SRHR-HIV KNOWS NO BORDERS
A SYNTHESIS REPORT OF THE REGIONAL, NATIONAL AND COMMUNITY DIALOGUES (2016-2020)

Government of the Netherlands

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Save the Children

IOM UN MIGRATION

The International Organization for Migration (IOM), Save the Children Netherlands (SC) and The University of Witwatersrand School of Public Health (WSPH) — the SRHR-HIV Knows No Borders Consortium — are collaborating to implement a holistic, regional project to improve sexual and reproductive health and HIV (SRH-HIV) related outcomes amongst migrant and non-migrant adolescents, young people and sex workers and others living in migration-affected communities in six countries in the Southern African Development Community (SADC) region, including Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia.

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Disclaimer

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Acronyms and Abbreviations

ART	Anti-Retroviral Therapy
AYP	Adolescents and Young People
BCC	Behaviour Change Communication
CSE	Comprehensive Sexuality Education
HIV	Human Immunodeficiency Virus
INERELA+	International Network of Religious Leaders Livingwith or Personally Affected by HIV and AIDS
IOM	International Organisation for Migration
KNB	Knows No Borders
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
M&E	Monitoring and Evaluation
MIDSA	Migration Dialogue for Southern Africa
SADC	Southern African Development Community
SC	Save the Children Netherlands
SCI	Save the Children International
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
UN	United Nations
WSPH	The University of Witwatersrand School of Public Health

Key Terms

Change Agents are peer educators who conduct health promotion activities at the community level and have direct influence on the target populations and gatekeepers. They are selected from among project beneficiaries, guided by the criteria of being a peer sex worker, adolescent and young people or migrant, being literate, and having the trust and confidence of the community. Their roles include: communicating with peers around social and behaviour change as it relates to SRHR-HIV and migration; providing accurate and relevant SRHR-HIV and migration information to peers; conducting community dialogues; being the voice of SRH-HIV rights in their community; monitoring and reporting their activities; referring and supporting peers to access health and other services in the community; and engaging with peers in the development of targeted social and behavioural change activities.

Dialogue is an enabling tool, used at all levels of the programme, to articulate and understand policy and socio-cultural drivers of access and use of SRH and HIV services and needs of the target groups, communicate these to those with the power and influence to deliver programme changes, and deliver feedback to and from beneficiaries. Within the programme, dialogue takes multiple forms: small group discussions, stakeholder consultative forums, round table advocacy forums and informal conversations during project related activities. At community level, it is a participatory process, facilitated by Change Agents, designed to support beneficiaries in sharing their experiences, information and concerns, and taking action to address these.
Policymakers include both politicians and government officials, for example from departments of health, National AIDS Commissions, local government, home affairs, education and social welfare, that intersect with migration and sexual and reproductive health and rights and HIV.

Gatekeepers include community, faith and traditional leaders in migration-affected communities who have power and influence in determining what SRHR-HIV information and services can be implemented within their spheres of influence. Gatekeepers are members of a community and as such, understand its cultural and political environment.

Executive Summary

Sub-Saharan Africa has some of the worst SRH outcomes globally, including high rates of unplanned pregnancies, maternal morbidity and mortality, unmet family planning needs, high prevalence of sexually transmitted infections, Human Immunodeficiency Virus (HIV), cervical cancer and unsafe abortions. Poor SRH outcomes are heightened among migrant girls and women, many of whom are pressured into risky migration decisions for their survival, while having limited choices, and often limited information available to them regarding their sexuality and sexual and reproductive health and rights.

SRHR-HIV Knows No Borders (KNB) is a project covering six migration-affected countries in Southern Africa: Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia. It seeks to improve the sexual and reproductive (including HIV-related) health of both migrant and non-migrant adolescents and young people, sex workers and others who live in migration-affected communities. This is achieved by generating demand for SRH and HIV services, encouraging providers to make these services available, accessible and relevant, and by ensuring that services are supported by policy- and decision-makers at local, national and regional levels.

One of the programme objectives of KNB envisages an environment in which sexual and reproductive health and rights and needs of migrants, sex workers, adolescents and young people are 'institutionalised at local, national and regional levels. To this end, the project has focused on enabling processes of dialogue, from local level activities with beneficiaries and other community members facilitated by change agents, to regional level collaborations led by members of the project consortium. The latter have included multi-country, stakeholder technical consultations, cross-border collaboration and roundtable fora for traditional and religious leaders. Through these mechanisms, the project has ensured that local level (downstream) priorities inform higher level (upstream) regional dialogue, agenda-setting and policymaking.

An example of the tangible result of such processes is the recommendations on migrant-related SRH-HIV health made by the Migration Dialogue for Southern Africa (MIDSA) in 2019 calling for strengthened migration health monitoring, improved cross-border collaboration and consideration of migrant access to healthcare in policies and plans.

Other tangible outcomes include three cross-border collaboration initiatives, which have led to a cross-border referral system and improved continuity of care for migrants and members of mobile populations who are living with HIV. Technical consultation fora have provided opportunities for beneficiaries - adolescents, young people, migrants and sex workers - to engage directly in dialogue with national and regional level policy and decision-makers. The latter hear first-hand accounts of the experiences of young people, migrants and sex workers and the need for beneficiary voices to inform the development of policies, plans and services.

Moreover, through the 'calls to action' (issued at the second and third fora) beneficiaries address a far wider audience, including national governments, regional bodies, international development partners and the global community. Key actions include securing the participation of target groups in decisions that affect them and in creating policy and legislative frameworks based upon respect for the human dignity and rights of all.

In these ways, the programme has laid strong foundations for future interventions to secure these rights and ensure they are reflected in suitable policies, laws and services.

Background: Migration and Sexual and Reproductive Health and Rights (SRHR) and HIV in Southern Africa

Migration

In 2019, Southern Africa had an estimated population of 353.9 million people, including 7.9 million international migrants. In mid-2019 it was estimated that there were 4.2 million migrants in South Africa alone, with a population of approximately 58 million. Mines in South Africa and Zambia have attracted both skilled and unskilled labour migrants from within the region and elsewhere. Both Malawi and Mozambique are frequently affected by natural hazards, such as cyclones and flooding. Slow-onset disasters, such as drought, impact the lives and migration patterns of millions in Eswatini, Lesotho and Zambia. Fluid, circular patterns of migration, and maintenance of socioeconomic networks between rural places of origin and urban centres, have become increasingly common strategies for resilience.4

Migration or spatial mobility is a key livelihood and survival strategy for many households in Southern Africa. Many people, including young women and girls, are migrating to escape hardship resulting from failed or failing economies, protracted civil unrest or conflict, gender-based violence, social marginalisation and other reasons. However, in crossing international borders, many continue to face harsh conditions as well as new or additional vulnerabilities, further increasing their risks for negative sexual and reproductive health (SRH) outcomes.

SRH and HIV

As highlighted in Table 1, Sub-Saharan Africa has some of the worst SRH outcomes globally, including high rates of unplanned pregnancies, maternal morbidity and mortality, unmet family planning needs, high prevalence of sexually transmitted infections, Human Immunodeficiency Virus (HIV), cervical cancer and unsafe abortions. The mature and related epidemics of tuberculosis and HIV threaten to undermine recent development gains and place a disproportionate burden upon girls and women. These diseases share common drivers in the form of extreme poverty and income inequalities, high mobility, gender inequality and gender-based violence, stigma, discrimination, alcohol abuse, conflict and social instability.

Poor SRH outcomes are heightened among migrant girls and women, many of whom are pressured into risky migration decisions for their survival, while having limited choices, and often limited information available to them regarding their sexuality and sexual and reproductive health and rights. For many, irregular migratory status also means marginalisation or exclusion from national SRHR initiatives, with lasting impact on human development, not just for migrants, but for host communities and countries as well.

SRHR policies vary significantly between countries. Only in Mozambique and South Africa is abortion available on demand in the first trimester. The age of consent varies between countries (and sometimes by gender), as does a requirement of spousal permission for women to access contraception. While several countries have specific adolescent SRHR policies, only Mozambique and South Africa do not require parental consent for adolescents to be able to access services. Homosexual sex is legal in Mozambique and South Africa and criminalised elsewhere, despite significant HIV prevalence among men who have sex with men and transgender people. Sex work is illegal in all six countries.

Table 1: Southern African Development Community (SADC) key socio-economic indicators[1]

Country	Life expectancy at birth years 2018	Unemployment % overall 2018 Among youth 15-24 2017	Maternal Mortality deaths per 100000 live births 2017	Adolescent births per 1000 women 15-19 2017	Contracptve prevalence women in union 15-49 2014	HIV Prev among adults 15-49 2018[1]	Experience of intimate partner violence (partnered girls and women) 2014-17[2]
Eswatini	58	22.5% - 54.8%	389	77	66.1%	27.3%	N/A1
Lesotho	46.3	23.6% - 38.5%	487	90	60.2%	23.6%	N/A[1]
Malawi	58.6	5.4% - 8%	634	140	58.6%	9.2%	24.3% (2016)
Mozambique	55	20.7% - 42.7%	489	135	27.1%[3]	12.6%	15.5% (2015)
South Africa	64.2	27.1% - 57.4%	138	43	54.6%[4]	20.4%	30.3% (2017)
Zambia	56.6	7.2% - 15.4%	224	83	49%	11.3%	26.7% (2014)

Gender-based Violence

The SADC Protocol on Gender and Development (2008) asserts regional commitment to addressing gender inequality, including violence. Gender-based violence is driven by a variety of complex factors including pervasive gender inequality and discrimination, reflected in women's economic dependence upon men, harmful cultural practices and social norms and traditions that perpetuate male entitlement and privilege. Such violence is reinforced by laws, policies and procedures that fail to respond to the specific gendered needs of women and men. This is compounded by failure to ensure that women are meaningfully engaged and involved in relevant decision-making processes.

[1] *Source: SADC, 2018. Selected Social and Economic Indicators. https://www.sadc.int/files/6215/6630/2592/SADC_Selected_Indicators_2018.pdf*
[2] *Source: https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf*
[3] *Source: https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf*
[4] *Source: https://migrationdataportal.org/regional-data-overview/southern-africa#foot*

SRHR-HIV Knows No Borders

SRHR-HIV Knows No Borders (KNB) is a regional initiative covering six migration-affected countries in Southern Africa: Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia. The KNB is implemented by the International Organization for Migration (IOM) in partnership with the University of Witwatersrand's School of Public Health (WSPH) and Save the Children Netherlands (SC). The project is funded by the Ministry of Foreign Trade and Development Cooperation of the Netherlands.

The project seeks to improve the sexual and reproductive (including HIV-related) health of both migrant and non-migrant adolescents and young people, sex workers and other individuals living in migration-affected communities. This is achieved by generating demand for SRH-HIV services, encouraging service providers to make these available, accessible and relevant, and by ensuring that services are supported by policy- and decision-makers at local, national and regional levels. In these ways, the project supports target groups and members of migration-affected communities to exercise greater freedom of choice over their sexual lives.

This publication focuses specifically upon the project's strategic use of dialogue processes and its contribution to the KNB objective of creating an enabling environment in which the needs and HIV-SRH rights of migrants, adolescents and young people and sex workers are progressively addressed in policies, laws and plans and reflected in more equal social and cultural norms.

Creating an enabling environment through Dialogue

While the focus of the KNB programme is upon health (and in particular, on sexual and reproductive health and HIV), delivering concrete change in this domain requires recognition of, and action on, underlying social, cultural and economic factors and dynamics that create and sustain ill-health.

It is for this reason that a key programme objective of KNB explicitly envisages an enabling environment in which sexual and reproductive health rights and needs of migrants, sex workers, adolescents and young people are 'institutionalised at local, national and regional levels'. This in turn, depends upon sustained and meaningful engagement with beneficiaries, gatekeepers and policy makers at all levels; local, national and regional. Only in this way can the barriers that result from unfavourable legal and policy frameworks and conservative values and social norms be constructively challenged.

Through this kind of engagement, it has been possible to sensitise decision-makers to the gaps that exist in health care delivery for target groups and the implications of these for peoples' health and well-being. Similarly, community gatekeepers have come to understand that improved health outcomes for target groups benefit the entire community.

To this end, the project has focused on processes of dialogue, from local level activities with beneficiaries and other community members facilitated by change agents, to regional level collaborations. The latter have included multi-country, stakeholder technical consultations, cross-border collaborations and roundtable fora for traditional and religious leaders.

Evidence generated through dialogue informs targeted advocacy to enhance political commitment to SRHR for all by SADC, national and regional policy makers and influencers. The Migration Dialogue in Southern Africa (MIDSA), initiated in 2000, is a non-binding regional consultative process through which member states engage in ongoing critical dialogue to enhance inter-state cooperation in an effort to improve migration governance. Dialogue also empowers networks of migrants, young people and sex workers to ensure their voices are heard and valued.

Through these mechanisms, the project has ensured that local level (downstream) priorities inform higher level (upstream) regional dialogue, agenda-setting and policymaking. This is reflected in figure one below. The needs and rights of beneficiaries are at the centre of the dialogue process which includes engagement with a variety of key stakeholders at all levels. Not only does the KNB dialogue process facilitate dialogue among specific groups, it also brings representatives of these groups together, acting as an honest broker in the resulting dialogues that are so crucial in bringing about change in policies, services and practice.

Figure 1: The dialogue process

Community level

Drawing from recent lessons learned, IOM and Save the Children have found community dialogues to be effective in promoting changes to social norms and policy that ultimately lead to improved access to and quality of SRH-HIV health care for young people, migrants and sex workers in migration-affected communities.

Community dialogues are facilitated local processes of discussion and action, led by Change Agents, through which members of target groups articulate their SRHR-HIV related needs and challenges experienced in attempting to realise these.

In Zambia, for example, where sex work is criminalised, Change Agents worked with sex workers in addressing stigma encountered in attempting to access SRH-HIV services. To this end, they established sex worker peer information hubs. Through the senior sex worker (dubbed the queen mother) who chairs the hub, SRH commodities and ART drugs are collected and delivered to group members in the community.

In community dialogues with boys and young men in Lesotho, discussions revealed how parents inadvertently expose sons to the risk of substance abuse and anti-social behaviour (including gender-based violence), both through modelling such behaviour themselves and by sending them to taverns to purchase alcohol and cigarettes on their behalf. There was also concern raised about general neglect of boys, leaving them vulnerable to bullying and future problems. A further concern was raised in terms of boys being diverted to attend tribal schools before the accepted age for such initiation. Resulting actions included follow-up with the traditional leaders committee and soliciting the support of the chief and councillor to verify the licensing and agreed opening hours of local taverns.

In a border area of South Africa, a discussion was held with community members on the subject of accessing SRH-HIV services. A number of specific barriers were identified including both attitudinal (on the part of providers) and structural, in terms of poor access by road, and general lack of community safety, reflected in substance misuse and gender-based violence. Beneficiaries complained of long waiting times and thought health-care providers had negative attitudes towards their clients, demonstrated, for instance, in a willingness to take personal telephone calls during consultations. In response, the Change Agent invited the local ward counsellor and municipality representatives and clinic manager to come and discuss these concerns with the community.

National level

In Malawi, the project team's efforts in national level technical working groups have provided a platform for advocacy on migration and migrant health, resulting in incorporation of these issues in the country's 2018-2022 national strategy on sexual and reproductive health. On a practical level, data gathered by change agents is now fed directly into the district health information monitoring system. Similarly, through the KNB dialogue process, In Eswatini, the ministry of health has included consideration of migrant health in its sexual and reproductive health policy. It has also introduced a client information management system that enables migrants to access SRH and other services throughout the country.

Regional Level

Regional dialogue processes have included engagement with the Migration Dialogue for Southern Africa (MIDSA) mechanism, technical consultations, cross-border collaborations and roundtable advocacy fora with religious and traditional leaders.

Migration Dialogue for Southern Africa

The Migration Dialogue for Southern Africa (MIDSA) draws senior participants from ministries of health, immigration, home affairs, foreign affairs and National AIDS Councils. In preparation for the 2019 MIDSA ministerial meeting, a preliminary session was held between IOM and senior government officials, focusing on migration and health. This session also provided an opportunity for the project to share lessons learned and successes to date, together with recommendations from regional technical consultations. Recommendations proposed by the health representatives included:

- strengthening public health interventions in cross-border communities
- preventing and eliminating major communicable diseases (focus on sustainable development goal targets to eliminate HIV and TB by 2030)
- enhancing HIV integration into SRHR and TB programming in the mining sector
- expanding collaborative and strategic partnerships on migration and health as a crosscutting issue.

As a result, health and migration-related information and management systems were recognised as regionally significant, as reflected in the following MIDSA statement:

> There is a need for health systems to be responsive to the needs of migrant and mobile populations, including internal migrants. This includes investment in relevant health monitoring, information and management systems to allow governments to monitor trends, formulate evidence-based policies and report progress on migrant health. Cross-border coordination on migration health, including bilateral and tripartite mechanisms for communicable and non-communicable diseases have shown promising results in the areas of HIV, TB, malaria and sexual and reproductive health.
>
> MIDSA, Namibia, 2019

Specifically, the 2019 MIDSA ministerial meeting recommendations included the following:

> Encourage the establishment and strengthening of migration health monitoring, information and management systems to inform planning and evidence-based migration and health policies, and report progress towards policy and programme commitments with the support of international actors, such as WHO.

> Urge for the strengthening of cross-border coordination and mechanisms that mitigate the spread of communicable diseases across borders and support continuity of care for migrants and mobile populations, especially for persons undergoing long-term treatment for chronic conditions such as HIV and TB. Good practices in this regard should be captured and shared among Governments.

> SADC countries, in line with their commitments under the WHO Global Action Plan for Promoting the Health of Migrants and Refugees, are encouraged to recognise migrants' access to healthcare in national health policies and implementation plans.

Technical Consultations

The project established regional technical consultations with participants from government, UN agencies and relevant civil society organisations from all six project countries to consider migration and health and sexual and reproductive health in particular.

The first regional technical consultation, in Eswatini in 2017, was attended by participants from the six countries, including representatives from departments of health, National AIDS commissions, parliamentarians, donors, UN agencies, community service organisations and beneficiaries

Key Results of 1st Regional Technical Consultation (2017)

As a result of this meeting, concrete actions included:

- Screening programmes established at border points to strengthen cross border disease surveillance for infectious and communicable diseases, such as Ebola, malaria
- Migration health programming integrated within the risk reduction and disaster preparedness and climate change

Discussion on migration and health at ministerial level

The second regional technical consultation forum (in South Africa, 2018), provided a platform to discuss and identify key priority intervention areas and strategies for enhancing cross-border collaboration, coordination and integration of SRH and HIV services for migrants, adolescents, young people and sex workers into the national plans of the various sectors. IOM also worked with UN partners to establish an efficient process for joint review of key national documents. The third and final forum took place in 2020.

Dialogue with Traditional and Religious Leaders

Engaging in dialogue with 'non-state' actors, such as traditional and religious leaders has also proved effective, not only in terms of gaining access to local communities, but in terms of taking concrete action on specific issues, such as harmful traditional practices, including child marriage. For instance, in eastern Zambia, action taken by traditional leaders led to a reduction in teenage pregnancies. Also, pregnant girls who had left school were enabled to return and leaders negotiated with school authorities to accept payment of fees in kind in lieu of cash. Similarly, in Malawi, girls who had been married before age 14 could leave their marriages and return to school.

The International Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (INERELA) has been implementing activities in Zambia and Malawi in partnership with KNB. Following training for religious leaders, a forum for religious leaders was held and formally declared a policy commitment against child marriages in Africa. Collaborating with religious leaders in this way contributes significantly to accessing local communities and their mobilisation.

Cross-border Coordination Fora

Migrants experience a variety of challenges in relation to their health and well-being. While many of these are shared with local, settled community members, there are also specific obstacles that migrants are more likely to encounter.

Box 1: Health-related challenges experienced by migrants

Box 1: Health-related challenges experienced by migrants

- Communication (language)
- Poor cross-border referral systems
- Inconsistent policy or treatment guidelines affecting continuity of care
- Lack of necessary documentation
- Fear of deportation
- Negative attitudes of health workers towards migrants
- Border-situated facilities sometimes targeted for theft of drugs and supplies
- Charges – sometimes at higher rates than settled population
- Lack of access to social amenities (sanitary facilities, including menstrual hygiene
- products, clean water, food) and other services
- Weak or lack of protection from security services
- Increased risk of exposure to communicable diseases
- Heightened vulnerability of women and children, including risk of sexual exploitation and abuse
- Dangerous working conditions

Box 1 above identifies some of the challenges encountered by migrants when they attempt to access health services. Through cross-border collaboration facilitated by KNB, action has been taken to address some of these. For instance, initiation of a cross-border referral system and improved continuity of care for migrants and members of mobile populations who are living with HIV.

Effective, multi-sectoral coordination and collaboration are critical for sustaining the demand created through the project, particularly in relation to strengthening cross-border health systems. Through the project, three multi-sectoral, cross-border fora have been established to address issues of migration, mobility and health affecting countries with shared borders:

Malawi Mozambique

Malawi Mozambique Zambia

Eswatini Mozambique South Africa

Zambia hosted the first tripartite forum in 2017 with Malawi and Mozambique, with the goal of creating an interactive, action-oriented, results-based platform of engagement on migration among the three governments to address migration, health and related challenges. Well over one hundred delegates participated and agreed to consider specific thematic areas, including mixed migration, cooperation on health issues, labour and persons with albinism/disabilities, human rights, documentation and infrastructure for migrant services. A workplan was developed and reviewed at a subsequent meeting in Mozambique in 2019. The plan focused on strengthening cross-border coordination and communication, coordination of health service delivery and community resilience. All fora have clear terms of reference and are co-convened by the respective government departments of health, with additional support provided by the project.

Several critical lessons have been learned through this cooperation. For instance, cross-border programming has been most feasible where bilateral agreements exist among neighbouring countries. Bilateral engagements are less political than multi-lateral approaches, as well as being more concrete and effective, in terms of addressing cross-border issues.

A multi-sectorial approach has been effective for engaging with multiple stakeholders, including departments of immigration, police, social welfare and education. Similarly, involvement of traditional leadership has been productive in addressing environmental barriers to SRH-HIV service access by members of target groups. Moreover, where cultural institutions have been fully involved and have participated in project implementation, substantial reduction has been recorded in traditional harmful practices, such as child marriage and sexual initiation of teenagers.

While SRHR policies exist in each country, they are inconsistent in terms of the role played by non-health sectors. For example, in Malawi and Zambia, Ministry of Health guidelines promote adolescent SRH services, while the Ministry of Education prohibits provision of SRH commodities in schools. To overcome this obstacle, the project has established youth-led community hubs, within easy access by the schools, to promote access to SRH commodities outside the school environment.

While these fora include consideration of health, their scope is deliberately multi-sectoral in order to discourage fragmentation and promote sustainability. Meetings consider a wide variety of cross-border issues, including migration, vulnerability, exploitation, gender, children and protection.

Achievements to date have included:

- establishing a critical core of regular representatives to the cross-border coordination forum for the three countries in order to promote continuity and development
- agreeing terms of reference that articulate key priority health focus areas and describe and formalize interactions and collaboration among the three countries
- completion of a comprehensive Cross Border Referral Directory to support community health referral systems in South Africa, Mozambique and Eswatini, to be replicated in other countries

- representatives of the three participating governments are also permanent members of the Regional Technical Consultation that brings together all six project countries to deliberate on action to secure barrier-free SRHR HIV services.

Dialogue between community and regional levels

Technical consultation meetings also provided an opportunity for beneficiaries - adolescents, young people, migrants and sex workers - to speak directly to policy and decision-makers and other national and regional-level stakeholders.

In this way, participants hear first-hand accounts of the experiences of beneficiaries. For example, issues raised by adolescents and young people included the need for the voices of young people to be taken into consideration in the development of policies, provision of youth-friendly services and sensitivity training for health providers, as well as income generation and economic empowerment.

Moreover, through the 'calls to action' (issued at the second and third fora) beneficiaries address a far wider audience, including national governments, regional bodies, international development partners, and the global community. Key actions include securing the participation of target groups in decisions that affect them and in creating policy and legislative frameworks based upon respect for human dignity and rights.

Conclusion

Through the processes of structured dialogue, described in this report, KNB has delivered a number of achievements.

First, it has established engagement with members of typically overlooked or marginalised groups, including sex workers, migrants, adolescents and young people, as a critical and essential first step towards understanding their needs.

The fact that at community level this process is led by Change Agents, who are themselves members of these same communities, also provides a clear demonstration (and role-models) of empowerment. This is also an important element of enabling people to articulate and claim their rights and entitlements.

Facilitated dialogue also creates an environment of collaboration, cooperation and conflict resolution. This is, essential for sustaining the continued community action necessary to tackle the underlying drivers of SRH and HIV-related ill-health that will require further effort.

In bringing together constituencies who seldom meet, KNB has exposed policy and decision-makers to the experiences, voices and demands of those who are often overlooked. Similarly, in giving beneficiaries access to these fora, the dialogue process has exposed them to decision-making platforms and enabled them, through their interactions and 'calls to action' to 'speak truth to power'.

By the end of this phase of the programme, KNB is aligned with relevant policy and regulatory frameworks, including, for example:

- global priorities of the Kingdom of the Netherland on SRHR/HIV
- UN Sustainable Development Goals (SGDs)
- SADC Strategy for SRHR:2019-2030
- IOM Regional Strategy for Southern Africa 2019-2023
- Migration Dialogue for Southern Africa (MIDSA)
- African Union (AU) Migration Policy Framework for Africa 2018-2030

It is also aligned with national SRHR/HIV strategies and policies and will continue to coordinate with other EKN funded partners and relevant SRHR/HIV programmes in the six focus countries.

In the next phase, IOM and partners will build and consolidate achievements through engagement with stakeholders, particularly with religious and traditional leadership. Dialogue will remain a critical element of future work.

Change Agents have proved to be an invaluable asset, both in terms of their individual activities at local level, but also in terms of demonstrating the potential power and agency of beneficiaries, given capacity building and support.

Work will focus upon strengthening health systems, to ensure they are responsive and accountable to those that most need them. Cross-border collaboration needs to continue together with strengthening of referral mechanisms.

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