specific contexts.
    - Coaching partners on deployment-ready module rollout. Guidance or mentoring from Oxfam or experienced partners on how to develop deployment-ready modules and session guides on the conduct of SRHR at the community level would be helpful as partners who have recently joined prepare for their rollouts.
    - Review for inclusive training designs. There is a clear need to address the growing demand for including non-binary gender approaches, i.e., not limited to the male-female dichotomy. Partners and community influencers receive queries about these issues and would like to have guidance on how to respond. There should be a trickled down information on the stance of the SHE Project that is well understood by its partners and stakeholders.

- Specific advocacy and policy influencing. Skills development on techniques and good practices on how to effectively deal and collaborate with LGUs to influence their plans as well as social accountability approaches would be useful. On-going efforts by partners in Bicol and plans in BARMM to assess existing Gender and Development plans and budgets of LGUs, Barangay Development Plan, and drafting ordinances were examples given. Such citizen-led assessments would be strategic at this point as LGUs draft their annual Gender and Development Planning and Budgeting and accomplishments reports. This is made vital given the affirmation of the Supreme Court on the Mandanas ruling, providing opportunities to strengthen decentralization and improve social service delivery.
- Program leadership among various organizations There is a need to be able to mentor each partner's respective project team on the technicalities and various aspects of running an effective program, for example -- hiring project leaders with technical background. This is even more relevant considering the intensified project activities that must be delivered.

5.4 MEL

While there were no significant findings on MEL, there were process-related recommendations and suggestions partially covered in the key section of the report and detailed further here. It extensively dealt with how to manage copious amounts of information given intensified activities, bandwidth of partners, and their MEL competencies.

5.3.1. CONTINUE DOING

- Continued use of the PMF tool. The PMF tool was consistently raised by the partners as a solid and reliable project management tool. It documented catch-up plans and provided responsive tactics to address delays. It helped to be more intentional and systematic to link the PMF as a main project management tool to other monitoring and reporting processes and tools. Where possible, partners can hyperlink documents as an additional row, indicating reference documents to support a strong connectivity and relationship on evidence-based outcomes.
- Continued guidance from Oxfam on reporting and documentation to capture qualitative information from different beneficiary groups.
- Continued conduct of Data Quality Assessment to ensure proper recording of project outputs. Due to travel restrictions associated with the pandemic, field monitoring visits were reduced, or absent, which may affect the quality and execution of project activities. As a result, it may be necessary to continue the Data Quality Assessment activities to ensure that changes are documented.

5.3.2. DO MORE OF

- Oxfam has a Framework for Resilient Development (The Future is a Choice) which provides practical guidance on how to design and implement resilience sensitive monitoring, evaluation, accountability, and learning that looks at enhancing resilience capacities and development. While this framework was not applied in the SHE Project, given the COVID-19 context, it may be relevant to explore ways on how resilience pathways could look like and be applied, or to assess if these were informally applied (especially during the first year of the COVID-19) and correspondingly documented as part of good practices later.
- In rethinking and reformulating strategies to hasten project implementation and achieve desired outcomes, it is imperative to continuously check the activities' contribution to the Theory of Change. This "litmus test" should be applied to all activities involving the domains and agents of change. A specific action on this was taken up in the findings section where the "learn better and faster curve" can be rigorously applied, given intensified activities. Frequent learning loops is also another way to check for relevance.

This can be embedded into the PCTs or in dialogues with partners to cover for two (2) aspects: learning by doing and putting learning into practice.

- Strengthening the MEL Systems and Dedicating a MEL Officer in all partner organizations. It was noted that the project's MEL system does not have an explicit indicator on GBV data, though partners agree that gender-sensitive and age-appropriate data (age- and sex-disaggregated) on SRHR are adequately captured, like the Field Health Service Information System, Adolescent Friendly Health Facilities and Adolescent Health and Development Program, among others. Additional coordinated review by all partners needs to be done on what other data gathering and consolidation processes could be put in place for improvement. Furthermore, partner organizations with dedicated MEL officers have a more organized, efficient, and accurate data collection and reporting. These officers can collect information from other staff members who internalize MEL principles in the field, such as considering communities as rich information sources who could provide more informed sources for identifying change indicators and project progress.
    - Aside from a dedicated MEL staff for each CSO, everyone should be active MEL participants and actors. Partner organizations and individuals at the community level are not adequately involved in MEL processes. Their understanding and appreciation of the importance and benefits of MEL should be enhanced, and their roles clarified as well. Dedicated MEL staff of some partners have been and should still be tapped for this purpose, to work towards a community of practice by the end of the project life that can link with other like-minded communities of practices.
    - Another option is to form a technical working group of SHE MEL officers who meet outside of PCT meetings and discuss all MEL concerns for the project. An Oxfam MEL specialist can lead these discussions/meetings. For partners who do not have MEL officers, they can assign one project staff who will perform a dual role and undergo MEL training. Furthermore, MEL should be one of the capacity building topics of all SHE project officers to let them embrace a MEL culture during regular project implementation.
    - For either option, the project must optimize the expertise of its partners. Closer collaboration, for example, between WGNRR and UPCWGS could be encouraged. This is because in Pillar 2, UPCWGS is assigned a research role, whereas WGNRR is the policy advocacy link.
    - Enhance Qualitative Data, especially the impact story outline. Admittedly, many partners need capacitating and strengthening for collecting and analyzing qualitative data. This was taken up in the key findings where partners need to shift from activity-based reporting to capturing emerging outcomes. One specific issue is the existing impact story templates provided by Oxfam for narrative reports. Upon review of the outline by the team, it was found to require an extensive amount of information which can lead to "patchy" or inadequate information as required. Specific actions to address this:
        - Journaling methods could be enhanced as part of skills-training or continuous informal coaching to ensure that even assigned non-MEL personnel are confident to collect the minimum qualitative data required. Regular reports could incorporate a collection of change stories from these journals/templates as an opportunity for partners to apply their skills. Some partners are keen on the idea of journaling and its incorporation in project strategies could be analyzed for effective adaptation.
        - The impact story outline needs to have specific instructions to whoever is filling up the story, on what the required and minimum basic information are needed. The outline needs to be revisited, perhaps at a PCT, or as a trigger for the first meeting among MEL officers. It must have a required and minimum compliant set of information where documented attitude and behavior changes are tracked over a period. "Rolling stories"

where qualitative panel data[48] and respondents are identified at the start and continuously updated and interviewed annually will save personnel from having to identify beneficiaries during each reporting period. Collecting SHE stories could also be expanded to include households or families, communities, and institutions participating in or reached by the project.

- There is a need to invest in IT capacities and digital tools that aid in reporting new technological innovations that can cut down routine work, freeing staff to do other important tasks. Some partners are using free subscriptions of offline data gathering tools that help manage data in project areas with intermittent to no internet connection, and have limited storage.

- Make SRHR Resource Hub Accessible and Useful. SHE developed an online SRHR Resource Hub as a repository of information for partners to enhance their knowledge and share project resources. Partners were encouraged to use the resource hub by signing up for accounts. It was found that while all partners have access, they are not necessarily utilizing the hub due to unfamiliarity with how to navigate the filing index and how files are cataloged.
  - This is an opportunity for the MEL officers to come together and consult each other's expertise on the use of the hub, their challenges, and suggestions for continuous improvement. This ensures that the archive is accessible and shareable for use as references. There is mention from Oxfam that the hub is open to partners with the idea to make it accessible to other stakeholders outside of SHE partners[49] . The working group can investigate the need for any folder or file sharing restrictions, so any sensitive or non-quality assured documents are not mistakenly accessed by non-SHE partners. This builds into an earlier recommendation to bear in mind a systematic and organized SRHR and Gender-Transformative delivery of products and services made accessible to project communities.
  - On a related issue, Oxfam tapped the services of a communications consultant to enhance the initial videos accomplished by partners, to ensure that final and quality-assured products are uploaded to the hub. It would be useful to continue to engage with the consultant and help repackage the videos and story narratives designed for asynchronous learning. This would make them useful for capacity building and community engagement. Partners also need IEC materials and training modules in the local language.
- Strengthening the policy research link of the project. The development of evidence-based data is important, but it is also significant to be able to communicate the knowledge and communication products that mobilizes stakeholders and translates into policy advocacy. A closer collaboration is needed to ensure complementation and synergy with WGNRR to mutually reinforce their respective SHE Project roles (i.e., knowledge product development and advocacy work), and influence policy makers through the organizations they work with. WGNRR can collaborate further with UPCWGS since they have both worked together in the production of infographics, video shorts, and policy briefs based on the latter's research studies.
  - Related to the above, there is also a need to strengthen the monitoring of policy change and implementation. The work of ensuring that policies and practices are SRHR- and gender-transformative is a continuing, iterative process, and technical assistance is needed for such a process to deliver current and better-informed policy changes. Capacity building learnings can only be sustained through conscientious and consistent application. Oxfam could consider providing the technical assistance needed for such a process, to deliver not only current and better-informed policy changes, but also enhanced in-house capacity to undertake this process and monitor implementation.

[48] https://www.greenbook.org/marketing-research/longitudinal-qualitative-panels Longitudinal qualitative panels are instrumental in observing changes in consumer behavior when affected by life changes.
[49] SRHR resource hub CN https://oxfam.box.com/s/6n5v4hnbnssn2u18o2u3x68mljl40s7

- Given that not all partners have a system and process in place for data privacy protection, the opportunity is ripe for Oxfam or a MEL technical working group to conduct continuous refresher courses or develop modules or guidance documents. This action will ensure that partners systematically integrate data protection into the routinary processes of ensuring project integrity.
- The PCT process can further evolve to accommodate the needs of the partners, as well as can be improved to be more reflective. This can include smaller, reflective meetings with specific themes and interests that some partners (not all) have in common. It can also take the form of "brown-bag" sessions. These sessions are informal, and participants typically bring their lunch as it occurs around lunchtime. These may not be formally called PCT but an off-shoot endeavor. Oxfam and Jhpiego can take the lead on this. Another suggestion would be to have one or two partners present their best practices, stories, and strategies. This can be systematically integrated when developing agendas. Cross-learning like the PLI of the MTE could be replicated and help partners to strategize. This peer learning activity can be considered "Magaan pero malaman" (translation: light but substantive) with learning outcomes in mind.
- Early planning for a robust endline study and project evaluation. Explore opportunistic utilization of the National Demographic and Health Survey 2022 data of the PSA, and the 2021 Young Adult Fertility and Sexuality Study of the University of the Philippines Population Institute for end-of-project evaluation. This is scheduled in the PMF, but it would be helpful to initiate thinking on this as early as now. To institutionalize change measurement and monitoring, SHE could review in-house government information systems such as that of the DOH Field Health Service Information System for SHE project areas. To efficiently capture and measure changes in project outcomes, comparability of baseline, pulse and midline surveys are required. Consideration of location bias through disaggregated analysis according to region and different time periods is needed. As early as now, opportunities to evaluate for a possible impact evaluation can be done in coordination between Oxfam in the Philippines and GAC.

ANNEXES

Sexual Health and Empowerment (SHE) Project

ANNEX 1: LIST OF DOCUMENTS REVIEWED

1. Project Implementation Plan 2019
2. Baseline Study Report 2019
3. Pulse Survey Report 2020
4. Comparative Statistical Analysis of Baseline, Pulse and Midline Survey 2021
5. Annual Reports 2019, 2020, 2021
6. Health Facility Assessment Report
7. SHE Partners Reports 2021
8. CAT4SRHR reports of 11 SHE partners
10. Project Coordination Meeting Reports

Annex 2: GUIDELINES FOR PROJECT PARTNERS TO PREPARE FOR AND PARTICIPATE IN THE PARTNERS LEARNING INTERACTION

1. Introduction

The Partners Learning Interaction of the Sexual Health and Empowerment (SHE) project of Oxfam will focus on assessing the assumptions, strategies, and drivers of the Theory of Change (see Annex 1 for SHE Project Theory of Change Infographics) as described in the Project Implementation Plan. Specifically, it aims to:[1]

1. Assess whether the project's assumptions as described in the Theory of Change are holding true in the new context
2. Assess whether the project's strategies, as described in the Theory of Change are still effective in the new context
3. Identify any obstacle that are hindering quality or implementation and recommend practicable solutions that can be implemented during the remainder of the project
4. Identify lessons learned and example best practices in SRHR from project partners
5. Facilitate cross-partner exchange of experiences and learnings

The key objective is to "share best practices, challenges, and learning within and between project partners". To facilitate cross-partner exchange, project partners will participate in the Partners Learning Interaction to share experiences of their respective organizations, to hear from a cross-section of partners about how they implement the project and provide their perspectives on the progress of the other partners' activities.

Why Partners Learning Interaction or commonly known as Peer Review? *- Peer reviews are often described as the systematic examination and assessment of the performance of an organization by other organizations with the ultimate goal of helping the reviewed organization improve policies, adopt best practices, and comply with established outcomes of the project. It is a mutual learning process in which best practices are exchanged. The Partners Learning Interaction will allow discussion of topics that otherwise might not be given sufficient attention in the Partners Coordination Team meetings. The activities will be conducted in a candid and non-adversarial manner, and will rely on mutual trust among project partners.*

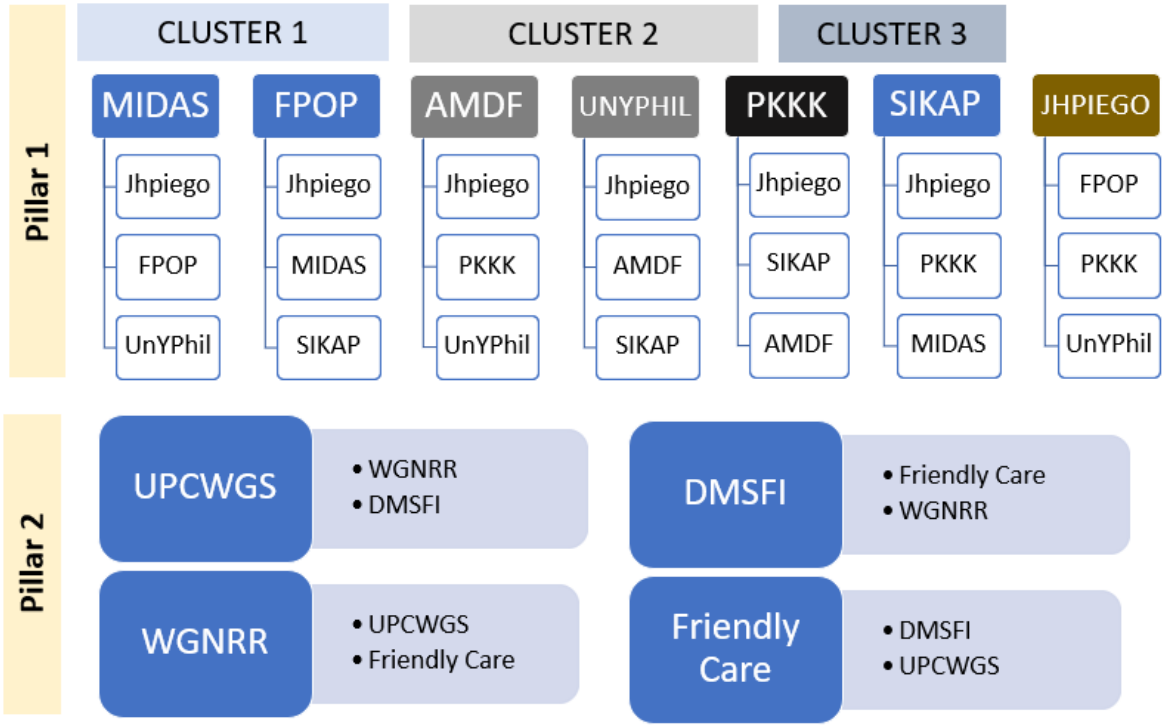
2. Mechanism of the Partners Learning Interaction

Each of the project partners will be asked to nominate a focal person from their organization. The nominated focal persons from two project partners will carry out the review of a third

[1] OXFAM Canada, 2021. Term of Reference Sexual Health and Empowerment Mid-Term Evaluation (MTE)

partner within their pillar group, with the exception of Jhpiego. Since Jhpiego works in all project sites, it will nominate a focal person for each project site. Figure 1 illustrates the pairing of the focal persons that will interact with each project partner. Each focal person will participate in two or three reviews. The focal persons, together with the external consultants and support from SHE team in OXFAM Philippines will make up the Partners Learning Interaction Team. External consultants will accompany each evaluation process, organize meetings, stimulate discussion and work closely with the focal persons.

Figure 1. Pairing of Partners Learning Interaction



3. The Actors

The Partners Learning Interaction is the combination of the activities of several actors: the reviewed project partners, the nominated focal persons, the external consultants, and the advisory committee.

Reviewed Project Partner – All project partners are subject to the Partners Learning Interaction. The project partner being reviewed will provide documents and data, respond to a self-assessment, present data, and nominate a focal person. Participation requires cooperation with the focal persons and external consultants.

Nominated Focal Person – The role of the nominated focal person is to represent their organization in the Partners Learning Interaction process and provide guidance in the collective discussions. Their task includes the examination of documentation and participation in discussions with the reviewed partner and external consultants. While focal persons carry out the reviews in their capacity as representatives of their organization, it requires the participation of focal persons in their personal capacity. In choosing the nominated focal person, the main criterion is their willingness to participate in the Partners Learning Interaction.

External Consultants – The external consultants have the role of supporting the whole Partners Learning Interaction process by producing documentation, organizing meetings and webinars, stimulating discussion, upholding quality standards, and maintaining continuity of the process. The external consultants will work very closely with the focal persons, and the division of labor between them is not always well defined, but the most labor-intensive part of the work is carried out by the external consultants.

Advisory Committee – Oxfam Canada, Oxfam Philippines and Jhpiego Philippines will form the advisory committee for the duration of the Partners Learning Interaction. The committee will provide the basis of the key questions and will review the inception report, questionnaires, and preliminary findings.

4. Platform for Interaction

The Partners Learning Interaction will be held using a preferred digital communication tool, Zoom. Zoom polls and chat box will also be used during webinars and meetings. This is to ensure opportunities to share both individually and in a group format. Google forms software will be used for online surveys. The nominated focal persons are expected to take part in the Partners Learning Interaction process in August 2021 for an estimate total of 10 working days[2].

5. The Process

The Partners Learning Interaction involves six (6) distinct stages grouped into three (3) phases. The 3 phases are: preparatory phase, consultation phase, and assessment phase. Table 1 shows the different stages of the 3 phases and the activities and required participation at the different stages.

Stage 1 – Preparations

Under the direction of OXFAM, consultants plan the activities and review the key questions of the Partners Learning Interaction. Partners, with the guidance of Oxfam, will choose a focal person from their organization who will participate in the Partners Learning Interaction and make decisions about it.

Table 1. Activities, Roles and Participants at Different Stages of the Process

PROCESS	ACTIVITIES/TOOLS	ROLE	PARTICIPANTS	SCHEDULE
PHASE I – Preparatory Phase: includes introduction to the Partners Learning Interaction (PLI) Process, background analysis and self-assessment by project partners				
Stage 1 Preparation	Manage the PLI	Manage the PLI activities	Consultants Oxfam	Completed
		Nominate focal persons who will conduct the PLI	Partners Oxfam	

[2] OXFAM Canada, 2021. Term of Reference Sexual Health and Empowerment Mid-Term Evaluation (MTE)

Stage 2 PLI Webinar (Kwentotuhan Webinar)	Introduction to the PLI process Review of key questions	Understand process, learn what is to be evaluated and how it is understood to work Finalize the parameters of the evaluation – purpose, key questions, criteria and standards to be used	Focal persons Focal persons Oxfam Consultants	3 Aug 2:00 PM via Zoom
Stage 3 Partners' Self-Assessment	Self-assessment questionnaire (see Annex 2 for questionnaire) Presentation for PLI	Answer descriptive questions about the activities of the project, the various results it has had and the context in which it has been implemented.	Partners	3-16 Aug
PHASE II – Consultation Phase: includes consultation with partners in groups and individually and drafting of partner report				
Stage 4 Partners Learning Interaction (Kwentotuhan)	Partner Presentations (see Annex 3 for presentation guide) Open discussion Pocket Chart data collection method	Collect data to answer descriptive questions about the activities of the project, the various results it has had and the context in which it has been implemented. (see Annex 4 for data collection sheet)	Focal persons Consultants	17–19 Aug 2:00 PM Via Zoom
Stage 5 Partners Meetings (Kwentotuhan over coffee) Draft Partner Reports	World Café technique Synthesize data (see Annex 6 for Partner's Report guide)	Understand causes, collect and analyse data to answer causal questions about what has produced the outcomes and impacts that have been observed.	Focal persons Consultants	23 Aug - 3 Sep (2 hrs sessions) (see Annex 5 for schedule)
PHASE III – Assessment Phase: includes drafting of final MTE report and sharing of draft.				
Stage 6 Editorial session of Evaluation Report	Open discussion	Overall assessment across partners	Consultants OXFAM Partners (Mgt)	TBD

Stage 2 – KWENTOTUHAN: A Partners' Learning Interaction Webinar

A webinar will be conducted with the focal persons from each partner focusing on creating a common understanding of the PLI processes, tools, and documents. Focal persons are expected to learn what is to be evaluated and finalize the parameters of the Partners Learning Interaction – its purposes, key questions, and the criteria and standards to be used. Issues with data availability and nature of evidence on qualitative indicators will be discussed. Inputs from the participants of the Webinar will be used to finalize the guidelines. After the Webinar, the guidelines to prepare for and to participate in the Partners Learning Interaction will be sent to focal persons.

Stage 3 – Partners' Self-Assessment

Each partner begins with a self-assessment at the organization level. A common set of questions guides this process of self-analysis. Guiding questions (see Annex 2) will be provided under the 4 core themes: project design, implementation, CAT4SRHR, and Monitoring and Learning. Facilitated by the focal persons in their organizations, partners answer descriptive questions about the activities of the project, the various results it has had and the context in which it has been implemented. Consultants are available anytime for guidance.

Stage 4 – KWENTOTUHAN: Partners' Learning Interaction

Project partners, through their focal person, will give a presentation about their organization based on the self-assessment (see Annex 3 for suggested outline of presentations). They will highlight what their initiatives wanted to achieve, what actually happened, and what the positive and negative factors are. Focal persons of other partners will collect data to answer descriptive questions about the activities of the project, the various results it has had and the context in which it has been implemented (see Annex 4 for a sample of a focal person's data collection sheet). This activity will provide a venue for dialogue especially between Pillar 1 partners and Pillar 2 partners. A Pocket Chart data collection method[3] will be available to all participants who wish to express their views anonymously (via chat or google form). The tool is great for participants who may not be comfortable speaking out in a big group.

Stage 5 – KWENTOTUHAN OVER COFFEE: Partners Meeting

This stage will use the World Café technique[4] of data collection. This involves a structured reflective conversational process to facilitate open discussion and link ideas. The small groups (like in coffee tables), following the pairings in Figure 1, discuss in response to a set of questions (see Annex 5 for schedule). The guide questions are predetermined by focal persons and focused on the specific objectives of the review. The technique provides a small, safer and focused space for implementing partners to share their experiences, perspectives, concerns and insights. The focal persons and the consultants will conduct the consultation with the partners. During this stage, the focal persons and consultants collect and analyze data to answer causal questions about what has produced the outcomes and impacts that have been observed. At the end of this stage, the focal persons together with the consultants prepare a draft of the Partner's Report, which will follow a standardized model comprising an analytical section, where the partners performance is examined in detail with recommendations (see Annex 6 for suggested outline of report). Consultants will synthesize all Partner Reports.

Stage 6 – EDITORIAL SESSION

The draft of the final report will be discussed in the meeting with the management of the partners and Oxfam. Management is encouraged to participate extensively.

[3] Donnelly, J. 2010. Maximizing participation in international community-level project evaluation: A strength-based approach. Evaluation Journal of Australasia 10.2:43

[4] http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/

Following the discussions, the final report will be adopted based on the feedback by the partners.

6. Summary of Roles of the Actors

Consultants

The consultants are available anytime to assist the partners and the focal persons.

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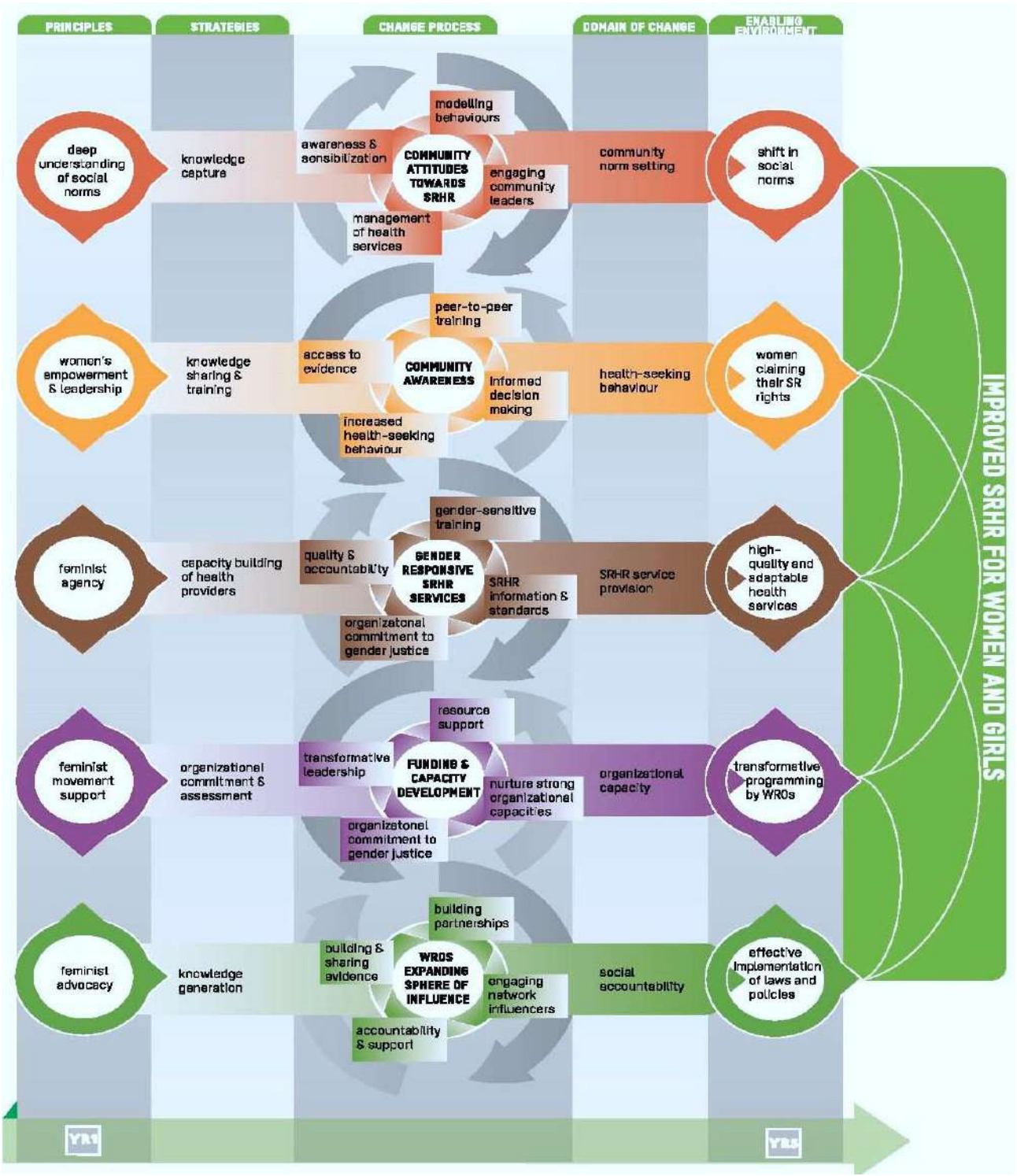
7. Annexes

Annex 1. SHE Project Theory of Change Infographics
Annex 2. Questionnaire for Self-Assessment
Annex 3. Guide for Partner Presentation
Annex 4. Focal Person's Data Collection Sheet
Annex 5. Schedule of Kwentotuhan
Annex 6. Structure of Partner's Report (2-3 pages)

Annex 1. SHE Project Theory of Change Infographics



Source: Sexual Health and Empowerment (SHE) Project Implementation Plan (February 2019).

Annex 2. Questionnaire for Self-Assessment

SHE PROJECT SELF-ASSESSMENT QUESTIONNAIRE

(For SHE Project Partners)

NOTE: This questionnaire is guided by key questions adopted by the SHE Project MTE TOR document; refined and finalized in consultation with the project partners and Oxfam prior to data collection.

This self-assessment tool will dig deeper and provide greater insight into how the partners have been implementing their respective parts of the SHE in their respective pillars and project sites.

It is preferable that partners identify/highlight specific project sites and engagements with stakeholders/intermediaries/beneficiaries that had demonstrated unique features or variances in implementation strategies, processes, and experiences. Partners are encouraged to be generous in providing information, insights and recommendations towards better understanding of SHE's progress and more tailor-fitted crafting of responses to continuing/emerging challenges for the remainder of the project.

Much as Partner's honest responses and perspectives are valued, they may choose to leave some questions unanswered. Confidentiality of each Partner's responses shall be strictly observed, unless voluntarily shared during the PLI process when partners have the opportunity for sharing their perspectives with one another.

It is understood that the information/data contained in the accomplished form is a team effort of relevant staff in the organization, and cleared/signed off by the responsible/authorized officer(s) for the SHE Project.

Name of Organization/SHE Project Partner: _____

Catchment Area covered for the SHE project: _____

List all staff who participated in answering the self-assessment questions:

Name/Position/Sex: 1 _____

2 _____

(Add as needed)

Name of designated SHE Project Lead in the organization: _____

Date Accomplished: _____

Key MTE Questions some have been used/included as is in the italicized self-assessment questions) ***Self-assessment questions***
Theme 1: Project Design
1. **What kind of local conditions have changed since project inception that might affect the original assumptions of the theory of change? What new assumptions have emerged in the new context?** *>Overall, what in the project design has been easy to implement and works best?* *>Why do you think it has been working well?* *>What is the main focus of your organization's initiatives in relation to the SRHR and GBV issues addressed by the SHE Project?* *>What is the historical context/situation regarding these issues in your project site?* *>Have you identified important factors affecting progress toward the desired outcomes? That is, <u>unanticipated</u> or <u>previously unidentified</u> external factors that came into play after the project started that might have hindered or facilitated project implementation.* 2. **If assumptions have changed, or new assumptions have emerged, how should strategies be adapted? How can programmatic activities be adapted to the new or adjusted strategies? How should the sustainability of the project be adapted?** *> If there was no change implemented, what practices worked best in the field?* *>Why do you think these were working well?* *>Were the beneficiaries positively responding to the strategies implemented?* *>On the other hand, how have project approaches and strategies been adapted to these changes, if any? Or how could these still/further be adapted?* *>Why was it important to respond and adapt to those changes?* *>What led you to adjust the strategies?* *>Why are the adjusted courses of action better than those originally planned?* *>Accordingly, how has the implementation of activities been adjusted? Or could be adjusted?* *>How would the external changes and the ensuing adaptation measures affect the sustainability of the project?*

3. **Are drivers of change facing any challenges to achieve the planned outcomes?**

>Are the *project's drivers of change facing any challenges to achieve the planned outcome? Specify which challenges are being faced by which influencers, including your organization, in relation to the outcomes:*
-pillar 1 Influencers (including community and religious leaders, men, youth); women and adolescent girls; boys; health care providers?
-pillar 2 CSOs and WROs; alliances and networks

4. **To what extent do the activities/outputs lead to achievements of intermediate or immediate outcomes?**

>To what extent have the challenges affected project activities and outputs toward achieving intermediate/ immediate outcomes?

5. **Are all the indicators still pertinent to measure all outputs and progress toward outcomes?**

>Are all the indicators identified by the project still pertinent to measure all outputs and progress toward outcomes?
>If not, what changes/additions would you suggest?

6. **Is there a common understanding of the concept of SRHR amongst project management, field coordinators, and partner organizations? (if there are any) being managed? How have any differences influenced delivery of the project?**

>Is there a common understanding of the SRHR concept among the project partners (different organizations implementing SHE including Oxfam and Jhpiego)?
>If not, can you cite specific cases, pronouncements in actual situations/events and documents for example, where differences have been evident?
>How were such differences managed?
>How have such differences influenced the delivery of the project, particularly to intermediaries and beneficiaries?

7. **In what ways are the SRHR concepts and dimensions of women's reproductive and sexual autonomies converging or complementing one another?**

>In what ways do the SRHR concepts and dimensions of women's reproductive and sexual autonomies converge or complement one another?
>Can you describe some examples, if any, of how such convergence or complementation has been considered/incorporated in developing strategies to achieve greater synergy and progress toward the desired outcomes:
- *In your project site?*
- *In your pillar?*
- *In your institution?*

On a scale of 1-10, to what extent do you feel the project design has been crafted to successfully address the project's objectives and reason for being, in the Philippine context:
- *As a whole?*
- *In relation to the pillars?*
- *In relation to project sites?*
- *In relation to intermediaries and beneficiaries?*

Theme 2: Implementation

8. **How are feminist principles being applied in the project's strategies and activities?**

>How are feminist principles being applied in the project's strategies and activities?
>What was the easiest to implement? Why?
>What was the most difficult or had met some resistance? Why?
>Which principles do you think have not been adequately addressed, if any?

9. **How are the SRHR concepts and women's rights dimensions being included in IEC materials, training manuals, and influencing messages?**

>Is there a process in place to systematically ensure that the SRHR concepts and women's rights dimensions are being included in IEC materials, training manuals, and influencing messages?
>Has a content analysis of the above over the 3-year period of the project been done- or planned – to determine if such inclusion has been progressive:
- *in your institution?*
- *in your pillar?*
- *in your project area?*

>What mechanism exists, if any, for sharing the partners' materials and experiences with one another?

10. **How have any implementation challenges and setbacks been managed? Which unintended outcomes, if any, have arisen from those challenges and setbacks?**

>How have any project implementation challenges and setbacks been managed?
>Provide example(s).
>What unintended outcomes, if any, have resulted from those negative or hindering factors or situations?

11. **What are the key lessons emerging from the project? To what extent are these lessons being disseminated or incorporated back into the SHE Project?**

>What do you think are the key lessons emerging so far from the project's three years of implementation?
>To what extent are these lessons being disseminated or incorporated back into the SHE Project?
>Give examples of how these lessons are actually disseminated or fed back to your pillar, project site, and institution.

12. **Are the necessary tools, skills or competencies needed for implementing SHE held by project staff? What is missing aspect may require technical assistance? What kind of capacity building can still be useful in the remainder of the project?**

>Do the project staff have the tools, skills and capacity needed for the implementation of SHE?
>What missing aspects may require technical assistance?
>What kind of capacity building can still be useful in the remaining life of the project?

13. **Are there examples of good practices by partners that can serve as lessons for other SHE partners?**

>Can you cite specific examples of good practices (other than your organization) that are replicable for other SHE partners?
>Why do you think this will also work in other locations?

>Do you have any good practice/s that other partners may adapt in the implementation of SHE?
>Do you know of at least one example that has actually been adapted by at least one other partner?

14. **What is the level and quality of multi-stakeholder involvement and participation in SHE? What are the strategies in involving different levels of stakeholders?**

>*In what ways has the engagement of all project duty bearers and claim holders and other stakeholders in advancing project outcomes been strengthened?*

>Please indicate on a 10-point scale the level of changes that you think have occurred in the engagement of key stakeholders over the past three years in the implementation areas. (from 1 -significantly decreased to 10 – significantly increased, you may put "don't know)

-Key religious leaders	*CONTENT (__), FREQUENCY (__)*
-Community leaders	*CONTENT (__), FREQUENCY (__)*
-IP leaders	*CONTENT (__), FREQUENCY (__)*
-Private sector (other CSOs, informal groups/alliances/networks, for example, PTA/Solo Parents Association, Fitness/Athletics Clubs, neighborhood associations, etc)	*CONTENT (__), FREQUENCY (__)*
-Public sector (LGUs, government departments at various levels of the governance hierarchy, for example, IPHO, Health Committees of LGUs, Barangay SK and municipal SK Federation, BHWs, etc?)	*CONTENT (__), FREQUENCY (__)*
-Women's Rights Organizations (WROs) and women leaders	*CONTENT (__), FREQUENCY (__)*
-Youth (especially the out-of-school)	*CONTENT (__), FREQUENCY (__)*
-Women	*CONTENT (__), FREQUENCY (__)*
-Girls	*CONTENT (__), FREQUENCY (__)*
-Men	*CONTENT (__), FREQUENCY (__)*
-Boys	*CONTENT (__), FREQUENCY (__)*

>What evidence or examples can you give of engagement strategies used by the project?
>If so, which project activities do you think have been most successful in strengthening the engagement of key stakeholders?
>What specific behaviors have changed resulting from those engagements?
>Cite examples of these changes.
>What are the main obstacles/challenges in engaging key stakeholders and securing more active support and participation?
>What more do you think can the project do towards improving access to SRHR services and decreasing GBV?
>What more can your pillar - and your own institution - do in your project site?

15. **How is the collaboration and complementarity among all SHE partners?**

>*How has the collaboration and complementation among partners changed over time?*
>In terms of frequency, do you think you need more –or less- frequent engagements?
If more, how often and which modes would you consider more appropriate and effective?
In terms of content, what do you think are the important matters that need to be prioritized in such engagements?

16. **How are project monitoring systems, narrative and financial reports, and various learning events used as effective management tools?**

>*Describe the various ways project monitoring systems, narrative and financial reports, and various learning events are disseminated within the project so that they can be used as effective management tools?*
>Can you identify gaps in the project's sharing and feedback mechanisms:
- *horizontally or among peers within each pillar at each level?*
- *vertically or up and down the project implementation hierarchy for example, Oxfam Philippines and partners, partners and intermediaries - at which levels?*

>What factors foster- or hinder - the uptake/use of learning resources to improve project management?
>What best practices can you recommend that are replicable that can be shared to other SHE partners?
>What kind of activities/engagements can be done that will effectively improve management of this project?
> Is there over or under reporting?
>If so, cite specific examples.

17. **What is the overall assessment of quality and level of progress against originally envisaged outcomes?**

>On a scale of 1-10, from your experiences and perspective as one of the project's partners, what is the project's quality and level of progress in the past 3 years of implementation against the originally envisioned outcomes? Quality (___) Level (___)
>Would you say that this quality and level of progress may be considered as the norm among the project sites?
-If not, what do you think are the key factors that contributed to the uneven progress?
- How about in your project site?
>On a scale of 1-10, to what extent do you feel the project's implementation over the 3-year period has closely adhered to the principles and standards of the Performance Management Framework (PMF) and Results-Based Management (RBM)?
- *As a whole?*
- *In relation to the pillars?*
- *In relation to project sites?*

>Has there been increased use of knowledge, including best and emerging practice, and accountability systems?
>What evidence or examples can you give of promising innovations that have emerged though project implementation? (For example, better policies, practices, approaches, technologies, behavioral insights, ways of delivering products and services, such as community awareness sessions and learning group sessions)
>On a scale of 1-10, which main project activities do you think have been more successful in promoting knowledge and innovation? (1- not at all to 10- most useful)
- Institutional capacity building, specifically addressing project outputs and outcomes (___)
- Research, including participatory action research, and development of knowledge products, including digital platforms (___)
- Development of ICTs and mechanisms for MEL (___)
- Convening and facilitating linkages and alliances (___)

*>**Focusing specifically on the institutional level:***
- As a project stakeholder, what did your institution want to achieve in terms of objectives and targets?

- What has actually happened during actual implementation in terms of your institution's - outputs toward achieving project outcomes?
- Describe what and how positive factors contributed to the results that you achieved.
- Describe what and how negative factors, if any, (still) hampered the institution from achieving some results.

Theme 3: CAT4SRHR

18. **How is the CAT4SRHR process supporting your institutional development? How are partners progressing in the implementation of the priorities in their CAT4SRHR work plans?**

> In what ways has the CAT4SRHR process been supporting your institutional development?
- How does the institutional strengthening activities help in meeting your pillar responsibilities and commitments, activities and outputs?
>How are you progressing in the implementation of the priorities in your CAT4SRHR work plan/ action plan?
[The CAT4SRHR process has supported the organization's development in support of its Pillar responsibilities and commitments and SRHR programming as a whole.]

19. **How are competing priorities (if any) being managed?**

>How are competing priorities such as implementing core SHE activities and the institutional strengthening activities, being assessed and accordingly managed?

20. **Which new/existing skills or institutional capacities have been acquired/improved in advocacy or influencing to advance SRHR?**

> Have new/existing skills/capacities been acquired/improved in advocacy or influence-building to advance SRHR?
>What are these, if any, specifically at individual(staff) and institutional level?

21. **What main lessons have you learned from the CAT process?**

>What main lessons have you learned from using the CAT process?
>Would you continue to use the CAT4SRHR tool after the project has been completed?
>Why, or why not?
>Any suggested modifications to improve the CAT4SRHR tool/process?
>Any redundancy? What activities can be simplified or streamlined?

On a scale of 1-10, to what extent do you feel the CAT4SRHR tool/process, over its first year of implementation (Year 3, 2020-2021, has achieved its objectives?
- *In the project as a whole?*
- *In relation to the pillars?*

Theme 4: Monitoring and Learning

22. **Assess the strengths of MEL, data collection and reporting systems being applied across the project sites. Are these meeting management, performance and learning requirements of Oxfam and the donor?**

>What are the strengths of the MEL data collection and reporting systems as applied in the project?
>Identify weaknesses, if any.

>How about strengths/weaknesses specific to your project site?
>What changes may be made to ensure that the MEL system is meeting the management, performance and learning requirements of Oxfam and the donor?

23. **Is baseline data available for all indicators? Is there clarity on how progress toward outcomes is measured?**

>Are all the project-identified indicators for your Pillar included/available in the baseline data, particularly for your project site?
>Do these indicators provide enough clarity in measuring progress toward your Pillar's outputs and outcomes?
>If not, what additional indicators, could possibly provide such clarity?

24. **Are MEL systems capturing gender sensitive data?**

>Are gender-sensitive and age-appropriate data (age- and sex-disaggregated) on SRHR and GBV adequately captured by the project's MEL systems?
>Why or why not?
>How Can the MEL systems be improved to generate greater data sensitivity?

25. **What MEL capacity gaps exist and what would be some corresponding strengthening measures?**

>What MEL capacity gaps/challenges do you see at this stage of the project?
>What strengthening measures do you think would be practicable or doable for the remaining project period?

26. **How is learning being documented, disseminated and applied? How can internal and external communication systems be improved?**

>Currently, what are the various ways or modes of documenting, disseminating and applying project learning?
>Have you tried any special or unique ways of doing this in your project site? In your institution?
>What are the challenges in monitoring, generating and disseminating project learning:
- across project sites?
- between pillars?
-across institutions within a pillar?
>How can the project improve on generating, disseminating and applying project learning?
>In particular, how can the project's internal and external communication systems be improved?
>What would you consider the most surprising, interesting or important learning or "takeaway" over the past three years:
-In relation to the whole SHE project?
-In relation to your project site?
-In relation to your Pillar?
-In relation to your institution?

On a scale of 1-10, to what extent do you feel the project's MEL systems over the 3-year period has ensured that the learning lessons, particularly best and emerging practices are disseminated for formative purposes during the project life and to inform programming of similar projects in the future?
- As a whole?

- *In relation to the pillars?*
- *In relation to project sites?*

>Has your organization started to put in place systems and processes to ensure data privacy and confidentiality?
>How do you think will these be managed upon close out?
>How can Oxfam and GAC help in addressing these concerns?

THANK YOU FOR YOUR INVALUABLE CONTRIBUTION!

Annex 3. Guide for PLI Presentations

NOTE: The main objective of the presentations for the Partners Learning Interaction is to stimulate discussion among and between partners in Pillar 1 and Pillar 2.

The presentations should not be more than 30 minutes. The focal persons are expected to represent their organizations but may elect to assign a presenter.

Presenters are requested to highlight specific project sites and engagements with stakeholders/intermediaries/beneficiaries that had demonstrated unique features in implementation strategies, processes, and experiences.

Among others, the presentations are expected to include the following:

1. Overview and scope of the organization
2. What did the project want to achieve? [Objectives, targets]
3. What has actually happened? [Results, output and outcome]
4. What were the positive factors? [Explanation of why and how results were achieved]
5. What were the negative factors? [Explanation of why and how results were not (yet) achieved]
6. Top 3 good practices of the organization

Annex 4. Focal Person's Data Collection Sheet

SHE Project

Data Collection Sheet

Name of Partner:

_____

Part I. Partner Profile and Context **Insert in the relevant rows below any general questions about the self-assessment report or requests for further information about the partner.**	
Project design	
Implementation	
CAT4SRHR	
Monitoring & Implementation	

Part II. Key Questions **For each key question, please describe how the partner is performing. Write specific questions you want to ask.**		
Key Question	**Assessment**	**Questions**

Annex 5. Schedule of Partners Meetings

Organization	Reviewers	Schedule	Time
MIDAS	Jhpiego FPOP UnYPhil	Aug 23, 2021	9:00 AM
FPOP	Jhpiego MIDAS SIKAP	Aug 24, 2021	2:00 PM
AMDF	Jhpiego PKKK UnYPhil	Aug 25, 2021	2:00 PM
UnYPhil	Jhpiego AMDF SIKAP	Aug 26, 2021	2:00 PM
PKKK	Jhpiego SIKAP AMDF	Aug 27, 2021	2:00 PM
JHPIEGO	FPOP PKKK UnYPhil	Aug 31, 2021	2:00 PM
Friendly Care	DMSFI UPCWGS	Sep 1, 2021	9:00 AM
UPCWGS	WGNRR DMSFI	Sep 1, 2021	2:00 PM
SIKAP	Jhpiego PKKK MIDAS	Sep 2, 2021	9:00 AM
DMSFI	WGNRR Friendly Care	Sep 2, 2021	2:00 PM
WGNRR	UPCWGS Friendly Care	Sep 3, 2021	2:00 PM

Annex 6. Structure of Partner's Report

Each Partner Report will have the same structure with five (6) sections framed by the following questions:

1. Background and context
    - What is the main focus of the initiatives in relation to the SHE Project?
    - What is the historical context of these issues or other major factors affecting its progress?
2. Description
    - What level of efforts has been made?
3. Strategy and approach
    - What were the key activities planned and undertaken?
    - Who were the main beneficiaries?
4. Achievements
    - What progress has been made towards achieving the relevant SHE project objectives?
    - What were the most significant achievements and what was Oxfam's contribution?
    - What facilitated and hindered these achievements?
5. Lessons learnt
    - What lessons can be drawn from this for other contexts?
6. Recommendations
    - Strategies, activities and changes in order to address the barriers, avoid repetition of mistakes or try out something new

Annex 3: Sexual Health and Empowerment (SHE) Project Partners' Learning Interaction Report

September 2021

Introduction

The peer-to-peer review (or Partners' Learning Interaction or PLI) was carried out July to September 2021 as the main component of the mid-term evaluation (MTE) for the Sexual Health and Empowerment (SHE) project. The key objective was to "share best practices, challenges, and learning within and between project partners". To facilitate cross-partner exchange, project partners participated in the Partners Learning Interaction to share the experiences of their respective organizations, to hear from a cross-section of partners about how they implement the project, and provide their perspectives on the progress of the other partners' activities

Mechanism of the Partners Learning Interaction

The Partners Learning Interaction involved six (6) distinct stages grouped into three (3) phases. Table 1 shows the different stages of the three (3) phases and the activities and required participation at the different stages. Guidelines to the Partners Learning Interaction were provided to the focal persons from each implementing partner.

Table 1. Activities, Roles and Participants at Different Stages of the Process

PROCESS	ACTIVITIES/ TOOLS	ROLE	PARTICIPANTS	SCHEDULE
PHASE I – Preparatory Phase: included introduction to the Partners Learning Interaction (PLI) process, background analysis and self-assessment by project partners				
Stage 1 Preparation	Manage the PLI	Manage the PLI activities	Consultants Oxfam	2-31 July via Zoom
		Nominate focal persons who will conduct the PLI	Partners Oxfam	
Stage 2 PLI Process Webinar (Kwentotuhan Webinar)	Introduction to the PLI process Reviewed of key questions	Understand the process, learn what is to be evaluated and how it is understood to work	Partners Focal persons Oxfam Consultants	3 Aug 2:00 PM via Zoom
		Finalized the parameters of the evaluation – purpose, key questions, criteria and standards to be used	Partners Focal persons Oxfam Consultants	
Stage 3 Partners' Self-Assessment	Self-assessment questionnaire Prepared presentation for PLI	Answered descriptive questions about the activities of the project, the various results it has had and the context in which it has been implemented.	Partners Focal persons	3-16 Aug

PHASE II – Consultation Phase: included consultation with partners in groups and individually and drafting of partner report				
Stage 4 Partners Learning Interaction (Kwentotuhan)	Partner Presentations Open discussion Pocket Chart data collection method	Collected data to for highlights of activities, best practices of the organization and strategies. (see Annex 4 for data collection sheet)	Partners Focal persons Consultants OXFAM	17–19 Aug 2:00 PM via Zoom
Stage 5 Partners Meetings (Kwentotuhan over coffee) Draft Partner Reports	World Café technique Synthesize data	Understand causes, collected and analyzed data to answer causal questions about what has produced the outcomes and impacts that have been observed.	Partners Focal persons Consultants	23 Aug - 27 Sep (2-hr sessions) Via Zoom
PHASE III – Assessment Phase: includes drafting of final MTE report and sharing of draft.				
Stage 6 Editorial session of	Open discussion	Overall assessment across partners	Consultants OXFAM Partners (Mgt)	TBD

The consultants had the role of supporting the whole Partners Learning Interaction process by producing guides, organizing meetings and webinars, stimulating discussion, upholding quality standards, maintaining continuity of the process, and documentation. Giving consideration to possible effects of the COVID-19 pandemic in project activities, lean staffing, health of participants and pandemic burnout, the consultants worked very closely with the focal persons and the most labor-intensive part of the work was carried out by the consultants.

Why Partners Learning Interaction or commonly known as Peer Review? -
Peer reviews are often described as the systematic examination and assessment of the performance of an organization by other organizations with the ultimate goal of helping the reviewed organization improve policies, adopt best practices, and comply with established outcomes of the project. It is a mutual learning process in which best practices are exchanged. The Partners Learning Interaction will allow discussion of topics that otherwise might not be given sufficient attention in the Partners Coordination Team meetings. The activities will be conducted in a candid and non-adversarial manner, and will rely on mutual trust among project partners.

Summary of Output of the Partners Learning Interaction

Table 2 shows the highlights of partners achievement as well as good practices and strategies as presented and discussed during the Partners Learning Interactions process. At the time of reporting, two partners did not fully participate in the self-assessment survey.

Table 2. Highlights of Achievements, Good Practices and Strategies

SHE Partner	Achievement Highlight (1 to3)	Good Practices	Strategies and recommendations
		PILLAR 1	
MIDAS	• A progressive programming for staff development (assisted by CAT4SRHR) helped MIDAS navigate through their strengths & weaknesses and peer educators' development. • With sustained effort, MIDAS surpassed its target (159%) on training peer educators and facilitators despite mobility restrictions and different levels of lockdown during the COVID-19 pandemic. Furthermore, to encourage youth involvement, MIDAS forged strong relationships with the Sangguniang Kabataan (at the barangay and municipal levels). In effect, SK became a wellspring of trained peer educators (integrating SRHR in SK plans and budgets, SK training on SRHR and HIV/AIDS). Likewise, it has established links with the men's group KATROPA and existing women's organizations to obtain their support to SRHR, and even develop peer educators among their ranks. • The importance of peer educators and other community leaders were recognized to sustain project benefits and successes, hence, initiatives by peer educators of organizing themselves as SRHR advocacy groups were supported by MIDAS.	• MIDAS integrated SRHR discussion in family development sessions and among the 4Ps beneficiaries through its partnership with MSWDO. It was seen that integrating SRHR discussions complements with the GAD awareness-raising agenda. • The use of PopCom's highly interactive module on Parent-Teen Talk proved to be a good move since it generated wide acceptance among this beneficiary group. • Through its community work, MIDAS recognized the importance of emphasizing gender justice to achieve social justice as its guiding principle. They also provided a lot of technical assistance to LGUs and NGAs on GPB, HGDG and other capability-building activities leading to SRHR mainstreaming in local plans and budgets. • To cope with the effects of the pandemic, they utilized a low dose - high frequency approach through the peer educators with the help of community leaders. They managed to catch up on target activities among youth and women though there is still a difficulty convening men as they were busy with livelihood. Also, massive roll-out and awareness-raising activities conducted by peer educators was highly effective	***To Continue Doing:*** • Close coordination with Jhpiego for complementation of activities on male-friendly services in the RHU. • Strengthening of IEC and advocacy work among partners, partnership building training, technical assistance to peer educators' efforts at forming themselves as an advocacy group; provision of technical assistance to LGUs in GPB preparation and conduct HGDG training/ workshop. • Aside from reflection sessions within organization and between organization and peer educators/facilitators, continue to disseminate learnings through creative forms like making video clips and printed materials featuring stories and lessons generated from the project. • Complementation of capacity-building activities at the VAW Desk Officers of the barangays with the Multidisciplinary Team training that Jhpiego is focused on is highly encouraged. ***To Start Doing:*** • Improve the utilization of Adolescent/ Youth Friendly Facility, peer educators actively taking part in referring clients for service provision with schedules of adolescents to assist in the I CARE HUB will be implemented.

		with the youth target group. ● Furthermore, MIDAS mobilized the support and technical assistance of other organizations like FPOP on PE Training and the LGBTQI –focused organization *Gayon Bicol*, in the conduct of training and other awareness-raising activities. ● MIDAS focused on how to sustain support beyond project life through the conduct of Sustainability Planning workshops among stakeholders. MIDAS saw the expressed desire of women's and youth groups to organize themselves as advocacy groups as a very promising move and the reception of the men to be part of MOVE (Movement Against Violence Everywhere).	● Give more attention to masculinity and the role that men and boys could play in transforming unequal gender patterns, more engagement with men's groups by organizing them as champions and advocates. ● Capacitate staff in feminist MEL as applied in SRHR especially in the strengthening and developing tools that would best capture significant changes obtained in the project. They may need assistance from Jhpiego in accessing municipal-level data for evidence-based reporting and planning. Comparison of HH survey of the project with the upcoming results of the NDHS for attributable impact to the project is also needed. MIDAS needs to develop a guide for collecting stories, identify indicators for specific changes in knowledge, skills, attitudes and behaviors relating to SRHR at the individual, household/family and community level. They need to look into existing journaling methods and incorporate story collection. Journal observations were discussed during PE meetings but need to have more thorough and in-depth analysis.
FPOP	● FPOP engaged champions among the CSOs/POs to fully implement RPRH laws and engaged and mobilized local advocates from the community and the youth, adolescent and adult sectors. ● FPOP conducted necessary TOT, trainings and learning events with key	● FPOP's good working relationship with local partners enabled them to give technical support for them. The systematic coordination between Jhpiego and FPOP in conducting activities complements the work of both	***To Continue Doing:*** ● FPOP must continue to engage SRHR champions among the communities for full implementation of SRHR advocacies among the various sectors they are working with. Aside from gender-sensitivity part of the training, they could

	actors on women's rights SRHR and relevant laws, facilitation skills, and interpersonal communication and counseling (IPCC) (i.e. rights and informed choice, volunteerism, family planning myths, gender and religion). They also developed IEC materials for targeted engagement activities. ● They conducted gender-sensitive training for men on male responsibility in supporting SRHR. ● Regular coordination between FPOP and Jhpiego proved efficient in the conduct of activities, and each organization complements the work of the other. Both organizations shared different expertise needed in the conduct of different activities of the project. There is also a shared calendar of activities of both Jhpiego and FPOP with the partner government agencies to ensure an organized and well-coordinated delivery of activities. Regular planning as part of the coordination meetings also helped in the successful delivery of activities. Furthermore, a professional culture of check and balance was practiced where both partners check on each other and provide constructive and objective criticism for improvement.	organizations by combining a monthly calendar of activities which they share with local partners. ● With their creation and organization of community groups such as peer educators, they were able to raise awareness on SRHR services. The youth also grew as advocates of SRHR and young peer educators became youth resource persons in their communities.	include sessions on how to encourage increased health-seeking behavior of men especially on FP and ANC. ***To Start Doing:*** ● Evaluation of IEC materials on their resonance to the audience for continuous improvement. IEC materials addressing teenage pregnancy need to be enhanced due to the increase in teen pregnancy in some areas. IEC materials must also be customized to include masculinity, and add hotline numbers for GBV, SRH services, HIV. ● Assess the impact of SHE project through learning sessions with stakeholders and peer educators. Furthermore, re-strategize the M&E plan with the team or have an internal reorientation on M&E concerns. ● Strengthen referral method from community to local agencies like linking peer educators to RHUs to see changes and progress in cases and include RHU information in gender sensitivity training. ● In order for the project to be sustainable, FPOP needs to create a group from the community to represent them in the LGU and adopt legislation that would support the goals and objectives of the group.
PKKK	● One of the milestones done was the organization of 24 GBV and SRH watch groups. They are accessible to GBV victims, provide referral to victims, and	● PKKK used LCFs at the barangay level as leader-facilitator-organizer of the SHE advocacy through an empowering conscientization approach in community	***To Continue Doing:*** ● PKKK should continue to adapt quickly to the new normal using a blended training format by creating a closed group page for

	bring victims to appropriate service providers. Current activities included continuous orientation with SHE modules, and facilitated formulation of their own goals and conduct self-assessment. Before their training, such as the Bodily Autonomy module, they only talked about family planning. With the SHE project, other aspects of SRHR were included especially on women's rights. ● SHEKAHAN for men and couple elders (barangay officials, tanod) was on male responsibility training via GST for couples through barangay champions who have bigger local influence such involvement on education committees and the like. ● Increased decision-making behavior among women participants were observed when after community sessions (SHEka SHeka), some women sought the advice of the LCFs on matters like how to negotiate with husbands who don't allow them to avail of contraceptives, how to access the FP commodities and services, how to address incidences of VAW. One Subanen woman asked the Local Community Facilitators (LCFs) to accompany her to talk with her husband who happened to be a Timuay or IP leader. This resulted to the woman acquiring depo for contraception.	organizing to draw out values and beliefs considered 0taboo to reach out, establish trust and raise awareness on the desire to act on SRHR issues. ● FGD workshops on Youth and Children's rights through creative activities and games from Play Your Rights manual were held from the beginning. Here, situations on teenage pregnancies and abuses were identified, and identified youth peer educators were trained for their municipalities. ● Training of male local barangay officials and volunteers on the concept and their roles and responsibilities on gender equality, human rights, SRHR, GBV; who later drafted their plans to hold the same process of conversations, dubbed as Kulo Kabildo sa Kalalakinhan. ● PKKK's continuous learning activities related to SRHR Foundation Training: MY BODY, MY SELF, MY PERSONHOOD are relevant and can be shared to other CSOs. ● CAT4SRHR led to values clarification for the PKKK women leaders and secretariat and increased capacity and confidence of the leader-cadres/ community facilitators. ● PKKK adopted the AOM Strategy, which basically is Arouse-Organize-Mobilize through awareness raising and changing mindsets; goal setting, self-assessment, collective action planning; strengthening	local facilitators and project teams, SHEkahan sa Kanayunan, to resolve the issue of internet connectivity. Zoom meetings are not feasible, hence provincial teams will continue to access and download videos when they do the TOT. ● Being constantly responsive to emerging situations, but still abiding protocols set for COVID 19, distribution of the hygiene kits, alcohol, helplines and the Inday Chika leaflets served the purpose of keeping the SHE advocacy and PKKK's presence felt during the lockdown. Access to social media is not that frequent in the GIDA barangays and therefore printed materials will be more helpful. ● Though dialogues with IP leaders have been pushed back due to the pandemic, some IP leaders have already expressed that they would like to see all their community members to be involved in the SHE Advocacy. IP dialogues planned will have the opportunity to correct the feeling of discrimination in RHU's. Traditional Birth Attendees are currently working with RHUs and they can coordinate with Jhpiego and RHUs, when applicable. ● For the youth peer educators, reduced activities were observed, especially when online schooling started. Their shift to community-based activities including awareness raising and mental health interventions need to be continued.

	● Increased capacity among the women LCF was evident, i.e. proving themselves capable of influencing their respective communities as far as SHE was concerned. They created an encouraging environment for the women to articulate and utilize SRHR services. The same is true among the youth peer educators, several them initiated their own activities and even coordinated with other youth from different barangays. They showed active participation and interest in the Teenage Pregnancy Prevention fora and campaigns. Some of the youth leaders were able to reflect the SHE advocacy in their respective SK plans.	rural women's organizations thereby influencing the power structures, social institutions, and communities to take transformative action in the realization of SRHR. ● The tools PKKK used subscribed to feminist pedagogy and popular education principles putting people, particularly women and girls, at the center of conversations. The processes encouraged them to speak and their importance, dignity and their rights were affirmed recognizing their potential to change the situation.	● They need to continue coordination with Jhpiego (e.g. input on where to establish the AYC in the case of Sumilao) on activities where both organizations can build synergies. ● Coordination with local agencies & BLGUs are equally important, as well as the community sensitization activities where the presence of local agencies is ensured as the sustainability mechanisms for the SHE advocacy. ***To Start Doing:*** ● Enthusiasm and willingness of men to learn their responsibilities may not have been brought on a personal level indicating resistance to the notions of gender equality, hence further sensitization strategies need to be explored. ● Reach out to men via GST for Couples, to parents, and to IP elders. Invite and train male facilitators, tap the male kagawads, some of whom are in charge of the education committees in the barangays. Ensure that local SRHR champions among the local officials will be recruited and sustained. Conversations have started with the male groups, starting with the barangay officials, and trained barangay officials will roll out the topics to other male groups in their respective areas. Male groups will be linked to PopCom and DSWD, with their ERPAT and KATROPA programs.

			● DILG/Government agencies' behavior towards CSOs (red tagging) could be addressed through sustained formal dialogues with LGUs, and DILG gets the monthly plan of activities and LGUs get invited to GBV training.
SIKAP	● SIKAP made a simultaneous focus on community norm setting, adaptable SRHR service provision, organizational capacity and social accountability (implementation of laws and policies) to improve health-seeking behavior among beneficiary-community partners. ● Enhanced their Manual of Operation with embedded SRHR. Collective decision of SIKAP to embrace SRHR as its flagship program is proof that the capacity building activities work well, resulting in dedicated staff who are competent and passionate at what they do. ● While relatively new to SRHR, SiKAP was able to conduct family planning outreach activities with a good number of FP acceptors and exceeded targets. They were able to complement activities for SRHR (Usapan Serye) for various groups (especially women) to generate demand and service provision with LGU support in the implementation of their plans through a local resolution. Effective IEC development through USAPAN Serye was done through participatory and dialogical manner and	● Performance Accountability System resulted in better governance support (policy, logistics, financial), engagement of key stakeholders in the municipality and barangays, responsive health service provision, community mobilization, transformation of women leaders (became more active and self-confident in spearheading community activities ex. survey of WRA with unmet needs) and more accountable local leaders. ● Through SIKAP's strong coordination and partnership with LGUs and various line agencies, they improved joint accountability with LGUs (e.g. Municipal Health Office included in planning and assessment) and mobilized regional, provincial, municipal and barangay partners in providing assistance to women. They were also able to develop breakthrough plan implementation with WROs for sustainability plans ● Adolescent and WROs-driven/ initiated activities for FP and GBV by using SK Fund for Usapang Barkadahan activities, and mobilized peer educators, VAWC Desk Officer to conduct awareness sessions. They have seen that this	***To Continue Doing:*** ● Internal monitoring systems such as following-through plans on higher or outcome level monitoring and reporting. Train in-house staff on DQC that would complement the activities of Jhpiego at the RHU level and provide another lens of correlating project numbers with that of the official count of the RHU/municipality vis-a-vis health indicators. There is a need for uniformity and harmonization of forms, particularly on FP outreach activities and Enhanced Usapan sessions, to easily collect and collate data for endorsement at the RHU and reporting to partners such as harmonized attendance sheets. ● Use of Jhpiego's modules and materials on different capacity-building and advocacy activities at the barangay level must be encouraged. ● SIKAP needs to continue parent-teen training and website development. ● Mentoring, coaching, and post-activity hand holding to follow through and reinforce decisions made and plans to address issues and concerns (ex.

	capitalized on youths being able to spearhead their own activities. Barangay health workers' sensitivity in dealing with beneficiaries was remarkably improved. ● Actively changed social norms and perspective of the local leaders and community for women to become empowered to claim their rights (women are now regarded with respect), became more confident in their capabilities, and was able to lobby for policy and funding support from their respective barangay council, as exhibited by WROs successfully accessing the GAD budget for the implementation of breakthrough plan on FP and GBV.	strategy works well due to committed WRO's and supportive local officials and health workers: 1. Increasing the number of influencers, providing information and capacitating them (WROs, BHWs) 2. Rights-based advocacy and rights claiming (ex. FP services for WRAs with unmet need) 3. Tapping, organizing, and mobilizing WROs 4. Use of performance accountability system as a tool where governance, service delivery, and community mobilization was synchronized and produced results on key performance indicators.	adolescents who attended Usapang Barkadahan) need to be continued. ● Comprehensive approach to planning and execution combining governance, health service delivery, community mobilization (ex. strengthening WROs) and systematic assessment of staff capacity resulting in identification of appropriate capability-building needs for both staff and institutional growth need to be continued.
AMDF	● AMDF-formed core groups consisting of community leaders from different sectors led to easier implementation and buy-in of project strategies. Men and boys were trained on Gender Sensitivity including GBV prevention. Women, men, girls, and boys were reached in the conduct of community-based awareness sessions. ● Through consultation of credible MRLs, 6 sermons/khutbah on SRHR and GBV were developed, as well as a booklet that served as an IEC material for Covid-19, SRHR, GBV, Mental Health and Referral hotlines. This booklet was reproduced and distributed to different areas along	● AMDF built the capacity of peer educators including youth from 5 high schools in the project site through the conduct of sessions on Adolescent Reproductive Health, GBV, early marriage. They tapped peer educators to implement SHE activities. ● They also anchored advocacies to Islamic teachings since they operate in a 99% Muslim area in Bangsamoro by using credible Muslim religious leaders as champions to discuss SRHR and GBV principles to supplement and bolster staff confidence in discussing these sensitive issues. A focus on empowering women by knowing their rights as human beings,	***To Continue Doing:*** ● To address technical terminologies and relate SRHR to Islamic teachings, capacity building for MRLs on SRHR issues and advocacies need to be continued. ● AMDF's strategy to target families instead of individuals on GBV awareness using family conversation process to achieve a leveled-off knowledge among family members (Parents Conversations and Peer Education Sessions or Family Conversation) is noteworthy. Family conversation is one of the designs that was popularized by AMDF since 2017, the idea of targeting the whole family to have a leveled knowledge on SRHR had

	with the hygiene kits provided by Oxfam as part of the Covid-19 response. Furthermore, development of SHE Project materials were consulted with AMDF leaders to ensure key messages were in line with advancing the advocacy of the project. ● AMDF continually strove for improvement of the organization through organizational review and updating of policies: a) review the organization's policies and programming and update them in compliance with minimum standards in promoting safe space for women and children, as well as other vulnerable groups in the society, b) capacitated the entire organization by improving their confidence in project management (skills), increasing their knowledge of the advocacy themes that the organization focuses their programming on, and deepening their understanding by promoting positive attitudes and values, c) created monitoring, evaluation and learning mechanisms as well as communication plans that are integrated in all the organizations' way of working.	as women, as a Muslim, as well as including their SRHR rights were carried out. Activities were designed with an objective of increasing the awareness on SRHR in the context of Islam including GBV prevention and increased understanding that SRHR services were essential and taking care of reproductive health was an essential part of being a Muslim. ● The CAT4SRHR process supported the organization's development and it enabled the organization to revisit its operational processes and policies, hence making it more beneficial for the implementation of its projects. ● The existing skills of members and staff on mediating GBV cases was further honed during the Enhancing Dispute Resolution and Management Processes. Staff and members also participated in project development management training that further enhanced their skills in developing and managing an entire project and ensuring it is successful and attained its intended outcome.	been practiced since the implementation of community-based sessions. For outreach services in conflict-affected areas, they inject family conversation (mental health, SRHR) in conflict-related activities in evacuation centers. Women are prone to GBV and lack essential services of SRHR, discussing these in this space enables men, women, and teenagers to discuss GBV and SRHR in breakout sessions and discuss together in the plenary session. ● Local training with reduced participants and consolidated modules are done since virtual sessions are not widely applicable due to connectivity issues, and not widely accepted. Local volunteers are tapped in project activity preparation too. ***To Start Doing:*** ● Archiving of project documents to be used as references and can also be shared with other partners. Highlight integration of SRHR principles on safety and security priorities, and support to psycho-social counseling. ● Staff capacity building to provide technical assistance for LGUs and BLGUs to make their offices functional, such as knowledge and skills on how to make ordinances, BDP, GAD budgeting, setting up referral systems and others so that budget for these activities will be allotted.

			● Constant communication and engagement of the trained community leaders help in the implementation of the project. Investing for their capacity building will help them, the community and the project as well for post project sustainability. Consistency in the quality of activities conducted adapting to the target audience needs to be sustained.
UnYPhil	● The SHE Project activities empowers women to take action on GBV cases, especially that among the municipalities it works, rape justice cannot be served due to the strong culture of silence. ● UnYPhil Women strengthened partnership with the Bangsamoro Women Commission, CSOs/INGOs to influence the inclusion of elimination of child early forced marriage, and respecting the rights of LGBTQ in Bangsamoro GAD Code. ● Trainings were conducted on SRHR, gender sensitivity, gender justice, GVB and VAWC, ICT, basic facilitation skills and leadership among different groups: (Service providers (RHU, PNP/WCPD, LGUs, Local Youth Development Offices), SK fed, Men leaders, BPAT, Local leaders (Commanders), MRLs, Tribal leaders, Women and youth leaders). Awareness raising was done, led by core/support groups though face-to-face community/school sessions,	● Community discussions started with an Islamic context of basic human rights and linking it with existing laws such as RA9262 (VAWC), 7610, family code and other pertinent laws as part of a holistic approach to human rights. ● They strongly influenced duty bearers to function and do their mandates and actively involved stakeholders for ownership and sustainability such as MRLS and IP leaders (i.e. Qu'ran scholars who speak Arabic), to add credibility to information dissemination and knowledge sharing activities of the organization. ● They also strengthened policy lobbying on GBV and SRHR supported by Darul Ifta to correct harmful culture and traditional practices. ● They formed, collaborated, influenced and actively involved stakeholders' support groups (LGU and line agencies, women and youth, SK, LYDO) for strengthened partnerships in the implementation of project activities.	***To Continue Doing:*** ● The Involvement of Muslim Religious leaders and IP leaders contributed in the reaching out to remote and conservative communities. ● Regular capacity building program for all their staff to build capacity on implementing SHE advocacies in other project areas with regular reminders of reading the Qur'an for a deeper knowledge of the teachings vis-a-vis SRHR and related concepts. SHE Project activities coincide with the GBV mandate of the organization and its capacity building component strengthens the organization's general operation too. ***To Start Doing:*** ● Collaborate with implementing partners (Jhpiego) for capacity building of staff and their intervention with the RHU. Ask technical support (from Oxfam Manila SHE team) and capacity building for the following areas need to be strengthened:

	recorida, radio programs, Mohadara/Khutba to the mosque. ● Project funds advocacy, lobbying, and networking among youth leaders such as Maguindanao Alliance of Youth Advocates (MAYA) and Buluan Youth Advocates (BYLA) and South Upi Youth Advocates, who were champions in both the congress and the senate on youth alliance as a voice to influence against child early and forced marriage. All of them commit not to engage CEFM in their early age. They also convinced their friends and family to support their advocacy. DEPED principals and teachers were trained to include SRHR in their curriculum.	● CAT4SHHR (Conducted strategic planning, financial management workshops, basic IT, photography to 30 staff for documentation and reporting purposes; Conducted training and workshop on manual development for SRHR, GBV and CEFM and proposal making) CAT4SRHR strengthened the capacities of all staff in monitoring, proposal making, GBV and gender justice and SRHR.	using social media platforms on MEL online advocacy, policy lobbying. ● Close collaboration and teamwork between the service providers such as the Rural Health Unit, Local Youth Development Office, Sangguniang Kabataan, Municipal local government unit and other groups also help facilitate smooth implementation of the project.
Jhpiego	● 100% of target health facilities had (i) space with audio-visual privacy for examination of clients and provision of counseling; (2) records of SRHR counseling provided by trained staff; and (3) provided at least three modern methods of FP (including 1 long-lasting reversible method). Ten (10) Level 01 AFHF and one Level 02 AFHF in all of the SHE project sites. Usapan Serye, SRHR caravans, FP outreach in collaboration with RHUs and SHE partners proved to be essential in bridging information and available services to the communities. Strengthened one referral mechanism	● A good understanding of the whole project design provided not just good information of the technicalities of the work that they do, but also helped partners in strategic planning and implementation. Jhpiego has ensured that all regional coordinators were trained on Gender Transformation for Health and on First Line Response for Health Sector (GBV) as facilitators and all key staff on gender and health perspectives. These would not only aid in the roll-out of gender training activities but also impart the project's goal of gender-responsiveness to be evident even in the workplace.	***To Continue Doing:*** ● Jhpiego's technical assistance which provided for improved management and coordination of AHDP, SRHR and GBV prevention services need to be maintained. ● They need to continue to build youth-friendly and gender- responsive SRHR services established and functional - Support house-to-house outreach of health service providers - Utilize video materials - Hotlines (The establishment of hotlines and provision of guidelines by Jhpiego is a promising innovation that needs follow up)

	for GBV and established a multi-discipline team (MSWD, PNP, RHU). ● Regular coordination of FPOP and Jhpiego prove efficient conduct of activities, and each organization complements the work of the other. The organization shares different expertise needed in the conduct of different activities of the project. There is also a shared calendar of activities of both Jhpiego and FPOP with the partner government agencies to ensure an organized and well-coordinated delivery of activities. Regular planning as part of the coordination meetings also helped in the successful delivery of activities. There is also a professional culture of check and balance where both partners check on each other and provide constructive and objective criticism for improvement.	● Extends technical expertise important in delivering project activities and providing technical assistance to partner LGUs for healthy cross-checking and accountability among partners and also helps partners in strategic planning and implementation ● Regular staff meetings and continuous learning activities (electronic research library, brown-bag seminars) during regular monthly meetings worked well with the organization. ● The Women and Child Protection Unit included in the core team of AHRP council, DepEd (will create a club in school through peer educators) helped too. ● Aside from conducting activities virtually, those that would need physical gathering were reduced to a lower number of participants hence the need to do several batches. Aside from the additional cost implementation of having more batches, larger venues were also sought to maintain social distance and provide hand hygiene during activities. Before, training activities were conducted with participants from all nearby project areas attending at the same time. The pandemic caused the activities to shift to facility-based activities to avoid the travel of participants and mingling with participants outside their municipality.	● Focus on gender-responsiveness which encompasses non-discrimination of a woman's decision on her reproductive and sexual decisions. The technical aspect of women's reproductive and sexual autonomies is most defined in demand-generation activities lodged to partner local CSOs. ● Focus on male-friendly services in health facilities.

		Technology and internet-based applications were very helpful in reaching out and conducting training activities, however for project areas with an intermittent internet connection, being physically present is still the best mode of implementation. When the RHU or the health staff are not available for an activity, Jhpiego would prioritize other technical areas (i.e. GBV, AHDP) that would only involve a few people – one each from the municipal health office, PNP WCPD, MSWDO, and local CSO partner. In this case, Jhpiego will still see progress in implementing SHE project activities. ● Proper coordination and partnership management paved the way in adapting to the new normal of project implementation. Jhpiego respects local IATF guidelines, and in return, partners in the LGU prioritize their activities when restrictions ease down.	
Pillar 2			
DMSFI	● The SHE project is the first project that DMSFI as an organization and its staff were capacitated in gender and SRHR. DMSFI was a generalist on its gender and development approach before. Through the SHE project, DMSFI enhanced its capacity in addressing gender and SRHR concerns not only at	● On time submission of plans (AWP, Annual budget, etc.) and reports (Narrative & Financial) helped in project implementation. ● Committed staff (target participants) to participate in all SHE training. They already include in their monthly workplan	***To Continue Doing:*** ● Correct and proper information in relation to SRHR and prevention of gender-based violence will be disseminated to partner communities and advocacy activities will be clearly defined. Determine the situation of women as a basis for beneficiary selection.

	the institutional level but also in the covered communities. ● The first year of SHE project implementation of DMSFI focused on the capacity building of the staff and identification of action points to be a gender-just organization. This was the period where most of the staff have acquired the basic concepts of SRHR and dimensions of women's reproductive and sexual autonomies. Conducted trainings despite using the online platform led to the achievement of project output which enhanced the capacity of IPHC staff on SRHR. ● The capacity building activity on Rights-Based Advocacy and IT technology/use of social media enhanced the knowledge of the senior staff of DMSFI on the basic guidelines in maximizing the social media for advocacy work. Adherence of the participatory process wherein all the DMSFI- staff were involved and consulted in the conduct of the CAT4SRHR process facilitated/ hastens the implementation of the project. ● DMSFI was able to revisit its institutional documents (Manual of Operation, HR policies, Sexual harassment policies, development framework, others) and have started to improve all these to become gender & SRHR sensitive with the technical assistance of the consultants through review and revision	the SHE activities as part of their commitment to the project. ● The training schedules were strategically placed in the last week of the month as some of the participants were doing field work and their availability falls on the last week of every month as they have to go back to the office for project meetings and other institutional activities. ● The CAT4SRHR process allowed DMSFI to objectively identify the gaps in mainstreaming gender and SRHR in the institutional processes and mechanisms. It pointed out what aspects of SRHR that IPHC lacks knowledge of and how this can be responded to. The results of the CAT4SRHR became the basis of DMSFI in developing the institutional workplan to respond to the identified gaps in knowledge, attitude and skills and actions to do in mainstreaming gender and SRHR in DMSFI.	● Participatory assessment and review of the organization's policies, programs and projects, and mainstreaming gender in the plans already started this Y4Q1 of the project implementation. ● They will review hiring policies to consider principles of inclusivity and develop policy on communication using non-sexist language and gender-neutral language, non-discriminatory policies together with the concern group (with limitations) and review sexual harassment policy of DMSFI: - Consider improvement in some infrastructures & facility to become SOGIE responsive - Explore possible engagement with Commission on Population, City Population Office, etc.) to complement resources to support SRHR programs that DMSFI will be implementing - Regular review of Gender Justice & SRHR in all DMSFI activities. Promotion of legal actions/laws that supports GJ & SRHR issues - Develop proposal for young & potential parent, elderly & LGBTQIA+ - Review of Institutional vision and mission that will reflect the principles of gender equality - Training designs must be empowering (not limited to the

	(if necessary) of DMSFI's organizational vision, mission, core principles and institutional policies, plans, processes, systems and procedures.		male-female binaries only). Spaces for SOGIE advocacy/education. Awareness of Management, Staff, and Community Partners on SOGIE must increase - The outputs from the SHE training needs to be reviewed to check the consistency of the context and content. There's a need to follow through the status of implementation and the steps forward of all the training outputs - Provide IEC in local language for GBV awareness, etc - Knowledge based change. Explore the use of journaling - Explore partnership with UPCWGS for arts-based research, Jhpiego, and other SHE partners
Friendly Care Foundation	• FCF staff deployed in itinerant missions were better educated in how to approach their counseling strategies. Implementation of learnings from training at the earlier days in the field showed in how their medical staff incorporated their classroom learnings to actual counseling and engaging with WRAs (women of reproductive age). • Staff were more consciously carving time in their counseling sessions to promote openness, to disarm and build trust among adolescents (privacy even in a plastic barriered setting), to probe concerns of women who tell and show	• FCF implemented immediate application of learnings in the classroom in clinics and itinerant missions. CAT4SRHR, ADEPT, HEADSS were immediately used in counseling encounters. This resulted to better services, for example, the Family Planning counselors were more proactive and were now giving time in the counseling conversations to probe sexual health concerns and address these with the LGU's referral network. • Their LGU network connections were leveraged during the pandemic with key players on the ground learning what's expected and adjusting	***To Continue Doing:*** • FCF has started to review organization policies and manual of operations to include SRHR language. They might need assistance from DMSFI on how to go about some of the policies and manuals revisions. • Capacitation of staff while maintaining flexibility and welcoming the change as they adjust to the following factors: their health, time availability given their clinics' staffing is lean due to lower foot traffic, itinerant missions, availability of online modules and skilled, available trainors.

	that they are coerced by their partners and provide means to get help. The techniques were enabling them to bring the guard down of adolescents and make them more open and a more compassionate stance is developed as a result. Attendees to their outreach activities increased and FCF was asked to return to the sites and cover more barangays	accordingly. Highlighting staff health and safety through full vaccination, use of PPE's, PPE's, triaging and LGU referrals promoted ease of operations for staff and clients. They promoted quality and compassionate service to build trust among their patients and service providers.	***To Start Doing:*** • They will document learning of medical staff and how they apply it and monitor through quarterly FGD. Use of journaling as a method of documenting knowledge and behavioral change to complement their quarterly feedback meetings. Additionally, they intend to borrow the great ideas of partners in IEC materials to easily teach and advocate to WRA clients in the language that is easy for them to understand. (videos from Oxfam, VAWC training from Jhpiego, IEC from MIDAS, social media content creation from WGNRR).
UPCWGS	• Their collaboration with like-minded individuals and organizations led to strengthening efforts against GBV and SRHR. In developing knowledge products such as research studies, modules, and policy briefs on SRHR and GBV (e.g., Teenage Pregnancy, SRHR efforts during the pandemic, etc.), the UP CWGS worked with consultants from Lunas Collective, Young Feminists Collective, Feminist Media Lab and other feminist organizations. Further, in conducting the creative workshops with the LGBTQIA+ and Young Adolescent clusters, the research team was surfacing new trends such as cis gay and heterosexual men experiencing body image issues. Body dysmorphia and other mental health concerns were also unearthed during the	• UPCWGS and the SHE Project have a good values-fit, with their pool of experts all have gender and SRHR lenses and the same values, beliefs, principles, and standpoint. They ground their work on feminist ethics, care and principles which enabled the best work to emerge. They were highly flexible and willing to learn, adjust, and adapt. With or without the pandemic, sudden changes in the environment required flexibility in project governance and work which they were quite ready to do. • In producing and monitoring the development of knowledge products, including research studies, workshops, webinars, policy briefs, infographics, video shorts, among others, the UP CWGS utilized various online and digital tools	***To Continue Doing:*** • Realignment of budget to accommodate activities that can be done ahead of schedule (3 new mini research studies, SRHR and Feminist Media 101) • Revise work plan to conduct online-ready activities in advance. Adjusting time frame for workshops, tightening schedule to deliver all planned output by end of project. • Revisiting budget realignment rules. Project pre-pandemic items such as transport, meals, and accommodations are no longer applicable, but now the need for output is high. Travel restrictions will require them to tap people from the community as research partners, but this is hindered by the 10% rule on budget realignment for consultancies.

	participants' discussions and creation of outputs.	(e.g., Zoom, Facebook Messenger, Google Docs, Google Sheets, Gmail, etc.). They have converted face-to-face training and workshop modules (e.g., feminist research training, feminist media 101 and SRHR, creative workshops, etc.) into online ones; conducting training programs and workshops via Zoom; looking for creative and engaging ways to conduct online sessions (e.g., integrating art and casualty into conversations, using other content such as video shorts or infographics, integrating short activities); enabling work from home (WFH) arrangements; migrating meetings and communication systems online; among others. Though these venues lack the physical responses and cues and develop Zoom fatigue, for now, this is the best avenue to get a job done. • Grassroots experience of partners, OXFAM's choice of partners was commendable and were helpful in gaining grounded insights on SRHR in local communities. • The project was able to proceed despite monumental environment changes because of flexibility in realigning the budget. • Work was able to continue because OXFAM was quick to adjust and foster online coordination.	• All activities such as the workshops, trainings, and conversations contribute to the generation of knowledge products which will be disseminated to SHE Partners, UP CWGS partners, and other key policymakers and implementers. Training, mentoring, and consultations will be held with partners for local research studies. The UP CWGS training and learning sessions will also be open to SHE Partners. Some of the creative workshops will be held in partnership with SHE Partners such as the Negros Oriental Creative Workshop with PKKK, and the Marawi Creative Workshop with AMDF. All research publications will be disseminated to SHE Partners. ***To Start Doing:*** • During SHE Partners' meetings, the UP CWGS may also present its current research output, methods, and activities to SHE Partners to encourage them to use these creative methods as well. • Proposed realignment will be utilized to produce seven (7) sets of videos with three to four (3-4) videos per set, on the following topics/themes: Feminist Pedagogy (as applied to SRHR); History of Feminism and SRHR; Filipino Feminist Movement and the SRHR Advocacy; Feminism/Feminist Perspectives on SRHR; Pleasure Positive Understanding of

			Sexuality; Reproductive Autonomy and Justice, Diversity, and SRHR; Media and SRHR; Intersection of Patriarchy, SRHR, and Media; Feminist Media and SRHR Advocacy and Campaigns; Media in SRHR Advocacy; and Media Production. The production of these short videos will not only address the concerns and issues discussed earlier but will also contribute to the generation of knowledge products as part of the SHE Project objectives. In addition, the videos will also be useful to the Project Partners and other women's rights organizations in understanding the role of media arts in the SRHR campaign. Lastly, it will help capacitate the said partners in producing their own content and media outputs in furthering sexual health and empowerment.
WGNRR	• WGNRR had a comprehensive SRHR/ rights-based approach to issues of sexuality and reproduction and campaigning contested issues (i.e., access to safe abortion, minors' access to contraceptives). • WGNRR's multimedia reach and strong social media and tech savvy helped them adapt quickly to the changing landscape of advocacy in the new normal. They made six (6) public advocacies and engagements such as various campaigns on SRHR mechanisms, 1 networking and alliance building too. An SRHR mobile application in partnership with UN SDSN	• WGNRR saw the importance of providing learning opportunities for WROs, advocacy groups and organizations working with young people on fundamentals of SRHR because of the need still to address knowledge gaps and demand from organizations themselves for these kinds of activities. • More established organizations were better engaged through advocacy and campaigns than capacity-building. To them, SRHR was something that really resonated with young people and they should be able to ensure a supportive	***To Continue Doing:*** • WGNRR project management needs to be adaptive to evolving situations. • Operational: Transfer to online modality resulted in delays in implementation of projects as well as need to adjust budget requirements. Burn rate is not as efficient as if projects were delivered offline. • Campaigns-wise: accountability asks and issue framing must also adapt. • Continue to address knowledge gaps on SRHR with organizations • WGNRR will continue their advocacy campaigns and capacity building and communication messages to promote,

	Youth was created and a webcast titled, "SRHR Roundups" which provided news and featured experts and guests from the government and civil society to discuss key SRHR issues. WGNRR adapted to the new normal modalities quickly and redesigned their strategies and budgets with its accompanying learning curve and challenges. • Pasya Advocazine was created aimed at presenting stories, perspectives and practices on SRHR in the PH. • Two partners reported to have improved their influencing skills	environment for organizations working with young people as well. • WGNRR used a feminist lens, along with rights-based and justice frameworks, in analyzing SRHR issues evident in their training materials, messaging and activities. They focus on connecting with the marginalized populations of the society.	defend, and advance SRHR so that women and girls, especially in the most disadvantaged situations, are empowered to make autonomous and informed decisions over their reproductive and sexual health. • Team review on SRHR materials is strongly guided by their feminist framework, including partners, through write ups, meetings, and hiring of consultants providing inputs and resources aids to WGNRR ensuring messages connect to the experiences of historically, economically, socially, physically, and/or geographically marginalized populations.

Annex 4: Sexual Health and Empowerment (SHE) Project Midterm Change Study: Health Service Providers

October 2021

1. Introduction

The midterm change study was carried out as a component of the mid-term evaluation (MTE) for the Sexual Health and Empowerment (SHE) project. The MTE was designed to provide the project with a basis for identifying appropriate actions to: (a) address issues or problems in implementation, and (b) reinforce initiatives that demonstrate the potential for greater impact. It focused on assessing the assumptions, strategies, and drivers of the Theory of Change as described in the Project Implementation Plan. This midterm change study aims to take stock on initial lessons from experience of healthcare providers in project activities to support and promote sexual reproductive health and rights (SRHR).

1.1. Sexual Health and Empowerment (SHE) in Health Facilities

SHE seeks to empower women and girls to secure their SRHR in six disadvantaged and conflict-affected regions of the Philippines. SHE has two components: (1) public education in communities and training of health care workers to shift attitudes, increase knowledge, and improve access to sexual and reproductive health information and services, and (2) build skills and knowledge in Women's Rights Organizations (WROs) to conduct research and advocate for sexual and reproductive health and rights, including the prevention of gender-based violence (GBV).[5] It will improve knowledge and awareness of SRHR, particularly among women and girls to equip them in the prevention of GBV. It will strengthen health systems and community structures to deliver rights-based, comprehensive SRH information and services, and improve the effectiveness and capacity of WROs and women's movements to advance SRHR and prevent GBV.[6]

To achieve project objectives, Jhpiego coordinated with other SHE implementing partners (MIDAS, FPOP, AMDF, UnYPhil, PKKK, Tarbilang, and SIKAP) in providing technical assistance package to project sites in six (6) regions in the Philippines which include training for health service providers on family planning (FP)/maternal and child health (MCH) services. This also includes the flagship Gender Transformation for Health training for health service providers. SHE supported FP service delivery at the facilities and community through outreach services, strengthened adolescent health services and GBV management and prevention. SHE enhanced health service providers FP services through competency-based courses, built health workers' competencies to address adolescent clients' needs through Adolescent Job Aid (AJA), Healthy Young Ones (HYO), and integrated Gender Transformation for Health training as crosscutting inputs given in low dose high frequency approach. SHE worked on capacitating health service providers toward transformation of gender roles, norms, and dynamics for a gender-responsive healthcare delivery.[7]

SHE strengthened the Adolescent and Reproductive Health program of the health facilities and its referral pathways. SHE trained health service providers who can provide at least three (3)

[5] https://www.oxfam.ca/project/she/
[6] OXFAM Canada, 2021. Term of Reference Sexual Health and Empowerment Mid-Term Evaluation (MTE)
[7] Jhpiego, 2020. Jhpeigo Annual Project Results Report Year 2.

modern FP services (OCP, Injectables, IUD, Implant, or Condom) and improved existing referral mechanism that includes hospitals that provide long term and permanent FP methods. SHE supported the refurbishment of adolescent-friendly health facilities to ensure gender-sensitive and youth-friendly spaces for SRHR services, and as a result, adolescents will have access to comprehensive health care and services in an adolescent- friendly environment. Jhpiego, through the SHE project, facilitated the provision of equipment, which includes a sofa set, office cabinet, bookshelf, board games, and an air-conditioner.[8]

1.2. Objectives of the Midterm Change Study

The main objective of the Midterm Change Study was to contribute to the MTE, including evidence-generation while also demonstrating social behavioral change among key drivers of change in SRHR. Specifically, the objectives are:

(i) To understand how the SHE project has changed the health service practitioners' SRHR related knowledge, attitudes, and behaviour
(ii) To identify changes in the capacity of the health facility to provide comprehensive and gender-responsive SRHR information and services
(iii) To identify capacity building needs of health service practitioners

1.3. Midterm Change Study Process

The following data collection tools and processes will be carried out for the Midterm Change Study (see Table 1):

Table 1. Data Collection Tools, Data Sources, Sampling and Data Analysis and Interpretation

Data Collection Tool	Data Source	Sampling	Data Analysis and Interpretation
1. Desk review	Health Facility Assessment Report SHE Project reports	52 respondents of the RHU Assessment[9]	The baseline data collected during the RHU Assessment provided the basis for testimonies of change and needs assessment.
2. Semi-Structured Qualitative Phone Interviews (see Annex A for questionnaire)	Health service practitioners	11 health service practitioners	Using the Stories of Change method, three (3) identified domains of change in the Project Implementation Plan were used in the analysis, which are (1) increase knowledge, skills and capacity of health workers, (2) improved positive attitudes modeled by health workers in support of SRHR information and services, and (3) improved capacity of the health system to provide comprehensive and gender-responsive SRHR information and services.

Data was collected by an external research team and not by staff of the project partners to ensure unbiased answers from respondents. All 52 respondents of the Health Facility Assessment conducted in 2020 were contacted from August to September 2021 through text blast and phone calls to get their consent to participate in the Midterm Change Study. Eleven (11) health service practitioners agreed to participate from all six (6) regional project sites (Bicol region, Northern Samar region, Zamboanga region, Caraga region, Northern Mindanao region,

[8] Jhpiego, 2021. Jhpeigo Annual Project Results Report Year 3.
[9] Jhpiego, 2020. SHE Project Rural Health Units Assessment – Baseline Report. July 2020, Philippines.

and BARMM). Four (4) respondents are also in the management team. Phone and video call interviews were conducted. It was the intent of the study to use the Most Significant Change method. However, due to high attrition rate of respondents, stories of change[10] tool were used in the analysis. Health service practitioners and managers were asked whether the project has resulted in any changes in them and in their health facilities and what else are needed to meet the expected outcome of the project (see Annex A for semi-structured questionnaire). Stories of change are used as a tool for communicating progress and the value of a project.

1.4. Scope and Limitations

As mentioned, the Midterm Change Study is a component of the MTE, conducted after the third year of the SHE project. It aims to shed light on the activities of SHE in engaging key community actors to support and promote SRHR and gender norms. The focus of the study are health service practitioners, who are key drivers of change in the SHE project. While monitoring activities have been useful in assessing the outputs of the project since its inception in 2019, the midterm change study allows for the collection of in-depth qualitative stories to better understand SRHR intervention.

For the data collection, despite repeated follow-ups to health service providers, the resulting attrition from the baseline sample is high. The Philippines was intensively rolling out COVID-19 vaccinations all over the country, and health service providers were very busy prioritizing these activities in vaccination venues, so it was harder to set appointments for a phone interview with them. At the same time, health service practitioners were already interviewed for the GAC semi-annual monitoring and Oxfam Philippines monitoring for the annual report hence many health service providers chose not to be interviewed anymore.

2. Engaging Key Community Actors to Support and Promote SRHR and Gender Norms

Analysis of the data collected was completed at two levels: (i) a reflection on the Stories of Change (see Annex B); and (ii) a reflection on three (3) domains of Theory of Change, which are: 1) increase knowledge, skills and capacity of health workers, (2) improved positive attitudes modeled by health workers in support of SRHR information and services, and (3) improved capacity of the health system to provide comprehensive and gender-responsive SRHR information and services.

2.1. Increase knowledge, skills, and capacity of health service practitioners

Key among the efforts to promoting SRHR is the development of committed, well-prepared, skilled, and knowledgeable health service practitioners. This was achieved through training health service practitioners to increase their knowledge and skills to provide quality SRHR services. Analysis of the Stories of Change revealed that capacity building activities of SHE provided (1) additional knowledge on SRHR services such as family planning and adolescent care, (2) new or updated counseling skills on family planning especially to adolescents, and (3) capacitated midwives and nurses in services that were otherwise only provided by doctors.

[10] Bailey, H., 2015. Stories of Change. Institute of Development Studies, UK.

Additional knowledge on SRHR services such as family planning and adolescent care - Training of health service providers is one of the most commonly effective intervention to improve health service providers' knowledge and skills to promote and support SRHR. The Stories of Change revealed that the trainings have provided additional knowledge on family planning that enabled health service practitioners to bring comprehensive and scientifically accurate information to the clients in the health facilities and during outreach activities. They can correct misconceptions on family planning methods, discuss side-effects of the various family planning commodities, and convince clients to avail of long-term family planning methods. The study also revealed that health service providers have gained knowledge in adolescent care.

> *"Before, clients who come to us only know of the withdrawal method. Now that I have better information on the different family planning methods and we have continuous supply of family planning commodities in the facility, I am able to counsel clients on the different options for family planning and they gain knowledge from me."*

New or updated counseling skills on family planning especially to adolescents- Better counseling skills on family planning especially to younger clients was given prominence across the project sites. The training deals with practical tips on how to handle adolescents, some do's and don'ts when working with teenagers and their parents, and guidelines on how to provide preventive health counseling[11]. Health service practitioners' skills in handling teenagers were enhanced and enabled them to engage with teenagers better. They noticed that younger clients are opening more about sensitive issues such as reproductive health, gender identity, and their own experiences of GBV or sexual assault. In one story, it was revealed that they have recorded a 40% decrease in teenage pregnancy in their health facility. The health service provider attributed the decline to the effective counseling on family planning to adolescents in the health facility and during outreach activities that made sure adolescents are reached.

Capacitated midwives and nurses in services that were otherwise only provided by doctors- The data suggest the provision of training and resources to midwives and nurses on family planning methods, especially on long-term contraceptive implants insertion, contributed to the increase of acceptors of family planning. In the past, clients need to wait for the availability of a doctor to get counseling and have the contraceptive implant inserted. In some areas, clients need to travel far to avail of these services in city or municipal hospitals. Capacitating the midwives and nurses was a significant improvement in the delivery of family planning services as it gave access to long-term contraception to clients by bringing the services to their villages or barangays. The issuance of training certificates gave the health service providers confidence in performing the insertion procedure without the doctor. This makes the doctors available to clients for other health services and counseling.

> *"The training provided a certificate of completion to participants, so it was empowering. After being trained in the SHE project, I feel I am now 100% knowledgeable on the topics during consultation whereas I only knew 50% before. I can handle family planning consultation and implant insertion without bothering our doctor. We can help our doctor now which gives her more time to do other services in the facility."*

[11] DOH, 2009. Adolescent Job Aid Manual.

2.2. *Improved positive attitudes modeled by health service practitioners in support of SRHR information and services*

Adolescents face considerable barriers when trying to access sexual and reproductive health (SRH) services, mostly within the service delivery. The study revealed that health service providers used to exhibit unfriendly or judgmental attitudes toward young clients. Some health service providers admitted that they used to behave in a way that is disrespectful or stigmatizing and may have unnecessarily restricted access to certain SRH services to young clients by requiring parental permission or not considering their privacy. As a result, adolescent clients were shy and never came back for consultation, including teenage pregnant women who required regular prenatal services.

> *"I had a lot of realization after the trainings of the SHE project. Before, I was judgmental to pregnant clients who did not observe birth spacing or who are too young to be in that situation. I would reprimand them, and oftentimes be upset or be mean to pregnant young clients. I would criticize and scold them. I would still advise them to come back after a month for a follow up checkup and they would never come back. After the training, I realized how wrong I was to reprimand and scold clients. Now, I have a more positive and welcoming attitude to all clients. I observed that more young clients are coming in for consultation, pre-natal, birth of their child, and vaccination of their infants. Now, I have self-confidence and happy with the work I do. I feel that I gained the trust of my clients because I am more knowledgeable, and I deal with them with a positive attitude."*

The most significant changes that occurred because of SHE is in the form of attitudinal and behavioral change modeled by health service practitioners. Among others, the stories revealed the following changes:

1. Deeper understanding on how to deal with adolescents at work and at home (dealing with own teenage children and relatives). Privacy and confidentiality are aspects that are now part of adolescent-friendly services in the facilities. As a result, improved service utilization among adolescents is observed in health facilities and outreach activities.
2. Favorable attitudes toward issues that relate specifically to youth sexuality and LGBT in general.
3. Reflective thinking in the trainings brought self-awareness and introspection and helped health service providers to be comfortable in fulfilling their responsibilities as caregivers and SRHR providers regardless of their personal beliefs.
4. Increased confidence in health service providers that were found to facilitate the transfer of learning to clients and use of clinical skills for family planning methods

"I used to work in a big hospital. I was following a routine that made me feel like a robot. With the training I received from Jhpiego and working in the communities, I feel more human serving the community. I became more empathetic to teens and mothers in the community. I listen more to their stories rather me dominating the conversations. Counseling them on family planning methods became easy. It really gave me self-fulfillment. I am now more passionate in raising awareness on family planning to clients. I and my colleagues are more confident in conducting awareness raising activities in the barangays. Right now, we are in full force for covid vaccination, but I hope we will continue with our outreach activities on family planning."

2.3. *Improved capacity of the health system to provide comprehensive and gender-responsive SRHR information and services*

Analysis of the Stories of Change revealed three (3) key SHE activities and support to health facilities that improved their capacity towards providing SRH information and services in geographically isolated and disadvantaged areas in the Philippines. These are: (1) technical and financial support for outreach activities, (2) provision of family planning commodities, and (3) adolescent SRH program.

Outreach activities – SHE provided technical and logistic support to outreach activities of the health facilities. Health service practitioners feel that this was significant as it expanded the scope of SRH services especially in geographically isolated and disadvantaged areas in the Philippines. They were able to reach new villages or barangays and more frequent visits to their administrative areas. Health facilities were able to promote their services, provide referrals and hotlines, and this increased uptake of services. The study showed the importance of distribution of contraceptives and availability of contraceptive implant services during outreach activities. This guaranteed access to SRH in remote areas and reduced referrals to municipal health facilities.

Provision of Free Family Planning Commodities – The stories reveal that the continuous supply of family planning commodities provided by the SHE project yielded good results. Without the supply from SHE, health facilities used to provide counseling services but were unable to provide free commodities because they ran out of stocks. This discouraged clients from coming back and had a negative effect on women who are dependent on the free family planning commodities being provided by the health facilities. The availability of long-term contraception methods, such as implants that do not require frequent replenishment, was reported significant as it can withstand the barriers of supply disruption.

"In the past, the RHU had limited resources for outreach services. But with the support and coordination of the SHE project, they were able to conduct SRHR-related training and services in the barangays, even during the pandemic. The SHE facilitators helped bridge the gap between the RHUs and the communities. We learned how SHE staff coordinated with LGUs. They also provided assistance in logistics for community activities. Commodities on family planning were provided and midwives were empowered to give trainings and counsel clients. In the past, we were always out of stock of family planning commodities like Implanon which discouraged clients from coming to our RHU. Now, we have continuous supply from Jhpiego. Clients are coming to the RHU because they know we have continuous supply of family planning commodities. But it is not only because we have continuous supply, the clients are now more comfortable coming to our health facility because they feel the health workers are capable and knowledgeable. More couples are convinced to use family planning methods. Because of the trainings provided to RHU staff, our midwives can conduct training and counseling on their own in the communities. This helped lessen the burden on the RHU. I think other RHUs do not have this kind of opportunity. We have lesser referrals from barangays to the municipal health facility because our midwives are empowered at the barangay level. The clients and community are now aware of the services we offer. They are confident that health staff are available 24/7 and we have a hotline number given to clients. We saw significant change in the community with the outreach program. This is especially important during the pandemic because many choose not to visit the RHU. We were able to distribute IEC materials. Clients' awareness on family planning widened. The RHU became popular, and clients are trusting the RHU more. The confidence of the health workers helped in improving the reputation and image of the RHU. An added benefit is that we gained the trust of clients coming to us with anxiety disorder. We have a feedback mechanism to help improve our services. We want other staff members to be trained in cervical screening for early detection of cancer. We have no OB in the RHU, so we have a referral system to the hospital. We attach the history and maternal records of the client to the referral slip.

Adolescent SRH program – The study revealed that teenage pregnancy was widespread in the project sites but specific intervention that solely focused on tackling teenage pregnancy and adolescent SRH was inadequate or missing in the health facilities. The technical, logistic, and financial support provided by SHE expanded the scope and reach of SRH services for adolescents. Key actions revealed in the study include:

1. Increased the ability of health facility and health service practitioners to support young clients in making informed, healthy SRH decisions;
2. Created enabling environments, that included confidentiality, to enhance adolescents' access to and use of SRH services;
3. Strengthening the capacity of health facilities to provide age appropriate, comprehensive, and scientifically accurate information and services for SRHR. For adolescents, the use of information, education, and communication (IEC) materials, especially the flipcharts, was seen as highly effective in sensitizing clients.
4. Provision of services and commodities to adolescents, including unmarried adolescents and hard-to-reach groups;
5. Strengthened capacity and knowledge of health service providers to provide quality services for adolescents, including adolescents from vulnerable, disadvantaged and hard-to-reach groups;

6. Ensured that interventions targeting adolescents are gender responsive by addressing gender bias in services that increase vulnerability of boys and girls and limit their access to services.

> *"We did not have an adolescent room in our RHU before. The SHE project provided furniture, air-conditioning, cabinet for records, and TV for the new designated room for adolescent care. We created an improved experience for the younger clients. We aim to provide the adolescents time and private space to voice out their concerns and be heard. Now, they can rely on the health service practitioners for support outside of their family. Here, we address teenage pregnancy and family planning. During this pandemic, adolescents are vulnerable to suicidal behavior. Through counseling we are hoping to reduce depression."*

3. Sustainability of gender-responsive SRHR information and services in health facilities

Capacity Building – Majority of the health service practitioners felt they are now confident in dealing with gender issues at work, but many feel they still need additional training. Additional training on elements such as: (1) male-friendly services, (2) handling GBV cases, (3) couples counseling, (4) gender awareness raising activities and (5) adolescent care services were suggested by the health service practitioners. This highlights their improved positive attitude in support of SRHR information and services. Related to confidence is the clients' belief in the health service practitioners' technical competence to provide the services offered.

Health Care Policies and Facility Management – The needs assessment revealed that most facilities still do not have written zero-tolerance policies that expressly prohibit sexual, physical, or other abuse of clients and health service providers. Most facilities also lack written anti-discriminatory policies. Written policies such as zero-tolerance for abuse and non-discrimination should be available and disseminated to health service providers.

4. Conclusion

The Stories of Change suggest that changes occurred at the individual level and organizational level due to the interventions of the SHE project. Some of the stories included positive changes on individual skills and behavior of health service practitioners toward clients that had a multiplier effect on the family and community. The enhanced qualities of the individual included their ability to transfer SRHR information and services to other people in the family and community. Health service practitioners were also certain that awareness-raising and delivery of services had benefited women and adolescents in the community. Further, SHE is perceived to have resulted in an increase in clients and a reduction in teenage pregnancy, showing that some success has been achieved.

The varying changes described in the stories include enhanced knowledge and skills in family planning methods, attitudinal and behavioral change in support of SRHR information and services, safer environment for adolescents, enhanced self-confidence of health service practitioners, and the ability of health service providers to influence clients.

Annex A. HEALTH PRACTIONER/MANAGER QUESTIONNAIRE – Midterm Evaluation

The coordinators and facilitators of the SHE Project would like to capture stories of significant change that may have resulted from their activities in your area. This will help them to improve what they are doing, enable them to celebrate the successes together as well as being accountable to the funders. The stories and information collected from these interviews will be used for several purposes including:

- to explore what the project have achieved already
- to help the project understand what health practitioners value, and support more of these sorts of outcomes
- to learn from what has already been achieved and what else needs to be done.

Confidentiality

We may like to use your stories for reporting to people involved in the project (internally) or funder -

- *Do you want to have your name on the report* □ **Yes or** □ **No**
- *Do you consent to us using your story for publication* □ **Yes or** □ **No**

Contact details

Name of respondent: _____
Name of interviewer: _____
Location: _____
Mobile number: _____
Date of interview: _____

Area:
□ Bicol Region □ Northern Samar, Samar
□ Zamboanga □ Northern Mindanao
□ CARAGA □ BARMM

Position: (Multiple answers)
□ Physician □ Administrator/Management
□ Nurse □ Support Staff
□ Midwife □ Others

1. Does your facility offer the following services (multiple answers)?

- ☐ Immunization, if yes: □ Covid vaccine □ Non-covid related vaccines
- ☐ Child Care Clinic
- ☐ Family Planning
- ☐ Adolescent Care
- ☐ Male Care
- ☐ Maternal Care
- ☐ Birthing Center
- ☐ Emergency Contraception
- ☐ Management of Medico Legal Cases/GBV/Violence Against Women and Children
- ☐ HIV Testing or Counselling

2. Does your facility have a referral system for Gender Based Violence or Violence Against Women and Children cases (physicians, gender-based violence services, etc) in place for clients of any gender and age (e.g., Specialists, DSWD, police, etc)?

- ☐ No (skip to 4)
- ☐ Yes
- ☐ I do not know

3. If yes, which up-to-date referral directory do you have (multiple answers)?

- ☐ Physicians
- ☐ Gender-based violence/VAWC services (DSWD)
- ☐ Gender-based violence/VAWC services (Police/PNP)
- ☐ Gender-based violence/VAWC services (NGOs)
- ☐ Others: _____

4. Does the facility have a written zero-tolerance policy/manual that expressly prohibits sexual or physical abuse of clients, facility workers, health providers, and staff?

- ☐ No
- ☐ Yes
- ☐ I do not know

5. Does the facility have written non-discrimination policy?

- ☐ No
- ☐ Yes
- ☐ I do not know

6. If a client needs emergency contraception due to irresponsible actions, what protocol does the facility follow?

- ☐ Provide service without further question
- ☐ Provide service but reprimand client
- ☐ Do not provide the service
- ☐ Service not available in the facility
- ☐ Others: _____

7. Can you name a few approaches how practitioners in this facility communicate effectively with client? (do not read answers)

- ☐ Listen to clients
- ☐ Encourage client to talk and ask questions
- ☐ Use terminology that is easy to understand
- ☐ Use visual aids
- ☐ Check if client understood
- ☐ Others: _____

8. Did you receive special training on:

a. Counselling clients on family planning	☐ No ☐ Yes ☐ Planned	If yes, is it through? ☐ SHE Project only ☐ Other programs ☐ Both
b. Counselling clients on HIV	☐ No ☐ Yes ☐ Planned	If yes, is it through? ☐ SHE Project only ☐ Other programs ☐ Both

c. Gender equality and human rights	☐ No ☐ Yes ☐ Planned	If yes, is it through? ☐ SHE Project only ☐ Other programs ☐ Both
d. Sexual harassment or abuse	☐ No ☐ Yes ☐ Planned	If yes, is it through? ☐ SHE Project only ☐ Other programs ☐ Both
e. How to show compassion to clients and address any feeling of fear, denial, shame, anxiety, depression, etc?	☐ No ☐ Yes ☐ Planned	If yes, is it through? ☐ SHE Project only ☐ Other programs ☐ Both
f. How to display non-judgmental attitude towards all clients, including adolescents seeking reproductive health services?	☐ No ☐ Yes ☐ Planned	If yes, is it through? ☐ SHE Project only ☐ Other programs ☐ Both

9. How confident you are in addressing gender issues in your work?
   - ☐ Very confident
   - ☐ Somewhat confident
   - ☐ I do not feel confident

10. What kind of additional support would you need to improve your confidence in addressing gender sensitive services and equality issues in your work? (Please probe)

11. Aside from the additional support you mentioned, do you think the following will improve your confidence in addressing gender sensitive services and equality issues in your work? (Read answers but do not mention options they already mentioned in Q10)
   - ☐ None
   - ☐ Training sessions on gender mainstreaming
   - ☐ Guidelines, tools, and methods on gender (materials)
   - ☐ Training on adolescent care services
   - ☐ Training on family planning methods
   - ☐ Training on male-friendly services
   - ☐ Training on how to respond to gender-based violence cases
   - ☐ Training on couple counselling
   - ☐ Gender awareness raising activities
   - ☐ Information and education materials for clients on gender equality
   - ☐ An adviser/unit to consult on gender issues
   - ☐ Others, please specify_____

Questions for Stories of Change [Encourage respondent to **elaborate** on their answers]

1. Tell me how you became involved with the SHE project? What activities of the SHE project have you participated in?

2. From your point of view, describe a story that sum up the most significant change in your health facility that has resulted from the SHE Project? (Can be more than 1 story)

(probe on facility policies, initiatives, practices, observable increase in clients - male, youth, couples, increase in contraceptive prevalence rate/demand. Please encourage to cite data)

3. Why is this change in your health facility the most significant for you?

4. Describe a story that sum up the most significant change in YOU that has resulted from the SHE Project? (Can be more than 1 story)

   (probe on knowledge gained, counselling techniques, change in attitude towards clients regardless of gender, age, ethnicity)

5. Please explain why this is important to you?

6. How has this affected your clients/patients in the community? Your family?

7. How has this affected your work during this pandemic?

8. Does the facility have a youth friendly or adolescent program? Was there one before? What changes did you observe in implementing the program?

9. How does your facility treat post-abortion cases? Does the facility treat clients in a non-judgmental manner?

Annex B. Highlighted Stories of Change

DOMAINS OF CHANGE	STORIES
Increased knowledge, skills, and capacity of health workers	[HSP1] The SHE Project gave me the opportunity to refresh my memory and provide additional knowledge on SRHR. It was important for me to self-assess my knowledge and skills during the trainings. As resource speaker during outreach programs for family planning, I had the opportunity to partner with NGOs like Jhpiego. I learned time management skills while coordinating activities with them. I work in many areas, so time management and prioritizing are important. Most significantly, it gave me confidence in partnering with NGOs. In the past, I had no experience working with NGOs, so I was apprehensive in the beginning. Now, I encourage my colleagues to interact with the SHE partners and join the SRHR trainings they provide in our facility. [HSP2] As a health provider, you should be equipped with skills and know how to handle cases. Because of the trainings, any questions from clients can be answered. We were able to counsel the client better. The trainings really boosted our confidence. We can correct misconceptions about family planning and convince them. For instance, there is a misconception that Depo can cause tumors. Now, we can explain the side-effects to our clients and make them accept the method. Learning the skills to implant was also important. [HSP3] There has been better engagement between health workers and clients since the project started. Health workers' knowledge in FP were enhanced. Before, clients only know of the withdrawal method. Now that I know the different methods and we have continuous supply of FP commodities in the facility, I can counsel clients on the different options for FP and they gain knowledge from me. [HSP4] Our campaign on family planning is effective. When I was giving family planning talks in barangays, I brought with me FP commodities, so the participants have immediate access to them. I also targeted the youth or adolescents that already have children. In this quarter, our teenage pregnancy cases decreased to 60 cases as compared to the usual 100 cases. We have seen a decrease of adolescents coming in for pre-natal services. [HSP5] Jhpiego conducted training on implants so more staff can provide the service instead of just the doctor. The training provided certificates of completion to participants, so it was empowering. After the training, my skills also improved in terms of handling adolescent clients. We gained the trust of our young clients since we know how to handle them now. This is particularly important for a midwife like me. Before I had the training, I only followed my job description as a midwife. After being trained, my knowledge in family planning and adolescent care broadened. I feel I am now 100% knowledgeable on the topics during consultation whereas I only knew 50% before. I am confident that what I am sharing with clients are true and factual information. I can handle family planning consultation without bothering our doctor. We can help our doctor now which gives her more time to do other services in the facility. We have easy access to the doctor if it is something we cannot handle. When the doctor is not around, we facilitate a teleconsultation with the doctor and clients. Prescriptions are sent online when clients have internet connection. [HSP6] We learned new skills from the SHE project training. Many health workers were trained on subdermal implants and removal. The new skills enabled us to provide additional FP commodities to the clients. We also raised awareness on FP services on the barangay level specially to targeted adolescents. Our skills in handling teens were enhanced by the training we received. Now, I can engage with teens better and let them open up about sensitive issues and their experiences.

	[HSP9] The most vital component of the project for me are the trainings. It really empowered the health workers.
Improved positive attitudes modeled by health workers in support of SRHR information and services	[HSP1] An important learning from the trainings is on how we deal with our clients. Dealing with clients is different depending on their condition (HIV, adolescent, adults). We need to accommodate our clients well to gain their trust. Adolescent clients should be approached differently than adults. Before, I and my colleagues did not consider these dissimilarities. We have to remember that adolescent clients have a different outlook, sometimes still immature, and they oftentimes go with their peers. They need privacy and prefer to keep things from their parents. [The pandemic has brought so much stress to the RHU staff and health workers. But we are happy to be able to continue to provide services. For Covid vaccinations, the younger clients have more positive behavior while senior citizens are afraid to get vaccinated. Most senior citizens are afraid because of fake news that are circulating. We try our best to convince them in a respectful manner.] [HSP7] After the trainings, I noticed self-improvement in how I deal with my colleagues and clients. I am more tolerant of my colleagues' moods and attitudes. I am calmer when I deal with clients. I used to quickly judge clients and reprimand them. I learned from the trainings the importance of listening. Now, I let the clients talk openly to identify their needs and concerns before I give advice. By doing this, I noticed that the younger clients are now more open to talk about sensitive issues and problems. They used to be shy and never come back for consultation. [HSP3] I had a lot of realizations after the training of the SHE project. Before, I was judgmental to pregnant clients who did not observe birth spacing or who were too young to be in that situation. I would reprimand them, and oftentimes upset or mean to pregnant young clients. I would criticize and scold them. I would still advise them to come back after a month for a follow up check up and they never come back. I realized after the training how wrong I was to reprimand and scold clients. Now, I have a more positive and welcoming attitude to all clients. I observed that more young clients are coming in for consultation, pre-natal, birth of their child, and vaccination of their infants. Now, I have self-confidence and happy with the work I do. I feel that I gained the trust of my clients because I am more knowledgeable, and I deal with them with a positive attitude. When the pandemic happened, empathy and a positive attitude really helped a lot as we have more pregnant clients coming for consultation. [HSP4] Through the SHE project, I gained more confidence in my skills and abilities. I realized that I can deal with adolescents. I feel that the younger clients became more open and trusting towards us. We heard them say that now they know where to go when they need to discuss sensitive matters. Oftentimes, they are unable to tell their parents or do not want their parents to know what they are going through. We continue to conduct adolescent care training but with limited participants due to the pandemic. We have not heard of GBV cases, and we have lesser cases of teen pregnancies. We only have 5 cases in the last 3 months. My behavior towards clients really changed after the trainings. I used to be too frank and tactless towards clients. After the training I realized that my actions were wrong. It is difficult to change oneself, but I really try hard to be calm now. I now listen and respond to clients in a positive manner, not anymore reactive towards clients. I am also now more open towards LGBT clients. This has been the most significant for me. It broadened my perspective and understanding towards LGBT clients. It is important to treat all clients equally, regardless of their gender. I am calmer when I handle LGBT clients now, no harsh words (hahaha). Being comforting makes clients open more so its easier to give proper counseling. [HSP5] The trainings made me confident and empowered me and my colleagues in conducting family planning trainings/seminars. We can reach more people. Before, we had to ask our doctor to conduct the trainings.

	[HSP8] Through self-observation, I noticed that I became more confident in handling topics on adolescent care and concerns. I am now more patient in listening to clients during FP counseling. I am no longer quick to judge their views hence I do not react negatively anymore. Instead, I learned to let them talk more and express their sentiments. The training on how to handle adolescents was really helpful. I also learned how to properly engage with LGBT clients. We really noticed that more young clients were coming to the facility for counseling but because of the pandemic, the numbers decreased. We still conduct FP awareness in the barangays but with fewer participants due to government restrictions. [HSP11] After the trainings of the SHE Project, I really gained a deeper understanding of how to deal with the youth, at work and at home with my teenage children. I learned to be watchful of unspoken messages in their gestures. I learned how to approach them. I really mind the tone of my voice when I speak to them now. I noticed they open easily now and trust me. Which makes counseling effective. During my outreach services in the barangay, I really noticed an increase of adolescent clients coming to the health center for counseling. I really could feel that they trust me more. They also tell their friends about the services we offer in the health center and in the RHU. I use the same technique at home in dealing with my two teenage boys. Now, they can easily approach me and discuss whatever is bothering them, including issues on male reproductive health. I am more understanding towards my teenage boys now and I am thankful that they listen to me, and they have no vices. I really feel more confident on how to engage with adolescents now and this change really shows in my work and when we conduct awareness raising activities in the barangays. My colleagues also feel the same. [HSP6] I used to work in a big hospital. I was following a routine that made me feel like a robot. With the training I received from Jhpiego and working in the community, I feel more human serving the community. I became more empathetic to teens and mothers in the community. I listen more to their stories rather me dominating the conversation. Counseling them on FP methods became easy. It really gave me self-fulfillment. I am now more passionate in raising awareness on FP to clients. I and my colleagues are more confident in conducting awareness raising activities in the barangays. Earlier this year, we were still conducting awareness raising activities in the communities during the pandemic. But now that we are in full force for Covid vaccination, our outreach activities on FP had to be reduced. [HSP9] The trainings conducted under the SHE project really boosted my confidence especially since I am a lecturer. I gained confidence in tackling sensitive topics of FP and in engaging with my clients. I can answer properly the questions posed by the clients. I have made myself more approachable to them. During outreach programs in the barangays, it was important for me that the clients understand what I was imparting to them and that they feel free to ask me anything. I feel like a good role model to the community and to my family. Whatever lectures I give to the community, I also discuss it with family and friends especially on family planning. We continue to have activities in the barangays during the pandemic, but we have limited participants. It is touching to hear from clients that the pandemic made them realize that having many children is difficult as it is difficult to be hospitalized with all the safety requirements. They are also facing financial constraints and access to the health facility is difficulty. [HSP10] I became more approachable and accommodating to adolescent clients and adult clients coming to the health facility for maternal care.
Improved capacity of the health system to provide	[HSP10] In the past, the RHU had limited resources for outreach services. But with the support and coordination of the SHE project, they were able to conduct SRHR-related training and services in the barangays, even during the pandemic. The SHE facilitators

comprehensive and gender-responsive SRHR information and services	helped bridge the gap between the RHUs and the communities. We learned how SHE staff coordinated with LGUs. They also provided assistance in logistics for community activities. Commodities on family planning were provided and midwives were empowered to give trainings and counsel clients. In the past, we were always out of stock of family planning commodities like Implanon which discouraged clients from coming to our RHU. Now, we have continuous supply from Jhpiego. Clients are coming to the RHU because they know we have continuous supply of family planning commodities. But it is not only because we have continuous supply, the clients are now more comfortable coming to our health facility because they feel the health workers are capable and knowledgeable. The outreach program coordinated by the SHE project is an immense help. More couples are convinced to use family planning methods. Because of the trainings provided to RHU staff, our midwives can conduct training and counseling on their own in the communities. This helped lessen the burden on the RHU. I think other RHUs do not have this kind of opportunity. We have lesser referrals from barangays to the municipal health facility because our midwives are empowered. The clients and community are now aware of the services we offer. They are confident that health staff are available 24/7 and we have a hotline number given to clients. We saw meaningful change in the community with the outreach program. This is especially important during the pandemic because many choose not to visit to RHU. We were able to distribute IEC materials. Clients' awareness on family planning widened. The RHU became popular and clients are trusting the RHU more. The confidence of the health workers helped in improving the reputation and image of the RHU. An added benefit is that we gained the trust of clients coming to us with anxiety disorder. We have a feedback mechanism to help improve our services. We want other staff members to be trained in cervical screening for early detection of cancer. We have no OB in the RHU, so we have a referral system to the hospital. We attach the history and maternal records of the client to the referral slip. [HSP10] Our facility had a AYRH program even before the SHE project. With the assistance from Jhpiego, we improved the AYRH area. We also received a cabinet to keep the records confidential. We added adolescent confidentiality in our existing policy. [HSP7] We had existing adolescent care services, but it was integrated into the Family Planning services. With the SHE project, we are setting up a separate adolescent care unit with signage for visibility. With the project's help, we are aiming to become a level 1 facility. Because of the SHE project, I feel we have become more effective in our campaign and counseling of family planning methods. During this pandemic, we continue to conduct meetings and counseling in the barangays but with limited participants due to restrictions and regulations of social distancing. We also have continuous supply of family planning commodities though sometimes we get items that are near expiration. There are more clients coming to our facility asking for FP commodities and avail of services. The good thing is, we noticed a decrease in the number of pregnancies especially on teenage pregnancies. Also, we noticed spacing in pregnancies. For services not available in our RHU, we usually escort the clients to the nearest hospital. [HSP2] We did not have an adolescent room in our RHU before. The SHE project provided furniture, air-conditioning, and TV for the new designated room for adolescent care. We created an improved experience for the younger clients. We aim to provide the adolescents time and private space to voice out their concerns and be heard. Now, they can rely on the health service practitioners for support outside of their family. Here, we address teenage pregnancy and family planning. During this pandemic, adolescents are vulnerable to suicidal behavior. Through counseling we are hoping to reduce depression. [HSP3] Our health facility was able to accomplish a lot in terms of SRHR activities. Clients are more aware of the services we offer. Before, pregnant women only come to the facility to give birth or prenatal on the last trimester of their pregnancy. Now, more pregnant women are coming in on their first trimester for prenatal, so we can test and counsel them

	early and have their health record. We also have an increasing number of adolescents and young adults who come to us for consultation on contraceptives and Implanon insertion. These clients only know about the withdrawal method of family planning before. With the continuous FP commodity supply, more clients are coming to the facility, and we can counsel more people on family planning. For vaccination, we now have a weekly schedule for infants and at the same time we check the health of the mothers. Before, we only did it once a month so most of the time mothers forget to bring their infants to the facility for vaccination and the mothers do not get their checkups. [HSP4] We had an existing adolescent program before but through Jhpiego, the facility now has a room for adolescent care. It has a comfortable sofa to make clients feel at home. It also has complete IEC materials for use as visual aid during counselling. We also made sure that we use the cabinet to safeguard confidential records of clients. It is a nice room, with a feeling of privacy and safety for clients. Many clients come in for counseling services. [HSP5] The SHE project improved our services to clients. First, we have a variety of FP commodities available in out facility now. When we ran out of oral contraceptives, the SHE project added to our stocks. The flip charts on FP methods that were provided by the project really helped. It is easier for health workers to explain, and our clients understand it better. Before, we did not have an adolescent room. After we received the training, a room was refurbished and designated for adolescent services. We have young clients visiting our adolescent center. We really have more clients coming in now for family planning services. They come because they get the right information from us. We were able to remove any doubts and concerns they have especially when we explain with the help of the flip charts. We really saw an increase of family planning users. During the pandemic, the hotline numbers we provided really helped the clients. We are accessible to them through phone calls. Some clients come to my house to clarify instructions on the use of FP commodities. That is how much they trust my knowledge of FP. [HSP8] With the project, we raised awareness in teens and youth that we have an exclusive program for them. We have a comfortable room for them where they are offered privacy during counseling. This is a meaningful change in our facility and truly relevant because of high incidence of teenage pregnancies in the area. We had an increase of adolescents coming to the facility for counseling. It is also important that we can provide FP commodities. The stocks we get from DOH is limited so the FP commodities we get from Jhpiego bridges that gap. This is the same for the IEC materials in the facility. [HSP11] We always had high demand for FP commodities. Many wanted to avail but we had limited supply from DOH. We can only rely on the allocation from DOH. The SHE project is a tremendous help as they now provide us with a continuous and good supply of FP commodities, especially the Implanon. With the availability of Implanon in the barangays, clients do not need to travel anymore to avail of the FP commodity. This is a vast improvement in the FP services our RHU offer. We can meet the demand or needs of out clients which we were unable to do before. There are more health workers trained in Implanon insertion that can do the services in the barangay. Our clients do not need to go to the hospital in the city anymore. Also, we used to have an adolescent program but not as intensive now. Now, we have a separate place for young clients where they can feel secure. [HSP6] Before the pandemic, we had an increasing rate of adolescent clients, but we did not have an adolescent/youth program. We had an increasing demand for FP commodities. With the support of the SHE project, our adolescent program is now in level 2. We have a special room for teens and adolescents where they have privacy during consultation and counseling. The area is more private and comfortable. The young clients can express their concerns better and are assured of the confidentiality of the conversation. The IEC materials and tarpaulin provided by the project also helped us communicate better to the

	younger clients. They understand better with the visual aids. With the project, we have continuous supply of FP commodities especially the Implanon. [HSP9] The continuous supply of FP commodities, especially Implanon, really enhanced our service delivery to clients. We are giving clients access to FP commodities plus giving them options. The monetary support the project provided for outreach allowed us to expand and reach more barangays in far-fetched areas. Also, we did not have an adolescent program before. Now we are in level 1 and the LGU is building a facility for adolescent care. Jhpiego had given assistance to refurbish it though it is still not operational. As far as I know, its under process so it can be operational soon. [HSP10] During the project, they had less cases of teenage pregnancy. According to their records, they have increased acceptors of family planning commodities. The project allowed them to focus on adolescents and teenage pregnancy.

Annex 5 - Performance Measurement Framework							Year 3: Oct 2020 - March 2021						
TITLE	Sexual Health and	Five Years											
Country / Region	Philippines	$18,629,813											
		Planned Targets											
Expected Results	Indicators	Year 1	Year 2	Year 3	Year 4	Actuals Previous Reporting Period (Cumulative from the start of the Project)	Cumulative Y3 Target		Actuals this Reporting Period	Cumulative from start of the project	Status	Progress Update	Variance
ULTIMATE OUTCOME													
1000 Improved sexual and reproductive health and rights for women and girls in remote conflict affected and disadvantaged regions of the Philippines	1000.a: % and number of women with unmet need for FP including modern methods, disaggregated by age group.			28.6%			Women	28.6%	14%	14%	on schedule	SHE partners have done a very important progress in reducing unmet need for family planning. Influencing, Lobby, Coordination and collaboration with local and national agencies are the factors of success.	Unmet need for women has dropped almost by half from the start of the project. But, unmet need for girls has double in the same period, demonstrating that girls are much more vulnerable during crisis mentioned in the context section of the narrative report.
				9.1%			Girls	9.1%	17%	17%			
	1000.b: % of teen pregnancy rates among target population			5.3%			Girls	5.3%	2.5%	2.5%	on schedule	All indicators show that teen pregnancy is slowing down. See Annex 3, Teen Pregnancy in SHE municipalities for a comparison of different methods of calculating and analyzing this indicator	Baseline (7.5), pulse survey (6.4) and midterm survey (2.5) show that teen pregnancy is slowing down.
	1000.c: Perspectives on positive attitudes that promote SRHR and GBV prevention among target population			55.2%			Women	55.2%	49.1%	49.1%	on schedule	SHE partners have been consistently working with influencers at all levels to model positive attitudes towards SRHR. Religious and political leaders, men and boys are demonstrating a change in their attitudes.	Midterm Index values are still very close to baseline values, showing that change in positive attitudes is more consistent for women and girls, but variable for men and boys.
				51.9%			Girls	51.9%	48.0%	48.0%			
				54.9%			Men	54.9%	48.6%	48.6%			
				53.2%			Boys	53.2%	46.0%	46.0%			
INTERMEDIATE OUTCOMES													
1100 Enhanced utilization of gender-responsive sexual and reproductive health information and services (public and private) by women of reproductive ages, adolescent girls and boys	1100.a: # of new family planning acceptors, disaggregated by age, sex, and by modern methods of contraception			5,209			Female (WRA)	5209	4744	4744	on schedule	coordination among multiple stake holders to implement the outreach activities, and collaboration in different working groups helped to increase the new acceptors during the project implementation.	FHSIS does not report age groups, therefore it is not possible to know the proportion of girls and boys as new acceptors. Condoms are the only option for men as new acceptors.
				1426			Male	1426	143	143			
	1100.b: # of individuals who have accessed quality and gender sensitive reproductive health services including modern contraception in the targeted health facilities, disaggregated by sex, and type of services			62,342			Female (WRA)	62,342	65,290	65,290	on schedule	coordination among multiple stake holders to implement the outreach activities, house by house visits, and collaboration in different working groups helped to increase the number of people seeking SRHR services.	Although, the project has reached a bit more than the 2% increase set as target for women, the total number set for men is below target. Condoms and vasectomies are the only options for men in the country.
				2509			Male	2,509	2,266	2,266			
1200 Improved effectiveness of women's rights organizations (WROs) to advance rights related to sexual and reproductive health and prevention of gender-based violence	1200.a: #/total inter-agency collaborations between WROs, CSOs, and government agencies promoting SRHR / preventing GBV			21			21				re scheduled	For the SRHR Advocacy Workshops, Interfaith Dialogues, Stigma Reduction Workshops and SRHR Roadmap consultations, the modalities of these activities have been adjusted.	Major activities that were designed for face-to-face interactions such as the SRHR Accountability and Justice Summit, were moved to Year 4.
	1200.b: Level of confidence of WROs on their own ability to coordinate and advocate to protect and promote the rights related to SRH and the prevention of GBV			TBD			TBD				re scheduled (June/July 2021) Mid Term Evaluation report will cover this indicator		we will carry out the mid term evaluation in Y4 (June/July 2021)
IMMEDIATE OUTCOMES													
				62.4%			Women	62.4%	86.6%	86.6%			

1110 Increased knowledge, skills, and capacity of women, girls, and boys regarding their Sexual and Reproductive Health and Rights (SRHR)	**1110.a: % and # of total target population knowing where to access SRHR services including contraceptives commodities**			39.3%			Girls	39.3%	60.8%	60.8%	on schedule	Through the provision of relevant information, SRHR issues and concerns were identified and talked about, misconceptions were corrected, and those with differing beliefs and understanding started to join SRHR dialogues	all gender and age groups have increased their knowledge about availability of services including FP commodities.
				66.5%			Men	66.5%	77.5%	77.5%			
				49.1%			Boys	49.1%	41.3%	41.3%			
	1110.b: %/total girls and women (WRA) able to make reproductive health choices alone and/or supported by their partner, disaggregated by age			62.7%			Women	62.7%	58.9%	58.9%	on schedule	Partners have created safe spaces for women, men, girls, and boys to discuss reproductive choices and increase their knowledge about the services available to them.	For women, the SHE project is falling short of achieving a 4% increase by midterm. For girls, on the other hand, the percentage exceeded the target by 5%. That means an increase of 9% since baseline for girls.
				39.1%			Girls	39.1%	44.4%	44.4%			
1120 Improved positive attitudes modelled by women, men, girls, boys, and influencers in support of SRHR information and services	**1120.a: Perspectives of targeted population on positive attitudes that promote women's reproductive autonomy**			63.0%			Women	63.0%	50.7%	50.7%	delayed	SHE have been working with a range of key actors – including men and boys, community and religious leaders and norm-setters – to transform discriminatory social norms, attitudes and behaviours hindering SRHR through awareness raising and mobilization activities focused on improving access to SRHR information and services, including GBV prevention and support services.	All age and gender groups have dropped in their measurements of positive attitudes toward reproductive autonomy of women and girls. Attitudes might fluctuate during the curse of the project, as people adjust their opinions about reproductive health. We acknowledge that positive attitudes are not increasing at the pace expected.
				58.9%			Girls	58.9%	49.1%	49.1%			
				64.5%			Men	64.5%	50.3%	50.3%			
				63.8%			Boys	63.8%	41.1%	41.1%			
	1120.b: #/total public declarations and actions by influencers to support SRHR, and in support of women's rights and leadership			21		0	21		26	26	On Schedule		24 barangay resolutions, 1 municipal ordinance and 1 municipal GAD budget have been issued in support of SRHR, GVB prevention, and reduction of teen pregnancies.
1130 Improved capacity of the public and private health systems to provide comprehensive and gender-responsive SRHR information and services	**1130.a: #/total facilities providing gender responsive SRHR information and services**		0	4	5	0	4		18	18	On Schedule	The following health facilities met the criteria for the indicator based on the semi-annual facility profiling: 1. Ozamiz City Health Office 2. RHU Buluan 3. RHU Bulusan 4. RHU Buug 5. RHU Cagwait 6. RHU Clarin 7. RHU Dangcagan 8. RHU Dimataling 9. RHU Ganassi	Number of facilities meeting the criteria might change as facilities face different challenges during the pandemic. Meeting of third criteria is highly dependent on the availability of FP commodities during the time of monitoring. Jhpiego will facilitate the provision of second batch of PSI and condoms to the health facilities in Y04 to augment the availability of stocks.
	1130.b: #/total rural health units that have at least 3 modern contraceptives available on day of assessment		4	5	5	20	9		21	21	On Schedule	All facilities have at least three modern contraceptives with at least one LARC at the time of facility profiling for this reporting period.	This indicator is a component of the previous one. It is the most susceptible to change because it depends on procurement time and availability in the local market. Number of facilities might change over time.
1210 Increased organizational capacity of partner organizations and selected WROs/CSOs to deliver effective programs on SRHR and GBV prevention	**1210.a: Level of confidence partners and/or WROs in their own ability to deliver effective programs on SHRH and GBV prevention**		4	3	3	0	7		7	7	On Schedule	11 partners have already started implementing their institutional strengthening activities. Midterm assessment will happen in Year 4.	All the mid-implementation assessments will be conducted in Year 4 since most of the partners just implemented their institutional strengthening activities in Year 3
	1210.b: #/total partners and/or WROs on target with their Action Plan to increase capacity		4	3	3	0	7		7	7	On Schedule		Most of the action plans were approved this FY. At the start of the fiscal year, most approved action plan were adjusted and shifted based on what can be achieved given the lockdown situations in the Philippines

1220 Strengthened capacity of WROs/CSOs to generate knowledge to influence policy and practice on women's rights, particularly on SRHR and GBV prevention	**1220.a: #/total partners and/or WROs drafting their own learning agenda on SRHR**		0	4	3	0	4		3	3	On schedule	Three learning activities were conducted. Three organizations submitted research proposals for deliberation and possible implementation.	One has been moved to Y4
	1220.b: Perceptions of partners on their capacities to generate knowledge on women's rights		0	4	3	0	4		2	2	delayed	There were 2 knowledge products developed for dissemination in Year 4: SHRH lecture videos and Module on Feminist 101.	Target for Y3 is 4 knowledge products, 2 will be done in Y4.
1230 Improved ability of WROs and networks to promote women's rights and influence policy makers on SRHR and GBV prevention	**1230.a: #/total advocacy and public engagement activities completed by funded partners that are focused on SRHR and prevention of GBV**		0	3	8	0	3		6	6	On schedule	6 public advocacy and engagements were completed during this reporting period: campaigns, Publication, Engagement in HR mechanism, Development of App, Policy Forum, Direct advocacy, and Interfaith Dialogue	No variance to report
	1230.b: #/total WROs/networks reporting on at least two improved influencing skills		0	5	5	0	5		2	2	delayed	2 partners reported to have improved their influencing skills: Youth for YOUth and Center for Women's Resources	
OUTPUTS													
1111 Facilitators, Peer Educators, and Barangay Health Workers trained and supported to raise awareness on SRHR in targeted areas	1111.a: #/total people trained by category, disaggregated by sex and age	259	2900	1797	1777	4978	Women	-22	933	5911	Re scheduled	SHE partners have reached 2187 people (933 women, 306 girls, 866 men, and 82 boys) which is 51% of the year 3 target for this output.	Some partners re-scheduled 1111 activities to year 4. Catch up plans have been drafted for y4.
		148	1657	1027	1015	599	Girls	2,233	306	905			
		117	1312	813	804	875	Men	1,367	866	1741			
		93	1036	642	635	273	Boys	1,498	82	355			
1112 SRHR awareness and mobilization activities conducted by trained actors (1111) in targeted areas	1112.a:#/total people reached per barangay, disaggregated by sex and age	78	3379	5346	5065	6417	Women	2,386	3604	10021	on schedule	SHE partners have reached 8,419 people (3,604 women, 2,324 girls, 1,267 men, and 1,224 boys) which is 92% of the year 3 target for this output.	Y4 AWP adjusted accordingly to absorb the 8% of Y3 target not reached this year
		45	1931	3055	2894	2617	Girls	2,414	2324	4941			
		35	1529	2418	2291	1062	Men	2,920	1267	2329			
		28	1207	1909	1809	1252	Boys	1,892	1224	2476			
1113 Technical assistance provided to partner organizations on women's participation in community governance structures	1113.a: #/total women trained and reached by category and disaggregated by age	0	37	264	152	208	Women	93	368	576	on schedule	SHE partners reached 368 women and 20 girls which is 157% over the target for year 3 for this output	Y4 AWP adjusted accordingly to focus on reaching girls and young women leaders, and to follow up on trained women.
		0	22	155	89	32	Girls	145	20	52			
1121 IEC materials developed on SRHR and social norm change for women, men, girls, boys, and influencers	1121.a: #/total communication materials validated and adapted	0	20	20	5	17		23	10	27	Re scheduled	SHE produced 10 IEC materials which makes 44% of the Year 3 target for this output	2 modules on-going development (by AMDF and SIKAP) and 2 modules set to be developed in Year 4 (SIKAP)

1122 Community sensitization and mobilization conducted with influencers on gender, SRHR, and GBV prevention	1122.a: #/total sensitization actions or activities per barangay	0	303	212	157	212	303		41	253	Re scheduled	SHE partners conducted 41 sensitization activities which is 14% of the year 3 target for this output. These acctivities were attended by 275 women, 86 girls, 235 men, and 111 boys. For a total of 707 people reached.	Sessions merged (3 to 1), cancelled, or re-scheduled because of COVID 19 restrictions and threat of armed conflict. We have drafted a catch-up plan for Year 4
1123 Technical assistance provided to local advocacy groups on women's rights, SRHR, and GBV prevention	1123.a: #/total people trained by category, disaggregated by sex and age	61	18	42	15	16	Women	105	165	181	on schedule	SHE partners have reached 239 people (165 women, 21 girls, 46 men, and 7 boys) which is 91% of the year 3 target for this output.	AWP for Y4 adjusted accordingly
		34	11	26	10	0	Girls	71	21	21			
		27	7	19	0	7	Men	46	46	53			
		21	6	14	0	0	Boys	41	7	7			
1131 Health service providers and managers trained and supported on gender-responsive and youth-friendly SRHR services	1131.a: #/total health service providers trained in SRHR services, disaggregated by professions and type of trainings	0	146	146	0	247	45		74	321	Completed	With the easing of mass gathering restriction in most SHE project areas, Jhpiego was able to conduct face-to-face trainings with limited capacity hence conducting one training in two or more batches.	With the target as focus, Jhpiego sought to prioritize untrained key health service providers to add up to the indicator.
1132 Youth-friendly and gender-responsive SRHR services established and functional	1132.a: #/total facilities that meet at least 80% of standards for youth-friendly and gender-sensitive services	0	0	5	3	1	4		0	1	delayed	Technical assistance is on going and responding to gaps identified during the RHU assessment.	Jhpiego moves to increase the target in Y4.
	1132.b: #/total supported facilities providing SRHR services accredited by PhilHealth on FP/MNH care packages	0	3	2	3	9	2		0	9	on schedule	The official list from the PHIC website did not include the regions where SHE is, hence the basis of the count is the environment sustainability assessment with means of verification provided by the regional coordinators.	Eight facilities are accredited until 31 Dec. 2021, with one until 21 Jan. 2022. above target: cumulated target at Y3 is 5 facilities.
	1132.c: #/total facilities compliant with healthcare waste management and infection control protocols	0	3	3	3	7	3		2	9	on schedule	Jhpiego was able to assess all 21 RHUs with additional one BHS serving as main birthing facility of the municipality to meet the commitment from previous reporting period and recommendation from GAC.	above target: cumulated target at Y3 is 6 facilities. Due to the pandemic, the team would be conducting the assessment semi-annually instead of quarterly and would assess referral hospitals when cases are manageable locally and the team has been vaccinated already
1133 Technical assistance provided for improved management and coordination of SRHR and GBV prevention services	1133.a: #/total RHUs with information management systems in place	0	3	5	5	9	5		6	15	On Schedule	These are the additional new facilities who have information management systems in place: 1. RHU Bongao 2. RHU Buluan 3. RHU Ganassi 4. RHU San Isidro 5. RHU Sapa-sapa 6. RHU South Upi	Corrected previously reported count to reflect changes in the information systems of the facilities.
1134 Technical assistance provided to local health and community structures	1134.a: #/total LGUs with referral mechanisms for SRHR services in place	0	3	2	3	5	2		0	5	on schedule	The following health facilities met the indicator details during the reporting period: 1. RHU Buug 2. RHU Dimataling 3. RHU Mobo 4. RHU Prieto Diaz 5. RHU Sta. Margarita	No new health facilities met the criteria for this reporting period.
1211 Funding mechanism developed and core support grants disbursed	1211.a: # of women's rights organizations and networks (national and local) advancing SRHR that receive capacity-building core grants from the project	0	4	6	0	8	2		3	11	On schedule	All 11 SHE partners received an institutional strengthening grant.	above target

1212 Capacity assessment of selected partner organizations undertaken and capacity development plan implemented	1212.a: #/total capacity assessment workshops undertaken with partners CSOs and WROs	0	10	10	0	10	10	0	10	re scheduled	A needs assessment survey was conducted among partners to know emerging needs and preferences of the implementation of capacity building activities given the present COVID 19 restrictions.	No CAT4SRHR midterm assessments were done because all partners are still implementing their institutional strengthening activities. Midterm Assessments in Year 4 will coincide with project midterm evaluation.
1221 Support knowledge generation on SRHR and GBV issues	1221.a: #/total annual pulse surveys on SRHR indicators implemented by partners and/or WROs	0	9	15	0	7	17	14	21	on schedule	Midterm survey carried out in 14 municipalities is counted here as a Pulse Survey. Consulting firm signed contract in March 15, 2021. Data collection will be conducted in April and final report in quarter	Midterm survey cover all baseline municipalties but pulse survey was carried out in different municipalities.
	1221.b: #/total Number of research studies, knowledge products disseminated and learning initiatives	0	0	5	8	1	4	2	3	re scheduled	2 research pieces were finalized: the SRHR 101 lecture videos and Feminist Media 101 for Young Women module.	Accomplished 60% of the year 3 target for this output. In addition, there are 4 items of research in their final draft for review. Dissemination will be in Year 4
1222 Support or establish a community of learning and practice on women's rights, SRHR, and GBV prevention	1222.a: #/total learning events/ initiatives carried out in coordination with project partners	0	0	3	3	1	2	2	3	on schedule	2 learning activities conducted in Q3 and Q4 with a total of 348 reach (263 women, 22 girls, 60, men, and 3 boys).	Accomplished 100% of the year 3 target for this output.
1231 SRHR and GBV accountability processes improved through advocacy and campaigns	1231.a: #/total of advocacy strategies identified and advocacy activities implemented	0	0	5	10	4	1	6	10	on schedule	A total of 6 strategies were implemented in this reporting period, and a total of 10 in Year 3. Strategies: campaigns, Publication, Engagement in HR mechanism, Development of App, Policy Forum, Direct advocacy, and Interfaith Dialogue	Exceeded Year 3 target
1232 Alliance building and networking for organizations working on SRHR and GBV facilitated	1232.a: #/total of key influencing activities or initiatives organized	0	0	5	10	0	5	6	6	on schedule	A total of six influencing initiatives were completed, representing 120% of the target for this project year.	Exceeded Year 3 target

Annex 6a. RECOMMENDATIONS FROM THE SURVEYS AND HIGHLIGHTS FROM THE INITIAL MIDTERM REPORT

RECOMMENDATIONS from the surveys:

- Use different tools for collecting information on GBV, such as focus groups that guarantee a safe space for women, separating them from the possible environment where they lived the situations of violence. For surveys, it is recommended that, immediately before the section on questions about violence, a paragraph should be included explaining again that the information provided is fully confidential and that the interviewer guarantees the total discretion in handling the information. Likewise, it is important that the interviewers have strategies to contain emotional crisis and greater awareness in relation to gender violence that allows them to generate a feeling of greater empathy and not re-victimization with the women interviewed.
- New questions have been introduced in the midterm surveys to assess the level of knowledge about the different contraceptive methods and it would be useful to have these questions in future surveys that can facilitate a comparative analysis about knowledge. In the same way, it is suggested to incorporate more questions that can assess the degree of knowledge about SRHR services other than family planning.
- Given the evidence of reductions in the positive attitudes of men and boys shown in the indicators of the SRHR index, the incorporation of questions that seek to measure the existence of negative actions or behaviors in daily life is recommended. Possible alternative questions may arise from the holding of workshops or focus groups directly in the communities or from the review of forms or questionnaires used to investigate more widely and indirectly attitudes of gender violence.

For Pillar 1:

1. The baseline provides evidence that teen pregnancy is a primary concern. It is recommended that the project redefine its target age/sex groups to add the 10 to 14 age group and develop outreach and information strategies to cover their needs. A specific needs assessment should also be undertaken on information and access to SRHR services for ages 10 to 19.
2. Addressing VAWG is also a priority; particularly emotional, physical and sexual violence might be under -reported in the national statistics. It is recommended that the project provides accurate information about the rights of and services available to survivors of violence.
3. Given the lack of resources and the constraints of local government units to address both teen pregnancy and VAWG, it is recommended that the project add a "follow up" component to the referral mechanism already planned. The project might explore using the Field Health Service Information System (FHSIS) to identify the number of cases reported.
4. Baseline data shows that most women did not wish to get pregnant in their most recent pregnancy. It is Recommended that the project highlight women's reproductive and sexual autonomy in its influencing strategies.

5. A clear empowerment framework for girls and women needs to be drafted to guide the influencing strategies to change attitudes of the target population and health service providers.

For Pillar 2:

6. Given the lack of information and research on SRHR issues, it is recommended that topics such as identifying the impact on women and girls of abortion and post-abortion care, rape, and VAWG should be a priority for the learning and knowledge generation the project is funding. Further research on behavior modeling is needed, specifically identifying reference groups for girls such as peers, family members and religious leaders.
7. The national reports on the state of international agreements like the CEDAW and the Millenium Goals provide an opportunity for the project to leverage its national influencing strategies. Project partners\ could produce shadow reports on those indicators relevant for international reporting.
8. The baseline found a dichotomy exists among jurisdictions and mandates, policy initiatives and developments among national agencies and local governments. It is recommended that WRO/CSOs design and establish social accountability strategies and mechanisms, from the local level up to the national level, to ensure the implementation of laws and policies and that SRHR services reach those who need them. At the local level, interagency actions should be promoted to reinforce local WROs' agendas to eliminate VAWG and prevent GBV.
9. It is recommended that project partners actively consolidate, support and tap the existing networks in advocacy, as they are a storehouse of lessons and strategies. As evidenced by the stakeholder analysis, it may be that the existence of a strong informal network of advocates and champions on SRHR, anti GBV, and gender equality, is what sustains the advocacy in times of backlash when there appear to be elements that threaten to derail or impede the progress made on these issues.

HIGHLIGHTS FROM THE INITIAL MIDTERM REPORT

Hypothesis 1 of the midterm survey: Is an increase in positive attitudes an indication of change in the following behaviors: rejection of GBV, rejection of early marriage, acceptance of women making decision about their reproductive health? The positive attitudes index was compared with an index of violence against women, with the indicators of rejection of marriage for minors under 18 and 16, and with the dimension of the SRHR index of reproductive autonomy.				
SRHR Community Attitudes Index SRHR Community Attitudes Index (females, all age groups) Females 15-19 Females 20-49 Males 15-19 Males 20-49	 54.14 53.77 56.72 52.30 54.64	 53.86 55.61 57.42 50.68 51.44	 56.72 (from Fig 5) 56.79 (from Figures 1 and 6) 57.08 (from Figures 2 and 7) 54.11 56.21	• **Overall, an increase in positive attitudes toward SRHR. For women, a stable increase in SRHR index. This correlated positively with a rejection on early marriage but did not directly result in reduction of GBV.**
GBV Index 1 (Occurrence of GBV) Females 15-19 Females 20-49	 1.54 2.35	 12.5 7.32	 2.38 3.34	• A slight increment in GBV cases (can be read as an increment in the number of respondents willing to declare it in front of a inteviewer, about the violence they have suffered, by their partner or husband in the last twelve months); • A slight increment in respondents willing to denouce violence
MIDTERM REPORT: Pulse Survey values are "high" compared with Baseline and Midterm. There is no statistical explanation for that difference. Since the Pulse Survey was carried out in a different set of municipalities, the SHE project could explore the GBV issues in those municipalities to have a better understanding of those values.				
GBV Acceptance Index 2 (Community acceptance of GBV) Females 15-19 Females 20-49	 questions used are not available for baseline survey	 7.68 9.08	 4.39 9.63	A small improvement in positive attitudes toward SRHR does not affect the social norms of acceptance of GBV.

Rejection of early marriage All age and gender groups have shown a significant increase in their rejection for early marriage since the baseline.				
It is not acceptable to arrange a girl to be married before the age of 18(females, all age groups) >Females 15-19 >Females 20-49	 67.20 65.54 68.08	 77.28 79.22 79.56	 78.49 (from Fig 5) 80.25(from Fig 6) 78.05 (from Fig 7)	Girls have a higher increase in rejection of early marriage than women
It is not acceptable to arrange a girl to be married before the age of 16(females, all age groups) >Females 15-19 >Females 20-49	 75.55 78.75 79.55	 80.81 84.21 Fig 6 and 7 83.16	 83.54 (from Fig 5) 84.39 (from Fig 6) 82.49 (from Fig 7)	The rejection values are higher for the marriage of girls under 16 years of age.
It is not acceptable to arrange a girl to be married before the age of 18 >Males 15-19 >Males 20-49	 67.68 67.44	 76.59 72.57	 81.06 74.62	Men and boys also show an increase in rejection of early marriage
It is not acceptable to arrange a girl to be married before the age of 16 >Males 15-19 >Males 20-49	 71.07 72.08	 78.70 76.51	 84.85 82.39	As with the opinions of girls and women, the greatest rejection is reported for the marriage of girls under 16 years of age.
Community acceptance of women's decisions about their reproductive health (Reproductive autonomy dimension of the SRHR index used as an indicator) **Reproductive Autonomy Dimension Index** **>**Females 15-19 >Females 20-49 >Males 15-19 >Males 20-49	 **54.94** **59.04** **59.81** **60.47**	 **48.45** **53.35** **49.48** **51.05**	 **49.15** **50.7** **41.12** **50.27**	A slight increase from 48.4 to 49.2 for girls from the pulse survey to the mid-term survey. For women, we see a reduction from 53.4 to 50.7 in their attitudes toward women's reproductive autonomy Increase in positive attitudes as measured by SRHR index is congruent with the increase in the acceptance of decision-making by women about their reproductive health is only true for girls. The evidence indicates that there are differentiated results for the other three age and gender groups, and at the aggregate level, the SRHR index reports very close values between the pulse survey and the mid-term survey. Remarkably, boys and men show a greater variability in their attitudes. The acceptance of women's reproductive autonomy drops for both groups.

MIDTERM REPORT: The drop from baseline to the midterm survey can be attributed to the difference in the wording of the questions and not to a change in attitudes: "how do you feel about girls and women… lumped in one question in baseline.				
Reproductive autonomy of women ("who makes the decision about how many children you should have?" was used as an approximate indicator)				
Females 15-19 >Respondent >Respondent and husband or partner jointly >Husband or partner >Others	available only for the pulse and midterm survey	53.1% 11.7 3.3 31.8	. 57.3% 14.0 8.9 19.7	Percentage of girls increase from the pulse survey (53%) to the midterm survey (57%) who think that they are the ones to make the decision themselves. The "others" category includes respondent's mother, respondent and respondent's mother jointly, respondent's father, and so-called others. The reduction in influence of "others" might be linked to the increase in their positive attitudes" towards SRHR.
Females 20-49 >Respondent >Respondent and husband or partner jointly >Husband or partner >Others	available only for the pulse and midterm survey	31.0% 46.9 17.1 4.9	33.1% 42.2 19.5 5.2	For women, a higher percentage reported joint decision-making, although there was a decline; in contrast, there was an increase in those reporting that they were the sole decision makers.
MIDTERM REPORT: No change in positive attitudes for women, therefore, the reason for change in their opinion about who makes the decisions about their reproductive health lies outside of the data captured by the surveys. The power dynamics between women and their partner explain their change in opinion and could be explored more with different tools other than the surveys.				
Hypothesis 2 of the midterm survey: Is a decrease in positive attitudes by men in the SRHR Index an indication of latent backlash to an increase of women's reproductive autonomy? As the indicators for each dimension approach 100, the greater the positive attitude of the community.				
Women's Reproductive Autonomy Dimension **>Males 15-19** **>Males 20-49** Indicator: Access to information and services on family planning >Males 15-19	 **59.81** **60.47** 68.81	 **49.48** **51.05** 59.77	 **41.12** **50.27** 48.08	Remarkably, boys and men show a greater variability in their attitudes. The acceptance of women's reproductive autonomy drops for both groups, with reduction more marked for boys

>Males 20-49 Indicator: Decision on whether and when to practice contraception >Males 15-19 >Males 20-49 Indicator: Decision on whether and when to have children/ become pregnant >Males 15-19 >Males 20-49	70.21 66.14 64.02 54.08 46.89	62.10 53.33 49.55 41.10 39.07	59.02 38.29 51.85 37.63 37.03	
Women's Sexual Autonomy Dimention **>Males 15-19** **>Males 20-49** Indicator: Access to information and services on sexual health >Males 15-19 >Males 20-49 Indicator: Decision on sexual initiation >Males 15-19 >Males 20-49 Indicator: Sexual negotiation and communication >Males 15-19 >Males 20-49	 **38.13** **40.58** 72.85 71.12 24.22 25.52 41.91 41.74	 **42.41** **41.75** 66.13 66.52 20.92 22.85 52.89 46.77	 **51.20** **51.25** - - 13.35 17.01 70.12 68.37	Boys and men show a reduction in positive attitudes for women and girls having access to information and for initiating sexual relations. However, both groups have a very strong increase for sexual negotiation and communication; It looks like men and boys are discussing more with women and girls about sexual relations; but both men and boys have difficulties letting women and girls make their own decisions. As a result, both groups show a better performance at the aggregate level of the index for this dimension as well as the improvement of the overall SRHR index.
Implementation of SRHR Policies Dimension Index **>Males 15-19** **>Males 20-49**	 **62.88** **62.31**	 **64.20** **62.03**	 **70.01** **67.11**	**The increase in rejection of early marriage by boys and men is significant and contributes to the increase in overall value for this dimension.** The greatest decrease in the positive attitudes of boys and men was identified in the dimension of reproductive

It is aceptable that a girl or woman chooses who she marries >Males 15-19 >Males 20-49 It is aceptable that a girl or woman chooses when she marries >Males 15-19 >Males 20-49	 70.16 67.64 64.73 64.35	 70.29 65.60 62.61 60.13	 62.22 62.87 64.92 61.99	autonomy. In the dimension of sexual autonomy, the indicator of sexual initiation is the one that presents the greatest deterioration for both boys and men. In the dimension of implementation of SRHR policies, the indicator with reduction for both boys and men is the decision on who to marry
Hypothesis 3 of the midterm survey: Quantify the increase in demand of RH services compared to the baseline and identify which services are most in demand. How do women demonstrate increase in demand (is this change linked to the assumption that "An increase in knowledge leads to a higher health seeking behaviour?")?				
Are you using now a method to delay or avoid getting pregnant?	Y-68.1%	Y-61.9	Y-58.1	Percentage of **women and girls** who report current use; these results do not necessarily represent a decline in access to contraceptive methods since the question asks about the current use of contraceptive methods that depend on the fact of being sexually active at the time the question was asked.
If yes, did you discuss and decide jointly with your partner?	Y-97.8	Y-94.2	Y-96.9	The difference of one percentage point cannot be considered as a substantial reduction, but rather as a behaviour that is maintained in a similar way between the surveys.
Did you and your partner ever discuss about family planning?	-	Y-83.3	Y-94.6	
Which method are you using now to delay or avoid getting pregnant? >Pills >Injectables	 46.2% 16.2	 45.7% 17.1	 45.3% 9.3	

>Implant	5.8	8.6	18.7	
>IUD	3.5	3.5	9.3	
>Female sterilization	4.0	5.7	6.7	
>Male condom	5.2	1.9	5.3	
>Withdrawal	13.9	11.4	0.0	
>Standard days/cycle beads	1.2	0.0	0.0	
>Rhythm	0.6	2.9	1.3	
>LAM	1.2	1.9	0.0	
Other traditional method	2.3	0.0	1.3	
More effective methods	75.7	80.6	89.3	
Where did you obtain your [most recent / current method] when you started using it?				
Barangay Health Center	43.6%	47.4%	76.9%	
Rural Health Unit	27.4	21.6	5.5	
District Hospital	0.3	1.6	0.3	
Regional Hospital	-	2.0	1.7	
Private Hospital	0.6	2.0	0.6	
Pharmacy	3.8	10.1	2.0	
Midwife	17.8	1.6	0.9	
Barangay Health Worker	1.0	1.0	2.0	
Family Member	0.3	1.0	0.3	

ANNEX 6b: COMPARATIVE QUANTITATIVE DATA FOR SHE OUTCOMES

The baseline study found that women and girls in the Philippines face significant inequities that limit their ability to enjoy their sexual and reproductive health and rights (SRHR), free of coercion or any form of violence. Social norms, attitudes and other systemic elements continue to limit education, sources of information and access to SRHR services in a society constrained by the Catholic Church and faith-based lobby groups.

The majority of the female respondents (girls and women) agreed with the statement that it is important to raise awareness on SRHR, protect women's security against domestic violence, and develop and maintain effective women's rights organizations. Most respondents felt that it is important for health service providers to be trained with regard to sexual and reproductive quality service delivery. The respondents felt that it is important to train these providers to appropriately respond to sexual violence cases.

Succeeding surveys showed that teenage pregnancy was somehow still perceived as a normal (and in some cases inevitable) event by the girls themselves. It is difficult for girls to make future plans and have overall productive life scenarios because of early age pregnancies. Some girls mentioned that they had considered abortion, despite knowing it was illegal. In the pulse HHS, 3.3% of the total number of respondents knew someone who had an abortion in the previous 12 months. They cited reasons like "girl was too young" or that "she was not ready to be a mother".

A separate matrix (Annex 6a) presenting the highlights from the midterm survey was prepared inasmuch as the midterm survey adopted a methodology that provides a new and different viewpoint apart from the straightforward comparative analysis.

INDICATOR	DESCRIPTION	BASELINE SURVEY	PULSE SURVEY	MIDTERM SURVEY/Y3 REPORT PMF Adjusted
		• 4 regions - 5 provinces - 9 municipalities - 1,923individuals (50/50 M/F)	• 6 regions -7 provinces -7 municipalities -1,004 individuals, same questionnaire with additional questions	• 6 regions -10 provinces -14 municipalities - 674 individuals, phone interviews, shorter questionnaire but maintaining same wording
• Only 2 municipalities are in all three surveys (San Isidro & Sta. Margarita) • 9 municipalities are in the baseline and midterm survey • 5 are in the pulse and midline surveys				

Ultimate Outcome (1000): Improved sexual and reproductive health and rights for women and girls in remote conflict-affected and disadvantaged regions of the Philippines				
1000.a % and number of women with unmet need for FP including modern methods, disaggregated by age group	WRA married or in a union who are not using contraceptive and do not want children on day of HHS	Target WRA population: 57,878 Baseline Value: Women 32.3% Girls 13.3%	(From Table 1 of Pulse Survey Final Report) Women: 33.3% Girls: 29.1% Total: 31.2%	Women: 14% Girls: 17%
1000.b% of teen pregnancy rates among target population	Teens are young women between 15 and 19 years old; baseline value is the percentage of those teens who have given birth or are pregnant on day of HHS	Target population (girls only): 20,732 Baseline Value: Girls 7.4%	6.4%	2.5%
1000.c Perspectives on positive attitudes that promote SRHR and GBV prevention among target population	Positive attitudes are those who strongly agree or agree with a set of statements referring to women's sexual, reproductive, and economic autonomy.	Target population: 86,386 **Original/New** Baseline Value: Women 49.7/50.2 % Girls 48.0/46.9 % Men 46.5/49.9 % Boys 46.8/48.2 %	Women: 70% Girls: 67% Men: 68% Boys: 63%	Women: 49.1% Girls: 48.0% Men: 48.6% Boys: 46.0%
Intermediate Outcome 1100: Enhanced utilization of gender-responsive sexual and reproductive health information and services (public and private) by women of reproductive age, adolescent girls, and boys				
1100.a: Number of new family planning acceptors, disaggregated by age, sex and by modern methods of contraception	% Calculated by subtracting the baseline value from the total % of those who say they are using an FPM <u>on day of mid term and final HH survey</u>	TBD Baseline Value will be set in Y2 following capacity assessment of RHU to determine how many individuals a RHU can serve in a year with present resources.		Cumulative Y3 Target/From Project Start: Female (WRA) -5209/4744 Male – 1426/143

1100.b: number of individuals disaggregated by age groups and sex, who have accessed quality and gender sensitive sexual and reproductive health services including modern contraception in the targeted health facilities	Access is the # of people who, during the life of the project, have received services from the targeted health facilities/service providers. SRHR services would include but are not limited to FP counselling, modern contraception, counselling and STI testing **(GAC Key Indicator)**	Female (WRA) - 61,120 Male - 2,460 (Not yet disaggregated by age)		Cumulative Y3 Target/From Project Start: Female (WRA) -62,342/65,290 Male - 2,266
Intermediate Outcome 1200: Improved effectiveness of women's rights organizations (WROs) to advance rights related to sexual and reproductive health and prevention of gender-based violence				
1200.a: #/total inter agency collaborations between WROs, CSOs, and government agencies promoting SRHR / preventing GBV	**OLD** During the life of the project, WROs, CSOs and networks improve their effectiveness through coordination and working groups as a result of org strengthening, alliances and public engagement activities funded by the project **NEW** Inter-agency collaborations between WROs, CSOs, and government agencies promoting SRHR/preventing GBV—encompasses any joint undertaking between NGOs, CSOs, WROs, and/or NGAs for research or advocacy campaigns.	Baseline value = 0 Partners are yet to identify key actors to form alliances, cooperation and collaboration priorities.		Cumulative Y3 Target: 21 **Rescheduled**

1200.b: Level of confidence of WROs on their own ability to coordinate and advocate to protect and promote the rights related to SRH and the prevention of GBV	Qualitative data on WROs' perceptions relating to expanding their sphere of influence (working with others in alliances or consortiums)	TBD Baseline Value will be set in Y2 following CAT4SRHR assessments.		Rescheduled to June/July 2021
Immediate Outcome 1110: Increased knowledge, skills and capacity of women, girls, and boys regarding their Sexual and Reproductive Health and Rights (SRHR)				
1110.a % and # of target population knowing where to access SRHR services of contraceptives commodities	Knowledge about Family Planning Method (FPM) and services; quantitative data from HHS, qualitative data from "I stories", FGD	Target population: 86,386 Baseline Value : Women 47.4% Girls 24.3% Men 51.5% Boys 34.1%	 Women: 87.3% Girls: 37.7% Men: 66.1% Boys: 30.3%	Actual same as Cumulative from Project Start: Women: 86.6% Girls: 60.8% Men: 77.5% Boys: 41.3%
1110.b %/Total girls and women (WRA) able to make reproductive health choices alone and/or supported by their partner, disaggregated by age	Right to decide and choice of FPM and services; cross calculation of those who have ever used FPM and those who are using one now. Quantitative data from HHS, qualitative data from "I stories", FGD **(GAC Key Indicator)**	Target WRA population: 57,878 Baseline Value: Women 58.7% Girls 35.1%	 Women: 55.4% Girls: 3.6%	Actual same as Cumulative from Project Start: 58.9% 44.4
Immediate Outcome 1120: Improved positive attitudes modelled by women, men, girls, boys, and influencers in support of SRHR information and services				
1120.a Perspectives of targeted population on positive attitudes that promote women's reproductive autonomy	Measured by a series of questions; an index (%) is calculated to quantify the value of reproductive autonomy. Qualitative information from FGD	Target population: 86,386 **Original/New** Baseline Value: Women 61.0/59.0 % Girls 55.0/54.9 % Men 66.0/60.5 % Boys 63.0/59.8 %	 Women: 63% Girls: 58% Men: 64% Boys: 59%	Actual same as Cumulative from Project Start: Women: 50.7% Girls: 49.1% Men: 50.3% Boys: 41.1%

	from midterm and final evaluations.			
1120.b: #/total public declarations and actions by influencers to support SRHR, and in support of women's rights and leadership	During the life of the project, quantitative indicator with evidence from changes in influencers' discourse (radio, sermons, articles, etc)	Baseline value = 0 Partners will document statements by influencers that reflect or quote directly project's messages.		Actual same as Cumulative from Project Start: 26 Y3 Target: 21
Immediate Outcome 1130 Improved capacity of the public and private health system to provide comprehensive and gender-responsive SRHR information and services				
1130.a: #/total facilities providing gender responsive SRHR information and services	Criteria for assessing gender responsive SRHR info and services: 1) Facility has space with audio-visual privacy for examination of clients and provision of counselling; 2) Facility has record of SRHR counselling provided by trained staff; 3) Facility is providing at least three modern methods of FP.	TBD (Y2 following capacity assessment of RHU)		Actual same as Cumulative from Project Start: 18 Y3 Target: 4 On schedule
1130.b: #/total rural health units that have at least 3 modern contraceptives available on day of assessment	The 3 modern methods include at least 1 long acting, reversible method **(GAC Key Indicator)**	TBD (Y2 following capacity assessment of RHU)		Actual same as Cumulative from Project Start: 21 Y3 Target: 5 On schedule
Immediate Outcome 1210 Increased organizational capacity of partner organizations and selected WROs/CSOs to deliver effective programs on SRHR and GBV prevention				
1210.a: Level of confidence of partners	This indicator measures the autonomy and	TBD		Actual same as Cumulative from Project Start: 7

and/or WROs in their own ability to deliver effective programs on SHRH and GBV prevention	awareness of the organization's own performance.	Baseline Value will be set in Y2 following CAT4SRHR assessments.		Y3 Target: 3 On schedule
1210.b: #/total partners and/or WROs on target with their Action Plan to increase capacity	Descriptive account of their self-assessment. The indicators measure the organization's agency to increase its own capacity	TBD Baseline Value will be set in Y2 following CAT4SRHR action plans to increase capacity.		Actual same as Cumulative from Project Start: 7 Y3 Target:3 On schedule
Immediate Outcome 1220 Strengthened capacity of WROs/CSOs to generate knowledge to influence policy and practice on women's rights, particularly on SRHR and GBV prevention				
1220.a: #/total partners and/or WROs drafting their own learning agenda on SRHR	Refers to the ability of partners to incorporate feminist MEL principles into their work during the life of the project.	Baseline value = 0 Although partners have already identified and classified learning questions to address during the life of the project		Actual same as Cumulative from Project Start: 3 Y3 Target: 4
1220.b: Perceptions of partners on their capacities to generate knowledge on women's right	Refers to the generation and use of knowledge products to support influencing and advocacy actions for women's rights during the life of the project	Baseline value = 0 Partners are yet to define influencing strategies and the knowledge products to support them.		Actual same as Cumulative from Project Start: 2 Y3 Target: 4
Immediate Outcome 1230 Improved ability of WROs and networks to promote women's rights and influence policy makers on SRHR and GBV prevention				
OLD 1230.a: #/total advocacy and public engagement	Refers to the ability of WROs and networks to engage the public	Baseline value = 0		Actual same as Cumulative from Project Start: 6 Y3 Target: 3

activities completed by funded partners which are focused on SRHR and prevention of GBV **NEW** 1230.a: #/total advocacy and public engagement strategies by funded partners that are focused on SRHR and prevention of GBV.	and policy makers in advocacy and influencing campaigns **(GAC Key Indicator)**	Partners are yet to define influencing strategies and the public engagement to support those strategies		On schedule
OLD 1230.b: #/total WROs/networks reporting on at least two improved influencing skills **NEW** 1230.b: #/total WROs/networks reporting on an improved influencing skill.	Descriptive account of the type of skills acquired or improved. These are project partners and WRO/networks involved in influencing activities during the life of the project.	Baseline value = 0 Measured during the life of the project according to self-assessments.		Actual same as Cumulative from Project Start: 2 Y3 Target: 5

NOTE: Overall targets will be the same but all unmet targets in Year 3 in each output indicator will be carried out in Year 4. The changes in output indicator targets were mainly due to the restrictions and other challenges brought about by the COVID-19 pandemic. Significantly affected is the work with young people, specifically those below 18 years old; students do not go to school and continue their studies at home to protect them from the risk of infection.