Sweden
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2gether 4SRHR

Fast tracking the attainment of sexual and reproductive health and rights in Eastern and Southern Africa

UNAIDS

UNFPA

unicef
for every child

World Health Organization

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Acronyms

AA	Administrative agent
AHO	African Health Observatory Network
AIDS	Acquired immune deficiency syndrome
AGYW	Adolescent girls and young women
ANC	Antenatal care
ART	Antiretroviral therapy
ARVs	Antiretroval therapy
ASRHR	Adolescent sexual and reproductive health and rights
AU	African Union
AUC	African Union Commission
BEmONC	Basic Emergency Obstetric and Newborn Care
CA	Convening Agent
CAC	Comprehensive abortion care
CARMMA	Campaign to Accelerate the Reduction of Maternal Mortality in Africa
CHE	Current health expenditure
CSE	Comprehensive sexuality education
CSO	Civil society organization
DAO	Delivering as one
DFA	Data for All
DSS	Demographic Surveillance Sites
EAAR	UNAIDS Expanded Accelerated AIDS Response towards High Level Meeting (HLM) targets and elimination commitments in the ESA Region
EAC	East African Community
ECHO	Evidence for Contraceptive Options and HIV Outcomes Trial
Emoc	Emergency obstetric care
EMTCT	Elimination of mother-to-child transmission of HIV and congenital syphilis
ESA	Eastern and Southern Africa
ESAR	East and Southern Africa Region
ESARO	Eastern and Southern Africa Regional Office
FP	Family planning
GFF	Global Financing Facility for women, children, and adolescents
GBV	Gender-based violence
GF	Global Fund
GNI	Gross national income

H6	A partnership between UNAIDS, UNIFPA, UNICEF, UN-Women, WHO and the World Bank.
HCW	Healthcare worker
HHA	Harmonization for Health in Africa
HIV	Human immunodeficiency virus
HLM	High Level Meeting
HMIS	Health management information system
HPDN	Humanitarian-peace-development nexus
HPV	Human papillomavirus
ICPD	International Conference on Population and Development
IOM	International Organization for Migration
JSF	Joint SRHR Fund
KP	Key population
LGBTQI	Lesbian, gay, bisexual, transgender, queer, and intersex persons
M&E	Monitoring and evaluation
MEL	Monitoring, evaluation, and learning
MISP	The Minimum Initial Service Package on SRHR
MMD	Multi-month dispensing of
MMR	Maternal mortality ratio
MOU	Memorandum of Understanding
MP	Maputo Protocol
MPoA	Maputo Plan of Action
MSM	Men who have sex with men
MTCT	Mother-to-child transmission of HIV
OOPE	Out-of-pocket expenditure
OCHA	UN Office for the Coordination of Humanitarian Affairs
OHTA	UNICEF Optimizing HIV Treatment Access for pregnant and breastfeeding women Initiative
PEPFAR	The President's Emergency Plan for AIDS Relief
PF	Parliamentary Forum
PHC	Primary health care
PLHIV	People living with HIV
RACI	Responsible, accountable, confidential, and informed
RBM	Results-based management
RCP	Regional Collaborating Platform
RECs	Regional Economic Communities
RIASC	Regional Inter-Agency Standing Committee

RHPT	Regional Humanitarian Partnership Team
RIWG	Regional Interagency Working Group
RMNCAH	Reproductive, maternal, new-born, child, and adolescent health
RISC	Regional Interagency Steering Committee
RITT	Regional interagency thematic team
SAA	Standard Administrative Agreement
SADC	Southern African Development Community
SDG	Sustainable Development Goals
Sida	Swedish International Development Agency
SLF	Strategic Leadership Forum
SRHR	Sexual and reproductive health and rights
SRMNCAH	Sexual, reproductive, maternal, new-born, child and adolescent health
STI	Sexually transmitted infection
TA	Technical assistance
TOC	Theory of change
UBRAF	Unified Budget, Results and Accountability Framework
UHC	Universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNSDCF	United Nations Sustainable Development Cooperation Frameworks
WHO	World Health Organization

Proposal at a glance

Title of Proposal	**2gether 4 SRHR: Fast tracking the attainment of sexual and reproductive health and rights in Eastern and Southern Africa**
Participating United Nations Organizations	UNAIDS, UNFPA, unicef for every child, World Health Organization
Region	Eastern and Southern Africa
Total Budget Proposed	SEK 425,000,000.00
Programme Duration	01 April 2023 – 31 March 2027
Vision	All people in the East and Southern Africa region are empowered and supported to exercise their SRH Rights and can access quality, people-centred integrated SRHR, HIV and GBV services.
Goal	Contribute towards the attainment of the SRHR-related targets of the SDGs.
Relevant Sustainable Development Goals	 **GOAL 3:** Ensure healthy lives and promote well-being for all at all ages. Contributing towards reducing maternal mortality (3.1), ending the AIDS epidemic (3.2), ensuring universal access to SRHR (3.7) and achieving universal health coverage (3.8).  **GOAL 5:** Achieve gender equality and empower all women and girls. Eliminating all forms of violence against all women and girls (5.2) and ensuring universal access to SRHR (5.6).
Beneficiaries	• Adolescents and young people • Women reproductive age 15-49 • Men • Key populations • People affected by crisis.
Partners	African Union, Regional Economic Communities (East African Community, Southern African Development Community), continental and regional forums of Parliamentarians, regional human rights institutions, regional professional associations, other UN agencies, civil society.

Proposal at a glance (cont'd)

Outcomes	**OUTCOME 1:** Legal, policy and financial environment strengthened to enable beneficiaries to access services and realize their SRHR rights. **OUTCOME 2:** Increased access to and utilisation of quality, people-centred integrated SRHR services. **OUTCOME 3:** Gender and social norms and behavioural drivers addressed for the realization of SRHR for all. **OUTCOME 4:** Resilient health systems and communities are enabled to ensure the continuity of SRHR Services during crises.
Implementation Modalities	**Regional Interagency Working Group (RIWG):** supported by interagency M&E and Communications Working Groups that will oversee the implementation of the programme. **Regional Programme Implementation:** through drawing on the collective technical expertise of the four partner agencies to support continental and regional coordination and harmonization, advocacy, knowledge brokering, provision of quality technical assistance, capacity building, promoting South-South learning and exchange and innovation. This includes piloting Regional Interagency Thematic Teams, a time-bound flexible mechanism that brings together the collective efforts of the four agencies to address a specific thematic area. **Joint SRHR Fund (JSF):** a flexible funding modality that provides time-bound and catalytic support for applied learning in countries selected against defined criteria and promotes innovative approaches to address key or emerging issues using small grants. **Technical Assistance Hub (TA-Hub):** A technical assistance, knowledge management, and capacity-building resource for regional partners and countries in the region.
Financial Management	A Joint UN Programme implemented in accordance with guidance by the United Nations Development Group using a pass-through modality. Administrative Agent: UNFPA Division for Strategic Communication and Partnerships. Convening Agent: UNFPA East and Southern Africa Regional Office. Each participating UN agency will be responsible for the administration of funds disbursed to them based on their policies and procedures and will be accountable for the resources and results entrusted to them.
Governance Structures	**Strategic Leadership Forum (SLF)** – platform for high level strategic dialogue between the regional directors and participating development partners. **Regional Interagency Steering Committee (RISC)** – Provides strategic direction and oversight over programme implementation comprised of the Deputy Regional Director or a representative as designated by the Regional Director and participating donor agencies. **Regional Interagency Working Group (RIWG)** – oversees the implementation of the programme, supported by interagency M&E and Communications Working Groups.

01.
Introduction

Since 2018, the Regional Offices of UNAIDS, UNFPA, UNICEF and WHO have been implementing 2gether 4 SRHR, a four-year joint UN regional programme, in partnership with Sida.

The development of the programme aimed to draw upon lessons learnt, as well as scale up and accelerate regional action through combining the joint efforts of the four partner UN organizations. This would be achieved by drawing upon previous investments by Sida through the UNAIDS/UNFPA Linkages Project; the UNICEF Optimizing HIV Treatment Access for pregnant and breastfeeding women (OHTA) Initiative; and the UNAIDS Expanded Accelerated AIDS Response towards High Level Meeting (HLM) targets and elimination commitments in the ESA Region (EAAR). WHO was included as a new partner with a view to ensure that programme implementation was aligned to global norms and standards.

The joint programme combined the comparative strengths and the technical expertise of the four participating UN agencies to improve the sexual and reproductive health and rights (SRHR) of all people in Eastern and Southern Africa (ESA) through using a regional approach with applied learning in ten countries. The beneficiaries of 2gether 4 SRHR included: adolescent girls and young people, pregnant and breastfeeding women, people living with HIV (PLHIV), men who have sex with men (MSM), lesbian, gay, bisexual, transgender and intersex persons (LGBTI), and sex workers.

2gether 4 SRHR is aligned to the Programme of Action of the International Conference on Population and Development (ICPD)[1] and outcome statements of related forums, including the ICPD+25 Nairobi Summit. During the implementation period, the programme incorporated the definition of SRHR and findings of the Lancet-Guttmacher Commission on SRHR[2] to inform its work.

2gether 4 SRHR is guided by the SRHR strategic frameworks of the African Union (AU), including the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), The Maputo Plan of Action for the Operationalization of the Sexual and Reproductive Health and Rights (SRHR) Continental Policy Framework, and the Campaign to Accelerate the Reduction of Maternal Mortality in Africa (CARMMA). The programme is aligned to SRHR regional frameworks and

[1] UNFPA (1994). *Programme of Action adopted at the International Conference on Population and Development*. Cairo, Egypt.

[2] Starrs, M. (2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. *The Lancet*, May 9, 2018. http://dx.doi.org/10.1016/ S0140-6736(18)30293-9.

strategies developed by the East African Community (EAC) and the Southern Africa Development Community (SADC).

This proposal for a Phase II of 2gether 4 SRHR is informed by the achievements and lessons of 2gether 4 SRHR over the past four years and the unfinished agenda of SRHR in the region, with the goal of fast-tracking the attainment of the SRHR related targets of the Sustainable Development Goals (SDGs) in Eastern and Southern Africa (ESA), in support of the Decade for Action.

This proposal outlines the current SRHR situation in the ESA region. It highlights the accomplishments, challenges and lessons learnt from Phase I of the 2gether 4 SRHR programme, which Phase II of the programme will build on. It defines the theory of change, the outcomes and outputs that the programme aims to advance, and describes how the programme will be monitored, evaluated, and lessons documented and amplified. It defines the programme implementation modalities that will further enhance Delivering as One UN. It demonstrates how 2gether 4 SRHR will continue to contribute towards global, continental, and regional frameworks, guided by the global and regional strategies of the four partner UN agencies. It defines the governance structures that are further streamlined to enhance the efficient and effective implementation of the programme.

02.

Context analysis, achievements and lessons learnt

Despite significant progress made in the region in strengthening SRHR outcomes for all people, progress in achieving the SDG targets is inconsistent; with faster progress being made in some areas, while others lag behind.

Progress is hampered by restrictive laws and policies, limited domestic and donor investments in areas of SRHR, weak health systems, restrictive social and cultural norms pertaining to SRHR, humanitarian crises linked to conflict, climate change, outbreaks of disease, and socioeconomic instability linked to rising inequality and poverty. Given the current pace and scale of the challenges facing the region and the impact of COVID-19, it is unlikely that the region will meet the SDG targets without a concerted effort.

2.1 Progress in meeting the SRHR targets of the Sustainable Development Goals

In 2020, the estimated population of the ESA region was 618 million, with adolescents and young people aged 10-24 years and women accounting for 33 per cent and 50 per cent of the population respectively.[3]

The maternal mortality ratio (MMR) has declined by more than 50 per cent since 1994, from 858 to 391 per 100,000 live births in 2017, a rate of 4 per cent per annum. This is significantly lower than the 12 per cent required for the region to reach the SDG MMR goal of 70 deaths by 100,000 live births by 2030[4]. The maternal mortality ratio is impacted by HIV accounting for more than 10 per cent of maternal deaths,[5] and by unsafe abortion. The average annual number of abortions among women aged 15–49 in the ESA region in the period 2015-2019 was estimated to be 4.7 million,[6] of which 77 per cent are estimated to be unsafe, with a resultant heavy toll on adolescent girls and women and their families.[7]

Progress in addressing the unmet need for family planning amongst women aged 15-49 years is slow and decreased by only 7 per cent from 30 per cent in the period 1990-1995 to 23 per cent by 2015-2018.

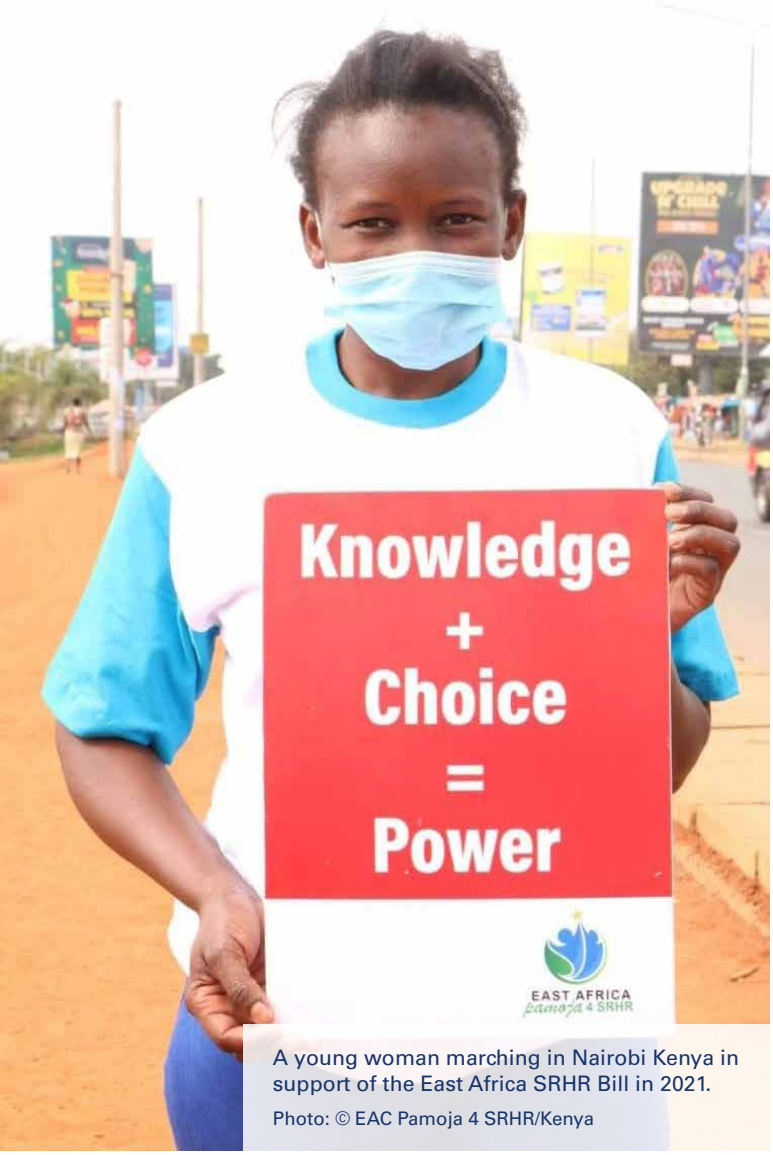
3 UNFPA (2021). *Strategic Plan 2022-2025, Annex 4.6: East and Southern Africa Regional Programme.*

4 UNFPA. *The State of the World Population Report*, 2019 and 2021.

5 UNFPA (2021). *Strategic Plan 2022-2025, Annex 4.6: East and Southern Africa Regional Programme.*

6 Guttmacher Institute: https://data.guttmacher.org/regions

7 Guttmacher Institute: https://www.guttmacher.org/report/from-unsafe-to-safe-abortion-in-subsaharan-africa#



A young woman marching in Nairobi Kenya in support of the East Africa SRHR Bill in 2021.

Photo: © EAC Pamoja 4 SRHR/Kenya

This equates to less than 1 per cent per annum.[8] The unmet need for contraceptives is highest amongst unmarried adolescents aged 15-19 (42 per cent) and unmarried young women aged 15-24 (29 per cent). The unmet need for family planning amongst adolescent girls and young women (AGYW) has translated to a modest decline in the adolescent birth rate from 139 births per 1000 girls in the period 1990-1995, to 111 in the period 2015-2018.[9]

ESA remains the epicentre of the global HIV epidemic, despite a 43 per cent reduction in new infections and a 50 per cent reduction in AIDS-related deaths between 2010 and 2020. The region is home to 20.6 million people living with HIV, more than half the total number of PLHIV globally. Fourteen of the world's most affected countries are in the region and collectively contributed to 85 per cent of all new infections globally. Women comprise 60 per cent of people living with HIV, and AGYW aged 15-24 years accounted for 32 per cent of all new HIV infections in 2020, as well as 70 per cent of all new infections amongst AGYW globally. An estimated 32 per cent of new HIV infections in the region are among key populations (KPs).[10]

High proportions of women and girls in the region continue to experience sexual and gender-based violence (GBV). One third of women (30.5 per cent) reported experiencing intimate partner violence in the past 12 months in the 16 Member States of the SADC region.[11] The region has witnessed significant increases in GBV during the COVID-19 pandemic. The GBV helpline in Kenya reported a 775 per cent increase in calls during the pandemic, and Zimbabwe saw a 90 per cent increase in calls to its telephone helplines.[12] In Uganda and the Democratic Republic of the Congo, reports of GBV at health facilities increased during COVID-19 pandemic. In August 2019 there were an estimated 4273 cases of GBV reported, compared to 6,437 cases in 2020.[13]

SRHR outcomes are also impacted by humanitarian crises and disease outbreaks. As of January 2020, over 45 million people in the region were estimated to need

8 UNFPA ESARO (2019). *SRHR Trend Analysis*. Hera. Belgium.

9 UNFPA (2019). *SRHR Trends in the East and Southern Africa (ESA) Region*. Hera. Belgium.

10 UNAIDS (2021). *Global AIDS Update: Confronting inequalities*. Accessed from: https://www.unaids.org/sites/default/files/media_asset/2021-global-aids-update_en.pdf.

11 SADC (2021). *Scorecard for Sexual and Reproductive Health and Rights in the SADC Region: 2021 Milestone Scorecard*. Accessed from: https://www.sadc.int/srhrscorecard/.

12 UNFPA (2021). *Strategic Plan 2022-2025, Annex 4.6: East and Southern Africa Regional Programme*.

13 Adegboyega, A. (2021). *Monitoring continuity of essential SRMNCAH services in the African region (Feb 2020 – May 2021*. Presentation delivered at SRHR funders meeting.

humanitarian assistance, and over 12 million people were internally displaced. Outbreaks of diseases such as Ebola and Cholera have impacted negatively on the SRHR of people and their access to quality services, but none have had as profound and widespread an impact as COVID-19.[14]

COVID-19 has significantly impacted on SRHR outcomes in the region owing to restricted population movements, fear, disruptions to global supply chains, lack of personal protective equipment, stock outs of commodities and supplies, increased unemployment, school closures, and deepening poverty. COVID-19 disrupted the provision of maternal health, family planning and HIV prevention, testing, and treatment services. Significant increases in reports of GBV, adolescent pregnancies, and harmful practices such as child marriage have been reported. The vulnerabilities of key populations, refugees and migrants were further exacerbated owing to exclusion from social protection schemes as well as SRHR and COVID-19 services, including vaccines.[15]

There are several contextual factors beyond health that continue to undermine the development of the region; including low economic growth rates, widening inequality between rich and poor, rising levels of unemployment, an increasing divide between urban and rural areas and those digitally connected; all of which have been further compounded by the pandemic and the impact of climate change.[16,17]

2.2 Progress in meeting global, continental, regional and country commitments

Countries in the region have committed, endorsed, or ratified various global, continental and regional commitments and frameworks on SRHR.

Global commitments and frameworks

Existing global commitments include Agenda 2030 and the SDGs; the Programme of Action of the ICPD and related outcome documents; and the Global Strategy for Women, Children's and Adolescent Health.

The ICPD Programme of Action defines reproductive health as "*the state of complete physical, mental and social well being, in all matters relating to the reproductive systems and to its functions and processes*."[18] It defines several sexual and reproductive rights and the core components of reproductive health in a primary health care (PHC) context.

Building on the ICPD Programme of Action, the Global Strategy for Women, Children's and Adolescent Health has as its vision to "*ensure a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping sustainable and prosperous societies*."[19]

[14] UNFPA (2021). *Strategic Plan 2022-2025, Annex 4.6: East and Southern Africa Regional Programme.*

[15] Presentations by the Joint UN Working Group: *Monitoring Continuity of Essential Health Services in Southern Africa, Feb - Dec 2020 & Impact of COVID-19 on essential SRHR and HIV services: Highlights of preliminary findings of second monitoring of continuity of SRHR services.*

[16] UNDP (2022). *New threats to human security in the Anthropocene: Demanding greater solidarity.* New York.

[17] Lopez, H. (2021). COVID-19 in Eastern and Southern Africa: Four Hurdles to Recovery in the Race to Protect the Region's Poorest. The East African, March 19. Accessed from: https://www.worldbank.org/en/news/opinion/2021/03/23/covid-19-in-eastern-and-southern-africa-four-hurdles-to-recovery-in-the-race-to-protect-the-region-s-poorest.

[18] UNFPA. *ICPD Programme of Action.* pp. 45 – 49.

[19] Every Woman Every Child (2017). *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).* https://www.everywomaneverychild.org/wp-content/uploads/2017/10/EWEC_GSUpdate_Brochure_EN_2017_web.pdf

A family waiting outside a clinic in the Omaheke region of Namibia.

Photo: © 2gether 4 SRHR/Namibia

Echoing the ICPD Programme of Action, the Lancet-Guttmacher Commission on SRHR provides an expanded definition of SRHR with clearly defined rights and a core package of interventions in relation to SRHR.

In 2019, UN Member States adopted the Political Declaration of the High-level Meeting on Universal Health Coverage (UHC) that incorporated sexual and reproductive health services and rights, based on ICPD and Beijing Platform for Action review documents.20 UHC is defined as "*all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course.*"[21]

Continental commitments and frameworks

At a continental level, the AU Agenda 2063 recognises the need to expand access to quality SRHR services to achieve its goal of eradicating poverty.[22] Key frameworks such as the Maputo Protocol (MP) define the rights of women that need to be promoted, realized and protected to enable them to fully enjoy all their human rights. Member States are obliged to report every two years on legislative and other measures undertaken towards the full realization of the rights enshrined in the Maputo Protocol, and the African Union commission (AUC) secretariat has developed the Maputo Protocol Scorecard and Index to enhance accountability by Member States.[23]

[20] United Nations (2019). *Political Declaration of the High-Level Meeting on Universal Health Coverage: Moving towards a healthier world.* Accessed from: https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf.

[21] WHO (2022). *Critical considerations and actions for achieving universal access to sexual and reproduc*tive health in the context of Universal Health Coverage through a primary health care approach. https://www.who.int/publications/i/item/9789240052659.

[22] African Union (2015). *Agenda 2063: The Africa we want.* Accessed from: https://au.int/en/agenda2063/overview.

[23] African Union Commission (2005). *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.* (Maputo Protocol).

The AU Continental Policy Framework on SRHR aims to mainstream the harmonization of reproductive health issues into national, sub-regional and continental development initiatives in support of the realization of the ICPD Programme of Action and the SDGs.[24] The Maputo Plan of Action outlines actions to be undertaken by AU Member States to end preventable maternal, new-born, child and adolescent deaths by expanding contraceptive use; reducing levels of unsafe abortion; ending child marriage; eradicating harmful traditional practices – including female genital mutilation; eliminating all forms of violence and discrimination against women and girls; and ensuring access of adolescents and youth to SRH by 2030 in all countries in Africa.[25]

Launched in 2009, the Campaign on Accelerated Reduction on Maternal Mortality in Africa (CARMMA) aims to operationalise key priority areas enshrined in the 2005 AU Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa and the Maputo Plan of Action (MPoA). The CARMMA reproductive, maternal, new-born, child and adolescent health (RMNCAH) Scorecard is a peer-reviewed accountability mechanism that Member States are expected to report against to track progress.[26]

Regional commitments and frameworks

Regional commitments, strategies and frameworks developed by the Regional Economic Communities (RECs) aim to harmonize the response across countries, in support of the attainment of global and continental commitments.

The Integrated Health Programme of the EAC aims to eliminate preventable maternal, new-born and child deaths, incidence of HIV and AIDS, and improve the wellbeing of women, children, adolescents and families in the EAC. Progress is tracked and reported to the EAC Council of Ministers through the integrated RMNCAH/HIV Scorecard of the EAC.[27]

The SADC SRHR Strategy (2019-2030) aims to ensure that all people in SADC enjoy a healthy sexual and reproductive life, have sustainable access, coverage, and quality SRHR services, information, and education; and can fully realize and exercise their SRH rights, as integral to sustainable human development in SADC. Progress with the realization of this strategy is monitored through the SADC SRHR Scorecard.[28]

Edinah, a midwife trained by 2gether 4 SRHR at Kisugu Health Centre in Uganda after delivering a healthy new born.
Photo: © 2gether 4 SRHR/Uganda

[24] African Union Commission (2005). *Sexual and Reproductive Health and Rights: Continental Policy Framework*. Accessed from: https://au.int/en/documents/20120327/continental-policy-framework-sexual-and-reproductive-health-and-rights.

[25] African Union Commission (2016). *Maputo Plan of Action 2016 – 2030*. Accessed from: https://au.int/sites/default/files/documents/24099-poa_5-_revised_clean.pdf.

[26] African Union Commission (2009). *Campaign on accelerated reduction of maternal mortality in Africa*. Accessed from: https://au.int/en/sa/carmma.

[27] East African Community (2017). *EAC Integrated Health Programme*. Accessed from: https://health.eac.int/eihp#gsc.tab=0.

[28] Southern African Development Community (SADC) (2019). *Strategy for Sexual and Reproductive Health and Rights in the SADC Region, 2019 – 2030*. Gaborone, Botswana.

How 2gether for SRHR contributed towards harmonizing and advancing SRHRin East and Southern Africa

2gether 4 SRHR partnered with and provided technical assistance to the RECs to develop, harmonize and monitor the implementation of regional frameworks using peer review accountability mechanisms to advance SRHR.

- EAC: The programme provided technical assistance to support the development of a Joint Ministerial Commitment in support of ICPD +25 and guidelines on the integration of RMNCAH/HIV integration. It supported the EAC to track progress using its integrated RMNCAH Scorecard.
- SADC: The programme assisted SADC to develop its Strategy for SRHR (2019 - 2030) and scorecard. The baseline scorecard was developed in 2019 and the first milestone score-card produced in 2021, providing a barometer of progress made. The programme supported SADC to develop its Key Population HIV/SRHR Strategy.

The programme strengthened regional coordination through convening annual meetings of SRHR Managers and National AIDS Council Directors, in partnership with SADC and the EAC, to develop regional guidance linked to global guidance, and to take stock of progress made using peer accountability mechanisms (scorecards), disseminating evidence, and sharing emerging and promising practices. The outcomes of these meetings fed into the meetings of senior officials convened at the level of Permanent Secretaries, and were validated by the Ministers of Health providing the political leadership and commitment to support implementation.

Lessons learnt that the programme would build upon include:

- The need to strengthen collaboration with the AUC through identifying entry points, opportunities, and approaches to engage the AUC.
- Ensuring that RECs and regional parliamentary forums have adequate financial and human resources to lead and drive the regional agenda.
- The need to ensure that continental and regional frameworks are harmonized and incorporated into national policies and strategies. A review is being undertaken to set a baseline on the extent to which national SRHR policies and frameworks are aligned to continental commitments in the ESA region.

2.3 Strengthening the legal, policy and financial environment

Ensuring that SRHR is incorporated into national laws, policies, strategies and plans is a key consideration for ensuring universal access to SRHR. This includes ensuring that:

- Laws, policies and strategies are aligned to human rights, as well as global, continental and regional frameworks;
- There are regional and national coordination mechanisms that allow for collective action reduce duplication and track progress; and
- Investments in SRHR are increased.

Legal and policy environment

In the ESA region, several legal and policy provisions continue to limit the ability of women, adolescents, young people, and key populations to exercise and attain their SRH rights.

Access to safe abortion services

The MP defines five instances upon which women on the continent should be able to access comprehensive abortion care (CAC) services, including: sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

The MPoA calls on Member States to implement national policies, strategies and action plans to end unintended pregnancies and unsafe abortion. The SADC SRHR Strategy (2019-2030) encourages its Member States to engage in the need for safe abortion services as a human right for women and to explore ways in which the policy and legal environment can protect the health, lives, and rights of women and girls, including the provision of comprehensive post-abortion care in all contexts.

At present, nine of the 23 countries of the ESA region meet the requirements of the MP. In many countries, even where the law permits access to safe abortion services, additional statutory or policy requirements such as consent of the medical provider, judicial consent, or third-party consent, further limit access to these services. Even in South Africa, where abortion is available on demand, limitations allowing conscientious objection by healthcare workers (HCW) often hamper access to such services.

Age of consent to sex and marriage amongst adolescents

The MPOA calls for countries to enact laws and regulations that guarantee all women aged 15-49 years access to SRH care services, information and education, and for improved access to and uptake of SRH services for youth, including HPV vaccination. It calls for countries to ensure that young people have access to age-appropriate and culturally sensitive comprehensive education on SRH.

The SADC SRHR Strategy (2019-2030) calls upon Member States to align their policy and legal frameworks to ensure that adolescents and youth can access SRH services, to limit the age of consent to marriage to 18 years of age, to engage in national consultations around the age of consent to sex, and to decriminalise consensual sexual acts amongst adolescents through including close-in-age provisions known as 'Romeo and Juliet' clauses.

A legal and policy review by the Safeguard Young People project (SYP) in 2020 found that the laws and policies on consent to sexual activity vary across countries in age and in some instances by gender. Comoros has the lowest age of consent at thirteen, followed by Namibia (14) and Seychelles (15). Seven countries have set the age of consent at 16 years of age (Eswatini, Lesotho, Malawi, Mauritius, South Africa, Zambia, and Zimbabwe) and six countries at age 18 (Ethiopia, Kenya, Mozambique, Rwanda, South Sudan, and Uganda). Three countries have different ages of consent for boys and girls namely: Angola and Democratic Republic of Congo (18 for boys and 16 for girls) and Tanzania (15 for boys and 18 for girls). Rwanda and Botswana have adopted provisions that recognise and do not criminalise sexual relations between consenting adolescents and young people.[29]

[29] UNFPA (2017). *Harmonization of the legal environment on adolescent sexual and reproductive health and rights in East and Southern Africa.* UNFPA ESA. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://esaro.unfpa.org/sites/default/files/pub-pdf/2017-08-Laws%20and%20Policies-Digital_0.pdf

Six countries have set the age of consent to marriage at 18 years, without exception (Eritrea, Kenya, Mozambique, Rwanda, South Sudan and Uganda), and nine countries have lower ages of consent to marriage for girls than for boys. In some instances, exceptions are included in the legal framework, such as allowing for judicial or ministerial consent to marriage below the defined age of consent.

Consent for adolescents to access healthcare services without third party consent

Ten countries do not have any legal or policy prescriptions that limit access to health services for adolescents and youth. Access to services may vary by the type of service; for example, adolescents and young people can access HIV testing services without parental consent at age 12 in Malawi, South Africa, and Uganda. In Tanzania however, this is only at age 18.

Legal barriers for key populations to exercise their SRH rights

All countries, except for Angola, Botswana and South Africa, have legal restrictions for LGBTQI persons despite constitutional provisions relating to non-discrimination. In some instances, there has been an upsurge in opposition to recognising LGBTQI rights. This undermines access to essential SRHR services for sexual minorities. In some countries however, despite legal restrictions, essential services have been provided. Mozambique is the only country that does not criminalise sex workers.

How 2gether 4 SRHR contributed towards an enabling legal and policy environment

2gether 4 SRHR advanced SRHR through engaging and providing technical assistance to regional forums of Parliamentarians to develop regional norms and standards or legislation that countries can benchmark against. These include:

- Pan-African Parliament: Technical support was provided for the adoption of a declaration advancing the right to health to ensure that budgetary resources are committed to promote SRHR outcomes.
- East African Legislative Assembly: Technical input was provided by eight UN agencies into the EAC SRHR Bill. The programme supported regional and national engagements with Parliamentarians, civil society and faith-based organizations on the Bill. This engagement has contributed towards a greater understanding of the SRHR needs of the people of East Africa.
- SADC Parliamentary Forum: Supported the SADC-PF to develop a framework and policy guidance tool for Parliamentarians to advance the SRH and rights of KPs. The programme also supported the SADC Parliamentary Forum on the development of the model law on GBV.
- Network of African Human Right*s Institutions (NANHRI):* Published Advancing HIV and SRHR in East and Southern Africa, a selection of experiences and good practices on advancing SRHR by National Human Rights Institutions to protect the right to health for people living with HIV, intersex rights, and access to safe abortion care.

How 2gether 4 SRHR contributed towards an enabling legal and policy environment (cont'd)

In the ten implementing countries, ongoing engagements with legislators, policy makers and civil society have contributed towards legal and policy processes to expand sexual and reproductive rights:

- Namibia, Malawi, and Zimbabwe engaged in national dialogues to expand the legal provisions to increase access to CAC.
- Lesotho passed a law that aims to ensure stronger measures to address domestic violence.
- Uganda, Zambia and Zimbabwe engaged stakeholders on the age of consent for adolescents and youth to access services.
- Countries have foregrounded the linkages between SRHR and HIV and the need for integrated services in SRHR/RMNCAH strategies (6), HIV prevention and condom strategies (4), ASRHR (2), male engagement (2) and reviewed their essential package of health services (2).
- Guidelines or standard operating procedures were developed to strengthen the quality of service delivery on RMNCAH/SRHR (2), FP/HIV integration (3), the continuation of SRHR services in the context of COVID-19 (3), STI's (3), GBV (2), and CAC (2).

Lessons learnt that the programme will build upon include:

- Democratic processes to amend laws and policies require a deliberate and flexible strategy to allow for extensive consultations across all sectors of society. Measurement of success should include intermediate variables that demonstrate progress or shifts, for example in attitudes or norms.
- Beneficiaries need to be meaningfully engaged in processes of importance to their sexual health and wellbeing.
- There is a need to monitor and to ensure a coordinated response to counter efforts that seek to erode or roll back advances gained in SRHR, while at the same time bolstering efforts by champions.
- The development of strategies and guidelines needs to be accompanied with deliberate dissemination strategies that include training, mentorships and the development of job-aids.

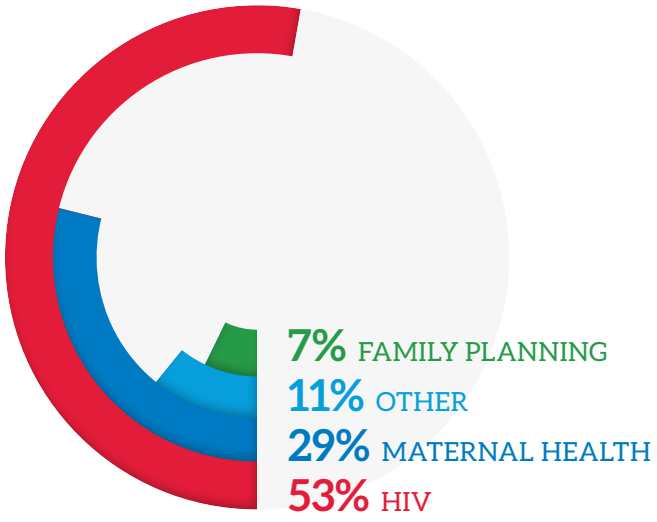
Investments for SRHR in East and Southern Africa

As the region progresses towards UHC, emphasis is not only on what services are covered (the essential UHC service/benefit package), but also how they are funded (innovative and sustainable financing) and how they are managed and delivered (efficiency and effectiveness of the delivery of people-centred services in a non-discriminatory manner), without increasing peoples' financial burden (providing financial protection).

The combined current health expenditure (CHE) in East and Southern Africa, including government, external and private sector sources, was $57.3 billion in 2019.[30]

Only 16 of the 23 ESARO countries have disaggregated expenditure data by different categories of SRHR. The total expenditure in 2019 on SRHR in the ESA region was 23.2 per cent of total CHE, a decrease from 24.4 per cent. This may be attributed to a decrease in funding for HIV from 57.1 per cent in 2016 to 52.3 per cent in 2019, with 84 per cent through external sources. The figure presented shows investments by the different categories of SRHR.[31]

Expenditure on SRHR in ESA



There are three main sources of funding for SRHR in the region: governmewwnt (domestic), external and private sector resources.

Government or domestic financing:

Accounted for $27.8 billion (46.2 per cent) of all CHE, the largest source in eight countries and the smallest source in seven countries.

Many countries are strengthening financial risk protection mechanisms for their UHC benefit package by supporting pooling health financing and/or establishing waiver schemes with a varying number of critical SRHR elements covered through these mechanisms and schemes. Countries are trying to either refine existing health financing and/or financial risk protection mechanisms, or planning to initiate new mechanisms and schemes. Many countries are refining their clinical guidelines and essential medicine lists to support delivery of UHC.

Health systems in Africa are operating under suboptimal capacity of their potential.[32] There is potential to increase investments for SRHR by supporting more efficiency in health systems planning and management.

External financing:

Accounted for $7.3 billion, representing the largest source of CHE in four countries and the smallest proportion in seven countries. External financing includes bilateral funding as well as funding provided through multilateral sources. Key external sources of funding for SRHR in the region include:

- The Global Fund for AIDS, TB and Malaria that provides funding to 22 countries in the region.
- The President's Emergency Fund for AIDS Relief (PEPFAR) funded by the United States Government that provides support to 13 countries in the region.

[30] All expenditure data reported are derived from the WHO Global Health Expenditure Database.

[31] SRHR expenditure data were not available for Angola, Burundi, Eritrea, Lesotho, Madagascar, Mozambique and Rwanda. If the sample's SRHR share of CHE (23.2 per cent) was applied to these countries, then this would represent an additional $1.2bn of SRHR expenditure.

[32] World Health Organization (2022). *Critical considerations and actions for achieving universal access to sexual and reproductive health in the context of universal health coverage through a primary health care approach.* https://www.who.int/publications/i/item/9789240052659.

- The Global Financing Facility on Women, Children and Adolescents (GFF) to scale up evidence driven interventions to improve RMNCAH and nutrition through targeted strengthening of the PHC sector supports 12 countries in the region.
- The European Union, in partnership with the UN, are working to eliminate all forms of GBV through the Spotlight Initiative.

Many developed countries are falling behind the target of providing at least 0.7 per cent of gross national income (GNI) as aid to the least developed countries. The percentage of official development assistance by developed countries to the world's least developed countries has not increased from 2011 to 2020, despite reaching record levels exceeding $200 billion.

Donor investments in SRHR between 2018 and 2019 declined by 21 per cent from an estimated $10.7 billion to $8.4 billion, the largest decline in a decade. This is primarily owing to declines in funding for HIV/AIDS and other STIs from 71.9 per cent in 2017, to 68.2 per cent in 2018, and 62.8 per cent in 2019. On the other hand, there has been a relative increase in aid for reproductive health and family planning. Some of these shifts may also be due to re-classifications of aid across budget items.

External funding in support of humanitarian emergencies increased between 2010 and 2019, relative to development-related funding, owing to an increase in the frequency of humanitarian emergencies. However, there is a lack of data on external funding in humanitarian emergencies in relation to SRHR.

Debt relief, reduction and rescheduling efforts declined over the past four years, while public debt has increased because of the COVID-19 pandemic. This may result in unsustainable debt burdens for both developing and developed countries, with significant consequences for development assistance, public spending, and ultimately women, youth, and older persons.

The private sector:

Accounted for 21.7 per cent of CHE. It was the largest source of CHE in 11 countries and the smallest in nine countries. In six countries, insurance was a larger share of private financing than out-of-pocket expenditure. However, out-of-pocket expenditure was above the WHO benchmark of 20 per cent for 14 ESA countries, bringing a higher risk of citizens being unduly burdened with healthcare costs not covered by government expenditure and social insurance. In particular, there is a lack of information on out-of-pocket spending through the private sector.

Kgomotso and her partner with their 6-month old son who was born at the Mmatshumo health facility supported by the 2gether 4 SRHR programme. Kgomotso receives an integrated package of services including post-natal care, child welfare services, family planning, general consultationsand counselling, children's weight, overall growth, PMTCT programme and all vaccinations.

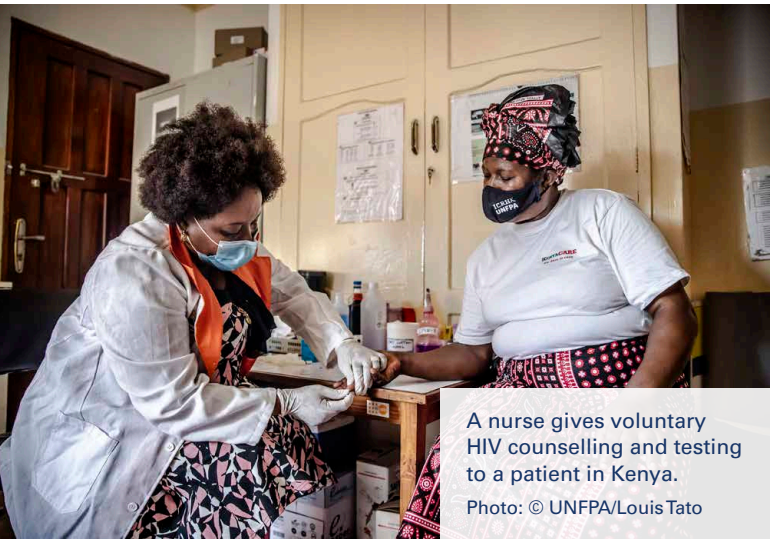
Photo: © 2gether4SRHR/Botswana

How 2gether 4 SRHR contributed towards increased investments in SRHR in the ESA Region

- Regional and Country Programme staff provided technical assistance to Ministries of Health to leverage Global Fund investments, PEPFAR Country Operational Plan, the EU and other resources to strengthen HIV and SRMNCAH outcomes. In four countries the total investment mobilised was $941,802,145.00.
- Technical assistance was provided to the EAC and SADC to develop resource mobilization and sustainable financing frameworks for health in the context of UHC. The SADC framework, validated by an extraordinary SADC ministerial meeting, committed to ensuring a basic package of HIV, TB and Malaria services as part of UHC by 2025.
- National AIDS Spending Assessments and fiscal space analyzes were conducted in Lesotho, Uganda, Zambia, and Zimbabwe.
- An integrated SRHR costing and financing model was tested and scaled up in Lesotho, Malawi, Mozambique, Tanzania, Uganda and Zambia.
- Advocacy was conducted with Ministries of Health and Parliaments to increase domestic investments in SRHR, HIV and GBV services.
- The government of Uganda was supported to increase domestic financial resources for SRHR through innovative public private partnerships.

Lessons learnt that the programme will build upon include:

- Coordination across partners working on SRHR in UHC, financing, and costing the development of investment case studies needs to be strengthened to ensure greater synergy and to avoid duplication.
- Advocacy efforts need to ensure that UHC benefit packages progressively realize all nine recommended SRH services, as well as vulnerable, key and marginalized populations.
- Leadership for domestic financing is needed, by demonstrating the benefits of investing in SRHR and holding governments to account for their commitments to invest in SRHR.
- There is a need to strengthen donor coordination and government overview; donor fragmentation and lack of government overview undermines performance.
- There is a need to address the gaps and build the capacity of non-state actors to advocate for increased domestic health financing.
- Investments in innovative approaches that unlock public-private partnerships for SRHR are needed.



A nurse gives voluntary HIV counselling and testing to a patient in Kenya.
Photo: © UNFPA/Louis Tato

2.4 Strengthening the delivery of people-centred integrated SRHR services using a primary health care approach

In the context of UHC, the integration of SRHR services is defined as those that are managed and delivered so that "people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course."[33] A key principle embedded within integration is that of bi-directionality that aims to ensure that different SRH policies, programmes and services are linked to each other.[34]

Efforts to integrate SRHR services are guided by global and regional guidelines. Global guidelines include: the Global Interagency Working Group on SRH and HIV Linkages, the Global Strategy for Women's, Children's, and Adolescent Health and the Essential Services Package for Violence against Women.

Regional frameworks include: the EAC Minimum Standards on the integration of RMNCAH and HIV as well as the SADC Minimum Standards on the integration of SRHR and HIV in the SADC Region; aiming to harmonize the package of integrated services across countries in the region.

At country level, the delivery of integrated SRHR services is guided by national SRHR policies, strategies, and guidelines that define the package and how SRHR services are to be provided within the context of PHC.[35]

The decision on which services are to be integrated at different service delivery points depends on the capacities of available HCWs; regulatory mechanisms for prescribing and scope of practice; the available equipment and supplies; whether referral to other sites or levels of the healthcare system is feasible or desirable; and the needs and preferences of the target population.[36]

Strengthening the capacity of healthcare workers to provide integrated SRHR services

The historical verticalization of SRHR services requires investments in the capacity of HCW to provide an integrated package of services that is responsive to evolving medical and scientific advances.

Approaches to strengthen HCW capacity include training of trainers, training individual HCWs, and strengthening pre-service training programmes.

[33] World Health Organization (2022). *Critical considerations and actions for achieving universal access to sexual and reproductive health in the context of universal health coverage through a primary health care approach*. https://www.who.int/publications/i/item/9789240052659.

[34] IPPF, UNFPA, WHO, UNAID S, GNP +, IC W and Young Positives (2009). *Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages: A Generic Guide*. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.unfpa.org/sites/default/files/resource-pdf/rapid_assesment_2009.pdf.

[35] World Health Organization (2022). *Critical considerations and actions for achieving universal access to sexual and reproductive health in the context of universal health coverage through a primary health care approach*. https://www.who.int/publications/i/item/9789240052659.

[36] Ibid.

A training of trainers ensures that capacity building efforts are institutionalized within existing in-service training programmes of national governments. Trained trainers cascade the training down to sub-national and facility level, complemented by supportive supervision and mentorship as provided by national and district health authorities. In some instances, trained facility-based HCWs also train, and provide mentorship and support, to others in the facility.

Pre-service training efforts embed global and regional clinical norms and standards within the curricula of schools of nursing, medicine and midwifery, ensuring that graduates entering the workforce are able to deliver the full package of integrated SRHR Services.

Approaches need to foreground not only clinical training but also address the norms and attitudes towards specific population groups (adolescents and youth, key populations, men and boys, and women accessing CAC services) that may inhibit service delivery.

COVID-19 saw a shift to the mainstreaming of digital online training programmes for HCWs. The benefits of digital online training platforms include greater cost-effectiveness and greater numbers of HCWs able to complete the training at their own pace and time. Challenges with these platforms include competing priorities, time and access, as related to connectivity infrastructure and costs. A hybrid approach – using both online platforms and in-person supportive supervision and mentorship – to enable the effective transfer of skills may be most effective.

How 2gether 4 SRHR has strengthened the capacity of countries to provide integrated SRHR services

- Regional training programmes, on CAC, the integration of GBV into SRHR, and the essential package of GBV services, contributed towards the development of country roadmaps and increased focus on these areas of work.
- 5000+ HCWs participated in regional e-learning programmes on the continuity of SRMNCAH services during COVID-19.
- Across the ten countries over 18,803 HCW have been trained on various aspects of SRHR including:
  - » Continuity of SRHR services in the context of COVID-19: 7503 in 3 countries
  - » Integration of SRHR: 6,418 in 9 countries
  - » Integration of GBV: 1,699 in 8 countries
  - » CAC: 740 in 8 countries
- Six countries developed in-service curricula on the integration of SRHR, HIV and GBV (4); AFYS (2) and maternal health (1).

Lessons learnt that the programme will build upon include:

- Digital training programmes can rapidly disseminate new global guidelines, however, HCWs also operate within national legal and health contexts, and training materials need to be contextualised to the national context in line with national clinical guidelines.

How 2gether 4 SRHR has strengthened the capacity of countries to provide integrated SRHR services (cont'd)

- Capacity building efforts should include a pre-post evaluation to determine whether the learning objectives were accomplished.
- Strengthening the capacity of HCWs allows for learning to be amplified through transferring skills and approaches, and to be further amplified when HCWs are moved to other areas.
- Integrating SRHR into pre- and in-service training curricula ensures that graduating HCWs are equipped with the knowledge to deliver an integrated package of services.
- Greater investments are required to address emerging health challenges such as mental health and GBV during pandemics.

Providing people-centred, quality assured, integrated SRHR services

Several programmes have piloted models and approaches to deliver integrated SRHR services, including the IPPF-led Integra Initiative on Sexual and Reproductive Health and Rights and the Linkages Programme (UNAIDS and UNFPA). In some countries, the 2gether 4 SRHR Programme piloted the provision of integrated services, and scaled up provision of integrated SRHR Services.

A metanalysis of the prevalence of adolescent pregnancies in the ESA region indicated that the region has the highest prevalence of teenage pregnancies on the continent. The prevalence of teen pregnancies in East Africa is 21.5 per cent and 20.4 per cent in Southern Africa. This occurs against the backdrop of high levels of HIV infection and GBV in the region.[37] Adolescent pregnant mothers are also more likely to experience poor mental health, stigma and discrimination, and increased risk exposure to both HIV and GBV.

To meet the needs of adolescents requires a shift from adolescent friendly projects to adolescent-responsive health systems, with national quality standards to minimize variability, ensure a basic level of quality services and protect adolescents' rights. This includes private and confidential services that provide respectful care. In addition to fulfilling the SRH needs of adolescents and youth, a multisectoral package of interventions is required, including access to childcare and food security, as well as fulfilling their aspirations and mental wellbeing.

Despite gains in integrating SRHR services, the Evidence for Contraceptive Options and HIV Outcomes Trial (ECHO) highlighted that more must be done to integrate SRHR, HIV and GBV services given low levels of condom usage, together with high levels of STIs and HIV infections. Amongst respondents the study found a high level of STIs (18 per cent had C. *trachomatis*, 5 per cent *N. gonorrhoeae*, and 38 per cent herpes simplex virus), and a high rate of new HIV infections at 3.81 per cent per year.[38] The study concluded that more must be done to integrate HIV prevention into family planning services.

[37] Kassa, G.M., Arowojolu, A.O., Odukogbe, A.A. et al. (2018). Prevalence and determinants of adolescent pregnancy in Africa: a systematic review and Meta-analysis. *Reproductive Health* 15, 195 (2018). https://doi.org/10.1186/s12978-018-0640-2.

[38] The Echo Trial Consortium (2019). *The evidence for contraceptive options and HIV outcomes. Presentation delivered at 9th* SA-AIDS Conference. Accessed from: http://echo-consortium.com/wp-content/uploads/2019/06/ECHO-primary-HIV-results-SA-AIDS-slides-final20190613.pdf.

A pregnant woman being examined by a midwife at Kisugu Health centre in Uganda. 2gether 4 SRHR assists with training of all staff on integration of SRHR/GV and HIV at the centre.

Photo: © 2gether 4 SRHR/Uganda

A systematic review on the integration of family planning into HIV services found that 55.9 per cent of pregnancies among women living with HIV are unintended, and maternal mortality is ten times higher than that for HIV-negative women.[39] Similarly, there is a need to strengthen the integration of other SRHR elements into HIV service delivery points.

The ESA region is the most affected by cervical cancer, with a strong association between HIV and cervical cancer. In Southern Africa, 63.8 per cent of women with cervical cancer were living with HIV, as were 27.4 per cent of women in East Africa.[40] Despite the availability of a vaccine to reduce the risk of cervical cancer, only six SADC countries reported on progress with the rollout of the HPV vaccine to girls under the age of 15. Integrating cervical cancer screening into HIV and family planning services is critical.

The estimated average annual number of abortions in ESA is 4.652 million.[41] Providing contraceptives at the point of service delivery reduces the risk of unintended pregnancies and repeat abortions.[42] Indications are that the HIV prevalence amongst women accessing post-abortion care services is considerably higher than that amongst the general population. A Ugandan study in 2015 found that 13 per cent of women accessing post abortion care services were HIV positive, 36 per cent HIV negative and 51 per cent

[39] Nkhoma, Luka, Doreen Chilolo Sitali & Joseph Mumba Zulu (2022). Integration of family planning into HIV services: a systematic review. *Annals of Medicine*, 54:1, 393-403, DOI: 10.1080/07853890.2021.2020893.

[40] Stelzel, D. (2020). Estimates of the Global Burden of cervical cancer associated with HIV. *The Lancet Global Health*, vol. 9. Issue 2. pp. E161-169.

[41] Bearak J. and others (2022). Country-specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015–2019. BMJ Global Health, 2022 Mar;7(3):e007151.

[42] High Impact Practices in Family Planning (HIP) (2019). *Postabortion family planning: a critical component of postabortion care.* Washington, DC: USAID; 2019 Mar. Available from: https://www.fphighimpactpractices.org/briefs/postabortion-family-planning/.

had an unknown status.[43] Data on the linkages between GBV and women accessing post-abortion care services in ESA are not readily available. A United States of America study found that the more women were exposed to GBV during their life course, the higher the chances were that they would have an abortion.[44] There is a need to address the family planning and HIV needs of women accessing post-abortion care services and to ensure that where necessary there are linkages to psychosocial services. This needs to be combined with interventions that address stigma, together with social and community barriers.

The four partner agencies of 2gether 4 SRHR undertook periodic surveys to monitor the indirect impact of COVID-19 on SRMNCAH services. These surveys found decreases in healthcare utilization across all countries with declines in patients attending in- and out-patient care. There were declines in the uptake of contraceptive services, in particular oral contraceptives. There was no change in the mean number of pregnant women attending antenatal care (ANC) who tested for HIV, pregnant women living with HIV who received antiretroviral medicines to reduce MTCT, nor the number of HIV- exposed infants tested for HIV within two months of birth, although two countries reported declines in 2021. No changes were found across countries, neither in the number of live births in facilities nor in home deliveries.

Innovative approaches adopted by countries to ensure the delivery of SRMNCAH services included: the use of digital or mobile health technologies; telemedicine; triaging to identify priorities; redirecting patients to alternative health facilities; task shifting or role delegation; self-care, and novel supply chain channels; dispensing approaches for medicines; and home-based care.

How 2gether 4 SRHR has strengthened the delivery of integrated SRHR services

- Six countries scaled up the provision of integrated services between 2018 – 2022:
  - » Botswana increased the number of sites from 54 to 123 in 13 districts, an 83 per cent increase.
  - » Eswatini increased the percentage of facilities providing integrated services from 59 percent to 80%.
  - » Lesotho scaled up the provision of integrated services to all districts including 10 hospitals.
  - » Namibia increased the number of sites providing integrated services from 7 to 87 sites.
  - » South Africa initially piloted the provision of integrated services and increased the number of facilities from 15 to 73 in 2 districts.
  - » Zimbabwe scaled up the provision of integrated SRHR services in 13 districts.

[43] Othieno, C., J.B. Babigumira, and B. Richardson (2015). Are women with complications of an incomplete abortion more likely to be HIV infected than women without complications? *BMC Women's Health*. Accessed from: https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-015-0237-7.

[44] McCloskey, LA (2016). The Effects of Gender-based Violence on Women's Unwanted Pregnancy and Abortion. *Yale Journal of Biology and Medicine*, 2016 Jun 27;89(2):153-9. PMID: 27354842; PMCID: PMC4918882.

How 2gether 4 SRHR has strengthened the capacity of countries to provide integrated SRHR services (cont'd)

- Three countries piloted the use of integrated services, including:
  - » Malawi (19 sites in 3 districts), Uganda (26 model facilities with supportive supervision by regional hospitals in 8 districts), and Zambia (24 health facilities).
- Approaches and outcomes from the provision of differentiated multisectoral SRHR interventions for adolescent and young mothers, including family planning, HIV, mental health, parenting and livelihoods were scaled up from three to nine countries.
- Advocacy and technical support were provided to countries to eliminate the vertical transmission of HIV and congenital syphilis (EMTCT).
- Integrated approaches to meet the needs of key populations were piloted in Lesotho, Kenya, and South Africa.
- Countries developed national roadmaps to strengthen CAC services, the integration of GBV into SRHR and the essential services package on GBV.
- Countries working on CAC increased to 12 countries, and three countries undertook strategic assessments on unintended pregnancies, contraception, and unsafe abortion.
- Operational research by the Accelerate Hub gathered evidence on 'what works' for adolescents and young people.

Lessons learnt that the programme will build upon include:

- Government leadership is important in piloting or scaling up integrated services.
- A plan outlining a step-by-step approach with guidelines and tools is essential.
- Stakeholders, including community structures, should be involved in providing strategic direction and identifying operational approaches and challenges.
- Ongoing mentorship and supportive supervision allow for sharing, learning, adaptation and sustainability.
- Pilot sites should be used as model sites for other facilities to benchmark against.
- Strengthening CAC requires a multi-disciplinary approach with national guidelines and training materials aligned to global norms, standards and national legal frameworks. Family planning; STI screening and treatment; HIV testing and referral to treatment; should be integrated at point of care.
- Contingency plans should be developed to ensure that basic health services are delivered during humanitarian emergencies. Investments are needed in regional procurement mechanisms and/or manufacturing of essential medicines and supplies to ensure an uninterrupted supply during emergencies.
- Risk communication and community engagement need to be intensified to raise awareness and address misinformation, fear and stigma.
- Digital solutions, such as telemedicine, and self-care should be expanded.

Monitoring and reporting on the provision of integrated SRHR services

While advances have been made in providing quality-assured integrated services, monitoring and reporting remains vertical and disease specific, which increases the burden of reporting for HCWs.

A review of national PHC monitoring and evaluation (M&E) tools indicates that there is a lack of harmonization across the region. The lack of a harmonized approach across countries hampers cross-country and regional comparisons, as well as the tracking of changes in the SRHR needs of people across the life course. Most countries rely on paper-based systems with multiple registers. None collate or report on disaggregated data by age, gender, geographic location or socio-economic status. Many do not have tools that monitor reproductive health cancers, STIs, GBV and CAC or post-abortion care services, nor are these services likely to be integrated into other service delivery points' monitoring tools. Furthermore, efforts need to be made to strengthen the reporting on HIV prevention services and family planning within antenatal care, HIV testing, and HIV care and support registers.

There are emerging promising practices from Kenya, Lesotho and Uganda which have developed registers or incorporated GBV into the registers of other service delivery points. Malawi and Uganda have both developed M&E tools to track the provision of CAC services. Lessons from Eswatini's digital client health information system illustrates how digitisation fosters the delivery of integrated services and ensures greater efficiencies in the management of commodities and supplies.

How 2gether 4 SRHR has strengthened national health information systems to better monitor and report on the integration on SRHR

- A review of the registers in ten countries benchmarked against the SADC and the EAC Minimum Standards on SRHR identified monitoring gaps relating to CAC, reproductive health cancers, GBV and STIs. Kenya and Zimbabwe are revising their M&E tools because of this review.
- Efforts are being made to pilot the Digital Adaptation Kit and digital health platforms in Kenya, Namibia and Malawi. The pilot sites will be used as model sites from which the digital adaptation kits and digital health platforms can be scaled up.
- Malawi and Uganda developed tools to strengthen routine data collection on the provision of CAC within national health management information systems (HMIS).

Lessons learnt that the programme will build upon include:

- Advocacy is required to digitize monitoring and reporting tools to reduce the burden of reporting on HCW. Digitizing requires leadership and vision from the Ministry of Health and also stakeholder engagement.
- Age and gender disaggregations across data collection tools needs to be harmonized.

How 2gether 4 SRHR has strengthened national health information systems to better monitor and report on the integration on SRHR (cont'd)

- Efforts must be made to strengthen the monitoring and reporting on GBV, CAC, STIs, and the provision of human papillomavirus (HPV) vaccines to adolescent girls to prevent cervical cancer.
- The COVID-19 pandemic exposed the huge inequity in data availability to inform and track progress in delivery of health services. Many systematic reviews and multi-country studies noted an absence of evidence from sub-Saharan Africa. HMIS data can fill this void.
- The quality of routine health information and community data to monitor and report on disruptions to essential health services needs to be strengthened to allow for timely corrective action.

2.5 Social norms and attitudes relating to SRHR

Social norms are the perceived, informal and mostly unwritten rules that define acceptable and appropriate actions within a group or community. Social norms are situated at the intersection between behaviour, beliefs and expectations. They encompass our own actions and our beliefs around what others do, approve of and expect of us.[45]

Gender norms are the collective beliefs and expectations about what behaviours are appropriate for women and men, and the relations and interactions between them. Gender norms are internalized from an early age and perpetuate discrimination and inequalities, amplifying male privilege and exacerbating discriminatory treatment of girls, women, and non-binary gender identities. As such, they not only inform girls and boys about how they should see themselves growing up, but also what they can aspire to, influencing their health-seeking behaviours, education, career, and reproductive choices.[46]

Social and gender norms inform how laws, policies, and strategies are developed, how resources are allocated, and how and to whom healthcare services are delivered. They influence the way service providers engage with users and the extent to which people can demand and exercise their sexual and reproductive rights within society, free from stigma and discrimination. Social and gender norms underpin and constrain progress in addressing the key areas of SRHR including adolescent SRHR, CAC, GBV, and the rights of key populations.

Across the region there are multiple norms overlapping and intersecting in complex ways that fuel gender inequalities. Despite the recognition that social and gender norms represent one of the key drivers that negatively influence demand for SRHR services and the adoption of preventive and protective behaviours, there is a need to invest more in evidence gathering. We need to better understand what evidence currently exists on the type of norms that influence SRHR outcomes in each country, and for

[45] Kincaid, D.L. and others (2007). *A Social Ecology Model for Social and Behavioral Change Communication*. Johns Hopkins Bloomberg School of Public Health. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://breakthroughactionandresearch.org/wp-content/uploads/2020/12/socio-ecological-model-of-communication-for-sbc.pdf.

[46] UNICEF (2021). *Defining social norms and related concepts*. Accessed from: https://www.unicef.org/media/111061/file/Social-norms-definitions-2021.pdf.

each population group; the strength of such norms; the relevant social networks that influence the persistence of the norms; and successful approaches to address them. While research, data and other evidence are available in specific ESA countries or for specific SRHR issues and population groups, it is essential to recognise that social and gender norms and behaviours are population and context specific. Hence, it is urgent to curate and deploy the existing evidence to inform targeted interventions that enable shifts in gender and social norms, and for these changes to be measured.

Given the multiplicity of interventions in this thematic area, evidence is also required to identify and catalogue successful approaches for upscaling, and to measure the incremental changes brought about through different interventions. There are a number of programmes being implemented across the region to generate evidence of 'what works' in terms of social and gender norms programming; these includes the work of the existing collaboration between Oxford University and the University of Cape Town on adolescent SRH, and the South Africa Medical Research Council (SA-MRC) on GBV. There is a need to analyze the evidence on male engagement, positive masculinities, engaging faith based organizations, as well as addressing conscious and unconscious bias with service providers through values clarification and attitude transformation engagements.

Shifting social and gender norms requires a deliberate process of continuous dialogue and capacity building; a movement for social change led by networks of beneficiaries (adolescents and youth, key populations, women, and men in all their diversity); and drivers of change such as leaders, technical experts, regional civil society, faith-based non-governmental actors, professional associations, academics, and researchers.

A group of young men at a workshop on SRHR,GBV and positive masculinity in Manzini, Eswatini.
Photo: © 2gether 4 SRHR/Esswatini

The region is confronting a well-coordinated effort to roll back SRH rights using misinformation, disinformation, personal attacks on advocates for SRHR and unscientific research. Countering this effort requires a strategic alliance of networks and organizations of like-minded partners to engage in proactive structured advocacy to promote and advance SRHR in continental and regional processes, and to address social norms.

Regional advocacy dialogues facilitated with civil society partners highlighted the need for greater capacity and deeper understanding on emerging areas of SRHR. These areas also highlighted the need to strengthen coordination with networks of civil society organizations (CSOs) and UN interventions by enhancing collaboration and coordination between the partners through strategic and sustained engagement with decision-makers in the region.

The meaningful engagement of youth-led organizations is critical to address social and gender norms. There is a need for networks of adolescents and youth to be better coordinated; and for opportunities to be provided for youth to meaningfully participate in global, regional and national processes on ASRHR, including the use of peer review accountability mechanisms. Adolescents and young people need to be included in engagements with traditional, religious, and cultural leaders, and their capacity strengthened to meaningfully participate in processes such as the push for UHC, to advocate for issues affecting adolescents and youth.

Men and boys are socialized into norms that promote risk-taking, and inhibit health-seeking behaviours, with a heteronormative bias to SRHR. Data on norms and attitudes relating to GBV indicate that there have been significant shifts in the period 2000-2018 in adolescent boys' perceptions of GBV. Men and boys can play a significant role in addressing social and gender norms as clients (with their own SRHR needs), partners, and even champions for women's rights.

As partners, men can support the reproductive choices of their partners and also reduce GBV as well as their own risk-taking behaviour, in the interests of preventing unwanted pregnancies, HIV and STIs. The SRHR needs of men and boys include information and services regarding contraception, HIV and other STIs, sexual dysfunction, infertility, and male reproductive health cancers, amongst others. Yet SRHR services are not orientated to cater to the needs of men and boys, and there is a lack of agreed standards or guidelines for delivering these services. A rapid assessment is currently being undertaken in five countries to better to understand male norms and attitudes towards SRHR, that will provide a baseline for engagement with networks of boys and men.

Young men at Khwakha Invodza "Building Men" resource centre in Eswatini where they attend sessions on SRHR, GBV, HIV prevention and income generation.

Photo: © 2gether 4 SRHR/Esswatini

There is a wide range of views on SRHR in the faith-based sector. Faith-based leaders acknowledge that faith, like culture, is dynamic, and that it needs to evolve and adapt to remain relevant to the times. Public health experts, networks of adolescents and youth, women and key populations need to engage with faith-based leaders to address misperceptions and misinformation on SRHR, with a view to advance and protect SRHR in the region. This includes deepening their understanding on the rights of all persons to bodily autonomy, clarifying misperceptions, and addressing SRHR through a faith-based perspective.

Traditional media and new media, including social media, are central in positioning the discourse on SRHR, GBV and HIV. While there is significant media coverage of SRHR, this tends to focus on national-level news, events, issues, and newsmakers rather than in-depth feature articles and human-interest stories on SRHR. A media scan and a media dialogue conducted during ICPD+25 called for greater investments to be made in supporting media reporting on SRHR through capacity building and support to enable in-depth investigative reporting.

TRADITIONAL and **NEW MEDIA** including **SOCIAL MEDIA,** are central in positioning the discourse on **SRHR, GBV** and **HIV.**

High-level influencers can be advocates for change, disseminate knowledge, navigate the boundaries between professional groups, build relationships, and bring together different constituencies to reach consensus.[47] There is a need to identify high level influencers from various sectors who can work at different levels to champion the fulfillment of the political commitments related to SRHR. This involves strategically positioning the rights-related recommendations on SRHR issues that are at times neglected or are seen as contentious.[48]

The programme will review and leverage, where available, existing mechanisms at the country level to track shifts in social and gender norms that can be aggregated at regional level to measure changes through social and behaviour change baselines, midlines and end-lines looking at the following areas:

- Perceived prevalence of a norm, or how common or pervasive a norm is (i.e., descriptive norms);
- Perceived expectations to conform to the norm (i.e., injunctive norms);
- Perceived social support or backlash (positive and negative outcome expectancies) for behaving outside a norm, and by whom (i.e., outcome expectancies); and
- Possible disagreement about a norm.

The four UN agencies will use their convening power to bring together different stakeholders from the region to ensure a better coordinated effort to address social and gender norms and to contribute towards a more enabling environment for SRHR. Speaking with one voice at the highest level on key issues relating to SRHR will send clear and unambiguous messages regarding the position of the UN.

[47] Dao, B., E. Otolorin, and others. (2015). Preparing the next generation of maternal and newborn health leaders: The maternal and newborn health champions initiatives. *International Journal of Gynecology and Obstetrics*. Volume130, IssueS2. DOI: 10.1016/j.ijgo.2015.03.004

[48] Barraguez Fernandez, A. (2020). Accountability for sexual and reproductive health and rights in development practice: building synergies. *Sexual and Reproductive Health Matters*, Volume 28, Issue 1. DOI: 10.1080/26410397.2020.1848399

The four UN agencies will also ensure that policy positions are cascaded down to Country Offices, engaging the entire UN country leadership structures and technical staff to promote greater action in addressing the key areas of SRHR. The four agencies will collaborate and empower critical opinion makers and leaders on the need to address social norms as means to ensuring that people can enjoy all their rights as defined in the ICPD Programme of Action and the Lancet-Guttmacher Commission on SRHR.

How 2gether 4 SRHR has advanced engagements on social norms and attitudes relating to SRHR

- The programme has empowered UN staff to work on SRHR through engagement on norms and values.
- Approaches on male engagement were strengthened regionally and nationally. At regional level, an assessment on men and boys is being undertaken in five countries looking at the extent to which countries have incorporated male engagement in laws, policies, and strategies, and exploring male norms and uptake of SRHR services, that will guide future regional efforts. Several countries have tested approaches for engaging men and boys that provide a basis for countries to learn from.
- Engagements with faith-based leaders were supported at the regional and country levels highlight the need for structured engagement with faith-based leaders on key SRHR outcomes.
- Engagements were undertaken with young people using peer-to-peer support modalities, community-led monitoring of access to services, adolescent friendly spaces and male action groups, to better understand and meet ASRHR needs.
- Routine media scans and monthly media monitoring of SRHR coverage in the regional media were conducted and shared, examining key trends.
- A series of advocacy dialogues was conducted to identify longer term strategic approaches to addressing maternal mortality, contraception and unsafe abortion, with clear guidance for future action and prioritisation. An advocacy strategy to guide future action is under review and will be finalized before the end of the programme.

Lessons learnt that the programme will build upon include:

- The UN, working in partnership with other key stakeholders, has a unique role to convene efforts to address social and gender norms.
- Partnerships are critical for addressing the counter movement to SRHR in the region. Partners can leverage their unique position to monitor actions, devise strategies and respond effectively.
- Responses to the counter movement should not be focused primarily on the movement, but rather on informing and educating relevant partners while protecting SRHR.
- Further engagements with civil society and faith-based leaders at the regional level need to be explored.

2.6. Humanitarian crises and SRHR in East and Southern Africa

The ESA region is experiencing a complex range of acute and chronic humanitarian crises. As of February 2022, more than 65 million people need humanitarian assistance in the region.[49] This is a result of conflict, climate shocks (including drought, flooding and extreme weather events), disease outbreaks (including COVID-19), and political and economic instability. Among the people in need, over 13 million people are internally displaced; close to 4.7 million are refugees, migrants, and persons of concern; and 36 million people are facing acute food insecurity. Women and children are disproportionately affected by these hazards.

Eight countries in the ESA region rank in the thirty most fragile states globally,[50] and eight face a moderate to very high risk of a humanitarian emergency occurring.[51,52]

In 2016, the global community adopted Agenda 2030, with a commitment to leave no one behind. An increasing proportion of poor, vulnerable and marginalized populations are living in fragile and emergency settings. This includes AGYW, migrants, internally displaced persons, persons with disabilities, indigenous populations, persons living in informal settlements, sex workers and LGBTQI persons. Women and adolescent girls experience multiple SRH challenges linked to poverty; harmful social, cultural and gender norms and values; and a lack of services – all amplified during emergencies when existing services may be disrupted, and access may be further denied.

Humanitarian crises, including those associated migration and displacement, undermine access to prevention, treatment, care, and support services – for example contraceptives, condoms, post-exposure prophylaxis, comprehensive sexuality education (CSE) for youth in and out-of-school, as well as mental health and psychosocial support. Disrupted access to services leaves those affected vulnerable to unintended pregnancies, including sequelae such as teenage pregnancies, unsafe abortions, STIs, new HIV infections, and maternal and neonatal mortality. Although much is known about the impact of humanitarian disasters on women, girls, and the general population, less is understood about their impact on other vulnerable populations.

The onset of natural disasters and other humanitarian crises exposes weaknesses in existing systems, development efforts and the humanitarian response. Development is focused on longer term approaches to strengthen national economic, social, health and political systems, particularly for those most deprived. National systems are often unprepared, and unable to cope when emergencies strike, and hard-won gains may be lost. Humanitarian efforts have a shorter-term mandate, responding to crises when they occur, with the emphasis on saving lives and ensuring safety. Current investments in preparedness and early action are inadequate and as a result, longer term development investments are increasingly compromised.

The Minimum Initial Service Package (MISP) Readiness Assessment conducted in the region in 2022 highlighted that either SRH or the MISP are rarely integrated into national emergency preparedness and

[49] OCHA (2022). *Global Humanitarian Overview.* Accessed from: https://gho.unocha.org/.

[50] ESA countries ranking by the Fragility index: South Sudan (4), Democratic Republic of Congo (5), Zimbabwe (10); Ethiopia (11), Burundi (16), Eritrea (17); Mozambique (22) Uganda (24)

[51] Interagency Agency Standing Committee (IASC) *Early Warning, Early Action and Readiness Analysis Report.*

[52] Very High Risk: Ethiopia and Democratic Republic of Congo linked to political crisis and internal conflict; High Risk: 5 countries in Southern Africa linked to ongoing drought, economic and political instability; Moderate Risk: Burundi linked to internal political crisis.

response policies, nor into national health preparedness and emergency response plans. In most countries, the existing health system has inadequate qualified medical personnel, facilities, supplies and equipment to cope with emergency situations.

Consequently, Phase II of the 2gether 4 SRHR programme will continue to strengthen the humanitarian/peace/development nexus (HPDN). It will build on the MISP Readiness Assessment and support countries to address identified priority actions including strengthening their humanitarian policies, and health systems e.g., by integrating SRHR in UHC, and seeking opportunities to amplify domestic financing for SRHR and preparedness efforts.

Efforts to strengthen the combined efforts of the four agencies in addressing the HPDN will leverage existing coordination mechanisms to strengthen the humanitarian response at regional level. Coordination efforts are anchored on two overarching forums convened by the UN Office for the Coordination of Humanitarian Affairs (OCHA) Regional Office based in Nairobi.

The Regional Inter-Agency Standing Committee (RIASC) and the Regional Humanitarian Partnership Team (RHPT) are platforms for the coordination of regional actors in the Southern and Eastern regions of Africa respectively. The platforms bring together humanitarian partners and development actors in the region and provide opportunities for advocacy to address ongoing and emerging crises, leverage the UN and NGO regional leadership to amplify messages, help countries navigate sensitive narratives to the crises and work with the donor community. All 2gether 4 SRHR agencies are represented and use these platforms to raise awareness of the impact of crises on SRHR as well as identify opportunities for partnerships. The platforms also provide an opportunity for knowledge-sharing and awareness-raising in ongoing regional initiatives. The platforms are convened monthly but often hold ad hoc sessions to address emerging or escalating crises. Sector specific regional working groups such as those on health, protection, food security, the prevention of sexual exploitation and abuse, and GBV feed into the overarching platforms.

How 2gether 4 SRHR has supported the humanitarian peace development nexus on SRHR

- The programme adopted a flexible approach to humanitarian crises affecting the region. Zimbabwe and Malawi reprogrammed funds to support the response to Cyclone Idai, Cyclone Kenneth, and outbreaks of drought, and all countries reprogrammed funds to support COVID-19 efforts.
- A review of the extent to which continental and regional SRHR frameworks incorporate a humanitarian perspective and the extent to which humanitarian frameworks incorporate SRHR is currently being undertaken. This review will provide a baseline for future action by the four agencies.
- A study on the impact of climate change on key SRHR outcomes including maternal mortality, family planning and GBV is being finalized and will inform future efforts to support the region in responding to climate change.

How 2gether 4 SRHR has supported the humanitarian peace development nexus on SRHR (cont'd)

- A readiness assessment on the extent to which countries are prepared to implement the MISP for SRHR in crisis is currently being undertaken across 23 countries of the region. Findings will be used to inform future responses to strengthen the preparedness of countries to implement the MISP.
- The programme is in the process of undertaking a study to explore the integration of SRHR into vulnerability assessment tools. A pilot will be undertaken to test the tool so that lessons learnt can be incorporated into the response.

Lessons learnt that the programme will build upon include:

- There is a need to strengthen collaboration and coordination between SRHR actors and humanitarian partners to promote a coherent, risk-informed approach to strengthen SRHR programming based on a shared analysis, joint planning, one national plan of action and collective outcomes.
- There is a need for high level advocacy and targeted action to work towards a more enabling legal and policy environment that would support the MISP during any emergency using an all-hazards approach.

2.7 Addressing corruption through a health systems approach

Corruption is defined as the abuse of entrusted power for private gain. Corruption diverts resources away from the health system, increasing out-of-pocket expenditure for the poorest of the poor; reducing the amount of funds available for investment in health infrastructure, commodities and supplies; and undermining access to quality health services and UHC.[53]

Transparency is critical to combating corruption. The programme supports governments to develop and popularize human rights-based laws, policies and strategies that are aligned to their global, continental, and regional commitments, enhancing transparency.

2gether 4 SRHR further promotes transparency using peer review mechanisms that measure progress against the commitments made by governments as outlined in international, continental, and regional commitments.[54] The programme will actively track and analyze annual national health accounts, including an analysis of the reproductive health sub-account, to regularly monitor the expenditure of reproductive health services and out-of-pocket expenditures on SRHR. This will enable trend data to be developed over time that will enable governments and citizens to monitor

[53] WHO, Reducing health system corruption, Accessed from: https://www.who.int/activities/reducing-health-system-corruption

[54] Koller, T. , Clarke, D. & Vian, T. 'Promoting anti-corruption, transparency and accountability to achieve universal health coverage'. *Global Health Action*, 13:sup1. (2020) DOI: 10.1080/16549716.2019.1700660

progress toward UHC goals and highlight action to improve performance to reduce out of pocket payments by citizens.[55]

The programme will place considerable emphasis on strengthening regional and national supply chains to promote good and efficient procurement practices for public health commodities and supplies, while promoting regional manufacturing of commodities and supplies. In doing so the programme will work with regulators, manufacturers, procurers and donors to promote the strengthening of procurement and regulatory mechanisms to ensure that quality registered commodities and supplies procured and/or manufactured are pre-qualified against WHO standards,[56,57] reducing corruption in the procurement process.

The programme promotes the integration of SRHR and HIV that has been shown to increase the efficiencies of health systems in delivering quality services for clients. Investments in HCW capacity increase the quality of care being provided. When linked to points for continuous professional development, this also contributes towards merit-based promotions, thus reducing nepotism and cronyism and associated corruption.[58]

A young woman coming for post natal check-up with her 8-month baby at a health centre in rural Lesotho.
Photo: © UNFPA/Lesotho

2.8 Leveraging the learnings from Phase I to inform Phase II

Phase I of 2gether 4 SRHR has drawn upon lessons learnt and gaps from the initial investments made by Sida, and the European Union in the UNFPA/UNAIDS Linkages Project; UNICEF Optimizing HIV Treatment Access for pregnant and breastfeeding women (OHTA) Initiative; and the UNAIDS Expanded Accelerated AIDS Response towards High Level Meeting (HLM) targets and elimination commitments in the ESA Region (EAAR). The inclusion of WHO in the 2gether 4 SRHR programme has added great value in ensuring that efforts are aligned to global norms and standards relating to SRHR.

Phase II of the programme will draw upon the lessons learnt from the implementation of Phase I with a focus on further enhancing the joint programming amongst the four partner agencies using a regional approach. In addressing these lessons and identified gaps, the programme will benefit from the gains made at the regional level and the investments in the ten participating countries that can serve as front-runner countries for other countries in the region to benchmark against.

[55] Vian, T. Anti-corruption, transparency and accountability in health: concepts, frameworks, and approaches. *Global Health Action,* 13:sup1. (2020) DOI: 10.1080/16549716.2019.1694744

[56] WHO. *Welcome to Medicines Prequalification*. Accessed from: https://extranet.who.int/pqweb/medicines

[57] Kohler, J. & Dimancesco, D. 'The risk of corruption in public pharmaceutical procurement: how anti-corruption, transparency and accountability measures may reduce this risk'. *Global Health Action*, 13:sup1. (2020) DOI: 10.1080/16549716.2019.1694745

[58] Vian, T. 'Anti-corruption, transparency and accountability in health: concepts, frameworks, and approaches'. (2020) *Global Health Action,* 13:sup1, DOI: 10.1080/16549716.2019.1694744

KEY AREA	Lessons learnt from Phase I	Enhancing implementation in Phase II
DELIVERING AS ONE	Delivering as One enables programmes to benefit from the collective technical expertise and the comparative advantage of the four partner agencies. There is a need to strengthen operational systems to guide programme implementation to further enhance joint efforts to deliver as one. Lessons learnt from the programme implementation need to be infused into global and regional programmatic and reform efforts.	Expand Delivering as One drawing upon the full technical expertise of the participating agencies. Develop a strategic operational plan to strengthen delivery of joint activities and implementation. Regional Flagship programme to test the principle of mutual recognition to support Delivering as One. Infuse lessons learnt from programme implementation through strengthening links and participation in global agency and interagency efforts. Better tracking and reporting on results and lessons learnt that are infused into regional UN reform initiatives.
LEAVE NO ONE BEHIND	In Phase I the programme focused its attention on adolescent girls and young people, pregnant and breastfeeding women, PLHIV, MSM, LGBTI persons, and sex workers (SWs). Work to advance the needs of these populations cut across all outcomes. Continental, regional and national laws, policies and frameworks that the programme has supported incorporate a focus on these populations and guide programme interventions. The programme supported the development of frameworks to advance the SRHR rights of specific population groups – e.g., regional strategy for HIV prevention, treatment and care, and SRHR for key populations in the SADC Region. The programme has supported countries to build the capacity of HCWs in meeting the needs of specific populations, for example adolescents and youth (9,715) and key populations (533). Programme interventions were tested to support the needs of population groups such as pregnant adolescents and young mothers, LGBTQI in Lesotho, and sex workers in South Africa and Kenya.	In Phase II the programme will focus on build upon the investments made in Phase I. Beneficiaries will be expanded upon, drawing on the Lancet- Guttmacher Commission recommendations to include men and boys and conflict-affected populations. The programme will advocate for expanded access to SRHR for adolescents and youth with a particular emphasis on: the age of consent to access services; expanding training for HCW on meeting the needs of adolescents and youth; adolescent youth responsive health systems; and addressing social norms that hamper SRHR outcomes amongst adolescents and youth. A specific focus will be incorporated on meeting the needs of men and boys; supporting the development of male engagement strategies, men as clients of the health system, and addressing male norms and attitudes. The programme will push for regional strategies and commitments relating to key populations; services for key populations to be expanded drawing upon the lessons learnt from Phase I; and engage social, cultural and religious groups to shift social norms relating to key populations. Consistent with the programme design the emphasis will be on strengthening laws, policies, strategies, guidelines and health systems so that they are more resilient in times of crisis and responsive to the needs of people affected by conflicts.

KEY AREA	Lessons learnt from Phase I	Enhancing implementation in Phase II
GEOGRAPHIC COVERAGE	Need for continuous assessments to review progress made in the integration of SRHR to inform future investments, while leveraging the ten countries as best practice examples for other countries. Funding earmarked to ten countries enabled valuable programmatic insights to be gained but also limited responsiveness of the programme and further expansion.	Focus on expanding knowledge and insights from ten participating countries to all countries in the region and leveraging opportunities to further strengthen key areas of SRHR. Shift to catalytic, timebound, and flexible funding that all countries in the region can benefit from, informed by programmatic assessments to strengthen delivery of results. Provide quality assured technical assistance (TA), strengthen knowledge management, capacity building and South-South exchange drawing on the experiences of the ten countries.
ADVANCING GLOBAL, REGIONAL COMMITMENTS	Continental and regional leadership and ownership of the response is critical for sustainability. The financial and human resources of the RECs to lead and guide the response are variable. There is a need to ensure that global, continental and regional commitments and frameworks are domesticated. Regional coordination mechanisms and peer accountability mechanisms can be used to strengthen country and regional responses.	Strengthen linkages with the AUC to strengthen operationalisation of continental framework. Provide both long-term and short-term technical assistance to the AUC, SADC and the EAC to lead the response, while leveraging the capacity of the four UN agencies at regional and country level to input into continental and regional processes. Support countries to domesticate and implement global, continental and regional commitments. Strengthen the use of regional coordination mechanisms and peer review mechanisms to track progress made; identify and document promising practices and lessons learnt; and facilitate South-South exchange and learning.
LEGAL AND POLICY ENVIRONMENT	Focused on supporting countries to update legal, policy frameworks on SRHR, HIV and GBV.	Focused efforts, guided by a regional advocacy strategy with agreed upon priorities clearly defined, that are flexible and able to respond to emerging issues, are monitored and evaluated. Strengthen the linkages between regional advocacy and country level outcomes.

KEY AREA	Lessons learnt from Phase I	Enhancing implementation in Phase II
FINANCIAL INVESTMENTS IN SRHR	Tools and approaches were piloted to develop investment case studies that can be used to advocate for increased domestic investments. Phase I focused on funding the SRHR response.	Support countries to define and progressively expand key elements of SRHR in national UHC and PHC packages. Shift towards financing the response with policies and strategies supported by implementation plans that are costed to increase domestic investments in SRHR in the context of UHC. Advocate for increased investments by bilateral and multilateral development partners in costed action plans for regional and national efforts for SRHR.
STRENGTHENING HEALTH SERVICES TO DELIVER INTEGRATED SRHR	Capacity building of HCW has an amplifier effect with knowledge generated infused into facilities and beyond. In-service capacity building efforts are more effective when combined with mentorship and supportive supervision. In-service capacity development needs to be supported through pre-service training curricula. Provisional data from the endline survey of the programme demonstrates that deliberate focused efforts to deliver people-centred integrated SRHR, HIV and GBV services has positive outcomes for clients. However, gaps still exist in the provision of integrated services. Country M&E systems do not disaggregate data making it difficult to track who is being reached and who is left behind. Reporting tools continue to be vertical and disease specific rather than reflecting the shift to integrated approaches. Paper based M&E systems result in increased reporting burden for HCWs and poor health outcomes for patients over time.	Apply a blended approach that combines e-learning/m-learning approaches with face-to-face learning to disseminate global and regional guidelines. Ensure that mentorship and supportive supervision are incorporated drawing upon the tools and experiences developed in the ten countries. Expand integrated SRHR services drawing on the experiences of the ten countries with a focus on integrated contraceptive services, CAC, and GBV through promoting South-South collaboration that countries can benchmark against. Focus on people-centred health systems that are responsive to the needs of youth, men and boys and key populations. Harmonize regional data disaggregated by age and gender, and harmonize indicators to allow for regional comparison. Progressively scale up digital monitoring and client HIMS to reduce reporting burden and strengthen client outcomes over time. Generate and use quality strategic information to inform policy and service delivery.

KEY AREA	Lessons learnt from Phase I	Enhancing implementation in Phase II
SOCIAL AND GENDER NORMS	Social and gender norms hamper progress to advance the rights dimension of SRHR as defined by the Lancet-Guttmacher Commission. Addressing social and gender norms relating to SRHR requires a deliberate multisectoral evidence-informed strategic approach leveraging off the comparative advantage of different stakeholders who can lead dialogues, conversations and efforts in their sphere of influence to address social norms.	Curate and use evidence and insights to strengthen the development of policies, funding and programming to address social and gender norms that undermine the advancement of the rights dimension of SRH. Coordinated efforts to advance the rights agenda led by networks of adolescents and youth, women, men and boys, faith-based leaders and media need who are capacitated to meaningfully lead regional efforts to address social and gender norms. Ground interventions in evidence and theoretical frameworks with lessons learnt, and document and use these to strengthen future efforts.
STRENGTHENING RESILIENCE OF HEALTH SYSTEMS TO DELIVER SRHR DURING HUMANITARIAN CRISIS	There is a need to strengthen the resilience of health systems to provide in a systematic manner that draws upon evidence-based approaches.	Advocate for the prioritisation of SRHR and funding during humanitarian crises. Draw upon investments in the past two years to generate evidence on the impact of global trends (climate change, MISP readiness and vulnerability assessments) to strengthen the resilience of health systems to ensure the continuity of SRHR services in humanitarian settings.
MONITORING AND EVALUATION	The Monitoring and Evaluation system used in Phase I primarily tracked performance of work plans and completion of activities. As a result compilation of annual reports was challenging as it required working through activity reporting to consolidate output and outcome results. A considerable number of indicators did not have clear targets and a few indicators did not have baseline figures.	Develop a comprehensive and relevant M&E system for the Phase II that: • Tracks performance at an output and outcome level. Output and outcome indicators that track programme performance should be clearly developed and used at all reporting, review and evaluation points that include baseline, quarterly and annual reports, mid-term review and final evaluation to show a clear progression of the programme. • Includes a baseline report with baseline figures for all indicators as a reference point for all subsequent reporting, reviews and evaluations. • Has clear targets set for all indicators in order to have a clear sense of what the Programme aims to achieve. • A standardized reporting platform so that different players report against the same indicators at all reporting intervals.

03.

Scope of 2gether 4 SRHR

3.1 Vision

All people in Eastern and Southern Africa are empowered and supported to exercise their SRH Rights, access quality, people-centred integrated SRHR, HIV and GBV[59] services to enjoy a healthy and productive life.

3.2 Goal

The overall goal of 2gether 4 SRHR is to contribute towards the attainment of the SRHR related targets of SDGs 3 (good health and wellbeing) and 5 (gender equality).

3.3 Mission

The programme combines the efforts of UNAIDS, UNFPA, UNICEF and WHO, working in partnership with the African Union, RECs and regional civil society, to support continental, regional and country efforts for a collective and coordinated strategic political and programming effort to ensure universal access to SRHR for all, including in humanitarian settings.

It will apply a rights-based approach to SRHR within the context of UHC to reduce maternal mortality (including from unsafe abortion), reduce new HIV/STI infections, reduce the unmet need for family planning, and reduce GBV.

The implementation of the programme will contribute towards the following core SRHR targets of SDG 3 and 5:

3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

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

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

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

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

[59] The programme recognises all forms of gender-based violence including sexual violence, intimate partner violence, economic and psychological violence.

3.4 Beneficiaries

The programme beneficiaries include all people in the ESA region, with a focus on leaving no one behind and reaching those furthest behind, including adolescents and young people, women reproductive age 15-49, men and boys, key populations and people affected by crisis.

Secondary beneficiaries include: the African Union RECs; continental and regional forums of Parliamentarians; human rights institutions; regional CSOs; regional professional associations; the UN; and national governments in ESA – in particular, but not limited to – Ministries of Health, Planning, Finance, Gender, Social Development, Education, Youth, and also National AIDS Councils.

3.5 Principles

This Joint UN regional programme will be guided by the following principles:

Regional in scope: 2gether 4 SRHR will use a regional approach with applied learning in countries in East and Southern Africa. It will support the efforts of the RECs, regional forums of Parliamentarians, human rights institutions, and other UN regional entities to convene regional forums to advocate for the development and domestication of global and regional commitments, track progress, document and share models, approaches and lessons learnt, and promote South-South triangular cooperation between countries and across regions. It will provide quality assured technical assistance to countries, support knowledge generation, management, and dissemination; and strengthen country capacity to apply global, continental, and regional normative guidance. It will collaborate with other regional UN, multilateral, and civil society SRHR initiatives in the region, across regions and between countries.

Delivering as One UN: 2gether 4 SRHR will draw on the comparative strengths and technical expertise of the four participating UN agencies to advance SRHR in ESA at regional level. Agencies will work collectively towards joint outcomes with defined roles and responsibilities based on their expertise and mandates thereby promoting greater coherence, efficiency, and accountability for results. Each agency will be accountable for its own programmatic and financial results as defined by its respective mandates, and global and regional strategies. Lessons learnt from this programme will be used to advance Delivering as One at the regional level for others to learn from.

Responsive and flexible: Implementation of the programme will allow for flexibility to capitalize on emerging opportunities and challenges to advance SRHR in the region. It will document and amplify lessons learnt, and be responsive to emerging needs and crises in the region.

Leaving no-one behind: In line with the human rights-based approach, the programme will seek to reach those furthest behind by ensuring that policies, services, and programmes are designed with an emphasis on non-discrimination, equality and equity through strengthening and using data to identify those most marginalized and vulnerable, and to address rising inequalities.

Promoting gender equality and empowerment of women and girls: The programme will promote gender equality and the empowerment of women and girls in the design of all policies, services, and programmes. It recognises the fundamental sexual and reproductive rights of all persons as defined in the ICPD Programme of Action and in the integrated SRHR definition by the Lancet Guttmacher Commission. This includes: the right to make decisions governing their bodies, to access services that support their right to decide freely whether, when, how many and by what means to have a child or children, and to live free from discrimination, coercion, exploitation, and violence.

A teenager spotted with a traditional music instrument during a community outreach in Namayingo district Uganda.
Photo: © UNFPA Uganda Mathias Mugisha

Right to information, education, and access to quality people-centred integrated SRHR services: The programme will promote a people-centred approach that integrates SRHR, HIV and GBV that is differentiated and organized around the health needs and expectations of people rather than diseases in all policies, services, and programmes.

Resilience: The programme will support the strengthening of resilient health and community systems to continue the provision of the MISP for SRHR to protect human life and produce good health outcomes in times of crisis guided by the comparative advantage, global and regional strategies, and the evolving HDPN guidance of the four participating agencies.

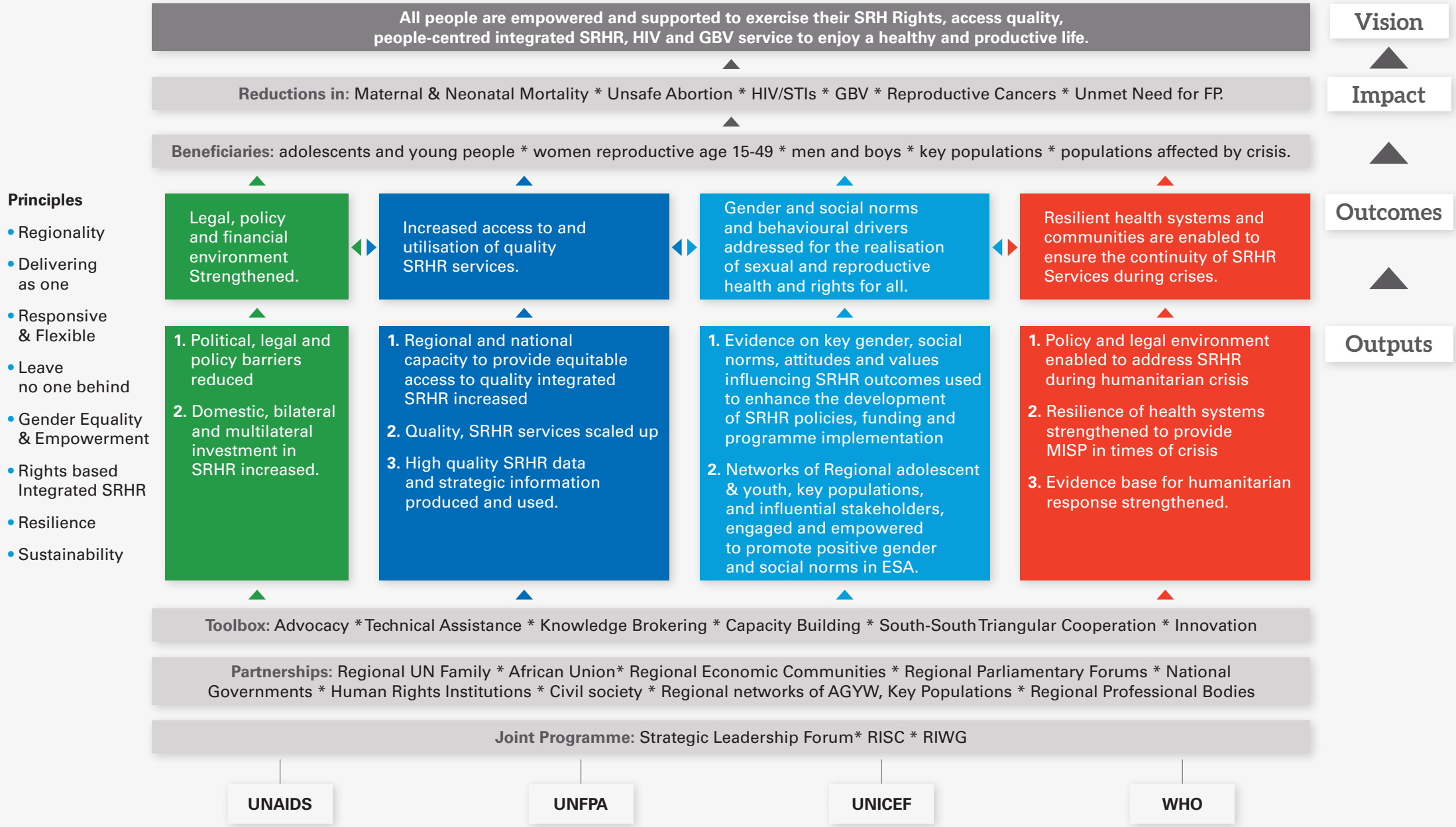
Conflict perspective: The programme will use a conflict-sensitivity lens to ensure that the design and implementation of activities do not contribute to and exacerbate violent conflict dynamics in countries where activities are carried out. As a regional programme, it must be ensured that stakeholders involved in implementation of activities in settings affected by violent conflict must be well acquainted with and understand the conflict context, be able to assess how planned interventions may interact with the conflict context, and act upon that understanding to adapt implementation to minimize potential negative impacts.

Sustainability: The vision, mission and objectives of this joint programme are aligned with priorities of the four participating agencies as defined in their respective global and regional strategies. Implementation will contribute towards the broader UN regional reform agenda including the regional collaborative platform, the regional H6, Education Plus and the Harmonization for Health in Africa initiatives. Programme implementation will support ownership and leadership by continental and regional entities and governments. Investments will strengthen existing health and community systems to promote SRHR outcomes.

3.6 Theory of change

The Theory of Change (ToC) maps the pathway towards achieving the overall vision of the 2gether 4 SRHR programme. It uses the health systems approach to strengthen the PHC system within the context of UHC to achieve the vision of the programme.

Theory of Change - Phase II



To achieve its vision, 2gether 4 SRHR will leverage the comparative advantage of the four regional UN agencies as defined in their respective global strategies and regional implementation frameworks to ensure universal access to SRHR for all, including in humanitarian settings. It will achieve this through promoting SRHR within the context of UHC to reduce maternal mortality including unsafe abortions; reduce new STI and HIV infections, reduce the unmet need for family planning and reduce GBV, with a focus on adolescents and young people, women, and men in all their diversity using an integrated approach.

The programme will document and amplify lessons learnt to strengthen programme planning and implementation. Through its implementation, the programme will document and share information using a mix of case studies, promising and best practices, and peer-reviewed journal articles. Learning will be infused throughout the programme using a blended approach that combines web-based technologies, online learning, and face-to-face meetings to share insights and strategies, and to identify, document and share promising practices, case studies, and human-interest stories and promote South-South triangular cooperation across regions and between countries.

In summary, the assumptions underpinning 2gether 4 SRHR are:

IF the participating UN agencies in partnership with the identified regional and national stakeholders (AU, RECs, Parliamentary Forums, human rights institutions, civil society, CSOs, national governments, networks of beneficiaries, and regional professional bodies) work together through regional mechanisms to deliver strategic interventions (e.g., advocacy, TA, capacity building, testing and scaling up models, knowledge brokering, South-South learning, and amplification of lessons);

THEN the political, policy and legal environment will be improved; domestic and multilateral investments will be made more available; regional and national capacity will be strengthened; quality integrated SRHR, HIV and GBV services will be scaled up; higher quality data and information will be produced and drive programming; and networks of beneficiaries will be further empowered, including in crisis;

THEN beneficiaries will have greater knowledge and skills to exercise their SRHR rights and access SRHR services;

THEN there will be a reduction in the number of unintended pregnancies, the unmet need for contraceptives; STIs and HIV; maternal and neonatal mortality including from unsafe abortion; GBV; and reproductive cancers;

AND the attainment of the SRHR-related SDGs will be fast-tracked.

The Draft Results Framework[60] that will be used to monitor and report on progress with the implementation of 2gether 4 SRHR is attached as Annex 2.

The programme will **document** and **amplify** **LESSONS LEARNT** to **STRENGTHEN** programme planning and implementation.

[60] The final results framework and baseline will be submitted to Sida in October 2023 as per Annex 1.5.

Youth delegates at asummit supported by 2gether 4 SRHR expressing their expectations from regional SRHR leadership.

Photo: © 2gether 4 SRHR

3.7 Programme outcome, outputs

Drawing on the context analysis, lessons learnt from Phase I, and the ToC, the following section outlines the outcomes, outputs and interventions that the 2gether 4 SRHR programme will focus its efforts on. A key accomplishment of phase I of the programme was to catalyze and expand the work on comprehensive abortion care in the ESA region. Annex 3 outlines how UNFPA and WHO will expand upon the investments made in Phase I into the next phase of this joint programme. Activities linked to the various interventions will be defined in the annual work plans and budgets.

Interventions may be updated during the mid-programme review/evaluation informed by programme implementation.

The manner in which the programme will be monitored and evaluated is defined and is complemented by the attached results framework. Targets and indicators may be updated as evidence is gathered to inform programme implementation.

The communications component of the programme will be guided by the outcomes and outputs, and will aim to amplify the lessons learnt across the region, including documenting promising and emerging practices that others can benefit from during programme implementation.

1 OUTCOME 1:
Legal, policy and financial environment strengthened to enable beneficiaries to access services and realize their SRHR rights

Output 1.1 - Political, legal and policy barriers reduced

Problem statement:

The leadership, ownership and coordination by the AUC and the RECs needs to be bolstered to ensure a harmonized regional approach to SRHR to advance SRHR for women, adolescents and young people, and key populations aligned to global, continental, and regional commitments. Currently, national laws, policies and strategies are not aligned with global, continental, and regional frameworks. Efforts need to be made to strengthen country reporting on progress using peer review accountability mechanisms such as the Universal Periodic Review, Maputo Protocol, CARMMA, RMNCAH/HIV Scorecard of the EAC and the SADC SRHR Scorecard, and efforts to monitor and report on these mechanisms need to be bolstered.

Interventions:

- **Undertake high-level advocacy and facilitate strategic dialogues** with Heads of State, law makers, governments, senior policy and decision makers (in partnership with civil society and rights holders), through the African Union, RECs, and other ministerial forums to: progressively expand the legal provisions for women to access safe abortion care services; decriminalize adolescents and youth engaging in consensual sex; expand access to SRHR services without third party consent for adolescents and youth; decriminalize key populations; promote male engagement and men's health; enable men to access SRHR rights and services.
- **Provide technical assistance to countries to harmonize national SRH policies and strategies in line with global, continental, and regional frameworks** relating to maternal health (including unsafe abortion), HIV and STIs, GBV, cervical cancer, and the unmet need for family planning, while also promoting male engagement and men's health.
- **Provide technical assistance to support countries to monitor and report on progress made in meeting their global, continental, and regional SRHR commitments** using regional accountability mechanisms including the Universal Periodic Review, HIV prevention Scorecard, CARMMA Scorecard, the EAC RMNCAH/HIV Scorecard, and the SADC SRHR Scorecard, while strengthening the capacity of civil society to monitor progress using shadow scorecards.
- **Promote regional integration and harmonization of the SRHR response through convening regional multisectoral forums** of technical officials, senior officials and ministers to develop regional technical and programmatic guidance to advance universal access to SRHR, share updated programmatic guidance, develop and

monitor programmatic roadmaps to fast-track progress in addressing continental and regional commitments, and identify promising and emerging best practices that can be amplified across the region.

- **Boost efforts by the AUC and RECs to: strengthen regional regulatory and procurement mechanisms**; identify and address barriers to strengthening regional regulatory mechanisms; examine opportunities for regional pooled procurement; and provide incentives and guidelines to promote regional manufacturing of SRH commodities and supplies.
- **Advance and protect SRHR by supporting global, regional, and country advocacy efforts** to track and proactively respond to efforts that seek to undermine or reverse the SRH rights of women, adolescents and young people, and key populations; and to advance efforts that promote bodily autonomy.

Output 1.1 expected results:

1. Continental and regional SRHR frameworks domesticated into national frameworks to harmonize the response.
2. Regional regulatory and procurement mechanisms strengthened to support pooled procurement and regional manufacturing.
3. Progress in realizing SRHR commitments tracked using global and regional peer review accountability mechanisms and scorecards.
4. National SRHR laws, policies and strategies aligned to continental and regional commitments and frameworks.

Output 1.2 - Domestic, bilateral and multilateral investment in SRHR increased

Problem statement:

The lack of tools to cost the SRHR response hampers efforts to demonstrate the cost effectiveness, benefits and return on investment in SRHR. Limited coordination amongst donors and stakeholders working on SRHR in the context of UHC results in fragmentation and duplication. The nine elements of SRHR are not consistently covered in the UHC benefit package, financing mechanisms, financial protection mechanisms, and waiver schemes. There is a need to ensure that the full bundle of SRH services is progressively realized in 'UHC Benefit Packages'.

Decision-making arrangements around UHC are complex, vary significantly by country and are driven by political, technical, and economic considerations. Civil society and networks of communities lack the capacity to be meaningfully engaged in regional and national processes around SRHR in UHC, yet are critical stakeholders for ensuring that all elements of SRHR are included in the

benefit packages, financing mechanisms, financial protection and waiver schemes. Technical assistance has been provided to countries to develop Global Fund concept notes on HIV prevention for AGYW, key populations, condoms, EMTCT and integration; additional support to countries is required to translate these into tangible strategies and programmes that are implemented, monitored, and evaluated.

Interventions:

- Develop regional guidance to support the implementation of country-specific roadmaps to include comprehensive SRHR in UHC benefit packages, National Health Strategic Plans, and National Health Development Plans, as well as costing, financing and financial protection mechanisms.
- Undertake high level advocacy with Ministries of Health and Finance at regional and country level to include SRHR in UHC benefit packages, financing mechanisms, financial protection mechanisms and waiver schemes.
- Bolster capacity and support civil society and networks of key stakeholders to play a more active role in regional efforts to advance SRHR in UHC.
- Strengthen the capacity of governments to undertake resource mapping and optimisation, and to advocate for the harmonization and alignment of SRHR donor funding.
- Support countries to undertake annual national health accounts that include an analysis of the reproductive health sub-account to regularly monitor expenditure of reproductive health services and out-of-pocket expenditures on SRHR.
- Identify, support and document promising practices on public-private partnerships to increase domestic resources for SRHR.
- Provide technical assistance to countries to strengthen investments in SRHR, HIV and GBV that leverage multilateral – Global Fund, PEPFAR, Global Financing Facility on Women, Girls, and Adolescent Health (GFF) – and bilateral development investments.

Output 1.2 expected results:

- Key-elements of SRHR incorporated in national UHC and PHC packages.
- Increased domestic investments in SRHR in the context of UHC.
- Increased investments by bilateral and multilateral development partners in regional and national efforts for SRHR.

2 OUTCOME 2: Increased access to and utilisation of quality, people-centred integrated SRHR services

Output 2.1 - Regional and national capacity to provide equitable access to quality integrated SRHR increased

Problem statement:

HCWs lack the capacity to deliver the full package of integrated services as defined by global norms and standards pertaining to maternal health including unsafe abortion, STIs and HIV, cervical cancer, and unmet need for family planning. HCW norms and attitudes remain a key constraint in the delivery of services to adolescents, key populations, PLHIV and those accessing contraceptives and comprehensive and safe abortion care services as permitted by national laws. Community HCWs need to be capacitated to provide information and basic services to communities, while linking those in need of care to healthcare facilities.

Interventions:

- Use regional platforms to advocate and provide technical assistance to review and update the in-service and pre-service training curricula through engaging Ministries of Health, schools of medicine, nursing, midwifery, and in-service training programmes to ensure that new and existing cadres of HCWs have the necessary skills to provide an integrated SRH package of services according to global and regional guidelines.
- Use a blended learning approach (m-learning, e-learning and face-to-face) that strengthens the capacity of regional professional associations and national trainers to strengthen the capacity of countries to deliver an integrated package of SRH services to strengthen maternal health, CAC, HIV/STIs, GBV, and family planning outcomes aligned to global and regional guidelines.
- Draw on regional institutions to address building the capacity of national trainers to address HCW attitudes to create a more enabling environment for adolescent girls and women accessing safe abortion services, and SRHR services for adolescents and young people, key populations, and men.

Output 2.1 expected results:

- National in-service and pre-service SRHR training curricula aligned to global norms and standards.
- Strengthened capacity of national HCWs and community health workers trainers to integrated package of SRHR including HIV and GBV services.

Output 2.2 – Quality, people-centred integrated SRHR services scaled up

Problem statement:

The continued high rates of maternal mortality, deaths relating to unsafe abortion, high levels of cervical cancer, and unintended pregnancies requires that interventions focus on ensuring that relevant guidelines are in place to ensure the provision of quality services. Efforts should be made to further strengthen SRH services so that they meet the needs of specific populations, in particular adolescents and young people, women living with HIV, key populations, and men and boys. Progress in the integration of SRHR services is variable across and within countries of the region, with some more advanced than others. More efforts are needed to strengthen the integration of SRHR in certain service delivery points such as: services for CAC incorporating HIV testing and referral to treatment services, STI screening, family planning and GBV; HIV services to strengthen the provision of family planning, cervical cancer screening and GBV; family planning services to integrate HIV testing and treatment, STIs and cervical cancer screening; and GBV services to include family planning and HIV services. Assessments on the need to be undertaken periodically to assess the status of integration, quality of services and to support countries to quantify and forecast their supply needs to ensure an adequate supply of commodities.

Interventions:

- Provide technical assistance to countries to:
    - Develop national guidelines and standards, technical, clinical, and standard operating procedures that are aligned to global, continental, and regional guidelines to strengthen the delivery of SRHR services.
    - Undertake strategic assessments that assess and improve the quality of care, the state of integration, maternal health (including Emergency obstetric care (Emoc), Basic Emergency Obstetric and Neonatal Care (BEmONC), CAC, STIs and HIV, GBV, reproductive health cancers, and reproductive health commodities.
    - Strengthen the forecasting, quantification and strengthening of reproductive health commodities and supply chains to ensure an uninterrupted market supply.
- Engage regional CSOs and community networks to implement community led SRHR services, that include providing and promoting options for self-care interventions.
- Support South-South exchanges and triangular cooperation to adopt and scale up models and packages of people-centred integrated SRHR interventions aligned to global, regional, and national guidelines.

- Convene regional technical meetings in collaboration with RECs and other partners to develop regional guidance to address emerging needs on SRHR, for example self-care and virtual care, and HPV vaccination.

Output 2.2 expected results:

- National guidelines, technical and clinical standard operating procedures aligned to global and regional norms and standards updated.
- Packages and models of integrated SRHR services targeting adolescents, men and boys, key populations, and CAC, including community-based approaches, scaled-up.
- Quality of SRHR services strengthened.

Output 2.3 - High quality SRHR data and strategic information produced and used to inform the development of SRHR policies, funding and programme implementation

Problem statement:

Despite the profound benefits and commitment of governments, there are challenges with routine data collection for SRHR. There is a need to standardize indicators on SRHR, including capturing the provision of integration of SRHR services within health management information systems. Monitoring and reporting continue to be programmatic (vertical) and paper-based, resulting in a high reporting burden for HCWs. Health systems in many countries do not have tools to monitor or report on STIs, CAC and GBV and even where these are collected the extent to which they are reported is limited. There is a lack of disaggregated data by age, sex, and geography, and where data is disaggregated there is a lack of uniformity that makes cross-country comparisons difficult. Countries have been slow to introduce digital M&E platforms but those that have done so, are seeing improvements in service delivery and client management outcomes. There is also a need to complement monitoring data with operational research that can assist in improving health outcomes for clients and improve the efficiency of service delivery.

Interventions:

- Develop a regional framework and a roadmap to support countries to transition to the use of digital health platforms to strengthen national health information systems.
- Collaborate with the AU and RECs to advocate for the harmonization of SRHR indicators to track progress in the implementation of global, continental, and regional commitments. This includes the standardization of readiness, outcome, and impact indicators with clear indicator definitions, and synchronizing the disaggregation of data by age.

- Provide technical assistance and catalytic support to countries to strengthen HMIS/DHIS2 to generate, gather, analyze, and use routine health-facility data for advocacy, programme management and monitoring of progress on SRHR.
- Identify areas for, and undertake operational research to, support innovative evidence-informed practices that address the challenges and constraints to programming, guide the development of laws and policies, and promote delivery of integrated services that meet the needs of specific population groups.

Output 2.3 expected results:

- HMIS using digital data collection systems that provide real-time data at facility and community levels piloted and scaled up.
- Key SRHR indicators are disaggregated by age and sex, and realized at national and regional levels.

3 OUTCOME 3: Gender and social norms and behavioural drivers addressed for therealization of SRHR for all

Output 3.1 – Evidence on key gender norms, social norms, attitudes and values influencing SRHR outcomes used to enhance the development of SRHR policies, funding and programme implementation

Problem statement:

Social and gender norms are recognised as one of the key drivers that negatively influence SRHR outcomes, particularly the adoption of preventive and protective behaviours by priority populations. There is a need to curate available evidence generation to identify the type and strength of norms that influence SRHR outcomes, the social networks that influence the persistence of these norms, and successful approaches to address them. While research, data or other types of evidence are available in specific ESA countries or for specific SRHR issues and population groups, it is crucial to recognise that social and gender norms and behaviours are population and context specific. Hence, it is urgent to identify gaps where further evidence may need to be generated to inform targeted interventions that enable gender and social norms changes to be encouraged and measured.

There are a number of efforts being implemented across the region to generate and curate the evidence of 'what works' in terms of social and gender norms programming; this includes the work of the existing collaboration between

Oxford University and University of Cape Town on ASRH, and the South Africa Medical Research Council (SA-MRC) on GBV, but there are gaps that can be filled such as male engagement and positive masculinities, faith engagement, and addressing conscious and unconscious bias with service providers.

Shifting social and gender norms is an incremental process, and beyond evaluative approaches, there is a need to develop guidelines and standards for governments and implementers to measure progressive shifts in programme implementation and inform programme adjustments, through (among others) social listening, operational research and qualitative assessments with programme implementers.

Interventions:

- Conduct a regional scoping study to identify available evidence and undertake formative research to address identified gaps on gender and social norms undermining SRHR outcomes to inform programming. The scoping review methodology reviews existing evidence related to a topic and incorporates consultation exercises which may enhance the results, making them particularly useful to policy makers, programme implementers and service users.[61]
- Undertake a regional mapping of programmatic interventions conducted by regional stakeholders to address gender and social norms and partner with ESAR academic institutions to enhance existing regional efforts to document and curate the evidence of 'what works' to support scale up.
- Provide technical assistance to UN country interagency working groups, governments and civil society to ensure that guidance and indicators measuring social and behaviour change among specific populations: adolescent girls, men and boys, key influencers (faith-based and traditional leaders) and service providers are incorporated into routine data systems.
- Conduct time-series regional social listening to identify and track rumours (including misinformation and disinformation) and trending conversations on SRHR to inform digital engagement strategies at country level.

Output 3.1 expected results:

- Evidence-based programming strengthened to address gender and social norms undermining SRHR by UN Country Interagency Working Groups, governments, civil society;
- Evidence based and context appropriate comprehensive intervention packages are developed and supported to address key social norms change on SRHR;
- Country and regional capacity strengthened to measure gender and social norms change on SRHR.

[61] Arksey, H. & O'Malley, L. Scoping Studies: Towards a methodological framework. *Int. J. Soc. Res. Methodol. Theory Pract.* 8, 19–32 (2005).

Output 3.2 – Networks of Regional adolescent & youth, key populations, and influential stakeholders, including religious and traditional leaders, engaged and empowered to promote positive gender and social norms in ESA

Problem statement:

To support social norm interventions on SRHR, partnerships should be considered across the socio-ecological model, from the household level up to the policy and social levels. Strategic partners include networks of adolescent and youth leaders and activists, representatives of key populations, local leaders (religious, traditional, official), policymakers and the media (local, national, digital). Several partners are already working across the region to address social and gender norms related to SRHR, but these efforts tend to be disparate, limited in scale and duplicative, resulting in limited efficiency and efficacy. A coordinated effort can amplify results through partners leveraging each other's comparative advantage to ensure greater impact and a more efficient use of resources.

While political, traditional and religious leaders and other influencers are custodians of societal norms and values, their engagement is critical to ensure that perceptions around interaction with SRHR services and adoption of preventive and protective behaviours can be shifted, accepted and publicly encouraged. Governments are key drivers of those social and behaviour change interventions that often fail to meaningfully involve adolescents and youth in their design. To generate shifts in norms affecting adolescents and young people, particularly those most at risk, it is essential to engage the relevant networks of youth SRHR advocates and champions, including those representing key populations. This can demonstrate to concerned communities that their peers and people similar to them do not practice (for example) a specific behaviour, and explain why and what they do instead. Interventions often neglect the needs of key populations owing to legal and policy barriers, and networks of key populations do not necessarily have the capacity to design, implement, monitor, and evaluate social and behavioural interventions. Furthermore, where toolkits have been developed, the extent to which they are rolled out is limited owing to a lack of resources.

Regional networks of influential youth, representatives of key populations and constituencies of men and boys promoting positive masculinity are critical stakeholders to ensure that evidence-based social and behaviour change approaches, tools and platforms are adapted and rolled out in the region. 2gether 4SHR UN partners can nurture youth-led social change by strengthening the capacity of these regional networks to conduct advocacy; identify and rally champions at both regional and country level; establish peer-to-peer counseling and referral pathways both digitally and on the ground (for in- and out-of-school adolescents and young people).

Interventions:

- Based on findings of the regional mapping, strengthen coordination and collaboration across networks working on gender and social norms and SRHR to form a regional alliance of like-minded partners and influencers to address social and gender norms on SRHR in the region.
- Based on the regional mapping, evidence-based strategies are developed, implemented, monitored and evaluated to engage regional coalitions and networks of traditional and religious leaders, as well as other influencers, in dialogue and consensus-building to address social norms undermining SRHR.
- Build the capacity of regional adolescent- and youth-led networks and champions, with a focus on youth-led advocacy, leadership skills, and digital engagement to promote access to youth friendly information and referrals to services promoting social accountability.
- Engage and strengthen the capacity of regional men and boys' networks to address gender and social norms to promote positive masculinity to enhance SRHR outcome.
- Support regional networks of media development partners to strengthen SRHR agenda-setting in the media while reporting on socio-cultural norms and practices that advance and protect SRHR in the region.

Output 3.2 expected results:

- Regional coordination, including South-South and triangular collaboration and cross learning, strengthened to improve efficacy and efficiency of programming to address gender and social norms.
- Regional and national networks of adolescents and youth, networks of key populations, men and boys systematically use social listening insights and leverage digital and peer counseling platforms to promote positive social norms among communities and gatekeepers.
- Religious and cultural leaders' support galvanized to advance the SRHR agenda in the region through issuance of favourable public statements, declarations and petitions.
- SRHR issues discussed more prominently and favourably in the media.

4 OUTCOME 4:
Resilient health systems and communities are enabled to ensure thecontinuity of SRHR Services during crisis

Output 4.1 - Policy and legal environment enabled to address SRHR during humanitarian crisis and emergency situations

Problem statement:

Most countries in the region face multiple hazards including conflict and climate change that manifest in acute and protracted episodes, and indeed, the recent COVID-19 pandemic demonstrated that every country is vulnerable to some form of crisis. Besides the importance of including SRH care in humanitarian responses, there is recognition that more collective efforts are required to further invest in preparedness and response strategies to strengthen the resilience of health systems. To sustain such efforts and hold governments accountable, work at the policy level is essential to ensure the integration of SRH into national emergency-related policies and development frameworks, including policies related to resilience, preparedness and disaster risk reduction. This need has clearly been highlighted by the results of the MISP Readiness Assessment, and consequently, most countries have included the strengthening of the policy environment as part of their national roadmaps.

Regional SRHR frameworks can be strengthened to take into consideration the need for resilient health systems responsive in times of humanitarian disasters. However, the extent to which progressive regional frameworks should be amended needs to be informed by the risk of roll-back of existing rights in those frameworks. Development and humanitarian efforts operate with different actors, different coordination mechanisms, and different legal, policy, strategic frameworks, as well as service delivery modalities. There is a need to strengthen coordination between SRHR actors and humanitarian partners to promote a coherent risk-informed approach to strengthening SRHR programming, based on a shared analysis and joint planning, with one plan of action and with collective outcomes.

Efforts to ensure resilient health systems and communities will be coordinated through the RIASC and RHPT as platforms for coordination of regional development and humanitarian actors.

Interventions:

- Advocate and provide technical assistance to the AUC and RECs to strengthen SRHR outcomes within continental and regional humanitarian and SRHR frameworks.
- Strengthen the coordination between humanitarian and development actors, including civil society, to be engaged in regional SRHR forums convened in partnership with the AUC and RECs.

- Strengthen capacity and provide technical assistance to civil society to advocate for SRHR in emergencies and preparedness.
- Advocate for a policy environment that supports the provision of SRH in emergencies by advocating for the integration of the MISP into national Ministries of Health (and other ministries as relevant) emergency, preparedness, recovery and disaster risk reduction policies and plans, and advocate for the inclusion of disaster management and/or emergency response into SRH development policies
- Strengthen preparedness and resilience efforts by enhancing domestic financing efforts to integrate SRHR in UHC, by building on the action plans deriving from the MISP Readiness Assessment.
- Strengthen regional buy-in for the integration of SRHR, HIV and GBV in vulnerability assessments through dissemination of evidence-based minimum viable products to facilitate adoption at country level, e.g., the National Vulnerability Assessment Committees.

Output 4.1 expected results:

- Continental and regional SRHR frameworks incorporate humanitarian aspects.
- SRHR incorporated into the national emergency preparedness and response plans of countries.
- UHC plans incorporate provisions to address the SRHR needs of refugees, migrants, and internally displaced populations.
- Civil society capacitated and engaged in regional advocacy efforts to strengthen SRHR in humanitarian settings.

Output 4.2 - Resilience of health systems strengthened to provide the minimum integrated SRHR service package (MISP) in times of crisis

Problem statement:

Humanitarian crises, including associated migration and forced displacement, undermine access to prevention, treatment, care, and support services, including for example: contraceptives, condoms, post-exposure prophylaxis, CSE for youth in- and out-of-school, mental health and psychosocial support. Disrupted access to health services leaves those affected vulnerable to early and/or unintended pregnancies, including teenage pregnancies, unsafe abortions, STIs, new HIV infections, all forms of GBV, chronic disease treatment interruption, and maternal and neonatal morbidity and mortality. The MISP Readiness Assessment clearly highlighted the need to strengthen the health systems in the region by building the capacity of HCW specifically on SRH in crisis, improving health infrastructures and improving access to medical commodities by having stronger supply chain management systems.

Interventions:

- Provide catalytic funding and technical assistance to countries to strengthen the implementation of the essential service package and Inter-Agency Standing Committee (IASC) guidelines for integrating GBV intervention in humanitarian actions, as well as the adoption of WHO protocols in humanitarian settings for the clinical management of rape and intimate partner violence, within the country context.
- Provide catalytic and technical support to countries to implement roadmaps for undertaking vulnerability assessments that integrate SRHR, HIV and GBV and sensitize countries on their vulnerability to political, climatic, and socio-economic shocks and disease outbreaks.
- Build the capacity of HCW to provide MISP on SRH in crisis situations.
- Advocate for the inclusion of the MISP or SRH in emergencies into national health training curricula and other relevant training platforms by providing technical support, guidance and enabling learning between countries.
- Provide catalytic and technical support to countries to implement national roadmaps to strengthen health systems to implement the recommendations arising from the MISP Readiness Assessment.
- Provide technical support to EAC and SADC for the establishment of a regional humanitarian supplies pre-positioning scheme to address rapid onset crises to support advocacy efforts for increased country level funding for supplies in humanitarian settings.

Output 4.2 expected results:

- Country capacity strengthened to implement key SRHR and GBV normative guidelines and protocols in humanitarian settings.
- Preparedness and resilience of national health systems to respond to humanitarian crisis strengthened.
- Regional pre-positioning schemes established in the EAC and SADC regions to enable a rapid response to the onset of humanitarian crisis.

Output 4.3 - Evidence base for humanitarian and emergency response strengthened

Problem statement:

Recurrent humanitarian crises caused by extreme climate-related and man-made hazards, political instability and outbreaks of disease highlight the need to strengthen the resilience of health systems to respond to protracted and recurrent humanitarian crises.

These crises result in an increased portion of the population at risk of death, disease, and loss of livelihoods. There is a need to strengthen the regional situational analysis by developing harmonized assessment tools, undertaking ongoing regional assessments of various forms of vulnerability and measuring their impact on the delivery of SRHR services. Monitoring and reporting systems during emergencies are undermined, such as reporting on the continuation of service delivery, as well as quantification of commodities and supplies; and the lack of real-time actionable data hampers programming in response. There is very limited understanding of the impact of the humanitarian crisis on key populations and other vulnerable populations.

Interventions:

- Facilitate data generation and collection of key SRHR needs, continuation of SRHR services in crisis settings, funding and prioritization in the region, including through the African Health Observatory (AHO) Network and Demographic Surveillance Sites (DSS).
- Provide technical assistance and catalytic support to countries to build on efforts to review and strengthen data collection monitoring tools and systems during humanitarian crisis, in health and community systems; ensure that readiness, outcome, and impact data are captured across the key elements of SRHR and disaggregated by age, gender and geography; and undertake reviews of the data to strengthen programming.
- Undertake operational research (to strengthen programming for SRHR) on the experiences of various population groups – including adolescents and young people, key populations, and people with disabilities – within humanitarian settings, identifying the barriers to accessing services and effective actions to reduce the vulnerability of these population groups in times of crisis.

Output 4.3 expected results

- Data collected and used to leave no one behind and to support resource mobilization.
- Monitoring and reporting strengthened in humanitarian crisis drawing on existing data collection tools.
- Operational research undertaken and recommendations implemented to strengthen programming to meet the SRHR needs of populations left behind in humanitarian crises.

3.8 Monitoring, evaluation and learning

2gether 4 SRHR will use a results-based management (RBM) approach that focuses on what is to be achieved, what has been achieved and what can be done differently to increase the chances of achieving Programme outcomes. A Results Framework that follows the RBM approach shows the logical sequencing of programme deliverables and key indicators that will be used as the basis for monitoring, evaluation and learning (MEL).

The programme will support evidence generation during routine reviews, learning and adaptive programming to ensure the realization of intended results. Based on learning and required adaptations during implementation, additional updates may be required to the ToC, the M&E Plan and reporting platform as the need arises.

Monitoring will happen on two levels:

1. *Monitoring indicators to track progress towards the achievement of outputs and outcomes:* Output and outcome indicators as captured in the Results Framework will be tracked and reported annually by the four agencies at country and regional level on the 2gether 4 SRHR monitoring and Data for All (DFA) platform. The Results Framework provides guidance on how to report on the indicators including the level of reporting expected, data disaggregation, indicator numerators and denominators where applicable and potential data sources. The indicator baseline and targets are also captured in the Results Framework.
2. *Monitoring of annual work plans:* Based on the interventions put forward in this proposal, the joint annual work plan developed by the Regional Interagency Working Group (RIWG) will reflect all activities to be completed in a year. The annual work plan will capture the rationale for the chosen activity, measurable milestones and intended results. Reporting against the work plan activities will be done on a bi-annual basis; at mid-year to assess the progress towards milestones and at the end of the year to assess progress towards the realization of intended results in the DFA. Following the RBM approach, the reports will reflect the achievements; what the activities have resulted in; the reasons behind the achievement or non-achievement of results; lessons learnt; what can be done to increase the chances of achieving results and an assessment of the expenditures. Supporting documentation (means of verification) will be uploaded in DFA against reported activities.

MONITORING
will happen on two levels:

1 Monitoring **INDICATORS** to track progress towards the achievement of outputs and outcomes

2 Monitoring of **ANNUAL WORK PLANS**

Evaluations and reviews

Programme evaluations and reviews will serve as critical inputs to the programme's learning agenda, supporting evidence generation, and required programme adaptation. The 2gether 4 SRHR M&E Plan provides for a baseline assessment of indicators, mid-term review and end of term evaluation for the purposes of determining the extent to which the programme has achieved the outcomes

and the related outputs. Additionally, these reviews aim to identify lessons learned and successes that can inform future joint efforts.

Baseline data will be sourced from the external evaluation and final report of Phase I. For (new) indicators where no data is available, the baseline will be established, and 2025 targets will be computed in the first quarter of implementation.

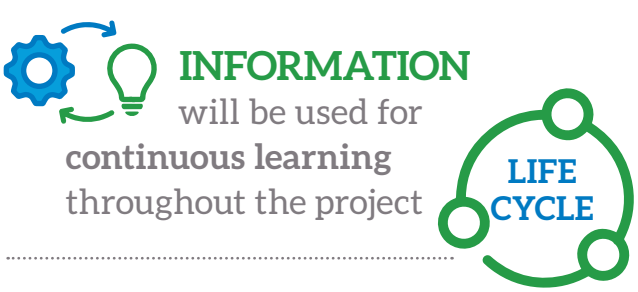
A *mid-term review* will be conducted to determine the extent to which the programme is on track to meet its objectives, to identify implementation successes, challenges, and lessons learnt, and to recommend corrective actions. This will be a light process intended to inform the programme in real time.

An *end-of-term evaluation* will determine the extent to which the project has progressed toward its goal of contributing to fast tracking the achievement of the SDGs in ESA and will identify lessons learnt as well evidence-based practices and successes to inform future efforts.

Learning

Information produced through programme implementation will be used for continuous learning throughout the project life cycle, for example:

1. *Internal and external collaboration:* The programme will actively track, and document lessons learnt on Delivering as One, including the development of standard operating procedures to guide the operational implementation of the programme. Lessons learnt from the use of thematic interagency platforms will use the information and evidence of actual results generated through programme implementation to inform decision-making on a continuous basis. This will be done via annual planning meetings, and resourcing and delivery of programmes and activities, as well as through accountability and reporting. Efforts will be made to continuously reflect on both collaborative efforts to advance progress in domesticating global, continental and regional frameworks, and engagements with regional forums of Parliamentarians, including the use of agile teams to address specific issues where appropriate.
2. *Technical evidence base:* The programme will develop, track, and contribute to a technical evidence base that can be used to inform planning and implementation. A document repository on data for all will serve as a means for tracking progress with joint work plans, budgets, and deliverables generated through the programme. Documents from this repository can be shared, and teams can learn from each other. The knowledge hub, as part of the Regional TA Hub, will be used as a platform for agencies to share relevant data, technical documents and reports, as well as advertise upcoming events supported by the programme.
3. *Testing the theory of change:* The programme will continuously test the ToC based on the findings from M&E products. This will be done annually during the work planning process and will encourage learning and constant reflection on what the programme intended, rendering the M&E Plan, ToC and the Results Framework more dynamic.
4. *M&E for decision-making and adaptive programme management:* The programme will ensure that information produced is used to guide decision-making processes around implementation.



3.9 Communication and amplification

The communication strategy of 2gether 4 SRHR will aim to galvanize, advocate, and amplify the combined efforts of the four participating agencies into one powerful voice to advance the SRHR targets of the SDGs in ESA.

The objectives of the communication strategy are to:

- Guide strategic communication of the programme to internal and external audiences in close collaboration with the RIWG and the regional interagency thematic teams (RITTS).
- Support high-level advocacy around SRHR, HIV and GBV by developing the requisite and agreed-upon communication and media materials to support programmatic efforts in this area.
- Build a public profile and visibility that emphasizes one UN voice and demonstrates Delivering as One, achievements, lessons learnt and benefits of the programme to expand awareness, implementation of, and demand for, integrated services.
- Amplify lessons on integration of SRHR, HIV and GBV by documenting and disseminating promising practices, lessons learnt and the programmes impact on challenges in the region.

Activities will be structured into four broad pillars:

- *Public advocacy and communication:* Use public platforms and processes to influence decisions on scaling up SRHR, HIV and GBV services (nationally and regionally), so that all persons can exercise their rights and enjoy improved access to quality integrated services. This may directly and indirectly influence decision makers, stakeholders, and relevant audiences to support the 2gether 4 SRHR programme.
- *Knowledge management* (documentation, amplification and sharing lessons): Support partners using a range of tailored communication and knowledge sharing tools, approaches, and methodologies to effectively share information and learning. Two broad sub-strategies include:
    - Internal knowledge sharing and learning
    - External information sharing and dissemination
- *Documentation and sharing of best practices:* Develop standardized criteria, informed by the evaluation, against which promising and good and promising practices to be amplified across the region will be determined.
- *Media engagement*: Focus on media capacity strengthening by developing media kits on SRHR, HIV and GBV and strengthen partnerships with media organizations to capacitate journalists reporting on these issues.

Implementation of the Communication Strategy will be monitored on an ongoing basis, and jointly, by all the communication focal persons in the agencies, to ensure success and apply insights gained. The three levels of M&E will be undertaken through:

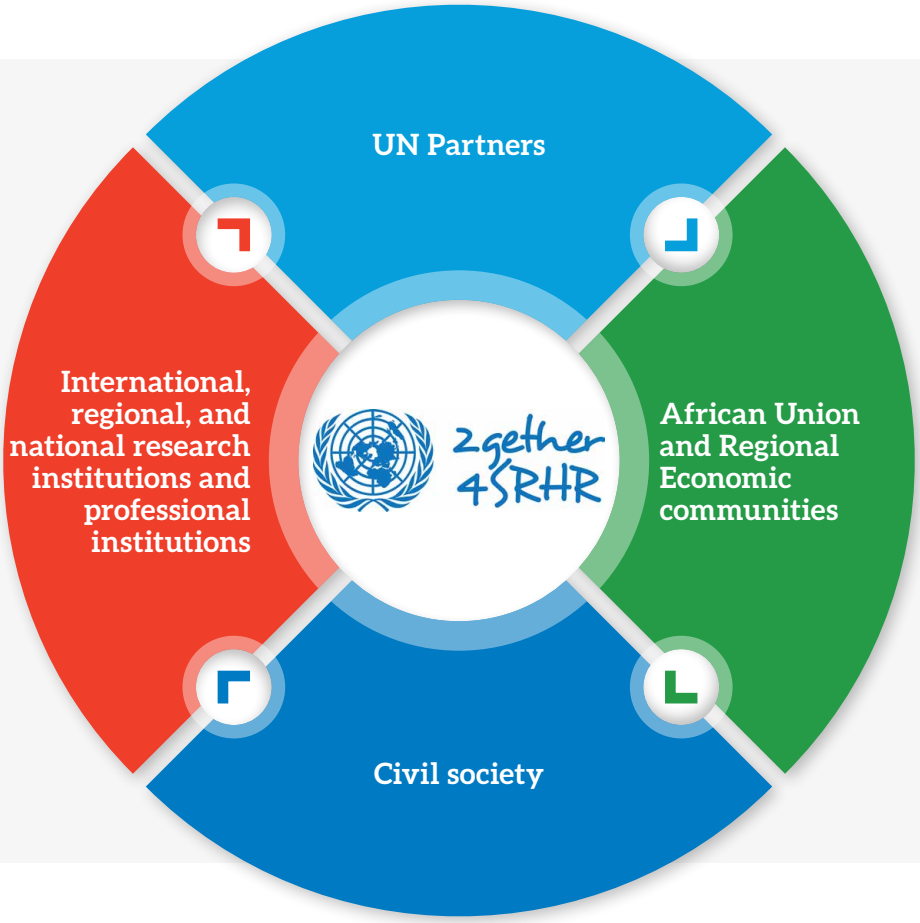
- Establishing key performance indicators for events and communication activities to measure reach and dissemination.
- Evaluating the impact of communication products and processes through short surveys on campaigns so that learning can improve future efforts.

04.

Partnerships and linkages

2gether 4 SRHR will develop a partnership strategy[62] to guide engagement of the programme to draw upon and expand existing partnerships, and to strengthen coordination mechanisms for programme implementation, advocacy, coordination, monitoring and reporting.

UNFPA ESARO as the Convening Agent (CA), working in close collaboration with the RIWG, will lead on the development of the partnership strategy and the convening of relevant partnership forums. In particular, the partnership strategy will outline how the programme will engage with UN partners, the AU and RECs, civil society, and research institutions and professional bodies.



[62] The Partnership Strategy to inform the implementation of Phase II will be developed by August 2023 as per Annex 1.5.

UN Partners

2gether 4 SRHR is aligned to and will support the broader regional UN reform agenda. The programme will coordinate, share tools, resources, results, and lessons learnt from existing regional agency-specific and interagency initiatives through the Regional Collaborating Platform (RCP), the H6, and the Initiative on Harmonization for Health in Africa (HHA).

Programmatically, 2gether 4 SRHR will leverage and collaborate with the UN Regional AIDS Team for East and Southern Africa (RATESA), the EU-funded Spotlight Initiative on GBV, harmful practices and SRHR (UNICEF, UNFPA); the Maternal and Newborn Health Trust Fund; The Joint Programme on Ending Child Marriage Programme; the Joint Programme to end female genital mutilation (UNICEF and UNFPA); the Technical Coordinating Group for Eastern and Southern Africa; the Ministerial Commitment on Sexuality Education and SRHR Services for Adolescents and Young People (UNFPA, UNESCO, WHO, UNICEF, UNDP, UNAIDS, among others); and Education Plus (UNAIDS, UNICEF, UNFPA UNESCO, and UN Women).

2gether 4 SRHR will collaborate and coordinate its efforts with SRHR initiatives implemented by other UN Agencies including, but not limited to:

- The UNESCO Our Rights, Our Lives and Our Future Campaign (O3) on CSE;
- UNDP Inclusive Governance Programme to strengthen laws, policies and programmes that address the rights of the LGBTQI community in ESA;
- The IOM SRHR-HIV Knows No Borders Consortium that aims to improve SRH and HIV related outcomes among migrants and non-migrant populations in six countries;
- The World Bank's Global Financing Facility on Women, Children and Adolescents' Health; and
- The Global Fund to Fight AIDS, Tuberculosis and Malaria.

African Union and Regional Economic communities

2gether 4 SRHR will work, and strengthen linkages and collaboration, with the AU to advocate for the domestication, monitoring, and reporting on the Maputo Protocol and CARMMA to operationalise the Maputo Plan of Action.

This will include:

- Expanding and deepening its collaboration with the RECs including the East Africa Integrated Health Programme at the EAC and the Social and Human Development Directorate of the SADC Secretariat to support the domestication of regional SRHR frameworks and track progress towards the SRHR targets of the SDGs.
- Convening annual programmatic meetings of countries to develop roadmaps, and take stock of progress made and lessons learnt.
- Strengthening linkages with the Indian Ocean Community to advance SRHR amongst the island communities.
- Continuing to partner with regional parliamentary forums (Pan African Parliament, East African Legislative Assembly, and the SADC Parliamentary Forum), and the human rights institutions to advance SRHR.

Civil society

2gether 4 SRHR will enhance its positive working relationship with civil society in ESA through continuing to advocate for the inclusion of civil society within high-level regional intergovernmental processes and structures that oversee the development of strategic regional frameworks, advocacy efforts, capacity building, and movement strengthening. It will convene annual partnership meetings with civil society and seek to strengthen a coordinated effort related to SRHR.

International, regional, and national research institutions and professional institutions

2gether 4 SRHR will partner with international, regional, and national research and professional institutions to support capacity building efforts and undertake operational and programmatic research to strengthen evidence-based programming. It will ensure that critical partners are incorporated into the TA Hub so that countries can benefit from these skills and expertise.

2gether 4 SRHR partners with regional and country-level SRHR-focused CBOs such as Kulima CBO in Malawi.

Photo: © UNICEF Malawi

05.

Implementation Modalities

Regional Interagency Working Group (RIWG): supported by interagency M&E and Communications Working Groups that will oversee the implementation of the programme.

Regional Programme Implementation: through drawing on the collective technical expertise of the four partner agencies to support continental and regional coordination and harmonization, advocacy, knowledge brokering, provision of quality technical assistance, capacity building, promoting South-South learning and exchange and innovation. This includes piloting Regional Interagency Thematic Teams, a time-bound flexible mechanism that brings together the collective efforts of the four agencies to address a specific thematic area.

Joint SRHR Fund (JSF): a flexible funding modality that provides time-bound and catalytic support for applied learning in countries selected against defined criteria and promotes innovative approaches to address key or emerging issues using small grants.

Technical Assistance Hub (TA-Hub): A technical assistance, knowledge management, and capacity-building resource for regional partners and countries in the region.

5.1 The Regional Interagency Working Group (RIWG)

The RIWG is responsible for day-day management and implementation of 2gether 4 SRHR. The RIWG brings together focal persons from the four agencies who coordinate efforts internally in their respective agencies and ensure collaboration and coordination across the four agencies in respect of programme implementation.

The RIWG is accountable for the development of the joint annual work plan and budget as aligned to the outcomes, output and interventions defined in this proposal. Agencies will agree on roles and responsibilities in relation to programme activities using the RACI model with the following delineation.

- Accountable Agency – allocates financial resources, coordinates and leads the implementation of the proposed activity.
- Responsible Agency – provides technical input to support implementation of the activity that may include the additional funding for the activity.

- Consulted Agency – provides input where necessary in the execution of the activity.
- Informed Agency - informed of progress as part of regular programme meetings.

The work of the RIWG is supported by an M&E Technical Working Group and Communications Working Group composed of focal persons from the four participating UN agencies. The M&E Technical Working Group will oversee the monitoring, evaluation and learning activities of the programme guided by the M&E Plan.

The Communications Task Team will oversee all external communication and visibility activities and the documentation of promising and emerging practices guided by the Communications Strategy.

The RIWG will coordinate the support by the four partner agencies through this programme to the AU, RECs, and regional forums of Parliamentarians.

The RIWG will promote the principle of Delivering as One through convening technical experts from the four participating agencies to collaborate in the implementation of the work plan. A modality that will be piloted is the convening of regional interagency thematic teams (RITTS). The RITTs will be flexible, time bound and implement an agreed upon action plan that is aligned to the outcomes, outputs and intervention of this joint programme. The initial focus will be on three RITTs (SRHR in UHC, CAC and ASRH). The illustrative contribution of the RITTs to outcomes and outputs of this joint programme is reflected in the table below.

Regional Interagency Thematic Teams

		OUTPUT CONTRIBUTION									
REGIONAL INTERAGENCY THEMATIC TEAM (RITT)	CONTRIBUTING AGENCIES	1.1	1.2	2.1	2.2	2.3	3.1	3.2	4.1	4.2	4.3
1. SRHR in UHC	UNAIDS UNFPA UNICEF WHO	◉	◉	◉	◉	◉			◉	◉	
2. Adolescent Sexual and Reproductive Health and Rights	UNAIDS UNFPA UNICEF WHO	◉		◉	◉		◉	◉			
3. Comprehensive Abortion Care	UNFPA WHO	◉		◉	◉	◉	◉	◉			

Crosscutting: Gender, Leave No One Behind and Data

5.2 Regional programme implementation

The programme will use a regional approach to strengthen country responses to improve the sexual and reproductive health and wellbeing of all people. In drawing upon the regional approach, the programme may use any of three modalities to engage and support countries:

Advocacy: The programme will support the undertaking of coordinated advocacy to create an enabling legal and policy environment guided by a regional advocacy strategy to address key SRHR priorities in the region[63].

Regional coordination mechanisms: The programme will work with regional economic communities, forums of Parliamentarians and civil society to harmonize the regional response through providing technical and financial support to the RECs: to convene regional coordination mechanisms with technical experts of Member States to track progress in implementation of regional frameworks; provide technical updates; and share promising practices. The outcomes of these regional meetings are inputted into the meetings of the Senior Officials of the Member States and Ministers of Health, providing political support and commitment to action.

Convening technical forums on key areas of SRHR: The programme may convene meetings with countries on a specific topic to strengthen their capacity on a key area of work. During the meeting country delegations comprising of country UN interagency working groups and relevant ministries and civil society partners develop plans of action to strengthen SRHR outcomes. Catalytic support is provided through the country UN interagency working groups to support relevant ministries or civil society partners to implement the action plans. Regular follow up forums provide the basis to facilitate cross-country learning and South-South cooperation, while identifying promising practices. This approach has been successfully applied in Phase I to advance the work on CAC that started with eight countries and has systematically expanded to 12 countries.

Programme assessments and strengthening programme implementation: The regional level agencies will provide catalytic funding to countries to undertake programme assessments to gather data that can be used for advocacy purposes at regional and national level, or that can be used to identify areas to strengthen programme implementation. Catalytic funding is provided through country UN interagency working groups to support relevant Ministries and civil society partners to implement priority recommendations from the country assessments, that can also be used as best practices to support programme implementation. This approach was successfully implemented in Phase I to track the disruption of COVID-19 on SRHR services and to assess the extent to which health systems are prepared to implement the MISP for SRHR.

Leadership from EAC and SADC in dialogue with youth at SRHR symposium organised by the 2gether 4 SRHR.
Photo: © 2gether 4 SRHR

[63] Advocacy strategy to be finalized April 2023 as per Annex 1.5

Nurse Fales Tchewa, 42 (left) follows up on various interventions children, like immunisation and growth monitoring, at Katozi Health Post, Kasungu, Malawi.

Photo: © 2gether 4 SRHR/UNICEF

5.3 The Joint SRHR Regional Fund (JSF)[64]

The Joint SRHR Regional Fund (JSF) was piloted in phase one to enable all country UN interagency working groups in the ESA region to have the possibility of receiving catalytic funding to support the efforts of relevant Ministries and/or civil society to adapt and apply global and regional frameworks, standards and guidelines to advance SRHR, and to sustain, scale up, and document programme implementation. In the context of COVID-19, funds were also intended to ensure the continuity of essential SRHR services and support the recovery by addressing neglected areas of SRHR, including CAC and GBV.

In Phase II it is foreseen that the JSF will comprise of two components namely:

- **Catalytic funding mechanisms**: These will be awarded to country UN interagency working groups to address a particular area of SRHR that may be underserved or to test approaches that others may learn from aligned to the outcomes and outputs of this joint programme.
- **Innovation**: These will be awarded to UN Country Interagency Working Groups, civil society partners, service providers, researchers, academics, or private sector to provide innovative solutions or ideas to address a key issue or strengthen a particular aspect of SRHR.

JSF catalytic funding mechanism

In Phase I of 2gether 4 SRHR, the JSF was piloted as a catalytic funding mechanism for country UN interagency working groups,

[64] Draft SOP for JSF Catalytic Funding Mechanism and Innovation Fund to be finalized by April 2023 as per Annex 1.5

Mavis, a young mother from Malawi, is proud that her daughter was born HIV negative. Mavis is part of the Mentor Mothers programme implemented by 2gether 4 SRHR.

Photo: © 2gether 4 SRHR

guided by standard operating procedures, that defined the process for developing the Terms of Reference for the call for proposals, distribution of the call for proposals, the selection process, the decision making process, and the disbursement of funds.

Lessons learnt from the piloting of the catalytic funding modality included the need to ensure that:

1. The expression of interest (22/23 countries in the ESA region submitted joint proposals) demonstrated both the interest and ability of countries to convene the four agencies to pull together a proposal.
2. Call for proposals should be preceded by an expression of interest upon which country UN interagency working groups could submit concept notes for consideration. Shortlisted countries can be invited to submit fully-fledged proposals.
3. Call for proposals should be more strategically focused, and issue-based rather than linked to the outcomes and outputs.
4. There needs to be a clearer definition of terms (interventions/activities) and the indicators that will be used to score the proposals.
5. Scoring should be agreed upon in advance, to ensure that there is consistency in scoring across the four participating agencies with a better understanding of what is being scored.
6. Feedback should be provided to country UN interagency working groups as to why proposals were selected or not selected.

The standard operating procedure in Phase II will be revised drawing upon the lessons learnt from Phase I. Issue-based terms of reference will be developed for the call for proposals by the RIWG, in consultation with relevant technical colleagues. The call for proposals will address gaps or keys areas of SRHR that are lagging behind, aligned to this programme document. All agencies will contribute 30 per cent of their funding allocations to support the catalytic funding modality.

The draft call for proposals will be submitted to Sida and other participating donors for concurrence prior to being shared with the Regional Interagency Steering Committee (RISC), the highest decision-making body of the programme, for approval.

The call for proposals will be disseminated through the UNFPA Regional Director as the convening agency. UNFPA Country Offices will be requested to coordinate the development of concept notes by the four participating agencies. Country UN interagency working groups will be invited to submit concept notes for consideration that will be selected against agreed-upon criteria, including:

- The extent to which conducive SRHR laws and policies are in place,

- SRHR is prioritized by the country and there is political will to advance SRHR ; and
- An enabling environment exists to advance a key issue.

Preference will also be given to countries furthest behind in meeting key SRHR targets of the SDGs including:

- Maternal mortality ratio (deaths per 100,000 live births)
- Average annual number of abortions per 1,000 women aged 15–49
- HIV incidence per 1,000 population
- STI incidence rate
- Unmet need for family planning, women aged 15-49
- Intimate partner violence prevalence
- Adolescent birth rate per 1,000 females
- World Bank FY22 list of fragile and conflict-affected situations.

The RIWG will review and shortlist the concept notes submitted by the country UN interagency working groups and make recommendations to the RISC on countries to be invited to submit fully-fledged proposals.

UNFPA in-country will convene the respective country UN interagency working groups in the shortlisted countries to develop a fully-fledged proposal with a two year work plan and budget using a standardized template adapted from the UNDG guidance pertaining to Joint Programmes. Country UN interagency working groups will be required to report on progress made on an annual basis. Funding allocations will be reviewed annually and disbursements will be determined against the annual expenditure rates by the respective country UN interagency working groups.

The RIWG will convene meetings with countries to share their work plans, results and lessons learnt so that they can benefit from each other's experiences. Countries will also share the results and lessons learnt as part of regional forums convened with the RECs and other partners.

JSF innovation funding mechanism

This is proposed as a new funding modality according to which funding can be awarded to civil society partners, service providers, researchers, academics, private sector bodies or UN Country Interagency Working Groups to provide innovative solutions or ideas to address a key area of SRHR. All agencies will contribute 10 per cent of their funding allocations to support this funding modality.

Terms of reference will be developed that will be shared with Sida and/or other donors prior to approval by the RISC. The call for proposals will be publicly advertised using the standard UNFPA procurement modalities. Implementation will not exceed more than one year. The selection will be based on a competitive process using the procurement mechanisms of the respective accountable agencies. The RIWG will receive and review bids based on an agreed-upon scoring criteria. Recommendations will be made to the RISC which will advise on the final selection.

5.4 Technical Assistance Hub

A key role of the regional entities of the UN agencies to is to ensure that countries are provided with quality technical assistance to broker the development of knowledge products including the generation of evidence, such as undertaking studies across countries

to inform programming, documenting "best and promising" practices, promoting cross country learning, South-South and triangular co-operation, and building the capacity of stakeholders across countries.

The RIWG will continue to oversee the development and expansion of the Joint UN Regional SRHR Technical Assistance Hub (TA Hub) that will be a TA, knowledge management and capacity building resource for regional partners, country UN interagency working groups, government ministries, and civil society partners across the region.

All agencies will contribute towards the management of the TA Hub proportional to their funding allocation and will procure technical assistance from the Hub on an as-needed basis, following internal agency procurement processes.

The TA Hub will comprise:

(i) *A database of technical experts* working on different areas of SRHR across the four participating UN agencies.

(ii) *A database of external technical experts, professional associations, organizations, academic institutions, and service providers* with long term agreements that can provide quality assured, timely and well-coordinated technical assistance to countries.

(iii) *The SRHR Knowledge Hub* as an online regional one-stop information and knowledge platform on SRHR. It will contain global and regional commitments, normative guidance, policies and standards, evidence and research, and promising practices, to strengthen regional capacity with a focus on translating knowledge into practice.

(iv) *A virtual capacity building platform* for country UN interagency working groups, RECs, HCWs, community health workers and other relevant professional cadres that will offer a range of interactive virtual training workshops, webinars and video conferences on existing and emerging SRHR training tools and resources.

TA Hub will be further refined based on the scoping assessments currently underway and a detailed proposal will be presented for SIDA's approval once the structure is defined.

06.

Financial management

2gether 4 SRHR will be implemented in accordance with the guidance provided by the United Nations Development Group (UNDG) for joint programmes, using a pass-through funding modality.

The relationship between the four UN agencies and Sida will be guided by the Standard Administrative Agreement between Sida and UNFPA, which is attached as Annex 6. The UNFPA Division for Communication and Strategic Partnerships will serve as the Administrative Agent (AA) for the effective and impartial fiduciary management and financial reporting.

The relationship between the four agencies will be guided by a Standard Memorandum of Understanding (MOU) that outlines the terms and conditions governing the relationships, implementation, M&E, and financial management of the programme. The standard MOU template is attached as Annex 7.

UNFPA ESARO will be the Convening Agent (CA), with programme implementation supported by a programme unit who will convene and coordinate the four participating UN agencies.

The disbursement of funds will be in accordance with the disbursement schedule agreed upon with Sida. The AA will request Sida to disburse funds in support of the implementation of the programme based on the agreed disbursement schedule. Funds will be disbursed to the four participating agencies based on the minutes of the RISC that will be submitted to the AA that indicates that the work plans and budgets were approved by the RISC. The Chair of the RISC will request the AA to disburse the funds to the participating UN agencies based upon the approved annual work plan and budget. Funds will be disbursed based on allocations agreed to in the finalized work plan and budgets as presented by the RIWG and agreed to by the RISC.

The internal disbursement of funds by each of the participating agencies is in accordance with the work plan and budget as approved by both Sida and the RISC by no later than 15 December each year. Each participating agency will be responsible for disbursing the funds in support of the joint work plan, based on their internal policies and procedures. Each agency will retain accountability for resources and results entrusted to them.

UNFPA as the AA will provide an annual programmatic report by 31 May each year and the Division for Strategic Communication and Partnerships will provide a financial report by 31 May of each year. UNFPA will submit the annual work plan and budget to Sida no later than the 15 November each year.

Youth representing inter-agency advocacy movements from across the region gathered at the annual UNITED Youth Summit on SRHR.
Photo: © 2gether 4 SRHR

A detailed budget (Annex 1) and budget notes (Annex 1.1) are included as annexes to the main agreement. Annex 1.2 outlines the human resources required to support the implementation of the programme by the four participating agencies, the costs of which are reflected in the detailed budget (Annex 1).

Annex 4 outlines the risks that may hamper or constrain programme implementation during the life cycle of the programme and mitigation strategies that the programme will put in place to mitigate these risks. The RIWG will review and monitor these risks as part of its mid-year and end of year review and will provide a report to the RISC with recommendations for actions to be taken. Where risks do arise the RIWG that may have a negative effect on programme implementation the RIWG may consider these during an ad hoc meeting, engage and provide recommendations to the RISC.

Annual programme and financial review meetings will be held with Sida and other donors. Sida and other donors will be invited to participate in joint meetings and activities, and country visits.

Financial sustainability and the resource mobilization

During Phase I of the programme investments by Sida were amplified through leveraging different funding sources.

Core resources: Each of the four agencies leveraged core resources through drawing upon existing technical experts at regional and country level to support programme implementation. Core resources for programme implementation were also leveraged to support programme implementation.

Unified Budget, Results and Accountability Framework (UBRAF): Resources were leveraged by the four partner agencies to complement investments in engaging with regional forums such as meetings of the National AIDS Councils at regional level and to support programme implementation.

Global Fund for AIDS, TB and Malaria: Countries leveraged off investments by the 2gether 4 SRHR Programme to unlock resources from the global fund to support and scale up the provision of integrated SRHR/HIV programmes.

Other bilateral funders: The programme leveraged funding by the large anonymous donor (LAD) through the Access Programme to support the work on CAC through applying a regional approach to support programme implementation. LAD funded the position of the regional coordinator, and resources from Sida and LAD were leveraged to ensure a multiplier effect. The programme complemented investments by the Governments of Switzerland and the Netherlands in the Safeguard Young People Programme to promote integrated adolescent and youth responsive health systems.

Regional Economic Communities: Funding provided by Sida supported the convening of technical meetings. Meetings of the senior officials and Ministers of Health were funded through resources made available through the RECs and thus ensured ownership, political commitment and sustainability.

Governments: All recipient country governments invested in the programme through making time available for senior officials to participate in regional meetings and forums. At the country level governments funded salaries of government staff overseeing and supporting programme implementation, HCW, the day-to-day operating costs for health care facilities in which the programme was implemented, and the procurement of commodities and supplies that were used to support programme implementation. Investments in existing government programmes ensure that investments made by Sida will be sustained even after programme implementation.

In Phase II, the programme will develop and implement a resource mobilization strategy[65] to further unlock investments in the joint programme. The development of the RITTs will also enable funders looking to invest areas of programme implementation to be able to provide targeted support based on their areas of funding.

[65] Resource mobilization strategy to be finalized by August 2023 as per Annex 1.5

07.

Environmental Considerations

Annex 5 outlines this joint programme will integrate environmental considerations into planning, implementation and monitoring of the programme to harness opportunities for positive environmental impact, avoid and mitigate negative environmental impact and ensure resilient contributions with sustainable results.

The manner in which the four partner agencies will integrate environmental considerations will be guided by the policies and standards of the four partner UN agencies that outlines the steps each agency will take to ensure that there is no inadvertent harm to the environment as a result of programme implementation. In some instances the policies of the agencies extend to incorporate social aspects as to ensure that there is no harm to the people in the process of programme implementation. The policies and standards of the four UN agencies are attached. The programme will draw on the risk assessment tools of UNFPA as the lead agency to ensure that environmental and social aspects are incorporated into the Standard Operating Procedures of the organization. Annex 5 outlines how the four agencies will contribute towards opportunities for longer term socio-economic development impact and transformation to green economies and resilient communities. It outlines the measures that have been identified to prevent any negative environmental impact as well as those aimed at enhancing the positive environmental impact.

2gether 4 SRHR supports the establishment of in-school and out-of-school clubs in Uganda to equip adolescents with information, knowledge and life skills that help them make informed decisions in the future, as well as a platform and space to discuss issues that concern them and find solutions to address them.

Photo: © 2gether 4 SRHR/UNICEF

08.

Capability statement

UNAIDS, UNFPA, UNICEF and WHO promote universal access to SRHR for all, including those who are marginalized and left behind.

The benefit of the 2gether 4 SRHR partnership is that it has created a powerful, united, and strategic voice led by the Regional Directors of the four participating agencies.

Maissa Paisse, 28, is a mother of six children. Her last born are 9-month-old twins, Janito and Janita, who were born at Ramiane Health Centre in Monapo District, Nampula Province, Mozambique.

Photo: © 2gether 4 SRHR/UNICEF

All four partner agencies draw upon their comparative advantage and technical expertise to address issues relating to maternal and neonatal health, STIs and HIV, family planning, SRHR in UHC, gender equality and GBV, and SRHR (including CSE and access to SRHR services for adolescents and youth). WHO and UNFPA have also worked together to lead regional efforts on CAC.

2gether 4 SRHR has ensured greater efficiencies in the use of resources, and the quality of the outputs produced by complementing and drawing on each other's technical expertise and Delivering as One, as demonstrated through the implementation of Phase II of 2gether 4 SRHR. Roles and responsibilities are defined not at the level of programme area (except for the work on CAC), objective or output, but rather at the level of activity defined in the annual work plan, allowing for joint ownership and accountability for results.

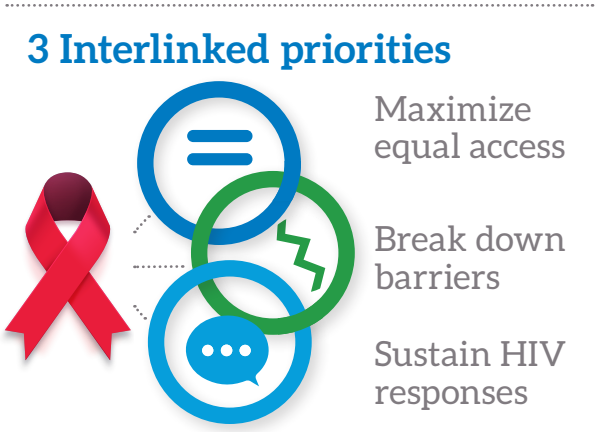
The focus and involvement of the four partner agencies in 2gether 4 SRHR will be guided by and support the attainment of the goals and objectives of each agency as guided by their respective global and regional strategies summarized below, which cumulatively will support the acceleration of the SDGs in the region.

UNAIDS

UNAIDS advocates for and supports Member States to realize the *Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 as a public health threat*. This is done by implementing the Global AIDS Strategy 2021-2026. The strategy highlights the need to identify, reduce and end inequalities that are barriers to people living with and affected by HIV, and to countries and communities fighting to end AIDS.

The strategy builds on three interlinked priorities, namely to:

1. Maximize equitable and equal access to HIV services and solutions;
2. Break down barriers to achieving HIV outcomes; and
3. Fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, and humanitarian crises.



UNAIDS is the initiator of the UN Joint Programme on HIV/AIDS Delivering as One model. 2gether 4 SRHR is consistent with the UNAIDS business model, emphasizing innovative partnerships and providing technical assistance, especially on human rights, gender equality and community empowerment. It focuses on driving transformation, incubating multi-sectoral approaches, and highlighting and addressing cross-cutting challenges.

UNAIDS will continue to build on its comparative advantage of high-level political advocacy, playing a critical role in strengthening capacity for multi-sectoral responses and strategic partnerships. Its comparative advantage lies in generating, analyzing, using, and sharing HIV-related knowledge to improve policies, strategies, and programmes, including strengthening data systems to accelerate the uptake of evidence.

2gether 4 SRHR will also benefit from the long experience UNAIDS has on working with communities in strengthening their HIV response, particularly the community-led response, and monitoring, capturing, and using granular data for programming and advocacy. It acknowledges the critical role played by civil society and communities, including organizations representing PLHIV and key populations, who are at the core of the AIDS response.

UNAIDS also supports the provision of basic humanitarian assistance to key populations, PLHIV and marginalized populations in transition, and facilitates access to broader schemes of support and social protection. Part of the COVID-19 response has been to systematically collect and analyze data on multi-month dispensing (MMD) of antiretroviral therapy (ARVs). Additionally, it has expanded the partnership with Africa CDC and PEPFAR to ensure that MMD within the differentiated service delivery approaches and policies are expanded and sustained by national programmes, thereby ensuring adherence and continuity of treatment for all PLHIV.

UNAIDS has created a portal that includes country-level data for advocacy and programmes and has strengthened the Health Situation Rooms (the online data analytics platform) with the visualization of the data.

At the regional office, UNAIDS has increased its capacity to address gender inequality and GBV, and inequality issues among youth by appointing dedicated staff with relevant expertise and background.

UNFPA

UNFPA's contributions within the 2gether 4 SRHR programme are aligned to and will advance the implementation of the UNFPA global Strategic Plan 2022 – 2025 and the East and Southern Africa Regional Programme 2022-2025.

UNFPA is the United Nations SRH and Rights Agency. UNFPA leads efforts on SRHR under the health cluster and has sole leadership of the GBV Area of Responsibility (GBV AOR) to coordinate GBV prevention, risk mitigation and response in humanitarian settings.

UNFPA's goal is to achieve universal access to SRHR, as defined by the Programme of Action of the ICPD and the SDGs, focusing on women, adolescents, and youth, with a commitment to leaving no-one behind. The work of UNFPA is centred around advancing three transformative goals, namely: i) zero maternal deaths; ii) zero unmet need for contraceptives; and iii) zero GBV. The regional programme has added zero sexual transmission of HIV as a regional priority area of focus, recognising that HIV remains one of the greatest threats to SRH and well-being, most notably amongst AGYW.

Six interrelated outputs have been identified to advance the three transformative goals, that have been adapted to guide the regional work of UNFPA ESARO, namely:

(a) enhanced SRHR policy, financing, and accountability, building off continental and regional frameworks and undertaken in collaboration with the AUC, SADC, EAC and regional parliamentary forums;

(b) improved provision of people-centred, high-quality SRHR care and services through improved functionality and resilience of the healthcare system, including supply chain management, integrated service delivery, and self-care;

(c) addressing harmful gender and socio-cultural norms and discriminatory practices affecting SRHR through supporting social movements, the meaningful involvement of men and boys, and strengthened integration of SRHR into human rights reporting and accountability mechanisms;

(d) enhanced use of population change and data for decision-making to inform regional frameworks, policies, the demographic dividend, expenditure and accountability frameworks;

(e) strengthened SRHR and systems resilience across humanitarian, development, and peace-responsive interventions through integrating MISP into disaster-preparedness plans, capacity-building, and strengthening the generation and use of data to inform decision-making on the multiple impacts of climate, fragility, conflict and violence on SRHR, and to enhance engagement with and amplify the voices of women-led and youth-led groups and networks in national preparedness and anticipatory and response plans; and

(f) improved empowerment, participation and accountability of adolescents and youth through advocacy for legal and policy reform to accelerate

3 Transformative goals

1 zero MATERNAL DEATHS

2 zero UNMET NEED FOR CONTRACEPTIVES

3 zero GBV

adolescent-friendly and youth-responsive health systems, as well as innovative solutions to promote access to information and services for youth, including CSE for in- and out-of-school youth.

In addition to working with regional partners and stakeholders, the regional office will advance progress towards the three transformative goals and the regional priority on HIV through providing tailored, integrated technical, policy and programme advisory support to countries to respond to national priorities; to translate and adapt global tools and methodologies; to knowledge management and exchange and experience-sharing of 'what works'; and facilitating South-South and triangular cooperation. This will be reflected in the country programme documents, developed with technical support by ESARO, aligned to the UNSCDF.

To accelerate the attainment of the three transformative goals and the regional priority of HIV, UNFPA ESARO will draw upon human rights-based and gender-transformative approaches, drawing upon data to ensure that it leaves no one behind while focusing its efforts on those furthest behind. UNFPA ESARO will work in partnership with partner UN agencies in the spirit of UN reform and with relevant regional and national stakeholders; will promote innovation and digitization; will strengthen and draw upon data to promote evidence-based approaches; and will promote resilience, adaptation and complementarity amongst development, humanitarian and peace responsive efforts.

UNICEF

The Convention on the Rights of the Child (CRC) is the basis for UNICEF's work and underpins its mandate. Addressing children, adolescents, and women's rights to health in development and humanitarian contexts has been at the core of UNICEF's mandate for the past 70 years. SRHR are critical for children, adolescents, and women and important in the achievement of the SDGs, as articulated in Goals 3, 4 and 5. In keeping with these global frameworks and aligned to national priorities and policies, UNICEF addresses SRHR for adolescent girls and boys and women across all goal areas of its new global Strategic Plan 2022-2025.

UNICEF works on SRHR across multiple sectors, including health, HIV, nutrition, child protection (mental health, child marriage, female genital mutilation and other forms of GBV), social protection (e.g., the Cash Plus initiative), education, water, sanitation and hygiene initiatives (including menstrual health), as well as the cross-cutting areas of adolescent development and participation, gender, and social/behavioural change. These efforts are undertaken in close collaboration with other UN agencies, particularly UNFPA, WHO, UNAIDS, UNESCO, and other partners. In line with the repositioning of the UN development system, and the System-wide Strategic Document, UNICEF works with UN partners to offer complementary and collaborative aspects of an overall integrated UN offer across the full range of the SDGs.

UNICEF ESARO's humanitarian action, resilience, and peacebuilding work aims to bridge the divide between

humanitarian action and development by strengthening preparedness to multiple environmental hazards and conflict-related risks, to minimize the impacts these have on children, adolescents, and women.

This includes efforts across the humanitarian, programme and operations sections to ensure that lives are saved, and the rights of children and women are protected as defined in the Core Commitments for Children in Humanitarian Action, which is aligned with internationally accepted standards.

UNICEF`s approach is based on robust conflict analysis which includes stakeholders, conflict dynamics, root and proximate causes, triggers, and peace capacities. UNICEF recognises that strengthening partnership and collaboration is key to success in both humanitarian and development work

UNICEF ESARO coordinates and supervises UNICEF's work in 21 countries. The regional office also coordinates UNICEF's engagement in the UN Coherence process in ESA, as well as supporting 21 Country Offices' resource mobilization efforts. The regional office is a hub of technical support, policy guidance, quality oversight, and thought leadership. A range of cross-cutting programmes support communication, M&E, supply and logistics, and other initiatives.

Under 2gether 4 SRHR, UNICEF contributes differentiated and integrated approaches to SRHR, including adolescent and young people's SRHR, HIV prevention, treatment and care; the elimination of vertical transmission of HIV, congenital syphilis and hepatitis; maternal and newborn health; adolescent and young people's engagement and leadership; health and community systems strengthening in the context of PHC and UHC; social and behavioural change, including shifting harmful norms; gender transformative programming; improved data disaggregation, quality and use to inform programming; knowledge management and communication; partnerships, including with RECs and youth-led organizations; strengthened multisectoral programming; and strengthening SRHR in the HPDN.

WHO

WHO will lead a transformative agenda that supports countries in reaching all health-related SDG targets through the implementation of its 13th General Programme of Work (GPW 13) structured around three interconnected strategic priorities to ensure healthy lives and well-being for all at all ages: achieving UHC, addressing health emergencies and promoting healthier populations.

In this context, WHO will support strengthening national health systems to deliver integrated SRHR services with HIV and GBV linkages in the countries. WHO will work with UN Country Interagency Working Groups to ensure that national policies and strategies incorporate SRHR, HIV and GBV and elaborate priority actions targeting adolescents, young people and key populations. In line with its mandate, WHO will ensure that countries have adopted up-to-date evidence-based guidelines, standards, recommendations, and training materials to guide the implementation of high-impact SRHR, HIV and GBV interventions; and will build the capacity of national trainers to support the scale-up of these services towards UHC.

Based on its technical comparative advantage, countries will be supported in implementing and monitoring interventions related to SRHR, HIV and GBV with emphasis on reducing maternal and neonatal deaths; post-abortion care and prevention of unsafe abortions; improving access to safe abortions where legal; prevention, control and management of STIs; prevention and management of GBV including intimate partner violence, violence against women and violence against children; institutionalization of quality improvement initiatives for SRHR, HIV and GBV;

implementation of accelerated actions for the health of adolescents, and strengthening linkages with other programmes, such as non-communicable diseases.

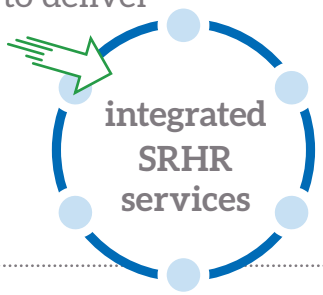
WHO convenes the care and treatment for people living with HIV including on issues of quality of care and human resources for health; co-convenes with UNICEF on the elimination of vertical transmission; collaborates with UNFPA on SRHR/HIV linkages, family planning access and GBV, all of which are linked to HIV prevention and care; collaboratively works with UNAIDS on strategic information; and as part of its core functions, oversees the setting, implementation and monitoring of norms and standards. In this regard, and in the broader context of SRHR, WHO will work with all three agencies to strengthen national HMIS through introduction of integrated digital accelerator kits (ANC, FP, STI, ASRH, and HIV) to improve access to quality integrated sexual and reproductive and HIV services, and generate high-quality, timely, and reliable disaggregated data to monitor progress towards UHC and ensure utilisation of health facility data for real-time decision-making. Furthermore, WHO will work with countries to strengthen SRHR within national essential service health packages and UHC benefit packages for improved access and financial protection for poor and vulnerable populations.

WHO has a Health Emergency Programme Hub for ESA based in Nairobi, with expertise to support countries. The hub has technical experts in emergency operations, country preparedness, information management, disease outbreaks control (epidemiologists), resource mobilization and logistics. The team members are deployed to countries depending on need to support their emergency response. At the country level, WHO works with the local Ministries of Health and partners to identify where health needs are greatest and to coordinate the efforts of partner organizations to ensure that these areas are covered by both medical supplies and personnel. WHO regularly collaborates with partner networks to leverage and coordinate the expertise of hundreds of partner agencies.

WHO will

SUPPORT strengthening

national health systems to deliver



with HIV and GBV linkages in the countries

09.

Governance structure

The following governance structure will guide and oversee the implementation of 2gether 4 SRHR including work plans, budgets and programme decisions. Annex 1.6 outlines the key meetings in which participating development partners and donor agencies will attend.

Strategic Leadership Forum (SLF) – platform for high level strategic dialogue between the regional directors and participating development partners.

Regional Interagency Steering Committee (RISC) – Provides strategic direction and oversight over programme implementation comprised of the Deputy Regional Director or a representative as designated by the Regional Director and participating donor agencies.

Regional Interagency Working Group (RIWG) - oversees the implementation of the programme, supported by interagency M&E and Communications Working Groups.

Strategic Leadership Forum (SLF)

This is a platform for high-level strategic advocacy and dialogue between the regional directors of the four UN agencies and participating development partners on key SRHR issues in ESA. This may be expanded, as necessary, to include other UN agencies working on SRHR in the region.

Composition:

The Strategic Leadership Forum convenes once a year and is chaired by the Regional Director of UNFPA. Members include the Regional Directors of UNAIDS, UNICEF and WHO. Heads of bilateral and multilateral partners will be included as determined by the Regional Director of UNFPA as the convener, in consultation with the three partner organizations.

Key tasks and responsibilities:

1. Engage with regional bilateral and multilateral development partners on key issues relating to SRHR in the region.
2. Advance SRHR in strategic high-level regional engagements with the AU, relevant continental and regional ministerial forums, Heads of State, civil society, and the private sector.
3. Leverage UN regional platforms such as international conferences and forums, including but not limited to the WHO Regional Committee of Ministers of Health and Harmonization for Health in Africa, to engage policy and decision makers on key issues relating to SRHR.
4. Advocate for and advance the regional approach and SRHR within the context of UN reform drawing upon lessons learned from 2gether 4 SRHR.
5. Undertake joint media and advocacy activities to increase the profile of SRHR in the ESA region and the work of the UN in the region.

Secretariat: The RIWG
Frequency of Meeting: Annually

Regional Interagency Steering Committee (RISC)

The Regional Interagency Steering Committee is responsible for overseeing the implementation of the Joint Programme. It will provide programme oversight and guidance, address barriers, monitor programme performance and ensure joint accountability as per the Standard Administrative Arrangements (SAAs) signed between UNFPA as the convening agency signed on behalf of the four agencies and Sida, and the Memorandums of Understanding (MOUs) signed between the four participating UN agencies.

Composition:

Comprises of the Deputy or Assistant Regional Director or a representative as designated by the Regional Director where a Deputy Regional Director does not exist, and designated representatives of participating donor agencies. The Deputy Regional Director for UNFPA ESARO will serve as the Chair of the Regional Programme Steering Committee.

Key tasks and responsibilities:

- Reviews and approves annual work plans, budgets for the Joint Programme and ensures that programme implementation is aligned to the programme document and conforms with the requirements of the SAA and MoU.
- Ensures sound programme management and coordination including consistent and common approaches to programme costing, cost recovery, implementation modalities, results-based reporting, impact assessments, and information management, including appropriate UN and donor visibility.
- Monitors programme implementation to ensure that financial and programmatic decisions are aligned to the programme document and is responsive to emerging issues, risks and changes.
- Reviews and approves periodic progress reports (programmatic and financial) as consolidated by the Regional Interagency Working Group and assesses progress in achieving outcomes.
- Reviews and approves allocation of funds to proposals submitted through the flexible funding modality as recommended by the Regional Interagency Working Group.
- Oversee the implementation of the mid-term and final independent review of the joint programme.
- Resolves barriers that may arise in the implementation of the project.

- Makes recommendations to the Regional Directors of the four participating agencies on strengthening the coordination amongst United Nations Agencies on SRHR in the context of UN-Reform.
- Provides guidance to the RIWG to resolve any emerging issues which are administrative or political in nature and need all participating agencies participation.
- Acts on opportunities to communicate positively about the project.

Secretariat: The RIWG
Frequency of meeting: Quarterly with decisions being able to be made through email between meetings

Regional Interagency Working Group (RIWG)

The RIWG will oversee the day-to-day implementation of 2gether 4 SRHR including work planning, budgeting, and reporting. The RIWG is responsible for coordinating programme implementation with the AU, RECs, and civil society. It will manage the implementation of the implementation modalities to support this joint programme including the regional programme activities, convening of the RITTs, the TA Hub and the JSF and report on progress made, challenges and barriers to the RISC. It will serve as the secretariat to the Strategic Leadership Forum and the RISC.

Composition:

Technical experts from the four participating UN agencies, as nominated by their Regional Directors and programme representatives as designated by the participating donor agencies who attend in an observer capacity in strategic meetings of the RIWG as defined in Annex 1.6. Regional Interagency Thematic Teams (RITTs) will nominate a lead technical person who will participate in RIWG meetings on a quarterly basis to report on progress made. The work of the RIWG and RITTs will be supported by the M&E and Communications Working Groups.

Key tasks and responsibilities:

1. Oversight of programme planning, implementation and MEL including the development of work plans, budgets, mid-year, and end-of-year progress reports.
2. Provides support to self-organizing RITTS including work planning, budgeting, monitoring programme implementation, expenditure, and reporting through annual planning, reporting and mid-year meetings to monitor programme implementation.
3. Coordinates partnerships with the AU, RECs, and engagement with civil society on issues relating to SRHR.
4. Coordinates efforts with existing relevant interagency coordinating structures (e.g. H6, Harmonization for Health in Africa) on progress made with a specific focus on SRHR.
5. Coordinates, monitors and ensures reporting on the implementation of Regional Programme activities as defined in the annual work plan and budget.
6. Oversees and manages the implementation of the Joint Strategic SRHR Fund guided by the Standard Operating Procedures, and monitors and reports on implementation and lessons learnt.
7. Oversees and manages the development, implementation, monitoring, reporting and evaluation of the Technical Assistance Hub guided by the Standard Operating Procedures, and monitors and reports on implementation and lessons learnt.
8. Serves as the secretariat to the Strategic Leadership Forum and RISC.
9. Provides oversight and support to the M&E and Communication working groups.

Convening Agency: UNFPA
Secretariat: UNFPA
Frequency of Meetings: Monthly, with annual planning and reporting meetings

M&E Working Group

The overall function of the working group is to provide a platform to engage and strengthen monitoring, evaluation, and strategic information related activities of the joint Programme.

Composition:

The M&E working group is comprised of M&E and Strategic Information specialists from the four participating agencies UNAIDS, UNFPA, UNICEF and WHO, who also are members of the Regional Interagency Working Group.

Key tasks and responsibilities:

1. MEL stewardship and coordination.
2. Coordinate and support all monitoring and reporting functions of the programme including development of indicators for reporting, reporting templates and platforms and quarterly and annual reporting.
3. Lead on all programme reviews and evaluations (including baseline, midterm and evaluations) and support the design of operational and implementation research.
4. Provide technical support to regional partners including the AU, RECs, and civil society to monitor global, continental, and regional commitments using scorecards and through providing support to AU, RECs and civil society.
5. Provide technical support to member states including the AU, RECs, and civil society to monitor global, continental, regional and national commitments using scorecards.
6. Advocate and provide technical support to strengthen health management information systems on data collection, disaggregation, reporting and the transition to digital platforms.
7. Generate, analyze and use data to ensure evidence-based programming and reporting.

Convening Agency: UNFPA
Frequency of meetings: Monthly

Communications Working Group

The Regional Communications Working Group is mandated to oversee the implementation of the Communication Strategy for 2gether 4 SRHR and make decisions that are in accordance with the objectives, approach, and scope of the approved communications strategy.

Composition:

The Communications Working Group comprises communication advisors from each of the four participating UN agencies (UNFPA, UNAIDS, UNICEF, WHO), who also are members of the RIWG.

Key tasks and responsibilities:

1. Guide and monitor the implementation of the Communication Strategy and the social media strategy for the programme in close collaboration with the RIWG.
2. Provide guidance and technical assistance on:
   a. 2gether 4 SRHR branding
   b. Documenting lessons learned and good and promising practices
   c. Ensuring programme visibility and product dissemination through traditional media, social media, and various online platforms including the 2gether 4 SRHR website and other relevant online platforms)
   d. Amplify lessons learnt
3. Work under the direction of the RIWG to support high-level advocacy interventions at regional and country levels.
4. Be responsible for joint ownership and implementation of the annual regional level communication action plan.

Convening Agency: UNICEF
Frequency of Working Group Meetings: Monthly, and as the need arises.

ANNEXURES

ANNEX 1.

ANNEX 1.1 Narrative Description of Positions and Posts Funded Through 2gether 4 SRHR

The table below provides a breakdown of the positions that will be supported by the four partner agencies through the joint programme. The positions reflect the human resources estimated by the four partner agencies to support programme implementation with a greater focus on the regional approach, drawing on the technical resources of the four partner agencies, with an expanded scope of work that incorporates the Humanitarian Development Peace Nexus.

UNAIDS Location: Johannesburg, South Africa	
Position	**Brief Description**
1 x P4 @100%, Partnerships adviser	Consolidates and coordinates strategic partners for high-level engagement of the SRHR programme.
1 x P3 @100%, Strategic information officer	Coordinates the work of the Health Situation Room, promotion of strategic information and documentation of inequality gaps in countries, while monitoring and reporting on the SADC SRHR strategy.
1 x P3 @50%, Humanitarian coordinator	Gathers (through varied sources) evidence-based information on HIV in humanitarian, migration, and disaster situations, and takes part in the early deployment phase to affected countries to provide back-up and support to the establishment of platforms/information sharing networks and best practices at country and regional levels.
1 x P2 @100%, Youth officer	Provides substantive support to countries in coordinating their youth activities by leading, facilitating, and promoting efforts to scale up, strengthen and fund the HIV response by and for young people.
1 x NO-D @100%, Strategic information officer	Liaises and works closely with the regional programme coordinators of the UNAIDS-UNFPA-UNICEF-WHO project on strengthening HIV and SRHR integration, and SGBV services, including coordination of the monitoring and reporting of results of the Regional Programme on strengthening SRHR/HIV Integration and SGBV, and provides the required technical support needed for project implementation.
2 x NO-B @100%, National officer	Supports the coordination, implementation, and monitoring of SRHR outcomes across the region as defined in the workplan. One position coordinates broader joint teamwork for planning, implementation and monitoring and reporting, as well as knowledge management.

UNFPA Location: Johannesburg, South Africa	
Position	**Brief Description**
1 x P5 @100%, Programme manager	Provides general oversight and strategic direction for the implementation of the programme. Supports coordination with the AUC and RECs and high-level advocacy efforts to expand SRHR (UNFPA focal point on the RIWG).
1 x P4 @100%, Programme coordinator	Supports the convening of leadership and statutory meetings to oversee programme implementation, coordinates the development of the joint workplan and budget, manages the disbursement of funds to partner agencies, oversees the operational implementation of the joint programme.
1 x P3 @100%, Communications specialist	Supports the convening of the Communications Task Team and the implementation of the communication strategy. Coordinates the development of the Knowledge Hub and supports the documentation of promising and emerging practices.
2 x P3 @100%, Programme specialists	Supports the convening of inter-agency forums to support the implementation of the work in key areas, including CAC, social norms, HPDN. Supports joint work planning and reporting in strategic thematic areas and provides input into work with the AUC and RECs. Coordinates advocacy efforts with civil society, professional associations, and other key partners, and identifies promising practices to be documented.
1 x P3 @100%, Programme specialist monitoring, evaluation and strategic information	Supports the convening and coordination of the M&E Task Team. Oversees the monitoring and reporting of programme implementation and the generation of strategic information to inform programme implementation guided by the results framework. Tracks programme implementation, coordinates reporting and develops the annual and midyear review progress report. Oversees the midterm review and external evaluation of the joint programme.
1 x P5 @70%, Programme adviser, Supplies	Supports regional efforts with the AUC, RECs to explore pooled funding and regional manufacturing of SRH commodities and supplies. Brokers technical support to countries to strengthen national frameworks for the procurement of commodities and supplies. Supports quantification, forecasting and last mile assurance at country level.
1 x P3 @40%, Programme specialist, Adolescent and youth	Coordinates joint efforts to strengthen policy and legal frameworks relating to adolescents and youth, and strengthens health systems to ensure that they are responsive to the needs of adolescents and youth.
1 x G7 @100%, Finance associate	Provides oversight of the 2gether 4 SRHR programme financial resources, focusing on overall efficiency, and success in programme implementation. Supports the programme coordinator to develop and consolidate the annual budget based on the annual workplan. Supports the procurement functions and management of implementing partners contracted through 2gether 4 SRHR.
1 x G6 @100%, Admin associate	Provides administrative, financial and logistic support to the 2gether 4 SRHR team and SRHR unit including travel, organization of meetings, and the contracting of consultants in support of programme implementation.

UNICEF Location: Nairobi, Kenya/Johannesburg, South Africa	
Position	**Brief Description**
1 x P5 @85%, Senior HIV specialist (Johannesburg, South Africa)	Provides senior technical oversight and contributes to strategic thinking, formulation, coordination, and collaboration of the programme both internally within UNICEF ESARO and with other UN agencies. UNICEF focal point on the RIWG.
1 x P4 @80%, Adolescent and HIV specialist (Nairobi, Kenya)	Leads AGYW SRHR interventions within UNICEF ESARO and co-leads inter-agency collaboration for the successful planning, management, and monitoring of the multisectoral adolescent and young people's SRHR agenda within the programme.
1 x P3 @75%, Adolescent and HIV specialist (Nairobi, Kenya)	Provides support in adolescent and young people's SRHR programming leveraging the Global Fund Strategic initiative on programming for AGYW, and coordinates technical support to 13 ESA countries. Serves as focal point on HIV/SRHR in humanitarian settings.
C1 x P4 @30%, Communication specialist (Nairobi, Kenya)	Provides lead support on all communications aspects of the programme, including programme documentation, generating knowledge, and amplifying lessons learned. Chairs the RIWG Communications Task Force.
1 x P4 @15%, Social and behaviour change (SBC) specialist (Nairobi, Kenya)	Provides technical support to enhance the capacity of ESA countries to collect and analyse social and behavioural data and promote positive social and behavioural interventions and outcomes on SRHR, HIV and GBV as well as the uptake of services.
1 x P4 @15%, Child protection/ Mental health psychosocial support (MHPSS) specialist (Nairobi, Kenya)	Supports the integration of GBV into SRHR and provides necessary expertise to address mental health and GBV issues, including during emergencies.
1 x P4 @20%, Gender/ Adolescent specialist (Nairobi, Kenya)	Supports continuous dialogue and capacity building to shift social and gender norms and promote gender transformative programming at regional and country levels. Leads regional cross-sectoral efforts toward resource mobilization and programming efforts on adolescent pregnancy.
1 x NOC @100%, HIV specialist (Johannesburg, South Africa)	Provides technical support focusing on data, M&E, and reporting support across UNICEF's 2gether 4 SRHR activities. Monitors budget expenditure, and effective and efficient utilization of funding. Serves on the RIWG M&E sub-committee.

WHO-AFRO Location: Brazzaville, Congo	
Position	**Brief Description**
1 x P4 @100%, Sexual reproductive health, East and Southern Africa (SRH-ESA)	Works with the other three UN agencies and as the focal person in the RIWG to provide technical guidance on day-to-day programme implementation, monitoring and reporting. Provides direct support to countries on SRHR components, including contraception, STIs, adolescent SRH, abortion, SGBV, FGM, cervical cancer, and infertility.
1 x P4 @25%, Routine health information systems, East and Southern Africa (HIS –ESA)	Provides technical guidance related to both health system and national health information system strengthening.
1 x P3 @50%, Communication/Partnership Regional Office	Participates in the Communication Working Group to oversee the implementation of the communication strategy for the programme and provide technical support for all aspects of communication and partnership of the programme.
1 x P4 @ 50%, Programme management officer, Regional Office (PMO/RO)	Responsible for programme and finance management and guidance of the programme.
1 x P4 @ 100%, Sexual and reproductive health (SRH), Regional Office	Provides overall technical guidance, oversight, and management for the project, including strategic technical support re norms and standards for a comprehensive rights based SRH/FP approach in the context of UHC. Engages with the RISC and liaises with other SRHR at regional level Afro-Reproductive Maternal Health (AF/RMH).
1 x P3 @100%, Monitoring and evaluation, Regional Office	Part of the M&E Working Group supporting the RIWG to strengthen monitoring, evaluation, data collection, reporting, reviews, and strategic information-related activities of the programme.

ANNEX 1.2 Fact Sheet on UN Joint Programmes using a Pass-Through Modality

Steering Committee

- Decision-making authority; highest body for strategic guidance, fiduciary and management oversight, and coordination.
- Facilitates collaboration between participating UN organizations and host government for the implementation of the joint programme.
- Includes senior programme managers of all signatories of the joint programme document; may also include other members in observer capacity, such as civil society organizations; may be co-chaired by the Government and UN Resident Coordinator at country level.
- Reviews and approves Joint Programme Document and annual workplans, provides strategic direction and oversight, sets allocation criteria, allocates resources, reviews implementation progress and addresses problems, reviews and approves progress reports, budget revisions/reallocations, and evaluation reports, notes audit reports (published in accordance with each PUNOs' disclosure policy), and initiates investigations (if needed). It may be supported by a Secretariat/Support Office.
- Meets at least twice a year.

Administrative Agent (AA)	Convening Agency (CA)
Accountable for effective and impartial fiduciary management and financial reporting. Selected jointly based on merit in a comparative review by all participating UN organizations. May be a Participating UN Organization or any other qualified UN organization; only one AA needed for global programme. Responsible for *financial/administrative management as follows:* Receives donor contributions, disburses funds to Participating UN Organizations based on Steering Committee instructions, and consolidates periodic financial reports and final financial report. Involved in day-to-day administration.	Accountable for coordination of programmatic activities and narrative reporting. Selected jointly based on merit in a comparative review by all participating UN organizations. Needs to be a Participating UN Organization with in-country presence. Responsible for *operational and programmatic* coordination, i.e: Coordinates all the joint programme partners, coordinates and compiles annual workplans and narrative reports, coordinates monitoring of annual targets, calls and reports on Steering Committee meetings, facilitates audits and evaluation, and reports back to the Steering Committee; may be involved in resource mobilization. Involved in day-to-day coordination but does not hold any financial or programmatic accountability.

Participating UN Organizations (PUNOs)	(Sub-)National Governmental Partners
UN organizations that participate in the joint programme, which may include UN funds, programmes, specialized agencies (including non-resident agencies) at national, regional or global level. Operate in accordance with their own regulations, rules, directives and procedures. Assume full programmatic and financial accountability for funds disbursed by the AA.	Governmental agencies at national or sub-national level that coordinate with UN organizations and implementing partners. Own the national programme to which the UN provides support.

Implementing Partners
National, regional or international governmental or non-governmental organizations, civil society organizations and/or private sector partners (as permitted by the rules and regulations of participating UN organizations) that may be working with Participating UN Organizations and/or (Sub-)National Governmental Partners to implement the joint programme

ANNEX 1.3 Mutual Recognition - Factsheet

BUSINESS INNOVATIONS GROUP | BIG

Advancing Common Business Operations

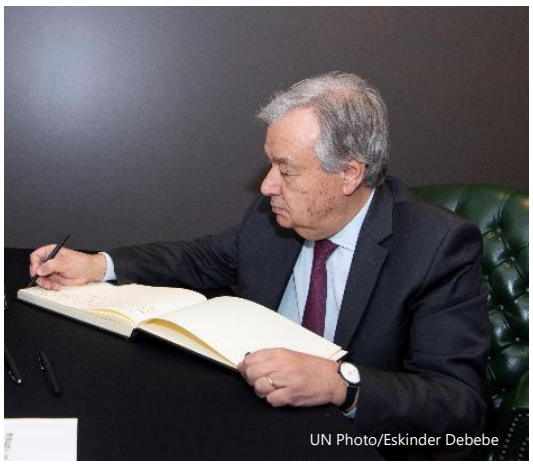
MUTUAL RECOGNITION

FACTSHEET | *December 2020*

The UN Reform context of Mutual Recognition

In his December 2017 report (A/72/684), and in line with calls from Member States, the United Nations Secretary-General set a number of ambitious targets to reform the UN System. – The Business Innovations Strategic Results Group (BIG) has been tasked with delivering and building on the proposals envisioned to maximize programmatic gains through **efficient and high-quality back-office operations**.

In July 2018, the BIG established a designated inter-agency Project Team to design and pilot methodologies to deliver on six of the **Secretary-General's targets,** including that of ***Mutual Recognition, i.e. "operating with the mutual recognition of best practices regarding policies and procedures"***.



UN Photo/Eskinder Debebe

The principle of Mutual Recognition

Mutual recognition allows a UN corporate entity to use or rely on another entity's policies, procedures, system contracts and related operational mechanisms for the implementation of activities without further evaluation, checks or approvals being required.

The Benefits of Mutual Recognition

Mutual Recognition increases the agility of operations in developing partnerships and working together towards the overall UN mission. It does so by removing bureaucratic barriers to such active collaboration and reducing administrative burdens.

Commitment to Mutual Recognition

In December 2017, the Secretary-General requested all entities to accelerate the efforts on the mutual recognition of policies and procedures.

The Statement had been signed by the Secretary-General on behalf of the UN Secretariat as well as 20 other heads of entities: FAO, ILO, IOM, ITU, UN Women, UNAIDS, UNDP, UNEP, UNESCO, UNFPA, UNHCR, UNICEF, UNOPS, UNRWA, WFP, WHO, IFAD, ITC, UNIDO and UN-Habitat.

The joint statement and Frequently Asked Questions (FAQ) can be found on the Chief Executives' Board website at: https://unsceb.org/mutual-recognition

continued: **Annex 1.3 Mutual Recognition - Factsheet**

All United Nations organizations are encouraged to adopt the statement to maximize the impact and benefits of this initiative.

Implementing Mutual Recognition

Mutual recognition is being implemented by signatory entities in various ways, including through establishing **policy instructions and guidelines** at headquarters, which can then be applied at regional or country levels.

These measures identify **business practices 'pre-approved' by the executive leadership** for mutual recognition. Heads of office at regional or country level are thereby authorized to use the policy or procedure of partner UN entities to reach objectives faster and more efficiently.

For business practices not included in such instructions or guidelines, prospective cases where Mutual Recognition could apply **may be submitted to headquarters for approval** on a case-by-case basis.

Signatory entities are also encouraged to convene **practical workshops** to explore opportunities to increase inter-agency work, to nominate **mutual recognition 'champions'** at every level to build a **body of knowledge** about the use of these principles, and to **replicate successful examples** of partnerships in practice.

Mutual Recognition in practice

- ***'UN system cooperation-based procurement' in UNHCR***

On 9 August 2019, the High Commissioner endorsed the application of mutual recognition in simplifying submissions made for and processing of "*UN system cooperation-based procurement*"[1].

As a result, if the relevant procurement function determines that the simplified submission is in accordance with the Agency's rules, then it shall be approved and the relevant contracts committee merely notified, "*without further evaluation, checks or approvals*".

- ***'Humanitarian Booking Hub'***

Started in 2016 as an internal service, the digital platform expanded as an inter-agency provisioning of 580 UN drivers, 285 UNHAS flights, 240 UN guesthouses, 100 UNDSS-listed hotels, 46 UN health clinics and 30 UN staff counsellors for the whole humanitarian community in more than 50 countries.

Four UN agencies are using the Hub as part of their global back-office, with 850 focal points daily connecting with the Hub to manage their local services. UN partners have mutually recognized WFP policies and procedures, which has thus resulted in a faster adoption of the same common provision service agreement, with easier internal checks and approvals.

- ***'Freight forwarding services'***

In 2016, UNICEF led a collaborative tender that resulted in global third party logistics and freight forwarding services contracts. Contracts were established from July 2017 for periods of up to seven years.

Today, the outcome of the UNICEF-led tender, through mutual recognition, benefits 12 UN entities; these entities implement separate contracts based on the tender outcome, established under UNICEF's policies and procedures.

[1] Administrative Instruction on the Rules and Procedures of UNHCR Committees on Contracts at Headquarters and in the Field. (UNHCR/AI/2018/5/Rev.1)

ANNEX 1.4 Timeline for the Development of Strategic Programme Documents

Strategic Programme Documents	Due Date
Advocacy Strategy	End of April 2023
SOP for the Joint SRHR Fund	End of April 2023
TA Hub	End of August 2023
Resource Mobilisation Strategy	End of August 2023
Partnership Strategy	End of August 2023
Results Framework and Baseline	End of October 2023

ANNEX 1.5 Work planning, reporting and key meetings

This annex provides an outline of the work planning and reporting schedule and the key meetings in which Sida and other development partners may participate to guide programme implementation. Where discrepancies or inconsistencies may arise between this annex and the Standard Administrative Agreement (SAA) and the Memorandum of Understanding (MoU), the provisions of the SAA and the MoU will prevail. The **dates set out in this annex are indicative**. The exact dates and venues for meetings will be agreed upon and included in the Annual Workplan and Budget.

The level of participation in the various meetings will be determined by the development partner and donor agency concerned at an appropriate level commensurate with the level of participation by the four participating agencies. Sida and other development partners will exercise their discretion regarding the nature of their participation in key decisions during statutory meetings relating to the approval of proposals, reports, and funding allocations in support of this joint programme.

The proposed implementation periods, workplan timelines and reporting cycles are as follows:

1. Work plan Implementation Period

This relates to the period of programme implementation based on the approved workplans by the Regional Interagency Steering Committee.

- Year 1 (2023): The workplan implementation period will be from April-December 2023.
- Year 2-4 (2024-2026): The workplan implementation period will be from January-December.
- Year 5 (2027): The implementation period will be from January-March 2027.

The indicative disbursement schedule against which funds will be disbursed from Sida to the Administrative Agent (AA) to support the implementation of the annual workplan is defined in Annex B of the Standard Administrative Agreement (SAA):

- Year 1 (2023): April 2023
- Year 2 (2024) to Year 5 (2027): October 2024, October 2025, October 2026

2. Work plan Timelines

The timelines for the development of the annual workplan are defined below to ensure implementation:

- Year 1 (2023):
  - Regional Inter-agency Working Group (RIWG) initiates work planning process in April or as soon as the agreement is concluded.
  - Draft workplans to be submitted to Sida for review by no later than mid-May.
  - Sida provides feedback on the workplans by no later than the last week of May.
  - Final workplans to be submitted to Regional Interagency Steering Committee (RISC) by end-May.
  - Final approval by RISC end-June.
  - AA to distribute funds by mid-July.
- Year 2-5 (2024-2026):
  - RIWG initiates work planning process in mid-September for the following year (e.g., start process in September 2023 for 2024).
  - Draft workplans to be submitted to Sida for review by no later than the beginning of October.

- RIWG meeting with focal persons from Sida and development partners in mid-October.
- Final workplans to be submitted to RISC by end-October.
- Meeting of the RISC and development partners to finalize workplans by mid-November.
- Workplans and budgets submitted to AA to distribute funds by end-November.

3. Narrative Programmatic Reporting timelines

The timeline for submission of the annual narrative report is 31 March, as defined by Section IV, clause 2a of the MoU to be concluded between the four participating agencies. The following timelines will guide the development of the narrative programmatic report:

- January to last week of February: Monitoring and Evaluation (M&E) Working Group develops the draft progress report for consideration by the RIWG.
- Last week of February: Draft progress reported submitted to Sida and other participating development partners for review.
- 2nd week of March: Meeting of the RIWG with Sida and other participating development partners to finalize draft narrative report.
- Mid-March: Final report submitted to RISC for approval.
- End-March: Meeting of RISC to validate final narrative report.

4. Annual Financial Reporting Timelines

The timelines for submission of the annual financial reports are defined by Section IV, clauses 1a and 1b of the Memorandum of Understanding (MoU), as indicated below, to be signed between the four partner agencies, and Section V of the SAA to be signed between Sida and the AA.

Clause 1: Each Participating UN Organization will provide the Administrative Agent with the following financial statements and reports prepared in accordance with the accounting and reporting procedures applicable to the Participating UN Organization concerned, as set forth in the Joint Programme Document. The Participating UN Organizations will endeavour to harmonize their reporting formats to the extent possible.

- Clause 1a: Annual financial report as of 31 December with respect to the funds disbursed to it from the Programme Account, to be provided to UNFPA AA no later than four (4) months (30 April) after the end of the calendar year.
- Clause 1b: Certified final financial statements and final financial reports after the completion of the activities in the Joint Programme Document, including the final year of the activities in the Joint Programme Document, to be provided no later than five (5) months (31 May) after the end of the calendar year in which the financial closure of the activities in the Joint Programme Document occurs, or according to the time period specified in the financial regulations and rules of the Participating UN Organization, whichever is earlier.

5. Close out reporting Process (2027)

The timelines for submission of final programmatic narrative report and annual financial reports are defined by Section IV, clause 2b, 5b and 6 of the MoU as indicated below to be signed by the four partner agencies. A more detailed timeline for preparation of the final report will be developed in 2026/7.

Clause 2: Each Participating UN Organization will provide the Convening Agent with the following narrative reports prepared

in accordance with the reporting procedures applicable to the Participating UN Organization concerned, as set forth in the Joint Programme Document. The Participating UN Organizations will endeavour to harmonize their reporting formats to the extent possible.

- Clause 2b: Final narrative reports, after the completion of the activities in the Joint Programme Document, including the final year of the activities in the Joint Programme Document, to be provided no later than four months (30 April) after the end of the calendar year in which the operational closure of the activities in the Joint Programme Document occurs.
- Clause 5b: Certified final financial statement ("Source and Use of Funds") to be provided no later than five months (31 May) after the end of the calendar year in which the financial closing of the programme occurs.

Clause 6: Consolidated reports and related documents will be posted on the websites of the Convening Agent, https;//esaro.unfpa.org/en/2gether-4-SRHR and the Administrative Agent https/aa.unfpa.org.

6. Programmatic Meetings

Sida and other participating development partners will be invited to participate in the RISC and RIWG meetings, programmatic meetings, activities, and country visits as may be defined in the Annual Workplan and Budget. Additional meetings may be held upon request.

The following is an outline of statutory meetings to be convened with Sida and other participating development partners linked to the work planning process.

Strategic Meeting	Period	Notes
Strategic Leadership Forum (SLF)	Annually (Tbd)	SLF will be convened annually to coincide with an existing forum that the four Regional Directors participate in.
Regional Inter-agency Steering Committee Meeting	No later than end-March	To coincide with the submission and approval of the annual programmatic and preliminary financial reports submitted by the RIWG with the final financial reports submitted to Sida by the AA as per the timelines defined in the SAA and above.
	No later than 15 November	To coincide with the approval of the final approval of the workplans and budgets for the Joint Programme.
RIWG Meetings	No later than mid-March	Annual meeting to review and finalize the progress reports for the Joint Programme.
	No later than the 3rd week of August	Midyear review meeting of the RIWG to take stock of programme implementation and select proposals for funding through the JSF.
	No later than mid-October	Annual work planning and budgeting meeting of the RIWG to review and finalize draft workplans and budgets for submission to RISC.

ANNEX 2. Results framework for the Joint Programme

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

2gether 4 SRHR Phase II Results Framework						
Vision: All people in East and Southern Africa are empowered and supported to exercise their SRH rights and access quality, people-centred, integrated SRHR, HIV and GBV services to enjoy a healthy and productive life. **Mission:** Brings together the combined efforts of UNAIDS, UNFPA, UNICEF, and WHO — working in partnership with the African Union (AU), Regional Economic Communities (RECs), regional forums of parliamentarians, and regional civil society — to support continental, regional and country efforts for a collective and coordinated strategic political, and programmatic effort to ensure universal access to SRHR for all, including in crisis settings. **Goal:** To contribute towards the attainment of SRHR-related targets of Sustainable Development Goals (SDGs) 3 & 5.						
SDG 3: Ensure healthy lives and promote well-being for all at all ages **SDG 5:** Achieve gender equality and empower all women and girls						
Programme Management: Regional Joint Programming						
Delivering as One	OP PM 1: Number of Regional Inter-agency Thematic Teams (RITTs) established and that are functional.	Thematic Area: Comprehensive Abortion Care, SRHR in UHC, Adolescent-Responsive SRHR Systems Agencies engaged: UNAIDS, UNFPA, UNICEF, WHO	RITTs bring together two or more participating agencies who work collaboratively to strengthen one or more SRHR outcomes as defined in this results framework. Functional means there is a joint workplan and budget, a regional road map highlighting priority areas and countries to be addressed, joint knowledge products developed, and joint TA provided to countries.	Programme reports	0	3
	OP PM 2: Number of inter-agency meetings held to ensure the efficient implementation of the programme.	SLF RISC RIWG	Will document the level of effort by the four participating UN agencies to ensure the efficient implementation of the programme. These include SLF (one per annum), RISC (one per quarter), RIWG (one per month).	Programme reports Meeting minutes	0	17
	OP PM 3: Number of countries provided with technical support to strengthen SRHR outcomes.	TA by PUNOs (Joint/ Individual) TA through TA Hub South-South cooperation	Includes TA provided through the TA Hub, virtually and through joint missions. Qualitative reporting to provide detail on the type of TA provided and what it resulted in.	Programme reports	0	23

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
Knowledge Management and Communications	OP PM 4: Number of knowledge products developed, uploaded to and downloaded from the Knowledge Hub.	Thematic area: MH (ANC/PNC), Contraceptives, Gender/GBV, HIV/STIs, AYP, Humanitarian, Safe Abortion Services, SRHR in UHC, Reproductive Cancers Types of knowledge product: e.g., technical publications, training curricula, best practices, human interest stories, social media Uploads Downloads	Includes individual and joint UN knowledge products developed through this programme. Qualitative reporting is required to detail the process, provide a summary of the product, how it was disseminated and uploaded onto the knowledge hub.	Programme reports	0	TBD
Outcome 1: Legal, policy and financial environment strengthened to enable beneficiaries to access SRHR services and realize their SRHR rights						
Output 1.1: Political, legal and policy barriers reduced						
SDG 5.6.2 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.	OP 1.1.1: Number of continental and regional SRHR Frameworks developed/revised that are aligned to global and continental commitments.	By organization: AUC SADC EAC Regional forums of parliamentarians: SADC-PF, EALA By type of document: law policy strategy guideline	Qualitative reporting to capture how the programme supported continental bodies (AUC), Regional Economic Communities (RECs), regional forums of parliamentarians, and regional human rights institutions to develop and/or revise relevant frameworks; how countries were engaged in the development process and the dissemination of the frameworks.	Laws, policies, strategies and guidelines REC reports Programme reports	**Laws:** EAC 1 (EAC SRHR Bill) **Strategies:** EAC: 1 (EAC resource mobilization strategy for UHC SADC: 3 (SADC SRHR Strategy, SADC KP Strategy SADC financial sustainability road map) **Guidelines:** EAC Minimum Standards on RMNCAH/HIV Integration	3

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
continued	OP 1.1.2: Number of continental and regional accountability tools supported to enable continental and regional entities to monitor and report on progress in meeting their SRHR commitments as defined by their continental and regional SRHR frameworks.	By organization: AUC SADC EAC Type of support: 1) Revision and updating; reporting by countries; dissemination	Indicator measures the support provided by the programme to the AUC and RECs to track progress using score cards and/or other accountability mechanisms in meeting the SRHR targets of the SDGs and their regional frameworks. This includes: 1) technical assistance to review and revise indicators targets, data collection tools, and data visualization; 2) support provided to countries to report on progress made; and 3) validation and dissemination of the tool.	Scorecards	Continental accountability tools: 0 Regional accountability tools: 2 Number of countries reporting SADC SRHR Scorecard: 16 EAC RMNCAH Scorecard: 6	Continental accountability tools: 2 Regional accountability tools: 2 Number of countries reporting CARMMA: 23 Maputo Protocol: 23 SADC SRHR Scorecard: 16 EAC RMNCAH Scorecard: 6
	OP 1.1.3: Number of ESA countries supported to align their national SRHR laws, policies, and strategies to continental and regional commitments and frameworks.	By country By type of document: Disaggregated by law, policy, strategy Disaggregated by thematic area: 1. Age of Consent to access SRHR services for Adolescents and Youth 2. Safe Abortion Care in line with Maputo Protocol 3. Key Populations 4. Male Engagement 5. Gender-based Violence 6. HIV/AIDS	Provide qualitative reporting to indicate if the revised framework includes one or more of the nine SRHR key elements and indicate if framework includes the agreed-upon target groups. Qualitative reporting to also capture processes leading up to the revised frameworks including how the programme has supported them, how the frameworks have been engaged with and the incremental changes observed in the process of development, and results where laws, policies and strategies have been adopted (e.g. countries that have adopted laws or policies that expand access to SHRH rights).	Programme reports	TBD	TBD

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
continued	OC1.1: Percentage of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information, and education.	By country	**Definition:** Seeks to measure the extent to which countries have national 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. The indicator is a percentage (%) scale of 0 to 100 (national laws and regulations exist to guarantee full and equal access), indicating a country's status and progress in the existence of such national laws and regulations. Indicator 5.6.2 measures only the existence of laws and regulations; it does not measure their implementation. The indicator measures specific legal enablers and barriers for 13 components across four sections. The calculation of the indicator requires data for all 13 components. The 13 components are placed on the same scale, with 0% being the lowest value and 100% being the most optimal value. Each component is calculated independently and weighted equally. Each component is calculated as: Ci=(ei/Ei-bi/Bi) ×100 Where: Ci: Data for component i Ei: Total number of enablers in component i ei: Number of enablers that exist in component i Bi: Total number of barriers in component i bi: Number of barriers that exist in component i Value for Indicator 5.6.2 is calculated as the arithmetic mean of the 13 component data. Similarly, the value for each section is calculated as the arithmetic mean of its constituent component data.	Country HMIS UNFPA global database	75% for ESA (UNFPA Global Database, 2021)	85%

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
Output 1.2: Domestic, bilateral and multilateral investment in SRHR increased						
SDG 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income.	OP 1.2.1: Number of countries with health financing strategies and mechanisms to fund UHC benefit packages that include critical SRHR services for the country.	By country: By critical SRHR services included	Provide qualitative reporting to indicate the processes leading up to the development or updating of the Health Financing strategies or mechanisms including the support provided by the programme and the results observed. National financing strategies and mechanisms that fund critical SRHR services (for the country) through inclusion in UHC benefit packages will reduce the proportion of SRH services funded by out-of-pocket expense. This is a priority and it shows increased domestic funding to SRHR in the context of UHC. Key SRHR elements that the programme will focus on include: (i) Prevention and treatment of HIV and other STIs (ii) Safe abortion services and treatment of unsafe abortion (iii) Detecting and preventing sexual and gender based violence (iv) Antenatal childbirth and postnatal care (v) Detecting, preventing and managing reproductive cancers (vi) Counselling and services for sexual health and well-being (vii) Comprehensive sexuality education (viii) Counselling and services for modern contraceptives.	Health financing strategies Programme reports	TBD (scale of inclusion in benefit packages needs to be determined - say 0-30% inclusion as baseline)	TBD (all countries at say 50-80% inclusion)
	OP 1.2.2: Number of countries provided with TA to increase investments in SRHR through bilateral and multilateral funding mechanisms (e.g. Global Fund, Ubraf, Global Financing Facility, PEPFAR)	By country Domestic Bilateral/Multilateral	Provide qualitative reporting to indicate the support provided by the programme and the results observed for countries to benefit from multilateral and bilateral funding initiatives (e.g development of Global Fund Proposals etc) and the funding envelope unlocked.	Programme reports	10	23
	OC1.2.1 Percentage of annual health budget allocated to SRHR	By country Domestic Bilateral/Multilateral	Per cent of annual allocation to SRHR.	Financial reports	TBD by baseline	TBD

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
continued	OC 1.2.2 Current health expenditure (CHE) as percentage of gross domestic product (GDP)	By country By region	WHO indicator; (Abuja Declaration target is 15%)	National Health Accounts	TBD by baseline	15%
	OC 1.2.3. Reduction of out-of-pocket (OOP) expenditure on health services Fraction of the population protected against catastrophic/ impoverishing out-of-pocket health expenditure	By country	**Definition:** Out-of-pocket health spending is defined as any spending incurred by a household when any member uses a health good or service to receive any type of care (i.e., preventive, curative, rehabilitative or long-term care), provided by any type of provider, for any type of disease, illness or health condition, in any type of setting (e.g., outpatient, inpatient, at home). It includes formal and informal expenses directly related to the cost of seeking care. It excludes pre-payment (e.g., taxes, contributions, or premiums) and reimbursement of the household by a third party such as the government, a health insurance fund or a private insurance company. It also excludes indirect expenses (e.g., non-emergency transportation cost) and the opportunity cost of seeking care (e.g., lost income)	National Health Accounts	TBD by baseline	TBD
Outcome 2: Increased access to and utilization of quality, people-centred integrated SRHR services						
Output 2.1: Regional and national capacity to provide equitable access to quality, integrated SRHR services increased						
SDG 3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.	OP 2.1.1: Number of countries supported to revise and develop in-service and pre-service curricula on SRHR in line with recent technical updates and recommendations supported by the programme.	Country SRHR Element: MH, Contraceptives, Gender, HIV/STIs, AYP, Humanitarian, Comprehensive Abortion Care, UHC Pre-Service In-Service	Provide qualitative reporting to indicate the type of service, support provided by the programme, and the results observed.	Programme report Training curricula	10	23

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
continued	OP 2.1.2: Number of countries supported to strengthen the capacity for training of health-care workers to deliver the essential package of SRHR, including HIV and SGBV services, through the use of national training-of-trainers modalities.	Regional Country SRHR Element: SRHR Element: MH, Contraceptives, Gender, HIV/STIs, AYP, Humanitarian, Comprehensive Abortion Care, UHC	Provide qualitative reporting that details the aim of the training, the training provided, curricula and/or platform used, and the results of the training.	Programme report Training registers and reports	10	23
	OC 2.1: Proportions of births attended by skilled personnel (SDG 3.1.2)	Country	**Definition:** Percentage of live births attended by skilled health personnel during a specified time period. **Numerator:** Number of births attended by skilled health personnel (doctors, nurses or midwives) trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, childbirth and the postpartum period, to conduct deliveries on their own, and to care for newborns. **Denominator:** The total number of live births in the same period.	National population-based survey Routine facility information systems	64% for ESA (UNFPA Global Database, 2021)	TBD

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
Output 2.2: Quality, people centred integrated SRHR services scaled up						
SDG 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. **SDG 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.	OP 2.2.1: Number of countries supported to develop/update and disseminate SRHR national guidelines and SOPs	Type of document Country	Provide qualitative reporting that stipulates the support that was provided by the programme and specifying the national guidelines and SOPs that were revised and/or disseminated. Where guidelines have been disseminated, discuss the results.	National guidelines and SOPs	10	23

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
continued	OP 2.2.2: Number of countries supported to implement a quality, integrated, people-centred SRHR package	Country Pilot Scale up	Qualitative reporting that defines the support provided to countries to implement an integrated package of SRHR services in line with WHO and regional guidelines (e.g., SADC SRHR/HIV Minimum Standards, EAC RMNCAH/HIV Minimum Standards) against key SRHR elements. Provide qualitative reporting to provide details on the support provided by the programme to countries to strengthen the quality SRHR services and specify which SRHR elements were supported. This indicator includes the measurement of provision of integrated services in countries piloting integration and also the scaling up of services in countries that have already piloted.	Country HMISs DHS scorecard UNAIDS AIDSInfo can be used for baselines and targets Programme reports	10	23
	OP 2.2.3: Number of countries supported to implement innovative approaches to SRHR	Country	Provide qualitative reporting to provide details on the innovative approaches being offered e.g., self-care/virtual care, digitization, etc. in hard-to-reach populations, emerging areas in SRHR, etc. and how the programme supported this, the results and lessons learned from offering these services.	Programme Reports	0	23
	OC 2.2.1: Proportion of girls who have received the recommended number of doses of HPV vaccine prior to age 15	Country	**Definition:** Proportion of girls who have received the recommended number of doses of HPV vaccine prior to age 15. **Numerator:** Number of girls aged 15 in target population who have received two/three doses of the HPV vaccine. **Denominator:** Total number of 15-year-old girls in target population) x 100.	Country HMIS UN data estimates	TBD	TBD

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
continued	OC 2.2.2: Cervical Cancer Screening	Country	**Definition:** Proportion of women aged 30–49 years who report they were screened for cervical cancer using any of the following methods: visual Inspection with acetic acid/ vinegar (VIA), pap smear, human papilloma virus (HPV) test. **Numerator:** Number of women aged 30–49 years who report ever having had a screening test for cervical cancer using any of these methods: VIA, pap smear and HPV test. **Denominator:** All women respondents aged 30–49 years.	National population-based survey UN data estimates	TBD	TBD
	OC 2.2.3: Proportion of women of reproductive age between 15-49 who have their need for family planning satisfied with modern method (SDG 3.7.1)	Country	**Definition:** The percentage of women of reproductive age (15–49 years) who desire either to have no (additional) children or to postpone the next child, and who are currently using a modern contraceptive method. **Numerator:** Number of women of reproductive age (15–49 years old) who are currently using, or whose sexual partner is currently using, at least one modern contraceptive method. **Denominator:** Total demand for family planning (the sum of contraceptive prevalence [any method] and the unmet need for family planning).	National population-based survey	62% for ESA (UNFPA Global Database, 2021)	TBD
	OC 2.2.4: Percentage reduction in new HIV Infections (from 2010) for 15 – 24 male and female	Country	**Definition:** Percentage reduction in new HIV infections. **Numerator:** Number of people newly infected during the reporting period. **Denominator:** Total number of uninfected population (or person-years exposed) **Calculation Rate:** (Numerator x 1,000)/ Denominator	UNAIDS Regional Support Team (RST) for East and Southern Africa (ESA)		

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
continued	OC 2.2.5: Percentage of women aged 15–49 who received four or more antenatal care visits	Country	**Definition:** Percentage of women aged 15–49 years with a live birth in a given time period who received antenatal care, four or more times from any provider. **Numerator:** Number of women aged 15–49 years with a live birth in a given time period who received antenatal care four or more times. **Denominator:** Total number of women aged 15–49 years with a live birth in the same period.	Registry/facility reporting system National population-based surveys	TBD	TBD
	OC 2.2.6: Percentage of obstetric and gynaecological admissions due to abortion	Country	**Definition:** Obstetric and gynaecological admissions due to abortion as a percentage of the overall obstetric and gynaecological admissions. **Numerator:** Admissions for abortions. **Denominator:** All obstetric and gynaecological admissions.	DHIS	TBD	TBD
Output 2.3: High quality SRHR data and strategic information produced and used to inform the development of SRHR policies, funding and programme implementation						
See SDG targets under 2.2.	OP 2.3.1: Number of countries supported to strengthen SRHR reporting in their national health information system.	Country Facility Community-led monitoring	Qualitative reporting that outlines the support provided by the programme to strengthen health information management systems at regional and country level that defines the intervention, the results and lessons learned. Support may include: 1) At regional level developing a framework to harmonize the indicators and disaggregation; 2) Supporting countries to harmonize, track, monitor and utilize key SRHR indicators including disaggregation by age and sex; and 3) Support to strengthen HMIS using digital data collection systems that provide real-time data at facility and community level.	Programme reports National health information systems	10	23

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
Outcome 3: Gender and social norms and behavioural drivers addressed for the realization of sexual and reproductive health and rights for all						
Output 3.1: Evidence on key gender, social norms, attitudes and values influencing SRHR outcomes used to enhance the development of SRHR policies, funding and programme implementation						
SDG 5.6.1. Proportion of women aged 15-49 years who make informed decisions regarding sexual relations, contraceptive use and reproductive health care.	OP 3.1.1: Number of knowledge products developed to strengthen evidence-based programming to address gender and social norms undermining SRHR.	N/A	Number of knowledge products developed with support from the programme which include: (i) a regional scoping study to identify available evidence and undertake formative research to address identified gaps on gender and social norms undermining SRHR outcomes to inform programming; (ii) a regional mapping of programmatic interventions to address gender and social norms; (iii) a regional evidence-based package of successful interventions suitable for scale up; and (iv) time-series regional social listening reports to identify and track rumours (including misinformation and disinformation) and trending conversations on SRHR to inform digital engagement strategies at country level. Qualitative reporting to record and report on dissemination and use of developed products including results.	Knowledge products	0	4
	OP 3.1.2: Number of countries supported to strengthen the capacity to generate evidence and measure gender and social norms change on SRHR.	Countries	Qualitative reporting is required to stipulate the technical assistance provided to countries to establish social and behaviour change baselines, midlines, and end lines to track intended change among specific populations: adolescent girls, men and boys, key influencers (faith-based and traditional leaders) and service providers.	Programme reports	0	23

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
Output 3.2: Networks of regional adolescent & youth, key populations, and influential stakeholders, including religious and traditional leaders, engaged and empowered to promote positive gender and social norms in ESA						
See SDG Indicator 5.6.1 above	OP 3.2.1: Number of regional social, cultural, religious and community (AGYWs & KPs) networks engaged to address social, religious and cultural norms.	Type of network of champions (faith-based leaders, traditional leaders, media and other)	Qualitative reporting is required to stipulate the support provided by the programme and the results of the support. Empowerment refers to mentoring, workshop, capacity-building, trainings.	Programme reports	0	4
	OP 3.2.2: Number of adolescent and youth networks and champions (including men and boys) supported to strengthen capacity to promote access to youth-friendly information, referrals to services and to promote social accountability.	Regional National	Documentation (minutes/reports and other qualitative reporting) of the forums and processes should indicate contributions made by a regional network of communities. Qualitative documentation and reporting to record and report on empowerment initiatives for networks of communities to demand their rights through laws, policies, programmes and various tools and instruments for community-led response.	Programme reports	0	TBD
	OC 3.2: Measurement of change in gender and social norms in the population of interest.	Population: Men and boys Adolescents and young people Faith-based, traditional leaders Media	The programme is currently undertaking a study on social and gender norms among men and boys in five countries that can serve as a baseline to identify the knowledge, attitudes, norms, behaviours that the programme seeks to influence to address SRHR outcomes. The programme will support countries to conduct baseline, midterm and end line social and behavioural studies to identify knowledge, attitudes, norms, and behaviours that will be contextual to the countries and that can identify the predominant social and gender norms hampering SRHR outcomes. The programme will measure incremental changes in knowledge, norms, attitudes of faith-based, traditional leaders and the media as a result of exposure to the programme.	Surveys Programme reports	TBD	TBD

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
Outcome 4: Resilient health systems and communities are enabled to ensure the continuity of SRHR services during crises						
Output 4.1: Policy and legal environment enabled to address SRHR during humanitarian crises and emergency situations						
SDG 5.6.2 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.	OP 4.1.1: Number of continental and regional SRHR frameworks strengthened to incorporate humanitarian aspects.	**By type of document:** law policy strategy guideline and **organization**: SADC EAC AU	Provide qualitative reporting to indicate the actual support received from the programme and the results of the support.	Programme Reports Continental and Regional SRHR frameworks	0	3
	OP 4.1.2: Number of national plans supported to incorporate SRHR response in emergencies.	**By type of plans:** National Emergency Preparedness and Response Plans UHC plans incorporate provisions to address the SRHR needs of refugees, migrants and internally displaced populations	Provide qualitative reporting to indicate the actual support received from the programme e.g., TA, capacity-building, advocacy efforts, coordination, and the results of the support.	Programme reports National plans	0	3
	OP 4.1.3: Number of coordination meetings held to strengthen coordination of clusters (such as Health, GBV and Emergency).	N/A	Provide qualitative reporting to detail the different actors in attendance and what the meetings have achieved. Strengthen the coordination between humanitarian and development actors, including civil society, to be engaged in regional SRHR forums convened in partnership with the AUC and RECs.	Programme reports	0	TBD

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
Output 4.2: Resilience of health systems strengthened to provide the minimum integrated SRHR service package (MISP) in times of crisis						
SDG 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. **SDG 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.	OP 4.2.1: Number of countries with road maps implemented to strengthen the preparedness and resilience of national health systems for the provision of SRHR services before crisis strikes.	Country Type of road map	Provide qualitative reporting that details the process taken to develop the road maps including assessments, meetings, etc and how the road maps are being used. This includes implementation of road maps for undertaking vulnerability assessments and implementation of national road maps to strengthen health systems to implement the recommendations arising from the Minimum Initial Service Package (MISP) readiness assessment.	Country road maps	0	TBD
	OP 4.2.2: Number of countries supported to integrate GBV interventions in humanitarian actions.	Country	Provide qualitative reporting that details the process taken to develop the road maps including assessments, meetings, trainings, development of action plans etc. This includes the implementation of the essential service package and IASC guidelines for integrating GBV intervention in humanitarian actions, as well as the adoption of WHO protocols in humanitarian settings for clinical management of rape and intimate partners violence within the country context.	Programme reports	0	TBD
	OP 4.2.3: Number of Regional pre-positioning schemes established in the EAC and SADC regions to enable a rapid respond to the onset of humanitarian crisis.	Country RECs (SADC, EAC)	Provide qualitative reporting detailing the technical support provided to EAC and SADC for the establishment of a regional humanitarian supplies pre-positioning scheme to address rapid onset crises to support advocacy efforts for increased country level funding for supplies in humanitarian settings and the use and results of the schemes.	Programme reports	0	TBD

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Indicators	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
Output 4.3: Evidence base for humanitarian and emergency response strengthened						
See SDG targets under 4.2.	OP 24. Number of countries supported to strengthen their national health information system to be able to generate data to support preparedness efforts.	Country	Qualitative reporting required to stipulate the support provided by the programme and the results of the support. Supported refers to harmonization, tracking, monitoring and utilization of key SRHR indicators, including support on disaggregation by age and sex. Furthermore, support includes strengthening systems to provide real-time data, and where possible, the utilization of digitized systems.	Programme reports Country HMISs	0	TBD

Impact Indicators

Impact indicators are introduced here to ensure focus on the bigger picture. The selected impact indicators are aligned to the SDGs and key SRHR elements that the programme will contribute to.

SDG 3: Ensure healthy lives and promote well-being for all at all ages						
SDG Goals	**Indicators**	**Disaggregation**	**Indicator Notes**	**Source**	**Baseline (2021)**	**Target (2025)**
SDG 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.	IM 1: Maternal mortality ratio (per 100, 000 live births) ***(SDG 3.1.1.)***	Country	**Definition:** The annual number of women's deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100,000 live births, for a specified time period. **Numerator:** Number of maternal deaths. **Denominator:** Number of live births.	Civil registration vital statistics	407.7	TBD

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Goals	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
SDG 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases, and other communicable diseases.	IM 2: HIV Incidence ***(SDG 3.3.1)***	Country	**Definition:** Number of people newly infected with HIV in the reporting period per 1,000 uninfected population. Numerator: Number of people newly infected during the reporting period. **Denominator:** Total number of uninfected population (or person-years exposed). Calculation: (Numerator x 1000)/denominator.	Routine facility information systems National population-based surveys in high-burden epidemics, otherwise, modelled estimates	TBD	TBD
	IM 3: Sexually transmitted infections (STIs) incidence rate ***(Core indicator)***	Country	**Definition:** Number of new cases of reported STIs (syndromic or etiological reporting) in a specified time period (year). **Numerator:** Number of new cases. **Denominator:** Total population.	Routine facility information systems	TBD	TBD
SDG 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.	IM 4: Unmet need for family planning (Contraception) ***(SDG 3.7.1)***	Country	**Definition:** The percentage of women of reproductive age who have an unmet need for family planning. Women with unmet need are those who want to stop or delay childbearing but are not using any method of contraception. **Numerator:** Number of women of reproductive age with an unmet need for family planning. **Denominator:** Number of women of reproductive age.	National population-based survey	14.8	TBD
	IM 5: Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group ***(SDG 3.7.2).***	Country	Annual number of births to females aged 10–14 or 15–19 years per 1,000 females in the respective age group. **Numerator:** Number of live births to women aged 10–14 years or 15–19 years. **Denominator:** Exposure to childbearing by women aged 10–14 years or 15–19 years.	Civil registration and vital statistics system with high coverage	77.7	TBD

Output (OP) Indicators Outcome (OC) Indicators Impact (IM) Indicators

SDG Goals	Indicators	Disaggregation	Indicator Notes	Source	Baseline (2021)	Target (2025)
SDG 5: Achieve gender equality and empower all women and girls						
SDG 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.	IM 6: Intimate partner violence prevalence.	Country	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months. **Numerator:** Total number of ever-partnered women aged 15 years and older (or aged 15–49) who reported having experienced physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months. **Denominator:** Total number of ever-partnered women aged 15 years and older (or aged 15–49).	National population-based surveys that have a module on violence against women National population-based surveys focused on violence against women	29.3	TBD
	IM 7: Non-partner sexual violence prevalence.	Country	Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months. **Numerator:** Number of women and girls aged 15 years and older (or aged 15–49) who experience sexual violence by persons other than an intimate partner in the previous 12 months. **Denominator:** Number of women and girls aged 15 years and older (or aged 15–49).	National population-based surveys that have a module on violence against women National population-based surveys focused on violence against women	TBD	TBD

ANNEX 3. Areas of Support on Comprehensive Abortion Care

UNFPA and WHO's work, as guided by Paragraph 8.25 of the ICPD Programme of Action and Paragraph 63 of the Key Actions is to support governments to prevent unsafe abortions, to save the lives and protect the well-being of women and girls threatened by the complications of unsafe abortion; and to ensure that quality, comprehensive abortion care, including post abortion care, is safe and accessible to all who need it, and that it is provided on a timely basis and in a manner that is respectful of the needs and rights of women and girls.

UNFPA and WHO, in relation to the 2gether 4 SRHR Programme, are guided by their organizational strategies including the UNFPA Strategic Plan (2022-2025) and WHO´s Global Reproductive Health Strategy. The UNFPA Strategic Plan identifies ending preventable maternal deaths as one of three transformative results, along with ending unmet need for family planning and modern contraceptives, and ending gender-based violence and harmful practices, such as child marriage and female genital mutilation. The Strategic Plan reaffirms that the Sustainable Development Goals (SDGs) will not be achieved without addressing all causes of maternal mortality and morbidity, including unsafe abortion. The ICPD+25 reaffirmed safe abortion care as part of the essential elements of SRHR.

WHO´s Global Reproductive Health Strategy identifies the elimination of unsafe abortion as a priority mandate for the acceleration of achievement of international development goals. The UN Global Strategy for Women´s, Children's and Adolescents' Health includes evidence-based interventions for abortion and post-abortion care as part of the effort to facilitate individuals´ ability to thrive and to transform communities. WHO´s commitment to ensuring quality in comprehensive abortion care provision across the continuum of care is underlined and expressed specifically in its 2022 Abortion Care Guideline.

UNFPA and WHO do not support any form of coerced or forced abortion and gender-biased sex selection. While legal, regulatory, policy and service-delivery contexts may vary from country to country, UNFPA and WHO work with governments – at their request and in partnership with others – to prevent unsafe abortion; to ensure that health systems are sufficiently resilient to support delivery of quality abortion care; and that health systems have the capacity to deal effectively with the complications of unsafe abortion – including in humanitarian settings – thereby saving women's lives.

The spirit of this Joint UN Regional Programme is to foster inter-agency collaboration on work that supports prevention of unsafe abortion and provision of comprehensive abortion care in relation to the outcomes, outputs and interventions outlined in the detailed programme document.

UNFPA and WHO in the ESARO region will collaborate to:

1. Provide scientific, technical and strategic information to inform legal and policy discourses.
2. Advocate for comprehensive abortion care to be incorporated as part of the minimum package of essential SRHR services in UHC and work with partners to cost the impact of unsafe abortion on the health-care system.

3. Strengthen the quality of integrated comprehensive abortion care services through:

   - Strengthening clinical skills and addressing health-care worker norms and attitudes for the delivery of comprehensive abortion care services.
   - Undertake assessments to strengthen the delivery of quality, comprehensive abortion care services, including the forecasting and quantification of reproductive health commodities.
   - Promote the provision of integrated services to ensure that women and girls receive a comprehensive package of integrated services that incorporate family planning, HIV, STIs, cervical cancer screening, and gender-based violence.
   - Advocate to strengthen reporting on comprehensive abortion care within national health systems to generate real-time data that can be used to inform policy and decision makers.

Address the social norms and attitudes that hinder women from exercising their rights as defined by the Lancet-Guttmacher Commission on SRHR, including the right to bodily integrity, privacy, and bodily autonomy, and to have access over their lifetimes to the information, resources, services, and support necessary to achieve and exercise their sexual and reproductive health and rights free from discrimination, coercion, exploitation, and violence.

Strengthen the provision of comprehensive abortion care services in the context of humanitarian emergencies, including as part of the provision of the minimum initial service package for SRHR.

The joint programme will support the implementation of these interventions through technical assistance, knowledge brokering and sharing, promoting South-South collaboration and predictable funding to countries to advance the work on comprehensive abortion where an enabling environment exists or may arise to advance this area of work.

ANNEX 4. Risks and Mitigation Strategies

The Regional Inter-agency Working Group (RIWG) will monitor the risk and mitigation strategies as outlined in this annex and report on them in the midyear and annual report submitted to the Regional Inter-agency Steering Committee (RISC). The RIWG and the RISC may convene ad-hoc meetings to consider serious risks that may arise during the course of programme implementation.

Internal Risks	Risk Level	Risk Management
Inadequate oversight and accountability resulting in constrained implementation of the joint programme.	Low	Several mechanisms are being put in place to ensure oversight and accountability including, the Regional Inter-agency Working Group, and the Regional Inter-agency Steering Committee being convened at the level of DRD, and individual agency-specific monitoring as part of the work planning process.
Resistance to efforts to address laws, policies, and strategies, as well as changes in government, may hamper progress in addressing key areas of SRHR such as CAC, age of consent to sex and access to services, and SRHR in general.	Medium	The efforts of the programme are guided by the global and regional strategies of the four partner agencies, continental and regional frameworks that address the key areas of SRHR, and global inter-agency and agency specific normative guidance such as: the WHO Guideline on Abortion; the Sex Worker Implementation Toolkit; the Men who have Sex with Men Implementation Toolkit; and, at regional level, the ongoing dialogues by the four agencies to harmonize issues relating to age of consent. Efforts to engage countries around legal and policy barriers will be addressed through both technical and high-level advocacy by the four agencies at continental and regional levels, guided by the mandate of the respective agencies.
Aligning policy and legal reforms to social norms takes considerable time and effort owing to a lack of understanding and knowledge of social, religious, and cultural leaders. This is coupled with an organized and well-resourced opposition to advancing key areas of SRHR such as abortion care.	Medium	The development of laws and policies is an ongoing process that requires investments in relation to time and effort and is rooted in social and cultural norms. The programme will engage with social, political and religious leaders regarding social and gender norms underpinning the critical areas of SRHR. Progress will be measured through identifying process indicators that can be tracked for the development of laws, policies and strategies. Lessons learned will be continuously documented, both where success has been attained and where it has not. These lessons will inform and strengthen future efforts for policy and legal change. The programme will give preference to supporting efforts in countries where opportunities exist to advance key areas of SRHR (front runner countries) that can serve as examples to others in advancing progress. It will continue to engage with countries where barriers exist to advancing SRHR.

Internal Risks	Risk Level	Risk Management
Operational aspects hinder the ability of the joint programme to effectively and efficiently implement joint activities, e.g., procurement, joint digital working platform, etc.	Low/ Medium	The programme will develop a standard operating procedure to guide programme decision making in relation to the implementation of joint activities. The SOP will be developed in consultation with the operations managers of the four partner agencies. It will be a flagship programme for the principle of mutual recognition. The AA will lead engagement with the operational leadership of the four agencies and UNDG to discuss and seek solutions to resolve the operational barriers. Lessons learned will be documented and shared through the AA to strengthen UN operational reform efforts. The TA Hub has consolidated the roster of consultants, service providers, and professional organizations that the four partner agencies have agreements with and that agencies can leverage using the principle of mutual recognition.
The absorptive capacity of the four partner agencies to effectively and efficiently programme and utilize funds in support of regional level activities across countries without dedicated human and financial resources may hamper programme implementation.	Low	The RIWG will – on a bi-annual (midyear and end-of-year) basis – provide a progress report to the RISC on the implementation of this joint programme, with a detailed programmatic and financial report that identifies and highlights challenges and barriers for the RISC to address. The Strategic Leadership Forum may be engaged where necessary to provide additional leadership support for programme implementation. Agencies will draw on internal technical and monitoring systems to monitor and report on programme implementation and adapt where necessary to ensure that countries have the necessary absorptive capacity.
The lack of clearly defined criteria for the documenting of promising practices hampers the ability of the programme to identify and document promising practices.	Low	The programme will review guidance by the four partner agencies on the identification and documentation of best practices and develop a guideline with defined criteria. Given that this programme builds on previous investments and promising practices, human interest stories and others will be documented and amplified throughout the life cycle of the programme.
The M&E system is limited to providing activity-based information and is unable to provide data on set output and outcome indicators; or lacks clear targets and baselines to track both qualitative and quantitative data.	Low	The programme will review the M&E system. The Results Framework will ensure that data is generated against output and outcome indicators. Targets and baselines are being defined and will be solidified based on data generated in the current and start-up phase of the programme. Provision will be made for both qualitative and quantitative data.

Internal Risks	Risk Level	Risk Management
The lack of a sustainability plan limits the extent to which countries and regions can sustain the gains made in the implementation of the programme.	Low	A resource mobilization plan will be developed in consultation with partners. Sustainability is embedded as the programme will aim to situate interventions within existing programming by partners at both regional and country level.
Weak absorptive capacity of country UN inter-agency working groups owing to competing demands.	Low	Funds will be disbursed through the JSF catalytic funding mechanism to country teams on an annual basis. Expenditures will be tracked on a regular basis to ensure that funds are being utilized. Annual disbursements will be determined based on the level of expenditure with countries achieving 80% or more of funds disbursed in the first year.
Weak absorptive capacity of the implementing partners largely due to inadequate human resources, weak financial management capacity and bureaucracy.	Medium	Each agency is responsible for the implementation of this joint programme drawing on their individual financial and procurement policies. The selection of implementing partners is governed by the HACT. At regional and country levels, the programme may engage implementing partners drawing upon an implementing partners agreement. At regional level such partners may include, but are not limited to, regional economic communities, civil society partners, and academic institutions. At country level, they may include relevant ministries and civil society partners. Implementing partners are selected following a stringent capacity assessment that includes technical capacity, managerial capacity, administrative capacity and financial capacity, which are assessed on an annual basis. Macro and micro assessments are used as the basis for the cash transfer modality, and may be direct cash transfer (quarterly advances based on an agreed workplan), or direct payment where disbursements are made directly to suppliers. Specific actions: • Orient and engage programme and financial managers in monitoring expenditures and ensuring adequate human resource deployment. • Build capacity for operational and financial managers to ensure reporting in line with the HACT to prevent fraud and corruption, through assessments, spot checks and other agency mechanisms. • Regular monitoring through joint missions by programme and operations teams of the four agencies to provide programme and operational oversight. • Regular programmatic monitoring through midyear and end-of-year reporting and the use of agency-specific modalities.

Internal Risks	Risk Level	Risk Management
Outbreaks of pandemics, natural disasters, war and a prolonged COVID-19 pandemic.	Medium	The programme will be flexible and collaborate with the IAWG in responding to humanitarian crises in the region. It will support the coordination and monitoring of the continuity of essential SRHR services in times of emergencies, evaluate the potential impact of disruption, and review and update workplans in response. The programme will use ICTs for capacity-building, digital health, and support self-care options differentiated to the particular context.
Corruption risk: Circumstances may lead to short-circuiting the normal procedures designed to control corruption risks and affect delivery of results.	Medium	The governance systems are aligned with the UN financial systems for the disbursement and utilization of funds. Each agency will draw on their internal protocols for the prevention of fraud and corruption. Operations managers will be invited to RISC meetings annually to provide inputs on implementation, financial management, fraud and corruption. The developed workplan, budgets and M&E framework will be used to ensure that the programme is vigilant in monitoring implementation, expenditures and deliverables. Agency-defined procurement protocols will be applied for the procurement of technical assistance, goods and services with adherence to SOPs in times of emergencies. Agencies will follow the UN systems-wide procedures and defined rules for the prevention of sexual exploitation and abuse of authority and harassment.

ANNEX 5. Environmental Considerations

This environmental assessment outlines how the second phase of the 2gether 4 SRHR programme will integrate environmental aspects into planning, implementation, and monitoring to harness opportunities for positive environmental impact, avoid and mitigate negative environmental impact and ensure resilient contributions with sustainable results.

The way the four partner agencies will integrate environmental considerations will be guided by the policies and standards of the four partner UN agencies that outline the steps each agency will take to ensure that there is no inadvertent harm to the environment because of programme implementation. In some instances, the policies of the agencies extend to incorporate social aspects as to ensure that there is no harm to people in the process of programme implementation. The policies and standards of the four UN agencies are attached. The programme will draw on the risk assessment tools of UNFPA as the lead agency to ensure that environmental and social aspects are incorporated into the Standard Operating Procedures of the organization.

Opportunities for a positive impact: The implementation of the 2gether 4 SRHR programme will contribute towards opportunities for longer term socio-economic development impact and transformation to green economies and resilient communities through:

- Promoting a human rights-based approach that seeks to advance SRHR with a commitment to leave no one behind and reach those furthest behind.
- Investing in formative research to examine the impact of climate change on gender-based violence that will enable mitigating strategies to be tested and scaled up.
- Integrating SRHR, HIV and GBV into vulnerability assessment (VA) tools and in other development sectors in East and Southern Africa.
- Strengthening the resilience of the health system to be able to respond to humanitarian crises including those relating to climate, outbreaks of disease and conflict through strengthening the delivery of the minimum essential services package (MISP) for SRHR, including for marginalized and vulnerable groups.
- Increasing access to reproductive health and promoting family planning contributes towards environmental sustainability. Preventing unintended pregnancies slows population growth and reduces the economic burden and environmental demands.
- Promoting delivery of integrated SRHR services. The endline survey of phase I of the programme shows that integration has the following advantages:
    - Reduces amount of travel by a client to a facility, thus contributing to reduced carbon emissions and reduced out of pocket expenditure for clients.
    - Reduces time spent by clients at facilities, thereby enabling them to be more productively engaged.
    - Improves client retention which contributes to improved health outcomes for all.

- Where possible, the programme will give priority to implementing partners who have socially and environmentally responsible policies in place, and, where these are not in place, promote integration of the social and environmental standards in their workplan design and implementation.
- The programme will ensure that all stakeholders and key affected populations are engaged throughout programming cycles, including during decision-making processes. Where there are grievances, the programme will aim to collate and document such grievances to ensure stakeholder accountability to key affected populations and for institutional redress and learning.

Measures identified to prevent any negative environmental impact as well as those aimed at enhancing the positive environmental impact.

Risk	Rating*	
Paper usage	Low risk	The programme will reduce the use of paper through promoting paperless meetings wherever possible and producing electronic reports and publications. The programme will invest in the development of a knowledge hub to serve as the central repository for the dissemination of information generated through the programme and beyond. It will promote the use of other electronic platforms including websites, email, and flash drives.
Air travel	Moderate	This Joint UN Regional Programme will aim to reduce air travel through the use of digital platforms such as Zoom, Google and MS-Teams, and emails for programme implementation. Face-to-face meetings may be convened for strategizing, joint programming and undertaking programme reviews but will be limited to two per annum. The programme will use a mix of modalities to provide technical assistance to countries including the use of digital platforms. Where joint missions are undertaken the programme will promote carpooling. Missions to countries will be combined with other responsibilities to minimize the use of travel. Where possible, the programme will promote the use of hybrid approaches to capacity-building activities (such as training sessions) and explore creative ways to ensure that online trainings are complemented with mentorship and supportive supervision using telemedicine. The programme will promote the use of hybrid knowledge-sharing meetings and, as far as possible, promote South-South collaboration
Vehicle fleet	Low	This Joint UN Regional Proposal will promote the use of carpooling where joint missions are undertaken to reduce carbon emissions.
Increased medical waste	Low	Aspects of waste management, efficient use of water resources, and general sanitation and hygiene issues to be included in relevant training curricula.
Increased use of water resources	Low	Efficient use of water resources, and general sanitation and hygiene issues, to be included in relevant training curricula.

* *Low Risk:* minimal or no adverse environmental and social risks and impacts,
Moderate Risk: environmental/social risks and impacts limited in scale, not unprecedented, largely irreversible, limited to programming area.
High Risk: significant adverse environmental/social impacts that are irreversible, cumulative or unprecedented and/or which raise significant concerns among potentially affected communities and individuals.

ANNEX 6. Standard Administrative Agreement

https://esaro.unfpa.org/en/2gether-4-srhr

ANNEX 7. Memorandum of Understanding

https://esaro.unfpa.org/en/2gether-4-srhr

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