

REVISED ANNEX J

THEMATIC PROGRAMME *INVESTING IN PEOPLE*
SUPPORT MEASURES

1. IDENTIFICATION

Title/Number	Support measures for the programme DCI-SANTE/2010/022-137 DCI-EDUC/2010/022-140 DCI-HUM/2010/022-139 DCI-GENRE/2010/022-774		
Total cost	EUR 2 142 290.57		
Aid method/Method of implementation	Direct centralised management		
DAC code	n.a.	Sector	n.a.

2. DESCRIPTION

This amount is reserved for potential support measures for the programme (e.g. audits, evaluations, monitoring, studies, conferences, information, publications, etc.), as provided for under Article 26 of the DCI Regulation, not exceeding EUR 200 000 each.

The total amount will be distributed between the individual budget items as follows:

- Budget item 21 05 01 01 (Health) EUR 580 565.68
- Budget item 21 05 01 02 (Education) EUR 533 105.95
- Budget item 21 05 01 03 (Other aspects of human and social development) EUR 926 000
- Budget item 21 05 01 04 (Gender equality) EUR 102 618.94

Method of implementation

Direct centralised management.

Procurement and grant award procedures

The procedures laid down in EuropeAid's 'Practical Guide to Contract Procedures for EU External Action' will be followed.

ANNEX K

THEMATIC PROGRAMME *INVESTING IN PEOPLE*THEME 1.2: *GOOD HEALTH FOR ALL*

1. IDENTIFICATION

Title/Number	DCI-SANTE/2010/ 248-682 Linking HIV and sexual and reproductive health and rights in Southern Africa		
Total cost	Indicative total cost: EUR 7 million EU contribution: EUR 7 million		
Aid method/Method of implementation	Project approach – <i>joint management with UN (UNFPA and/or UNAIDS)</i>		
DAC code	12110 (13020) (13040) (13030)	Sector	Health policy and administrative management (Reproductive health care) (STD control including HIV/AIDS) (Family planning)

2. RATIONALE

This action is financed by the additional funding provided by the European Parliament's amendment at the end of 2009 for the Thematic Programme 'Investing in People', theme 1.2 'Good health for all'.

2.1. Sector context

In September 2006, the African Union agreed to implement the '[Maputo Plan of Action](#)'¹, calling on countries to 'strengthen commitment to achieving universal access to sexual and reproductive health services, including family planning, and recognise and support the contribution of these services to

¹ Maputo Plan of Action for the operationalisation of the continental policy framework for sexual and reproductive health and rights 2007-2010, AU, 2006.

HIV prevention efforts'. Fifty-two African States re-committed themselves to the goal of universal access to sexual and reproductive health and rights (SRHR) and to linking SRHR and HIV services.

In 2010, the South African Development Community recognised strengthening the linkages between SRHR and HIV as the key to achieving its target of a 50% reduction in new HIV infections by 2015. Linkages with SRHR feature in the UNAIDS outcome framework.

Overall, the AIDS epidemic along with poor sexual and reproductive health remain major challenges for many developing countries in their efforts to achieve millennium development goals (MDGs) by 2015, as the European Union has recognised by giving priority to combating HIV/AIDS and strengthening sexual and reproductive health and rights².

A growing body of evidence suggests that better linking of efforts addressing HIV and SRHR produces mutually reinforcing progress in both areas³. The rationale for such linkages is sound: the majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding, while ulcerative or inflammatory sexually transmitted infections can also affect HIV transmission. Poor sexual and reproductive health and HIV share the same root causes, including socio-economic and gender inequality, social marginalisation of the most vulnerable populations and social and cultural sensitivities that complicate communication and evidence-informed action on all these issues. A combination of better maternal and child health, reproductive health and HIV services on the one hand with structural measures to create a more enabling environment and greater demand for these services on the other is required to bring about lasting changes in these long-standing problems.

HIV has a devastating impact on maternal, infant and child health and survival⁴. It is now the leading cause of mortality among women of reproductive age⁵ in Africa: HIV-related maternal mortality in sub-Saharan Africa is on the rise and overtaking other causes. Moreover, maternal morbidity and mortality affect not only women but also their children, since a mother's death can significantly increase her child's risk of death.

Stronger linkages between efforts on HIV and SRHR are therefore the key to achieving the health-related MDGs 4, 5 and 6⁶ and illustrating their interdependence. MDG 3⁷ is also at the heart of the linkages between SRHR and HIV, since gender equality, empowerment of women, tackling gender-based violence and advancing educational attainment are critical factors for progress on SRHR and HIV⁸ and performance on MDG 3 itself is directly improved by better maternal and HIV-related health programmes.

Better linking of HIV and SRHR can greatly increase access to and take-up of information and a wide range of services, which is particularly important for women in Sub-Saharan Africa who account for nearly 60% of HIV infections in the region and have a lifetime risk of death during pregnancy and childbirth as high as one in 26⁹. Improving linkages between HIV and SRHR can improve the lives of key populations affected by HIV¹⁰ and ensure that both women and men — whether they suffer from

² The 'European Programme for Action to confront HIV/AIDS, malaria and tuberculosis through external action (2007-2011)' was adopted by the Council of the European Union in 2005 as the basis for concerted and strong EU responses and action to combat the three diseases. In its Conclusions of May 2010 on the role of the EU in global health, the Council reaffirmed sexual and reproductive health and communicable diseases as the main health challenges to be addressed.

³ 'Linkages' means synergies achieved by bringing together policies, programmes, services and advocacy related to SRHR and HIV.

⁴ See, for example, Margaret C. Hogan et al. 'Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5', *Lancet*, 12 April 2010.

⁵ 'Women and Health — Today's Evidence, Tomorrow's Agenda', World Health Organisation, 2009.

⁶ Reduce child mortality (MDG 4). Improve maternal health (MDG 5). Combat HIV/AIDS, malaria and other diseases (MDG 6).

⁷ Promote gender equality and empower women.

⁸ In accordance with the 1994 Programme of Action agreed at the International Conference on Population and Development (ICPD).

⁹ Compared with a lifetime risk of one in 7300 in developed countries. 'Women and Health — Today's Evidence, Tomorrow's Agenda', World Health Organisation, 2009.

¹⁰ Key populations include, *inter alia*, injecting drug-users, men who have sex with men, sex workers and transgender people.

sexual and reproductive ill-health, are at risk of HIV or are living with HIV — have access to a continuum of services that meets their needs related to HIV and SRHR.

Integrating HIV and SRHR services contributes to, but also requires, strengthening health systems, but the wider agenda of linking policies and programmes on HIV and SRHR also requires a multi-sectoral and community-based approach, reaching beyond the health sector. Moreover, such efforts should be based on and can advance human rights and gender equality, for example by addressing gender-based violence and health needs, stigmatisation and marginalisation of people living with HIV and other worst affected and vulnerable populations.

Under the Joint United Nations Programme on HIV/AIDS (UNAIDS)¹¹, UNFPA, along with other co-sponsors of UNAIDS and civil society organisations and coalitions, such as the Mobilising for RH/HIV Integration Initiative¹², has made considerable efforts to create policy consensus on the need to link SRHR and HIV better. This understanding was first articulated in 2004 in the [New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health](#) and the [Glion Call to Action on Family Planning and HIV/AIDS in Women and Children](#). These calls were echoed by the adoption of the [Maputo Plan of Action](#) by the African Union.

The strong linkages between HIV prevention and treatment and efforts to reduce child mortality (MDG 4) and, in particular, maternal mortality (MDG 5) in developing countries have been well recognised and the UN SG Strategy for Women's and Children's Health explicitly mentions them.

In the context of the European Union, the strong consensus on the need to link HIV and SRHR better has been expressed in many statements, most recently in the Council Conclusions of May 2010 'strongly reaffirming the linkage between HIV/AIDS policies and programmes and sexual and reproductive health and rights policies and services'¹³.

Recent developments provide new opportunities to enhance linkages between HIV and SRHR. With the adoption of the Gender Equality Strategy of the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria in 2008, the Board decided that the Global Fund should explicitly champion and fund activities that strengthen integration of SRHR and HIV services. The new US administration has also largely abandoned previous policies and funding restrictions on sexual and reproductive health and HIV programmes.

Massive worldwide momentum and enthusiasm is being generated in support of the goal of virtually eliminating mother-to-child transmission by 2015¹⁴. This momentum provides a great opportunity and stimulus for more comprehensive and effective strategies to prevent mother-to-child transmission¹⁵ and full recognition of the need to strengthen and link SRHR and HIV policies, programmes and services as an essential part of these efforts. In particular, it provides a chance to strengthen two of the four critical pillars for preventing mother-to-child transmission: primary prevention of HIV among women of reproductive age combined with preventing unintended pregnancies among women living with HIV.

With the endorsement of the new Communication on the EU role in global health, the Council has reaffirmed health as a human right and the significance of efforts to address social exclusion, power structures that impede equity and gender equality. Emphasising the central role of the EU in

¹¹ Supported by its Secretariat, UNAIDS brings together in the response to AIDS the efforts and resources of ten UN organisations — the UNHCR, UNICEF, the WFP, the UNDP, UNFPA, UNODC, the ILO, UNESCO, the WHO and the World Bank.

¹² <http://www.globalaidsalliance.org/index.php/1402>.

¹³ [Council conclusions on the EU role in Global Health, 3011th Foreign Affairs Council meeting, Brussels, 10 May 2010](#).

¹⁴ This goal was proposed by the UNAIDS Executive Director in May 2009 and has subsequently gained massive support, including the launch of the 'Born HIV-free' campaign of the Global Fund, endorsement by the African Union summit in July 2010 and efforts to reprogramme Global Fund grants in twenty African countries towards this goal.

¹⁵ Including (i) primary prevention of HIV infection among women of child-bearing age; (ii) prevention of unintended pregnancies among women living with HIV; (iii) provision of ARV drugs to reduce infection during pregnancy and delivery; and (iv) provision of appropriate treatment, care and support to mothers living with HIV and their children and families.

accelerating progress on global health challenges, the Council has called on the EU and its Member States to act together and make strengthening comprehensive health systems in partner countries a priority for their support. The Council acknowledges the principles of the International Health Partnership¹⁶ as the preferred framework to apply the aid effectiveness commitments to health and strengthen health systems.

In this context, this project intends to support the EU's partner countries in overcoming barriers to strengthening linkages between SRHR and HIV policies, programmes and services. The project will focus on catalytic action in selected pilot countries in Southern Africa and will stimulate scaling-up in other countries by means of regional-level action. Southern Africa is the region most heavily affected by HIV in the world, with HIV prevalence rates of more than 10% in the adult population in nine of the ten countries¹⁷ and more than 20% among women attending antenatal clinics. While there is a renewed political commitment in many countries in the region dramatically to step up and refocus action on HIV and SRHR, resources for programmes aiming explicitly to strengthen links between SRHR and HIV are scarce.

2.2. Lessons learned

There is strong evidence, both from formal research and from experience with implementation in individual countries, of the mutual benefits gained by linking efforts on HIV and SRHR, especially *in the form of integrating HIV and SRHR services*.

A variety of studies cover different aspects of the very broad research on linkages between HIV and SRHR. In 2008, a systematic review of the literature published between 1990 and 2007, using the Cochrane approach¹⁸, examined the effectiveness, optimum circumstances, best practices and potential trends for stronger integration of HIV and SRHR services¹⁹.

The main findings were that, regardless of setting and type of clients, access to and take-up of services along with quality of service generally improved when they were integrated. Integrated approaches led to greater HIV testing and counselling, better health and behavioural outcomes, such as reductions in the incidence of HIV and other sexually transmitted infections and improved use of condoms and other contraceptives. Linking HIV and SRHR services was found to be beneficial and feasible, especially in family planning clinics, in HIV testing and counselling centres and in clinics for HIV treatment. Furthermore, an increasing number of programmes not only closely link SRHR with HIV treatment services but also provide antiretroviral treatment (ART) in SRHR/maternal and child health settings, especially in very high-prevalence countries. Sharing and shifting tasks among service providers are key components of such approaches.

In particular, measures which also included training for service providers to improve their knowledge and attitudes led to better provision of HIV and SRHR services.

Preliminary analysis of two cost-effectiveness studies suggested net savings from integration of prevention of HIV and other sexually transmitted infections in maternal and child health services. The potential benefits of integration included cost savings achieved by linking different forms of service, e.g. multi-tasking, sharing equipment and robust referrals, in addition to the direct benefit to clients. Moreover, increased coverage can produce a greater impact in terms of improved health outcomes and offset any initially higher start-up costs.

¹⁶ Support a single national health strategy, with a single budget process and a single monitoring framework.

¹⁷ In this context, Southern Africa includes Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

¹⁸ Cochrane reviews are systematic reviews of primary research in human health care and health policy.

¹⁹ 'Sexual and reproductive health and HIV - Linkages: Evidence review and recommendations', IPPF, UCSF, UNAIDS, UNFPA, WHO, September 2009.

Lessons learned from country-level strengthening of linkages between HIV and SRHR have been shared in a series of international consultations and fora²⁰ and via country-level assessments in 16 countries in five regions of Southern Africa, including Botswana, Malawi and Swaziland²¹. The following challenges for strengthening linkages between HIV and SRHR have been identified:

At the political and policy level, historically, linking HIV and SRHR has not been perceived as a priority. Separate earmarked funding streams and donor conditions have spurred vertical programming and created financing gaps, especially for family planning and SRHR. This has prevented full scaling-up of linkages between HIV and SRHR and integrated services. Despite the growing international policy consensus, at country level understanding among national ministries, sectoral and multi-sectoral coordination bodies, civil society organisations and donors of the broad range of social norms, policies, systems and services related to HIV and SRHR and of the need to address the key barriers to linking SRHR and HIV programmes more closely, coherently and consistently often remains limited.

Consequently, there has been a singular lack of related strategies and implementation plans and also insufficient coordination to support and reflect stronger linkages between HIV and SRHR in national health strategies and other sectoral and broader development strategies.

In many countries the Ministry of Health's lack of political influence beyond the health sector is a problem. Those working in the health sector are often still doing so in relative isolation and are unable to engage sufficiently with other relevant sectors such as education, law and law enforcement, finance and gender policy, as required for effective linkage between HIV and SRHR. Although many national HIV strategies still cite multi-sectoralism as a goal, neither its significance nor what is expected from each sector in the event of general, hyperendemic epidemics in the region is widely understood. This results in lack of coordination between multi-sectoral national AIDS coordinating authorities and the Ministry of Health, SRHR departments and other line ministries and coordination bodies that contribute to health and development.

In many countries civil society and community-based organisations representing people living with HIV, women, young people and key populations are inadequately involved in and/or have weak capacity for planning, implementing, monitoring and evaluating efforts to safeguard sexual and reproductive rights, human rights and gender equality.

There is an urgent need for legal and policy reforms and instruments to address issues which increase vulnerability to HIV and poor sexual and reproductive health and prevent access to services. These include the high age of consent for access to services, gender inequality and gender violence, the low age at marriage, criminalisation of sexual transmission and risk behaviour and widespread stigmatisation of and discrimination against people living with HIV and key populations. More should be done to engage men and boys in efforts to address HIV and sexual and reproductive health and to include SRHR prominently in school-based education on health and human rights. Advocacy and collaboration with human rights and community development organisations are needed to build partnerships and to raise awareness amongst and support the judiciary, police and defence forces so that they can deal appropriately with SRHR.

SRHR require structural intervention to shift social norms towards building acceptance and demand for inclusive, rights-based services, to endorse sexual rights for all, including people living with HIV, women and girls, and to build the political will to combat gender-based violence and uphold the rights of vulnerable groups at both community and government levels. For example, to ensure effective provision of services, there is a critical need to address the barriers of stigma, discrimination and judgmental attitudes among service providers against people living with HIV and key populations.

²⁰ Including consultations of 20 African countries in Kenya in May 2010 and the meeting of the UNAIDS Programme Coordinating Board in Geneva in June 2010, which focused on linkages between HIV and SRHR.

²¹ The country assessments made use of the 'Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages' developed by UNFPA, UNAIDS, WHO, IPPF, GNP+, ICW and Young Positives in 2008.

In terms of systemic constraints, in many countries weak health systems are a key barrier to effectively strengthening both linkages between HIV and SRHR programmes and service integration, which are severely hampered by general shortages of human resources for health and a lack of incentives to retain motivated and skilled staff.

In many countries there are little or no facilities and equipment for integrated service provision. There are no coordinated, efficient procurement systems to ensure continuous supplies of antiretroviral and other essential drugs, pharmaceutical commodities and diagnostic tools. Lack of effective information systems prevents joint and shared national monitoring and evaluation of HIV, SRHR and other health and development programmes.

At the level of service provision, capacity for multi-tasking and tasks shifting is often weak and there are insufficient knowledge and skills for integrated provision of HIV and SRHR services, resulting in poor quality of service. There is a strong need for adequate supervision and management to facilitate the process of introducing integrated services and avoid overburdening health centres and to mitigate potential physical and/or psychological burn-out of service providers as a result of increased numbers of clients for a broader range of services.

While integration of services over the longer term can strengthen health systems and service provision, the transition process has to be carefully managed to ensure continuous and better provision of quality services and avoid temporary breakdowns and/or substandard provision of services.

Finally, the 2010 joint WHO, UNFPA, WB and UNICEF publication ‘Packages of interventions for family planning, safe abortion care, maternal, newborn and child health’ provides a set of practical examples of how to link SRHR and HIV prevention and care at the different levels of the health system²². These need to be complemented by efforts to build the broader linkages and social changes that are needed to make a lasting impact on people’s dignity, fulfilment and health, without discrimination based on gender, age or HIV.

2.3. Complementary actions

African Ministers of Health recently endorsed extension of the ‘Maputo Plan for Action’ to 2015. The importance of better linking HIV and SRHR was also emphasised in two workshops held in Naivasha and Nairobi, Kenya, in May 2010. These brought together representatives of twenty African countries, including all Southern African countries, to support redirecting of round 9 Global Fund grants and round 10 proposals towards quality programming for prevention of mother-to-child transmission and other efforts on linkage of SRHR and HIV. The African Union summit in Kampala from 19 to 27 July 2010 reaffirmed African nations’ commitment to strengthening linkages between HIV and SRHR when they decided to extend the Abuja Call for accelerated action towards universal access to HIV/AIDS, tuberculosis and malaria services in Africa (‘the Abuja Call’) to 2015 to coincide with the target date set for achieving the MDGs.

As the biggest provider of development cooperation in the world, the EU is supporting these Africa-led policies to link SRHR and HIV. This is reflected in its contributions to the efforts on HIV and sexual and reproductive health and rights. The European Commission and the Member States collectively provided around 55% of the total contributions to the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria from 2004 to 2008, with an annual contribution of USD 1.5 billion for 2008. The Commission itself has pledged a total of EUR 1.072 billion until 2013, with annual contributions

²² http://whqlibdoc.who.int/hq/2010/WHO_FCH_10.06_eng.pdf, WHO, 2010.

of EUR 100 million. In 2007, EU donors provided around 54% of the earmarked financing disbursed for HIV/AIDS totalling USD 4.9 billion²³.

Population assistance, including for SRHR, from EU donors is estimated at around EUR 300 million per year. The Commission provided UNFPA with co-financing totalling EUR 195 million from 1998 to 2010 and is providing grants totalling EUR 84 million²⁴ under the budget line for 'Investing in People' (2007-2013)²⁵.

Moreover, the Commission and other EU donors are making funds available from a variety of financing instruments to strengthen health systems, address sexual and reproductive health and rights and combat communicable diseases. In the case of the Commission, an estimated total of EUR 3.043 billion of ODA is earmarked for health for 2007-2011 and general budget support has been increased to EUR 2.571 billion²⁶.

In Southern Africa, the Commission is providing a total of EUR 152.2 million for direct support for the health sector during the 10th EDF and EUR 771.8 million in general budget support²⁷. Approved HIV grants from the Global Fund to countries in the region total USD 2.1 billion²⁸, while the US President's Emergency Plan for AIDS Relief (PEPFAR) has provided more than USD 3.1 billion for 2007-2009 and is expected to provide similar contributions via PEPFAR-2 and the new Global Health Initiative of the US President²⁹.

As mentioned in the previous sections, there is strong political momentum and a wide range of initiatives are in progress specifically to advance joint efforts on HIV and SRHR. The decision by the Global Fund to champion and fund integration of HIV and SRHR services, the shift in US government policy in support of SRHR and the call by the Council of the European Union to give priority to strengthening health systems and integration of SRHR/HIV services provide a fertile climate for financing further advances. Technical and normative resources and guidance tools have been made available in the course of the activities undertaken by the IPPF, UNFPA, UNAIDS, WHO and other partners to strengthen the research evidence base obtained from the above-mentioned comprehensive review and to guide country-level implementation by developing the rapid assessment tool and providing support for 16³⁰ country assessments.

Also in 2010, UNAIDS, acting on a recommendation by its second independent evaluation, established a global interagency HIV Health Systems Strengthening Working Group to help identify and fill gaps in the evidence regarding linkages and integration, harmonise approaches and enhance support for priority countries. The Group is made up of representatives of UNAIDS co-sponsors — the WHO, UNICEF, UNFPA, the GFATM, PEPFAR and the DFID, also on behalf of the EU and Australia, as in the case of IHP+ — plus one representative of civil society.

2.4. Donor coordination

As outlined in Section 2.3, progress on linking HIV and SRHR has been severely hampered by the lack of country ownership and insufficient donor coordination. Separate donor funding streams and

²³ These figures are based on the progress report on implementation of the 'European Programme for Action to confront HIV/AIDS, malaria and tuberculosis through external action (2007-2011)', Commission Staff Working Document, Brussels, 29.5.2009.

²⁴ This figure includes the grants allocated for SRHR under the 'Good health for all' theme.

²⁵ Figures are from the NIDI/UNFPA Resource Flows Project, the UNFPA Resource Mobilisation Branch and the Investing in People Strategy Paper 2007-2013.

²⁶ Progress report on implementation of the 'European Programme for Action to confront HIV/AIDS, malaria and tuberculosis through external action'.

²⁷ Based on informal information from the European Commission on the 10th European Development Fund — indicative sector breakdown, national indicative programmes (A envelopes), 31 March 2010. Information on support for South Africa and Zimbabwe is not available and is therefore not included.

²⁸ Grant portfolio database: www.theglobalfund.org, accessed in May 2010.

²⁹ Fiscal year 2009, PEPFAR operational plan.

³⁰ Another four countries — Ghana, India, Nepal and Sudan — will be carrying out a rapid assessment of linkages in 2010 with financing provided to the IPPF.

funding conditions have encouraged vertical and isolated programming, strategies and planning on HIV and SRHR. This has created funding gaps, especially for SRHR, and prevented full implementation of the comprehensive agenda for linkages between HIV and SRHR. This fragmentation has also resulted in, and is being reinforced by, the weak or non-existent mechanisms which are preventing effective country-led coordination between HIV, SRHR and other efforts on health and development. This has hampered wider integration and reflection of the linkages between HIV and SRHR in national health and development strategies.

While the major global funders now recognise the need to strengthen linkages between HIV and SRHR, this is still not happening with the scope and coverage required. The barriers to donor support include the lack of a structure to promote linkages and make them operational at country level, the existence of vertical plans, budgets and monitoring and evaluation plans for SRHR and HIV and the need for country-level ownership to lead processes.

The decision by the EU Member States and the Commission to give priority to support for strengthening health systems and applying the aid effectiveness principles to health³¹ provides a solid platform for strengthening country ownership and donor coordination by harmonising and aligning donor financing with national priorities, plans and budgets for health and development. Moreover, these efforts provide an optimum framework for country-led and coordinated efforts to strengthen and expand linkages between HIV and SRHR, provided they are accompanied by adequate support in terms of policy dialogue, capacity-building, technical and financial resources, stronger accountability mechanisms and support for involvement by civil society. This project will seek to provide and leverage such support and to ensure that linkages between HIV and SRHR are reflected and addressed in national health and broader development planning and financing.

3. DESCRIPTION

3.1. Objectives

Aim and objectives

The overall aim is to support at least seven countries in Southern Africa in addressing barriers to efficient and effective linkages between HIV and SRHR policies and services as part of strengthening health systems and to increase access to and use of a broad range of quality services and achieve the goals of universal access to reproductive health (MDGs 3, 4 and 5) and HIV prevention, treatment, care and support (MDG 6) by 2015, while making relevant linkages with the education, gender and legal sectors.

The specific objectives are:

- to support seven countries in Southern Africa to allow full integration of HIV/AIDS and SRHR in national health and broader development strategies, plans and budgets;
- to enable three countries in Southern Africa to link efforts on integration of SRHR and HIV better and scale them up effectively;
- to stimulate formulation and dissemination of lessons learned in the Southern Africa region, formulate best practices and facilitate South-South cooperation in this field.

³¹ In the framework of the International Health Partnership+ and similar initiatives.

3.2. Expected results and main activities

The project will support catalytic action to follow up the findings of the above-mentioned rapid country assessments on linkages between sexual and reproductive health and HIV³² and regional activities to stimulate scaling-up in other countries in Southern Africa. The countries will be selected after considering the following criteria:

- Expression of interest by the country concerned³³;
- High maternal mortality;
- High HIV burden/prevalence;
- Upcoming broader health and development planning and review processes;
- Potential for results;
- Significant barriers;
- Inclusion on the existing list of priorities for joint action on HIV, strengthening health systems and integration.

The combination of countries selected should reflect the diversity of national contexts, for example include both 'low hanging fruit' and countries with higher barriers, countries with weak health systems and others with stronger systems, etc. This will allow the project to develop and define different models of best practice, which will be disseminated via regional-level activities to stimulate and support stronger linkages between HIV and SRHR in other countries in Southern Africa and beyond.

Similarly, the package of catalytic action for strengthening linkages between HIV and SRHR will differ from one country to another, depending on the national context, the findings of the rapid assessments and the agreed priorities. The expected results and main activities described below will therefore be further defined and adapted to the national context during the inception phase and throughout the process of implementation, as described below. Country ownership and the aid effectiveness agenda will be the guiding principles of all activities in this project.

Expected result 1: Linkages between SRHR and HIV integrated in national health and development plans in seven countries (possibly Zambia, Namibia, Zimbabwe, Lesotho, Malawi, Swaziland and Botswana).

Under government leadership and in a country-led process, the indicative main activities will include but not be limited to:

- conducting rapid assessments of linkages between HIV and SRHR policies, systems and services³⁴;
- as part of the rapid assessments, investigating key legal, policy and related barriers to effective implementation of HIV and SRHR services, including for key populations;
- holding technical consultations with national stakeholders to review findings and recommendations of the assessment of linkages between SRHR and HIV, identify priorities for strengthening linkages between policies, systems and services and define interim working arrangements (technical working groups/task forces), *modus operandi* and resource requirements for follow-up work on the agreed priorities;
- meeting high-level representatives of key sectors, donors, civil society and other policy stakeholders to increase broad understanding of and support for the full scope of linkages between SRHR and HIV and the policy and systems barriers to them, present the conclusions

³² Rapid assessments have been conducted in 16 countries. Four more are planned during 2010 — in Ghana, India, Nepal and Sudan.

³³ In each country selected this expression of interest will be formalised by a memorandum of understanding/cooperation agreement to be signed by the Minister of Health, the national AIDS coordinating authority, the EU Delegation and the UN country team.

³⁴ In Southern Africa rapid assessments have already been conducted in Botswana, Malawi and Swaziland.

- and recommendations of the technical consultation and seek endorsement for the proposed national process to strengthen such linkages;
- developing strategies and a consolidated package of action to address the agreed priorities for scaling up linked and/or integrated programmes;
 - mapping ongoing and upcoming national policy, planning and review processes for health and development and reviewing them for opportunities to address the agreed priorities, securing the support of key sectoral stakeholders and development partners and incorporating priority linkages in national health and development plans;
 - supporting the capacity of civil society organisations, women and people living with HIV and representatives of key populations to engage meaningfully in the above-mentioned consultations and processes.

Expected result 2: Improved take-up and delivery of integrated quality services for HIV and SRHR in three countries³⁵ (possibly Malawi, Swaziland and Botswana).

Country-specific activities will be further defined once the countries to be covered have been selected. They will be based on specific needs identified in the rapid assessments and the consultation process³⁶. Activities could include:

- based on the agreed priorities and the consolidated package of action for scaling up linked and/or integrated services, developing an operational health workforce strategy (if not already part of the package) to ensure proper introduction of and support for linked/integrated services;
- with the meaningful participation of service providers and beneficiaries (including people living with HIV, members of key populations and civil society organisations), designing programmes to support rights education, access to quality health services and SRHR and to address discrimination and stigma, including by means of redress mechanisms;
- implementing effective approaches to end stigma and discrimination by and against health care providers and increasing involvement of men and vulnerable groups;
- with the aid of regional and national workshops, as appropriate, building the capacity of programme managers and service providers in governmental and community-based organisations to implement integrated SRHR and HIV services;
- addressing security of RH and HIV/AIDS commodities with country-specific priority intervention;
- reviewing existing and, if needed, piloting new integrated approaches in selected provinces, e.g. regarding district and primary health care services and community health workers;
- defining the contribution of each non-health sector (especially education, law and law enforcement and gender policy) in successful models and making recommendations for including them in the coordinated programmes of support.

Expected result 3: Best practice models disseminated to support strengthening linkages between HIV and SRHR in other countries.

Under the leadership of the countries participating, the main activities will include, but not be limited to:

- documenting lessons learned and identifying bottlenecks and best practice models at the policy, system and service delivery levels and disseminating them widely;
- convening regional consultations with countries involved in the project to share their experience of linkages/integration via South-South cooperation;
- exploring and pursuing options for global and regional sharing of information and experience, including via the AU/SADC and other relevant continental and global frameworks.

³⁵ The eight countries selected as priorities by the UNAIDS HIV HSS Working Group following mapping of various relevant criteria are Ethiopia, Malawi, Mozambique, Nigeria, South Africa, Uganda, Zambia and Zimbabwe.

³⁶ The country selection process will be finalised by the end of October 2010 and will be followed by definition of country-specific action.

Implementation arrangements

Throughout implementation, major emphasis will be put on supporting the countries in implementing aspects of linkages between HIV/AIDS and SRHR. All the countries have already committed themselves to the African Union's policies on linking HIV/AIDS and RH (i.e. the Maputo Plan of Action). Now they will be able to put in place the mechanisms to implement, monitor and evaluate their stated priorities in this field.

Relevant ministries and national coordinating authorities will take responsibility for and lead implementation of the project at country level with support from partners. Where necessary, they will call on experts of their choice (e.g. non-state actors, researchers and private consultants or individuals) to support parts of the national action plans.

The project will propose a Regional Project Steering Committee chaired by representatives of the governments concerned, the UN agencies' country representatives and non-state actors.

A Technical Committee and an Evaluation Committee could also be proposed as additional project support mechanisms.

A regional project coordinator will be appointed to guide countries and coordinate overall implementation of the project. He or she will oversee the project and its progress, help with arranging the appropriate support, help with overcoming bottlenecks, ensure proper exchanges of information and joint learning, be responsible for financial management and balanced allocation of funds in line with Steering Committee decisions, etc.

The regional project coordinator will coordinate collaboration between the headquarters and regional offices of UNAIDS, UNFPA, the WHO and other UN partners and also via the joint UN country teams on AIDS, where the UN delivers 'as one' combining the efforts of the ten co-sponsoring UNAIDS agencies³⁷. He or she will also coordinate and support implementation of activities at regional level. The project coordinator will collaborate closely with UNFPA and UNAIDS staff already working at country, regional and HQ level and be supervised jointly by the UNAIDS and UNFPA Regional Directors based in Johannesburg as part of the Regional Directors' Team (RDT) and the Project Steering Committee.

In each country, project management will be under the leadership of the Ministry responsible. The country offices of UNFPA and UNAIDS will deliver direct support, as agreed in the country-led work plan.

³⁷ UN country-level coordination on action to combat HIV/AIDS occurs at Head of Agency level within the UN Theme Groups on HIV/AIDS, chaired by the Resident Coordinator, and at operational level via the joint UN technical teams, supported by the UNAIDS Country Coordinator. Coordination on SRHR programmes is carried out in the framework of implementation of United Nations Development Assistance Framework (UNDAF) and coordinated by the UNFPA country office.

3.3. Risks and assumptions

Successful implementation of the project depends on the following assumptions:

Risk/Assumption	Mitigating measures
<i>Sufficient government commitment and leadership are maintained</i>	<i>Implement strategies to sustain commitment and support from key stakeholders (champions, media, high-level policy dialogue, etc.)</i>
<i>Coordination mechanisms can be established between SRHR and HIV stakeholders</i>	<i>Review existing coordination mechanisms and gaps, establish linkages working groups/task forces and include strategy for effective coordination as an integral component of the project</i>
<i>Integration does not result in overburdening of health systems</i>	<i>Change management strategy defined to address integration challenges; identify systemic constraints and bring them forward in efforts to strengthen health systems</i>
<i>Sufficient engagement of key populations, women, young people, people living with HIV, vulnerable groups and other key stakeholders</i>	<i>Raise awareness among all stakeholders that engagement of key populations, women, young people and people living with HIV is a fundamental principle for linking SRHR and HIV and project activities and specify their engagement in all working groups/task forces, etc.</i>
<i>Availability of HIV and SRHR commodities and related equipment</i>	<i>Plan costing of commodities and equipment to implement integrated SRHR and HIV services effectively and incorporate it into national health and development plans</i>
<i>Project monitoring is maintained, reporting honoured and timelines respected</i>	<i>Establish clear lines of responsibility at the outset of the project, designate an overall coordinator to troubleshoot and agree reasonable reporting requirements, using existing structures wherever possible</i>
<i>Available human resources receive adequate incentives to perform</i>	
<i>Country partners agree with and engage in the human rights component of the SRHR agenda</i>	<i>Ensure that national and regional networks of people living with HIV and national and regional human rights organisations are included in the Steering Committee and that they help define and include human rights indicators in the targets and performance management system</i>

3.4. Crosscutting issues

The key areas for action in this project include promotion of gender equality, sexual and reproductive rights, children's rights and human rights. The project will also directly focus on HIV as a crosscutting issue in accordance with the European Consensus on Development. By aiming to strengthen linkages between efforts on HIV and SRHR, thus improving the quality, availability and accessibility of SRHR and HIV services, the project will clearly benefit the end-users of these services, i.e. women and men of reproductive age, their families, youths and people living with HIV/AIDS. Children will also directly and indirectly benefit from better service as a result of improving maternal health and avoiding mother-to-child HIV transmission. The project will seek to create a supporting and enabling legal, policy and social environment for SRHR. It will promote rights-based approaches to access to services for health, HIV and sexual and reproductive health. One critical factor in strengthening

linkages between HIV and SRHR in the broader context of health and development is to ensure good governance and democracy in the form of effective and transparent coordination, planning and monitoring, which includes non-state actors such as women and youth organisations, people living with HIV and key populations and will allow oversight by civil society and parliaments. Moreover, this approach will increase partner countries' ownership, thus directly supporting the objectives of the Paris Declaration.

3.5. Stakeholders

Under a memorandum of understanding/cooperation agreement with EU Delegations and UN country teams, implementing Ministries and national coordinating authorities in the countries selected will be supported in their joint efforts to engage and convene partnerships, ensure effective coordination across the wide range of relevant stakeholders and enable better harmonisation and alignment of international financing with national priorities and processes for health and development. At country level, such stakeholders include civil society organisations, Global Fund country coordinating mechanisms, EU Member States, other development partners and the private sector.

Women of reproductive age, people living with HIV, young men and key target populations defined in country strategies are key beneficiaries and their representatives could be engaged both in the project activities and in the expected results with the aid of more effective and inclusive coordination, implementation and monitoring of HIV and SRHR linkages.

At regional and global levels, partners could include the African Union Commission, the SADC, the International Health Partnership+, the Global Fund Secretariat, PEPFAR/USAID and other major and emerging donors, the IPPF, Marie Stopes International and other members of the Inter-Agency Working Group on SRH and HIV linkages³⁸.

4. IMPLEMENTATION ISSUES

4.1. Method of implementation

A standard Contribution Agreement will be signed with UNFPA, providing for joint implementation with UNAIDS. The Contribution Agreement will be under the Financial and Administrative Framework Agreement between the European Community and the United Nations (FAFA) and will follow the current standard procedures between the UN and the European Commission.

UNFPA will enter into an agreement with UNAIDS as implementing partner for specific tasks, as agreed in the joint work plan.

UNFPA will act as the lead agency responsible for follow-up and coordination and, as such, will be responsible for reporting to the European Commission, as stipulated in the Contribution Agreement.

4.2. Procurement and grant award procedures

All contracts will be awarded and implemented in accordance with the procedures and standard documents laid down and published by the relevant international organisation.

³⁸ Co-led by UNFPA, the WHO and the IPPF and also including UNAIDS, the UNDP, EngenderHealth, the Global AIDS Alliance, the International AIDS Alliance, the World Bank, Family Health International, USAID, the Population Council, the Global Fund, CDC and the Global Network of People Living with HIV.

4.3. Budget and time-table

The funding required implementing the project in seven countries in Southern Africa is estimated at EUR 7 million for four years between January 2011 and December 2014, with a proposed contribution of EUR 7 million from the EU.

The action will start with an inception phase, during which efforts will be made to mobilise contributions from the many EU and other international donors who have expressed strong interest in supporting efforts to strengthen linkages between HIV and SRHR. Such contributions would allow the project to include more countries in Southern Africa and beyond. As a catalytic project, it will seek to leverage existing resources for HIV, SRHR, health and development, including budget support, effectively to help strengthen linkages.

A more detailed budget will be defined for the contracting phase and also during the inception phase, when detailed budgets will be defined for country-specific action, based on the national implementation plan in the countries selected and on the following indicative budget breakdown:

Human resources	EUR 1 400 000
Project activities in three countries (result 2)	EUR 2 400 000
Project activities in four countries (result 1)	EUR 1 000 000
Conferences/meetings	EUR 300 000
Travel	EUR 300 000
Equipment and supplies	EUR 300 000
Monitoring and evaluation	EUR 300 000
Other costs/services/studies	EUR 510 000
Indirect costs (maximum: 7%)	EUR 490 000

The process to select countries to take part in this project started in September. Selection is expected to be finalised and written expressions of interest to be received from countries before contracts are signed in mid-December 2010.

Following selection of each country, before the contract is signed detailed country-level activities plus global and country-specific log frames including indicators will be defined and then finalised during the inception phase.

4.4. Performance monitoring

This project will be jointly monitored by UNFPA and UNAIDS. Results and outputs were described in Section 3.2 and means of verification will be defined by log frame analysis. A detailed implementation plan and monitoring and evaluation framework will be prepared during the first three months of the inception phase, which will last no longer than six months. This process will include national consultations with all stakeholders in the countries selected to assess and/or review the findings of the country assessment on linkages between HIV and SRHR and define a package of key measures to overcome barriers to strengthening such linkages. Implementation will be monitored routinely at country level as part of the national monitoring processes and systems. Annual progress reports will be submitted to UNFPA by UNAIDS. As lead agency, UNFPA is responsible for reporting to the European Commission in accordance with the Contribution Agreement.

4.5. Evaluation and audit

A detailed review will be undertaken half-way through the planned project implementation period. Further details of routine and periodic (mid-term, final and *ex post*) evaluations will be included in the detailed monitoring and evaluation plan.

Terms of reference for evaluations will be developed together with the European Commission. The usual UN audit procedures and schedule will apply.

4.6. Communication and visibility

A specific action plan will be developed on communication and visibility, in compliance with the *Communication and Visibility Manual for EU External Actions*³⁹. The European Commission will be kept informed of developments and activities and be involved in activities, especially in critical policy events (this includes the EU Delegations at country level).

All relevant communication and visibility activities will be carried out in collaboration with the European Commission and the EU Delegations.

Internal communication within and between countries (regional component) will be established and maintained throughout the project to ensure knowledge-sharing, replication of good practice and South-South cooperation. Communication on other relevant experience and practice outside the project will also be ensured to inform and improve implementation of this project.

³⁹ http://ec.europa.eu/europeaid/work/visibility/documents/communication_and_visibility_manual_en.pdf.