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A Portfolio Mapping of CARE's Sexual and Reproductive Health and Rights Programming in the African Great Lakes Region

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Master of Public Health

Global Health

_____

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By

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B.A., University of Michigan, 2015

Thesis Committee Chair: Cari Jo Clark, ScD, MPH

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
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Abstract

A Portfolio Mapping of CARE's Sexual and Reproductive Health and Rights Programming in the African Great Lakes Region

By Talya Nakash

Background: The fulfillment of Sexual and Reproductive Health and Rights (SRHR) remains a challenge across the globe. As a key player in the SRHR sector, CARE aims to reach 100 million women and girls in SRHR by 2020. There was a need to conduct an in-depth review of SRHR projects in CARE's East, Central, and Southern Africa (ECSA) region in order to determine contributions to this goal and to inform the SRHR approach and priorities for the region.

Project Goal: This portfolio mapping aims to provide a better understanding of the strengths and gaps in CARE's current SRHR programming in five countries in the Great Lakes sub-region of ECSA: Burundi, Democratic Republic of Congo, Rwanda, Uganda, and South Sudan.

Methods: CARE's Project and Program Information and Impact Reporting System (PIIRS) and intervention forms completed by Country Office program staff were used to identify SRHR projects being implemented in the Great Lakes countries. Project data from the two sources were aggregated and organized to draw comparisons and identify patterns across different projects and countries.

Results: In PIIRS, fourteen projects were classified as meeting the Sexual, Reproductive and Maternal Health and Rights (SRMH) outcome area and seven SRHR projects were reported through the intervention forms. For both data sources, additional projects were also identified as having SRHR components. This portfolio mapping found that a wide array of SRHR projects are being implemented in the Great Lakes countries. The fourteen projects classified as SRMH in PIIRS had a combined 1,667,045 total direct beneficiaries and $34.3 million in funding. Examples of project challenges, as identified by the intervention forms, included capacity issues and negative attitudes about SRHR. Requests for desired or needed support from project staff centered on capacity building, trainings, communication, and young people.

Discussion: CARE's SRHR programming addresses key SRHR issues across the region, but many pressing SRHR needs are not being met. Country Office responses regarding project challenges and needed support provide a clear pathway for recommendations. The strengths of each country's SRHR portfolio can also be leveraged horizontally to address challenges and calls for support across the Great Lakes sub-region.

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INTRODUCTION

The Importance of SRHR

The fulfillment of Sexual and Reproductive Health and Rights (SRHR) remains a challenge across the globe. Approximately 830 women die from complications resulting from childbirth or pregnancy every day, while for girls between the ages of 15 and 19, maternal mortality is the second-leading cause of death (World Health Organization, 2016 and HRP, 2017). Additionally, 225 million women around the world have an unmet need for family planning (HRP, 2017). Improving SRHR saves lives and provides women and girls with the opportunities to plan their futures. Protecting and fulfilling the SRHR of women and girls everywhere is a human rights issue. In fact, sexual and reproductive health (SRH) is connected to numerous human rights, including the right to health and the prohibition of discrimination, amongst others. These rights are enshrined in international human rights covenants, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (OHCHR, 2018).

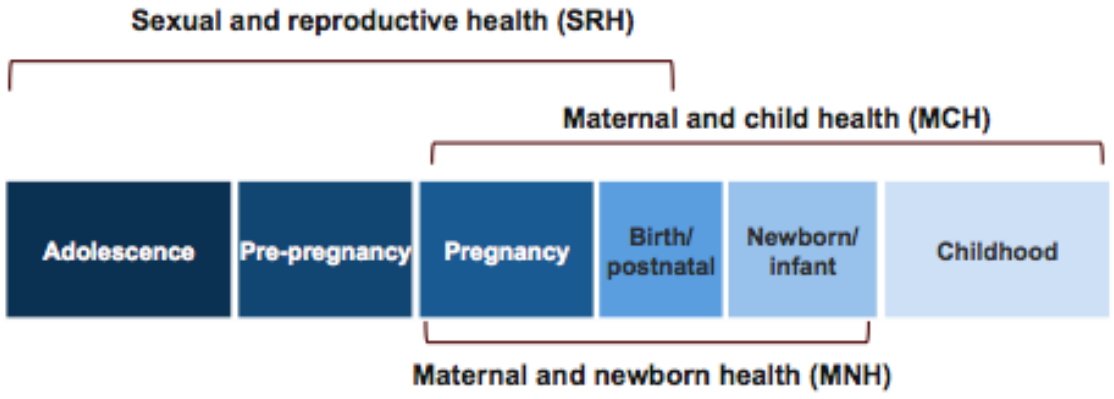
Sexual and Reproductive Health and Rights are also central to reducing global poverty and to empowering women and girls. The importance of SRHR to sustainable development is reflected by its inclusion in the Sustainable Development Goals (SDGs), the global development agenda that took effect in 2016, which lays out 17 goals for transforming the world by 2030 (United Nations, 2015). The SDGs have identified SRHR as key issues, and ensuring sexual and reproductive health and rights is explicitly mentioned in the targets and indicators for Goals 3 and 5. SRHR also underpin the other goals and are thus integral to the achievement of the SDGs overall (United Nations, 2015). CARE's commitment to achieving social justice and defeating

poverty by empowering women and girls makes SRHR central to its mission. CARE is a major player in the field of SRHR, and conducting this portfolio mapping will provide greater programmatic understanding of CARE's SRHR portfolio.

The SRHR Continuum

CARE defines Sexual and Reproductive Health and Rights (SRHR) as covering "the full spectrum of women's needs and rights during their reproductive life span, from adolescence through motherhood and beyond" (CARE SRHR, 2016). Figure 1 demonstrates that Sexual and Reproductive Health and Rights are a continuum and that sexual and reproductive health, maternal and child health, and maternal and newborn health are all part of CARE's global SRHR work. CARE's SRHR programming includes work in family planning, sexuality education, breastfeeding and nutrition, and emergency obstetrics, among other areas of care. Finally, CARE's SRHR approach focuses on "ensuring women and girls have access to the information, services and enabling environment necessary to decide if, when, and how many children to have, and to achieve a healthy pregnancy, safe delivery, and healthy newborns" (CARE SRHR, 2016).

Figure 1. CARE's SRHR Continuum



(CARE SRHR Global Team, 2018)

Purpose

CARE aims to expand and institutionalize its sexual and reproductive health and rights (SRHR) work in its East, Central, and Southern Africa (ECSA) region. Currently, country offices in this region are implementing various SRHR initiatives, but there has not been an in-depth review of the projects or an analysis of the collective reach of these projects. Thus, it is difficult to ascertain what the ECSA region is contributing to CARE's goal of reaching 100 million women and girls in SRHR by 2020. There is a need to conduct a landscaping of the SRHR situation in the countries in ECSA and a need to better understand CARE's SRHR portfolio in the region in order to inform the SRHR approach and priorities for the ECSA region (CARE SRHR Global Team,[a] 2017).

This portfolio mapping aims to provide a better understanding of the strengths and gaps in the current SRHR programming in the Great Lakes sub-region of ECSA, which includes the countries of Burundi, Democratic Republic of Congo, Rwanda, Uganda, and South Sudan.[1] The goal of this Special Studies Project is to determine the current reach of CARE's SRHR portfolio in the Great Lakes countries and to provide a cross-country assessment of gaps based on the most pressing SRHR needs of these countries. CARE's Project and Program Information and Impact Reporting System (PIIRS) and intervention forms completed by specifically designated "SRHR focal points" in each country office were used to map CARE's projects.

[1] CARE's Great Lake sub-region includes the countries of Burundi, DRC, Rwanda, and Uganda. Although South Sudan is technically not part of CARE's Great Lake Region, it has been included as part of this sub-region for this portfolio mapping because it follows similar programming of the other countries in the Great Lakes.

Great Lakes Sub-Region

The thematic area of programming of CARE's Great Lakes sub-region is gender-based violence (GBV). CARE's 2020 Program Strategy calls this "the right to a life free from violence" (LFFV), and this is one of the five outcome areas of the 2020 Program Strategy. The different Country Offices in the Great Lakes countries (Burundi, DRC, Rwanda, and Uganda) created a Great Lakes GBV Strategy, as the Country Offices "have been using similar programming models, and are faced with similar challenges (including cross-border challenges)" (CARE SRHR Global Team,[b] 2017, p. 2). The strategy works on integrating GBV into all of its programming areas. Because of the relatedness and close relationship between the areas of GBV and SRHR, the LFFV thematic focus of the Great Lakes sub-region programming makes the sub-region well suited for this portfolio mapping.

BACKGROUND: THE STATE OF SRHR BY COUNTRY

BURUNDI

SRHR Indicators

- Maternal Mortality Ratio:[1] 712 deaths per 100,000 live births
- Modern Contraceptive Prevalence Rate (All Women):[2] 16.4%
- Unmet Need for Modern Contraception (Married Women):[2] 33.0%
- Demand Satisfied for Modern Contraception (Married Women):[2] 43.5%
- Modern Contraceptive Method Users:[2] 456,000
- Total Fertility Rate:[3] 5.6 births per woman
- Adolescent Fertility Rate:[3] 26.8 births/1000 women aged 15-19
- Refugees and Asylum Seekers:[4] 64,876
- Internally Displaced Persons (IDPs):[4] 191,806

Country Context:

Burundi is among Africa's most densely populated countries, and it has a very large young population, with 45 percent of people under the age of 15 (World Bank Group, 2018). Burundi is also one of the poorest countries in the world - it is ranked 184 out of 188 in the UN human development index - and 81 percent of the population lives on less than $1.25 a day (UNDP, 2016). In April 2015, election-related violence triggered the displacement of thousands of people in Burundi and more than 420,000 Burundian refugees have fled to the neighboring countries of the Democratic Republic of Congo, Rwanda, Uganda, and Tanzania. Humanitarian and socio-economic indicators are worsening in Burundi, and refugees fleeing face sexual and gender-based violence, fear of persecution, and human rights abuses. In addition to refugees fleeing Burundi and the IDPs within the country, returnees from neighboring countries are a population of concern (UNHCR[a], 2017). Displacement and instability are exacerbating healthcare challenges in the country, and land scarcity is a concern.

Sexual and Reproductive Health and Rights:

Burundi faces many sexual and reproductive health challenges that are exacerbated by the current violence and displacement. Firstly, the country has an extremely high maternal mortality ratio, (712 deaths per 100,000 live births) (WHO, 2015). There has been some success in reducing deaths in the western municipality of Kabezi, and the government hopes that these efforts can be duplicated across the country (MSF, 2012). In conjunction with its low use of modern contraceptives, Burundi has the sixth highest fertility rate in the world, and its population is growing by 3.1 percent every year (UNPD, 2017). The main challenges of young people in the areas of sexual and reproductive health in Burundi are low use of modern contraceptive methods, high rates of unintended pregnancies among schoolgirls, early marriage, and high exposure to gender-based violence. However, Burundi is emerging as a leader in comprehensive sexuality education. A curriculum for children and adolescents between the ages of 10 and 19, called *The World Starts With Me*, is being implemented nationwide as part of a national program being rolled out from 2016 to 2020 (Rutgers, 2018).

[1] (World Health Organization, 2015); [2] (FP2020, 2018); [3] (United Nations Population Division, 2017); [4] (United Nations OCHA, 2017); Map: Reprinted from Centers for Disease Control and Prevention website (CDC, 2018).

DEMOCRATIC REPUBLIC OF CONGO

SRHR Indicators

- Maternal Mortality Ratio:[1] 693 deaths per 100,000 live births
- Modern Contraceptive Prevalence Rate (All Women):[2] 10.3%
- Unmet Need for Modern Contraception (Married Women):[2] 40.0%
- Demand Satisfied for Modern Contraception (Married Women):[2] 19.9%
- Modern Contraceptive Method Users:[2] 2,171,000
- Total Fertility Rate:[3] 6.0 births per woman
- Adolescent Fertility Rate:[3] 124.2 births/1000 women aged 15-19
- Refugees and Asylum Seekers:[4] 544,509
- Internally Displaced Persons (IDPs):[4] 3,900,000

Country Context:

The current humanitarian crisis in the Democratic Republic of Congo (DRC) is considered one of the worst in the world. As of 2016, 3.9 million people were displaced in the DRC, which makes it the country with the most displaced people in Africa (UN OCHA, 2017). Almost four decades of conflict and war has restricted people's access to health services, including access to reproductive health care. The country's infrastructure and social services have been severely damaged by conflict and displacement. Furthermore, the large size of the country, the fact that a majority of the population resides in rural areas, and poor road network and communication systems make it difficult for people to access health care (Engender Health, 2018). Finally, there is great need to focus on SRHR, and young people in the DRC, as 68 percent of the country's population is under the age of 25 (UNFPA, 2012).

Sexual and Reproductive Health and Rights:

The DRC has one of the highest incidences of rape in the world, with rape being used as a weapon of war by armed groups in the country (CARE, 2017). In the eastern region of the DRC in particular, high rates of sexual violence have been documented. There are high rates of PTSD and depression in survivors, and overall there is a great need for programs focusing on sexual violence and mental health (Verelst, 2014). Traumatic fistulas, inflicted by sexual violence, are common in the DRC, and the majority of women are not able to have reparative surgery due to the lack of gynecologists trained to repair fistulas (Engender Health, 2018). Other issues resulting from sexual violence include HIV infection and negative social stigma attached to survivors (Omba Kalonda, 2013).

In addition to a high incidence of rape, the DRC has a high rate of intimate partner violence (IPV), with 57% of married women having experienced IPV (MPSMPRM, 2014). The country also has the third highest fertility rate in the world and a high maternal mortality due to poor maternal health care (UNPD, 2017). In 2008, the DRC adopted a National Reproductive Health Programme, and SRH (including family planning services) was integrated into the Ministry of Health's package of health services. But in practice SRH services have not been prioritized, especially in the east (Women's Refugee Commission, 2013).

[1] (World Health Organization, 2015); [2] (FP2020, 2018); [3] (United Nations Population Division, 2017); [4] (United Nations OCHA, 2017); Map: Reprinted from Centers for Disease Control and Prevention website (CDC, 2017).

RWANDA

SRHR Indicators

- Maternal Mortality Ratio:[1] 290 deaths per 100,000 live births
- Modern Contraceptive Prevalence Rate (All Women):[2] 28.6%
- Unmet Need for Modern Contraception (Married Women):[2] 24.1%
- Demand Satisfied for Modern Contraception (Married Women):[2] 66.9%
- Modern Contraceptive Method Users:[2] 901,000
- Total Fertility Rate:[3] 3.8 births per woman
- Adolescent Fertility Rate:[3] 25.7 births/1000 women aged 15-19
- Refugees and Asylum Seekers:[4] 160,197
- Internally Displaced Persons (IDPs):[4] N/A

Country Context:

Rwanda is a small, landlocked, and densely populated country in Central Africa. It is ranked 159 out of 188 countries in the UN human development index, and the country has one of the fastest growing economies in the region (UNDP, 2018 and CIA, 2018). Although Rwanda has made huge strides in reducing poverty rates in recent years, 63 percent of the population still lives in extreme poverty (World Bank, 2014). The country has a young population with roughly sixty percent of the population being under the age of 25 and roughly forty percent being under the age of 15. Additionally, Rwanda has a predominantly rural population, and it has recently dealt with the most severe drought the country has seen in decades (CIA, 2018). It is significant to note that the legacy of the Rwandan genocide in 1994 endures; during the genocide, at least 800,000 people were murdered and 2 million became refugees. Finally, the country currently hosts almost 160,000 refugees from neighboring Burundi and the Democratic Republic of Congo (UN OCHA, 2017).

Sexual and Reproductive Health and Rights:

Clandestine and unsafe abortions are common in Rwanda, as almost half of all pregnancies in the country are unintended. Of these unintended pregnancies, it is estimated that 22 percent end in induced abortion. This translates to 25 induced abortions per 1,000 women aged 15-44. Almost no safe legal abortions take place in Rwanda, and untrained individuals perform half of all abortions. Many abortions (forty percent) lead to complications that require treatment in a facility, but a third of women who suffer complications do not receive treatment (Guttmacher Institute, 2013).

Rwanda increased contraceptive use at one of the most rapid rates worldwide. The modern contraceptive prevalence rate was just four percent in 2000, increasing to ten percent by 2005, and 27 percent in 2008. The rapid increase between 2000 and 2008 resulted from government commitment, national and district-level support, widening the choice of methods available, and involving communities (USAID, 2010). Although Rwanda was successful in rapidly increasing contraceptive use between 2000 and 2008, Rwandan officials have been concerned about the recent increase in teenage pregnancy. Results from the most recent Demographic and Health Survey, conducted in 2015, showed that pregnancy among teenage girls increased from 6.1 percent in 2010 to 7.3 percent in 2015 (UNFPA, 2016).

[1] (World Health Organization, 2015); [2] (FP2020, 2018); [3] (United Nations Population Division, 2017); [4] (United Nations OCHA, 2017); Map: Reprinted from Centers for Disease Control and Prevention website (CDC, 2018).

SOUTH SUDAN

SRHR Indicators

- Maternal Mortality Ratio[1]: 789 deaths per 100,000 live births
- Modern Contraceptive Prevalence Rate (All Women):[2] 2.4%
- Unmet Need for Modern Contraception (Married Women):[2] 30.6%
- Demand Satisfied for Modern Contraception (Married Women):[2] 10.6%
- Modern Contraceptive Method Users:[2] 75,000
- Total Fertility Rate:[3] 4.7 births per woman
- Adolescent Fertility Rate:[3] 62.0 births/1000 women aged 15-19
- Refugees and Asylum Seekers:[4] 276,900
- Internally Displaced Persons (IDPs):[4] 1,870,000

Country Context:

South Sudan is Africa's youngest and newest country; it gained independence from Sudan in 2011, which ended the continent's longest-running Civil War. However, challenges and conflict remained after independence. A civil war between 2013 and 2015 displaced 2.2 million people, and the fact that most of the country lacks infrastructure exacerbates challenges (BBC, 2018). South Sudan's economy is dominated by the oil sector, and the country has a very young population, with just two thirds of the population being under the age of thirty. South Sudan also has very low literacy rates, as just 27 percent of the population above fifteen years of age is literate (World Bank Group, 2016). Finally, South Sudan also faces severe climate change threats, and the Climate Change Vulnerability Index ranks it as one of the five countries in the world that is most vulnerable to climate change. Northern parts of the country have been experiencing famine since early 2017, which has been caused by severe drought and years of war and instability (UNDP, 2017).

Sexual and Reproductive Health and Rights:

South Sudan has one of the highest maternal mortality ratios in the world with 789 deaths per 100,000 live births (WHO, 2015). The country has some of the poorest reproductive health indicators in the world, with a modern contraceptive prevalence rate of just 2.4 percent (FP2020, 2018). Tensions surround family planning in South Sudan and misconceptions about contraceptives are widespread. During the war the Sudan People's Liberation Army's stance was against contraception, increasing risk for women and sometimes health workers. Limited access to contraceptives also results in clandestine and unsafe abortions, which has led to a high need for post-abortion care (Palmer and Storeng, 2016).

South Sudan is one of the ten countries with the highest prevalence of adolescent pregnancy in the world, as approximately one third of girls in South Sudan start childbearing between the ages of 15 and 19 (Vincent and Alemu, 2016). Additionally, fistulas are a concern within the country, as it is estimated that 60,000 women and girls suffer from the condition (UNFPA, 2015). Finally, conflict in the country has prompted upsurges in sexual violence, and the rates of sexual violence and gender-based violence in the country are alarming. A UNFPA survey conducted in 2015 found that 72 percent of women living in the Juba Protection of Civilian sites were raped (most often by soldiers and police), while another study found that sexual and gender-based violence increased by 61 percent in South Sudan between 2015 and 2016 (Amnesty International, 2017).

[1] (World Health Organization, 2015); [2] (FP2020, 2018); [3] (United Nations Population Division, 2017); [4] (United Nations OCHA, 2017); Map: Reprinted from Centers for Disease Control and Prevention website (CDC, 2018

UGANDA

SRHR Indicators

- Maternal Mortality Ratio:[1] 343 deaths per 100,000 live births
- Modern Contraceptive Prevalence Rate (All Women):[2] 27.3%
- Unmet Need for Modern Contraception (Married Women):[2] 33.2%
- Demand Satisfied for Modern Contraception (Married Women):[2] 50.8%
- Modern Contraceptive Method Users:[2] 2,569,000
- Total Fertility Rate:[3] 5.5 births per woman
- Adolescent Fertility Rate:[3] 106.5 births/1000 women aged 15-19
- Refugees and Asylum Seekers:[4] 1,381,207

Country Context:

Located in East Africa, Uganda is a country of 34 million people and has one of the fastest growing populations in the world, with a 3.3 percent growth rate (UNDP, 2017). Uganda is ranked 163 out of 188 countries and territories on the human development index and also has a very young population: 48 percent of people are between the ages of 0 and 14, and 21.2 percent are between the ages of 15 and 24 (UNDP, 2018 and Rutgers, 2016). The National Resistance Movement has been in power in Uganda since 1986, and the country has faced the Lord's Resistance Army's brutal insurgency in the northern part of the country over the past two decades (BBC, 2017). Additionally, Uganda shares a border with South Sudan and hosts more than one million South Sudanese refugees. UNHCR estimates than more than 1,800 South Sudanese refugees have fled to Uganda each day over the past year (UNHCR[b], 2017).

Sexual and Reproductive Health and Rights:

The abortion rate in Uganda (39 per 1,000 women aged 15-49) is higher than the estimated rate for the East Africa region overall (34 per 10,000 women aged 15-49). In Uganda, 52 percent of pregnancies are unintended, and of these unintended pregnancies, approximately one quarter end in abortion. Many of these abortions are unsafe, which can result in maternal mortality or dangerous complications. In Uganda, almost 100,000 women were treated for complications that resulted from unsafe abortions in 2013 (the last year that data was available). Additionally, it is significant to note that abortion incidence varies greatly between regions in Uganda: on the lower end, the abortion rate was 18 per 1,000 women in the Western region, and on the higher end the rate was 77 per 1,000 in Kampala. The unmet need for modern contraception is high in Uganda (34.8 percent among married women), which contributes to an increased number of unintended pregnancies and more abortions. In Kampala, the urban capital, the unmet need is sixteen percent, while in rural areas in the north, the unmet need is as high as 43 percent (Guttmacher Institute, 2017).

Finally, the sexual and reproductive health of young people in Uganda remains a challenge and deserves more attention. Adolescent sexual and reproductive health services are limited despite the fact that half of the population is of adolescent age. Additionally, adolescent pregnancy is high in the country; almost one quarter of adolescents between the ages of thirteen and nineteen are already mothers or pregnant with their first child (Atuyambe et al., 2015).

[1] (World Health Organization, 2015); [2] (FP2020, 2018); [3] (United Nations Population Division, 2017); [4] (United Nations OCHA, 2017); Map: Reprinted from Centers for Disease Control and Prevention website (CDC, 2018)

METHODS AND DATA SOURCES

CARE's Project and Program Information and Impact Reporting System (PIIRS) and intervention forms completed by country offices were used to map CARE's projects. Project information was compiled from the two data sources and aggregated and summarized across projects and countries. Quantitative data were used to understand the number of projects identified, the classification of projects into outcome areas and into development versus humanitarian categories, the numbers of beneficiaries, and project funding. Figures were added and compared within and across countries. Qualitative data provided information about project goals, activities, primary challenges, and needed support. This information was organized to identify common themes across projects. Qualitative and quantitative data were examined side-by-side within each project in order to gain an in-depth understanding of each project, and in order to draw comparisons and patterns across different projects in the sub-region.

PIIRS

CARE's Project and Program Information and Impact Reporting System is the system through which CARE International conducts its data collection and reporting process. The PIIRS 2017 reach data consists of project information reported by Country Offices on active projects and initiatives in all countries where CARE had a presence during the 2017 fiscal year (July 1, 2016 through June 30, 2017). This project information includes donor and budget information, articulation of the main goal of the project, its geographic scope, beneficiary data, and whether the project is classified as a humanitarian or development project. PIIRS also provides information about which outcome areas of CARE's 2020 Program Strategy a project fulfills. The

five outcome areas are: 1) Humanitarian Assistance, 2) Food and Nutrition Security and Climate Change Resilience, 3) Sexual, Reproductive and Maternal Health and Rights (SRMH), 4) A Life Free From Violence, and 5) Women's Economic Empowerment[2] (PIIRS FY2017 Data).

For all five countries, projects from PIIRS were included in this portfolio mapping if they met certain criteria: 1) they were marked as fulfilling the SRMH outcome area, or 2) they were not marked as fulfilling the SRMH outcome area but were identified as having clear SRHR components through the projects' main objective or impact group data. (See "The SRHR Continuum" section of the Introduction for an explanation about the scope of SRHR). Finally, to be included, the projects had to last into the year 2017; if the project ended in December 2016 or earlier, it was excluded from the mapping and analysis.

Intervention Forms

As part of the CARE SRHR Global team's larger landscaping of the ECSA region, intervention forms were sent to members of the ECSA SRHR Working Group.[3] Intervention forms asked focal points to list the CO's current SRH project(s) and to give technical information about the SRH project(s). More specifically, this technical information included general and specific objectives, key activities, beneficiary information, primary challenges of the project, and desired or needed support. Additionally, intervention forms asked for focal points to

[2] Country Offices do not directly report which outcome areas their projects fulfill. Instead, outcome areas are automatically populated based on 26 themes/sectors listed in PIIRS; CO program staff check off which themes/sectors apply to their project on the PIIRS form, which then automatically populates the outcome area.

[3] The ECSA SRHR Working Group was formed in January 2018 as part of the CARE SRHR Global Team's larger aim of institutionalizing its SRHR work in ECSA through a regional approach, and consists of focal points from all of CARE's 15 ECSA countries. Country Directors nominated 1-3 staff members (usually program staff on an SRHR or GBV project) from their respective Country Offices to be focal points on the ECSA SRHR Working Group.

list the names and provide a brief description of other health projects in their country offices (CARE Intervention Forms, 2018). Project information provided on the intervention forms completed for Burundi, DRC, Rwanda, Uganda, and South Sudan were utilized for this Special Studies Project.

RESULTS

Data Sources and Number of Projects

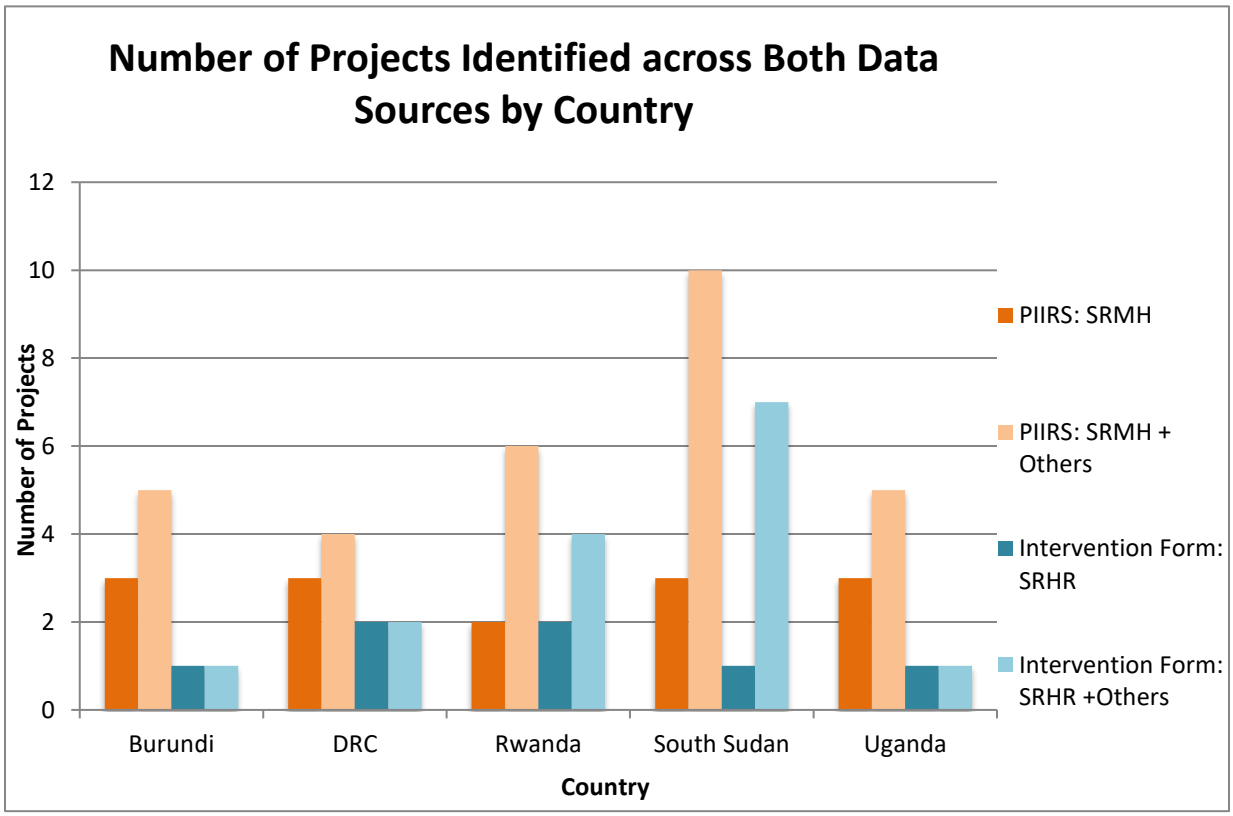
Thirty SRHR projects were identified in the PIIRS database across Burundi, DRC, Rwanda, South Sudan, and Uganda. Of these thirty projects, fourteen were marked as meeting the Sexual, Reproductive & Maternal Health and Rights (SRMH) outcome area, and were therefore automatically included (identified as "PIIRS: SRMH projects" in Figure 2). In addition to these fourteen projects, sixteen other projects, which were not marked under the SRMH outcome area in PIIRS, were identified as SRHR projects for having Sexual, Reproductive and Maternal Health and Rights project components. Inclusion of these additional sixteen projects gives a more robust and accurate picture of the SRHR project portfolio for these five countries. In Figure 2, these additional projects are added to SRMH projects and identified as "PIIRS: SRMH + Others."

Intervention forms captured fewer projects than PIIRS but provided greater detail about the projects described, including information about project challenges and desired support. Seven SRHR projects were described in the intervention forms, and an additional eight projects that were listed as "others" (for Rwanda and South Sudan) also had SRHR components. Thus, from the intervention forms there were fifteen total projects when "other health projects" were included. In short, for both sources, a little more than double were captured when "others" were included.

Results showed that useful information captured in intervention forms was not captured in PIIRS and vice versa. But information in the two sources was also often discordant. Firstly, projects included often did not align across data sources. For example, the project listed on Uganda's intervention form that focuses on South Sudanese refugees is not the same project

focused on South Sudanese refugees that was reported on PIIRS. The project reported on the intervention form was not reported in PIIRS, and the project reported in PIIRS was not reported on the intervention form. Additionally, information was sometimes discordant between the two data sources in terms of total project funding and number of beneficiaries.

Figure 2. Number of Projects Identified across Both Data Sources by Country



(Data from PIIRS FY2017 and CARE Intervention Forms, 2018)

Scope of Projects

There are a wide array of SRHR projects being implemented in Burundi, DRC, Rwanda, South Sudan, and Uganda, and these projects cover areas across the SRHR continuum. Programming includes work on family planning, adolescent sexuality education, and maternal and child nutrition, amongst other areas. Although many of these SRHR projects are unique to

one country in the Great Lakes sub-region, there are also projects in the sub-region that operate in multiple countries, such as Supporting Access to Family Planning and Post-Abortion Care (SAFPAC) and Gender Equality and Women's Empowerment Program (GEWEP).

SAFPAC Project and Family Planning

SAFPAC is a main CARE SRHR project operating in a number of countries across the globe; in the Great Lakes sub-region it operates in the DRC, South Sudan, and Uganda (CARE Intervention Forms, 2018 and PIIRS FY2017 Data). SAFPAC works to increase access to family planning and post-abortion care, and also aims to open the dialogue on safe abortion. The project specifically works in crisis-affected and/or fragile states, as it aims to "integrate SRH programming throughout CARE's emergency response work and culture" (CARE SAFPAC Team, 2018). SAFPAC has been in the DRC since 2011, when SAFPAC was fist implemented; more recently, there have also been SAFPAC projects in South Sudan[4] and Uganda[5]. A second SAFPAC project was also launched in the DRC in September 2017 in the country's Kasai Region after a budget realignment.

SAFPAC is unique in its emphasis on family planning, post-abortion care, and safe abortion, but other projects in the Great Lakes countries also have family planning components. For example, the Mawe Tatu project (funded by the Netherlands government in the DRC) is a

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[4]In January 2017, the Global SAFPAC team decided that South Sudan would be one of the countries receiving money from the SAFPAC Catalytic Fund ($150,000). In September 2017, there was a realignment of the SAFPAC budget (when the Pakistan project closed) and part of that funding (~$240,000) went to South Sudan. The funding listed on the intervention form includes the Catalytic Fund and the funding from the realignment.

[5] SAFPAC project ended in Uganda in December 2017 (which is probably why it was not listed on the intervention form). Instead, this project was captured through PIIRS, where it is grouped with other funders as an Emergency Response Project for South Sudanese refugees and asylum seekers, and host communities (see Appendices 1 and 2).

comprehensive project addressing gender-based violence prevention, improved economic management at the household level, and SRH behaviors, which works to increase awareness of family planning options (CARE Intervention Forms, 2018 and PIIRS FY2017 Data). Additionally, Aid Match, a smaller project in the DRC funded by DFID, worked to improve access to family planning services in the country (PIIRS FY2017 Data).

GEWEP and Women's Socio-Economic Empowerment

The Gender Equality and Women's Empowerment Program (funded by the Norwegian government and a Norwegian foundation) operates in all countries in the sub-region, with the exception of South Sudan.[6] GEWEP focuses on the economic and social empowerment of women through the realization of rights "to education, health, economic activity, security and participation in decision making" and through "gender transformation in the community" (PIIRS FY2017 Data). Other projects in the sub-region also contain women's socio-economic empowerment components, which often overlap with projects focused on GBV. For example, the DRC's Mawe Tatu project and Uganda's United Nations Joint Program on GBV (PIIRS FY2017 Data) all have important women's socio-economic empowerment components intertwined with their GBV programming. Finally, many of the adolescent empowerment projects – like Burundi's ISHAKA II project (A Promising Innovation for Girls' Social and Economic Empowerment) and Rwanda's Better Environment for Education and Safe Schools for Girls

[6] GEWEP projects operating in Burundi, DRC, Rwanda, and Uganda were identified through PIIRS; they were not reported on the intervention forms. In PIIRS, the GEWEP projects in Burundi and DRC are classified under the SRMH outcome area, while the GEWEP projects in Rwanda and Uganda are not. (Note: this affects beneficiary figures and funding figures calculated below.) CARE Norway is the CARE International Member related to the project for all four countries. The funder for all countries, except for Rwanda, is through the Norwegian government; Rwanda's funding comes through a Norwegian foundation.

projects – also focus on improving women's socio-economic status (CARE Intervention Forms, 2018 and PIIRS FY2017 Data).

Adolescent SRH and Adolescent Empowerment/Education

Another major theme in the Great Lakes' SRHR programming is the focus on adolescents. On the SRHR intervention forms, Burundi and Rwanda's projects are all centered on adolescents. Burundi's largest project, the Joint Program for the Improvement of Sexual and Reproductive Health of Adolescents and Young People, focuses on empowering youth in schools and out-of-school by providing them with accurate SRHR information, increasing their access to youth-friendly and quality health services, and building the capacity of community leaders. The project is using *The World Starts With Me* curriculum, which is being implemented nationwide, and CARE is working in 8 of the country's 18 provinces. Similarly, Rwanda has two major SRHR projects focused on adolescent empowerment: Better Environment for Education and Safe Schools for Girls Project. These projects train teachers to become mentors and provide adolescents with life skills on SRH. These adolescent SRHR projects have family planning components, showing the crosscutting nature of these areas. The Mawe Tatu project (DRC), listed above in the "Family Planning" section also has adolescent SRH components; Mawe Tatu and Rwanda and Burundi's adolescent empowerment projects all work with their countries' respective Ministries of Education (instead of or in addition to their Ministries of Health), which exemplifies the projects' focus on young people and youth sexual education (CARE Intervention Forms, 2018).

Right to a Life Free From Violence

Projects focused on addressing and preventing gender-based violence operate across all five countries. The Agent for Change (DFID) and Every Voice Counts (Netherlands government) projects in Rwanda, and the United Nations Joint Program on GBV in Uganda (UNFPA project) are prime examples of the GBV programming implemented in the Great Lakes. Agent for Change works to prevent GBV by working with couples, while Every Voice Counts works with community members, local leaders, and national civil society organizations. Many projects focused on GBV work to improve gender equality and promote healthy relationships, especially in projects centered on adolescents (CARE Intervention Forms, 2018 and PIIRS FY2017 Data).

Forced Migration, Refugees, and Emergency

In addition to SAFPAC, which as mentioned above works in emergency response, other projects in the sub-region are addressing emergency humanitarian response, particularly in South Sudan and Uganda. In South Sudan, various short-term projects in 2017 focused on providing services, especially emergency nutrition response, for refugees, IDPs, and host communities. More specifically, these projects addressed maternal, newborn, and child health, and focused on prevention and treatment of malnutrition in pregnant/lactating women, infants, and young children (PIIRS FY2017 Data). Uganda's programming also addresses emergency response for refugees: an ECHO project (European Commission for Humanitarian Aid and Civilian Protection, which has some funding from SAFPAC) and a GAC project (Global Affairs Canada) work to address emergency response for refugees and asylum seekers from South Sudan and host communities in West Nile, Uganda (CARE Intervention Forms, 2018 and PIIRS FY2017 Data). There is also a project in Burundi called Addressing Root Causes/Nyubahiriza (Netherlands

Government) that focuses on violence, instability, and forced migration faced by Burundians (PIIRS FY2017 Data).

Nutrition and Other Sectors

There are a number of nutrition programs in South Sudan with SRHR components specifically focusing on Maternal and Child Health. For example, UNHCR, UNICEF, IOM, and Disaster Emergency Committee projects focused on emergency nutrition for pregnant and lactating women and young children affected by humanitarian crises. Finally, one WASH project was also identified during the PIIRS review as having SRMH components: the Safe Water for Health Facilities project in Uganda (funded by General Electric Foundation) was included because pregnant mothers and children who were patients in the hospital were highlighted as the project's impact group (PIIRS FY2017 Data).

Outcome Areas

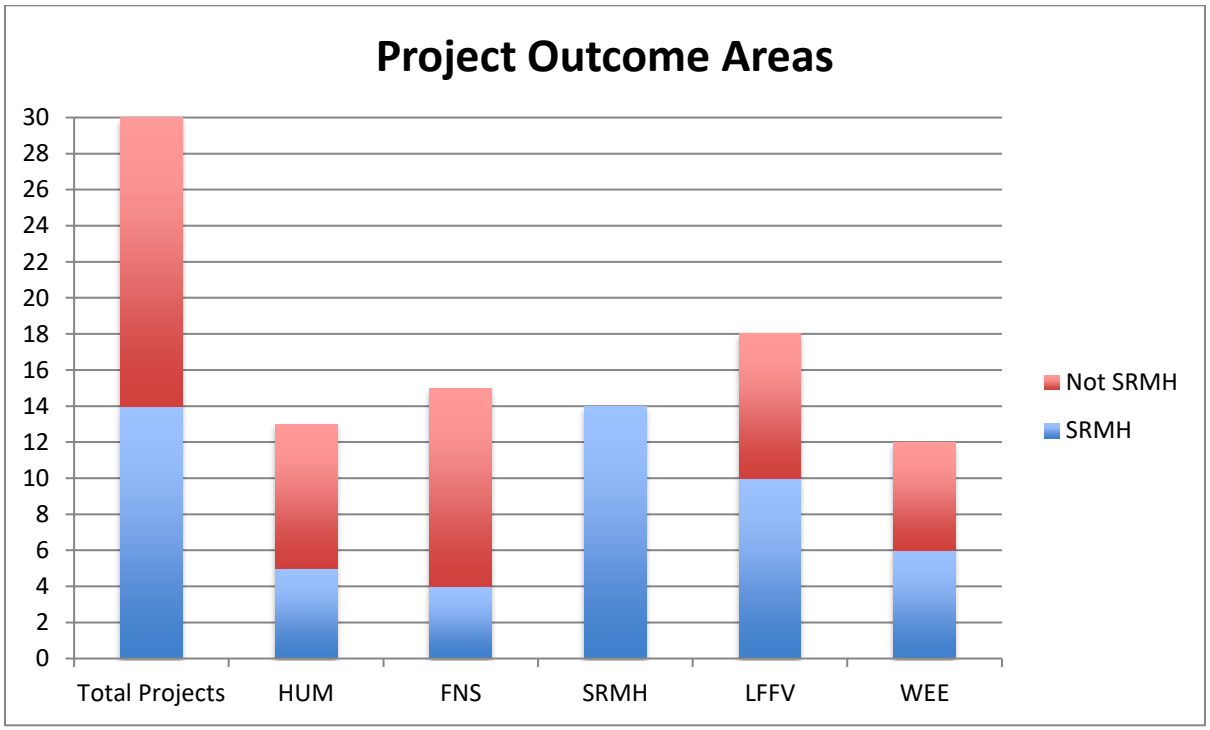
A project in PIIRS can fulfill multiple outcome areas of the five that make up CARE's 2020 Program Strategy.[7] Figure 3 depicts the outcome areas fulfilled by the thirty projects identified in PIIRS. Each column is disaggregated by SRMH projects (projects fulfilling the SRMH outcome area) and projects that are not SRMH (projects that do not fulfill the SRMH outcome area in PIIRS). Projects that met the SRMH outcome area (in blue) also met other outcome areas, and between all fourteen of these projects, projects fell into all four other

[7] These five outcome areas are 1) Humanitarian Assistance (HUM), 2) Food and Nutrition Security and Climate Change Resilience (FNS), 3) Sexual, Reproductive and Maternal Health and Rights (SRMH), 4) A Life Free From Violence (LFFV), and 5) Women's Economic Empowerment (WEE).

outcome area categories. Overall, projects that did not fulfill the SRMH outcome area (in red) were also classified in each of the four other outcome area categories. In other words, not every project hit all outcome areas, but across the board, every area was hit by some project.

Overall, projects most frequently fulfilled the LFFV outcome area (eighteen out of the total thirty projects), which makes sense considering the Great Lakes sub-region's LFFV thematic focus and the relatedness of SRHR and LFFV. Even the WEE outcome area, which was the category with the least amount of projects overall, had almost half of the projects marked as fulfilling it (twelve out of the total thirty projects). The disaggregated data showed that SRMH projects were most frequently classified in the LFFV outcome area (ten projects) and least frequently in the FNS outcome area (four projects). Non-SRMH projects were most frequently classified in the FNS outcome area (eleven projects) and least frequently in the WEE outcome area (six projects).

Figure 3. Project Outcome Areas



(Data from PIIRS FY2017)

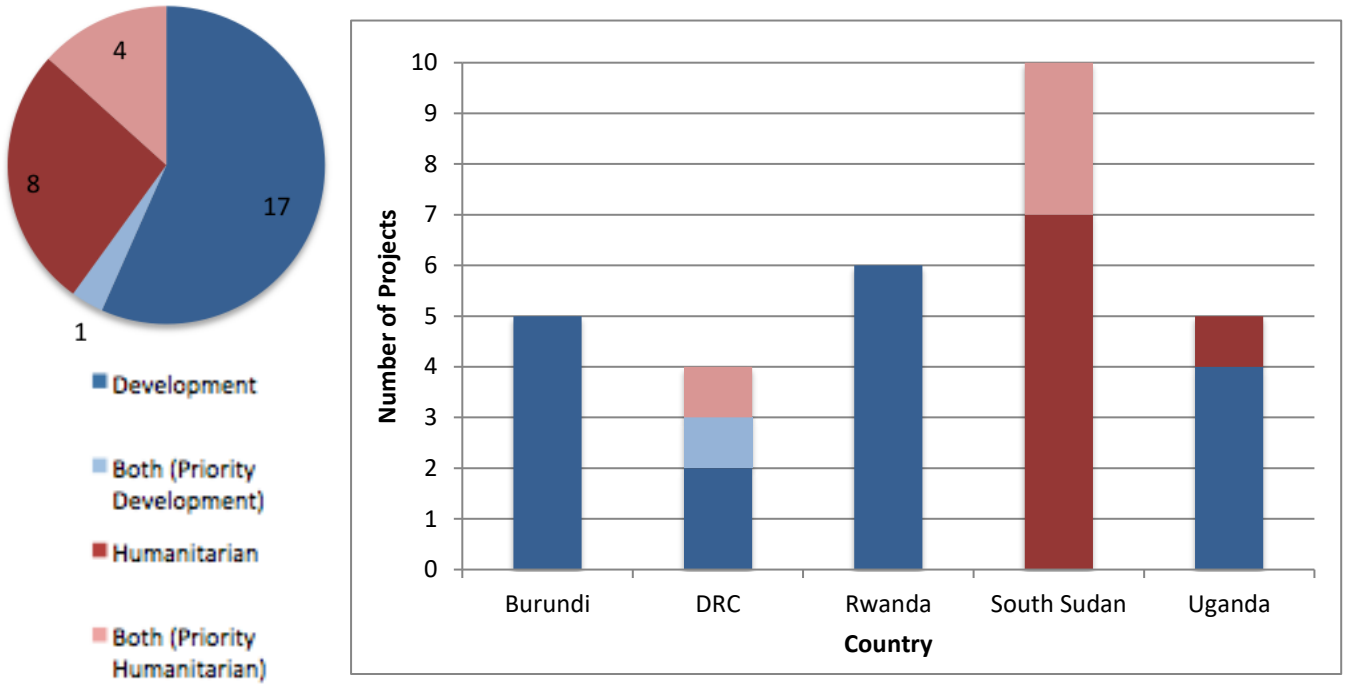
Additionally, results showed that outcome areas were fulfilled with different frequencies across countries. (See appendix 3 for figures depicting project outcome area breakdown by country.) For example, all of Rwanda's projects (6) fulfilled the LFFV outcome area, while all SRMH-classified projects also fulfilled the LLFV outcome area for Burundi (3) and Uganda (3). All of South Sudan's projects (10) fulfilled the humanitarian outcome areas, while no projects in Burundi and Rwanda fulfilled this area. Additionally, in South Sudan all non-SRMH projects (7) were classified as fulfilling FNS area, and the only category fulfilled by South Sudan's 3 SRMH projects (aside from SRMH) was the humanitarian outcome area.

Development versus Humanitarian

In PIIRS, projects are classified as humanitarian, long-term development, or both, depending on the focus of the project's action. Figure 4 shows that none of the projects identified for Burundi and Rwanda are classified as humanitarian projects in PIIRS. Conversely, all of South Sudan's projects are classified as humanitarian. The DRC and Uganda each have one humanitarian project (SAFPAC) (PIIRS FY2017).

Figure 4. Development versus Humanitarian Classification

Total: ***By Country:***



(Data from PIIRS FY2017)

Beneficiaries

The beneficiaries of SRHR projects in the Great Lakes sub-region are described in PIIRS and on the intervention forms and include a wide range of people. Beneficiaries include women/girls of reproductive age (15-49), young people between the ages of 10-24 (e.g. Burundi's Joint Program), school-going adolescent girls and boys, and out-of-school adolescents. Specifically, beneficiaries for some projects are women who are organized in Village Savings and Loan Associations (VSLAs) (e.g., GEWEP) and men in men's engagement groups (e.g., DRC's Mawe Tatu project). Beneficiaries for many of the projects include male partners of women of reproductive age, and in some of the GBV projects, beneficiaries are couples. Maternal, newborn, and child health projects target pregnant and lactating women and children

under five. A significant beneficiary group of the SRHR projects in the sub-region include refugees, IDPs, host populations, and people affected by conflict more generally (especially women and girls). Additionally, beneficiaries include community leaders, local authorities, and religious authorities (e.g., GEWEP and Burundi's Joint Program); they also include teachers, parents, and peer educators (e.g., Rwanda's adolescent empowerment projects and Burundi's Joint Program). Finally, beneficiaries of projects with capacity building components are health service providers, CARE and partner staff, and community volunteers.

Figures 5 and 6 depict three categories of PIIRS beneficiary data: 1) the total beneficiaries, which refers to the number of beneficiaries during the life of the project, 2) the number of total beneficiaries that are women and girls, and 3) the number of beneficiaries counted toward the SRMH outcome area in the fiscal year. Figures 5 and 6 show that SRHR projects in the Great Lakes have 1,667,045 total direct beneficiaries and 10,444,952 total indirect beneficiaries across the fourteen SRMH projects identified in PIIRS.[8] Overall, women and girls make up approximately 67% of the direct beneficiaries and 65% of the indirect beneficiaries across all of these projects. Additionally, in terms of beneficiaries tracked by outcome area in PIIRS, there are 521,859 direct beneficiaries and 3,590,149 indirect beneficiaries for the SRMH outcome area. However, it is significant to note that some major projects have data listed as "0" for beneficiaries of the SRMH outcome area, including DRC's SAFPAC project (in both the direct and indirect categories), Burundi's GEWEP project (indirect), and Uganda's Emergency

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[8] When all 30 projects identified through PIIRS are included the beneficiary totals are higher: 2,315,957 direct beneficiaries and 14,062,143 indirect beneficiaries. Some beneficiaries are missing when all 30 projects are not included, but these figures focus on the 14 SRMH projects, because these may be more likely to be beneficiaries of SRHR programming. (See Appendix for beneficiary figures for all 30 projects.)

Response for Refugees Project (indirect). Beneficiaries of the DRC's SAFPAC project and the SAFPAC-funded portion of Uganda's Emergency Response project would probably all fall into the category of SRMH outcome area beneficiaries, so this missing data gives us an underestimate of the true number.

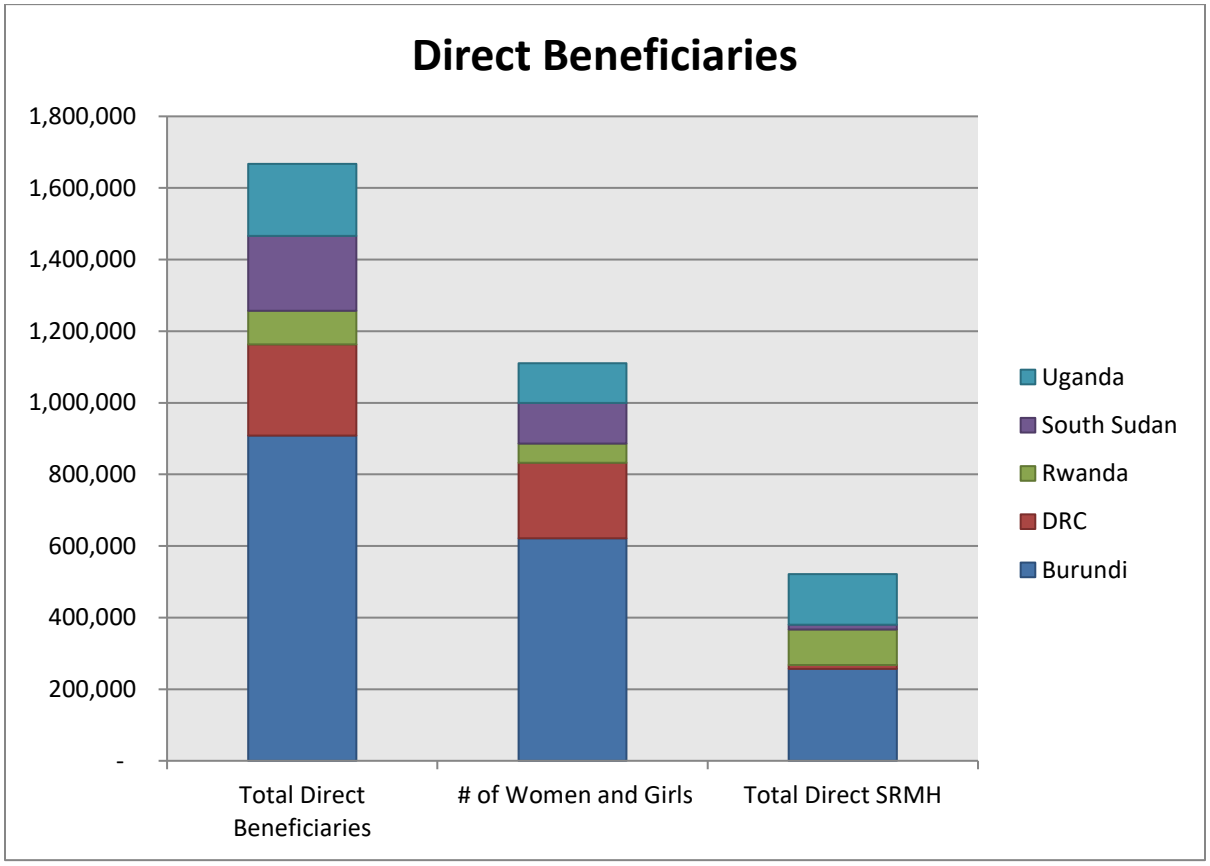
In terms of direct beneficiaries, Burundi is the country with the most beneficiaries in all categories (total, number of women and girls, and total SRMH). In fact, Burundi's direct beneficiaries' account for more than half of the beneficiaries from all five countries, in all three beneficiary categories (see Figure 5). This makes sense, as the projects with the two largest numbers of beneficiaries are both in Burundi: the Joint Program (554,264 total direct) and GEWEP (351,825 total direct). Other projects with large numbers of beneficiaries are Uganda's Emergency Response for Refugees Project (136,240), the DRC's SAFPAC Project (107,280 total direct), and South Sudan's Pariang Integrated Primary Health Care Project (HPF) (97,523 total direct).[9] Rwanda is the country with the fewest total beneficiaries across these fourteen SRMH projects; but Rwanda also has one fewer project included in the compilation of this total compared to the other countries (two projects rather than three). In terms of the total direct SRMH outcome area, DRC and South Sudan have the smallest number of beneficiaries.

Overall, some of the direct beneficiary patterns are similar across the indirect beneficiaries. For example, Figure 6 shows that Burundi's projects account for the most total indirect beneficiaries. Although, the indirect women and girls beneficiary category shows Burundi contributing a large portion of the sub-region's beneficiaries, the DRC's projects actually contribute slightly more. Finally, Uganda's projects contribute a greater percentage of

[9] See Appendix for detailed project beneficiary information.

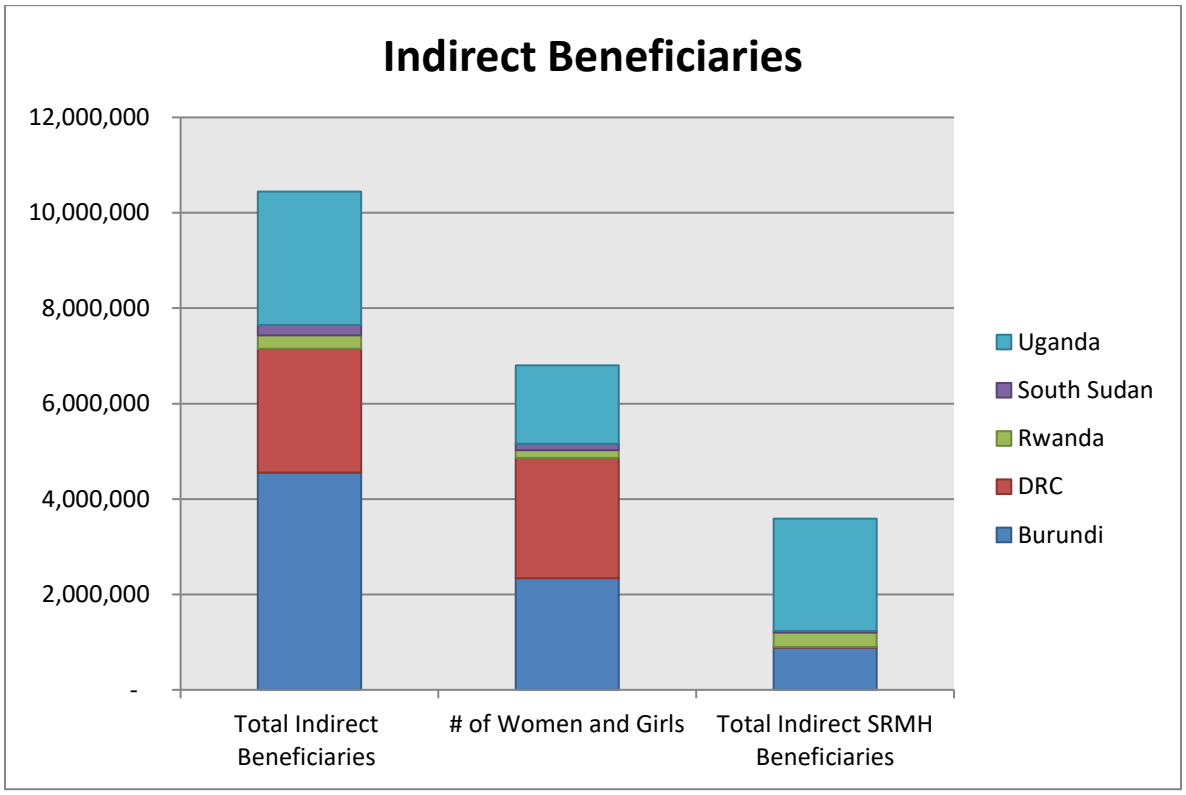
beneficiaries across the indirect beneficiary categories compared to the direct beneficiary categories. In fact, Uganda's projects account for a greater number of total indirect SRMH beneficiaries than any of the other countries. Uganda's high indirect beneficiary figures can be attributed to its United Nations Joint Program on GBV project, which reports 2,500,000 total beneficiaries, of which 1,500,000 are women and girls, and 2,300,000 SRMH beneficiaries.

Figure 5. Direct Beneficiaries



(Data from 14 projects classified as SRMH in PIIRS FY2017)

Figure 6. Indirect Beneficiaries



(Data from 14 projects classified as SRMH in PIIRS FY2017)

Funding

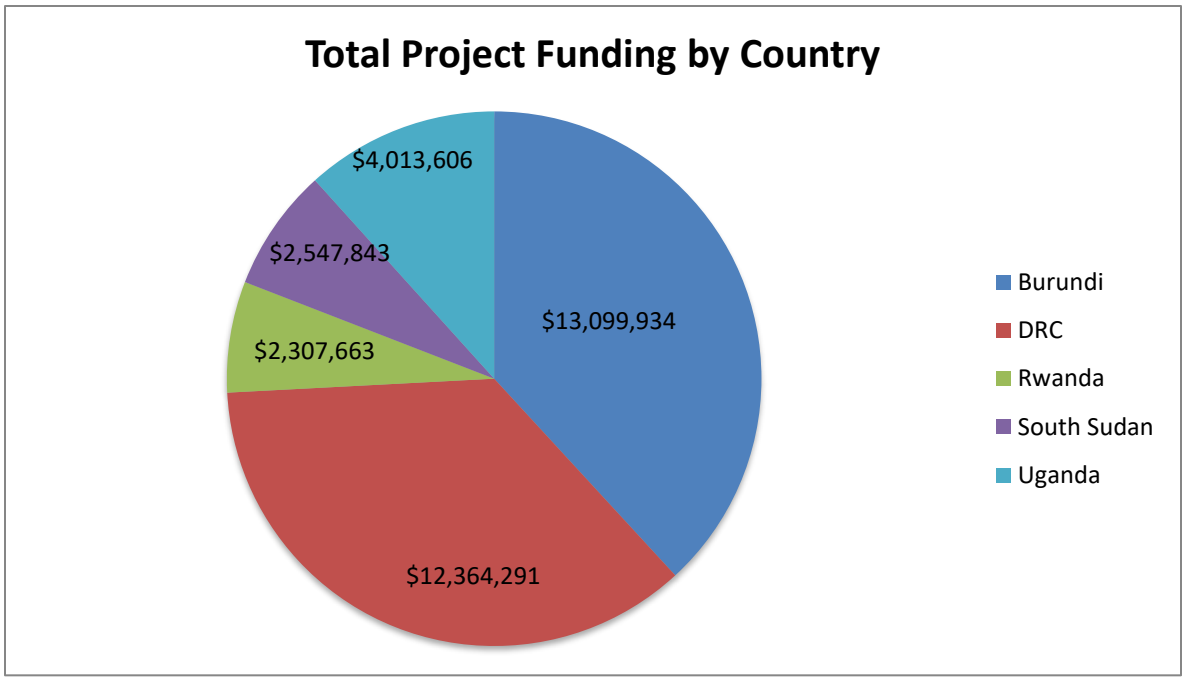
Results showed that total funding for the fourteen SRMH projects identified in PIIRS was roughly $34.3 million ($34,333,337.60) and Figure 7 depicts the breakdown of this funding by country.[10] This figure shows that Burundi and DRC have the largest amount of funding in terms of SRMH-classified projects in PIIRS, while Rwanda and South Sudan have the least. Burundi's largest projects in terms of funding are the Joint Program ($7.3 million) and GEWEP ($5.7

[10] The total funding for all 30 projects from PIIRS is $55.5 million ($55,502,391), and the total funding for the 7 projects listed on the intervention forms is almost $22 million ($21,935,221). This section focuses on the 14 SRMH projects from PIIRS, as this may provide the most accurate picture of SRHR funding in the sub-region. (A portion of the funding for the thirty projects from PIIRS is likely not funding SRHR components, and the funding figure from the intervention forms would be an underestimate since only seven SRHR projects are captured.)

million), while the DRC's are SAFPAC ($5 million) and Mawe Tatu ($4.9 million). In Uganda, the project with the greatest amount of funding is the Emergency Response project ($3.5 million), and the project with the greatest amount of funding in South Sudan is the UNHCR Health and Nutrition Project for Refugees and Host Communities Project ($1.8 million) (PIIRS FY2017 Data).

Additionally, Safe Schools for Girls is the project with the greatest amount of funding in Rwanda ($1.4 million). It is worth noting that although Figure 7 shows that Rwanda's project funding portfolio is the smallest overall, as mentioned above it only has two projects classified as SRMH projects, while the other countries have three projects. Furthermore, two of the projects with the largest amount of funding in Rwanda -- Agent for Change project ($4.8 million) and GEWEP ($4 million) -- are not classified as SRMH on PIIRS. (GEWEP is classified as SRMH for Burundi and the DRC, however.) Rwanda's funding portfolio would not seem as small compared to some of the other countries if these projects had been classified as SRMH.

Figure 7. Total Project Funding by Country



(Data from 14 projects classified as SRMH in PIIRS FY2017)

Project funders vary from governments, foundations, and multilateral agencies (e.g., United Nations agencies). European governments, and in particular the Government of Netherlands, fund many projects in the sub-region. (See Appendices 1 and 4 for complete list of funders by project).

Primary Challenges and Desired or Needed Support

Primary Challenges

On the intervention forms, challenges facing each of the seven SRHR projects were described. Across the projects, common themes regarding challenges included 1) *coverage issues/access to facilities, 2) facility/supply chain issues, 3) capacity issues and communication challenges*, and 4) *attitudes about SRHR.* In terms of *coverage issues/access to facilities,* South Sudan's SAFPAC project listed "insecurity and physical access to facilities" as a main challenge,

while a primary challenge for Uganda's refugee project is that the Ministry of Health's health facility referral pathway is not functional in the settlements in which the project works. Project challenges for DRC's SAFPAC project are low geographical coverage and a lack of coverage in non-CARE supported health facilities in the region. Also, the primary challenge of both of Rwanda's education projects was the large coverage area (CARE Intervention Forms, 2018).

Facility/supply chain issues were described as a challenge for numerous SRHR projects. Uganda's refugee project, for example, faces "inadequate space for SRMH services in the health facilities" and deals with SRMH commodity stock outs (especially family planning commodities) "due to the drastic increase in the catchment population as a result of the refugee influx." Like the Uganda project, the SAFPAC projects in South Sudan and the DRC face supply chain challenges: South Sudan described the "unreliable pipeline of SRH supplies" as a primary challenge, while the international purchase of GBV kits and some medical equipment is a challenge for the DRC (CARE Intervention Forms, 2018).

A third issue that came up across projects and countries included *capacity issues and communication challenges*. A primary challenge of Burundi's Joint Program is staff's limited knowledge on effective mechanisms of communication with young people on SRH. Similarly, DRC's SAFPAC project describes the transition from mass communication to community dialogues surrounding social and gender norms as a challenge area. Harmonization of data collection tools is also a challenge faced by the DRC's SAFPAC project. The DRC's other major project, Mawe Tatu, does not have sufficient resources to meet the needs of young people in terms of youth SRH services. Finally, inadequate in-country capacity in certain thematic areas, like VCAT (Values Clarification for Abortion Attitude Transformation), presents challenges for South Sudan's SAFPAC project (CARE Intervention Forms, 2018).

Projects in South Sudan and the DRC face challenges relating to *attitudes about women and SRHR*. For the SAFPAC project in South Sudan, intervention forms stated that negative attitudes towards SRH interventions are a challenge; for SAFPAC in DRC, the perception of the status of women (especially in Kasai) presents a challenge. Finally, the DRC's Mawe Tatu project deals with the following difficulties: social norms affecting family planning method choice for young people, religious barriers on women using family planning methods, and involving parents, as "talking about sexuality remains a taboo for the majority of families" (CARE Intervention Forms, 2018).

Desired or Needed Support

In addition to challenges, country office staff also listed areas of desired or needed for the SRHR projects on the intervention forms, and similar responses showed up across projects and countries, especially around capacity building, trainings, communication, and young people. For example, Burundi's Joint Program included capacity building on youth communication mechanisms and strategies as an area of desired or needed support, to address the challenges it faces in this area. Similarly, DRC's Mawe Tatu project support needs include strategies for youths' and adolescents' access to reproductive health services and the sharing of youth experiences with comprehensive sexuality education to overcome barriers. These two projects also included "organization of exchanges/debates on SRH best practices" and "support documentation of lessons learned from SRH projects" (Burundi – Joint Program), and didactic materials and summary brochures (DRC – Mawe Tatu) as areas of desired or needed support (CARE Intervention Forms, 2018).

Additionally, Rwanda's adolescent empowerment projects included "support mentors to deliver the program" as their area of needed or desired support. The SAFPAC projects also requested support for those delivering programs: South Sudan listed trainings in comprehensive family planning and post abortion care as an area of desired or needed support, while DRC listed conducting a Social Analysis and Action workshop for former staff, new staff, and partners as an area of support. DRC's SAFPAC project also listed support for continuing efforts to scale up the project, and support for rapid response in emergency situations. Conversely, Uganda's Lifesaving Shelter, Protection, and Health Support for South Sudanese Refugees project noted a shift away from its emergency programming: "Since we are now transitioning from the emergency, CARE needs to invest in long term initiatives like putting up maternity wards at the project health facilities and also provide ambulance services for referral of PLW" (CARE Intervention Forms, 2018).

DISCUSSION

Strengths and Gaps in Programming

This portfolio mapping provided valuable insights into the current state of CARE's SRHR programming in the Great Lake countries, including into the numerous strengths of SRHR programming in the sub-region as well as areas for program strengthening. More broadly, this portfolio mapping also yielded insights into how CARE's SRHR programming is situated within the larger context of key SRHR needs in the sub-region. Overall, some of these key SRHR needs are addressed by CARE's SRHR programming in the Great Lakes countries, while other needs are not addressed by the current programming.

Firstly, this portfolio mapping showed that a major strength of CARE's SRHR programming is the breadth of projects in the sub-region; projects covered SRHR areas ranging from family planning and adolescent health to maternal health and post-abortion care. Furthermore, multiple SRHR issues from across the SRHR continuum are often addressed within the same project. Also, this mapping demonstrated that there are programmatic similarities across the sub-region and that each country also has a unique project portfolio. Strengths of each country's programming can be leveraged to bolster programming of the other countries in the sub-region.

The major strength of Burundi's portfolio is its large role in the Joint Program, which aims to empower young people nationwide using the "World Starts With Me" curriculum. CARE's role as one of the implementers of this program makes CARE-Burundi a major player in the country in terms of adolescent empowerment and SRH education. Through the Joint Program, CARE is addressing some of the key SRHR needs in the country, which (as mentioned in the review of the state of SRHR in Burundi) include family planning and adolescent SRH.

Other pressing SRHR needs in Burundi that are not fully addressed by CARE's current programming in the country, include the country's very high maternal mortality ratio (712 deaths per 100,000 live births) and the exacerbated healthcare challenges due to forced migration (WHO, 2015 and UNHCR[a], 2017). Currently Burundi's SRHR projects do not focus on childbirth, and although one project (Addressing Root Causes/Nyubarhiriza Project) does focus on forced migration and instability, further integrating SRHR programming and programming centered on IDPs and instability would help address this major need in Burundi.

Like Burundi, a strength of Rwanda's SRHR portfolio is its focus on adolescent empowerment and education projects (Better Environment for Education and Safe School for Girls). The emphasis on adolescent empowerment projects makes sense given the country's young population, but perhaps a greater emphasis should be placed on integrating comprehensive sexuality education, including family planning, into the projects, because the increase in adolescent pregnancy in Rwanda has been a concern in the country. Another key SRHR concern highlighted in the review of the state of SRHR in Rwanda is post-abortion complications. Forty percent of abortions in the country lead to complications that require treatment, but a third of women who suffer complications do not receive treatment (Guttmacher Institute, 2013). Post-abortion care is outside the scope of CARE's current SRHR projects in Rwanda, but perhaps CARE's experience in this area (with SAFPAC in the DRC, South Sudan, and Uganda) can be used to stimulate future post-abortion care programming in Rwanda in order to tackle this significant SRHR need.

In addition to Rwanda's SRHR education-focused projects, another strength of CARE-Rwanda's general programming portfolio is its central focus on the right to a life free from violence. Its LFFV approach has been a presence in the country since 2005, and LFFV projects

and models that have been developed in this sector have had a great impact. Other countries in the sub-region can use the LFFV best practices, lessons learned, and successes and challenges documented by CARE-Rwanda in order to inform their own programming (CARE International in Rwanda, 2018).

CARE-South Sudan's SRHR project portfolio is strong in its humanitarian emergency response focus, which is a common thread through all of its projects, and its emphasis on refugees and displaced populations makes sense considering the ongoing conflict in the young country. Additionally, another strength of South Sudan's SRHR portfolio is that it integrates FNS and SRHR programming. South Sudan is an appropriate place for SAFPAC programming given that the country has some of the poorest reproductive health indicators in the world, including a modern contraceptive prevalence rate of 2.4 percent (FP2020, 2018). SAFPAC is helping to address family planning in the country, and other CARE projects are addressing maternal health needs (especially nutrition) of pregnant and lactating women. Although these family planning and maternal nutrition projects are addressing South Sudan's high maternal mortality ratio (789 deaths per 100,000 live births), there is a gap in that none of the current SRHR projects are focused on women in childbirth (World Health Organization, 2015). In addition to maternal mortality, sexual and gender-based violence (SGBV) is a key SRHR issue in South Sudan, and although some activities of the SAFPAC project address this, other projects are not focusing on SGBV (Amnesty International, 2017). Integrating SGBV programming into CARE's SRHR programming in South Sudan would help fill this gap.

Like South Sudan, Uganda's focus on emergency response for South Sudanese refugees is a major strength of Uganda's SRHR project portfolio (GAC project[11] and ECHO project with SAFPAC funding[12]), especially considering that Uganda hosts more refugees than any other African country. Also, it is important to note that SAFPAC in Uganda ended in December 2017, and the ending of this project means a reduction in CARE's family planning programming and a gap in CARE's post-abortion care programming in the country. Although SAFPAC has ended, unmet need for modern contraception (the unmet need is high at 34.8 percent) and unsafe abortion remain key SRHR issues in Uganda (FP2020, 2018 and Guttmacher Institute, 2017).

SAFPAC is still a large fixture of SRHR programming in the DRC, and a major strength of the DRC's SRHR portfolio includes a family planning focus (primarily SAFPAC), which addresses the country's low levels of family planning. SAFPAC's emergency focus is also important considering the conflict and displacement in the DRC. Additional strengths of the DRC's SRHR programming include a focus on the right to a LFFV and girls'/women's empowerment.

Overall, the review of the state of SRHR and of country contexts in all of the Great Lakes countries emphasized the need to focus on adolescents. In general, the sub-region addresses this need as many programs are focused on adolescent SRH. But while Burundi and Rwanda have strong adolescent SRH focuses, the DRC, South Sudan, and Uganda could gear more programming towards adolescent SRH, as adolescent SRH is a key issue in these countries. The DRC, South Sudan, and Uganda all have high adolescent fertility rates at 124.2, 62.0, and 106.5 births per 1000 women aged 15-19 respectively (UNPD, 2017).

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[11] As reported on the intervention form (CARE Intervention Forms, 2018)
[12] As reported on PIIRS (PIIRS FY2017 Data)

Lastly, a humanitarian emergency theme runs through the Great Lake countries, as seen in the review of the state of SRHR background section. Whereas South Sudan, Uganda, and the DRC have programming addressing humanitarian emergency response that provides services for refugees and others affected by displacement and conflict, Burundi and Rwanda do not have programming with an emergency response focus. This is a programmatic area that could be developed further in Burundi and Rwanda (and Uganda and DRC as well), especially given instability in Burundi, which has caused people to flee to the DRC, Rwanda, and Uganda.

Limitations and Challenges

The discordant information in PIIRS versus the intervention forms presented a challenge during this portfolio mapping. There are various explanations for this discordance, and first among them is room for subjectivity and interpretation of what gets classified as a SRHR project. Discordance can also be attributed to the fact that a person filling out the PIIRS form for a specific project may not have been the same person completing the intervention form. Additionally, the reporting for PIIRS and filling out of the intervention form were completed at least 5 months apart (PIIRS was completed 5 months before), so some project information could have changed. Finally, some of this discordance can be attributed to the difference in dates, as PIIRS accounted for projects running during the 2017 fiscal year (including those that ended during this time), and the intervention forms include projects running currently in 2018. Although discordant information between the two data sources presented a challenge during this portfolio mapping, using both data sources allowed for the capturing of information that would have been lost with just one data source. Thus, it is more useful to use PIIRS and the intervention

forms to supplement each other, rather than attempting to reconcile all of the differences between them.

Not only did the subjectivity in classifying projects as SRHR present a challenge in terms of discordance between data sources, lack of standardization and room for subjectivity in what constitutes an SRHR project is also limiting in terms of making numeric comparisons across countries. Specifically, in PIIRS, Country Offices provide information about all projects and then these are sorted into outcome areas (based on thematic areas that the staff member reporting checks off); for the intervention forms, focal points of the Working Group were asked to self-report their SRHR projects specifically as well as other health projects. The fact that fewer projects were self-reported on the intervention forms than projects marked with the SRMH outcome area in PIIRS could be because of subjective interpretations of what constitutes a SRHR project. For both data sources, projects that could be considered SRHR projects for having some SRHR components were not included under the SRMH outcome (PIIRS) or not included as an SRHR intervention and rather included as "other health projects" (intervention form).

Finally, general issues with PIIRS created challenges during this portfolio mapping. Some projects that were marked as SRMH projects in PIIRS had missing data about SRMH outcome area beneficiaries, which limited the ability to make comparisons across projects and make accurate summations for individual countries and the sub-region in total. In fact, beneficiary data presented a confusing view for various projects in PIIRS due to the multiple types of beneficiary categories that could be reported on the form (e.g., general, by outcome area, by gender, direct, indirect, etc.). Although PIIRS includes multiple beneficiary categories, it does not disaggregate by age, which means that there are not beneficiary figures for women of reproductive age, which is a limiting factor when considering SRHR programs. Due to the

confusion of multiple beneficiary types, it was unclear if all beneficiary information reported by Country Offices was reported in the correct area; and because it is unclear which beneficiary data might give the most accurate estimate, multiple beneficiary categories were aggregated in this portfolio mapping.

Another issue regarding PIIRS is that the outcome areas are limited as far as what they actually tell. As mentioned, projects that could have been classified under the SRMH outcome area were not, and projects may have had the same problem with other outcome areas. The GEWEP project, for example, was classified under SRMH for some countries and not for others, showing inconsistencies across projects. The PIIRS 2017 project forms were set up so that staff could click on themes/sectors that apply to the project, which would then automatically populate the five outcome areas. Although this would ideally limit the amount of subjectivity of having people click on five outcome areas, this may have added another level of complication. If this form is not filled out carefully, a theme or sector could easily be missed, and then an outcome area would possibly be missed as well.

Recommendations

Country Office responses regarding challenges and desired or needed support provide a clear pathway for recommendations. The SRHR Global team is well equipped to address many of the challenges highlighted by Country Office program staff on the intervention forms, and these staff in the Great Lakes countries should be connected with the appropriate members of the SRHR Global team. For example, there is expertise in supply chain management and adolescent SRH on the SRHR Global team, and those with expertise can help brainstorm and address commodity stock-out challenges and adolescent health issues, respectively. The challenges and desired or needed support sections of the intervention forms provided fruitful information not

available on PIIRS, and there should be consistent follow-up around these areas of the intervention forms for projects in all Country Offices. This can be used as a feedback loop mechanism in order to get and understand asks for desired or needed support and to leverage existing resources and strengths across the Great Lakes.

Not only can the SRHR Global Team be used as a resource, but also now that a Working Group has been created for the whole ECSA Region (East, Central, and Southern Africa), this Working Group can be utilized. The knowledge and experience of Working Group members and experience with various SRHR programming can be leveraged to address challenges and calls for support across the Great Lakes sub-region (and the larger ECSA region, as well). For example, Burundi and Rwanda's experience with adolescent SRH programming can be used in countries like South Sudan that may not be as familiar with this type of programming.

Another recommendation that comes out of this portfolio mapping is that trainings should be provided to staff across CARE to improve understanding about the scope of SRHR and the continuum of SRHR programming possibilities. The "Introduction to CARE's SRHR Global Portfolio" presentation given to the Working Group was a great step in providing clarity about CARE's approach to SRHR and the range of programming options that can constitute SRHR work. Additional guidance should continue to be provided to SRHR focal points during and between Working Group calls so they are afforded approaches for integrating SRHR programming into all aspects of their programming. The Great Lakes sub-region's experience with formulating a strategy for integrating GBV into all aspects of programming can be used as a model in integrating SRHR programming into other sectors, especially as LFFV and SRHR programming complement each other well. Additionally, SRHR programming should be further

integrated with programming like FNS, because this portfolio mapping showed that there is less integration of SRHR with the FNS outcome area.

A recommendation in terms of the data sources aspect of this portfolio mapping includes improving clarity of the project form that PIIRS Country Offices fill out, specifically regarding beneficiary information. Reporting beneficiary figures under so many categories seems like it causes confusion. Additionally, gathering beneficiary information on women of reproductive age, rather than just women and girls, is important for SRHR programming. Going forward, this should be done on PIIRS or additional data gathering tools (such as the intervention forms), which should ask projects to report women of reproductive age. Finally, the discordance between information on intervention forms and PIIRS should be explored further by speaking with CARE staff in order to better understand the reasons for it.

This portfolio mapping reinforced the recommendation that CARE should continue in its implementation of a regional SRHR approach to institutionalize SRHR in ECSA, and in the Great Lakes sub-region specifically. It also highlighted both strengths and gaps in programming according to the most pressing SRHR issues in Burundi, DRC, Rwanda, South Sudan, and Uganda. As a leader in the global SRHR sector, CARE should explore the implementation of SRHR projects that tackle these gaps, while continuing to fortify the strengths of its existing projects. By doing so, CARE can better support women and girls in exercising their right to sexual, reproductive, and maternal health.

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APPENDICES

Appendix 1. Project Information (PIIRS) Part 1

Country	Name of Project	Funding Information			Number of Beneficiaries (Total Life of the Project)				Number of Beneficiaries by SRMH Outcome Area (FY 2017)	
		Type of Funder	Funder	Budget	Direct		Indirect			
					Total	Women and Girls	Total	Women and Girls	Direct	Indirect
Burundi	Joint Program for the Improvement of Sexual and Reproductive Health of Adolescents and Youth "Menyumenyeshe"	Government	Government - Netherlands (Ministry of Foreign Affairs of the Netherlands)	7,342,603	554,264	288,217	2,771,318	1,441,085	88,536	442,680
Burundi	Gender Equality Women's Empowerment Programme II (GEWEPII) UMWIZERO III	Government	Government - Norway (NORAD)	5,716,244	351,825	331,825	1,783,543	900,743	80,164	0
Burundi	Wottro research project: Young Burundians tactil agency regarding Sexual relations and decision making	Government	Dutch research Council(NOW-WOTTRO)	41,087	1,980	1,287	N/A	N/A	88,536	442,680
Burundi	Addressing roots causes/Nyubahiriza	Government	Ministry of Foreign Affairs of the Netherlands	1,927,030	4,000	2,000	80,000	30,000	X	X
Burundi	ISHAKA II: A Promising Innovation for Girls' Social and Economic Empowerment " Courage pour le future"	Foundation	Tim and Debbie Kiss/Oliver Kiss Endowment	60,000	1,500	1,500	7,649	3,840	X	X
Burundi: SRMH Project Totals	3 Projects			13,099,934	908,069	621,329	4,554,861	2,341,828	257,236	885,360

BurundI: All Project Totals	5 Projects			15,086,964	913,569	624,829	4,642,510	2,375,668	X	X
DRC	Gender Equality Women Empowerment Program (GEWEP)	Government	Norwegian Agency for Development Cooperation (NORAD)	2,472,112	89,200	70,550	2,400,000	2,400,000	1,369	8,214
DRC	Mawe Tatu	Government	Netherlands Government	4,905,285.93	58,550	33,760	72,000	50,000	8,734	2,800
DRC	SAFPAC - Supporting Access to Family Planning and Post Abortion Care: Phase 3	Foundation	Anonymous	4,986,893	107,280	106,744	122,151	73,291	0	0
DRC	AID MATCH	Government	DFID	388,495	14,000	9,000	56,000	36,000	X	X
DRC: SRMH Project Totals	3 Projects			12,364,291	255,030	211,054	2,594,151	2,523,291	10,103	11,014
DRC: All Project Totals	4 Projects			12,752,786	269,030	220,054	2,650,151	2,559,291	X	X
Rwanda	Better Environment for Education (BEE)	Foundation	SunBridge Foundation	870,013	48,712	28,569	148,472	83,144	44,822	136,802
Rwanda	Safe Schools for Girls (SS4G)	Other	Patsy Collins Trust Fund Initiative (PCTFI)	1,437,650	44,887	25,014	137,445	76,969	54,326	165,762
Rwanda	Learning for change (L4C): Strengthening Women's Voices in East Africa-ADA Framework Programme	Government	Austrian Development Agency (ADA)	533,415	505	N/A	59,540	N/A	X	X
Rwanda	Gender Equality & Women's Empowerment Project & Literacy for Empowerment	Foundation	GRIEG Foundation	4,023,856	227,072	153,678	749,338	507,139	X	X
Rwanda	Every Voice Counts "EVC"	Government	Ministry of Foreign Affairs of the Netherlands	2,354,786	18,464	14,051	40,001	30,441	X	X

Rwanda	Indashyikirwa "Agent For Change" Project	Government	DFID	4,821,973	78,576	39,854	1,134,026	590,162	X	X
Rwanda: SRMH Project Totals	2 Projects			2,307,663	93,599	53,583	285,917	160,113	99,148	302,564
Rwanda: All Project Totals	6 Projects			14,041,693	418,216	261,166	2,268,822	1,287,855	X	X
South Sudan	CARE South Sudan Integrated Safe Motherhood Project	Foundation	SAFPAC Catalytic Fund	150,000	24,735	20,735	24,735	4,000	1,589	1,589
South Sudan	Health and Nutrition Project for Refugees and Host Communities (UNHCR)	Multilateral agency	UNHCR	1,775,843	86,959	44,131	86,959	71,260	6,257	6,257
South Sudan	Pariang Integrated Primary Health Care Project (HPF)	Multilateral agency	Health Pooled Fund (HPF)	622,000	97,523	49,062	97,523	60,415	5,913	29,565
South Sudan	Dutch NGO South Sudan Joint Response 3 (SSJR3)	Government	Ministry of Foreign Affairs of the Netherlands	1,117,000	2,619	1,362	13,095	6,810	X	X
South Sudan	Disasters Emergency Committee Response to the East Africa Crisis - CARE UK Humanitarian Appeal	Other	Disaster Emergency Committee (DEC)	296,174	16,700	11,690	83,500	58,450	X	X
South Sudan	Emergency NFI and Nutrition Project in Eastern Equatoria and Unity States	Multilateral agency	UN: IOM-International Organisation for Migration	276,780	15,032	8,197	90,192	46,900	X	X
South Sudan	Integrated Emergency Nutrition Response to Malnourished Children Under Five Years of Age and Pregnant and Lactating Mothers in 4 Counties (Mayom, Rubkona, Abiemnon and Pariang) and Bentiu POC IDP Camp in Northern Unity State	Multilateral agency	UNICEF	2,442,791	14,844	7,719	405,000	210,600	X	X

South Sudan	Integrated Food Security and Nutrition project in Pariang county, Unity State.	Foundation	Latter-Day Saint Charities	405,373	12,870	12,500	63,000	61,110	X	X
South Sudan	WFP Project - TSFP and Warehouse Management	Multilateral agency	World Food Programme (WFP)	864,108	135,853	75,747	679,265	378,735	X	X
South Sudan	CHF Project - Nutrition	Multilateral agency	UN OCHA	581,996	44,377	30,035	20,709	10,928	X	X
South Sudan: SRMH Project Totals	3 Projects			2,547,843	209,217	113,928	209,217	135,675	13,759	37,411
South Sudan: All Project Totals	10 Projects			8,532,065	451,512	261,178	1,563,978	909,208	X	X
Uganda	SRMCH (Improving Access to Reproductive, Child and Maternal Health in Northern Uganda)	Government	Austrian Development Agency (ADA)	386,667	5,600	1,680	57,500	17,250	7,831	53,800
Uganda	Emergency response for refugees, asylum seekers from South Sudan and host communities in Rhino and Imvepi Camps in West-Nile Uganda (2017)	Multilateral agency	ECHO - European Commission for Humanitarian Aid and Civil Protection (with funding from Czech, ECHO-Oxfam, SAFPAC, UNFPA, Norway and UNHCR)	3,466,939	136,240	73,667	243,306	126,437	88,404	0
Uganda	United Nations Joint program on GBV	Multilateral agency	UNFPA	160,000	59,290	35,574	2,500,000	1,500,000	45,378	2,300,000
Uganda	Gender Equality and Women's Empowerment Programme (GEWEP II)	Government	Norwegian Agency for Development Cooperation (NORAD)	880,053	25,000	17,500	125,000	87,500	X	X

Uganda	Safe Water for Health Care Facilities	Corporation	General Electric Foundation	195,223	37,500	27,946	10,876	7,737	X	X
Uganda: SRMH Project Totals	3 Projects			4,013,606	201,130	110,921	2,800,806	1,643,687	141,613	2,353,800
Uganda: All Project Totals	5 Projects			5,088,882	263,630	156,367	2,936,682	1,738,924	X	X
Sub-Region: SRMH Project Totals	14 Projects			34,333,338	1,667,045	1,110,815	10,444,952	6,804,594	521,859	3,590,149
Sub-Region: All Project GRAND TOTALS	30 Projects			55,502,391	2,315,957	1,523,594	14,062,143	8,870,946	X	X

Data from PIIRS FY2017

*This coloring signifies a project classified as SRMH on PIIRS

Appendix 2. Project Information (PIIRS) Part 2

Country	Name of Project	Years	Outcome Area					Development versus Humanitarian
			Hum	FNS	SRMH	LFFV	WEE	
Burundi	Joint Program for the Improvement of Sexual and Reproductive Health of Adolescents and Youth "Menyumenyeshe"	Dec 2015 - Dec 2020			✓	✓		Development
Burundi	Gender Equality Women's Empowerment Programme II (GEWEPII) UMWIZERO III	Mar 2016 - Feb 2020			✓	✓	✓	Development
Burundi	Wottro research project: Young Burundians tactil agency regarding Sexual relations and decision making	July 2016 - June 2019			✓	✓		Development
Burundi	Addressing roots causes/Nyubahiriza	Sept 2016 - Sept 2020		✓		✓	✓	Development
Burundi	ISHAKA II: A Promising Innovation for Girls' Social and Economic Empowerment " Courage pour le future"	June 2014 - Jan 2017					✓	Development
DRC	Gender Equality Women Empowerment Program (GEWEP)	Jan 2016 - Feb 2020		✓	✓	✓	✓	Development
DRC	Mawe Tatu	Dec 2015 - May 2019		✓	✓	✓	✓	Development
DRC	SAFPAC - Supporting Access to Family Planning and Post Abortion Care: Phase 3	Jan 2016 - Dec 2018	✓		✓			Both (but priority is Humanitarian)
DRC	AID MATCH	Nov 2015 - Nov 2017	✓					Both (but priority is Development)
Rwanda	Better Environment for Education (BEE)	Jan 2016 - Dec 2018		✓	✓	✓	✓	Development
Rwanda	Safe Schools for Girls (SS4G)	Jul 2015 - Jun 2020			✓	✓	✓	Development
Rwanda	Learning for change (L4C): Strengthening Women's Voices in East Africa-ADA Framework Programme	April 2016 - Mar 2019				✓		Development

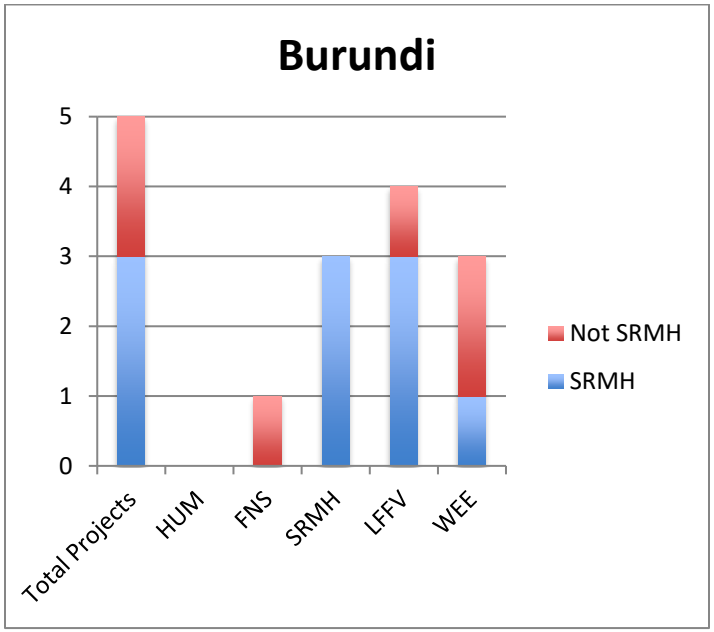
Rwanda	Gender Equality & Women's Empowerment Project & Literacy for Empowerment	Mar 2015 - Feb 2020		✓		✓	✓	Development
Rwanda	Every Voice Counts "EVC"	Jan 2016 - Dec 2020				✓		Development
Rwanda	Indashyikirwa "Agent For Change" Project	Sept 2014 - Aug 2018				✓		Development
South Sudan	CARE South Sudan Integrated Safe Motherhood Project	Mar 2017 - Oct 2017	✓		✓			Humanitarian
South Sudan	Health and Nutrition Project for Refugees and Host Communities (UNHCR)	Jan 2017 - Dec 2017	✓		✓			Humanitarian
South Sudan	Pariang Integrated Primary Health Care Project (HPF)	Oct 2016 - Feb 2018	✓		✓			Both (but priority is Humanitarian)
South Sudan	Dutch NGO South Sudan Joint Response 3 (SSJR3)	Mar 2017 - Dec 2017	✓	✓		✓		Humanitarian
South Sudan	Disasters Emergency Committee Response to the East Africa Crisis - CARE UK Humanitarian Appeal	Jun 2017 - Sept 2017	✓	✓		✓	✓	Both (but priority is Humanitarian)
South Sudan	Emergency NFI and Nutrition Project in Eastern Equatoria and Unity States	Oct 2016 - Jan 2017	✓	✓			✓	Both (but priority is Humanitarian)
South Sudan	Integrated Emergency Nutrition Response to Malnourished Children Under Five Years of Age and Pregnant and Lactating Mothers in 4 Counties (Mayom, Rubkona, Abiemnon and Pariang) and Bentiu POC IDP Camp in Northern Unity State	Jan 2017 - Dec 2017	✓	✓				Humanitarian
South Sudan	Integrated Food Security and Nutrition project in Pariang county, Unity State.	Dec 2016 - Aug 2017	✓	✓				Humanitarian
South Sudan	WFP Project - TSFP and Warehouse Management	Oct 2016 - Sept 2017	✓	✓				Humanitarian
South Sudan	CHF Project - Nutrition	Sept 2016 - Jan 2017	✓	✓				Humanitarian
Uganda	SRMCH (Improving Access to Reproductive, Child and Maternal Health in Northern Uganda)	Sept 2014 - Aug 2017		✓	✓	✓		Development

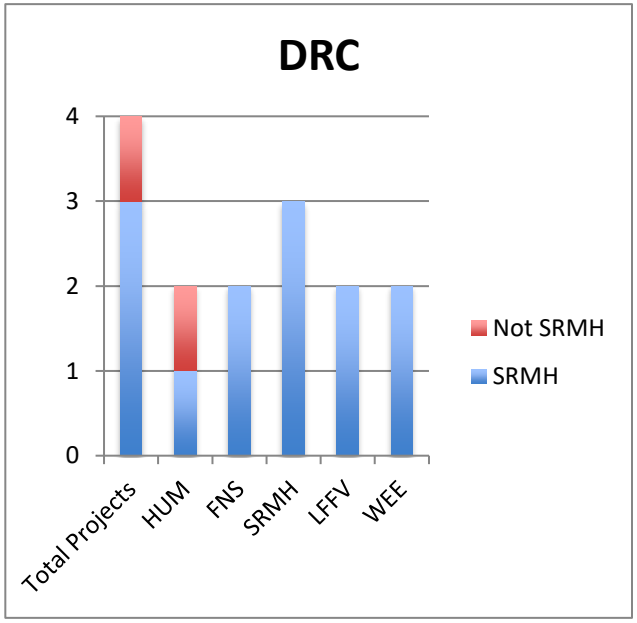
Uganda	Emergency response for refugees, asylum seekers from South Sudan and host communities in Rhino and Imvepi Camps in West-Nile Uganda (2017)	Jan 2017 - Oct 2018	✓		✓	✓		Humanitarian
Uganda	United Nations Joint program on GBV	Jan 2017 - N/A			✓	✓	✓	Development
Uganda	Gender Equality and Women's Empowerment Programme (GEWEP II)	Jan 2014 - March 2017		✓		✓	✓	Development
Uganda	Safe Water for Health Care Facilities	April 2016 - Sept 2017		✓				Development

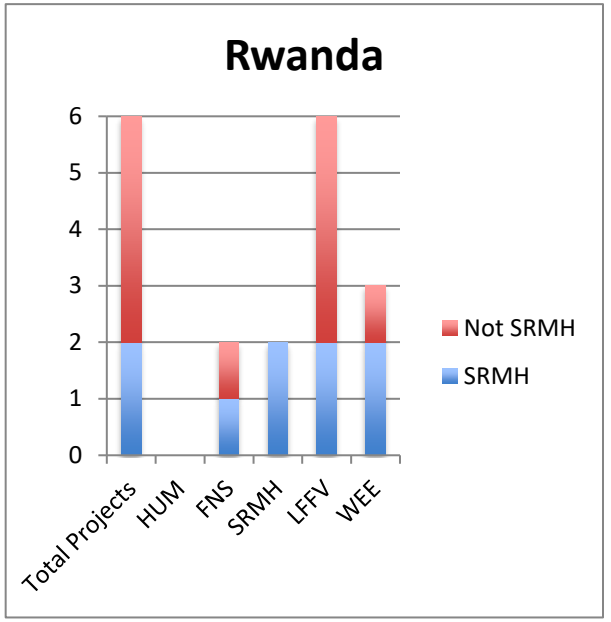
Data from PIIRS FY2017

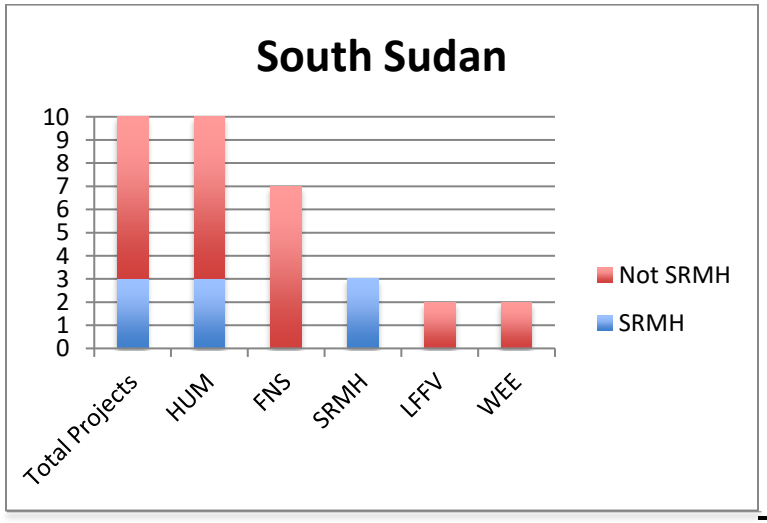
*This coloring signifies a project classified as SRMH on PIIRS

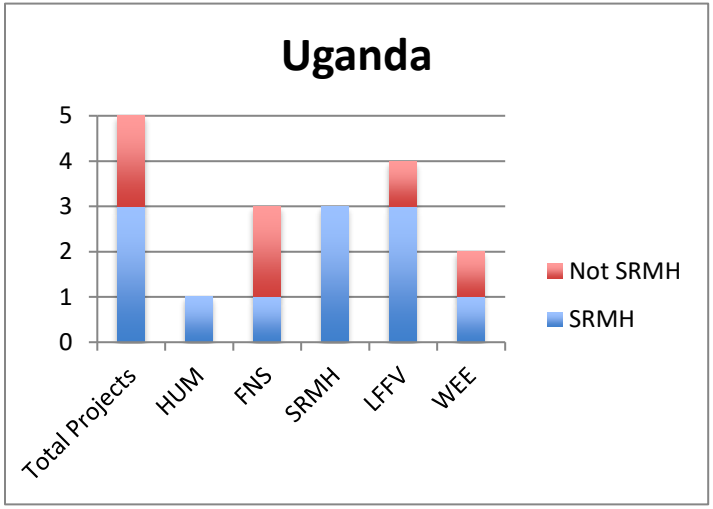
Appendix 3. Project Outcome Areas by Country











Appendix 4. Project Information (Intervention Forms – SRHR Projects)

Country	Name of Project	Duration of Project	Total Budget (USD)	Funder	General Objective
Burundi	Joint Program for the Improvement of Sexual and Reproductive Health of Adolescents and Young People aged 10-24 "Menyumenyeshe"	Dec 2015 - Dec 2020	$8,047,850 ($17,932,712 US for the entire Consortium)	Embassy of the Kingdom of the Netherlands in Burundi	The adolescents and young people of Burundi are empowered and enjoy good Sexual and Reproductive Health
DRC	Supporting Access to Family Planning and Post Abortion Care (SAFPAC, Phase 3)	SAFPAC North Kivu: Jan 2016 - Dec 2018; SAFPAC Kasai Oriental: Sept 2017 - Dec 2018	SAFPAC North Kivu - $4,415,453; SAFPAC Kasai Oriental - $700,000; TOTAL - $5,115, 453	Private Foundation	Goal: Contribute to the reduction of unintended pregnancies and the reduction of maternal deaths related to abortions. Objective: By December 2018, 101,520 in North Kivu and 5040 in Kasai new users have sustainable access to quality FP, SAA, SGBV, SONU (Kasai) services
DRC	Mawe Tatu	December 2015 - May 2019	4,499,994 Euros ($5,479,417)	Government of Netherlands	The goal of "Mawe Tatu" is that by 2019, women, men and young people (young boys and girls) in five territories of North and South Kivu are key players in more equal gendered relationships to prevent GBV, promote improved economic management of households and healthy SRH behaviors, including family planning, in a trans-generational perspective.
Rwanda	Better Environment for Education	January 2016-December 2018	870,013	The SUNBRIDGE FOUNDATION/C-USA	Both project targeting adolescen girls and boys in schools to address issues that affect education attainment
Rwanda	Safe Schools for Girls Project	July 2015-June 2020	1,436,000	Patsy Collins Trust Fund Initiative/C-USA	
South Sudan	South Sudan SAFPAC Project	March 2017- July 2018	390,000	CARE USA	Increased access to reproductive health services for men and women in Torit
Uganda	Lifesaving Shelter, Protection and Health Support for South Sudanese Refugees in Uganda	July 2017 - March 2018	555,555 ($107,387 FOR SRMH OUTCOME)	Global Affairs – Canada (GAC)	To save lives, alleviate suffering and maintain human dignity for South Sudanese refugees and host communities affected by the humanitarian crisis in West Nile, Uganda

Data Presented as Reported on Intervention Forms (CARE Intervention Forms, 2018)

Appendix 5. Project Information (Intervention Forms – "Other" Projects)

Country	Project	Description
Burundi	None	
DRC	None	
Rwanda	Agents for Change Project Phase I and Phase II	It is essentailly a GBV intervention project for adults (couples, peer educator, activism) which touches some RH elements.
Rwanda	EDOAG: Entreprise développent for out of schools adolescents girls	(May 2015 - August 2018) EDOAG is benefiting 10,000 adolescent girls aged between 14-19 years in Huye and Nyamagabe district through financial inclusion and provision of life skills on SRH.
South Sudan	Emergency Health, Nutrition and Protection Project	OFDA funded one year project integrating SRH, GBV and nutrition interventions with both preventive and curative interventions. Includes CMR, and distribution of SRH and dignity kits to women and girls
South Sudan	Provision of Primary Health Care for vulnerable populations	Two year project funded by Health Pooled Funds to provide BEmONC services as part of primary Health care in seven Primary Heath Care Facilities in parieng County, Unity State, South Sudan.
South Sudan	Increased access to primary and post elective health care services to Refugees and Host communities	Annual funding from UNHCR for provision of quality Health Care services including CEmONC in Pariang and Yida Yida. Include provision of 24-hour referral and contraceptive use
South Sudan	Emergency Nutrition Response for Children Under five and Pregnant and lactating Women in SS	Annual funding from UNICEF for treatment of children, Pregnant and Lactating women with acute malnutrition, Rubhall management. Nutrition surveillance activities and Promotion of optimal maternal Infant and young child nutrition. Includes capacity building and coordination with MOH to effectively delivery of the service and sustainability of the nutrition interventions
South Sudan	Targeted Supplementary Feed Program for Vulnerable children and women	Annual funding from UNICEF for treatment of children, Pregnant and Lactating women with acute malnutrition, Rubhall management. Nutrition surveillance activities and Promotion of optimal maternal Infant and young child nutrition. Includes capacity building and coordination with MOH to effectively delivery of the service and sustainability of the nutrition interventions
South Sudan	Integrated Nutrition & GBV response in Mayom & Abiemnom	6 months GAC funded project targeting women and children with Nutrition and GBV interventions
Uganda	None	

Data Presented as Reported on Intervention Forms (CARE Intervention Forms, 2018)