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ANNEX 3

to the Commission Implementing Decision on the financing of the multiannual action plan in favour of Sub-Saharan Africa for 2024-2025

Action Document for Fighting harmful practices, improving access to and deepening accountability for Sexual and Reproductive Health and Rights (SRHR) services in Africa

MULTIANNUAL PLAN
This document constitutes the multiannual work programme within the meaning of Article 110(2) of the Financial Regulation, within the meaning of Article 23 of the NDICI-Global Europe Regulation.

1 SYNOPSIS

1.1 Action Summary Table

1. Title **CRIS/OPSYS business reference** **Basic Act**	Fighting harmful practices, improving access to and deepening accountability for Sexual and Reproductive Health and Rights (SRHR) services in Africa OPSYS number: ACT-62355 Financed under the Neighbourhood, Development and International Cooperation Instrument (NDICI-Global Europe)
2. Team Europe Initiative	Yes: Regional Team Europe Initiative (TEI) on Sexual and Reproductive Health and Rights (SRHR) in Sub-Saharan Africa
3. Zone benefiting from the action	The action shall be carried out in the Sub-Saharan Africa.
4. Programming document	Sub-Saharan Africa Multi-Annual Indicative Programme 2021-2027
5. Link with relevant MIP(s) objectives / expected results	Priority area 1: Human Development Result 1.4: The environment for SRHR is enabled Expected Results: To accelerate the elimination of harmful gender related practices and to accelerate the realization of SRHR for women and girls in Africa.
PRIORITY AREAS AND SECTOR INFORMATION	
6. Priority Area(s), sectors	Priority Area 1: Human Development DAC Code 130: Reproductive Health DAC Code 120: Health
7. Sustainable Development Goals (SDGs)	Main SDG: SDG 3: Ensure healthy lives and promote well-being for all at all ages. Target 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births. Target 3.2 By 2030, end preventable deaths of newborns with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births.

	Target 3.B**:** Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all. Target 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. Target 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Other significant SDGs (up to 9) and where appropriate, targets: SDG 5: Achieve gender equality and empower all women and girls. Target 5.1 End all forms of discrimination against all women and girls everywhere Target 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation Target 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation Target 5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences. SDG 10: Reduced inequalities SDG 16: Peace, justice and strong institutions			
8 a) DAC code(s)	13020 – Reproductive health care – 70% 13081 – Personnel development for population and reproductive health – 15% 12110 – Health policy and administrative management – 15%			
8 b) Main Delivery Channel	Other public entities in donor country - 11004 UN entities - 41100			
9. Targets	☐ Migration ☐ Climate ☒ Social inclusion and Human Development ☒ Gender ☐ Biodiversity ☐ Education ☒ Human Rights, Democracy and Governance			
10. Markers (from DAC form)	**General policy objective** @	**Not targeted**	**Significant objective**	**Principal objective**
	Participation development/good governance	☒	☐	☐
	Aid to environment @	☒	☐	☐

	Gender equality and women's and girl's empowerment	☐	☐	☒
	Reproductive, maternal, newborn and child health	☐	☐	☒
	Disaster Risk Reduction @	☒	☐	☐
	Inclusion of persons with Disabilities @	☐	☒	☐
	Nutrition @	☒	☐	☐
	RIO Convention markers	**Not targeted**	**Significant objective**	**Principal objective**
	Biological diversity @	☒	☐	☐
	Combat desertification @	☒	☐	☐
	Climate change mitigation @	☒	☐	☐
	Climate change adaptation @	☒	☐	☐
11. Internal markers and Tags:	**Policy objectives**	**Not targeted**	**Significant objective**	**Principal objective**
	Digitalisation @	☒	☐	☐
	digital connectivity digital governance digital entrepreneurship digital skills/literacy digital services	YES ☐ ☐ ☐ ☐ ☐	NO ☐ ☐ ☐ ☐ ☐	
	Connectivity @	☒	☐	☐
	digital connectivity energy transport health education and research	YES ☐ ☐ ☐ ☐	NO ☐ ☐ ☐ ☐	
	Migration @	☒	☐	☐
	Reduction of Inequalities @	☐	☒	☐
	Covid-19	☒	☐	☐
BUDGET INFORMATION				

<table>
<tr><td>12. Amounts concerned</td><td>Budget line(s) (article, item):
14.020120: EUR 16 000 000
14.020121: EUR 8 500 000
14.020122: EUR 15 500 000

Total estimated cost: EUR 40 000 000:

Total amount of EU budget contribution: EUR 40 000 000:

Ten EU Member States are involved in the SRHR TEI in SSA including Belgium, Czech Republic, Denmark, Finland, France, Germany, Ireland, Luxembourg, Netherlands, Sweden. The combined indicative financial contributions towards the TEI amount to EUR 1 786 581 971.

<table>
<tr><th>Team Europe Initiative Member</th><th>EUR Indicative contribution to the TEI</th></tr>
<tr><td>European Commission</td><td>222 170 000</td></tr>
<tr><td>Belgium</td><td>44 772 298</td></tr>
<tr><td>Czech Republic</td><td>400 000</td></tr>
<tr><td>Denmark</td><td>49 500 000</td></tr>
<tr><td>Finland</td><td>18 955 000</td></tr>
<tr><td>France</td><td>298 998 786</td></tr>
<tr><td>Germany</td><td>417 660 887</td></tr>
<tr><td>Ireland</td><td>7 990 000</td></tr>
<tr><td>The Netherlands</td><td>523 023 000</td></tr>
<tr><td>Sweden</td><td>203 112 000</td></tr>
</table>
</td></tr>
<tr><td colspan="2">MANAGEMENT AND IMPLEMENTATION</td></tr>
<tr><td>13. Type of financing</td><td>Indirect management with the entities to be selected in accordance with the criteria set out in section 4.4.1</td></tr>
</table>

1.2 Summary of the Action

The action will contribute to advancing the realisation of sexual and reproductive health and rights (SRHR) in Africa through reducing the harmful practices that violate the human rights of girls and young women and increase the availability, affordability and accessibility of quality assured, life-saving sexual and reproductive health (SRH) knowledge and services.

The action is proposed in the framework of the Global Gateway Health Package presented at the EU-AU Summit in 2022 and is elaborated in the context of the Sexual and Reproductive Health and Rights Team Europe Initiative (SRHR TEI). The TEI aims to work in partnership with the Regional Economic Communities (RECs) including the East African Community (EAC), Economic Community of West African States (ECOWAS)/West African Health Organization (WAHO), and Southern African Development Community (SADC) and with interested EU Member States (MS) to co-create programmatic responses to address urgent SRHR priorities. The Action will contribute to the EU human development target, SDG 3 and SDG 5, and it is principally aimed at sexual and reproductive health and health systems. Its secondary objective is gender and women's and girls' equality. Through its focus on equality, the realisation of SRH rights, and on reducing harmful practices, the Action contributes to the delivery of Gender Action Plan III[1] (GAP III) and to the EU Global Health Strategy[2].

Child marriage, female genital mutilation (FGM) and other harmful practices and their consequences continue to pose a significant risk to the health and well-being of girls and women across many African countries and are violations of human rights. There are currently an estimated 190 million girls and women living in East and Southern Africa who

[1] Gender Action Plan III: https://ec.europa.eu/commission/presscorner/detail/en/IP_20_2184; SRHR is a key thematic area of engagement of GAPIII.

[2] EU Global Health Strategy: https://ec.europa.eu/commission/presscorner/detail/en/ip_22_7153; a key objective is to expand health and well-being across the life-course making SRHR a top priority.

were married before they turned 18. Over 115 million girls are at risk of female genital mutilation mainly in West and East Africa while 40 million girls and women have suffered both early marriage and FGM.[3] Both in the context of FGM and child marriage and beyond, women and girls also experience other forms of sexual violence, exploitation and abuse, particularly during and after conflicts or humanitarian disasters.

Maternal deaths (from all causes) are the second highest cause of mortality among girls aged 15-19. Adolescent mothers (aged 10–19 years) face higher risks of obstetric fistula[4], eclampsia, puerperal endometritis and systemic infections than women aged 20–24 years, and babies of adolescent mothers face higher risks of low birth weight, preterm birth and severe neonatal illnesses.[5] Of the more than six million births that occurred to adolescent girls aged 15-19 in Sub-Saharan Africa, almost half were among married adolescents. Among these, those with less education or of low economic status are particularly vulnerable and are also hard to reach; progress in reducing adolescent first births has been particularly slow amongst these vulnerable groups according to the WHO.

Addressing harmful practices requires a combination of legal, governance, social, economic and cultural shifts. From a programme delivery perspective, reaching communities is a key challenge. The engagement of all stakeholders, especially civil society, community and faith leaders and families, is fundamental to achieving sustainable change. The Action will continue the longstanding EU support to eliminating child marriage and FGM, including through the Spotlight Initiative Africa Regional Programme (stream I and II), working in collaboration with the African Union Commission, governments and civil society organizations (CSOs) to protect women and girls at risk, and to support survivors. Increasingly, programmes invest in and through groups led by adolescent and young women themselves.[6]

Inadequate availability, affordability of quality assured SRH commodities negatively affects a range of SRHR outcomes. The action will contribute to better access to quality assured SRH commodities to strengthen regulatory capacity, improve sustainable procurement and more predictable supply chain management functioning including by improving economies of scale through efficient well-functioning regional procurement mechanisms. The action will be rooted in on-going EC action in this area (AD2023) building on progress and expanding on opportunities that arise from earlier efforts while avoiding duplication.

Data and evidence are insufficiently generated, disseminated, and used to advance advocacy and promote accountability**.** Improved prioritisation and SRHR-related systems strengthening requires better use of relevant, strategic data to identify and target evolving challenges and needs. The Action will promote better collection and management and more productive use of strategic information, improving priority setting and capacitating CSOs to hold governments and local authorities to account for progress against SRHR commitments.

EU and Africa objectives and priorities are addressed through this action. In the context of the SRHR TEI the action will advance the empowerment and realisation of rights for girls and women and expand reproductive health in the context of the International Conference on Population and Development Programme of Action[7] and the EU GAP III, investing in essential pharmaceutical capacity and access in the context of the emerging EU Global Health Strategy and Global Gateway, strengthening regional partnerships, and achieving the SDGs. Additionally, commitments by

[3] https://data.unicef.org/topic/child-protection/female-genital-mutilation/

[4] Obstetric fistula is a hole between the birth canal and bladder or rectum, caused by prolonged, obstructed labour without access to timely, high-quality medical treatment. It leaves women and girls leaking urine, faeces or both, and often leads to chronic medical problems, depression, social isolation and deepening poverty. Ninety percent of pregnancies involving fistula end in stillbirth (https://www.un.org/en/observances/end-fistula-day)

[5] https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

[6] For example, Girls not Brides invests in supporting leadership among a highly diverse range of 500+ partners including hundreds working in and for their communities: https://www.girlsnotbrides.org/documents/1688/Partnership_Strategy_2022-2025.pdf

[7] https://www.unfpa.org/icpd#:~:text=The%20ICPD%20Programme%20of%20Action,of%20the%20global%20development%20agenda.

African RECs to realize SRHR are strong and well-documented[8]. The African Union Commission is also committed to strong action to end to harmful practices – particularly child marriage and FGM.[9]

The TEI SRHR has broad EU MS support: ten MS are involved in the TEI working group and the combined indicative financial contributions towards the TEI amounts to over EUR 1.786 billion, of which 12,4% consists of the EU's ongoing[10] and planned[11] contributions. The TEI also has the support of African partners (i.e., EAC, WAHO/ECOWAS and SADC) and this Action responds to their priorities. The regional economic communities currently monitor progress towards commitments through a series of scorecards and are expected to be key partners in this Action. Implementation will be undertaken by trusted entities and, in part, by participating TEI Member States alongside both current and planned programmes.

1.3 Zone benefitting from the Action

The Action shall be carried out entirely in the Africa Region in the context of the Africa SRHR TEI. All countries are included in the list of ODA recipients.

2 RATIONALE

2.1 Context

Overarching context. Access to sexual and reproductive health and rights (SRHR) is fundamental for the achievement of the Sustainable Development Goals and the Africa Union's Agenda 2063 and vital to health and well-being. This Action centres on the realisation of SRHR in Africa. It is situated within a context of broad commitments by both Europe and Africa to the delivery of the Programme of Action of the International Conference on Population and Development (ICPD),[12] reconfirmed through the 2019 Nairobi Summit of the ICPD 25[13] and in the Sustainable Development Goals (Goals 3 and 5).

EU and Global Commitments to realising SRHR. SRHR is a priority of the new EU Global Health Strategy adopted in November 2022 which reasserts EU commitments to tackle key global health challenges and health inequalities, and in the Health Package presented at the EU-AU Summit in 2022[14]. The regional SRHR TEI[15] has strong EU Member States support (BE, CZ, DK, FI, FR, DE, IE, LU, NL, SE are members of the TEI). The EU's commitment to uphold SRHR is confirmed in the European Consensus on Development[16] and in several Council Conclusions and EP resolutions. Similarly, African political and economic leadership bodies including the African Union, the Regional Economic Communities (RECs), the Africa CDC, the newly established African Medicine Agency (AMA) and others have long-standing commitments to advancing the realization of SRHR for all women and girls in all contexts and

[8] Commitments include the African Charter on Human and People's Rights, the Maputo Protocol and the African Children's Charter, SADC Protocol on Gender and Development, the Model Law for Ending Child Marriages (2016), SADC SRHR Strategy (2018/2019) and Scorecard (2020), EAC Gender Equity and Development Bill, EAC Child Policy, EAC Community SRHR Bill is under development, ECOWAS Act on Equality & Rights between Women & Men for Sustainable Development.

[9] https://au.int/sites/default/files/newsevents/workingdocuments/41106-wd-AU_ACCOUNTABILITY_FRAMEWORK_ON_THE_ELIMINATION_OF_HARMFUL_PRACTICES-_ENGLISH.pdf

[10] Including Spotlight Africa Regional Program and Spotlight Africa countries (€130 million) and multi-country projects from CfP on vulnerable adolescents' SRHR (€32 million)

[11] EUR 60 million from the Africa MIP. A first EUR 20 million action focusing on improving access to innovative and life-saving commodities for preventing and treating post-partum haemorrhage was programmed under AAP 2023.

[12] https://www.icpd25commitments.org

[13] https://www.unfpa.org/icpd

[14] https://commission.europa.eu/strategy-and-policy/priorities-2019-2024/stronger-europe-world/global-gateway_en

[15] https://capacity4dev.europa.eu/resources/team-europe-tracker/partner-countries/sub-saharan-africa/sexual-and-reproductive-health-and-rights-srhr-sub-saharan-africa_en

[16] Art 34 of the European Consensus on Development, , https://international-partnerships.ec.europa.eu/policies/european-development-policy/european-consensus-development_en

these are unambiguous and well-documented[17] and operationalised in the Maputo Plan of Action. RECs are guided by regional strategic frameworks aligned to continental and global commitments monitored through peer accountability mechanisms or scorecards against which Member States report periodically at the level of Ministers of Health and/ or head of government/ state.[18,19]

Many girls are at risk of harmful practices including child marriage[20] and female genital mutilation (FGM), which is still practiced in many countries across Africa[21]. Children at risk of marriage are usually experiencing a range of vulnerabilities including poverty, a parental perception that marriage will provide 'protection', family honour, social norms, customary or religious laws that condone the practice, an inadequate legislative framework and the state of a country's civil registration system. The practice is more common among girls than boys, but it is always a violation of rights regardless of sex. With sustained action, the situation has slightly improved in some countries but across the Africa region, 130 million girls and women were married before their 18th birthday while 140 million have suffered FGM[22].

The scale of child marriage and its consequences continues to be significant across the continent. In relation to child marriage, there are currently 55 million girls and women living in East and Southern Africa who were married before the aged of 18 with the largest numbers in absolute terms in Ethiopia (17.5 million), Tanzania (5.7 million), Uganda (4.7 million), Mozambique and Kenya (4.4 and 4.2 million respectively)[23]. More than 10% of these marriages occurred among girls under the age of 15, a practice which continues today. In West and Central Africa, the situation is similar; almost 60 million girls and young women were married before the age of 18 (and 12% of these before age 15). The highest numbers are in Nigeria (24 million), DRC, Niger, Burkina Faso, Mali and others.[24] Across the Africa region the highest prevalence of FGM is in West and East Africa and 40 million girls and women have suffered both early marriage and FGM. [25] In addition, girls who become pregnant are much more vulnerable to obstetric fistula[26]. WHO estimates that there are about half a million girls and women affected by fistula in Africa today.[27] Fistula leads to social exclusion and raft of physical and mental health problems. Repair is possible but it requires specialised surgery and long periods of care and recuperation. Most babies born to women who develop fistula are stillborn.

[17] Commitments include the African Charter on Human and People's Rights, the Maputo Protocol and the African Children's Charter. Within the Southern African Development Community (SADC) there is the Protocol on Gender and Development, the Model Law for Ending Child Marriages (2016) and the SADC SRHR Strategy (2019 -2030) and Scorecard (2020). In the East African Community (EAC) there is the Gender Equity and Development Bill, and the EAC Child Policy. The EAC Community Sexual and Reproductive Health Bill is under development and the EAC is in the process of revising its Reproductive, Maternal, Newborn, Child and Adolescent Health Policy.. The Economic Community of West African States (ECOWAS) has a supplementary Act on Equality and Rights between Women and Men for Sustainable Development, and Common Standards to Protect and Care for Children on the Move.

[18] List and reference the EAC, SADC, ECOWAS and other scorecards

[19] Reference that child marriage/ FGM sometimes is a head of state/ government level commitment.

[20] Child marriage is an issue of global concern. African countries with the highest rates of child marriage include: Niger, CAR, Chad, Mali, Mozambique, Burkina Faso, South Sudan, Guinea, Nigeria, Malawi, Eritrea, Ethiopia, Madagascar, Mauritania, Liberia, Somalia, Benin, Togo, Ghana, Angola, DRC, Kenya, Uganda and others (https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/atlas/)

[21] In Africa, FGM is known to be practiced among certain communities in 33 countries: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Democratic Republic of Congo, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, South Africa, South Sudan, Sudan, Tanzania, Togo, Uganda, Zambia and Zimbabwe. (https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions) https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation#:~:text=Key%20facts,Asia%20where%20FGM%20is%20practiced

[22] https://data.unicef.org/resources/harmful-practices-in-africa/

[23] https://data.unicef.org/resources/child-marriage-in-eastern-and-southern-africa-a-statistical-overview-and-reflections-on-ending-the-practice/

[24] https://data.unicef.org/resources/child-marriage-in-west-and-central-africa-a-statistical-overview-and-reflections-on-ending-the-practice/

[25] https://data.unicef.org/topic/child-protection/female-genital-mutilation/

[26] Obstetric fistula is a hole between the birth canal and bladder or rectum, caused by prolonged, obstructed labour without access to timely, high-quality medical treatment. It leaves women and girls leaking urine, faeces or both, and often leads to chronic medical problems, depression, social isolation and deepening poverty. Ninety percent of pregnancies involving fistula end in stillbirth (https://www.un.org/en/observances/end-fistula-day)

[27] https://www.who.int/news-room/facts-in-pictures/detail/10-facts-on-obstetric-fistula#:~:text=It%20is%20estimated%20that%20more,of%20harmful%20traditional%20practices%3B%20

Addressing harmful practices requires a combination of legal, governance, social, economic and cultural shifts. From a programme delivery perspective, reaching communities is a key challenge. The engagement of all stakeholders, especially civil society, community and faith leaders and families, is fundamental to achieving sustainable change. The Action will continue the longstanding EU support to eliminating child marriage and FGM, including through the Spotlight Initiative Africa Regional Programme (stream I and II), working in collaboration with the African Union Commission, governments and civil society organisations (CSOs) to protect women and girls at risk, and to support survivors. Increasingly, programmes invest in and through groups led by adolescent and young women themselves.[28]

Inadequate availability, affordability of quality assured SRH commodities negatively affects a range of SRHR outcomes and can contribute to significant maternal and neonatal morbidity and mortality. Addressing the challenges in health systems thus needs to include efforts to improve the availability, affordability, and quality assurance of SRH commodities at all stages of health delivery including infrastructure, supply chain management, and regulatory systems, as well as promoting policies that prioritize SRHR and ensure universal access to basic health services. To address this, the action should contribute to better access to life enhancing and life-saving SRH commodities with previous and contemporaneous actions at regional and country level (including those of the AD 2023 and the MAV+ TEI) to generate synergies in related health systems strengthening, including regulatory capacity and procurement including through improving the value and efficiency of regional procurement mechanisms.

Data and evidence are insufficiently generated, disseminated, and used to advance advocacy and promote accountability. Improved prioritisation and SRHR-related systems strengthening requires better use of relevant, up-to-date and complete data to identify and target service investments appropriately. The Action will promote better management and more productive use of strategic information, particularly on result indicators of regional and continental SRHR commitments, improving priority setting and capacitating CSOs to hold governments and local authorities to account for progress against SRHR commitments.

Accountability for progress is weak and there is a persistence of preventable death in Africa. Although gradually declining in many contexts, and despite persistent engagement by a growing range of civil society groups and other stakeholders, progress on reducing adolescent births is slow and the number of adolescent births remains high and carries with it a range of additional risks (unsafe abortion, miscarriage, low birth weight, maternal death and neonatal illness (failure to thrive) and death). Girls who become pregnant are less likely to complete school or achieve their potential. Maternal deaths (from all causes, including unsafe abortion) in many African countries are declining too slowly to achieve the SDG target; it is the second highest cause of mortality among girls aged 15-19 years. Adolescent mothers (aged 10–19 years) face higher risks of eclampsia, puerperal endometritis, and systemic infections than women aged 20–24 years, and babies of adolescent mothers face higher risks of low birth weight, preterm birth and severe neonatal illnesses.[29] Of the more than six million births that occurred to adolescent girls aged 15-19 years in Sub-Saharan Africa, almost half were among married adolescents. Among these, those with less education or of low economic status are particularly vulnerable and are also hard to reach; progress in reducing adolescent first births has been particularly slow amongst these vulnerable groups according to the WHO.

The SRHR Team Europe Initiative (TEI) creates opportunities to accelerate progress. The Team Europe Initiative was launched in Kigali, Rwanda on 14 December 2022[30] to advance the Global Gateway and concentrate international EU partnerships on accelerating growth, removing barriers to progress and strengthening alignment across the European development effort to maximise the impact of combined political and economic resources for development. The overarching objective of the SRHR TEI is to "Improve sexual and reproductive health and rights in Africa, particularly among adolescent girls and young women".

The TEI has strong support and commitment: ten EU Member States are involved in the TEI working group[31] and the combined indicative financial contributions towards the TEI amounts to EUR 1.8 billion as of February 2023, of

[28] For example, Girls not Brides invests in supporting leadership among a highly diverse range of 500+ partners including hundreds working in and for their communities: https://www.girlsnotbrides.org/documents/1688/Partnership_Strategy_2022-2025.pdf

[29] https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

[30] EU and African partners launch flagship initiative (europa.eu) https://ec.europa.eu/commission/presscorner/detail/en/IP_22_7738

[31] Belgium, Czech Republic, Denmark, Finland, France, Germany, Ireland, Luxemburg, Netherlands, Sweden

which 12% consists of the EU's on-going[32] and planned[33] contributions including actions planned in this AD. Harnessing alignment and unity of purpose, the combined funding commitment to SRHR TEI objectives creates potential to achieve ambitious results on addressing structural barriers to progress.

The EU Global Gateway strategy highlights health as one of five key areas of partnership with particular focus on supply chain security and the development of local production and distribution capacities as well as through strengthening health systems which includes the better use of health commodities in service delivery. The action contributes to the EU Global Health Strategy[34] contributing to two of its three overarching objectives: (i) Deliver better health and well-being of people across the life course; and (ii) Strengthen health systems and advance universal health coverage. As well as a focus on young people and adolescents, the Global Gateway mainstreams the Gender Action Plan III which includes a comprehensive approach to enabling the realization of SRHR in all development contexts. In addition, it will contribute to other important aims including to expand the **EU's** international partnerships on health based on co-ownership and co-responsibility among partners. Improving health sovereignty will ensure more resilience and autonomy, both critical to sustainability.

Three Regional Economic Communities (RECs) including the East African Community (EAC), the West African Health Organization (WAHO) of the Economic Community of West African States (ECOWAS), and the Southern African Development Community (SADC) are engaged in the TEI[35] including the co-creation of TEI objectives and priorities. Developing these relationships further, the EU has engaged regional partners and MS in the elaboration and refinement of the action proposed in this AD. As a result of this co-creation process, and reflecting the main barriers to SRHR progress, three specific objectives have been identified for the TEI Joint Intervention Logic (JIL). These are: (i) Increased implementation of continental and regional SRHR commitments in health and education sector; (ii) Improved availability, affordability, acceptability and use of quality assured SRH commodities for all, especially women and girls and (iii) Strengthened advocacy and accountability to ensure SRHR needs are met.

Working with MS and RECs: Addressing inequities in SRHR including the protection from gender-related harmful practices and boosting access to quality SRHR services and knowledge is critical to achieving universal health coverage, protecting human rights, advancing gender equality, combating discrimination and improving the social determinants of health. Pursuing these aims lies at the heart of the WHO mandate to support countries to achieve SDG 3 and the ICPD targets.[36] The mapping of TEI members' ongoing and forecasted contributions to the TEI highlighted that there is scope for the proposed action to be implemented in alignment with ongoing or planned MS programmes. This was corroborated by explorative discussions with TEI members and endorsed by RECs in a series of workshops. In light of the above, there is potential for sustained commitment, enhanced coordination in a Team Europe approach in partnership with African stakeholders, resulting in real impact both on the ground and politically.

2.2 Problem Analysis

Short problem analysis:

Harmful gender-related practices and insufficient realisation of sexual and reproductive health and rights prevents girls and women in Africa from achieving their potential (such as completing education, entering the labour market). Access to quality SRHR knowledge and services is fundamental to ensuring that women and girls, individuals and couples, are able to protect their own health and the health of their children.

Progress on eliminating harmful norms needs to be maintained. African countries have made progress on eliminating female genital mutilation (FGM) and child, early and forced marriage. However, during the covid-19 pandemic and as a result of wider economic challenges, some of this progress may have been eroded. It is vital to support countries to reverse any slippage and rebuild momentum towards elimination.

[32] Spotlight Africa Regional Program and Spotlight Africa countries (€ 130 million) and multi country projects from CfP on vulnerable adolescents' SRHR (€ 32 million)
[33] €60 million from the MIP for SSA 2021-2027
[34] https://ec.europa.eu/commission/presscorner/detail/en/ip_22_7153
[35] SADC (Southern African Development Community), ECOWAS (Economic Community of West African States), WAHO (West African Health Organisation), EAC (East African Community).
[36] WHO Inequality monitoring in sexual reproductive, maternal, newborn, child and adolescent health. February 2022 file:///C:/Users/sara.sotillos/Downloads/9789240042438-eng.pdf

Girls are at higher risk of dying or becoming incapacitated from maternal causes. Adolescent girls, especially those in early adolescence, are vulnerable as their bodies may not be physically ready for pregnancy and delivery. Among the health consequences, obstetric fistula, eclampsia, puerperal endometritis and systemic infections are among the most serious and can lead to lasting or permanent disability or death. Globally, maternal conditions are among the top five causes of disability-adjusted life years (DALYs) lost and of death among girls aged 15-19.[37]

Availability and correct use of quality commodities can reduce unwanted pregnancies, preserve health and save lives. On the whole, African countries underutilize quality-assured[38] SRHR commodities. Pooled or coordinated procurement as a means to increase availability and quality while reducing commodity prices and costs requires effort from three participating groups: Participants, buyers (within the coordinating organization) and suppliers. All participating groups need skills and capacities, and all have a range of incentives and motivations. For example, to participate in pooled or coordinated procurement, country procurement authorities (buyers) from different countries need compatible laws and regulations and a sufficient level of technical and financial capacity. To supply the mechanism with health commodities, commercial manufacturers (suppliers) need sufficient incentives, such as access to markets[39].

Data and evidence are insufficiently generated, disseminated, and used to enforce advocacy and accountability. Improved prioritisation and SRHR-related systems strengthening requires better use of relevant, up-to-date and complete data to identify and target service investments appropriately. The Action will promote better management and more productive use of strategic information, improving priority setting and capacitating CSOs to hold governments and local authorities to account for progress against SRHR commitments.

Accountability for progress (by both governments and regions) is uneven while socio cultural factors affecting SRHR continue to influence attitudes of both health staff and women and their families. While countries have made far-reaching commitments to increase sexual and reproductive rights, to deliver SRHR services and to reduce preventable SRHR-related morbidity and death, realizing these commitments is challenging and requires sustained effort and investment across a wide geography, using a multi-sectoral approach that tackles legal, social, economic and demand-side factors in additional to service quality and supply. Identifying what is working and where (feedback and strategic information for decision-making and progress reporting) relies on information and data gathering and analysis from across a range of sources including a growing network of CSOs many of which are led by and focused on adolescent girls and young women, plus the commitment and leadership to use this data for planning and budgeting. Women and girls (as well as men and boys) have vested interests in ensuring commitments are met and knowledgeable and trained civil society organisations – especially those run by and for adolescents and women – are well placed to track and analyse progress, motivate for and support sustained action.

Women with disabilities are almost one-fifth of the world's population of women[40] and have the same SRH needs, rights, and desires as other women and girls. Due to multiple and intersecting forms of discrimination on the basis of gender and disability, however, women and girls with disabilities face unique and pervasive barriers to the full realization of their SRHR. For example, women and girls with disabilities are deeply affected by restrictions on access to SRH knowledge and services[41]. Limited access contributes to and exacerbates other restrictions faced by women and girls with disabilities including around education, employment, and participation in public life, undermining their health, well-being, and self-esteem, and often leading to isolation, disempowerment, and infantilization. Hence, SRHR may be a prerequisite or corollary to fulfilling other human rights and, concurrently, its realization depends on the realisation of other rights, such as universal access, non-discrimination, freedom from violence, privacy, and

[37] https://data.unicef.org/topic/child-health/adolescent-health/

[38] Quality assured in this context refers to the finished pharmaceutical product and is taken to mean prequalified under the WHO RH Medicines schemes and/or certified by a Stringent Regulatory Authority. In this instance, what is meant by 'quality assured' refers solely to the FPP and does not extend to the in-county activities needed to ensure that the products reach the final beneficiary in the intended state to ensure safety and efficacy. These additional in-country activities are of critical importance but are not within this definition of quality assured.

[39] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9188018/

[40] WHO and United Nations Population Fund (UNFPA), Promoting Sexual and Reproductive Health for Persons with Disabilities: WHO/UNFPA Guidance Note 3 6-7 (2009), https://www.unfpa.org/publications/promoting-sexual-and-reproductivehealth-persons-disabilities.

[41] S. Hameed, A. Maddams, T. Shakespeare, et al, From words to actions: systematic review of interventions to promote sexual and reproductive health of persons with disabilities in low- and middle-income countries 2 (2020), https://gh.bmj.com/content/5/10/e002903.

information.[42] Girls and women affected by fistula experience disabilities that can prevent them leaving home, seeking work or interacting with others. FGM can cause severe life-long consequences both on the physical and mental health of survivors. These consequences, ranging from chronic infections and chronic pain to mental illnesses, can have a long-lasting impact on the ability of survivors to access and enjoy normal activities. The consequences of FGM mean that it can create impairments in some survivors, and thus lead to disability.

Addressing these problems. This action will focus on protecting gains and accelerating progress for girls and women in Africa in defined aspects of SRHR in ways that intersect with the specific objectives of the SRHR TEI Joint Intervention Logic. The Action will strengthen country partnerships with regional actors while also creating space for better capacitated civil society groups to take a sustained and structured role promoting accountability. In each of its three specific objectives, the action responds to critical EU priorities: Advancing empowerment and the realization of human rights among women and girls and expanding opportunities for women and girls in the context of the ICPD and the EU GAP III, investing in making essential pharmaceutical products available all in the context of the emerging EU Global Health Strategy and Global Gateway, while strengthening regional partnerships, and advancing the SDGs.

Successful Action will reduce inequalities and improve health outcomes across geographies and wealth quintiles. The Action will be targeted to preventing the violation of rights in girls and young women especially prevalent among certain economically and socially marginalised communities. The Action will contribute to climate change mitigation through supplies solutions and service efficiencies that consume less energy (e.g., conservation at room temperature, regional manufacturing reducing the environmental impact of transport). Health systems emit 5% of greenhouse gas emissions with transport, including the logistic chain, an important factor along with digital information management. These areas (and others) are amenable to adaptation and mitigation. For example, with adequate planning, shipments can be mainly done by sea, reducing the necessity of emergency orders that are normally shipped by air (more polluting). Packaging can also be environmentally friendly while community engagement can be planned with energy conserving transport options.

Components of this Action will advance the steps most needed to accelerate regional engagement and progress:

- Take steps to maintain and accelerate the momentum behind eliminating child marriage and FGM.
- Generate demand in countries for access to quality SRHR services and knowledge.
- Stimulate and strengthen coordinated/pooled procurement arrangements and linked to this.
- Stimulate market responses to pooled procurement demands and
- Update and strengthen country regulatory systems.
- Engage, motivate and capacitate CSOs to step up their accountability role while supporting.
- Operational and implementation research to help identify problems and point to effective solutions.
- Engage a wide range of stakeholders around using strategic data to make faster progress.

Identification of main stakeholders and corresponding institutional and/or organisational issues (mandates, potential roles, and capacities) to be covered by the action:

Primary stakeholders

As duty-bearers: The main stakeholders in this Action include national health and finance authorities in African countries (including Ministries of Health and Finance, Gender and Education, national health planners and providers, gender focal points at Ministries and health workers especially midwives and, district and community health services),

Other important stakeholders include regional and continental partners (the RECs, the AU), partners engaged in and accountable for maternal health in the global health system (including United Nations agencies and the regional development banks), commodity producers, and women and girls across the continent. The action will support innovative partnerships to increase the availability and use of commodities in the health system and ensuring that these commodities are incorporated into national policies and essential medicines lists.

Other key stakeholders related to health systems strengthening include country governments through whom much of the action will be delivered as well as local health authorities.

[42] See U.N. Committee on Economic, Social, and Cultural Rights (ESCR Committee), General Comment No. 22: The right to sexual and reproductive health, U.N. Doc. E/C.12/GC/22 (2016) [hereinafter ESCR Committee, Gen. Comment 22].

It is also important to reference other processes underway where synergies can be expected. Addressing the regulatory barriers for innovative SRH products will primarily be supported through the MAV+ TEI.[43] However, there will be important synergies between MAV+ and the SRHR TEI at the point of defining interventions for strengthening aspects of commodity availability including through strengthening regulatory capacity and pooled procurement. Similarly, the EU's support to the UNFPA Supplies Partnership is an important driver of access to low-cost commodities, and the action will seek to complement and build on the Partnership's achievements investing at the regional level to reinforce country priorities. Across all these investments (through the SRHR TEI, the MAV+ TEI and the global UNFPA Supplies Partnership, all of which are also supported by EU MS and WHO leadership and capacity on medicines regulatory systems[44].

Partnerships:

- The SRHR TEI in Sub-Saharan Africa has strong EU Member States (MS) support: 10 MS are involved in the TEI working group[45] and the combined indicative financial contributions towards the TEI amounts to €1.786 billion, of which 12.4% consists of the EU's ongoing[46] and planned[47] contribution.
- MS are engaged in supporting SRHR across the continent through a range of structured, on-going programmes.
- The TEI has the support of African partners: three Regional Economic Communities (REC) EAC, ECOWAS/WAHO and SADC[48] have been involved in the co-creation of the TEI and are expected to have a meaningful role in the EU programme. This action will contribute to demonstrating the concrete added value and results of the co-creation process related to the TEI on SRHR, which is deemed to be pertinent at both political and technical levels.
- Civil society organisations, especially those led by or working in support of adolescent girls and young women are expected to play an important role in participating in data collection processes and strengthening accountability for national progress.
- In relation to commodities, Africa CDC and AUDA-NEPAD, as key agencies of the African Union and, along with the Africa Medicines Agency (AMA), with a continental remit, are partners with the designated mandate to strengthen disease surveillance and management, pharmaceutical manufacturing, and regulatory strengthening and harmonisation in Africa, working closely with regional economic communities. While the action may not partner directly with Africa CDC, the RECs will be connected to each other through this partnership and through AUDA-NEPAD. The AMA will increasingly be a partner for all aspects of commodity strengthening.
- Among global health and development partners, Unicef and UNFPA work together with over 500 CSOs to eliminate child marriage and encourage FGM abandonment in two global programmes that attract funding from a wide range of bilateral, multilateral and private donors.

Direct beneficiaries and key stakeholders as rights-holders are:

- All girls and women in all their diversity throughout the reproductive life course as well as their families, especially newborns and young children.
- Women's and adolescents' human rights associations, CSOs, ethnic and religious groups.

Other partners and stakeholders

Political and/or civil society organizations mobilized to strengthen advocacy for local health financing, with a particular focus on reproductive health and family planning.

Media, including social media, plays critical role in changing social norms and behaviours among mass. With an aim to raise awareness and transformative changes in behaviour and social norms, the partnership with media will ensure

[43] MAV+ (Manufacturing and Access to Vaccines, Medicines and Health technology products in Africa)
[44] https://extranet.who.int/prequal/medicines/welcome-medicines-prequalification
[45] Belgium, Czech Republic, Denmark, Finland, France, Germany, Ireland, Luxemburg, Netherlands, Sweden
[46] Spotlight Africa Regional Program and Spotlight Africa countries (€ 130 million) and multi country projects from CfP on vulnerable adolescents' SRHR (€ 32 million)
[47] €60 million from the MIP for SSA 2021-2027 to Support SRHR in two tranches (AD2023 which is €20m to support "SafeBirth Africa" and AD2024 under development valued at €40m)
[48] SADC (Southern African Development Community), ECOWAS (Economic Community of West African States), WAHO (West African Health Organisation), EAC (East African Community).

reporting of sexual and reproductive health practices.

3 DESCRIPTION OF THE ACTION

3.1 Objectives and Expected Outputs

The Overall Objective of this action is to advance the realisation of sexual and reproductive health and rights in Africa.

The Specific Objectives of this action are to:

1. Protect gains and accelerate momentum towards the elimination of harmful practices affecting girls and young women.
2. Increase the availability and use of essential, underused, or difficult to access quality assured SRH commodities.
3. Strengthen accountability for progress towards achieving SDG-linked SRHR targets and commitments.

The Outputs to be delivered by this action contributing to the corresponding Specific Objectives are:

Contributing to Specific Objective 1:

1.1 Reduced child marriage in girls under the age of 18.
1.2 Reduced risk and occurrence of female genital mutilation in girls and young women.

Contributing to Specific Objective 2:

2.1 Strengthened regional commodity financing systems including pooled procurement arrangements progressively increase availability and use of quality assured SRHR commodities.
2.2 Increased country regulatory and supply chain management capacity of SRH commodities leads to increased availability and quality.

Contribution to Specific Objective 3:

3.1 Improved collection, management and use of strategic SRHR data at national and regional levels
3.2 Strengthened accountability for SRHR commitments through supporting and expanding the role of civil society organisations to monitor progress.

3.2 Indicative Activities

Activities relating to Output 1.1

- The Action will support governments and civil society organisations across the most affected countries in Africa through a combination of legal, political, social norms and behavioural norms change processes (technical assistance, policy analysis support, capacity building, communications advice) to reduce the number of child marriages.

Activities relating to Output 1.2

- The Action will support governments and civil society organisations across the most affected countries in Africa through a combination of legal, political, social norms and behavioural norms change processes (technical assistance, policy analysis support, capacity building, communications advice) to motivate communities, families and girls to abandon FGM.

Activities relating to Output 2.1

- Capacity building support complemented by technical support, policy analysis and practical programmatic assistance targeted to scale up regional pooled/ coordinated procurement and other mechanisms to strengthen the contribution and use of regional modalities.

Activities relating to Output 2.2

- Technical support, training, policy dialogue and practical support to countries and RECs to enable regional and country systems to function efficiently and to increase countries' ability to use these through stronger regulatory and related procurement and supply processes and supply chain management.

Activities relating to Output 3.1

- Technical support for the development and use of information systems plus training, mentoring and workshops to strengthen capacity and performance among all SRHR stakeholders including civil society organisations to identify, collect, manage and use strategic data.

Activities relating to Output 3.2

- Technical assistance, coordination, meetings and institutional and practical support to strengthen research capacity, and accountability mechanisms, including the use of scorecards and other monitoring tools.

The commitment of the EU's contribution to the Team Europe Initiative to which this action refers, will be complemented by other contributions from Team Europe members. It is subject to the formal confirmation of each respective member's meaningful contribution as early as possible. In the event that the TEIs and/or these contributions do not materialise, the EU action may continue outside a TEI framework.

3.3 Mainstreaming

Environmental Protection & Climate Change

Outcomes of the SEA screening. The Strategic Environmental Assessment (SEA) screening concluded that no further action was required.

Outcomes of the EIA (Environmental Impact Assessment) screening. The EIA (Environment Impact Assessment) screening classified the action as Category C (no need for further assessment).

Outcome of the CRA (Climate Risk Assessment) screening. The Climate Risk Assessment (CRA) screening concluded that this action is no or low risk (no need for further assessment)

Gender equality and empowerment of women and girls

As per the OECD Gender DAC codes identified in section 1.1, this action is labelled as G1. This implies that the programme will make a significant contribution to gender equality. It will do this through contributing to strengthening women's and girls' sexual and reproductive health and rights (SRHR) in the context of the SRHR TEI. The Action aims to build partnerships across Africa to (i) eliminate child marriage and FGM, (ii) support and increase access to SRHR commodities by all women and girls whenever they need them (including to realise fertility preferences, to ensure safe delivery, to prevent sexually transmitted infections and to prevent, detect and treat reproductive cancers); and (iii) support CSOs to hold governments more accountable for delivery their SRHR related commitments. Delaying pregnancy until girls have reached physical maturity is a key strategy for reducing obstetric fistula and other morbidities. Together with better access to contraceptive services, safe delivery enables women and girls to choose with confidence whether, when and how many children to have while improving maternal outcomes and enabling newborns to better thrive. This Action supports a package of services and interventions that aim to enable girls and women to realize their sexual and reproductive rights, gain more control their lives, and build their own futures.

Human Rights

The Action supports the realization of human rights through its focus on the sexual and reproductive rights of girls and women. Specifically, the action will invest in accelerating the elimination of child marriage and FGM, protecting girls' rights, averting preventable deaths in girls and young women (and their newborns), strengthening services and holding governments more closely accountable for their commitments to ensure SRHR, to protect girls from child marriage and to eliminate FGM in line with SDG Target 5.3.

Disability

As per OECD Disability DAC codes identified in section 1.1, this action is labelled as D1. This implies that the action is relevant for inclusion of persons with disabilities in two ways. Firstly, the Action targets all women and girls in underserved and hard to reach areas including those women and girls living with a disability. The rights of women to expect quality of SRHR information and care extends to those who live with a disability. In addition, the elimination of child marriage and the expansion of adolescent access to family planning services and quality maternal health care when needed will prevent disabilities in girls and young women during delivery (from fistula for example) and in infants during delivery. Quality maternal care contributes to reducing some types of disability. Elimination of FGM and child marriage removes risk of some kinds of disabilities as well.

The Action will be in line with the EU Strategy for the Rights of Persons with Disabilities 2021-2030, and the EU Guidance Note Disability inclusion in EU external action.

Reduction of inequalities

Inequalities in relation to SRHR (including access to quality services and protection of associated rights) are well documented and have been referenced. They are multidimensional in nature and compound in effect. Inequalities can begin before birth and include socioeconomic factors affecting health and nutrition, geographic and employment factors which in turn, affect access to essential services (health and social services) and others. Intergenerational effects can result in children failing to improve their life chances relative to their parents, a situation that is overwhelmingly determined by educational attainment and socio-economic factors. Children in poorer households are vulnerable to early or forced marriage especially during periods of fragility and conflict.

Inequality makes it much harder for women and girls to access the health care they need in a timely way. Inequalities are horizontal as well as vertical and drivers of inequality reinforce structural barriers to progress. For example, women in the lower quintiles are more likely to be living in rural, underserved, overcrowded, poor or other marginal areas or to have less access in real terms to quality health information and services. Such services would empower women to avoid or time their pregnancies, the foundation of safe pregnancy and birth. In addition, access to quality information and services would enable and encourage women (and girls) to seek out sufficient antenatal care (ANC) and deliver in a safe setting.

On a systems level, investment into health services across the national system is often uneven with more invested into doctor-led services delivered in referral hospitals in urban areas relative to primary care, nurse-delivered services, and areas that would be considered rural or peri-urban slums. Inequality in health systems investments also affects health staff and inadequate training leaves staff with insufficient knowledge to deliver quality care at birth. Indeed, in some cases, staff are documented as being hostile and abusive to women and girls seeking family planning or when they are in labour, and the impact on demand for services can be negative and persistent. This is an equity issue related to training, experience of supportive supervision, terms and conditions of service, deployment and retention and is one of the main determinants of quality of care (and thus equitable access to care). A final point is that SRHR inequalities are often intergenerational and contribute to structural and multi-generational poverty in that women who are unable to complete their education and join the labour market are less able to support themselves and their children, including then, keeping their children in school (girls and boys). And they are less able to decide whether, when and how many children to have or to control household income.

Democracy

Government commitments to raising tax and using available resources for the delivery of quality services in support of health and well-being is a reasonable expectation of women and men in the context of modern democratic processes. The rights of all citizens need to be protected including girls. In addition, accountability for quality of care, including accountability where women and girls (and their infants) have unnecessarily died or suffered debilitating disease during delivery is vital for a functioning democracy as is also a vibrant and positive role of civil society.

Conflict sensitivity, peace and resilience

Needs increase in conflict settings. The restoration of basic services of adequate quality can support and reinforce peace arrangements. The Minimum Initial Service Package (MISP) guides the delivery of SRHR services in the immediate response to a humanitarian and/or conflict setting. Quality family planning, maternal, and gender-based violence (GBV) services are critical elements of this package and need to be available to all girls and women.

Typically, about 4% of a population will be pregnant and many women and girls may not have received sufficient ANC care if they have been internally displaced. More women and girls will be vulnerable to complications during birth and will need as much quality care – including new and underused maternal health commodities – as possible.

Lastly, in conflict settings household vulnerabilities increase with possible loss of assets and income, and increased uncertainty. Girls and boys can be at risk of being taken out of school, forced to work, and/or married young.

Disaster Risk Reduction

No specific or direct contribution to DDR. However, having coherent guidelines, trained health staff and practical, accessible tools and commodities to manage SRHR and all related services especially maternal health care

including the prevention and treatment of maternal emergencies in the context of a resilient health system is relevant to reducing the impact of disasters and the risks to girls and women. Specifically, the Action aims to scale up the availability and use of critical SRHR commodities including those that could be suitable for self-care, reducing impact and saving lives during periods of service disruption and difficult transport.
Other considerations if relevant
N/A

3.4 Risks and Lessons Learnt

Risks relate variously to managing technical, regulatory, data protection. SRHR is associated with political sensitivities, although the FGM, child marriage, data and maternal health focus of the present action is deemed to be relatively less controversial.

Category	**Risks**	**Likelihood (High/ Medium/ Low)**	**Impact (High/ Medium/ Low)**	**Mitigating measures**
External environment	Country governments fail to increase their political commitment to and investments into SRHR including eliminating child marriage and FGM.	Medium	Medium	On-going dialogue and advocacy by all partners around countries' political and financial commitment to health and rights especially by the specific UN agencies and EUDs partnered in the programme. To be effective, these efforts should focus on empirical evidence.
Planning, processes and systems	Available resources are invested too thinly to make any substantial difference at the community level. This risk is linked to the scale of the programme and the importance of working strategically using funds to drive catalytic change.	High	Medium	In mitigation, resources will be invested strategically in intermediary partners and processes especially those with on-going partnerships that reach target communities and other stakeholders (regulatory authorities, networks of CSOs) leveraging on the regional approach
To people and the organisation	Attitude change is slower than expected and girls and women continue to be excluded from health services. The risk is linked to the extent and depth that attitudes underpinning the rights of women and girls need to change across all of society including by health workers, community leaders, parents and families and political and economic decision-makers.	Medium	Medium	Mitigation rests on two elements: maintain a realistic and practical approach with managed expectations about pace of change, coupled with comprehensive programme approaches that target key drivers of change (advocates) and identify and challenge opposition.
To legality and regulatory aspects	Pooled/coordinated procurement processes fail to gain traction in practical day-to-day country supply systems	High	Medium	Mitigation rests on ensuring that the pooled procurement model is designed and implemented in ways that enable countries to solve clearly identifiable problems (including through better

				coordination of existing pooled/ coordinated procurement models). This is more likely when pooled procurement leads to *significant* cost savings and/ or timely delivery of commodities that would otherwise be delayed and/ or fulfilment of orders for unusual or difficult to access commodities.
Planning processes and systems/ External environmental	Country commitments to health systems strengthening and inclusive services not sustained or maintained	Medium	Medium	On-going dialogue and advocacy by all partners including the MOH with the Ministry of Finance and also around political and financial commitment to health and rights especially by UN agencies and EUDs.
Planning, processes and systems	Capacity of regional actors is too limited to implement or support the activities	High	High	Mitigation can take place by directly supporting additional capacity through consultancy linked with the RECs secretariats; Project inputs will be used to support capacity building among RECs.

Lessons Learnt:

Lessons concerning protecting gains and maintaining momentum:

Lessons relate to the experience to date regarding the importance of maintaining momentum around large scale, difficult social norms change (such as eliminating FGM). Such changes require whole communities to take action jointly. It is relatively easy for affected communities to revert to previous practices during periods of fragility or upheaval (such as the Covid-19 crisis). Where progress is accelerating, it is efficient to continue implementing and supporting programmes including well after practices have been abandoned to prevent slippage.

Lessons concerning pooled procurement processes:

Pooled or coordinated procurement has the potential to enable countries to access some kinds of commodities, more inexpensively and with greater reliability than each one individually. This is especially the case for small quantities of specialist medicines. Lessons point to the importance of sustained investment in structure, capacity building and institutional strengthening. Pooled procurement will only serve its purpose where countries have the skills and capacity to quantify needs and plan and manage supply orders and where the procurement body can effectively plan cycles of orders, negotiate effectively with suppliers and manage procurement and payment processes. Despite being clearly useful, pooled procurement mechanisms require substantial and sustained investment and support to become autonomous and efficient.

Lessons concerning the engagement of CSOs in supporting the realisation of SRHR for all girls and women:

CSOs can be effective champions of rights and are well placed, when well organised, to hold governments accountable for their SRHR commitments but they need concrete inputs, skills, development and support. CSOs, especially those engaged in realising SRHR rights for girls and women, need skills and capacity building including around personal development, leadership, knowledge about rights, budget analysis skills and others.

3.5 The Intervention Logic

The underlying intervention logic for this action is that:

IF countries develop policies and strategies to eliminate harmful gender norms and promote gender equality and women's empowerment AND if they legislate a minimum age of marriage at 18 years and pass laws banning female genital mutilation and other harmful practices AND those laws are enforced at all levels of society with sensitivity and support from social and human development services

IF girls are empowered to understand and claim their rights to bodily autonomy, an education, a life without forced marriage AND their parents and families and communities support these claims with broad approbation including from community, traditional and faith leaders, and

IF girls and women's empowerment enable better education and economic outcomes AND basic health and SRHR services and social services including GBV prevention and response

THEN in practical terms, girls will have more opportunities to improve their life chances and determine their own choices AND they will have healthier and more successful pregnancies with lower risk of morbidity and death.

At the same time,

IF health systems strengthen their regulatory and commodity supply capacity in ways that enables them to identify, procure, stock and maintain adequate supplies of critical SRHR commodities at all points of the health system AND

IF through regional mechanisms, common challenges including to contain costs, improve quality, increase procurement efficiency, and increase availability of underused commodities, can be better tackled across countries working in collaboration, AND IF health workers access these commodities and use them correctly especially during pregnancy and birth to save the lives of girls and women during delivery,

THEN girls and women will more likely be able to realise their fertility preferences and decide whether, when and how many children to have, AND fewer girls and women will experience unwanted pregnancy and/ or preventable disability or death during and after labour AND fewer newborns will die at birth or be stillborn.

Furthermore,

IF countries including governments, civil society stakeholders and others are better able to collect, manage and use strategic data for decision-making AND if that data is collected regularly AND consistently used to make budgeting, programming, staffing and other operational decisions,

IF in each country as well as across each African region, citizens - through their civil society organisations and other bodies - can hold governments accountable for the commitments they have made to ensure girls and women can realise their sexual and reproductive health and rights,

THEN progress towards eliminating harmful norms, strengthening service delivery including through improved availability and use of quality SRH commodities and enabling the empowerment of girls and women will steadily increase with wide knock-on or catalytic effects on national economic and social development AND on equity, social inclusion, and health outcomes.

3.6 Logical Framework Matrix

This indicative logframe constitutes the basis for the monitoring, reporting and evaluation of the intervention.
On the basis of this logframe matrix, a more detailed logframe (or several) may be developed at contracting stage. In case baselines and targets are not available for the action, they should be informed for each indicator at signature of the contract(s) linked to this AD, or in the first progress report at the latest. New columns may be added to set intermediary targets (milestones) for the Output and Outcome indicators whenever it is relevant.

- At inception, the first progress report should include the complete logframe (e.g., including baselines/targets).
- Progress reports should provide an updated logframe with current values for each indicator.
- The final report should enclose the logframe with baseline and final values for each indicator.

The indicative logical framework matrix may evolve during the lifetime of the action depending on the different implementation modalities of this action.
The activities, the expected Outputs and related indicators, targets and baselines included in the logframe matrix may be updated during the implementation of the action, no amendment being required to the Financing Decision.

PROJECT MODALITY (3 levels of results / indicators / Source of Data / Assumptions - no activities)

Results	Results chain (@): Main expected results (maximum 10)	Indicators (@): (at least one indicator per expected result)	Baselines (values and years)	Targets (values and years)	Sources of data	Assumptions
Impact	To advance the realisation of sexual and reproductive health and rights in Africa	1. Proportion of women aged 20 to 24 years who were married or in a union before age 15 and before age 18 (SDG indicator 5.3.1) 2. Maternal mortality ratio (Sub-Saharan Africa countries) SDG 3.1 3. Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (SDG 5.6.2)	1 2	1 2	1 2	*Not applicable*
Outcome 1	1. Gains protected and momentum accelerated towards the elimination of harmful practices affecting girls and young women[49] [50]	1.1 Number of countries with updated, costed national action plans to eliminate child marriage and/ or FGM funded from the national budget and under implementation	1.1 1.2	1.1 1.2	1.1 1.2	

[49] The log frame relies on indicators developed, measured and tracked globally: https://www.unicef.org/media/90811/file/Compendium-Indicators-FGM-v3.pdf
[50] Indicators linked to child marriage elimination are drawn from the global program for the elimination of child marriage: https://www.unicef.org/media/143861/file/Phase-III-Summary.pdf

		1.2 Proportion of people who think it is justifiable to subject a woman or girl to FGM, disaggregated at least by sex and age (SI 3.2 amended)				
Outcome 2	2. Increase the availability and use of essential, underused, or difficult to access quality assured SRH commodities	2.1 Number and scale of regional pooled procurement mechanisms in operation in Africa. 2.2 Number of SRHR commodities available through regional pooled procurement mechanisms	2.1 2.2	2.1 2.2	2.1 2.2	
Outcome 3	3. Strengthened accountability for progress towards achieving SDG-linked SRHR targets and commitments	3.1 Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (SDG 5.6.2) 3.2 Number of countries completing and reporting on their SRHR Scorecard every year	3.1 3.2	3.1 3.2	3.1 3.2	
Output 1 relating to Outcome 1	1.1 Reduced child marriage in girls under the age of 18	1.1.1 Number of girls reached with life-skills and comprehensive sexuality education 1.1.2 Number of partnerships established to support social protection and girls' economic empowerment	1.1.1 1.1.2	1.1.1 1.1.2	1.1.1 1.1.2	
Output 2 relating to Outcome 1	1.2 Reduced risk and occurrence of female genital mutilation in girls and young women	1.2.1 Proportion of communities that have made a public declaration of abandonment of female genital mutilation 1.2.2 Percentage of communities where surveillance systems were established to monitor compliance with commitments made during public declarations of FGM abandonment, including commitments made by health service providers	1.2.1 1.2.2	1.2.1 1.2.2	1.2.1 1.2.2	
Output 1 relating to Outcome 2	2.1 Strengthened regional commodity financing systems including pooled procurement arrangements progressively increase availability of quality assured SRHR commodities.	2.1.1 Number of SRH commodities included in regional commodity financing mechanisms 2.1.2 Procurement trainings held in each region	2.1.1 2.1.2	2.1.1 2.1.2	2.1.1 2.1.2	

Output 2 relating to Outcome 2	2.2 Increased country regulatory capacity of SRH commodities leads to increased availability	2.2.1 Number of countries per region procuring stocks of new and underused (tbd) SRH commodities 2.2.2 Increased information sharing among countries on forecasts, stock levels and orders of essential SRHR commodities within regions	2.2.1 2.2.2	2.2.1 2.2.2	2.2.1 2.2.2	
Output 1 relating to Output 3	3.1 Improved collection, management and use of strategic SRHR data	3.1.1 Capacity building workshops held per region to support strategic data and information collection, management and use 3.1.2 Evidence of decision-making using better SRHR data	3.1.1 3.1.2	3.1.1 3.1.2	3.1.1 3.1.2	
Output 2 relating to Output 3	3.2 Strengthened accountability for SRHR commitments through supporting and expanding the role of civil society organisations to monitor progress and	3.2.1 Number of CSOs attending advocacy capacity building and training events 3.2.2 Evidence of CSO activities for accountability on GBV and/or family planning and/or SRHR generally especially for girls and young women	3.2.1 3.2.2	3.2.1 3.2.2	3.2.1 3.2.2	

4 IMPLEMENTATION ARRANGEMENTS

4.1 Financing Agreement

In order to implement this action, it is not envisaged to conclude a financing agreement with the region or with any country or territory.

4.2 Indicative Implementation Period

The indicative operational implementation period of this action, during which the activities described in section 3 will be carried out and the corresponding contracts and agreements implemented, is 60 months from the date of adoption by the Commission of this Financing Decision.

Extensions of the implementation period may be agreed by the Commission's responsible authorising officer by amending this Financing Decision and the relevant contracts and agreements.

4.3 Implementation of the Budget Support Component

N/A

4.4 Implementation Modalities

The Commission will ensure that the EU rules and procedures for providing financing to third parties are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures[51].

4.4.1 Indirect Management with an entrusted entity

4.4.1.1 Indirect management with an entrusted entity

A part of this action may be implemented in indirect management with entities, which will be selected by the Commission's services using the following criteria:

- Demonstrated track record in active engagement in Africa on social norms change including leadership of global or regional programmes for the elimination of child marriage and FGM
- Prior experience implementing EU funded support to child marriage and FGM elimination
- Specific expertise in SRHR services and gender
- Established relationships with country governments and national health and social protection authorities.
- Established relationships with regional bodies at continental and/or sub-continental levels
- Operational capacity on the ground in targeted countries to carry out the envisaged activities, in-country presence across most countries

The implementation by these entities entails the continental component of the action i.e. Specific Objective 1 of the Action "Protect gains and accelerate momentum towards the elimination of harmful practices affecting girls and young women".

4.4.1.2 Indirect management with an entrusted entity

A part of this action may be implemented in indirect management with entities, which will be selected by the Commission's services using the following criteria:

- Existing, well-established relationships with the concerned African regional entities
- Contributing to broad ownership of advancing the SRHR agenda in the African region
- Ability to support African stakeholders in the field of SRH commodities and in strengthening SRHR accountability

[51] www.sanctionsmap.eu. Please note that the sanctions map is an IT tool for identifying the sanctions regimes. The source of the sanctions stems from legal acts published in the Official Journal (OJ). In case of discrepancy between the published legal acts and the updates on the website it is the OJ version that prevails.

- Ability to reinforce regional and country leadership and mandates
- Demonstrate flexible and responsive programming model and approaches
- Capacity to deliver programmes that focus on systems and institutional strengthening
- Track record in delivering with value for money

The implementation by these entities entails the regional components of the action i.e. Specific objective 2 "Increase the availability and use of essential, underused, or difficult to access quality assured SRH commodities" and Specific Objective 3 "Strengthen accountability for progress towards achieving SDG-linked SRHR targets and commitments".

4.4.2 Changes from Indirect to Direct Management Mode (And Vice Versa) due to Exceptional Circumstances (One Alternative Second Option)

Should the implementation through indirect management with an entrusted entity as described in section 4.4.1 reveal not possible due to circumstances outside of the Commission's control, the Commission will revert to direct management through grants contributing to achieving Specific Objective 1, 2 and 3 of the action, with the type of applicants targeted: Potentially eligible candidates are international organizations as defined in Article 156 of the Financial Regulation of the European Union and NGOs and economic operators such as SMEs established in eligible countries as indicated in the basic act.

4.5. Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply, subject to the following provision.

The Commission's authorising officer responsible may extend the geographical eligibility on the basis of urgency or unavailability of services in the markets of the countries or territories concerned, or in other duly substantiated cases where application of the eligibility rules would make the realisation of this action impossible or exceedingly difficult (*Article 28(10) NDICI-Global Europe Regulation*).

4.6. Indicative Budget

Indicative Budget components	**EU contribution (Amount in EUR)**
Implementation modalities – cf. section 4.4	
Continental Component composed of **Specific Objective 1**: Protect gains and accelerate momentum towards the elimination of harmful practices affecting girls and young women	10 000 000
Indirect management with entrusted entities cf. section 4.4.1.1	10 000 000
Regional Component composed of **Specific Objective 2:** Increase the availability and use of essential, underused, or difficult to access quality assured SRH commodities **Specific Objective 3:** Strengthen accountability for progress towards achieving SDG-linked SRHR targets and commitments	15 000 000 15 000 000
Indirect management with entrusted entities cf. section 4.4.1.2	30 000 000
Evaluation – cf. section 5.2	May be covered by another Decision

Audit – cf. section 5.3	
Totals	**40 000 000**

4.7 Organisational Set-up and Responsibilities

This action is part of the regional Team Europe Initiative (TEI) on SRHR in Africa that is the general framework to which the three specific objectives of this action contribute. The objectives of this Action contribute to the corresponding three Strategic Objectives of the TEI Joint Intervention Logic (JIL), with a structured and coherent approach. The action as a whole, will therefore be embedded in the overarching coordination and management structure of the SRHR TEI:

- The TEI Oversight and Coordination Committee (OCC) will be responsible to provide and adjust the longer-term vision of the TEI in consistency with relevant strategic orientations by TEI members and partners, and facilitate the policy dialogue with key African partners, including delivery of joint messages to support the TEI ambition, and ensure alignment of its priorities with those of the partner regions.
- TEI Regional Management Groups will be responsible for the operational management, implementation, monitoring and communication of the TEI at regional level.
- Above this particular TEI, a High-Level Steering Committee of the EU-AU Health Flagships is being established to provide high level political steer and strategic guidance of the health programmes pertaining to AU-EU relations, including health TEIs.

Organisational set up. The programme will be delivered by trusted entities working in partnership with other trusted entity each taking the lead to implement the programme in a defined region (West Africa and Southern/ East Africa) working in partnership with other MS.

Programme Steering Committee. SO1 will use established governance arrangements. For SO2 and SO3, one Steering Committee will be established with a mandate to monitor progress and ensure strategic direction. The Steering Committee will meet at least twice yearly and will be comprised of major stakeholders including at least once country from each REC, the RECs, implementing partners including MS, and other stakeholders. Subject to negotiation, one steering committee may be formed for each of the regions.

Operational day-to-day management of the programme. Implementing partners (trusted entities) will be responsible for coordination of their designated areas of the Action. In this regard, designated managers will hold responsibilities for the management of funds, delivery of results and achievement of programme outcomes and will be accountable for the contribution of all partners and for the achievement of full value for money.

As part of its prerogative of budget implementation and to safeguard the financial interests of the Union, the Commission may participate in the above governance structures set up for governing the implementation of the action and may sign or enter into joint declarations or statements, for the purpose of enhancing the visibility of the EU and its contribution to this action and ensuring effective coordination.

5 PERFORMANCE MEASUREMENT

5.1 Monitoring and Reporting

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process, and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (Outputs and direct Outcomes) as measured by corresponding indicators, using as reference the log frame matrix (for project modality) and the partner's strategy, policy or reform action plan list (for budget support).

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

Roles and responsibilities for data collection, analysis and monitoring:

Joint implementation will be promoted and mechanisms to ensure the joint reporting may also be put forward Partners will ensure consistent reporting formats and timeframes in order that the lead partner can compile coordinated reports.

All monitoring and reporting shall assess how well the action promotes the principle of gender equality which lies at the heart of this programme and takes a human rights-based approach and enables the rights of persons with disabilities including through strengthening inclusion and diversity. Data collected, where appropriate and possible, will be disaggregated by sex and age, and by disability if tenable.

Indicators of changes in situation with health services for persons with disabilities will include those on inclusive information, removed barriers, inclusive services, trained personnel of health services, aids and others supports.

5.2 Evaluation

Having regard to the importance and nature of the action, a mid-term and a final evaluation may be carried out for this action or its components via independent consultants contracted either by the implementing partners or by the Commission.

Mid-term evaluation may be carried out for problem solving and learning purposes, in particular with respect to progress made in contribution to larger programme goals including the potential value of extending to a second phase.

Final evaluation may be carried out for accountability and learning purposes at various levels (including for policy revision, taking into account in particular the fact that the elements of the programme have varying measures of success; where piloting new approaches, a formative-summative final evaluation will contribute to decision-making about future scale up, for example in relation to pooled procurement mechanisms.

As part of the TEI, and where practicable, evaluations jointly with contributing Member States will be the preferred option to provide an overview of the action within the larger impact of the TEI.

The Commission shall inform implementing partners at least 1 month in advance of the dates envisaged for the evaluation missions. Implementing partners shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities.

Evaluation reports may be shared with the partners and other key stakeholders following the best practice of evaluation dissemination. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, apply the necessary adjustments.
In addition, all evaluations shall assess to what extent the Action is taking into account human rights-based approaches as well as whether and how the Action contributes to gender equality and women's empowerment and disability inclusion. The evaluation process will include expertise on human rights, disability and gender equality assessment.

Evaluation financing may be covered by another measure constituting a Financing Decision.

5.3 Audit and Verifications

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audit or verification assignments for one or several contracts or agreements.

6 STRATEGIC COMMUNICATION AND PUBLIC DIPLOMACY

The 2021-2027 programming cycle will adopt a new approach to pooling, programming and deploying strategic communication and public diplomacy resources.
In line with the 2022 "Communicating and Raising EU Visibility: Guidance for External Actions", it will remain a contractual obligation for all entities implementing EU-funded external actions to inform the relevant audiences of the Union's support for their work by displaying the EU emblem and a short funding statement as appropriate on all communication materials related to the actions concerned. This obligation will continue to apply equally, regardless of whether the actions concerned are implemented by the Commission, partner countries, service providers, grant beneficiaries or entrusted or delegated entities such as UN agencies, international financial institutions and agencies of EU member states.

However, action documents for specific sector programmes are in principle no longer required to include a provision for communication and visibility actions promoting the programmes concerned. These resources will instead be consolidated in Cooperation Facilities established by support measure action documents, allowing Delegations to plan and execute multiannual strategic communication and public diplomacy actions with sufficient critical mass to be effective on a national scale.

Appendix 1 REPORTING IN OPSYS

A Primary Intervention (project/programme) is a coherent set of activities and results structured in a logical framework aiming at delivering development change or progress. Identifying the level of the primary intervention will allow for:

Articulating Actions or Contracts according to an expected chain of results and therefore allowing them to ensure efficient monitoring and reporting of performance;

Differentiating these Actions or Contracts from those that do not produce direct reportable development results, defined as support entities (i.e., audits, evaluations);

Having a complete and exhaustive mapping of all results-bearing Actions and Contracts.

Primary Interventions are identified during the design of each action by the responsible service (Delegation or Headquarters operational Unit).

The level of the Primary Intervention chosen can be modified (directly in OPSYS) and the modification does not constitute an amendment of the action document.

The intervention level for the present Action identifies as (tick one of the 4 following options);

Action level (i.e. Budget Support, blending)		
☒	Single action	Present action: all contracts in the present action
Group of actions level (i.e. top-up cases, different phases of a single programme)		
☐	Group of actions	Actions reference (CRIS#/OPSYS#):
Contract level		
☒	Single Contract 1	Agreement with entrusted entities
☒	Single Contract 2	Agreement with entrusted entities
☒	Single Contract 3	Agreement with entrusted entities
Group of contracts level (i.e. series of programme estimates, cases in which an Action includes for example four contracts and two of them, a technical assistance contract and a contribution agreement, aim at the same objectives and complement each other)		
☐	Group of contracts 1	NA