INVESTING IN AFRICA'S YOUTH
How the EU can better support adolescent SRHR

DSW
Deutsche Stiftung Weltbevölkerung

youth can

ABOUT DSW

Deutsche Stiftung Weltbevölkerung (DSW) is a global development organisation that focuses on the needs and potential of the largest youth generation in history. We are committed to creating demand for and access to health information, services, supplies, and economic empowerment for youth. We achieve this by engaging in advocacy, capacity development, and reproductive health initiatives, so that young people are empowered to lead healthy and self-determined lives. With our headquarters in Hannover, Germany, DSW operates two liaison offices in Berlin and Brussels, as well as maintaining a strong presence in Ethiopia, Kenya, Tanzania, and Uganda.

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CONTENTS

ABBREVIATIONS

ACP	African, Caribbean and Pacific countries
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AU	African Union
AUC	African Union Commission
CCM	GFATM ´s Country Coordinating Mechanism
CPA	Cotonou Partnership Agreement
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisations
CSO/LA	Civil Society Organisation/Local Authorities
CSP	Country Strategic Plans
DCI	Development Cooperation Instrument
DFID	UK Department for International Development
DG DEVCO	Directorate General for International Cooperation and Development, European Commission
DG ECHO	Directorate-General for European Civil Protection and Humanitarian Aid Operations, European Commission
EC	European Commission
EDF	European Development Fund
EIDHR	European Instrument for Democracy and Human Rights
ESAP	Ethiopia Social Accountability Programme
EUTF	European Union Emergency Trust Fund for stability and addressing root causes of irregular migration and displaced persons in Africa or European Trust Fund for Africa
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
GAVI	Global Alliance for Vaccination and Immunisation
GBS	General Budget Support
GFF	Global Financing Facility
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit, German development agency
GPGC	Global Public Goods and Challenges programme
GPE	Global Partnership for Education
HDA	Health Development Armies
HEP	Health Extension Programme
HEW	Health Extension Workers
HIV	Human Immunodeficiency Virus
HRH	Health Human Resources

HSTP	Health Sector Transformation Plan
ICPD PoA	International Conference on Population and Development and its Programme of Action
ICT	Information and Communications Technology
INSD	National Institute of Statistics and Demography
JAES	Joint Africa-EU Strategy
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LMICs	Low and Middle-Income Countries
MDGs	Millennium Development Goals
MDGi	Millennium Development Goals Initiative
MDG PF	MDG Performance Fund
MFF	Multiannual Financial Framework
NDICI	Neighbourhood, Development and International Cooperation Instrument
NGO	Non-Governmental Organisation
NIP	National Indicative Programme
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
OECD-DAC	Organisation for Economic Co-operation and Development Development Assistance Committee
PAPS	Programme d´Appui a la Politique sectorielle de Santé
PBS	Protection of Basic Services
PNDES	National Development Plan
PROS	Programme de Renforcement des capacités des Organisations de la Société civile initiative
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, New-born, Child and Adolescent Health
SBS	Sector Budget Support
SDGs	Sustainable Development Goals
SIDA	Swedish International Development Cooperation Agency
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
SWD	Staff Working Document
TVET	Technical and Vocational Education and Training
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation
YFS	Youth Friendly Services

EXECUTIVE SUMMARY

This report presents the findings and recommendations of research, commissioned by Deutsche Stiftung Weltbevölkerung (DSW) that assesses how European Union (EU) development cooperation programmes have supported young people's[i] access to sexual and reproductive health and rights (SRHR), with a focus on African countries.

In many African countries, young people are a majority, often accounting for more than 60 percent of the population. Africa's youth population is expected to continue to grow throughout the remainder of the 21st century, and to more than double its current levels by 2055[1]. In such contexts, there is no development without youth.

Young people can be key agents for development and change today and tomorrow in any national context. In order for these drivers of transformation to realise their full potential, special attention needs to be given to youth policies and programmes at all levels. As such, this age group has been frequently put at the centre of the EU´s cooperation with Africa, particularly for some sectors that are central to youth empowerment. Most recently, the EU´s new Consensus on Development (2017) has reinforced attention to the needs of young people, particularly in the sectors of education and technical and vocational education and training (TVET), as well as employment and decent work, both of which had already been given key importance even before 2007, mostly in the context of the Cotonou Partnership Agreement (CPA) and the Joint Africa-Europe Strategy (JAES).

THERE IS NO DEVELOPMENT WITHOUT YOUTH

These two sectors are however not exclusive to youth agency. The start of adolescence brings challenges not only in terms of body changes but also social vulnerabilities. Such challenges prevent young people from exercising some of their most basic human rights. The International Conference on Population and Development (ICPD) and its Programme of Action (PoA) (Cairo, 1994), which set the basis for what today is called sexual and reproductive health and rights (SRHR), recognised a comprehensive range of needs of adolescents and young people that should be addressed in order to improve the quality of life of present and future generations.[2] Following their reaffirmation by the Beijing Declaration and Platform for Action, adolescent sexual and reproductive health and rights (ASRHR) have, unsurprisingly, received attention from policy makers at various levels.

i This study interchangeably refers to the terms youth and young people to mean people between the ages of 10-35 in order to accommodate the definition of the African Youth Charter.

While EU development cooperation is supposedly no exception, literature reviews have shown that none of the EU policy documents, including the recently renewed European Consensus on Development, or Africa-related frameworks, directly correlate the importance of providing SRHR or broader health services to the needs of young generations in these specific sectors. Moreover, while the EU currently supports the SRHR agenda through multiple channels and modalities, these investments do not always prioritise youth needs, unless a project or programme specifically targets youth as a core beneficiary group.[ii]

Based on the premise that no solution fits all, this research builds upon three case studies to identify EU practices which either promote or compromise young people's sustainable access to health services in African countries[iii]. The assessment, which is not aimed at prescribing a universal approach, includes a SWOT analysis on the effect of the EU´s most commonly used modalities, funding channels and mechanisms, namely: general and sector budget support, sector-specific or thematic project-type funding[iv] and pooled funding mechanisms.[v]

Have EU-funded programmes been supporting equitable, accessible, acceptable, appropriate and effective youth-friendly sexual and reproductive health services (YFS)?

For each criterion (equity, accessibility, acceptance, appropriateness and effectiveness), the report uses a specifc methodology to test EU-funded health programmes against characteristics developed based on expert interviews and literature review. The study also looked at whether programmes included measures for long-term effect. The report however does not aim to confrm if the programmes are impactful, but rather to evaluate if they offer the right conditions to deliver broader agency to youth.

General and sector budget support can be conducive to key YFS components, such as non-biased training of health human resources (HRH) and availability of a comprehensive package of reproductive health commodities. If well-designed, it can include feedback mechanisms and indirectly support community mobilisation. However, in practice, budget support indicators used are neither youth-friendly, nor age-disaggregated. This reduces the EU´s steering capacity for ensuring the quality and youth friendliness of services. Effective youth outreach can also be undermined by lack of proximity.

Sector-specific/ thematic project-type[vi] funding usually provides the EU with the ability to ensure that key components of YFS, such as youth needs assessments, dialogue and advocacy between beneficiaries, implementers and the government, non-biased training to HRH, outreach to different population groups and improved infrastructures, are included in the programme design and implementation. Projects can also promote innovative piloting approaches with a potential for scale-up, if governments are adequately involved or consulted.

ii See Chapter 2 – EU support to SRHR.
iii See Chapter 3 – Methodology.
iv Single donor (non-pooled) global or country-level support for a specific sector or theme project. Possible channels: government, civil society, or multilaterals. Decision-making for this modality can be done at country or headquarters level.
v Global, regional or country-based pooled funds managed by an entity different from the donor country government. Decision-making for this type of initiatives is usually joint with other donors.
vi The emphasis here being on "project-type" funding (versus budget support and pooled funding modalities).

EU-supported pooled funding mechanisms can help scale up YFS, if these are earmarked, and enable elements for YFS, such as human resources and infrastructures. However, many of these mechanisms are still implementing siloed approaches, thus undermining comprehensive service provision.

Do EU programmes include pre-conditions for youth empowerment and sustainability of services?

While **general and sector budget support** can promote government ownership and improve national resource allocation capacities, this process does not tend to be very inclusive of stakeholders other than the national government (hence "government" but not "country" ownership), and there is, to date, little evidence of efforts for mainstreaming youth friendliness and empowerment across sectors and related services.

Sector-specific/ thematic project-type funding can contribute to inclusive, country ownership and raise civic awareness, while including feedback mechanisms. Some EU-funded projects have also demonstrably helped strengthening youth leadership, informing national guidelines and integrating youth friendliness beyond a single sector. Despite their potential for being inclusive, many projects still lack structured approaches on how to involve youth-led organisations in particular. While projects can promote innovative piloting approaches, they need to be designed in consultation with the government, youth and local communities to ensure their sustainability.

EU-supported pooled funding mechanisms can help harmonise donor funding in line with the government's needs and provide for increased accountability and inclusiveness through dedicated mechanisms. However, these mechanisms´ decision-making processes are not always inclusive; possible duplication of related coordination mechanisms might imply increased transaction costs.

How do EU programmes meet its development policy objectives?

The new Consensus on Development has reconfirmed EU commitments towards the SRHR agenda. This research has also identified EU strengths and limitations in fulfilling these commitments. The present paper found that EU funds targeting SRHR are usually expected to follow both the ICPD PoA and the Beijing agenda, even if these are not explicitly mentioned in the decision documents. Sexual rights, notably Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) rights, seem to remain a sensitive area for EU funding, with EU political dialogue and/or funding for targeted Civil Society Organisations (CSO) projects continuing to be the most common ways of addressing these issues.

Most of the remaining aspects that are key for ensuring "free and responsible decision on matters related to sexuality and sexual and reproductive health"[vii] tend to receive EU support through different modalities and channels, with a focus on harmful traditional practices and child marriage. The EU has been a supporter of ensuring universal access of young people to SRH information and services. The exception is comprehensive sexuality education (CSE), which tends to be supported by other donors, including EU Member States. The "universal" nature of this access to SRH information and services has nonetheless been challenged by some of the evidence from this research, which has shown that the lack of comprehensive approaches, including with different government bodies and other stakeholders, limits the outreach of EU support.

The present analysis also takes a prospective view, by trying to bridge observed EU practices with upcoming EU policies and programmes, particularly in the context of the Multiannual Financial Framework (MFF) for 2021–2027[viii]. It shows that the EU´s future financial architecture, currently under discussion, offers some good opportunities, but also threats to the possibility of upscaling EU support for young people's access to SRHR in African countries. Accordingly, this research has identified several recommendations aimed at helping the EU accelerate progress towards fulfilling its commitment to meet young people's needs, as per the new Consensus.

vii As stated in para. 34 of the New European Consensus on Development.
viii For a complete reading of this section please go to Chapter 5 – Conclusions and Recommendations.

RECOMMENDATIONS

Within the new MFF

- Tap into the potential of young people. Make youth friendliness a standard criterion for delivering health and social services in the development context, especially in African countries; continuous consultation with youth should inform policy development, project design based on youth needs assessments, implementation and monitoring.
- Ensure a balanced mix of aid modalities and channels when supporting the health sector at country level; ASRHR should be addressed through modalities that work both at the supra- and national level – and not just supranational, as the current MFF proposal suggests.
- With the emergence of new financing instruments whose impact on social sectors and youth needs still need to be assessed, continue to prioritise traditional grants as a demonstrably effective way of making services youth friendly, equitable, accessible, acceptable, appropriate and effective.
- Ensure that whatever the modality and channel used, an integrated approach to health is adopted. Ensure that programming within the country considers all relevant national policies that affect the chosen cooperation sector, notably ASRHR.
- Ensure an enabling environment for civil society operations, paying special attention to targeting youth and youth-led organisations. Consider the role of CSOs as "development and governance actors" (as mentioned in the MFF proposal), including as service providers.

With regards to the specific modalities

General and sector budget support

- Ensure that trigger indicators attached to the variable tranche of budget support reinforce YFS components and that these indicators are both gender and age-disaggregated.
- Ensure that budget support includes feedback and social accountability mechanisms, by reinforcing linkages with relevant initiatives supporting civil society´s oversight role. Scrutinise forecasted results under budget support.
- Ensure that new funding includes provisions to verify if the rights of women, youth and children, such as SRHR, are "recognized and effectively protected" (as per text of the new budget support guidelines) by the candidate country.

Sector-specific or thematic project-type funding

- Ensure that projects support monitoring and documenting health system practices related to YFS standards, in order to enable the scaling-up of innovative solutions.
- Provide more targeted and sustainable support to youth leadership, going beyond single and short-term interventions.
- Work with government structures, both through policy dialogue and project implementation to ensure ownership and sustainability. Align projects with relevant national policies and plans and use national indicators where possible.
- Support cross-sector approaches and innovative initiatives using new tools (e.g. social media, ICT) for reaching out to young people and out-of-school youth.

Pooled funding mechanism

- Promote the integration of ASRHR services into the initiatives of vertical mechanisms such as the Global Fund against Tuberculosis, Aids and Malaria (GFATM) at both board and country level.
- Adopt a holistic, non-siloed approach towards addressing young people's needs and engage national Ministries, including Health, Youth and Gender (where applicable) in these efforts.
- Through the new MFF, change the governance structure of the EC-established trust funds, allowing for more participation of partner countries and local stakeholders in the decision-making.

With regards to EU political and policy dialogue

- Ensure the participation of youth organisations in the structured dialogue with EU Delegations, in the context of EU CSO roadmaps and other CSO consultations.
- Continue tackling sensitive issues, such as LGBTI rights or CSE, which cannot always be addressed at programme level, by using political or policy dialogue.

Impact of EU coordination on young peoples´ health and well-being

- Consider demography and population growth as a strategic objective within the Joint Programming processes, in light of the importance of addressing population growth to ensure Africa´s development.
- Where health is chosen as a priority sector for donor coordination, ensure a comprehensive approach is taken, including the consideration of ASRHR.

Endnotes: Executive Summary

1. United Nations, Population Facts, 2015, p.1. Available at: http://www.un.org/esa/socdev/documents/youth/fact-sheets/YouthPOP.pdf, accessed 29/10/2018.
2. United Nations Population Fund, Programme of Action, International Conference on Population and Development, Cairo, 1994, In Objective 6.3. Available at: https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf, accessed 1/10/2018.

CHAPTER 1: OVERALL CONTEXT

1.1 Defining youth

The definition of "youth" is not clear cut. The term mainly captures the shift from childhood dependence to the physical and social independence of adulthood. This being a complex process, age is the variable most commonly used to define this group.[3]

The United Nations (UN) originally defined youth in 1981 as "those persons between the ages of 15 and 24 years, without prejudice to other definitions by Member States".[4] This has since become the globally accepted statistical definition of the term.

UN agencies themselves also have different definitions of youth, all of them recognised by the Secretariat. The World Health Organisation (WHO), for example, describes "adolescents" as individuals between the ages of ten and 19, "youth" covering the 15-24 age range and "young people" as individuals between ten and 24 years.

The meaning of the term "youth" varies according to country context and is subject to changes resulting from political, economic, social and demographic settings. Recognising this and the importance of this cohort, the African Union Constitutive Act and the African Union Commission (AUC) have since long prioritised youth development and empowerment and have consequently adopted the African Youth Charter in 2006 (although still to be ratified by some AUC members). In this Charter, "youth" and "young people" refers to every person between the ages of 15 and 35.[5] The EU's youth policy for 2010-2018, entitled "An EU Strategy for Youth – Investing and Empowering",[6] on the other hand defines youth as individuals between the ages of 15 and 29.

This study will nonetheless interchangeably use terms youth and young people to mean people between the ages of ten and 35 years in order to accommodate the definition of the African Youth Charter.

While in 2015 youth (aged 15-24) accounted for 1.2 billion of the world population, this number is expected to grow up to 1.3 billion by 2030.

Africa remains the world region where youth population continues to grow. According to 2017 data, 60 percent of the population is below the age of 25, out of which 19 percent are aged 15-24.[7]

Young people can be key agents for development and change of today and tomorrow in any national context.[8] In order for these drivers of transformation to realise their full potential, special attention should be given to youth policies and programmes at all levels. The ways in which needs and prospects for young people are addressed is instrumental to determining the well-being of future generations.

1.2 The EU's overall policies on youth

Young people are the backbone of society.[9] Recognising this, the EU has long since addressed the needs of youth through its foundational documents, currently framed by the Treaty of Lisbon.[10] Most recently, the EU's 2010-2018 youth policy "An EU Strategy for Youth – Investing and Empowering"[11] has led to the creation of several new programmes aimed at promoting young peoples' potential. However, the core target group of these policies and programmes remains youth within the EU´s borders.[ix]

Limiting the EU's focus on youth to within its own borders, would, however, be at odds with the universal nature of the 2030 Agenda and with the global demographic trends: while young people represent around about 18 percent of the EU's population,[12] the age group of people under 30 often accounts for 50 percent or more of the population in a large number of low and middle-income countries (LMICs). This is particularly true in Africa, where the number of youth is growing rapidly. In 2015, 226 million youth aged 15-24 lived in Africa, accounting for 19 percent of the global youth population. Africa's youth population is expected to continue to grow throughout the remainder of the 21st century, and to more than double its current levels by 2055.[13] While a growing, young population can be a valuable engine for change, it can also be at the root of social unrest and poverty aggravation, if young people´s specific and growing needs are not adequately addressed.

EU development cooperation has been changing its approach through time. The first ever policy declaration establishing the EU's and its Member States' common values, objectives and means towards poverty eradication, the European Consensus on Development, was adopted in 2005 and failed to include any reference to youth or young generations.[14] The EU's Agenda for Change from 2011[15] only mentions youth once, by merely highlighting that advancing the Millennium Development Goals (MDGs) can help ensure a "better future for young people".

The new European Consensus on Development, revised in 2017 and which aims at aligning EU development policy and the 2030 development agenda, has signalled a change in the EU's approach: For the first time, the EU and its Member States have prioritised youth in their development policy. Not only is youth identified as a "cross-cutting element for sustainable development", but the policy also states that "young people are agents of development and change and, as such, are essential contributors to the 2030 Agenda". This new or revised Consensus hence commits the EU and its Member States to concrete actions that will allow to address young people's needs and potential".[16]

Of relevance also are the EU Guidelines for the Promotion and Protection of the Rights of the Child, developed in 2007 and revised in 2017.[17] Based on the UN Convention on the Rights of the Child, the guidelines set priorities and operational guidelines for policy on children under 18 in the EU external action.[18]

Example of global initiatives: EU/Organisation for Economic Co-operation and Development (OECD Youth Inclusion Project)

The Youth Inclusion project, implemented between 2014 and 2017, aimed at supporting countries' responses to the ambitions of young people. It did so by analysing existing policies in nine developing and emerging economies with a focus in four areas considered key for youth empowerment: employment, education, health, and civic participation.

The study concluded that some of the priorities that should be addressed urgently for youth inclusion included reducing the market demand vs. skills mismatch, promoting entrepreneurship and rural youth employment, improving sexual and reproductive health of adolescents and youth, making civic participation inclusive and, finally, the development of integrated youth policies to deliver in all these priorities. The project resulted in case studies; a toolkit for youth well-being diagnosis and practical examples of youth policies; a guidance note for development practitioners and theme studies.[19]

ix With some exceptions, such as the Erasmus+ programme – see section on Education and TVET below.

1.3 The EU's youth policies in Africa

The Cotonou Partnership Agreement (CPA) is the current framework for cooperation between the EU and 79 African, Caribbean and Pacific countries (ACP), coming to an end in 2020. Aimed at "reducing and eventually eradicating poverty consistent with the objectives of sustainable development",[20] the CPA commits to making specific improvements in the social sector. In this context, it includes a targeted provision aimed at realising the potential of youth. Several measures are identified with a view to, inter alia, protect the rights of children and youth, support active participation of young people and promote "the skills, energy, innovation and potential of youth in order to enhance their economic, social and cultural opportunities".[21] Moreover, the CPA also mainstreams the focus on youth concerns into other fields of action.

Another key framework supporting youth in Africa is the Joint Africa-EU Partnership, (Cairo, 2000). Framing cooperation between the EU and the African continent, it is based on the Joint Africa-Europe Strategy (JAES), adopted for the first time in 2007. Once more, youth is given attention under the objective of human and social development, with a focus given to "youth empowerment and inclusion in the economic sector".[22] The same attention has been given to the topic under successive declarations during subsequent Africa-EU Summits.

The implementation of the JAES has been based in Action Plans or Roadmaps, which are renewed every three years. While the First Action Plan (2008-2011) included education and decent work activities targeting young people under the strategic priority "Migration, mobility and employment", the Second Action Plan (2011-2013) failed to make any specific reference to youth, although it did tackle relevant sectors to that cohort, such as education. The situation changed with the Roadmap for 2014-2017, which places a focus on youth under different priorities, such as human rights dialogues, higher education and decent jobs and entrepreneurship, including in rural settings. This emphasis was further reinforced in 2017, under the African Union (AU) - EU Summit. With the theme of "Investing in Youth for Accelerated Inclusive Growth and Sustainable Development", the outcome Joint Declaration mainstreams youth issues under all respective strategic areas, namely: i) Investing in people, with a focus on education and skills development; ii) Resilience, Peace, Security and Governance; iii) Migration and mobility and iv) Investments.

1.4 Thematic analysis of EU youth policies

Some specific sectors which are central to youth empowerment have had a constant presence in EU development policy. Two of these sectors have been selected for closer analysis, on the basis of importance given to them in the context of youth empowerment in Africa since 2007. These two sectors are however not exclusive to youth agency, as the second chapter will show.

1.4.1 Employment and decent work

The concern with youth employment is a global one, and particularly present in settings where youth populations are large. In LMICs in Africa, which due to high fertility rates are in the early stages of demographic transition, youth cohorts either try to join a labour market without absorption capacity or are subject to precarious employment conditions, i.e. lack of formal work arrangements or unpaid work[23]. Because the informal economy is predominant in most African countries, reducing "the informal sector has to be part of any policy addressing youth employment"[24].

Following the adoption of the MDGs, the EU incorporated the need to prioritise employment and the quality of employment into its development policy as fundamental for sustainable development. It has consequently adopted a Communication on "Promoting decent work for all" (2006), which identifies young people as those mostly affected by the informal sector and poor quality jobs25. While the same concern is reflected in the Staff Working Document (SWD) "Promoting Employment through EU Development Cooperation" (2007), this document now also recognises the positive role young people can have in "lifting themselves and their families out of poverty". As such, the SWD mainstreams youth issues throughout all policies conducive to employment.

Language on the importance of employment and decent work for all can be found in the European Consensus on Development from 2005, although without a specific focus on young people. However, the revised Consensus from 2017 stresses the need to create employment and decent work, in particular for the youth cohort: "the EU and its Member States will focus on concrete actions to meet the specific needs of youth, particularly young women and girls, by increasing quality employment and entrepreneurship opportunities [...]". Moreover, the new Consensus commits to combating child labour26, a priority also identified in the above-mentioned EU Guidelines for the Promotion and Protection of the Rights of the Child.

Example of initiatives: EU Expert Facility on Employment, Labour and Social Protection

This multi-country initiative created in 2015 aims at supporting LMICs to develop effective, inclusive and sustainable strategies for employment, labour and social protection. Young people are amongst the key beneficiaries of the project.

EU support to youth employment and decent work in Africa

Under the CPA, employment plays a central role and it is considered a priority under its three different pillars: development, political and economic cooperation. It is a specific point pertaining to the provision on youth issues[27] as the Parties commit to "promoting the skills, energy, innovation and potential of youth in order to enhance their economic, social and cultural opportunities and enlarge their employment opportunities in the productive sector". It is important to note however that the agreement does not make reference to decent work. In addition, although it does mainstream youth under several provisions, it does not include any other reference to youth employability beyond the above-mentioned.

The inclusion of youth in the economic sector has been equally central under the JAES. This objective has been identified since the beginning of the Joint Africa-EU Partnership and reinstated throughout most of the successive Summit Declarations. This was also reflected in respective action plans.

The First JAES Action Plan (2008-2011) outlined as a specific priority area the implementation and follow up of the 2004 Ouagadougou Declaration and Action Plan on Employment and Poverty Alleviation in Africa[28]. Its objective was "to create more, more productive and better jobs in Africa, in particular for youth and women in line with the UN "Decent Work for all Agenda". After the absence of reference to youth under the Second Action Plan, the Roadmap 2014-2017 reinstated the importance of youth employment, with the particular intention to "stimulate economic growth that reduces poverty, create decent jobs and mobilise the entrepreneurial potential of people, in particular the youth and women, in a sustainable manner". More recently, the declaration from the 2017 Summit reinstates youth employment and entrepreneurship as crucial under all joint strategic priority areas. It specifically declares that Parties "acknowledge that creating sufficient quality jobs that enable youth to enjoy decent livelihoods is important for their empowerment and sustainable development at large, and all the more so in light of demographic developments".

The analysis above suggests that the EU's approach to supporting youth employment and decent jobs in Africa is based on both preventive and remedying measures[x] [29], as per the classification developed under the above-mentioned EU/OECD Youth inclusion project. On the one hand, the EU has remedying initiatives supporting youth groups that are unemployed or dependent on the informal sector and subject to vulnerable conditions. On the other, it invests in preventive measures, such as education, entrepreneurship and the development of skills of the youth cohort, helping to qualify the labour force in that age cohort.

1.4.2 Education and TVET

General EU policy on Education for young people in low and middle-income contexts

The former Consensus on Development (2005) mirrored related MDG priorities and focused on access to "quality primary education and vocational training"[xi]. It therefore failed to comprehensively address all types of education most relevant to young people aged 15 to 35. Similarly, while the 2010 European Commission Staff Working Document on More and Better education in Developing Countries recognised that "education has a pivotal role to play in enabling long-term growth and improvements in productivity, eradication of poverty, improving health status, empowering women, reducing inequality", the focus of this document was primarily on basic (primary and lower secondary) education, and therefore was not targeting youth. This link was nonetheless recognised by the 2011 Agenda for Change, which recommits to quality education to give young people the means to become active citizens[30].

The 2017 Consensus highlights the need to support the types of education neglected by its predecessors, namely: education at (upper[xii] [31]) secondary and tertiary (higher education) level, technical and vocational training, and work-based and adult learning, including in emergency and crisis situations. According to this document, "responding to the educational needs of children and youth is crucial to promoting responsible citizenship, developing sustainable and prosperous societies

x Preventive measures are those applied to youth at risk, young people who are exposed to risk factors but who have not yet suffered negative well-being outcomes. Remedying measures are dedicated to already deprived youth, young people who already experience deprivation in one or more dimensions of well-being as a result of their exposure to risk factors.

xi As in the Former European Consensus on Development, 2006 (reference 14), para. 96: "The Community aims to contribute to "Education for All". Priorities in education are quality primary education and vocational training and addressing inequalities. Particular attention will be devoted to promoting girls' education and safety at school. Support will be provided to the development and implementation of nationally anchored sector plans as well as the participation in regional and global thematic initiatives on education.

xii Upper secondary applies to age group from 15/16 years of age, according to UNESCO's international standard classification of education (ISCE).

and boosting youth employment". Furthermore, the Consensus states that "special attention will be paid to education and training opportunities for young women and girls". Education also plays a pivotal role related to other sectors, as the EU further stresses the need for "universal access to quality and affordable comprehensive sexual and reproductive health information, education, including comprehensive sexuality education".

EU support to youth education in Africa

Under the CPA, there is a focus on improving education and training at all levels under the headings of social sector development and gender issues. After its second revision, the agreement also reinstates commitment towards recognition of tertiary education qualifications, establishment of quality assurance systems for education, including education and training delivered online or through other non-conventional means[32].

In the EU's Africa-specific policy frameworks, emphasis is put on education and vocational training. According to the aforementioned first JAES action plan, creating a more direct link between skills training and the needs of local labour markets as well as possible investment opportunities, including through the provision of TVET, is key to foster youth employability. This same importance on skills development is also recognised in the second JAES roadmap, although without a clear association to young generations. More recently, the aforementioned JAES roadmap 2014-2017 explicitly mentions that higher education initiatives and mobility programmes are important to Africa and also stresses the need to "foster education, vocational training and entrepreneurship among women and youth".

In 2014, EuropeAid published a concept note on vocational education and training in development cooperation[33], serving as a policy guidance for the EU external aid programmes in this sector. For Sub-Saharan Africa, the concept note stresses that in light of the "unprecedented demographic youth bulge" that African countries are experiencing, holistic VET programmes can play a major role in combining technical and entrepreneurial skills acquired in the workplace and in informal/traditional apprenticeship with elements of self-development and business tools.

Endnotes: Chapter 1

3. United Nations definition. Available at: http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf, accessed 1/10/2018.
4. United Nations, Secretary-General's Report to the General Assembly, A/36/215, 1981.
5. African Union Commission, African Youth Charter, 2006, p.11. Available at: http://www.un.org/en/africa/osaa/pdf/au/african_youth_charter_2006.pdf, accessed 1/10/2018.
6. European Commission, Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions - An EU Strategy for Youth: Investing and Empowering - A renewed open method of coordination to address youth challenges and opportunities, 2009, section 2. Available at: http://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:52009DC0200, accessed 1/10/2018.
7. United Nations, World Population Prospects – Key findings and advance tables, 2017 revision, p.17. Available at: https://esa.un.org/unpd/wpp/publications/Files/WPP2017_KeyFindings.pdf, accessed 1/10/2018.
8. United Nations, World Programme of Action for Youth, 2010, p.10. Available at: https://www.un.org/esa/socdev/unyin/documents/wpay2010.pdf, accessed 1/10/2018.
9. DSW, Activating Youth Potential. Available at: http://www.dsw.org/en/themes/activating-youth-potential/, accessed 1/10/2018.
10. European Union, Treaty of Lisbon amending the Treaty on European Union and the Treaty establishing the European Community, under Social policy. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A12007L%2FTXT, accessed 1/10/2018.
11. European Commission, Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions - An EU Strategy for Youth: Investing and Empowering - A renewed open method of coordination to address youth challenges and opportunities. Available at: https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:52009DC0200, accessed 1/10/2018.
12. Eurostat, Being young in Europe today - demographic trends, 2017. Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Being_young_in_Europe_today_-_demographic_trends#Main_statistical_findings, accessed 1/10/2018.
13. United Nations, Population Facts, 2015, p.1. Available at: http://www.un.org/esa/socdev/documents/youth/fact-sheets/YouthPOP.pdf, accessed 1/10/2018.
14. Joint statement by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission on European Union Development Policy: 'The European Consensus', 2006. Available at: http://eur-lex.europa.eu/LexUriServ/LexUriServ.

do?uri=OJ%3AC%3A2006%3A046%3A0001%3A0019%3AEN%3APDF, accessed 1/10/2018.
15. European Commission, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions - Increasing the impact of EU Development Policy: an Agenda for Change, 2011. Available at: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM%3A2011%3A0637%3AFIN%3AEN%3APDF, accessed 1/10/2018
16. Joint statement by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission on European Union Development Policy, The New European Consensus on Development, 2017, p.13. Available at: https://ec.europa.eu/europeaid/sites/devco/files/european-consensus-on-development-final-20170626_en.pdf, accessed 1/10/2018.
17. EU Guidelines for the Promotion and Protection of the Rights of the Child - Leave no child behind, 2017. Available at: https://eeas.europa.eu/sites/eeas/files/eu_guidelines_rights_of_child_0.pdf, accessed 1/10/2017.
18. United Nations, Convention on the Rights of the Child, 1989. Available at: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx, accessed 1/10/2018.
19. OECD, Youth Inclusiveness Project. Available at: http://www.oecd.org/dev/inclusivesocietiesanddevelopment/youth-inclusion-project-about.htm, accessed 1/10/2018.
20. The Cotonou Agreement and Multiannual financial framework, 2010, Second Revision, Article 1. Available at: http://www.europarl.europa.eu/intcoop/acp/03_01/pdf/mn3012634_en.pdf, accessed 1/10/2018.
21. Idem, Article 26
22. Idem, Article 26
23. International Labour Organisation, Employment by status in employment. Available at: http://www.ilo.org/ilostat-files/Documents/description_STE_EN.pdf, accessed 1/10/2018.
24. Pieters, Janneke, Institute for the Study of Labor, Youth Employment in Developing Countries Background Paper, Commissioned by the European Commission, p.23. Available at: https://ec.europa.eu/europeaid/sites/devco/files/study-background-paper-youth-employment-2013_en_0.pdf, accessed 1/10/2018
25. European Commission, Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions - Promoting decent work for all - The EU contribution to the implementation of the decent work agenda in the world, 2016, p.3. Available at: http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52006DC0249&from=EN, accessed 1/10/2018
26. Idem reference 16, The New European Consensus on Development, para. 54.
27. Idem reference 20, The Cotonou Agreement, Article 26.
28. African Union Commission, Declaration on Employment and Poverty Alleviation in Africa, 2004. Available at: https://www.tralac.org/documents/resources/african-union/1563-au-declaration-on-employment-and-poverty-alleviation-in-africa-september-2004/file.html, last accessed 1/10/2018.
29. OECD Development Policy Tools, Evidence-based Policy Making for Youth Well-being A Toolkit
30. Idem reference 15, An Agenda for Change, Section 3.1. Social protection, health, education and jobs.
31. UNESCO international standard classification of education (ISCE). Available at: http://uis.unesco.org/en/topic/international-standard-classification-education-isced, accessed 1/10/2018.
32. Idem reference 20, The Cotonou Agreement, Article 25.
33. European Commission, Concept Note Vocational Education and Training in European Development Cooperation, 2014. Available at: https://ec.europa.eu/europeaid/sites/devco/files/concept-note-tvet_en.pdf, accessed 1/10/2018.
34. European Commission, Press release, 2017. Available at: https://ec.europa.eu/europeaid/news-and-events/eu-steps-its-support-education-all-eu100-million_en, accessed 1/11/2018.

CHAPTER 2: EU SUPPORT FOR SRHR

2.1 Introduction

Population dynamics and its links to development have long been a subject of discussion within the international community. The ICPD and its PoA (Cairo, 1994) mark a major milestone in this regard. This Conference replaced the "focus on human numbers with a focus on human lives"[35] by establishing a population policy which reinforces the mutual links between development and population. For the first time the importance of reproductive health and women's empowerment was put at the forefront of the agenda.

The ICPD PoA also recognised a comprehensive range of needs of adolescents and young people that should be addressed in order to "improve the quality of life of present and future generations"[36]. In particular, the text stressed the need for sexual and reproductive health (SRH) information, education and services. These needs of adolescents and young people were in 1995 echoed in the outcomes of the Fourth International Conference on the Status of Women, which led to the adoption of the Beijing Platform of Action.

The ICPD PoA and the outcomes of its review conferences,[xiii] happening every five years, have hence become the basis of what today is called sexual and reproductive health and rights (SRHR). This evolving definition has spilled over into other global agendas, such as the Beijing Declaration and Platform for Action (1995), the Millennium (2000) and Sustainable Development Goals (SDGs) (2015). SRHR refers to four different elements that, albeit independent, are inherently intertwined. Below are the internationally agreed definitions (UN language):

Sexual Health

Included in the comprehensive definition of reproductive health, it is the "enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases" (ICPD PoA, Para 7.2).

The WHO has also developed a definition: "Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and

xiii The ICPD+10 conference, which took place in Mexico in 2004, adopted additional recommendations underscoring the importance of addressing the needs of adolescents. It reaffirmed the "rights of adolescents and youth to access information, counselling and youth-friendly services" and the need to involve them at all stages of youth programmes.

sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence".

Reproductive Health

It is a "state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes". It implies the ability to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to reproduce (ICPD PoA, Para 7.2).

Reproductive Rights

Encompassing "some human rights that are already recognized, […] these rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health, as well as the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents". (IPC PoA, para 7.3)

Sexual Rights

Sexual rights have not yet been internationally agreed upon in any UN document. Nonetheless, the Montevideo Consensus on Population and Development in 2013, a regional conference for the review of ICPD, suggests the following definition: "the right to a safe and full sex life, as well as the right to take free, informed, voluntary and responsible decisions on their sexuality, sexual orientation and gender identity, without coercion, discrimination or violence, and that guarantee the right to information and the means necessary for their sexual health and reproductive health"[37].

Guttmacher Institute and the Lancet Commission published a report

In 2018, the Guttmacher Institute and the Lancet Commission published a report titled "Accelerate progress – sexual and reproductive health and rights for all". The report is the outcome of decades of attempts to redefine and advance SRHR and introduces an integrated concept that should address both public health and human rights standards. Accordingly, the definition recommended by the report includes all the above-mentioned SRH elements, in addition to "care for sexually transmitted infections (STIs) other than HIV; comprehensive sexuality education (CSE)[xiv]; safe abortion care; prevention, detection, and counselling for gender-based violence; prevention, detection and treatment of infertility and cervical cancer; and counselling and care for sexual health and wellbeing"[xv].

2.2 Overview of EU policies on SRHR at global and African level

Sexuality and reproduction are key components of the transitional period that young people face from childhood to adulthood. The start of adolescence brings challenges not only in terms of body changes but also social vulnerabilities, such as harmful traditional practices like early, child and forced marriage and consequences of precocity in childbearing. These vulnerabilities place young people's healthy lives at risk: the leading cause of death for 15– 19-year-old girls globally is complications from pregnancy and childbirth.[38] Teenage pregnancies can also lead to elevated school dropout rates, particularly among female students, and the subsequent loss of human capital. Such outcomes prevent young people from accessing some of their most basic human rights[39]. It is hence not surprising that adolescent sexual and reproductive health and rights (ASRHR) has received attention from policy makers at various levels, with increasing – although not always sufficient – consideration granted by the EU, as outlined in the section below.

xiv According to UNESCO, "CSE´ is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality". Available at: http://unesdoc.unesco.org/images/0026/002607/260770e.pdf, accessed 1/10/2018.

xv Although this report has been welcomed by EU institutions, it has not had a direct impact in terms of policy or EU supported services, at the time of writing of this report.

Overall policies

The EU and its Member States have been supportive of SRHR in its policy declarations in the context of development, although this support has evolved over time.

The first EU policy declaration on development, the EU Consensus on Development (2005), has recognised that the MDGs could only be attained if SRHR would be advanced "as set out in the ICPD Cairo Agenda"[40]. The EU commitment to SRHR has since been framed mainly in relation to two relevant international instruments: "We remain committed to the promotion, protection and fulfilment of all human rights and to the full and effective implementation of the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development and the outcomes of their review conferences and in this context sexual and reproductive health and rights[xvi]".

In 2015, the EU strengthened its political commitment to SRHR within its Council Conclusions on Gender in Development,[41] which "reaffirm the EU's commitment to the promotion, protection and fulfilment of the right of every individual to have full control over, and decide freely and responsibly on matters related to their sexuality and sexual and reproductive health". This commitment was literally reiterated in the revised European Consensus on Development adopted in 2017. The new Consensus also introduces the importance of including CSE as part of comprehensive SRH information and education.

The EU´s political commitments to SRHR have, in addition, been translated into different EU Action Plans, namely the Action Plans on Gender Equality and Women's Empowerment (2010-2015 and 2016-2020) and the Action Plan on Human Rights and Democracy (2012-2014 and 2015-2019)[xvii].

However, none of these documents, including the Consensus, directly correlates the importance of providing SRHR or broader health services specifically to young generations[xviii]. Nonetheless, they often reinstate EU commitment towards the needs of young women or girls.

The EU position towards HIV and SRHR

HIV and SRHR are intrinsically linked. On the one hand, most HIV infections are sexually transmitted, and have strong implications for pregnancy, birth and breastfeeding. On the other hand, people living with HIV have specific SRHR needs, particularly young people. The correlation between both elements had already been recognised by the ICPD PoA. Strategies to address their common root causes and the provision of integrated services have also started targeting young people due to respective vulnerabilities.

The EU underlined the importance of the interlinkages between HIV and SRHR already in the first Consensus on Development. While this was later reaffirmed by the Council of the EU in its position towards "EU role in Global Health (2010)", the link is absent from the new Consensus. Moreover, none of these EU policies specifically targets the link between both HIV and SRHR towards young people's needs.

xvi Language from several Council conclusions dedicated to development cooperation. The sentence "We remain committed to … and in this context sexual and reproductive health and rights" was replaced since 2015 by "…and remains committed to sexual and reproductive health and rights (SRHR), in this context", which signals a stronger political commitment.
xvii It is important to note that none of these Action Plans specifically commits to SRHR as a whole, but to parts of it.
xviii The new Consensus only mentions that the "social needs" of youth should not be neglected in order to achieve the SDGs.

Africa-specific policies on SRHR

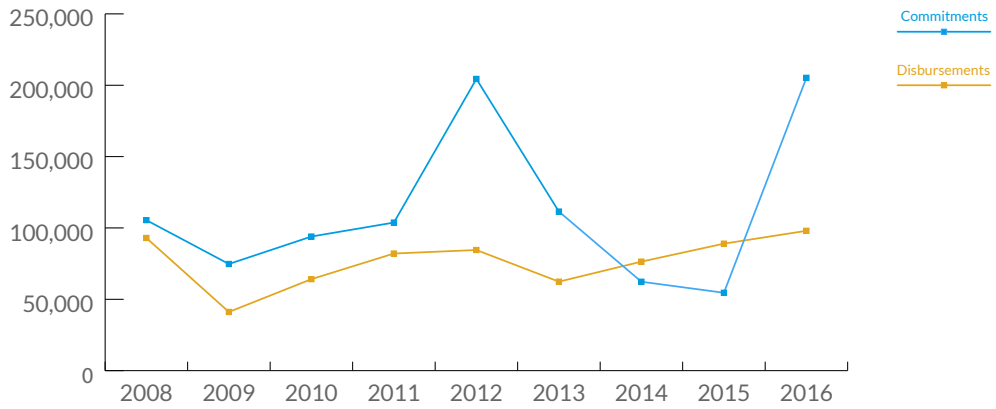
The CPA, dated 2000, includes several provisions in favour of SRHR. Throughout its revisions, occurring every five years, the Agreement states that cooperation between EU and ACP countries should promote the fight against "HIV/AIDS, ensuring the protection of sexual and reproductive health and rights of women[42]", in addition to access to family planning (FP). The CPA also includes a unique clause that aims at "integrating population issues into development strategies in order to improve reproductive health, primary health care, FP; and prevention of female genital mutilation". This integration of population issues has however not taken place in a systematic way[43]. Yet again, the specific provision on youth (article 26) does not include any specific reference to health or SRHR.

The commitment to SRHR in the JAES has varied over time. While the First Declaration and Action Plan (2008-2011) aimed at promoting SRHR in the context of ICPD, the second Action Plan (2011-2013) does not include any mention to it. The third Action Plan (2014-2017) includes some reference as it aims at complementing national actions to improve access to "health care, including Sexual and Reproductive Health". The most recent AU-EU Declaration (2017) reaffirms a commitment to SRHR in line with the ICPD and Beijing Platform of Action, the SDG 5 on Gender equality and the Maputo Protocol[xix]. In this Declaration, the Parties also highlight "the importance of complementing education with the delivery of comprehensive health services, including access to sexual and reproductive health, as well as promotion of well-being of young people to maximize the potential of large youth populations[44]".

Country, regional and global-level funding support for SRHR

EU official development assistance (ODA) reflects the Union's political priorities and is one of the key instruments to operationalise policies. Because European institutions remain the fourth largest provider of ODA worldwide, it is unsurprising that their contribution to health and SRHR is also one of the highest in absolute terms. Contribution to these fields has been steady throughout the years. Commitments tend to increase on the occasion of global milestones, such as the London Summit on FP in 2012, which led to several donors and countries' pledges under the global partnership FP 2020.

Graph 1: EU global funding to Population Policies / Programmes and Reproductive Health



Graph 1 shows financial commitments and disbursements from EU institutions to the specific area of Population Policies/Programmes and Reproductive Health, a category that covers most of SRHR elements as per ICPD, and as reported to the OECD[xx]. It is however important to note that several SRHR-relevant expenses are also reported as part of general or basic health, or under the category "Government and civil society". Therefore they are not reflected in this table. Ongoing efforts at the OECD level to improve the tracking of resource flows allocated to SDGs are however expected to ease this financial reading after 2020, particularly regarding those SRHR components that are included in the SDGs[xxi].

xix The Maputo Protocol to the African Charter on Human and People's Rights on the Rights of Women was adopted by the African Union Commission in 2003 in order to reinforce women's rights in the continent. It includes several specific provisions on SRHR, although some of these are subject to exemption by some African member states. To be noted that Article 14 of the African Women's Protocol further recognises the link between women's sexuality, their dignity, and other rights.

xx As per CRS code 130, which includes i) Population policy and administrative management, ii) Reproductive health care, iii) Family planning; iv) STD control including HIV/AIDS; v) Personnel development for population and reproductive health. In million EUR, constant. Source: OECD DAC database. Available at: https://stats.oecd.org/#, accessed 11/10/2018. Amounts in EUR, converted by respective annual rate.

xxi It is not expected however that the full SRHR will be captured under this new OECD tracking, as the SDGs exclude some key elements, such as sexual rights. For more information, please consult: http://www.oecd.org/officialdocuments/

It is important to note that, while in terms of political discourse and language included in documents such as the new Consensus there has been a shift away from discussing SRHR in the context of health and towards considering it to be a women's rights and empowerment issue, SRH (and specifically services and commodities) continues to be funded under the health or human development heading.

The 20 percent benchmark

The new Consensus recommitted to spending 20 percent of EU ODA on human development and social inclusion, originally introduced by the Agenda for Change. While there is no formal EU definition of what is understood by "human development", issues such as health, SRHR, gender equality and youth employment and employability, as well as youth empowerment more broadly fall under this heading, as per the text of the Consensus. Financial reporting against this 20 percent benchmark however includes only health, education and social inclusion.

Overall EU funding priorities are identified on a multiannual basis within the MFF. Earmarked decisions for specific programmes are then made on a more regular basis, both at headquarters and at the level of EU Delegations.

TABLE 1. SNAPSHOT OF HOW EU FUNDING TO SRHR WORKS FOR AFRICA

	Financial Instruments	Modalities	Channels
EU funding on SRHR: Country Decisions	European Development Fund (EDF) & European Neighbourhood Instrument – National programmes	Project modality Budget support	Government Multilateral agencies CSOs Pooled/Trust funds Private sector
	Development Cooperation Instrument (DCI) – CSO/LA programme	Project modality	CSOs Local Authorities
	European Instrument for Democracy and Human Rights (EIDHR)		CSOs
EU Funding on SRHR: Headquarters Decisions	European Development Fund – Intra-ACP		Multilateral agencies CSOs Pooled/Trust funds Private sector
	Development Cooperation Instrument – Global Public Good Challenges programme (GPGC)		
	Development Cooperation Instrument – Pan-African programme		Multilateral agencies CSOs Private sector

Funding priorities at the **country level** are identified in line with the EU bilateral strategy with the partner country, expected to advance the latter's national development strategy. In the case of Sub-Saharan Africa, the EU co-defines National Indicative Plans together with the partner country under the European Development Fund (EDF) and in line with the commitments of the CPA. In Northern Africa, bilateral strategies, or Single Support Frameworks, include financial allocations under the European Neighbourhood Instrument. Ever since the approval of the Agenda for Change,

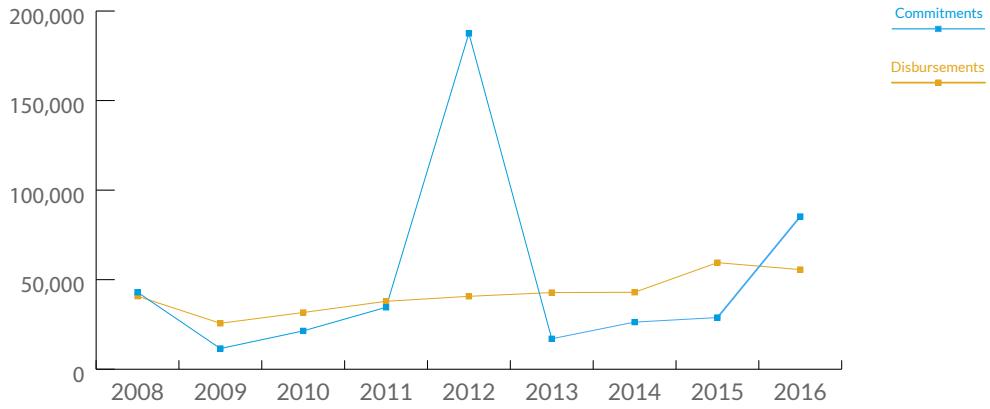
publicdisplaydocumentpdf/?cote=DCD/DAC/STAT(2018)41/REV1&docLanguage=En.

EU cooperation in country is required to focus on three sectors only, except in the case of fragile countries, where four focal sectors can be chosen.

The Millennium Development Goals contract

The MDG contracts are a form of general budget support provided by the EU and that focused on MGD-related results, including on health and education. These contracts were awarded under the 10th EDF (2008-2013) particularly to Burkina Faso, Ghana, Mali, Mozambique, Rwanda, Tanzania, Uganda and Zambia. These are now expected to be succeeded by the SDG contracts.

Graph 2: EU funding to Population Policies / Programmes and Reproductive Health in Africa



SRH is most likely to benefit from EU support at the country level when health is chosen as a priority sector. The level of priority given by the EU to health & SRH in African countries however seems to be declining when compared to previous financial frameworks: only 14 African partner countries requested health as a priority sector under the 2014-2020 MFF, down from 16 in the previous programming period 2007-2013[xxii]. This trend is even more visible when comparing bilateral strategies worldwide: from a total of 40 countries that have chosen health as a focal sector under the previous MFF, only 17 have done so under this framework. When health is chosen as a priority sector and is financed through budget or sector budget support, it is difficult to estimate how much funding benefits SRH alone, as most funds target health systems strengthening and universal access to the essential package of health services, including SRH. Existing research however shows that EU financial contributions to the specific component of FP tend to be relatively low, compared to other health components[45]. It should be noted that such research could not take into account the possible contribution of budget support to SRH alone, but only reproductive, maternal, newborn and child health.

xxii Same source and information as in footnote 't', although Graph 2 includes only EU allocations to African countries. To be noted that Graphs 1 and 2 would have been very similar if migration-related expenses, eligible under CRS code "Population policy and administrative management", would have been subtracted. This might indicate that African countries remain the largest recipients for EU SRHR-related expenditures.

Support to SRHR at country level is however not only provided in contexts where health is a focal sector.

The EU earmarks a significant amount of its SRHR funding to programmes of multilateral institutions such as the UNFPA, namely its Supplies Programme, UNICEF, UN Women and WHO (under which EU voluntary contributions are targeted to reproductive health, among others). In September 2017, jointly with the UN, the EU launched the Spotlight Initiative to eliminate violence against women and girls with an initial allocation of 500 million EUR. The initiative will be primarily channelled through regional offices of UN agencies and is set to also include a call for proposals on gender equality addressing specific activities on the provision of services, including SRH. In addition, EU institutions remain a key donor to the GFATM, whose HIV component has proven to be instrumental in advancing the SRHR agenda. Funding to support this type of programmes is mainly decided at headquarters, and not at country level.

In addition, the SRHR agenda is advanced through EU support to CSOs. When CSO programmes are defined at the country level, they tend to complement the EU bilateral strategy with partner countries to both reinforce service delivery or good governance. However, as opposed to the last MFF (2008-2013), opportunities for SRH-earmarked funding for civil society within the EU's thematic health portfolio (under the DCI), decided at headquarters level, have significantly declined over the past years. Under the 2007-13 DCI´s Investing in People Programme, two calls for proposals specifically targeting non-state actors working in the field of SRHR as a main beneficiary group and worth a total amount of 37 million EUR, were published in 2009 and 2013[46]. Under the programming phase 2014-2017 of the Global Public Goods and Challenges programme (GPGC), no new global call for proposals were published in this field; in fact, health was one of the few support areas of the DCI that did not include direct awards to civil society, only indirectly through international organisations. This decline has been partially offset by new opportunities that have arisen under the EU's gender or youth thematic portfolio[xxiii]. As an example, in 2016, the EC announced a new funding decision amounting to 32 million EUR for a new call for proposals on ''Promoting Gender Equality and Women's and Girls' empowerment in developing countries", which aims at increasing access to SRHR, among others. Also of relevance at regional level, in 2016, EU institutions awarded 5 million EUR under the Pan African Programme for a CSO project that created the #RightByHer campaign[xxiv] and which aims at improving women's rights in Africa, namely through the implementation of the Maputo Protocol[47]. Other CSO projects relevant to SRHR were also awarded under the DCI CSO-LA programme between 2014 and 2017[xxv].

New financing mechanisms have opened new opportunities for SRHR funding at both country and regional level. Some country-specific EU or multi-donor trust funds have a focus on health and/or population issues, such as, for example, the Bekou Trust Fund[xxvi] (Central African Republic), which (according to its 2017 report[48]) channelled 44 million EUR to health between 2014 and 2017, including some SRHR-relevant indicators within the health support programmes. Moreover, the EU Trust Fund for Africa (EUTF)[xxvii], established in 2015 and whose portfolio is both national and regional, includes projects that promote access to basic social services, comprising SRH, under the Fund's strategic priority for strengthening resilience. Although access to these services has been included as an indicator under the EUTF results framework, respective data was not available at the time of writing of this report[xxviii]. Moreover, it is not possible to assess how much of these pooled funds is specifically earmarked to SRHR.

Furthermore, the envelope for the intra-ACP programme within the 11th EDF, which is also decided at headquarters level, includes a funding decision of 30 million EUR to be allocated to SRH. At the time of writing of this report it was however unknown how these funds would be implemented.

xxiii Particularly in the case of the DCI programming for 2014-2017, gender and youth represented only between 9-13 percent of funding under human development, while health received the biggest share, between 42-47 percent. Only a small share of health services and commodities however is supported by the initiatives under gender and youth.

xxiv For more information, please consult the campaign's website: https://rightbyher.org/.

xxv For a more complete overview of all recent EU funding decisions supporting the broad SRHR agenda, refer to: European Commission, Annex 14 of the Joint Staff Working Document EU Gender Action Plan II, Annual Implementation Report 2017, p. 14:33.

xxvi To be noted that the vast majority of EU funds to the Bekou TF comes from the EDF national envelope to Central African Republic.

xxvii Or European Union Emergency Trust Fund for stability and addressing root causes of irregular migration and displaced persons in Africa.

xxviii While there is no compilation of data for all EUTF projects, the first EUTF Monitoring and Learning System quarterly report for the Horn of Africa does include information for that region: 30,000 were women provided with family planning tools and assisted with antenatal care. This has been mainly achieved under the Health Pooled Fund II programme in South Sudan, p.73. Available at: https://ec.europa.eu/trustfundforafrica/sites/euetfa/files/eutf_mls_q1_master_as_at_110618.pdf, accessed 1/10/2018.

Other new regional multi-donor coordination initiatives supported by the EU, such as the World Bank-spearheaded "Sahel alliance"[49], have included access to basic services as well as youth employment among their top priorities. Hence, there is potential for new funding for SRH or sexual and reproductive rights in this context. The EU also regionally supports Africa through the Regional Economic Communities. But this support tends to focus in more structural sectors and disregard issues such as SRH.

SRHR and EU Member States

Despite a context of cuts in Official Development Assistance (ODA) across many of the European countries (e.g. Belgium, Finland, Denmark, The Netherlands), SRHR continues to feature prominently in a number of EU countries, for example Belgium, Denmark, Finland, France, Sweden and the Netherlands. In all those countries, with the exception of the Netherlands[xxix], new policy documents on SRHR were endorsed in 2016 and 2017.

Endnotes: Chapter 2

35. United Nations Population Fund, Programme of Action, International Conference on Population and Development, Cairo, 1994, In introduction. Available at: https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf, accessed 1/10/2018.
36. Idem, ICPD PoA, Objective 6.3.
37. United Nations, Regional Conference on Population and Development in Latin America and the Caribbean, Montevideo Consensus on Population and Development, 2013. Available at: https://www.unfpa.org/sites/default/files/resource-pdf/Montevideo%20Consensus-15Aug2013.pdf, accessed 1/10/2018.
38. World Health Organisation, Key Facts Adolescent pregnancy, 2018. Available at: http://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy, accessed 1/10/2018.
39. United Nations, Universal Declaration of Human Rights, 1948, Article 25. Available at: http://www.un.org/en/universal-declaration-human-rights/. And UN Convention on the Rights of the Child, 1989, Article 6. Available at: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx. Both accessed 1/10/2018.
40. Idem reference 14, The European Consensus, 2006, para. 94.
41. Council of the EU, Council Conclusions on Gender in Development, 2015, para. 10. Available at: http://data.consilium.europa.eu/doc/document/ST-9242-2015-INIT/en/pdf, accessed 1/10/2018.
42. Idem reference 20, The Cotonou Agreement, Article 25.
43. European Commission and European External Action Service, Joint Staff Working Document Evaluation of the Cotonou Partnership Agreement, 2016, p. 120. Available at: https://ec.europa.eu/europeaid/sites/devco/files/evaluation-post-cotonou_en.pdf, accessed 1/10/2018.
44. 5th African Union-European Union Summit - Joint declaration Investing in Youth for Accelerated Inclusive Growth and Sustainable Development, 2017, para. 25. Available at: https://www.consilium.europa.eu/media/31991/33454-pr-final_declaration_au_eu_summit.pdf, accessed 1/10/2018.
45. For more information, please refer to the Euromapping publication: https://euromapping.org/2015-overall-rankings/.
46. See related calls ref. 127575 and 134837. Available at: https://webgate.ec.europa.eu/europeaid/online-services/index.cfm?do=publi.welcome&nbPubliList=15&orderby=upd&orderbyad=Desc&searchtype=RS&aofr=134837, accessed 1/10/2018.
47. European Commission, Annex 14 of the Joint Staff Working Document EU Gender Action Plan II Gender equality and Women's Empowerment: Transformation the Lives of Girls and Women through EU External relations 2016-2020, Annual Implementation Report 2017, p. 14:33. Available at: https://www.parlament.gv.at/PAKT/EU/XXVI/EU/03/85/EU_38563/imfname_10847186.pdf, accessed 29/10/2018.
48. European Commission, Annual Report of the Bêkou EU trust fund 2017, p.5-6. Available at: https://europa.eu/capacity4dev/trust-fund-bekou/documents/rapport-annuel-2017-du-fonds-fiduciaire-bekou, accessed 1/10/2018.
49. The World Bank, Press release, 2018. Available at: http://www.worldbank.org/en/news/press-release/2018/02/23/the-sahel-alliance-officially-announces-the-implementation-of-over-500-projects-for-a-total-amount-of-eur-6bn-to-be-disbursed-between-2018-and-2022, accessed 1/10/2018.
50. 4th Africa-Europe Youth Summit, Abidjan Youth Declaration, 2017, https://www.africa-eu-partnership.org/sites/default/files/documents/010-ypii-youth-agenda-english_bon_leger.pdf
51. European Commission, Pan-African Programme Multi-annual Indicative Programme 2018-2020, 2018, https://ec.europa.eu/europeaid/sites/devco/files/mip-pan-african-programme-2018-2020-annex_en.pdf
52. African Union and IPPF, Youth Guide and Action Framework for the Maputo Plan of Action, 2016, https://youth.africa-union.org/wp-content/uploads/2018/08/mpoa-5.pdf

xxix SRHR has however already been a priority within Dutch development assistance for some time, with the Netherlands being one of the only EU countries having a separate budget line and reporting mechanisms in this sector.

A snapshot of specific EU-AU cooperation on youth

In the run-up to the AU-EU Summit in Abidjan in 2017, the EU and AUC launched the Youth Plug-In Initiative. This brought together young people from both continents to discuss several topics that could impact their wellbeing: job creation, education, governance, peace and security, culture and climate change. Unfortunately, health was not on the agenda. This initiative led to the development of the AU-EU Youth Agenda, which has been presented at the Abidjan Summit[50], and has been followed up by the AU-EU Youth Cooperation Hub. The Hub brings together 42 youth fellows to pilot new youth-led projects around the same clusters as the Youth Plug-In Initiative. Based on the AU EU Summit declaration, the European Commission has established the programming for the Pan African programme 2018-2020,[51] which is supporting the implementation of the JAES. Under the approved programming the EC will focus on improving employability through TVET for young people and engagement with private sector.

Although health has been absent from these joint initiatives, there are nonetheless opportunities for the future, as the AUC has been developing projects that could be relevant to young people's SRHR. Examples are the Youth Volunteer Programme, which is based in the African Youth Charter, and aims at integrating young people in professional paths including public health. It comprises comprehensive trainings to deployed youth with elements such as life skills and the importance of harnessing the demographic dividend. In addition, the AUC, together with the International Planned Parenthood Federation, developed a Youth Guide and Action Framework for the Maputo Plan of Action [52]. This guide aims to ensure young people are aware of the SRHR agenda and encourages individuals and youth-led organisations to take action in further implementing the Maputo Plan of Action through actions such as advocacy, youth participation and capacity-building.

CHAPTER 3: METHODOLOGY

3.1 Assessing the youth friendliness of EU SRHR programmes and their sustainability

While the EU currently supports the SRHR agenda through multiple channels and modalities, this investment does not always target youth, unless a specific project or programme specifically sets this target. Given the lack of review of EU programmes focused on this cohort, this study assesses if EU SRHR funds have been programmed and implemented in a youth-friendly way.

To do so, this report uses a specific methodology to measure if EU-funded health programmes have been implemented in a youth-friendly manner, by testing them against a set of criteria: **equity, accessibility, acceptance, appropriateness and effectiveness** of the health services.

To develop this methodology, the research team conducted a literature review of existing guidelines for youth-friendly services developed by UN agencies and international organisations[xxx]. Key elements were then updated through a series of semi-structured interviews with 17 representatives from organisations working on SRHR, youth and ASRHR, such as civil society, UN agencies, EU institutions and AUC[xxxi].

The following dimensions of quality health services for youth were assessed through these different steps:

- **Equitable:** What is needed for all adolescents and youth, and not just some groups, to be able to obtain the health services that are available?
- **Accessible:** What is needed for adolescents and youth to be able to obtain health services that are available?
- **Acceptable:** What is needed for adolescents and youth to be willing to obtain the health services that are available?
- **Appropriate:** What is needed for the right health services (the ones youth needs) to be provided to adolescents and youth?
- **Effective:** What is needed for the right health services to be provided in the right way and make a positive contribution to their health?

xxx Full list of sources available in Annex 1.2.
xxxi Full list of interviewees can be found in Annex 2.

Findings from literature review and interviews led to the identification and validation of the following characteristics that satisfy these dimensions:

	EQUITABLE	ACCESSIBLE	ACCEPTABLE	APPROPRIATE	EFFECTIVE
ASSESSMENT OF YOUTH NEEDS at the design stage and during service delivery	●	●	●	●	●
THE PROMOTION OF AN ENABLING ENVIRONMENT through youth health promotion, peer-to-peer learning and outreach to different stakeholders	●	●	●	●	
THE OBJECTIVE TO SHAPE GOVERNMENT POLICIES, including removal of legal and social barriers and safeguard and reinforcing space for activists	●	●	●		
INVESTMENT IN YOUTH-FRIENDLY AND NON-BIASED CARE TRAININGS for health human resources, non-health staff and EU staff or other relevant actors (e.g. NGOs)	●		●		●
THE PROMOTION OF AN AVAILABLE AND COMPREHENSIVE PACKAGE OF RH COMMODITIES, updated in line with youth needs				●	●
PROVISIONS TO PUT IN PLACE APPROPRIATE INFRASTRUCTURE, including spaces for privacy and referral systems		●	●	●	●

Beyond this assessment about the "youth friendliness" of EU-funded health services, the study also looked at whether youth-friendly programmes included measures for long-term effect in a **sustainable** way. It should be noted that the study does not aim to confirm if the programmes are impactful, but rather to evaluate if they offer the right conditions to deliver broader **agency** to this cohort. Based on the same approach as mentioned above these pre-conditions are:

- Support to youth leadership and, indirectly related, existing space for civil society
- Promotion of civic and/or accountability education
- Support to the continuous adaptation of the health system
- Support to the integration of ASRHR into other sectors
- Involvement of government and civil society for ownership and domestic resource mobilisation
- Integration of EU funded ASRHR programmes or elements into national budgets

3.2 Selection of case-study countries

The selection of countries for the case studies also implied a mix of data collection and analysis methods. The research team mapped out African countries that have selected health as a focal sector under EU cooperation in the last ten years. This was followed by an analysis of EU programming documents such as Country Strategic Plans (CSPs), National Indicative Programmes (NIPs), funding decisions and evaluations, when available. This analysis enabled identifying a sample of countries on the basis of a number of criteria, particularly: geographical balance; health as a focal sector, under past or current MFF; the existence of EU support to health and SRHR programmes through a mix of modalities; existence of budget support, including MDG contract; key role of civil society and existence of a health technical working group or joint programming.

As part of the countries' selection phase, the research team conducted 14 semi-structured interviews with stakeholders from the EU institutions, civil society and international organisations based in Brussels, aimed at gathering first-hand information about the EU's youth, health and SRHR programmes at country level.

Three core country case studies were selected on the basis of identified criteria and the feedback from interviewees: Burkina Faso, Ethiopia and Zambia.

3.3 Field phase

The field phase (one week per case study country) focused on three country case studies: Burkina Faso, Ethiopia and Zambia. The case studies were selected to illustrate different experiences in supporting youth SRH at different geographic contexts, and to maximise the lesson-learning opportunities. The field phase involved semi-structured individual or small group interviews with stakeholders from the EU Delegations, Member States, national governments, UN agencies, CSO, including youth representatives, and other development partners[xxxii].

The compilation of this primary and secondary data forms the basis of the analysis of the country case studies. The key report findings, led by the above methodology, are arranged around five standard OECD Development Assistance Committee (OECD-DAC) criteria: relevance, effectiveness, efficiency, sustainability, impact. The order was nonetheless inverted to better serve the structure of the report.

xxxii For full list of interviewees in country, please refer to Annex 3.

CHAPTER 4: BURKINA FASO

1. Country profile

Young people´s needs are Burkina Faso´s needs

Burkina Faso is one of the poorest countries in the world, and its high demographic growth and non-inclusive development are widely seen as major constraints to poverty reduction. According to the National Institute of Statistics and Demography (INSD), the total population of Burkina Faso has doubled in less than 30 years. If population growth continues at the same pace, the world could see Burkina Faso´s population double once again by 2050.

Addressing young peoples´ needs in Burkina Faso means addressing the needs of the majority: According to INSD estimations for 2017, 58.25 percent of the population is under 19 years of age and 67 percent under 24 years of age. The fact that, in Burkina Faso, the definition of youth extends until the age of 35 only reinforces the idea that young people are, indeed, the ´trunk´ of Burkina´s society.

Addressing the issue of population growth and the unmet need has also been recognised as a top priority by the government as a whole, as witnessed during various public statements made by the head of state and ministry of finance[xxxiii].

Burkina Faso´s Health and SRHR/FP policies: A Snapshot

Accordingly, "accelerating the demographic transition to trigger the demographic dividend" has been integrated as a **national priority** into the National Development Plan (PNDES 2016-2020[53]), with population growth being one of the PNDESs key impact indicators, which will be translated into priority action "to progressively provide free family planning (FP) services, to combat unwanted pregnancies and to sensitise the population".

xxxiii For example: Minister of Finance speech on the occasion of the "World Population Day" on 11 July 2018.

As part of a set of FP repositioning efforts, Burkina Faso published a **Strategic Health Plan for Adolescents and Young People 2016-202054**. It also actively participated in the second edition of the London Summit held in July 2017, where the country committed to progressively working towards providing free-of-charge FP products and services for its population.

Following up on these commitments, the government developed a **National Action Plan for Accelerating Family Planning (2017-2020),**[55] which succeeds the third programme of action on population 2012-2016. It systematically incorporates youth-friendliness as a core implementation principle, while highlighting the need to work both on the supply and the demand side to increase young peoples´ access to FP and SRHR. In addition, it is backed by its **own and progressively increasing budget line.** The plan reiterates the government´s budgetary commitment made at the London summit to increase by at least ten percent each year the budget line allocated by the state to the purchase of contraceptive products between 2017 and 2020. In addition, the government committed to achieve, by 2020, that at least half of the country´s local authorities include a line for the financing of FP activities within their municipal budgets. Such commitments have already been translated into increasing the 2017 (national-level) budget line for contraceptive products to CFA 500 million (about 760 000 EUR), as compared to CFA 150 million in 2016.

Since 2016, the government of Burkina Faso has also significantly improved the access of vulnerable populations to health services through the implementation of **free healthcare for children under five and pregnant women**. Indeed, more than 76 million EUR have been injected by the state budget to ensure the implementation of this historic measure in the years 2016 and 2017. The government also organises bi-annual **national FP weeks**, which have, to date, been very successful in increasing the contraception usage rate, due to related sensitisation activities and the free distribution of products during those days.

Such policy and budgetary commitments have already born fruits, as seen from Burkina Faso´s progress, between 2008-2015, on health MDG indicators related to skilled birth attendance and contraceptive use, highlighted in the national development: set targets were exceeded almost every year.

With regard to youth participation, Burkina Faso has, among other efforts, established a **"Children´s Parliament"**, which brings together young people between the ages of 10 and 15 from private and public primary schools, high schools and colleges, and childcare structures from 45 provinces, which democratically elect 120 members to a children's parliament. These members are actively involved in some of the EU´s activities – e.g. the UNFPA/UNICEF programme on child marriage.

Remaining Obstacles to Access/Use: The price of forgetting youth´ needs

Despite progress, the government admits that much remains to be done, particularly when it comes to addressing young people´s specific health and SRHR/FP needs. In its new National Plan on Accelerating FP, the Ministry of Health highlights the following set of **key obstacles** impeding young people from accessing the services and supplies they need:

- **Human resources** for health problems, which are too few or "insufficiently trained for providing youth and adolescent- friendly FP services" (National Plan FP).
- The **price of contraceptives** and the fact that they need to ask their parents for money to purchase them prevents many girls and women from using them or using them on a regular basis.
- The **quality of FP services** is "unsatisfactory, especially for young people and adolescents, […] often overlooked by health centre staff. This can be explained by the lack of training of medical staff, but also by the lack of equipment and a failure to upgrade health centres´ to meet operating standards" (National Plan FP).
- **Supply chain problems:** 99.5 percent of public health centres offer some FP services, but they are sometimes constrained by supply problems (only 30 percent offer the full range of existing contraceptives) and other logistical problems such as storage.
- **Funding problems for FP**, despite the existence of a specific budget line and the high priority assigned by the government to the issue.

2. EU-Burkina Faso partnership

The National Indicative Programme (NIP) 2014-2020 details the current focal sectors of EU cooperation with Burkina Faso (Good governance – including general budget support; Health; Food

security/ agriculture) under the 11th EDF, which amounts to 623 million EUR in total. The Country Strategy Paper for Burkina Faso (2008-13) and a multi-annual indicative programme described cooperation priorities for a 708 million EUR allocation (in total) under the 10th EDF. Under both envelopes, approximately four percent were reserved for strengthening civil society´s domestic accountability function, translating into a 21 million EUR envelope for CSOs in 2014-2020 and 25 million EUR in 2008-2013.

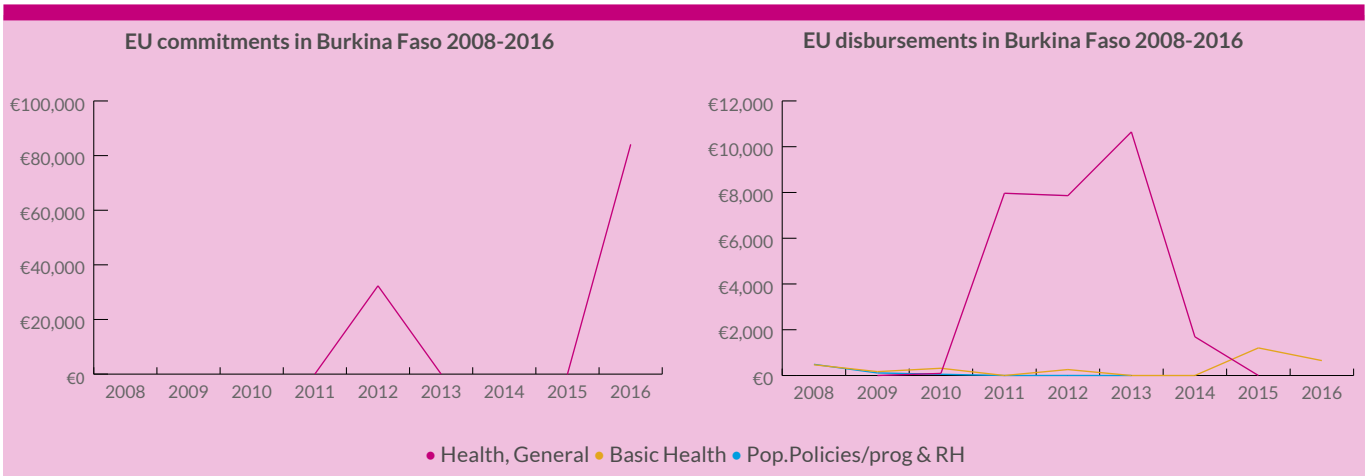
Over half of the EU´s (current and past) envelope for Burkina Faso is being channelled through general budget support (GBS) to back the government's macroeconomic reform programme for poverty reduction. Additional funds to speed up the country's progress on the MDGs was channelled through the "MDG contract" budget support top up of 28 million EUR in 2010, with related indicators.

The EU bilateral envelope is complemented through funding from the EU´s regional and thematic programmes in Burkina Faso.

EU donors as key players in the health and SRHR sectors

Not only have EU (including EU Member States) donors been key players and funders for health and SRHR during the past decade, but in light of the national plan´s aforementioned prioritisation of the issue, some have also significantly increased related funding in recent years.

EU funding for SRH in Burkina Faso over 2008-2016[xxxiv]



Health is a focal sector of the EU´s EDF envelope for Burkina Faso in 2014-2020 (80 million EUR to health under the NIP 2014-2020). Health funding under the EDF is channelled through sector budget support – the so-called "Programme d´Appui a la politique Sectorielle de Santé" (PAPS I 2013-17 + PAPS II - 2017-2020), which includes (among others) the following key monitoring indicators related to SRHR and FP:

- Couple-years of protection (i.e. the estimated protection provided by FP services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period).
- Number of caesarean deliveries in health facilities
- Pre-natal consultations coverage rate
- Number of successful surgical interventions for vesicovaginal fistula
- Maternal mortality rate
- Increased government budget to finance free health (including women contraceptive) care for mothers and children under five.

Burkina Faso´s aforementioned MDG contract included several indicators related to maternal health (e.g. supervised delivery or antenatal care visits) and child vaccination.

After Burkina Faso´s NIP mid-term review, a new 25 million EUR programme on population was

xxxiv Graphs consider only Health, general (121), Basic health (122) and Population policies/programmes and reproductive health (130), as per OECD. It is however important to notice that the EU may have also spent SRHR-related funds in the country reported as Government and civil society (I.5) or Other Social Infrastructure & Services (I.6). Available at: https://stats.oecd.org/#, last accessed 11/10/2018. Amounts in EUR, converted by respective annual rate. The discrepancy between the high level of disbursements made between 2012 and 2014 is most likely related to commitments made under the previous MFF (2008-2013).

launched by the EU for the period 2018-2022, under the "Governance" NIP focal sector. While the general budget support had already placed the issues of civil status and mastering population growth through FP at the heart of its objectives, the general purpose of the new Population Programme Financing Agreement is to strengthen the capacity of the state to record and better control the dynamics of its population, to accompany the country's development policies.

The Population programme will be implemented together with the concerned Ministries (Finance and Health) by using service contracts, support to civil society, in partnership with UNICEF and the Higher Institute of Population Sciences. It will include applied research to better integrate the societal dimension related to population dynamics.

In addition to the EU´s bilateral envelope, various other EU thematic or regional initiatives have or are benefitting both young people as well as the health and SRHR sectors in Burkina Faso, for example:

- Under the EU´s global thematic call on SRHR in 2009, a regional project of Equilibres & Populations on adolescents´ access to SRHR in Burkina Faso, Benin and Niger was awarded close to 1 million EUR over three years.
- Under the Thematic Programmes ´Investing in People´ and the 'Global Public Goods and Challenges', Burkina Faso has, since 2008, been one of beneficiary countries of the EU/ EU Member States jointly financed programme on the "Abandonment of Female Genital Mutilation/Cutting: Accelerating Change" and the UNFPA/UNICEF "Global Programme to accelerate action to end child marriage".
- Under the EU´s Emergency Trust Fund for Africa (EUTF) various newly launched programmes in Burkina Faso are targeting young people as a key beneficiary group.
- Burkina Faso is one of the beneficiary countries of the EU-Luxembourg-WHO partnership on universal health coverage.
- The EU-supported UNFPA Supplies as well as the GFATM programmes have played and continues to play a significant role in increasing access to contraceptives in Burkina Faso. However, as the EU´s support is at a global-level, its contribution cannot be tracked directly to a specific country.

EU member state presence and support to the SRHR agenda in Burkina Faso

Several EU Member States – including France, The Netherlands, Germany, Luxembourg, Belgium, Italy and Sweden – have, over the past ten years, also been engaged in the health sector and contributed to SRHR/FP. They are using a mix of modalities (mainly project support, some budget support and technical assistance) and channels (CSOs, multilaterals and government) for their sector contributions. Various UNFPA projects aimed at increasing young people´s access to SRHR and FP services and products are supported by EU Member States such as Belgium and Luxembourg.

Within the EU Joint Programming process, launched in Burkina Faso in 2017, demography was selected as one of the strategic objectives and a first draft of a joint EU/Member States position on the topic was elaborated.

3. Key Findings

Relevance: have EU-funded programmes been supporting equitable, accessible, acceptable, appropriate and effective youth-friendly sexual and reproductive health services?

According to Burkina Faso´s Ministry of Health, neither the EU´s General (GBS), nor its Sector Budget Support (SBS) Programme (PAPS I+II) have, to date, been systematically underpinned by a youth needs assessment. Neither the indicators used to monitor the EU´s GBS nor the PAPS II programme have been age-disaggregated to date.

Nonetheless, some efforts to assess the needs of the most vulnerable – including young people – were made under one small component of the EU´s SBS programme: Under the PAPS II, an amount of 2 million EUR of the EU´s Budget Support funding was reserved for a call for proposals (published in 2017), aimed at guaranteeing women´s and children´s right to the health through a **community watch system ("veille communautaire")**.

Moreover, the National Plan on Accelerating FP is based on a thorough youth needs assessment and describes young peoples´ specific needs in each of its sections. The **EU´s new population programme** explicitly refers to the Plan as its reference policy document that funding beneficiaries and implementers will have to align to.

Needs assessments which included a focus on young people´s needs, have also been made for some of the **EUTF´s projects**, notably one aimed at promoting youth employment in Burkina Faso's border region, for example. In the context of this specific needs assessment, early pregnancies were even identified as a key obstacle to the employment of young women – according to the EUTF implementer, however, no follow-up action could be taken, as SRHR and FP had been considered "beyond the scope" of the project´s intervention focus. Nonetheless, another EU Trust Fund project on strengthening linking relief, rehabilitation, and development and the resilience of Burkina Faso´s border region population actually includes a component on access to FP.

According to health professionals interviewed for this study, the provision of **services in youth-friendly and non-biased manner** is far from being a reality in Burkina Faso. Youth is often hesitant to use existing services, notably if they are too specialised (e.g. in HIV detection), due to the stigma associated with using them. Centres offering a more integrated package of services (e.g. through integrating SRHR and FP) are hence seen as providing more confidentiality.

Views on whether the EU has promoted youth-friendly service provision in the health sector differ according to interviewees: while the EU maintains that the institutional capacity-building component within its SBS programme (PAPS) also included training on non-biased care, the Ministry of Health of Burkina Faso deplores[xxxv] the limited attention given by donors, in the past, to supporting its adolescent and youth health strategic plan - when compared to donor contributions in the area of maternal and child health, for example. The ministry hopes that a renewed impetus will be given to the issue, notably thanks to the new National Plan on Accelerating Family Planning.

A new step has already been made in this direction, at the design stage of the EU´s new population programme: a first call for proposals under this programme, published in April 2018, which covers no less than 16 million EUR (over 60 percent) of the programme´s 25 million EUR total amount, includes

xxxv Interview during field visit to Burkina Faso

an explicit reference to the National Plan on FP. It also features youth as a primary target group, with "stimulating the demand for support in the area of sexual and reproductive health of young people and teenagers" being one of four specific objectives. Youth-friendly care and promoting an enabling environment for young people are also key priorities for action under the call for proposals, which notably requires to adequately place services within community spaces and ensure youth-friendly messaging, as well as unbiased, youth needs-tailored service delivery.

In a country where around 60 percent of the population is Muslim and 25 percent is Christian, it is crucial to involve religious leaders in that dialogue. When challenged by religious leaders on their online youth platform approach, the local UNFPA task manager explained "We are doing this because the Church´s moral approach has, to date, failed to protect Burkina´s youth: why is it that young people are religiously following your principle on refraining from contraceptive use, but then proceed to ignore your rules related to abstinence and to refraining from doing harm to other people? So, until you show me that your approach works, I will continue to protect our youngsters by using methods which have proven to be effective".

With regard to exemplary youth health promotion and outreach activities supported by EU or EU Member States donors, it is worth mentioning the following initiative: a Belgian cooperation-supported UNFPA programme aims at providing young people with direct and anonymous access to SRHR and FP information using ICT and social media – notably through the creation and maintenance of an interactive and freely accessible online platform (**www.QGJEUNES.org**[56]). The platform is also a means to reach out-of-school and illiterate youth, as it offers adapted audio-visual tools and a voice messaging service. Usage is further encouraged by granting phone data credit to users winning the platform quizzes. According to UNFPA, this very youth-friendly platform has already had, in less than 6 months and in 2 pilot cities, over 10 000 registered users. According to UNFPA, the initiative has also already prompted interest from neighbouring countries in replicating the model within their territory.

Significant progress was achieved through EU support to outreach initiatives aimed at promoting young girls´ sexual rights – notably the abandonment of harmful practices, such as female genital mutilation/cutting (FGM/C) and child marriage.

With support from the EU´s aforementioned thematic programmes, the latest **FGM programme** report[57] shows that the FGM/C prevalence has fallen significantly among younger women in Burkina Faso, with five percent of girls aged 0-4 years having undergone FGM/C, compared with 89 percent of women aged 45-49 years. This suggests that abandonment of FGM/C is under way.

The latest report of the EU-supported **UNFPA-UNICEF child marriage** programme[58] highlights the following results achieved:

- Community dialogue, media campaigns and empowerment activities led to public declarations for the abandonment of child marriage in 600 villages and the establishment of functional committees following up on such declarations through continued social dialogue with families.
- The partnership built with the National Coalition for the Abandonment of Child Marriage led to the training of national journalists on child marriage and an advocacy event with the new President of the National Assembly led by the First Lady.

This initiative also helped creating a favourable legal environment: in conjunction with Burkina Faso´s so-called Children's Parliament[xxxvi], the Global Programme advocated for the adoption and enforcement of a draft Code of Child Protection and a Code of Persons and Family, both of which will contribute to raising the official legal marriage age for girls from 17 to 18.

With regard to providing a **comprehensive package of supplies**: according to Burkina Faso´s latest annual health sector review (2017)[xxxvii], 77 percent of the country´s annual contraceptive funding needs were covered by UNFPA, with another 17 percent and five percent respectively covered by USAID and the national budget. A crucial measure supported by various Development Partners - notably UNFPA (no direct support from EU and Member States, however) – is the so-called "National family planning week" with free distribution of FP products on a massive scale is organised by the government on a bi-annual basis, and is said to have had a significant impact on the contraceptive prevalence rate. However, according to some interviewees under this study, youth-friendliness had not been systematically integrated into the UNFPA supplies programme to date.

Sustainability & Impact: will the benefits of EU funding for youth-friendly services continue after the programmes come to an end?

Accessing youth-friendly services is a fundamental step to promote well-being but is not on its own enough for the creation of comprehensive and long-term impact. This section will therefore consider if some pre-conditions are met to ensure the **sustainability** of the initiatives and their effect on **youth agency** based on selected criteria. It will not however attempt to assess the impact of EU-funded projects, due to the difficulty of establishing a correlation between EU support and national health indicators.

EU support to youth leadership and creating space for civil society: The European Union and its Member States have adopted a **Roadmap 2017-2020** for their engagement with the Burkinabe civil society featuring three shared priorities (consolidating an enabling environment and strengthening CSO legitimacy and representativeness, as well as capacity for participation).

Moreover, the EU Delegation organises every year a major consultation on its annual work programme for CSOs – the latest such consultation, to which 150 Civil Society representatives were invited, took place in Burkina Faso in February 2018.

However, interviewees in Burkina Faso claim that those organisations usually invited to the table are international NGOs already benefitting from EU funding, as well as the bigger national CSO platforms and that youth and SRHR/FP actors are rarely among the participants. CSO respondents interviewed claim that specific sector concerns raised by member organisations of platforms were not sufficiently addressed and voiced by these umbrella organisations.

In line with the CSO roadmap´s second objective, some EU calls for proposals included a specific component on strengthening the legitimacy of CSO networks – but it is unclear what impact this funding has had, to date.

Nonetheless, there are some EU/ EU Member States-financed programmes which specifically aim at supporting **youth leadership and empowerment**.

Notably, the **EUTF** has made youth a key priority for funded programmes benefitting Burkina Faso, some of which include youth leadership and/ or CSO and community based organisations -capacity-building components. For example, the regional, one-year pilot project "**La Voix des Jeunes**" ("The Voice of Young People ") in the Sahel region, financed by the EUTF and Denmark, has just been closed in March 2018. By working with representatives of youth organisations and cross-border networks, the project aimed at providing around 1,250 young people from the Sahel region with a stronger political voice, by contributing to the creation and consolidation of structured dialogues with the authorities. However, there does not appear to be a direct link between this project and young people´s unmet need for FP in Burkina Faso and in the absence of a publicly available project evaluation the effective impact of this project remains unclear. That said, a phase II has recently been launched, with double the amount of funding than in the previous phase – showing that EU donors have considered it to be successful.

xxxvi See explanation above, in the introductory section.

xxxvii **Documents not available online at the time of drafting this report.**

Support the integration of YFS into other sectors: The **National Action Plan for Accelerating FP** puts a significant emphasis on cross-sector collaboration and explicitly mentions comprehensive sexual education as a priority area for working with other ministries – notably education – during the coming years. In this context, some respondents however deplore that the Ministry of Youth is often "forgotten" in that picture, and that its available means, capacities and resources for youth needs promotion are not sufficiently leveraged.

Moreover, a new technical secretariat focusing on "accelerating the demographic transition" has recently been created at the highest levels within Burkina´s Ministry of Health in order to ensure multisector coordination, as well as the follow-up of agreed actions in the area of SRHR and FP – although it remains to be seen how cross-sector coordination materialises in action and whether youth will be a key focus. The fact that UNFPA has recently (May 2018) taken up the role as co-chair of the **national health sector coordination group,** within which several EU donors (e.g. the EU Delegation, Luxembourg, Belgium) are actively participating, is likely to provide additional "backwind" to the prioritisation of SRHR/FP issues within the sector.

The EU has shown that it intends to support cross-sector efforts in this area: the EU´s new population programme, for example, emphasises the need to strengthen the demand for FP services, "especially in schools".

To date, however, **sexuality education** in (and outside) school is far from being comprehensive in Burkina Faso, as it continues to be centred on promoting abstinence. Although first efforts to pilot the introduction of sexuality education in certain schools have been made by the government in collaboration with UNICEF in recent years, it has, according to interviewed stakeholders, to date, not materialised in a meaningful reform of the school curricula – mostly due to the resistance from parents' associations.

In light of these hurdles and limitations affecting the formal education sector, other options – aimed at reaching out to both in- and out-of-school youth - are being piloted by certain donors, notably by using ICT and social media – i.e. in the case of the aforementioned **UNFPA SRHR/FP online platform QG Jeune**, supported by the Belgian cooperation. The latter initiative has been officially endorsed by Burkina´s Ministry of Education as a viable alternative to formal sexuality education at schools. It also includes a section on academic and economic opportunities for young people, which provides an opportunity for cross-sector synergies, e.g. by increasing the visibility and accessibility of the EU´s youth employment actions and training offers (e.g. those under the EUTF) in Burkina Faso.

Another programme which has achieved good results in the area of cross-sector linkages and girls´ empowerment in Burkina Faso is the **EU-supported UNICEF-UNFPA global programme on child marriage**. According to the programme´s latest report[59], the 2017 results show progress in activities and in meeting or exceeding annual targets, with efforts being made towards the implementation of multisectoral interventions – such as the provision of integrated life skills training and FP counselling and services for girls.

In addition to that, most EUTF programmes in Burkina Faso propose to empower young people through **capacity-building, training and job creation,** including some programmes focused on young women´s economic empowerment**.** However, as most of them have only just started their implementation cycle, it remains to be seen if they can achieve the desired impact – notably because early pregnancies - a key obstacle to young women´s participation and empowerment - is also not addressed by these programmes.

When it comes to assessing whether EU programmes support **Country Ownership**, EU institutions argue that their preferred modality, **budget support** is, by nature, aligned with national policies and integrated into national budgets.

With regard to the EU´s other non-budget support programmes in the health and SRHR sectors, some have included ownership and sustainability as key criteria at the project design stage. For example, the recently published **call for proposals on population** requires applicants "to contribute to implementing public policies in a consistent way and aligning on them", by particularly mentioning the National Plan to Accelerate FP (2017-2020), as well as the national gender strategy. Moreover, the call for proposals aims to "promote innovative, effective and context-specific actions with the objective of sustainable transfer to public health and vital services".

Initiatives to strengthen **CSOS´ domestic accountability role** are seen by EU institutions as contributing to country ownership. This is reflected in the fact that under both the 10th and the 11th EDF, approximately four percent of the bilateral funding envelope was reserved for strengthening civil society´s domestic accountability function. Moreover, the EU´s thematic Programme CSO-LA, financed by the EU budget, which foresees an allocation of 3.15 million EUR for Burkina Faso´s CSOs in 2015-2017, aimed at supporting CSOs' contributions towards reinforced governance, accountability and inclusive policy-making.

As mentioned earlier on this paper, the EU also provided Civil Society with a particular monitoring function in the framework of its health sector support programme (PAPS II), through specific funding allocated to two pilot "community watch" initiatives aimed at ensuring that no one is left out within the national health insurance system.

While the impact of these new initiatives may be hard to measure to date, some CSOs have questioned the sustainability potential of these relatively short-term (three-year) projects.

In this context, some lessons could (and should) be drawn from the EU´s former, ten-year support to CSOs under the so-called **PROS** (Programme de renforcement des capacités des organisations de la société civile) initiative (2003-2012), which – according to the local press[60] - helped strengthening over 100 CSOs´ in their capacity to actively contribute to regional and local development. PROS has, however, received mixed reviews from CSOs interviewed and involved in its actions. While it was acknowledged that the programme helped establishing municipal accountability processes which were also open to youth participation, ensuring their sustainability failed due to a lack of understanding, on the side of participating citizens and community-based organisations, about the issues discussed during the consultation processes. CSOs also deplored that no evaluation of the programme had been made publicly available.

As highlighted by Burkina Faso´s Ministry of Finance, **CSOs themselves should also be held accountable** for aligning their actions to national policies and plans, and for ensuring that any of their pilot initiatives, if successful, can eventually be scaled up to benefit the country as a whole. A suggestion made by the Ministry of Finance representative interviewed for this study, was for the EU to consider introducing accountability clauses into the EU´s future calls for proposals in order to ensure CSOs report not only to donors but also to the government. It is interesting to note, in this context, that the new National Action Plan to Accelerate FP mentions two specific CSO mobile clinic initiatives (by MSI and ABBEF) that the government sees as "scale-worthy" and complementary to its own actions, as they are said to have contributed to increasing contraceptive use in remote areas over the past years. This shows that there is on the side of the authorities some level of recognition about the important role that other actors can play in this area.

With regard to the so-called **vertical funding** initiatives (e.g. the Global Alliance for Vaccination and Immunisation (GAVI), GFATM), which continue to be supported by EU donors, the latter have been criticised by interviewees under this study for creating parallel coordination systems as well as for focusing too narrowly on single health issues/diseases without taking into account the specific needs of vulnerable groups such as women and sexual minorities. Lately, echoing global level reforms undertaken by the GFATM in this area[61], efforts have been made to streamline vertical funding coordination and accountability mechanisms with national health sector mechanisms, notably by integrating the GFATM ´s Country Coordinating Mechanism (CCM) into the Ministry of Health´s organigramme. As mentioned by interviewees, this was welcomed by EU donors (see further details on this under "Effectiveness" section). The CCM´s integration could also mean a greater role for civil society within the formal health coordination structure.

Effectiveness & Efficiency: To what extent have the various modalities, channels and coordination mechanisms used by the EU been appropriate for contributing to and promoting young peoples´ health and well-being?

The EU´s preferred aid modality continues to be (general and sector) budget support. Budget support has scored relatively well throughout external evaluations made during the past ten years, in comparison with other aid modalities used by EU donors at country level. For example, the PADS common basket (Health Development Support Program) created in 2005 and supported by a number of EU donors (Sweden, France, The Netherlands, and Belgium) occupied an important place in the sector for some years, also as an EU coordination mechanism. However, evaluations made of the EU´s development cooperation in Burkina Faso uncovered that the fund had not contributed to a real sector-wide approach: it was criticised for having an external management unit and for putting into question the principle of fungibility of funds, as it provided donors with the option to geographically and thematically earmark their contributions to the fund, rather than leaving this decision to the Ministry of Health.

Past evaluations have highlighted a positive correlation between budget support, health and gender concerns: with regard to the EU´s MDG contract (GBS top up) in Burkina Faso, the EC´s 2012 evaluation showed an overall good performance and fulfilment of health-related indicators within its variable tranche. More recently, the latest available Gender Action Plan implementation report for Burkina Faso from December 2016 showed that efforts have been made by the EU Delegation, notably thanks to its designated **gender focal point,** to mainstream gender throughout the EU´s programmes. The reports notes that specific efforts were made with regard to EU budget support and the use of this modality to support gender budgeting and planning by the government, on the basis of the conclusions of a 2016 budget support evaluation[62]. Taking a gender-sensitive approach

to health sector budget support has most likely had an effect on introducing FP indicators among the budget support variable tranche.

That said, the EU continues to use a **mix of modalities,** as highlighted throughout this paper. In the area of SRHR and FP, in particular, it was recognised that working with CSOs, for example, could help complementing government programmes by increasing the latter´s accountability, as well as providing valuable best practices and lessons learnt from their often more locally-adapted, vulnerability and youth-centred approaches.

Moreover, EU donors have started to push for the adoption of a more comprehensive approach by **vertical funding mechanisms,** by supporting, in the case of the GFATM initiatives, the integration of health systems strengthening and SRHR (into its programmes in Burkina Faso). Germany for instance is providing support to the CSO Platform for Access to Essential Medicines as part of strengthening the strategic monitoring role of civil society within the process of health systems strengthening. German technical assistance also supported the 40 GFATM -supported Community HIV Testing Centres in expanding their range of services to include comprehensive and youth-friendly SRHR services. With regard to the Global Financing Facility (GFF), Burkina Faso has just developed an Investment case to submit to the GFF. However, EU and Member States respondents argue that the three mechanisms (GFATM, GFF and GAVI) should increase their harmonisation and alignment efforts over time, for the sake of aid effectiveness.

As mentioned above, the EU has also made extensive use of its relatively new funding mechanism – the **EUTF** – in order to help improve the lives of young people in Burkina Faso. Five projects benefitting Burkina Faso have young people as a primary target group. However, when it comes to strengthening interlinkages between **youth empowerment and gender equality on the one hand, and SRHR/FP on the other,** EUTF seems to play less of a role, with the exception of the EUTF project on linking relief, rehabilitation and development and resilience, which includes a related component. For most Trust Fund projects, however, mainstreaming SRH/FP is then all too often left to the good will of individual EU Delegation and EU Member States mission staff members. For some projects in Burkina Faso, technical staff has been able to influence project design thanks to one or several particularly dedicated staff members, who insisted on integrating access to FP as a key enabling factor for young women´s entry into the labour market. This shows how crucial the **"personality element"** can be; although with its own constraints, as the initiatives will be impacted by the level of available resources.

Modality/ funding mechanism	Are YFS equitable, accessible, acceptable, appropriate and effective?		Do programmes include pre-conditions for youth empowerment and sustainability of services?	
	Strengths	Weaknesses	Strengths	Weaknesses
General and sector budget support	• Gender, SRHR and Youth-friendly indicators attached to the variable tranche provide an advocacy entry point for donors with the national-level policy dialogue.	• Provides donors with limited oversight/ steering capacity on how much funding is actually used to support youth-friendly services. • Effective youth outreach limited by lack of proximity, lack of human and financial resources and socio-cultural barriers.	• High level of "government" ownership. • GBS can facilitate linkages between sectors which help youth empowerment (e.g. education, health etc), through relevant variable tranche indicators.	•"Government" is not necessarily "country" ownership: •Youth organisations are rarely invited or consulted within decision-making processes – CSO platforms tend to participate instead, but do not always report back to their constituencies.
Sector-specific or thematic project-type funding*	•Government programmes: More control and oversight on how funds are being used as it usually targets one specific sector programme – can be in the area of SRHR/ FP/ demography (e.g. EU population programme, subsumed by EU under governance focal sector).	•Youth friendliness of programmes depends on how youth-friendly specific sector policies are.	• Can involve different, complementary types of channels/ implementers: e.g. EU population programme in Burkina Faso: Government, UNICEF, CSOs.	•Less ownership on government side and less flexibility. Youth organisations rarely involved in priority setting.
	• Other channels: funding can support innovative pilot approaches to address youth needs across sectors and help overcome cultural and geographic barriers (e.g. UNFPA online youth platform). • Allows for support to organisations with the appropriate expertise to ensure youth-friendly service delivery.	• Risk of single-issue/ silo approach by implementers if government/ donors do not allow for more comprehensiveness.	• Funding can complement government programmes by supporting CSO accountability.	• Youth organisations involved in project implementation, are often obliged to follow donor priorities. Rarely involved in decision-making around these priorities. • Sustainability questionable if no buy-in from government.
Pooled funding	• Funding which can be earmarked for addressing certain issues (e.g. RMNCAH-Nutrition for GFF) and targeting specific population groups (e.g. youth in the context of EU) and needs.	• Lack integrated/ comprehensive approaches in addressing issues.	• Pooled aspect can ensure better harmonisation of donor funding. • Can provide for increased accountability and inclusiveness through dedicated mechanisms (e.g. GF CCM)	• Often reduced ownership (separate implementing. Unit, possible earmarking by donors) • Duplication of coordination mechanisms • Youth organisations rarely consulted.

*Single donor (non-pooled) global or country-level support for a specific sector (e.g. health, education, governance) or theme (e.g. gender, human rights, civil society) projects. Possible channels: government, civil society, multilaterals. Decision-making for this modality can be done at country or headquarters level).

Impact of EU coordination on young peoples´ health and well-being

According to some respondents, EU and Member States´ past **joint policy dialogue** has been working in favour of young people´s SRHR and FP, largely due to health being a focal sector for the EU, but also due to Member States´ acknowledgement of demography being a key priority and their respective collaboration with UNFPA. Burkina Faso has a relatively sophisticated **development partner coordination system** with 14 so-called "Cadres Sectoriels de Dialogue" (Sector Dialogue platform) mirroring the key planification sectors mentioned in the National Development Plan (PNDES 2016-2020). According to various respondents interviewed for this study, UNFPA, the EU and France have successfully used their influence within these mechanisms and related national consultations, e.g. around the national development plan elaboration, to jointly advocate for SRHR and FP to be "catapulted" on top of the country´s development agenda. Within the Sector Coordination group (Cadre de Concertation Santé) the EU has, in addition to that, used its variable tranche indicators to advance issues around the unmet need for FP. Nonetheless, major health CSO platforms interviewed for this study claim that they had not been invited to join these policy dialogue discussions, which makes it difficult for them to provide their counter-view on the actual impact of the EU´s sector budget support.

The **EU Joint Programming process**, initiated in 2017 by the EU donor group and picked up again in June 2018[xxxviii], could, in the medium term, help gathering further support for young peoples´ health and SRHR in Burkina Faso, as the issue of demography has indicatively been selected as one of the Joint Programming strategic objectives for 2017-2020. In that context, first efforts have been made to elaborate a **joint EU/Member States position paper** on the issue.

As the EU joint strategy for Burkina Faso has, however, at the time of writing up the present study, still been at draft stage, it remains to be seen how follow-up will be provided by the EU group to work together towards these objectives.

xxxviii After having been stalled for over 6 months due to the EU´s new presidency role (and related workload commitments) within the so-called "Troika" – the entity in charge of representing/ spearheading the donor community within the national coordination mechanisms.

How do EU programmes implemented in Burkina Faso meet its development policy objectives?

2017 European Consensus on Development	Implementation in Burkina Faso
Commitment to the promotion, protection and fulfilment of all human rights and to the full and effective implementation of the Beijing Platform of Action and ICPD PoA and the outcomes of their review conferences.	Even if the Beijing Platform of Action and the ICPD PoA are rarely (if at all) mentioned in the EU´s past and current programmes, it is clear that especially some of its new initiatives de facto meet their policy objectives. The EU´s new population programme 2018-2022 in Burkina Faso is certainly the most striking example in this respect, and responds to most of the ICPD PoA´s objectives, on integrating population concerns into development planning, reproductive health, population growth, the girl-child, child health, population distribution, among others.
Commitment to the promotion, protection and fulfilment of the right of every individual to have full control over and decide freely and responsibly on matters related to their sexuality and sexual and reproductive health, free from discrimination, coercion and violence.	Sexual rights, in particular LGBTI, but also girls´ sexual rights, continue to be sensitive issues in Burkina Faso. Interviews with EU development partners revealed that discussing the issue of early marriage and homosexuality was often rejected by the local population on the grounds of cultural practices and sensitivities. Notwithstanding, Burkina Faso was one of the beneficiary countries under the EU/ EU Member States jointly financed programme on the "Abandonment of Female Genital Mutilation/Cutting: Accelerating Change» and the "Global Programme to accelerate action to end child marriage".
Need for universal access to quality and affordable comprehensive SRH information, education, including CSE, and health-care services.	An obstacle to introducing a truly comprehensive sexuality education in Burkina Faso´s school curriculum has been the above-mentioned sensitiveness and taboos surrounding young people' s sexual rights, notably due to the role that religion takes in the Burkina´s society. Some (EU Member States-funded) innovative approaches using ICT and social media to reach out directly to young people (e.g. UNFPA´s online youth platform QG Jeune) may however, in the future, help overcome some of these barriers, by also helping to reach out-of-school youth.

Conclusions

Burkina Faso´s ambition for its demographic transition reflects the paradigm shift which has been taking place in the region on population dynamics and policies over the past decade. Recent efforts made by the EU and its Member States to integrate these priorities into country-level programming can be seen as promising in this context.

While the EU has, to date, not systematically conducted youth needs assessments when programming its initiatives in Burkina Faso, the EU´s intention to align its programmes with new, youth-friendly policies, such as the National Plan on Accelerating FP, is expected to influence the way that projects and programmes are both designed and implemented in future.

The extent to which programmes address young people´s health and well-being however also depends on the specific aid modalities and mechanisms used, as demonstrated by the table above. If general or sector budget support are used, Burkinabe government's strong commitment to promoting ASRHR is a factor which contributes to the effective implementation in favour of ASRHR. However, past EU efforts also show that agreeing on results indicators which are gender and age-disaggregated helps in monitoring whether the needs of women and young people are accounted for.

In addition, overcoming some of the country´s persistent obstacles to effectively reach young people across all sectors may require complementing government programmes through support for innovative approaches involving other types of partners (e.g. CSOs for vulnerability assessments) and new technologies (ICT/ social media). All respondents in Burkina Faso acknowledged that efforts to include and/or consult a greater diversity of actors and partners – notably youth organisations – could help increasing "country" - rather than "government" – ownership.

When it comes to (global, regional or country-level) pooled funds, all too often managed through separate implementation units, their silo approach is not always conducive towards addressing youth needs in a comprehensive, integrated manner. Youth empowerment, youth health, SRHR and FP, for example, are all too often dealt with as separate issues, while their interlinkages are not sufficiently taken into account. The potentially valuable role that Ministries of Youth could play in ensuring such linkages should be leveraged.

In this context, increasing and improving the coordination between EU donors contributing to these mechanisms could, potentially, help promote a more comprehensive approach, as evidenced by the EU partners´ successful advocacy for the integration of demography as a priority within Burkina´s national development plan. EU joint programming also has the potential to further help mainstreaming youth and population across sectors. Such potential can, however, only be fully leveraged if all parties involved agree to invest the appropriate amount of time and human resources needed for effectively maintaining such coordination.

Endnotes: Chapter 4

53. Ministry of Finance, National Development Plan 2016-2020, http://www.finances.gov.bf/index.php?option=com_content&view=article&id=302:plan-national-de-developpement-economique-et-social-pndes-2016-2021&catid=9:bannieres&Itemid=371 , accessed 26/10/2018
54. Minitry of Health, PLAN STRATEGIQUE SANTE DES ADOLESCENTS ET DES JEUNES 2015 – 2020: https://www.prb.org/wp-content/uploads/2018/05/Plan-Strate%CC%81gique-Sante%CC%81-des-Adolescents-et-des-Jeunes-2015-2020.-Burkina-Faso.pdf, accessed 26/10/2018
55. Ministry of Health, National Action Plan for Accelerating Family Planning (2017-2020), http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2017/11/Burkina-Faso-CIP-2017.pdf , accessed 26/10/2018
56. Drissa Zongo, Cahier des charges pour la conception et la mise en place de la plateforme jeune « q.g. jeunes », Dec. 2016: https://burkinafaso.unfpa.org/sites/default/files/submissions/CAHIER-DES-CHARGES-Plateforme-Jeune-%20FIN_0.pdf , accessed 26/10/2018
57. UNICEF-UNFPA, 2016 Annual Report of the UNFPA–UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change, July 2017, p. 1 - https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_UNICEF_FGM_16_Report_web.pdf , accessed 26/10/2018
58. UNFPA-UNICEF, 2017 ANNUAL REPORT ON THE GLOBAL PROGRAMME TO ACCELERATE ACTION TO END CHILD MARRIAGE, August 2018, p. 8, https://www.unicef.org/protection/files/Global_Programme_Child_Marriage_Country_Profiles_2017.pdf , accessed 26/10/2018
59. UNFPA-UNICEF, 2017 ANNUAL REPORT ON THE GLOBAL PROGRAMME TO ACCELERATE ACTION TO END CHILD MARRIAGE, August 2018, p. 8, https://www.unicef.org/protection/files/Global_Programme_Child_Marriage_Country_Profiles_2017.pdf , accessed 26/10/2018
60. LeFaso.net, SOUTIEN AUX OSC : Le PROS fait ses adieux, http://lefaso.net/spip.php?article48918 , accessed 27/10/2018.
61. Global Fund, Évolution des instances de coordination nationale, https://www.theglobalfund.org/fr/country-coordinating-mechanism/evolution/, accessed 26/10/2018
62. Particip GmbH ,Evaluation de l'appui budgétaire au Burkina Faso (2009-2014) Rapport Final - Note sur les dynamiques de croissance et de pauvreté , May 2016 - https://europa.eu/capacity4dev/coop-ration-ue-au-burkina-faso/documents/evaluation-de-lappui-budgetaire-2009-2014-au-burkina-faso-1 , accessed 27/10/2018

CHAPTER 5: ETHIOPIA

1. Country profile

Young people's needs are Ethiopia's needs

Despite some progress in terms of economic and social development, Ethiopia is still among the group of Least Developed Countries. Ethiopia has been listed the tenth most fragile country by OECD (2016) due to its vulnerabilities in political, societal and environmental spheres. Current population growth places the country as the second-most populated African country, following Nigeria, and the 14th most populated country in the world. With 42 percent of the population aged between 10 and 24, Ethiopia is a youthful country and will remain so in the years to come. While Ethiopia was praised by meeting the MDGs ahead of time in the health sector, challenges remain particularly with regards to young people's health.

According to recent statistics[63], teenage pregnancy remained stagnant at 12 to 13 percent from 2011 to 2016[xxxix]. This is partly due to high unmet need for FP within this cohort: only 20.5 percent of young people aged 15-19 and 18.5 percent for 20-24 years can access FP. Young people aged 15-24 also have relatively low comprehensive knowledge about HIV, between 24 percent for young women and 39 percent for young men. In addition, in Ethiopia 40 percent of girls marry before their 18th birthday and 20 percent before 15, and around 65 percent of Ethiopian women, aged 15-49, are reported has having been subjected to FGM/C.

Ethiopia's most recent national development strategies have been framed, inter alia, by Growth Transformational Plans, firstly covering 2010-2015 and later 2016-2020[64]. Both Plans prioritise reproductive health, with the first establishing as a target increasing contraceptive prevalence rate from 32 to 65 percent, and the second from 42 in 2014/15 to 55 percent by 2019/20 – so somehow the ambition declined. Both Transformational Plans consider the promotion of

xxxix To be noted that the country announced in its voluntary national review to the High-Level Policy Forum in 2017 that "fertility rate among teenagers has recently been controlled at 12/1,000" by 2015/16.

gender and youth empowerment as pillar strategies. In addition to eradicating harmful traditional practices, the latest Plan commits to organising women and youth as development armies so that they can be key implementers of the strategy themselves.

There have been successive health sector development programmes supporting the GTPs, the latter of which is the Health Sector Transformation Plan (HSTP) 2015/16-2019/20[65]. This is the first phase of a 20-year health sector strategy[xl] and represents a shift in the country's approach to the health system; whereas expanding the coverage of health services used to be the focus, the HSTP now prioritises quality and equity of services. The Plan introduces new targets, such as "reducing adolescent/teenage pregnancy rate from 12 to 3 percent" by 2020, among others. Such targets have been reaffirmed by the Ethiopian government during the 2017 Family Planning Summit in the context of the FP2020 movement. These commitments, as stated in the HSTP, are supported by strategic initiatives, such as "Strengthen adolescent and youth focused reproductive health services".

The HSTP is on its own supported by sub-sectorial strategies. The Ethiopian Ministry of Health developed National Reproductive Health Strategies, first between 2006 and 2015[66] and later replaced by a new edition covering 2016-2020[67]. Both strategies prioritise youth reproductive health and the need to, inter alia, invest in awareness, human resources capacity and influencing norms.

The current strategy also reflects a change of priorities in the country: now entitled National Adolescent and Youth Health Strategy, it encompasses more aspects of youth health, including non-communicable diseases, substance abuse and mental health. Nonetheless, adolescent and sexual reproductive health (ASRH) remains a priority with dedicated actions, including the promotion of YFS. The strategy also aims at preventing harmful traditional practices and supporting and facilitating youth engagement and ownership of health programs. Another important novelty lies in the recognition of the role that CSE can bring to positive SRH outcomes among youth, albeit little implementation in the country.

Snapshot of the Ethiopian health system

Ethiopia's service delivery is based on a three-tier system, which includes federal, region and district - or woredas- levels. In 2003, the government of Ethiopia created the Health Extension Programme (HEP) with a view to achieving universal coverage of primary health care among rural population. For this, 30,000 frontline community health workers, the health extension workers (HEWs), were deployed and trained in 16 different packages, including FP and ASRH. The government also created the Health Development Armies (HDA), groups of community volunteers, primarily women, that promote community health and that have been helpful in identifying bottlenecks to the use of SRH services. Following a government commissioned evaluation of the health system in 2008[68], Ethiopia and development partners agreed in setting up a pooled funding mechanism for health, the MDG Performance Fund (MDG PF), later replaced by the SDG PF. The SDG PF is a key channel for implementing the HSTP and includes components on SRH and youth. It focuses primarily on procurement processes.

Channel One	**'On treasure and on budget' resources = Current EU support**
Channel Two	**'Off-treasury but on-system' resources = SDG Ferformance Fund**
Channel Three	**'Off budget and off systems' resources = Current EU support**

Remaining Obstacles to Access / Use: The price of forgetting youth´ needs

As stated by one interviewee, "some of Ethiopian's health policies are even better than in Europe; the problem is respective implementation". The health system in the country relies heavily in ODA – approximately 50 percent - which does not seem to be enough to make the system sustainable. There is still a gap on the number of facilities and woreda health offices implementing continuous

xl As mentioned in the Health Sector Transformation Plan, the "Envisioning Ethiopia's Path to Universal Health Care through strengthening of Primary Health Care" is a long-term exercise to define "a framework for subsequent strategic actions which will enable Ethiopia to achieve the best health outcomes that would be expected of a lower middle income country by 2025 and to achieve at least median health outcomes of an upper middle income country by 2035", p. 16.

quality improvement for ASRH. Renewed efforts in refreshing training of health resources towards the youth clients are however too recent to be able to measure adequate uptake from an otherwise overloaded workforce. Furthermore, the Pharmaceutical Fund and Supply Agency and federal procurements have been areas requiring urgent improvement to ensure sustainable supply of medical commodities and sustain the decentralised system. According to recent national statistics, these issues are also exacerbated by little youth involvement in health services and reduced number of schools or youth centres providing ASRH services.

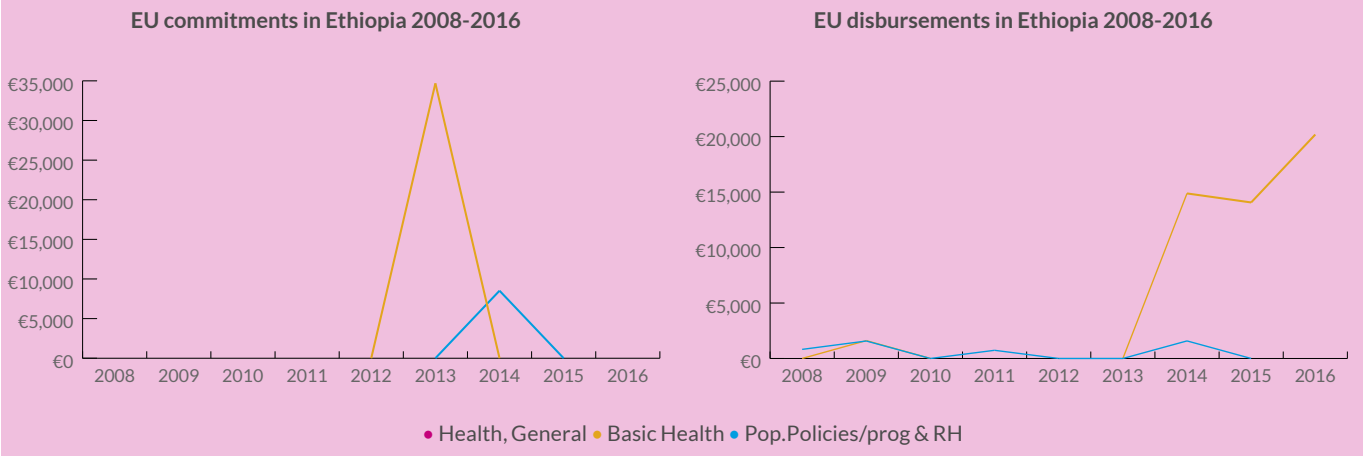
2. EU-Ethiopia partnership

The relations between the EU and Ethiopia date back to the EU partnership with ACP countries and are currently framed under the CPA. Ethiopia has been considered a priority country under the Migration Partnership Framework[xli]. In 2016, the Parties agreed upon a Strategic Engagement, against which six global challenges are discussed on a yearly basis[xlii].

xli Launched in 2016, these frameworks are tailor made partnerships with strategic third countries to manage migration. Building on the European Agenda on Migration, the Frameworks define short- and long-term objectives, including addressing root causes of irregular migration.

xlii These challenges are: Governance and Human Rights; Regional Peace and Security; Countering Terrorism and Violent Radicalisation; Migration; Social and Economic Development, Investment and Trade; and Climate Change and Environmental Cooperation.

EU funding for SRH in Ethiopia over 2008-2016[xliii]



EU cooperation in the country has been mainly financed by the EDF[xliv]. Health has been a traditional recipient area, but not always a focal sector[xlv]. Between 2002 and 2010, Ethiopia was the 16th country that received more EU funds through GBS[69]. The 10th EDF[70] in Ethiopia included 195 million EUR to strengthen socio-economic governance through GBS (which was not used), or, alternatively, the World Bank's Protection of Basic Services (PBS) programme. The PBS is a multi-donor and multi-sectoral trust fund created to support the expansion of quality basic social services at decentralised level. It is complemented by the Ethiopia Social Accountability Programme (ESAP), also managed by the World Bank and supported by the EU, among others. It aims at strengthening social accountability at the woreda level, supporting the identification of priorities and bottlenecks to accessing basic services.

The EU also supported back then the MDG PF by channelling funds through UNICEF and as part of the "Enhancing Skilled Delivery in Ethiopia programme"[71], which targeted maternal and newborn health.

The current EDF prioritises health as a focal sector between 2014 and 2020, with an envelope of 200 million EUR[72]. In line with Ethiopia's national poverty reduction strategies, EU supports basic health and SRH. The EU main modality to do so has been health SBS, amounting to 115 million EUR. EU SBS aims at supporting the implementation of the HTSP, in complementarity with the SDG PF. It intends to address gender specific issues in policy dialogue and at operation level. The 11th EDF is also expected to include a financial envelop to support social determinants of health in Ethiopia, which include the provision of FP and some focus given to youth.

Ethiopia has been a beneficiary country of several UN global programmes financed by the EU. These include UNFPA's Supplies Programme, the UNFPA-UNICEF Joint Programme on FGM/C and the UNFPA-UNICEF Global Programme to Accelerate Action to End Child Marriage. Plus, Ethiopia is a recipient country of the Universal Health Coverage Partnership, supported by the EU, WHO, Luxembourg and Ireland. The EU is also a key donor of the GFATM. HIV/AIDS has been by far the component that received more funds in the country, and often integrates SRH services.

Moreover, a global EU call for proposals for civil society under the DCI 2008-2013 targeting SRHR programmes in 2014 led to two initiatives in Ethiopia: "ASURE – HEALTH: Access, Service and Utilisation of Reproductive Health", from AMREF Africa, totalling 3.4 million EUR; and "Promoting Sexual and Reproductive Health and Family Planning Services for Marginalised Women and Girls", from Save the Children, amounting to almost 4 million EUR. This latter project was a second phase of one other EU-funded initiative. Support to civil society has also been decentralised, with the EU having set-up in 2006, and together with the government of Ethiopia, the Civil Society Fund. The

xliii Graphs consider only Health, general (121), Basic health (122) and Population policies/programmes and reproductive health (130), as per OECD. Available at: https://stats.oecd.org/#, last accessed 11/10/2018. Emigration-related expenses have been already subtracted (around 4 million EUR from disbursements and 8 million EUR in commitments). It is however important to notice that the EU might have also spent SRHR-related funds in the country reported as Government and civil society (I.5) or Other Social Infrastructure & Services (I.6). Amounts in EUR, converted by respective annual rate.

xliv To be noted that the current analysis focuses mainly on development cooperation programmes and excludes humanitarian aid, considering the scope of this study. According to the Annual Implementation Report 2017 of the EU Gender Action Plan II, there have been "SRHR and family planning activities in humanitarian interventions" in Ethiopia, which are not factored-in this assessment. Reference Joint Staff Working Document EU Gender Action Plan II Gender equality and Women's Empowerment: Transformation the Lives of Girls and Women through EU External relations 2016-2020, Annual Implementation Report 2017 – Annex 5, 2018, p.10. Available at: https://www.parlament.gv.at/PAKT/EU/XXVI/EU/03/85/EU_38561/imfname_10847182.pdf, accessed 19/10/2018.

xlv Other focal areas in the last ten years include agriculture and food security and transport.

focus of the Civil Society Fund has been to allow CSOs to implement projects concerning potentially sensitive elements, such as democracy, the rule of law, fundamental freedoms and equality.

Finally, Ethiopia is one of the main beneficiaries of the EUTF, and the country in the Horn of Africa currently with the biggest amount of contracted funds[73]. In Ethiopia, youth-targeted EUTF programmes are mainly focused on job creation and employability, as youth are agents prone to migrate, and often exclude health elements. Among the four ongoing programmes in the country, only a small part includes components targeting SRHR. The most relevant project is RESET II - Resilience building and creation of economic opportunities, co-managed by DG DEVCO and ECHO. The project foresees access to basic social services, including health, and considers demographic growth to be a long-term priority to be addressed. CSOs have been a main implementer of the RESET II[74].

EU member state presence and support to the SRHR agenda in Ethiopia

There are currently 21 Member States present in the country who, together with Norway and Switzerland, represent the EU+ group. Several Member States are currently supporting this sector, in addition to the EU: Ireland, Italy, the Netherlands, Spain, and the UK. Other donors have also been instrumental to the SRHR agenda, either due to past support to the health sector or focus on gender and human rights. Among these are Germany, Norway and Sweden.

Ethiopia was one of the first countries to sign a national International Health Partnership compact in 2008 to improve aid effectiveness in the health sector, and ensure government ownership and complementarity of resources flows. Against this framework, the Development Assistance Group was established in 2001 for different levels of concertation. Under the Development Assistance Group, development partners, including several EU Member States, meet in the Health, Population and Nutrition working group, or other structures dedicated to gender and civil society. The EU supports the work under the Development Assistance Group, as it funds UNDP in its role of Secretariat[xlvi]. Health was also a priority element of the first Joint Programming strategy 2013-2015 between the EU and its Member States[xlvii].

xlvi Under the financial envelope for the Technical Cooperation Facility of the 11th EDF.
xlvii An updated joint programming strategy is under negotiation at the time of writing of this report, but available information indicates that health will no longer be a key area.

3. Key findings

Relevance: Have EU-funded programmes been supporting equitable, accessible, acceptable, appropriate and effective youth-friendly sexual and reproductive health services (YFS)?

Given that young people represent a large segment of the Ethiopian population, the country has built notable frameworks aiming at improving the health status of this population group. EU programming in Ethiopia tends to be universal, considering this group as a significant segment of the population. The different modalities and channels the EU resorts to offer opportunities and gaps when it comes to YFS.

For a start, new programmes do not seem to always rely on a **youth needs assessment**. In addition to budget support, the EU directly awards the Ministry of Health with the aim to support its reform for improving the quality of services. One element of the Ministry of Health reform is the implementation of the National Adolescent and Youth Health Strategy which, inter alia, aims at ensuring youth meaningful engagement in health programmes. To do so, the Ministry of Health is currently engaging with TaYA – Talent Youth Association, the largest youth-led development organisation in the country. The intervention logic of the SBS however does not specifically mention this concern. However, there is no current requirement to include youth voices in the ongoing consultations between the EU Delegation to Ethiopia and civil society.

But both projects funded under the SRHR global call from 2014, implemented by AMREF Africa and Save the Children, relied on an assessment of young people's needs and their implementation depends on the continuous work with this age group, be it in- or out-of-school. The projects have also encouraged constant consultations between young people and government structures or community bodies, such as the HDAs, to ensure that dialogue is maintained beyond the project lifespan. Youth voices were also brought to some extent to the recent programming of the GFATM: the Consortium of Christian Relief Development Association, with over 400 members and who is represented in Ethiopia's Country Coordination Mechanism (CCM) of the GFATM, reflected youth concerns during the most recent grant proposal development under the GFATM. The Consortium of Christian Relief Development Association´s efforts are however not EU-funded.

In the context of EUTF programmes, young people are among relevant stakeholders usually consulted at the beneficiary and local level when defining the theory of change of the project[xlviii]. These consultations are led initially by the EUTF manager and later at the discretion of the implementer partner, mainly for the implementation of specific components of the project. Practice has shown that consultations with key stakeholders and beneficiaries, including youth, do take place to define the final strategy of the project. This has also been the specific case of RESET II.

xlviii Consultation processes under the EUTF usually occur at the beneficiary level, local and regional level with government and stakeholders, and federal government (line ministries) and national stakeholders. Possible consultations with youth occur under the first two levels.

EU's engagement to **shape the Ethiopian policies** affecting young people's SRHR is also diverse. Of relevance are the UNFPA-UNICEF Joint Programmes for FGM/C and to end child marriage. Both harmful traditional practices are still prevalent namely in the lowland or pastoralist regions of the country, where behavioural changes have proven to be more challenging. This is shown by the weak enforcement of existing policies and the vast gap between arrests and convictions of perpetuators of such practices. While working in partnership with government and CSOs, both programmes reinforce policies and support the removal of social barriers.

Space for activists has also been reinforced under the Civil Society Fund, currently in its second phase. An Ethiopian CSO, Impact, benefitted from the Civil Society Fund under both phases and reported positive results in enhancing capacity of local associations to promote SRHR and engage with the public sector. The first phase however excluded specific activities targeting youth, due to restricted guidelines of the call focused mainly on women. Also relevant is past and current EU support to the ESAP. The programme's objective to strengthen social accountability in the health system at the woreda level is reflected in one of the indicators in the monitoring matrix of the EU SBS and indirectly it can also contribute to increased allocations to the national SRH/FP Programme. Lastly but not least, the Civil Society Support Programme is also used to shape Ethiopia's policies. Funded only by some Member States[xlix], it has been promoting CSOs innovative projects in advancing also the SRHR agenda, including LGBTI rights, an area otherwise secluded.

Coordination between development partners has also been instrumental in shaping government programmes. One example is the Ethiopia school health programme, co-developed by the Ministry of Health and the Ministry of Education. The original school health service package was suggested to include the provision of CSE, in line with the national RH/FP strategy – this was however blocked due to lack of consensus between Ministries. But following joint development partners´´efforts, led by UNFPA, the package finally includes" integrated life skills education". The programme nonetheless promotes abstinence or bans condom provision in schools, depending on the age group: the second cycle is encouraged to delay or abstain from sexual activity, while secondary students are referred to nearby health facilities. Only the tertiary level of education will be able to access commodities and services.

Human resources constraints have been a long-standing challenge to improve the quality of health care in Ethiopia. The Health Extension Programme and its frontline Health Extension Workers (HEW) are considered innovative approaches, albeit with limitations. This has been the case for delivering YFS, as several interviewees reported HEWs and overall human resources for health (HRH) to adopt a judgmental attitude towards youth access to SRH, despite relevant training tools to avoid this[75].

Bearing this in mind, the Ministry of Health, together with the WHO, has been recently carrying a training programme at the facilities level, including training of trainers. The aim of this roll-out programme is to identify facility focal points for adolescent reproductive health by 2020. EU SBS is expected to indirectly contribute to this, as it includes an indicator for the increase of the federal block grant, which covers HEWs salaries, and supports "licensing exams for the different cadres of health professionals". It is important to note however that the monitoring matrix does not include any indicator for human resources nor did any of the interviewees acknowledged a direct link between EU funds and these new efforts from the government. Policy dialogue in the context of the SDG PF can also contribute to reinforce capabilities: recently, contributing states followed-up on the strategic initiative of the HSTP to "strengthen adolescent and youth focused reproductive health services" This iteration contributed to triggering some of this recent recycling training of HRHs.

The Protection of Basic Services programme, also contributes to improving HRH in Ethiopia, even if not specifically targeting YFS. Yet, EU's contribution to the programme under the 10th EDF was done mainly through block grant transfers to cover salaries and

xlix Although currently under review, traditional donors have been Ireland, the Netherlands, the UK and Sweden, in addition to Norway and Canada.

maintenance of overall basic services and it is currently allocated to the Programme's Secretariat – so not specifically allocated to health.

Most of the CSO projects interviewed for this research have included a training or skills recycling component for HEWs, in partnership with the Ministry of Health and in line with national guidelines. To complement these trainings, the projects have established feedback mechanisms through which the youth client could reflect on the quality of health services.

These feedback mechanisms also contribute to an enabling environment of young people's development. **Youth health promotion** is key to ensure a balance between the quantity and quality of supply and the need for demand. This is even more the case in regions where social attitudes remain problematic. Most of the above EU-funded sector-specific or thematic projects implied or imply community-led engagement, with a focus on young people, through educational and consensus-building activities. Programmes implemented by both UN agencies and CSOs engage with youth clubs, both in- and out-of-school. Other common approaches to inform youth and outreach to different stakeholders include educational activities through schools' media, an approach that several interviewees considered being impactful, in addition to informal dialogues with community or religious leaders. Also relevant to this was the "Enhancing Skilled Delivery in Ethiopia programme", implemented by UNICEF (2014-2016) and funded by the EU: it worked to reinforce good practices among HDAs and reinforce the link with the Health Extension Program. Although the focus was specifically on maternal and child health, this has proven to be a good practice for enabling environment at the community level.

The UNICEF-UNFPA Joint Program "A Rights-Based Approach to Adolescent and Youth Development in Ethiopia", funded by Norway, is another good practice in supporting youth health promotion in Ethiopia. Activities include sexuality education, awareness raising and YFS that benefit the general young population in- and out- of school. A recent evaluation of the programme showed improved knowledge and behaviour towards SRHR, HIV, and gender equality. It has also contributed to improved livelihood and access to education.

The EU has also promoted frontline services through **improved facilities**. Cognisant of the need to improve readiness and quality of health facilities, the intervention logic of the EU SBS targets the availability of quality utilities, particularly at the level of the health facility. It is yet to be shown if this support is done in a youth-sensitive way as, for example, the safeguard of private spaces might not be a priority. The interviewed CSO and UN projects however do take this into consideration and support those facilities that need equipment or materials. CSOs also reported playing a positive role in improving the referral system, namely by linking activities in youth corners with other health services.

While most interviewees recognised that the availability of a **comprehensive package of commodities** is not the biggest bottleneck for youth health in Ethiopia, many also pointed to the fact that the Pharmaceutical Fund and Supply Agency is still performing inefficiently, namely in forecasting tasks. UNFPA and USAID have been leading in technical assistance to ease the supply chain; this is complemented by the EU SBS, which aims at reinforcing public financial management through financial and procurement audits, namely through budget support and direct award to the Ministry of Finances and Economic Cooperation. Unsurprisingly, contraceptive prevalence rate is one of the key outcome indicators of SBS, as reflected in the EU Results Framework. Although not supported by the EU under the current financial period, the SDG PF also aims at improving procurement processes. These efforts are in addition complemented by UNFPA's Supplies programme in Ethiopia, which the EU supports through global contributions. The programme aligns with the country's commitments towards FP2020, under which the most recent update focuses on increasing contraceptive prevalence rate among the age group of 15 to 24 years[76].

Despite these collective efforts to improve the supply chain, it was also recognised by some interviewees that there has been a generic implementation in terms of package in Ethiopia, and not specifically targeted to young people. This seems to be reaffirmed by the rare youth needs assessments that could otherwise support this group's evolving needs.

Sustainability & Impact: will the benefits of EU funding for youth-friendly services continue after the programmes come to an end?

Accessing youth-friendly services is a fundamental step to promote well-being but is not on its own enough for the creation of comprehensive and long-term impact. This section will therefore

consider if some pre-conditions are met to ensure the **sustainability** of the initiatives and their effect on **youth agency** based on selected criteria. It will not however attempt to assess the impact of EU-funded projects, due to the difficulty of establishing a correlation between EU support and national health indicators.

During the last ten years, not all EU-funded projects on or affecting SRHR in Ethiopia have targeted the youth cohort. That is the case, for example, of the PBS programme or the Enhancing Skilled Delivery programme implemented by UNICEF. Others nonetheless have been proactively contributing to **youth leadership**. Both the UNFPA-UNICEF Programmes targeting harmful traditional practices support youth agency by assisting youth groups and developing youth-friendly tools, such as ICT and social media campaigns. Moreover, some projects funded under Civil Society Fund II specifically builds capacity of this group regarding SRHR, gender-based violence or even harmful traditional practices. CSO projects funded under global calls in Ethiopia also closely engage with youth themselves, both in- and out-of-school, including youth centers. Specific activities include life skills training, **civic education** and community mobilisation developed by youth themselves. EU SBS does not include an indicator on youth engagement in the monitoring matrix, nor does the EU Delegation engage directly with this group. However, in aiming to enhance the implementation of the national RH/FP strategy, EU SBS may contribute to "building the capacity of adolescents and youth organizations in program planning, implementation and monitoring [...]"[77]. Projects under the EUTF in Ethiopia have also been instrumental in empowering youth, though mainly with a view to guarantee employability and job creation rather than access to health.

Youth empowerment in the country can be reinforced if there is also an enabling **space for civil society.** Despite citizens' overall support to CSOs, in 2009 the government of Ethiopia adopted a law that implies administrative restrictions on the work of CSOs, namely those dedicated to human rights. This has been a stumbling block to CSOs action, particularly in sensitive areas such as SRHR. Against this background, on the one hand, the EU has been a strong supporter of the role of CSOs as development actors in the country. Specific tools have been developed for this purpose, such as the recently updated CSO roadmap[l]. Besides, current negotiations for the Civil Society Fund

l The new version of the roadmap aims at: i) promoting a conducive environment for CSOs and their meaningful and structure participation in policy discussions; ii) promoting meaningful CSO engagement in EU-Ethiopia cooperation programming and

III seem to indicate that youth will be a focus area. On the other hand, the SBS monitoring matrix includes a specific indicator on the application of social accountability tools, which are often led by civil society and citizens. This is also channeled through the above-mentioned EU support to the ESAP. But more donor efforts could be encouraged: while there is a specific working group between development partners, government and CSOs under the Development Assistance Group structure, this has been dormant in recent years. In addition, despite existing coordination bodies of CSOs, some interviewees had the perception that CSOs are not always aligned in the dialogue and regular meetings with government and development partners.

EU SBS has the intention of ensuring sustainability of services by investing in improved public finance management and more coordinated **capacity for resource mobilisation**. These gains are also the reason why SBS is considered a favourite modality. But the conditions were not always gathered for this. Under the 10th EDF, the EU had identified general budget support as a favourite modality for socio-economic support; resorting to GBS would nonetheless depend on the country's performance in the governance sector, as monitored under the Policy Matrix on Good Governance of the national development strategy[78]. As a result, GBS turned out not to be used under the 10th EDF, so support was instead challenged through pooled funds or sector-specific projects. SBS under the 11th EDF has been designed in a way to improve the financial capacity of all government levels to implement the HSTP – including through allocations to the RH/FP strategy. Through SBS the EU directly awards both the Ministry of Finances and the Ministry of Health, whose cooperation is expected to improve without altering national budget processes. The aim is to strengthen coordination of expenditures between federal and regional levels, while also improving procurement processes. It is early to assess if capacity for resource mobilisation will be achieved through this modality, but the grounds seem to be established.

This modus operandi also contributes to **national ownership**, as the solutions are developed and implemented by the Ministries themselves, even if in partnership with other channels. Plus, all above-described projects, be it sector-specific/thematic or delivered through pooled funds, always partner with government bodies for implementation, be it at the federal, regional or local level. The inclusion of oversight functions of SBS through social accountability tools also ensures citizens' ownership. This scrutiny system, if properly reflected in a dialogue between public services and its clients, can contribute to the **continuous adaptation of the health system**. This latter aspect could nonetheless be reinforced if consultations with youth would be carried out more often, as the previous section showed not always being the case.

Several EU-funded projects are also supporting the **integration of YFS into other sectors**. The UNFPA-UNICEF joint programmes targeting harmful traditional practices bridge the health and education sectors in striving for youth responsiveness. Based on lessons learned from RESET II, the subsequent RESET Plus (2017-2020) aims at improving knowledge on the impact of demographic pressure and consolidate FP practices, while integrating these in the different components of the project. Some implementing partners were invited to develop an approach to do so, but this process in still in early stages. Moreover, all the interviewed sector-specific/thematic projects above-mentioned intervene with both in- and out-of school youth, and ensure complementary elements are also designed in a youth-friendly way, such as nutrition and WASH. It remains to be seen if SBS also implements projects in an integrated manner. While it does include a comprehensive approach to the health system, it does not include elements nor oversight of national initiatives that could be instrumental in integrating YFS in other sectors. One such case is the already mentioned Ethiopia school health programme, co-developed by both the Ministry of Health and the Ministry of Education. Moreover, the Ministry of Health also partners with the Ministry of Youth and Sports to target out-of-school youth through a network of youth centers, and by providing capacity-building and technical assistance to those clubs. None of these elements however are reflected in the EU SBS, which might be symptomatic of a rather siloed approach.

Finally, there have been good practices of **integrating EU funded ASHR programmes into national budgets**. This was the case of Save the Children's EU-funded projects, both past and current: the project's good practices have been acknowledged by the competent regional health bureaus and most components have been adapted in the national Youth and Adolescent Health strategy (2016 – 2020), upon peer review. In addition, some of the progress done under the UNFPA-UNICEF joint programme to address harmful traditional practices contributes to the national frameworks of the country in tackling both early forced marriage and FGM/C.

implementation; iii) increasing capacity of local CSOs and iv) increasing capacity for CSOs in human rights promotion and protection, among others.

Effectiveness & Efficiency: To what extent have the various modalities, channels and coordination mechanisms used by the EU been appropriate for contributing to and promoting young peoples´ health and well-being?

When asked about the importance of investing in the SRHR agenda in Ethiopia, all interlocutors stated the fact that this is a very young country. However, the above analysis shows that not all EU-SRHR programmes, past or present, specifically target this cohort.

In a country where pooled funding has been instrumental in scaling up efforts to strengthen the health system, **budget support** remains the EU's favourite modality. This is mainly since the SDG PF focuses mostly on procurement processes, while challenges in the Ethiopian health sector are wider. The adoption of SBS requires close coordination between health and finance Ministries and at the regional and local levels, reinforcing the country ownership. Albeit the merit of SBS, the above analysis seems to indicate that there are still some unfulfilled elements to enable young people's access to health. While SBS does contribute to most of the above elements that make YFS equitable, accessible, acceptable, appropriate and effective – exception being continuous youth needs assessment -, the current intervention logic seems not to include all pre-conditions considered by this study to make services sustainable. One example is the integration of YFS in other sectors, as the intervention logic of the EU SBS seems to be restrained to the health sector. To be noted that EU SBS includes a mix of implementation modalities, including support to the World Bank's PBS programme and ESAP. But none of these seem to contradict the above conclusion.

As mentioned by a representative of the EU Delegation "each modality has its own merits, making it important to leverage on complementarities". In Ethiopia, the EU and its Member States also prioritise **sector-specific and thematic projects**. Resorting to multilateral agencies and CSOs has also been a constant by the EU at least in the last ten years. Not only do these programmes seem to encourage equitable, accessible, acceptable, appropriate and effective YFS, they have also pioneered some of the pre-conditions for sustainability of services. The work with and by CSOs was commended by all interviewees, particularly due to respective innovative approaches and grassroots outreach. Of relevance is also the role these can play in bridging communication channels between the government and citizens. Having said so, Ethiopian civil society still faces hurdles regarding sustainability. Considering the current law imposing administrative restrictions to CSOs working on Human Rights, interventions in more sensitive SRHR issues can be undermined. This also creates severe competition for funding, as the law in place at the time of this study prohibits Ethiopian CSOs from receiving more than ten percent of their funds from foreign sources.

Finally, even though the EU does not currently support the SDG PF, **pooled funding mechanisms** are still an option often resorted to. As the above analysis shows, the EU remains a major donor of the GFATM, which includes significant programmes for ASRH. To be noted however that this is done through global contributions, hence not directly allocated to Ethiopia. Contributions to the PBS and ESAP programmes further validate the fact that this type of approach is also relevant in Ethiopia – although, none of these seem to include a specific focus on youth or even health. The EU has also made extensive use of its relatively new EU TF to help improve the lives of young Ethiopian people. However, as above-mentioned, this has not been a primary channel to encourage young people's access to health, due to its focus on job creation and employability. The specific RESET project seems however to offer an exception, with possibilities of being scaled up.

	Are YFS equitable, accessible, acceptable, appropriate and effective?		Do programmes include pre-conditions for youth empowerment and sustainability of services?	
	Strengths	**Weaknesses**	**Strengths**	**Weaknesses**
General and sector budget support	• Relevant trigger indicators for disbursing funds: i.) allocation to RH/FP programmes, ii.) Increased federal block grant that covers salaries, quality infrastructure and RH supplies, namely by improving procurement processes in complementarity with other programmes • Includes social accountability, enabling feedback mechanisms that influence policies • Grant award to Ministry of Health can indirectly support community mobilisation through HAD, and youth engagement, as foreseen in National Adolescent and Youth Health Strategy	• There are no SBS youth-friendly indicators attached, nor obligation to disaggregate data by age. This reduces overview or steering capacity for funding allocation to and quality of YFS • Elements of policy dialogue and social accountability do not include any youth-relevant element, so limited youth outreach	• High level of national ownership, by aligning programmes with government policies, working with different Ministries and levels • Include social accountability mechanisms that enable continuous adaptation of the health system • Improves capacity for resource allocation through the improvement of public finance management and procurement processes	• Little direct support to youth leadership or engagement in programmes, undermining the national ownership of programmes – only indirectly through support to Ministry of Health • Current approach is very comprehensive regarding the health sector but does not include any integration aspect of YFS in already existing national initiatives that aim at advancing this combination
Sector specific or thematic project-type funding*	• Direct youth outreach, enabling: i) needs assessments conducted at the baseline and during the projects; ii) ongoing youth promotion and enabling environment and iii) interface between youth advocates and public services, shaping policies and removing social barriers • Particularly on the analysed CSO and UN agencies' projects: while partnering with the government, projects reinforce i) HR capabilities on YFS, ii) quality of infrastructures and referral system iii) supply and demand for a comprehensive package of RH supplies • Projects have led to innovative approaches that embrace YFS appropriate expertise	• Need to rely on partnership with the government, against the risk of undermining sustainability of the approach	• Can be promoter of youth leadership by working with youth and raising civic awareness • National ownership reinforced by alignment of policies, partnerships with government facilities and dialogue between the HDAs, youth and public services • Feedback mechanisms between public services and youth clients support continuous adaptation of the health system • Innovative approaches have informed national guidelines and supported integration of YFS in other sectors	• Particularly in the case of CSO projects, there is a risk of undermined sustainability in case of absence of funding • Depending on the channel, reinforcing space for civil society and respective accountability role can be only very limited • If implemented independently, can disrupt national ownership and undermine sustainability if the government does not ensure buy-in
Pooled funding	• YFS can be scaled up due to pooled resources, should these be earmarked (eg EUTF - RESET Plus) or programmed in a youth-sensitive way (to be seen with GFATM) • Can support enabling elements for YFS, such as HR and infrastructures (eg PBS)	• Existing experience shows little focus in targeting or working with youth (eg PBS) or promoting YFS (eg EUTF)	• Can harmonise donors funding with government's needs and health system strengthening • Youth organisations can engage, depending on governance structures (eg CCM of the GFATM)	• Depending on the governance structure, youth might be removed from decision-making (eg PBS), or even the government itself (eg under the EUTF the country is an observer, even if consulted) • Little evidence of integration of YFS in other sectors

*Single donor (non-pooled) global or country-level support for a specific sector (e.g. health, education, governance) or theme (e.g. gender, human rights, civil society) projects. Possible channels: government, civil society, multilaterals. Decision-making for this modality can be done at country or headquarters level).

It is also important to stress that coordination between development partners and government has led to positive efforts towards the YFS agenda. Although these have not been EU-led, the above analysis shows that existing **coordination mechanisms**, in line with the IHP, seem to be effective in at least not neglecting the importance of the youth agenda.

How do EU programmes implemented in Ethiopia meet its development policy objectives?

2017 European Consensus on Development	Implementation in Ethiopia
Commitment to the promotion, protection and fulfilment of all human rights and to the full and effective implementation of the Beijing Platform of Action and ICPD PoA and the outcomes of their review conferences	All EU programmed funds targeting SRHR in Ethiopia are expected to follow both agendas, even if these are not specifically mentioned in the decision documents.
Commitment to the promotion, protection and fulfilment of the right of every individual to have full control over, and decide freely and responsibly on matters related to their sexuality and sexual and reproductive health, free from discrimination, coercion and violence.	Sexual rights, with a focus on LGBTI rights, remain a sensitive area in Ethiopia. According to most interviewees, interventions in this area are mainly done through CSOs, particularly covered under the Civil Society Support Programme. Most of the remaining aspects seem to be a target for EU support in country, with a focus on harmful traditional practices. These are directly implemented by UN agencies and CSOs, and indirectly through EU SBS, as the programme supports the HEWs who address these practices in their work.
Need for universal access to quality and affordable comprehensive SRH information, education, including CSE, and health-care services.	The EU has been supporting the country's efforts in ensuring this universal access of young people to SRH information and services; exception being CSE, due to objections from some Ministries. By centering policy dialogue mainly with the Ministry of Health and the Ministry of Finances, there are also some lose ends in the promotion of universal access to SRH information and services, as it can be observed in the shortcomings of the School Health programme (only fully available for youth in university, with secondary students having to be referred and the 2nd cycle being encouraged to delay or abstain from sexual activity).

4. Conclusions

Despite – or due to – existing fragilities, the government of Ethiopia has been striving to put in place the right measures to improve the wellbeing of its population. The country's focus on young generations is not new and can be reflected in the prioritisation of this cohort in its policies. All interviewees for this study have agreed that Ethiopian policies targeting young people's health are strong and that the problem is weak implementation. In fact, weak efforts in developing young-sensitive programmes were more often attributed to donors' than the government itself. Considering that Ethiopian population has been growing at an increasing rate, it is very timely to ensure that new efforts factor in the needs of young people.

As this analysis shows, EU programming in Ethiopia tends to be universal and hence considers youth as a large segment of the Ethiopian population. By following the principles of development effectiveness, the EU aligns its programmes with national priorities, including ASRH. However, this does not mean that funds are always programmed in a youth-sensitive way. Considering the landscape of health support in the country, the EU has been promoting coordination between actors and resource flows for alignment of priorities and ownership of the country. Cognisant of the added-value of a mix of modalities, the EU has been using sectorial budget support, sector-specific or thematic projects and pooled funding mechanisms.

All the assessed EU-funded projects contribute to some extent to making YFS equitable, accessible, acceptable, appropriate and effective, in line with this study's assessment criteria. One of the identified weaknesses nonetheless has been little attention given to youth needs assessments, at the baseline of or during the projects. Furthermore, most projects have also included some pre-conditions for youth empowerment and sustainability of services, beyond the provision of YFS. However, there seems to be little attention given to enhancing capacities of youth organisations, which are key to bridge youth voices in programming and implementation. In addition, the integration of YFS in other sectors has only scarcely been encouraged by EU-funded projects. This integration can also be further promoted by the numerous coordination mechanisms in Ethiopia. All the currently used EU modalities in country nonetheless offer space to improve these weak elements.

Endnotes: Chapter 5

63. UNFPA and Government of Ethiopia, Baseline statistics to support the National youth health strategy, 2017.
64. The Federal Democratic Republic of Ethiopia, Growth Transformational Plan I, 2010. Available at http://www.ethiopians.com/Ethiopia_GTP_2015.pdf. And Growth Transformational Plan II, 2016. Available at: https://europa.eu/capacity4dev/resilience_ethiopia/document/growth-and-transformation-plan-ii-gtp-ii-201516-201920, accessed 11/10/2018.
65. The Federal Democratic Republic of Ethiopia Ministry of Health, Health Sector Transformation Plan, 2015. Available at https://www.globalfinancingfacility.org/sites/gff_new/files/Ethiopia-health-system-transformation-plan.pdf, accessed 11/10/2018.
66. The Federal Democratic Republic of Ethiopia Ministry of Health, National Reproductive Health Strategy 2006-2015, 2006. Available at http://www.phe-ethiopia.org/admin/uploads/attachment-161-National_RH_strat%5B1%5D.pdf, accessed 11/10/2018.
67. The Federal Democratic Republic of Ethiopia Ministry of Health, National Reproductive Health Strategy 2016-2020, 2016. Available at http://corhaethiopia.org/wp-content/uploads/2016/08/RH-strategy-2016.pdf, accessed 11/10/2018.
68. Independent Review Team, Mid-term review of the HSDP, 2008. Available at http://www.moh.gov.et/eu/web/guest/-/ethiopia-health-sector-development-programme?inheritRedirect=true, accessed 11/10/2018. The evaluation concluded that sector allocation was inadequate and inefficient (p.130-131) and that donors' contributions were not provided under a broader health system strengthening agreement (p.123:125).
69. Particip GMBH, Thematic evaluation of the European Commission support to the health sector, 2012, p.23. Available at http://ec.europa.eu/europeaid/how/evaluation/evaluation_reports/reports/2012/20121217-health-new-vol-i_en.pdf, accessed 11/10/2018.
70. European Commission, Country Strategy Paper for Ethiopia (2008-13), 2008. Available at https://ec.europa.eu/europeaid/sites/devco/files/csp-nip-ethiopia-2008-2013_en.pdf, accessed 11/10/2018.
71. For more information: https://www.unicef.org/ethiopia/UNICEF_Flier_1.pdf.
72. European Commission, National Indicative Programme for Ethiopia (2014-2020), 2014. Available at: https://ec.europa.eu/europeaid/sites/devco/files/nip-ethiopia-20140619_en.pdf, accessed 11/10/2018.
73. As per EUTF annual report 2017, p.43. Available at: https://ec.europa.eu/trustfundforafrica/all-news-and-stories/2017-annual-report_en, accessed 11/10/2018.
74. For more information about RESET II: https://ec.europa.eu/trustfundforafrica/region/horn-africa/ethiopia/resilience-building-and-creation-economic-opportunities-ethiopia-reset_en.
75. The Federal Democratic Republic of Ethiopia Ministry of Health, Tools (Planning, Implementing, and Monitoring) for Adolescent and Youth Friendly Reproductive Health (AYFRH) Service Standards in ETHIOPIA, 2010. Available at: http://www.expandnet.net/PDFs/H2.%20Ethiopia%20AYFRHS%20implementation%20tool.pdf, accessed 11/10/2018.
76. For more information about Ethiopia's commitment to FP2020: http://www.familyplanning2020.org/entities/56.
77. The Federal Democratic Republic of Ethiopia Ministry of Health, National Reproductive Health Strategy, 2016, p.17. Available at: http://corhaethiopia.org/wp-content/uploads/2016/08/RH-strategy-2016.pdf, accessed 11/10/2018.
78. The Federal Democratic Republic of Ethiopia Ministry of Finance and Economic Development (MoFED): Ethiopia: Building on Progress - A Plan for Accelerated and Sustained Development to End Poverty (PASDEP), 2006, p.224-225. Available at: https://www.afdb.org/fileadmin/uploads/afdb/Documents/Policy-Documents/Plan_for_Accelerated_and_Sustained_(PASDEP)_final_July_2007_Volume_I_3.pdf, accessed 11/10/2018.

CHAPTER 6: ZAMBIA

1. Country profile

Young people's needs are Zambia's needs

Zambia is an LMIC with a population of 13.1 million (2010 census) and an annual population growth rate of three percent. The population increased steadily from 5.7 million in 1980 to 13.1 million in 2010[79] and is expected to grow to 17.9 million in 2020 and to 26.9 million by 2035, nearly doubling within a 25-year period.[80] In 2011, 35.5 percent of the population was 15-35 years of age.[81]

However, Zambia's economic growth and graduation to LMIC status have not translated into significant improvements in the health of its citizens. Although progress has been made, as confirmed by the 2013-2014 Demographic and Health Survey, the health situation is highly concerning. While the maternal mortality ratio declined from 591 per 100,000 live births in 2007 to 398 in 2013, 63.3 percent of births were attended by skilled health personnel in 2014. However, Zambia failed to meet the MDG target of 162 deaths per 100,000 live births in 2015.[82] In 2015, 63.8 percent of the family planning needs of women of reproductive age were being met[83] although women aged 15-19 had a low contraceptive prevalence rate of 10.2 percent[84] and reported the highest unmet need for FP (standing at 25 percent for women of that age married at the time of the survey – suggesting an overall higher unmet need),[85] indicating that many adolescent girls who wanted to access contraceptives were unable to.

Zambia's Seventh National Development Plan (2017-2021)[86] contains strategies on strengthening public health programmes and increasing access to quality healthcare. The National Health Strategic Plan 2017-2021[87] makes further provisions for delivering the unfinished MDG agenda and implementation of the SDGs, with a specific focus on Reproductive, Child and Adolescent Health (RMNCAH) and Nutrition. These commitments were reiterated during the second edition of the London Summit for Family

Planning held in July 2017, where the government committed to specifically address policy barriers adversely impacting the delivery of sexual and reproductive health services for adolescents and young people.[88]

Key policies guiding programming for SRHR and adolescent SRH include:

- National Family Planning Scale-Up Plan (2013-2020), which aims to increase the national contraceptive prevalence to 58 percent and reduce the unmet need for FP to 14 percent by 2020.
- National AIDS Strategic Framework for 2017-2021,[89] implemented by the National HIV/AIDS/STI/TB Council which contains a dedicated section outlining the legal and administrative challenges faced by adolescents in accessing relevant health services.
- Adolescent Health Strategic Plan, designed to promote the delivery of appropriate, comprehensive, accessible, efficient and effective adolescent-friendly health services, with a specific focus on adolescent SRH.
- National Strategy on Ending Child Marriage, 2016-2021, aims to accelerate national efforts to end child marriage by 2030.
- National Youth Policy, 2015, sets out the objectives of strengthening commitment to and support for SRHR of adolescents and youth, increasing access to a broad range of youth-friendly health services and comprehensive, youth-friendly, gender-sensitive sexuality education.

The legal framework with regards to SRHR includes the Termination of Pregnancy Act of 1972, which allows abortions in cases where there is threat to the health of the pregnant woman, to that of her existing children, and the foetus. The introduction of the Anti-Gender-Based Violence Act, amendments to the Penal Code and national guidelines for the multi-disciplinary management of survivors of gender based violence in 2011 has created a stronger foundation to deal with the high incidence of sexual and gender based violence and improve social protection of women and girls in Zambia (although marital rape is not explicitly covered by any legislation). There is a two-year service gap between the minimum legal age for sexual consent (16, though customary law permits marriage earlier, after puberty) and to access sexual health services without parental consent (18).

In 2014, the government of Zambia completed the development of a CSE curriculum targeting children aged 10-24 in grades 5-12. In 2015, a curriculum for out-of-school adolescents was developed. At the time of research, the government held a policy of no access to condoms in schools.

Snapshot of the Zambian health system

Health care in Zambia is provided by a variety of providers, including the Ministry of Health, church organisations, and the private sector, although the majority of facilities are part of the public health sector. The public healthcare system is split across four levels of decreasing specialisation: specialist care is provided in Level 3 hospitals, provincial-level care is provided in Level 2 hospitals, district-

level care is provided in Level 1 hospitals and community-level care is provided through health posts and health centres.

Aside from the Ministry of Health, national units were established to oversee specific health programmes, including the Reproductive Health Unit and National Aids Council.[90]

Remaining obstacles to access/ use: the price of forgetting youth's needs

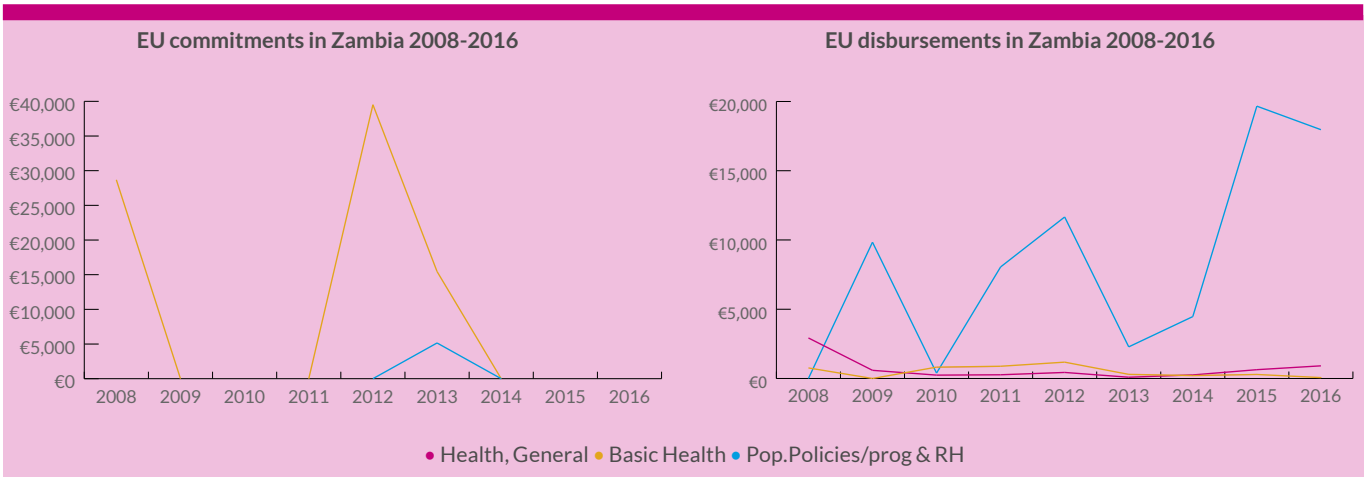
While the government has introduced a minimum service package to be provided at each level of care, due to limited communication and ambulance services the referral system between the levels is poor. In addition, the healthcare system in Zambia suffers from severe disparities in access: in 2013, less than half of the population lived within a five-kilometre radius of a health facility and many had to travel for over 50 kilometres to reach one. Moreover, rural areas are particularly underserved when it comes to FP commodities, which are overall susceptible to stockouts.[91] There is a national shortage of clinical staff and health facilities are at times staffed by unqualified staff;[92] until recently adolescent SRH was not included into the staff training curricula.

The packages of health services available to adolescents include specific adolescent-friendly health services offered through youth-friendly corners (where such facilities exist) and services offered to the general public, which do not necessary provide a specific adolescent-friendly service. However, youth corners do not exist in all facilities, and are often underequipped and understaffed. In its 2013-2020 FP Scale Up plan, the Ministry of Health recognised that its healthcare services were not sufficiently oriented towards adolescents.[93] In particular, the social stigma associated with providing FP to unmarried women was highlighted as likely impacting on its availability to adolescents and youth.

2. The EU-Zambia partnership

Zambia joined the Africa, Caribbean and Pacific (ACP) group of states and became a signatory to the Lomé Convention in 1975; in 2000, it became a signatory of the CPA, which provides the framework for EU's relations with 79 countries from the ACP.

EU funding for SRH in Zambia over 2008-2016[li]



Under the 10th EDF Country Strategy Paper and National Indicative Programme for Zambia (2008-2013),[94] the EU prioritised health and regional integration/ transport infrastructure. As a result, the EU allocated 59 million EUR to health in Zambia. Between 2009 and 2012 a Sector Budget Support Programme of 35 million EUR was implemented with a focus on improved access to healthcare across the country, but especially for children, women and those living in very rural and disadvantaged areas. Between 2013 and 2019, an additional 18 million EUR was allocated to strengthening health sector support systems; the funding will continue being disbursed until 2021.

The biggest part of the EU support to Zambia was a six-year GBS programme as part of the MDG

li Graphs consider only Health, general (121), Basic health (122) and Population policies/programmes and reproductive health (130), as per OECD. It is however important to notice that the EU may have also spent SRHR-related funds in the country reported as Government and civil society (I.5) or Other Social Infrastructure & Services (I.6). Available at: https://stats.oecd.org/#, last accessed 11/10/2018. Amounts in EUR, converted by respective annual rate.

Contract[lii] which totalled 225 million EUR over the period 2009-2014 and specifically targeted health indicators. Among all countries benefitting from EU cooperation funding, Zambia was the recipient of the fourth highest amount in GBS referencing the health sector 2002-2010.[95] 30 million EUR was added in 2009 to help the country deal with the impact of the global financial crisis. It should be noted that the last two tranches of GBS for 2013 and 2014 could not be disbursed.

Between 2012 and 2017, 44 million EUR was made available to Zambia in the context of the Millennium Development Goals Initiative (MDGi) to accelerate the achievement of MDGs 1C, 4 and 5 by improving maternal, neonatal and child health and nutritional status. The programme's implementation period was further extended until 2019 and the EU's contribution raised to 49.5 million EUR. The MDGi was extended until 2019.

A global call for proposals in 2009 under the DCI 'Investing in People: Good Health for all', and specifically targeting sexual and reproductive health and rights led to a 1.5 million EUR regional project based in Southern African countries, including Zambia, implemented by CSOs.

The 11th EDF allocates 484 million EUR in programmable funds to Zambia. However, the 2014-2020 NIP for Zambia[96] no longer lists the health sector as one of the funding priorities (these are instead energy, agriculture and governance). The NIP does however foresee a large-scale programme for the Prevention of Sexual and Gender-based Violence and Support to Sexual and Gender-based Violence Survivors with an allocation of 25 million EUR, which sets ending violence against women and children as its main objective and improvement of reproductive health care as a significant objective.

Zambia has been a beneficiary of several UN global programmes financed by the EU, like the UNFPA's Supplies Programme, UNICEF's programme towards universal birth registration[97] and the UNFPA-UNICEF Global Programme to Accelerate Action to End Child Marriage. Zambia is also a recipient country of the Universal Health Coverage Partnership, supported by the EU, WHO, Luxembourg and Ireland. The EU is also a key donor of the GFATM, which funds activities contributing to the promotion of SRH in Zambia.

EU Member State presence and support to the SRHR agenda in Zambia

EU Member States are some of the key development and funding partners in the Zambian health sector. The UK development agency, DFID, and Sweden's SIDA are key contributors to SRHR funding, although DFID is in the process of scaling back its engagement in the country. The German development agency, GIZ, is also present in Zambia, but plays a technical assistance and implementing partner role rather than that of a donor.

While there is no official Joint Programming process in place in Zambia, the EU Member States active in the Zambian health sector coordinate their work through a Joint Sector Programme and have signed a Memorandum of Understanding on Health Cooperation. DFID and Sweden are collaborating on joint support to the Ministry of Health for Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH) and nutrition.

The UK, through DFID, focuses on improved human resources for health, FP, maternal and child undernutrition, RMNCAH, nutrition and emergency preparedness. Sweden, through SIDA, focuses on RMNCAH and nutrition, SRHR with a focus on youth and raising youth awareness, CSE in schools, human resources for health and improved nutrition to pregnant women and new-borns.

3. Key findings

Relevance: have EU-funded programmes been supporting equitable, accessible, acceptable, appropriate and effective youth-friendly sexual and reproductive health services?

EU funded programmes do not systematically apply a **youth needs assessment**, even though the EU Delegation in Lusaka recognised that the needs of youth are a rising priority for the EU and

lii An MDG Contract refers to a long-term form of general budget support which was being provided the 10th EDF. This type of contacts focused on delivering on MDG-related results. Eight countries were awarded an MDG Contract, accounting for around half (1.8 billion EUR) of all general budget support commitments in the 10th EDF national programmes: Burkina Faso, Ghana, Mali, Mozambique, Rwanda, Tanzania, Uganda and Zambia.

admitted that due to the demographic structure of the country, all programmes implemented in Zambia count youth as a significant number of end beneficiaries. Nevertheless, EU programming is aligned with government policies on adolescent health, specifically the Adolescent Health Strategic Plan and the National AIDS Strategic Framework, which were developed following a nationwide consultation with young people. With regards to the EU's own policies and programming, under projects funded by the EDF, youth needs with regards to SRH services are usually only assessed at the level of implementing partners, i.e. CSOs. The EU Delegation reported that addressing gender-based needs is mainstreamed throughout programming.

For the MDGi programme, interviewees confirmed that youth was consulted for the drafting and validation of the project concept in the area of improving coverage and accessibility of adolescent and YFS. This consultation helped determine the selection of clinics for the roll out of the programme and the most effective types of interventions. The programme further tracks district adolescent pregnancy rates and feedback on services is collected through mobile platforms targeting youth, community outreach and feedback from peer educators and facility focal points. The 2017 mid-term evaluation of the programme included focus group discussions and exit interviews with clients, including adolescents and youth. The evaluation also tracked adolescent SRH indicators to assess the progress towards the programme's expected results in the area of YFS.

With regards to programmes funded under the DCI, which allow for grants to be provided directly to CSOs, the EU Delegation reported that grantees always include consultations with youth at the programme design stage. A young people's organisation working toward the empowerment of children and adolescents in five districts in Zambia which had benefitted from EU funding over 2015-2018, Barefeet Theatre, reported conducting a baseline study to determine youth needs and priorities in the different districts. A gender analysis of the needs was further conducted, and gender balanced project leads appointed. Barefeet Theatre additionally consults adolescents through its Children's Council, which elects representatives to provide weekly recommendations to project design and implementation.

With regards to programmes funded by the EU Member States, while SIDA does not currently consult youth as part of their programme design, the design of the above-mentioned CSE curriculum which was funded by SIDA has been developed in consultation with school students and youth organisations; the ongoing mid-term evaluation process involves consultations with girls and boys in grade five, parents and teachers.

The EU's engagement to **shape the Zambian government's policies with regards to SRHR** is based on the priorities listed within the human rights country strategy for Zambia, which guides the EU's political dialogue on human rights issues, although it does not necessarily impact its programming. The priorities included into the human rights country strategy for Zambia include SRHR and sexual and gender based violence, which the EU Delegation reports regularly raising in dialogue with the government. LGBTI issues in particular are a sensitive topic in the Zambian context but the EU sees it as a serious issue on which it continues to engage in, even though it does not currently provide funding for projects in this area. The EU further interacts with the government in the

framework of the adolescent health technical working group, which gathers all donors present in the country, UN bodies, civil society regularly as well as relevant ministries and national mechanisms. The adolescent health technical working group was created at the request of the government and CSOs and provides a space for discussion and coordination of efforts, as well as updates on statistics, exchanges on monitoring and evaluation, improving service delivery and youth friendliness indicators.

Within the framework of the MDGi, UNICEF as well as the implementing CSOs engage in direct advocacy towards the government on issues relevant to adolescent SRH such as the legal age of consent and the collection of age-disaggregated data at facility level. Many of the organisations funded by either the EU or EU Member States further reported advocating towards the government on the allocation of funding towards the budget lines on adolescent health included within the Seventh National Development Plan, which are currently unfunded or underfunded.

According to interlocutors from the Ministry of Health, the MDGi has allowed to systematise and coordinate **training on adolescent health and YFS for health workers** and peer educators. Under the initiative, CSO partners train at least one staff member in each participating facility on adolescent SRH, while peer educators are trained through a cascade training model. Participating health facilities designate a staff member who becomes the district adolescent health focal point on government payroll, which contributes to the long-term sustainability of the position.

Despite the clear progress made in establishing adolescent SRH focal points within health facilities, the mid-term evaluation of the MDGi pointed out that the number of healthcare workers trained in adolescent SRH was still insufficient. While ASHR has been included into training for health human resources and the nursing pre-service curriculum, there is no provision for repeat or refresher training, mainly due to lack of resources. SIDA is taking steps towards addressing the HRH challenges by providing the Ministry of Health with support in recruiting circa 150 staff, who are set to eventually be taken onto the government payroll.

With regards to adolescent SRH **training for non-healthcare staff**, under the SIDA funding for CSE, UNESCO is delivering capacity building for in-service teachers, headteachers and standards officers in six provinces, thereby covering approximately 65 percent of the workforce. The first cohort of new teachers who have received pre-service training on CSE will graduate in 2018. As part of its EU-funded activities, Barefeet Theatre includes a component on the psycho-social skills for engagement with youth into its training for facilitators.

The EU Delegation recognised that the **promotion of adolescent SRH through creating an enabling environment and outreach to different stakeholders** was crucial in Zambia as social attitudes remain a problem: the Ministry of Health adolescent SRH policies focus on abstinence and roughly half of the health facilities are run by religious groups which refuse to provide FP. As part of the efforts to address these challenges, the MDGi is supporting a health promotion unit within the Ministry of Health.

Interlocutors further highlighted that different outreach methods were needed to address youth in urban and rural areas. To address social attitudes outside urban areas, the MDGi programme contains a demand-generating component of providing information at community level about the continuum of care for all elements of RMNCAH. Within this component, neighbourhood health committees composed of health workers from the local facilities, leaders of communities and youth from the community have been set up to develop positive messages on adolescent SRH and SRH, expand FP acceptance and counteract barriers in accessing services. Outreach to the communities is further done through peer educators who work with church groups, often including elements of skills or assertiveness training or participative activities such as theatre performances. SIDA contributes to outreach and attitude change efforts through the creation of safe motherhood groups which spread awareness and create demand for SRH services, as well as funding community radio stations which raise SRHR awareness.

The newly launched EU programme targeting sexual and gender based violence is designed to include a mass media campaigning element for the radio; advocacy towards political and religious leaders at community level; and setting up youth groups in schools and communities.

The MDGi programme targets 55 facilities in 11 districts, 87 percent of which have dedicated youth-friendly spaces or youth corners. As the project objectives include improving delivery wards, emergency obstetric care and overall **infrastructure**, the project budgeted for the equipment and refurbishment of youth corners. The main role of the youth corners is to create demand and provide **referrals** to other health services. Implementing partners monitor to make sure that the youth corners meet the minimum standards: they open during the same hours as the facility and are manned by two trained peer educators of either gender. The importance of referrals made by peer educators was especially stressed in rural settings, where ICT tools for referrals are not available.

The EU's sexual and gender based violence programme will support one-stop shops for victims of violence or sexual assault within health facilities, which will include health services, legal aid, psychosocial care and victim support. There will also be provision of psychosocial services on the phone and through mobile platforms.

Zambia's Adolescent Health Strategic Plan provides for a **comprehensive RH services package**. To support its delivery, the EU is part of a UNFPA-coordinated technical working group on supplies and FP as well as provides UNFPA with support towards FP and SRH-HIV- gender based violence linkages.[98] However, interlocutors suggested that it was not so much the supply chain or availability of commodities that was the issue in Zambia but their uptake, as evidenced by HIV services having a much higher uptake than other SRH services due to clear and consistent messaging and parental buy-in and consent. CSOs reported trying to ensure a comprehensive package of RH by training staff and creating links between different programmes (RH, HIV, STI and FP).

Sustainability and impact: will the benefits of EU funding for youth-friendly services continue after the programmes come to an end?

Accessing youth-friendly services is a fundamental step to promote well-being but is not on its own enough for the creation of comprehensive and long-term impact. This section will therefore consider if some pre-conditions are met to ensure the **sustainability** of the EU-funded initiatives and their effect on **youth agency** based on selected criteria. It will not however attempt to assess the impact of EU-funded projects, due to the difficulty of establishing a correlation between EU support and national health indicators.

The EU and Member States present in Zambia meet regularly with the government, political parties, CSOs and other stakeholders to discuss issues of democratic space. The EU's strategy for engaging with Zambian civil society is outlined in the EU country roadmap for engagement with CSOs (CSO roadmap). The roadmap analyses the **state of civil society operations and the space for its activity** available in Zambia and sets out the priorities for the EU's engagement with the local civil society. These, for the period of 2015-2017, were enhancing CSOs' capacities in project management,

internal governance, fundraising, monitoring and evaluation; enhancing CSOs´ contribution to governance and development processes, improved interaction with the government; and improved coordination between the EU Delegation, EU Member States and other international donors to provide joint support where possible.

To support the development of Zambian civil society, in 2009 the EU has assisted in setting up the Zambian Governance Foundation, which offers multi-annual funding, also as core funding, to more established civil society organisations, selected on a competitive and needs-assessment basis, as well as one-off grants and capacity building for small and emerging organisations. The Zambian Governance Foundation is financed by a basket fund set up with contributions from Denmark, Ireland, Sweden, the UK and Germany. Under the 10th EDF, the Zambian Governance Foundation received a grant from the EU with a focus on CSOs with an interest in policy influencing from a media perspective.

There appears to be no systematic policy for **supporting youth leadership** on behalf of the EU. In terms of ad hoc actions, the EU Delegation in Lusaka reported inviting ten young people from partner organisations in June and October 2017 to discuss challenges and recommendations in preparation of the AU EU Summit and to select a representative to participate in the AU EU youth meeting. This process also allowed the EU to assess youth needs in the country. In addition, the EU provided ad hoc financial support to the Zambia Youth Platform, a network of 200+ Zambian youth organisations, to organise a conference to launch their first joint strategy.

Government interlocutors admitted that there was limited provision for **civic education** in Zambia, especially for out-of-school youth, and that this subject was seen as politically sensitive. With regards to EU-funded projects in this area, Barefeet Theatre trains youth on engaging with policy makers by including an annual module on the policy cycle and how to get engaged within it.

In terms of supporting the **continuous adaptation of the health system**, EU project implementer UNICEF is involved in developing of an adolescent services platform designed to help the government find more cost-efficient ways to implement its objectives with regards to adolescent health. Through its health systems support programme, DFID is working on embedding child and adolescent care and adolescent SRH into the health system.

The EU Delegation reported supporting the **integration of youth-friendly services into other sectors** through projects such as: a project to improve retention of four to 17 year-old girls in school with a focus on water, sanitation, health and education including SRHR; working directly with Ministry of Health authorities to assess needs of children with disabilities, including necessary SRHR interventions; providing capacity building for partners running projects which enable young girls to speak up and become community journalists; providing youth access to services and scholarships and preventing child labour. In addition, a part of the MDGi programme focuses on increasing birth registration and thus contributes to the protection of adolescents and youth by helping to determine cases of early and child marriage, SGBV against minors, etc.

The EU's MDGi ensures **government ownership** of the solutions it introduces by operating through Ministry of Health-run health facilities and staff on government payroll as much as possible. Furthermore, its implementation is based on policies adopted by the Zambian government which refer to the full SRH services package for youth, such as the National Adolescent Health Strategy and the Peer Educators Manual. The government's commitment to promoting adolescent SRH is further evidenced by the appointment of a designated post of assistant director for adolescent health within the Ministry of Health and the inclusion of adolescent SRH into curricula for health workers.

While it is funded not through an EU but a SIDA scheme, the mainstreaming of CSE throughout the school curriculum is an important indicator of government commitment to improving adolescent SRH.

With regards to the **integration of EU funded adolescent SRH programmes into national budgets**, as mentioned above, while Zambia's National Strategic Health Plan contains a strong commitment

to adolescent health in the narrative, as well as budget lines dedicated to adolescent SRH, at the time of research these were unfunded or underfunded. CSO interviewees reported advocating towards the government to allocate funding to these lines, in particular to ensure the sustainability of the work done under the MDGi. Project implementers suggested that some of the peer educators could be taken on as staff by the Ministry of Health. On its part, the Ministry of Health was of the opinion that it was the funding for training staff which may pose the biggest funding challenge and should therefore continue to be provided by donors, but that service provision and commodities would remain stable.

Effectiveness and efficiency: have the various modalities, channels and coordination mechanisms used by the EU been appropriate for contributing to and promoting young peoples´ health and well-being?

The EU provides funding towards health in Zambia through **two main modalities**: sector budget support for health systems strengthening directly to the Ministry of Health; and project funding, either to UN agencies which then partially subgrant to CSOs (like the MDGi programme funding provided to the Ministry of Health and UNICEF) or directly provided to CSOs (as under the DCI funding). Other EU donors stressed that currently, the majority of assistance in the country goes through UN agencies and there is little appetite to expand implementing partners.

While **budget support** is the preferred working model of the EU, allowing for a focus on outcomes rather than implementation, this has faced some obstacles in Zambia, specifically a corruption scandal within the Ministry of Health in 2009. As a reaction to that development, the EU and other donor funding began to be channelled through UN partners and CSOs, and the previous modalities were only now beginning to be brought back. However, the EU Delegation stressed that government structures and resources were essential for any intervention in the healthcare sector where standardisation of service and scale up potential are key. UNICEF staff in charge of implementing the EU MDGi agreed with this assessment, stating that as long as the government was found to be accountable, there was a preference for channelling funds through its structures to promote ownership.

With regards to the **role of CSOs as project implementers,** the EU Delegation pointed to the challenges of staff turnover and attrition of volunteers; government complaints about the low accountability of CSOs; and the duplication of CSOs' work. UNICEF further shared a concern about the sustainability of CSO projects which risk structures at community level collapsing in the absence funding. To address these challenges, the EU Delegation reported that its calls for proposals specify that the grants are to be spent in partnership with government structures. Furthermore, the EU prefers to work with CSOs through UN agencies or by partnering up with those perceived as well-established and reliable. This approach was criticised by some of the CSO representatives interviewed who felt that it worked against smaller, youth-led organisations with lower capacity, therefore excluding youth input from project implementation.

Modality/ funding channel/	Are YFS equitable, accessible, acceptable, appropriate and effective?		Do programmes include pre-conditions for youth empowerment and sustainability of services?	
	Strengths	Weaknesses	Strengths	Weaknesses
General and sector budget support	• Adolescent SRH and non-judgmental care training provided in pre-service training to HRH • Traditional leaders are included into the dialogue on adolescent SRH policies to ensure buy-in from gatekeepers • Comprehensive package of RH available	• In-service HRH do not all receive adolescent SRH training • Supporting infrastructure: not all facilities provide YFS	• Youth organisations consulted ahead of policy and project design • Programmes aligned with government policies • Government buy-in is demonstrated through the appointment of an assistant director for adolescent health within the Ministry of Health	• Weak structural policy for inclusion of YFS into other sectors (for example, CSE for in and out of school youth is presently not funded by the EU)
Sector-specific or thematic project-type funding*	• Youth needs assessments conducted at the baseline and during the projects • Dialogue and advocacy on SRHR maintained between project implementers and the government • Training on adolescent SRH provided to HRH by project implementers • Adolescent SRH focal points appointed in health facilities • Enabling environment for adolescent SRH reinforced by reaching out to gatekeepers, communication to different population groups • Infrastructure (youth-friendly spaces) refurbished • Referrals to government health facilities provided by project implementers • EU support to an integrated SRH-HIV-Gender based violence programme	• Successful implementation implies partnerships with different actors, not only the government, to ensure all YFS elements can be delivered	• Support to youth-focused projects through grants provided through the Zambian Governance Foundation (ZGF) • Enhancing the efficiency of the health system to promote greater availability of resources • CSO projects designed to raise civic awareness and ability of youth to reclaim their rights • Programmes aligned with government policies • MDGi operating through government-run facilities • Staff funded through MDGi progressively taken over onto government payroll • Ad hoc EU support to youth leadership	• Weak structured support to youth leadership or consultation with youth-led organisations

*Single donor (non-pooled) global or country-level support for a specific sector (e.g. health, education, governance) or theme (e.g. gender, human rights, civil society) projects. Possible channels: government, civil society, multilaterals. Decision-making for this modality can be done at country or headquarters level).

In terms of **donor coordination**, the EU Delegation reported a joint focus on RMNCAH, and nutrition across the health sector among the EU donors present in Zambia. Donors are building on the achievements of the MDGi and replicating them in other provinces either through support to government or through CSOs. However, while funding modalities may differ, implementation modalities remain the same as all implementing partners, independent of where they receive funding from, are encouraged to work through the systems that are being put in place through the MDGi programme.

How do EU programmes implemented in Zambia meet its development policy objectives?

2017 European Consensus on Development	Implementation in Zambia
Commitment to the promotion, protection and fulfilment of all human rights and to the full and effective implementation of the Beijing Platform of Action and ICPD PoA and the outcomes of their review conferences.	Yes: all EU funding targeting SRHR in Zambia is expected to follow both agendas.
Commitment to the promotion, protection and fulfilment of the right of every individual to have full control over and decide freely and responsibly on matters related to their sexuality and sexual and reproductive health, free from discrimination, coercion and violence.	Sexual rights, with a focus on LGBTI rights, remain a sensitive area in Zambia. According to the EU Delegation, the EU continues to engage in political dialogue on this topic, although it does not currently provide funding for projects in this area.
Need for universal access to quality and affordable comprehensive SRH information, education, including CSE, and health-care services.	The EU has been supporting the country's efforts in ensuring this universal access of young people to SRH information and services. While the EU itself is not providing funding towards safe abortion and CSE, this is being done by SIDA, an agency of one of its Member States.

4. Conclusions

While the EU does not at this point conduct a youth needs assessment at the inception phase of its programming in Zambia, most of the projects examined for this report meet the other criteria of relevance due to the strong focus of the implementing partners on the promotion of adolescent SRH as part of efforts to improve the overall healthcare service in the country. This angle taken by the UN agencies and CSOs operating on the ground is not surprising, given the demographic structure of the country and the problems which the lack of adequate adolescent SRH are posing both within the public health and non-health sectors, in particular education, where teenage pregnancies have caused high dropout rates for female students.

The Zambian government's strong commitment to promoting adolescent SRH is a factor which contributes to the effective implementation of programmes championing adolescent and young people's SRHR. The existence of specific policy documents targeting adolescent health and SRHR as part of that means that donor programmes in this area are implemented with full government buy-in, boding well for their long-term sustainability. Nevertheless, there is scope to improve government policies in this area, in particular when it comes to the promotion of abstinence or the ban on condom provision in schools. Furthermore, the lack of Ministry of Health financial attributions in this area suggest that donors need to continue playing a significant role in ensuring the availability of adolescent SRH services.

The strong focus on capacity building as well as provision of technical assistance to government-run healthcare facilities, as well as working wherever possible through these facilities, even if funds are not directly channelled through the Ministry of Health, promotes the sustainability of EU projects. Good coordination between donors allows for the geographical expansion of the scope of EU programmes and the replication of the tested models, all while raising the capacity of the government-run healthcare facilities through which these projects are implemented. However, it should be noted that while EU

programming provides the blueprint for donor interventions, the EU Delegation does not appear to play a pivotal role in the donor coordination process itself. Furthermore, the failure to involve young people in the decision-making process or the initial needs assessments has the potential to undermine the relevance of these programmes.

Indeed, the strongly government-centred implementation model preferred by the EU and its UN agency implementing partners is seen as excluding youth-led organisations from the discussion. Few young people's organisations in Zambia benefit directly or systemically from EU funding, suggesting that that their approaches and ideas may not receive the recognition they deserve from donors or policy-makers. As mentioned above, this can undermine the sustainability and potential for positive impact of these projects on youth-friendly services in Zambia. To ensure that youth voices are taken into account in programming and implementation, the EU should make further efforts to strengthen the capacity of youth organisations and ensure that they are systematically consulted and when possible involved in project implementation.

Endnotes: Chapter 6

79. Zambian Central Statistical Office, 2010 Census of Population and Housing National Analytical Report, 2012. Available at: https://www.zamstats.gov.zm/phocadownload/2010_Census/2010%20Census%20of%20Population%20National%20Analytical%20Report.pdf, accessed 18/09/2018.
80. Zambian Central Statistical Office, 2010 Census of Population and Housing National Analytical Report 2012, p.13. Available at: https://www.zamstats.gov.zm/phocadownload/Zambia%20Census%20Projection%202011%20-%202035.pdf, accessed 18/09/2018.
81. Zambian Central Statistical Office, 2010 Census of Population and Housing National Analytical Report, 2012, p.13. Available at: https://www.zamstats.gov.zm/phocadownload/Zambia%20Census%20Projection%202011%20-%202035.pdf, accessed 18/09/2018.
82. Zambian Ministry of Health, Seventh National Health Strategic Plan 2017-2021, 2017, p. 19. Available at: http://www.moh.gov.zm/docs/ZambiaNHSP.pdf, accessed 18/09/2018.
83. SDG indicators Database, SDG indicator 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods for Zambia, 2015. Available at: https://unstats.un.org/sdgs/indicators/database/, accessed 18/09/2018.
84. Zambian Ministry of Health, Seventh National Health Strategic Plan 2017-2021, 2017, p. 27. Available at: http://www.moh.gov.zm/docs/ZambiaNHSP.pdf, accessed 18/09/2018.
85. DHS Program, Zambia DHS survey 2013-2014, 2015. Available at: https://www.dhsprogram.com/pubs/pdf/fr304/fr304.pdf, accessed 18/09/2018.
86. Zambian Ministry of National Development, Seventh National Development Plan 2017-2021, 2017. Available at: www.mndp.gov.zm/download/7NDP.pdf, accessed 18/09/2018.
87. Zambian Ministry of Health, Seventh National Health Strategic Plan 2017-2021. Available at: http://www.moh.gov.zm/docs/ZambiaNHSP.pdf, accessed 18/09/2018.
88. FP Summit 2017, Revitalized Commitments for Zambia, 2017. Available at: http://summit2017.familyplanning2020.org/revitalized-commitments.html#Zambia, accessed 28/09/2018.
89. Zambian National AIDS Council, National AIDS Strategic Framework 2017-2021, 2017. Available at: https://hivhealthclearinghouse.unesco.org/sites/default/files/resources/zmb_str_national_aids_strategic_framework_2017-2021_30may2017.pdf, accessed 18/09/2018.
90. ACCA, Key health challenges for Zambia, 2013. Available at: https://www.accaglobal.com/content/dam/acca/global/PDF-technical/health-sector/tech-tp-khcz.pdf, accessed 28/09/2018.
91. Zambian Ministry of Health, Family Planning Services, Integrated Family Planning Scale Up Plan 2013-2020, 2013. Available at: https://www.healthpolicyproject.com/ns/docs/CIP_Zambia.pdf, accessed 28/09/2018.
92. ACCA, Key health challenges for Zambia, 2013. Available at: https://www.accaglobal.com/content/dam/acca/global/PDF-technical/health-sector/tech-tp-khcz.pdf, accessed 28/09/2018.
93. Zambian Ministry of Health, Family Planning Services, Integrated Family Planning Scale Up Plan 2013-2020, 2013. Available at: https://www.healthpolicyproject.com/ns/docs/CIP_Zambia.pdf, accessed 28/09/2018.
94. European Commission, Country Strategy Paper and National Indicative Programme for the period 2008-2013 - Zambia, 2013. Available at: https://ec.europa.eu/europeaid/node/13491, accessed 23/10/2018.
95. European Commission, 2012, Thematic evaluation of the European Commission support to the health sector, Vol. I, p. 23. Available at: http://ec.europa.eu/europeaid/how/evaluation/evaluation_reports/reports/2012/20121217-health-new-vol-i_en.pdf, accessed on 18/09/2018.
96. European Commission, National Indicative Programme for Zambia 2014-2020, 2015. Available at: http://ec.europa.eu/europeaid/national-indicative-programme-zambia-2014-2020_en, accessed 23/10/2018.
97. European Commission, Action Document for "Towards universal birth registration in Africa", 2015. Available at: https://ec.europa.eu/europeaid/sites/devco/files/commission-implementing-decision_c2015-_8571_-_annex_1_en.pdf, accessed 23/10/2018.
98. UNFPA Zambia, Annual Report 2016, p. 15
99. EU-Egypt Partnership Priorities 2017-2020, https://www.consilium.europa.eu/media/23942/eu-egypt.pdf
100. European Commission, Implementing Decision adopting a Single Support Framework for European Union support to Egypt for the period 2017-2020, 30.10.2017, https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/single-support-framework-2017-2020-decision_and_annex_egypt.pdf

An example from Northern Africa: EU-Egypt cooperation on youth and SRH

Egypt faces significant challenges connected to its rapid population growth – with a population of over 95 million and a 2 million per year growth rate, the country is forced to consider the impact that its demographics are having on health and education policy-making. Indeed, addressing the needs of a growing and very young population is a clear priority for the Egyptian government. This is also reflected in the EU-Egypt Partnership Priorities for 2017-2020,[99] which place an emphasis on modernising education (including TVET) and health systems; a focus on youth and women is mainstreamed throughout the priorities.

Most recently, the Single Support Framework between the EU and Egypt provided for support to the Egyptian population strategy[100] and "effective family planning services". As a result, in January 2018, the EU and Egypt have signed a financing agreement for 27 million EUR funding in support to population, set to be implemented through the UNFPA. The overall focus will be on primary healthcare and the social heath system. Out of the total sum, 17 million EUR is earmarked for supplies and 8 million EUR is earmarked for increasing demand – education campaigns and capacity building for government agencies.

Despite restrictive national NGO laws, essentially limiting civil society´s space for action to service delivery, the around 40, 000 existing NGOs in Egypt continue to operate, even in the area of advocacy. The EU´s Joint Civil Society Roadmap aims to support and strengthen organisations in the area of participation and advocacy, but reaching out to and involving youth organisations in the process remains difficult, to date. Ensuring services are not only youth-friendly, but also contribute to youth empowerment and participation continues to be a challenge in an environment where youth organisations and movements are still associated with anti-government activism and thus often forced to remain underground and unstructured.

CHAPTER 7: CONCLUSIONS & RECOMMENDATIONS

While no one solution fits all situations, the three case studies identify EU practices that both promote and compromise young people's access to health services in a sustainable way. For a complete overview, it is important to look ahead and bridge these practices with upcoming policies and programmes.

At the time of writing of this report, the EU institutions were negotiating the MFF for 2021–2027, including through a discussion on reforming the current landscape of EU development cooperation funding. This includes the merging of several funding instruments into one, the so-called Neighbourhood, Development and International Cooperation Instrument (NDICI). While discussions are still at an early stage, some of the already introduced elements allow to reflect on how the future EU financial architecture may allow for the continuation or disruption of these practices.

The following analysis is based on the observation of the three case studies and does not intend to represent a universal approach. Instead, it aims at recognising the strengths and limitations of existing aid approaches for providing youth-friendly and youth empowering services in partner countries, while identifying some of the opportunities and threats the new MFF could present in this context.

Modality/ funding channel/ mechanism	Are YFS equitable, accessible, acceptable, appropriate and effective?		Do programmes include pre-conditions for youth empowerment and sustainability of services?	
	Strengths	**Weaknesses**	**Strengths**	**Weaknesses**
General and sector budget support	Relevant trigger indicators attached to the variable tranche may reinforce YFS components, if appropriately used – e.g.: • adolescent SRH and non-biased care training provided to HRH; • comprehensive package of RH available; • improved facilities and referral systems for youth • Can include feedback and social accountability mechanisms • Can indirectly support community mobilisation, if the national health system comprises mechanisms for community participation	• GBS and SBS do not, to date, tend to include youth-friendly indicators, nor the obligation to disaggregate data by age. This reduces overview or steering capacity for ensuring the quality and youth friendliness of services. • Effective youth outreach can be limited by lack of proximity, lack of human and financial resources and socio-cultural barriers.	• Ensures a high level of government ownership, by aligning programmes with government policies, working with different Ministries and levels • Can include feedback and social accountability mechanisms • Can improve capacity for resource allocation through the improvement of Public Finance Management and procurement processes • GBS has shown that can facilitate linkages between sectors which help youth empowerment by linking related indicators under a broader variable tranche (e.g. which includes education, health and population indicators).	• In the case of SBS, little evidence of integration of YFS in other sectors beyond health • "Government" is not necessarily "country" ownership: Youth organisations are rarely invited or consulted within decision-making processes
	Opportunities	**Threats**	**Opportunities**	**Threats**
	The new EU MFF reaffirms the need for "satisfactory progress" on key objectives and indicators for disbursements under budget support.[101] According to the latest guidelines[102], the assessment to apply future SDG contracts includes provisions to confirm if the rights of women and children, such as SRHR, are "recognized and effectively protected" by the candidate country. According to the recent official evaluation[103], GBS/SBS has proven successful in advancing policy reform processes, be it in terms of health (SDG 3) or social inclusion with a focus on youth (SDG 10). The evaluation has also proven BS instrumental in advancing gender equality in partner countries.	Few references to SRHR in the new MFF instrument refer to a "supra-national" level[104], excluding the possibility of using BS. The guidelines ask for indicators to be disaggregated only by gender and whenever possible. The most recent evaluation does not link health sectorial reforms with any age cohort. Finally, the EU BS is considered key to implement the third pillar of the European External Investment Plan, as a way of improving economic governance[105], which might dilute attention for basic sectors like health.	The new MFF reaffirms the need for budget support to be based on country (as opposed to government) ownership and shared commitments to universal values, democracy, human rights, and the rule of law. It aims at reinforcing policy dialogue, capacity development, and improved governance. It also reiterates the need for "increased public access to information", which the recent evaluation shows have indeed improved.	The global budget support evaluation[106] does not reflect on the engagement with citizens nor on the spill over effect across sectors (in the case of SBS).

Sector-specific or thematic project-type funding	Strengths	Weaknesses	Strengths	Weaknesses
	• For a number of projects in the case study countries, youth needs assessments were part of the project approach – both at the design and the implementation stage • Projects have, in several cases, been an opportunity to create or increase the dialogue and advocacy between project beneficiaries, implementers and the government • Training on adolescent SRH is often provided to HRH by project implementers • Enabling environment for adolescent SRH reinforced by reaching out to different population groups • Infrastructure (youth-friendly spaces) often improved and referrals to government health facilities provided • Can support innovative pilot approaches to address youth needs • Government programmes: more control and oversight on whether donor funds are being used by the authorities to improve the quality of services.	• Need to rely on partnership with the government, against the risk of undermining sustainability of the project	• National ownership can be ensured by aligning projects to government policies and through partnerships with government facilities • CSO and UN projects can be designed to raise civic awareness and ability of youth to reclaim their rights – can help overcome existing rigidities / constraints of public systems in this area (e.g. by using ICT for youth messaging), and increasing outreach to those outside the formal education system (out-of-school youth, etc). • Can include feedback mechanisms that support continuous adaptation of the health system programmes • Allows for targeted EU support to strengthen youth leadership • Innovative approaches have informed national guidelines and supported integration of YFS in other sectors	• Most projects include weak structured consultation with youth-led organisations • Sustainability questionable if no buy-in from government (e.g. in the case of some CSO projects) or from local communities and youth orgs (in case of government projects). • Government programmes: Less ownership from the government side compared to GBS/SBS.
	Opportunities	**Threats**	**Opportunities**	**Threats**
	The proposal for the new MFF lists grants as a first type of financing. It aims at supporting access to SRHR at supra-national level. It also foresees shaping "global markets to improve access to essential health commodities and healthcare services, especially for SRH", which may indicate that support to some key vertical funds and programmes such as UNFPA Supplies will continue – however, it is not clear yet how youth-friendly these programmes will be.	It is expected that the upcoming MFF will prioritise new types of reimbursable financing (e.g. blending, loans, budgetary guarantees) to the detriment of traditional grants, which raises concerns about the continued prioritisation of not-for-profit sectors like health, especially with a focus on youth.	The proposal for the new MFF suggests reinforcing the role of civil society as development and governance actors in their national contexts, including through new ways of partnering and revived structured dialogue with the EU Delegations. The new MFF also expects to keep a project and programme cycle management methodology for effectiveness and efficiency.	There is no reference to the type of civil society, ie youth-led organisations. In addition, although civil society is recognised as "development and governance actor", there is little or no reference to their role in service delivery, crucial for young people's access to health.

Pooled funding	Strengths	Weaknesses	Strengths	Weaknesses
	• YFS can be scaled up through pooled resources, if the latter are earmarked accordingly • Can support enabling elements for YFS, such as human resources and infrastructures	Effectiveness and comprehensiveness of service provision at times undermined by siloed / single issue approach of mechanisms	• Can help harmonise donors funding in line with government's needs and health system strengthening • Can provide for increased accountability and inclusiveness through dedicated mechanisms	• Depending on the governance structure, youth – or even government itself - might be excluded from decision-making and overall priorities are decided upon by donors and do not always respond to country realities • Possible duplication of coordination mechanisms and increased transaction costs (e.g. separate application and reporting procedures). • Little evidence of integration of YFS in other sectors beyond health
	Opportunities	**Threats**	**Opportunities**	**Threats**
	Trust Funds will also be used in the next MFF, although it is too early to identify respective scope (if any change). The next MFF also aims at supporting access to SRHR at supra-national level, which may indicate continuous support to some key vertical funds. Considering the EC´s position as a key donor within the board of some of these mechanisms (eg GFATM), there is room to influence for a higher focus on YFS.	For some EC-established pooled funding mechanisms, such as the EU TFs, for example, there is little evidence to date that they have had a significant impact on the youth friendliness of health and notably SRHR/ FP services.	Pooled funds supported by the EU tend to include mechanisms to engage with civil society. The new MFF may offer an opportunity to change the governance structure of the EC-established trust funds that are relevant in Africa, opening more space for partner countries. The same reforms should also be encouraged under other EC-supported pooled funding mechanisms.	Nothing in the current proposal for the next MFF indicates that governance mechanisms will change, allowing for partner governments to become more active. There is also no reference to youth-led organisations.

HOW DO EU PROGRAMMES MEET ITS DEVELOPMENT POLICY OBJECTIVES?

The new Consensus on Development has reconfirmed EU commitments towards the SRHR agenda. The three case studies also allow to identify EU strengths and limitations in fulfilling these commitments.

2017 European Consensus on Development	Implementation in Burkina Faso, Ethiopia and Zambia
Commitment to the promotion, protection and fulfilment of all human rights and to the full and effective implementation of the Beijing Platform for action and ICPD PoA and the outcomes of their review conferences.	All EU funds targeting SRHR are expected to follow both agendas, even if these are not specifically mentioned in the decision documents.
Commitment to the promotion, protection and fulfilment of the right of every individual to have full control over and decide freely and responsibly on matters related to their sexuality and sexual and reproductive health, free from discrimination, coercion and violence.	Sexual rights, notably LGBTI rights, seem to remain a sensitive area in all three case study countries. EU engagement seems to be done mainly through political dialogue or CSO projects. Most of the remaining aspects tend to receive EU support through different modalities and channels, with a focus on harmful traditional practices and child marriage.
Need for universal access to quality and affordable comprehensive SRH information, education, including CSE, and health-care services.	The EU has been a supporter of ensuring universal access of young people to SRH information and services. The exception is CSE, which tends to be supported by other donors, including EU Member States. The "universal" nature of this access can nonetheless be challenged by this research, which has shown that the lack of comprehensive approaches and work with different government bodies limits the outreach of EU support.

RECOMMENDATIONS

With the new Consensus, the EU has vowed to meet the specific needs of youth and to strengthen their rights and empowerment. The current political framework offers opportunities to scale up efforts in this direction. This research has found that, to fulfil these commitments, the following recommendations should be considered:

Within the new MFF

- Tap into the potential of young people. Considering the importance of young people within the demography of many African countries, youth friendliness should be a standard criterion for delivering health and social services in those countries. Youth should be **involved at all levels of programming, implementation and monitoring of EU development programmes**. This implies initial and continuous consultation with this cohort to ensure their needs, which are continuously evolving, are always addressed. The outcome of these needs assessments – as opposed to donor priorities - should guide the project design.
- Continue using a **balanced mix of aid modalities and channels at country level** in order to ensure youth-friendly service delivery across different sectors in partner countries. The health sector in particular should be able to benefit from the advantages of each modality and the expertise of different partners in order to allow for the effective access of young people to health. The next financial period should ensure that the crucial aspect of ASRHR is addressed through modalities that work both at the supra- and national level – and not just supranational, as the current MFF proposal suggests.

- Guarantee that traditional grants are not neglected in favour of new financing types (often reimbursable), such as blending, budgetary guarantees, loans and other financial instruments. Doubts have been raised about the appropriateness of using such mechanisms in non- profit areas such as health. Conversely, this research has shown that grants have been an effective way of ensuring that services are youth friendly, equitable, accessible, acceptable, appropriate and effective.
- Regardless of the type of modality and channel used, ensure an integrated approach to health and avoid siloes. Ensure that programming within the country considers all relevant national policies that affect the chosen cooperation sector, such as ASRHR if health is chosen. Only if a siloed approach to the sector is dropped will the "universal" character of accessing SRH be achieved, as per EU's commitment.
- Continue widening the space for civil society operations. CSOs, including, youth-led organisations, can be pioneers in developing innovative approaches and in facilitating dialogue and interaction between different stakeholders. CSOs should be considered "development and governance actors" (as mentioned in the proposal for the next MFF), including as service providers.

With regards to the specific modalities

General and sector budget support

- Ensure that trigger indicators attached to the variable tranche of budget support reinforce YFS components and that these indicators are both gender and age-disaggregated.
- Ensure that budget support includes feedback and social accountability mechanisms, by reinforcing linkages with relevant initiatives supporting civil society´s oversight role. Scrutinise forecasted results under budget support.
- Ensure that new funding includes provisions to verify if the rights of women, youth and children, such as SRHR, are "recognized and effectively protected" (as per the text of the new sector budget support guidelines) by the candidate country.

Sector-specific or thematic project-type funding

- Ensure that projects support monitoring and documenting health system practices around YFS standards, in order to enable scaling-up of innovative solutions.
- Provide more targeted and sustainable support to youth leadership, going beyond single and short-term interventions. This can be done by systematically engaging young people and youth-led organisations throughout EU programmes in order to create youth agency.
- Work with government structures, both through policy dialogue and project implementation. This ensures ownership and, in the long-run, the sustainability of approaches. Projects should also be aligned with relevant national policies and plans and, where possible, use the existing set of national indicators.
- Support cross-sector approaches and innovative initiatives using new tools (e.g. social media, ICT) for reaching out to young people and out-of-school youth.

Pooled funding mechanism

- Promote – both at board and country level – the integration of ASRHR services into the initiatives of vertical mechanisms such as the GFATM.
- Ensure that EU supported mechanisms embrace a holistic understanding of what young people need and not limit support to only a few of their social needs. This is applicable to pooled funds such as the EUTF, which should mainstream access to health and FP in order to, ultimately, increase young people's and women´s employability. Engage national Ministries, including Health, Youth and Gender (where applicable) in these efforts.
- Through the new MFF, change the governance structure of the EC-established trust funds, allowing for more participation of partner countries and local stakeholders in the decision-making.

With regards to EU political and policy dialogue

- Ensure the participation of youth organisations in structured dialogue with EU Delegations, in the context of EU CSO roadmaps and other CSO consultations.
- Continue tackling sensitive issues, such as LGBTI rights or CSE, which cannot always be addressed at programme level by using political or policy dialogue.

Impact of EU coordination on young peoples´ health and well-being

- Given the importance of addressing population growth to ensure Africa´s development, consider demography and population growth as a strategic objective within the Joint Programming processes.
- Where health is chosen as a priority sector for donor coordination, ensure a comprehensive approach is taken, including the consideration of ASRHR.

Endnotes: Chapter 7

101. European Commission, Proposal for a Regulation of the European Parliament and of the Council establishing the Neighbourhood, Development and International Cooperation Instrument, 2018, p.43. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=COM%3A2018%3A460%3AFIN, last accessed 12/10/2018.
102. European Commission, Budget Support Guidelines, 2017. Available at: https://ec.europa.eu/europeaid/sites/devco/files/bsg_web_version_20180206-v2_1.pdf, last accessed 12/10/2018.
103. European Commission, Budget Support Trends and Results, 2018. Available at: https://ec.europa.eu/europeaid/sites/devco/files/budget_support_-_trends_results_2018_final_1.pdf, last accessed 12/10/2018.
104. European Commission, Annexes to the Proposal for a Regulation of the European Parliament and of the Council establishing the Neighbourhood, Development and International Cooperation Instrument, 2018, p. 11. Available at: https://ec.europa.eu/info/law/better-regulation/initiatives/com-2018-460_en, last accessed 12/10/2018.
105. Idem reference 103, Budget Support Trends and Results, p. 24.
106. 106 Idem, Budget Support Trends and Results.v

ANNEXES

Annex 1: Bibliography

1.1 General reading

ADE, Evaluation of EU Joint Programming Process of Development Cooperation (2011-2015) Final Report, Commissioned by the European Commission, 2017

Country Strategy Papers 2007-2013 between the EU and Burkina Faso, Ethiopia and Zambia

COWI A/S, ADE, Itad, Evaluation of EU Support to Gender Equality and Women's Empowerment in Partner Countries, 2015.

Demographic Health Surveys, 2006, 1010 and 2011 for Burkina Faso, Ethiopia and Zambia

Joint Staff Working Document EU Gender Action Plan II Gender equality and Women's Empowerment: Transformation the Lives of Girls and Women through EU External relations 2016-2020, Annual Implementation Report 2016 and Annual Implementation Report 2017

Joint statement by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission on European Union Development Policy, The New European Consensus on Development, 2017

Joint statement by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission on European Union Development Policy: 'The European Consensus', 2006

National Indicative Programmes 2014-2020 between the EU and Burkina Faso, Ethiopia and Zambia, and respective Action Decisions

Particip GMBH, Thematic evaluation of the European Commission support to the health sector, 2012

The Cotonou Agreement and Multiannual financial framework, 2010, Second Revision

The Partnership and Joint Africa-EU Partnership

1.2 For the assessment criteria

African Union Commission, Maputo Plan of Action 2016-2030 Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa, 2016

AIDS Accountability International, The Urgency We Require: The State of the African Youth Report, 2017

Beijing Declaration and Platform for Action, 1995

CHOICE for Youth and Sexuality and YouAct, The Flower of Participation, Undated

CHOICE for Youth and Sexuality, training manual The A-Z of MYP. How to integrate Meaningful Youth Participation into your organization and program, 2017

Every Woman Every Child, Technical guidance for prioritizing adolescent health, 2017,

International Planned Parenthood Federation (IPPF), Explore, Toolkit for involving young people as researchers in sexual and reproductive health programmes, 2013

OECD, Evidence-based Policy Making for Youth Well-being: A Toolkit, OECD Development Policy Tools, OECD Publishing, Paris, 2017.

Pathfinder International, Mainstreaming Youth-Friendly Sexual and Reproductive Health Services in the Public Sector in Mozambique and Tanzania, Technical Brief, 2017

Rutgers, Essential Packages Manual: Sexual and Reproductive Health and Rights Programmes for Young People, 2016

UNESCO, Emerging evidence, lessons and practice in Comprehensive Sexuality Education - a global review, 2015

United Nations Population Fund, Adolescent and Youth Demographics: A Brief Overview, Undated

United Nations Population Fund, Framework of Actions for the follow-up to the Programme of Action of the International Conference of Population and Development Beyond 2014, 2014

United Nations Population Fund, Programme of Action, International Conference on Population and Development, Cairo, 1994

Wegelin-Schuringa, Madeleen Miedema, Esther, Van der Kwaak, Anke, 't Hooft, Karen, Ormel, Hermen, Youth friendly health services in multiple perspectives, 2014, Amsterdam, KIT Health

World Health Organisation, Making health services adolescent friendly - Developing national quality standards for adolescent friendly health services, 2012.

1.3 Country-specific

Ethiopia

Ethiopian Ministry of Health, Her Space Handbook, Ahmara Region

Ethiopian Public Health Institute, Improving skilled birth attendance in Ethiopia (SURE policy brief). Addis Ababa Ethiopia: Ethiopian Public Health Institute, 2014

Ethiopian Public Health Institute, Improving Health Extension Program in Ethiopia (Policy dialogue), 2014

EU+ Joint Cooperation Strategy for Ethiopia, 2013

JaRco Consulting, Qualitative Baseline Survey of Safe Space Pilot Programme, DFID Ethiopia, 2016

Pathfinder International and John Snow, Inc., Bringing Youth-Friendly Services to Scale in Ethiopia, 2012

Population Council, Understanding Adolescent and Youth Sexual and Reproductive Health-seeking Behaviors in Ethiopia: Implications for Youth Friendly Service Programming, The Evidence Project, 2017

UNFPA Ethiopia Country Programme Document, Country Programme Document for Ethiopia, 2015

Zambia

EU Delegation to Zambia and COMESA, Compendium of Programmes managed by EU Delegation & Government of Republic of Zambia 2000-2014, 2015

EU delegation to Zambia and COMESA, Development Partnership Factsheet 2017/2018, 2018

EU delegation to Zambia and COMESA, Development Partnership Factsheet 2016, 2016

EU delegation to Zambia and COMESA, Development Partnership Factsheet 2014, 2014

Marie Stopes Zambia, Promotion of MDG 5 through civil society strengthening in underserved rural communities of Zambia, 2015-16 Evaluation Report, 2016

UNESCO, Annual Progress Report 2016: Strengthening Comprehensive Sexuality Education for Young People in School Settings in Zambia, 2017

UNESCO, Strengthening comprehensive sexuality education for young people in school settings in Zambia: A review and documentation of the scale-up process, 2016

UNFPA Zambia, Annual Report 2017, 2018

Annex 2: List of interviewees for the selection of assessment criteria and case studies

Organisation	Position
AIDS Accountability	Director of Research and Communications
	Executive Director
	Senior Researcher
AUC Youth division	Project officer
CHOICE	Executive Director
DG DEVCO	International Aid / Cooperation officer - Burkina Faso
	International Aid / Cooperation officer - Egypt
	International Aid / Cooperation officer - Ethiopia
	International Aid / Cooperation officer - Rwanda
	International Aid / Cooperation officer - Tanzania
	International Aid / Cooperation officer - Zambia
	International Aid / Cooperation officer - Gender Equality and Non-discrimination
	International Aid / Cooperation officer – Health sector
	International Aid / Cooperation officer – Health sector
	International Aid / Cooperation officer – Health sector
	International Aid / Cooperation officer - Migration and Employment
DG for Neighbourhood and Enlargement Negotiations (DG NEAR)	International Aid / Cooperation officer - Egypt
DSW	International Programme Coordinator
	Field officer
European external Action Service	Policy officer - Desk for Africa- EU Summit
	Desk Officer - Egypt
FEMNET	Advocacy officer
IPPF	Advocacy officer
Rutgers	Advocacy officer
	Senior Researcher
UNFPA	Regional Programme Specialist, Adolescent and Youth
UN WOMEN	Director, Brussels Office

Annex 3: List of interviewees in-country

3.1 Burkina Faso

Austrian Development Cooperation Office	Head of Office
AfD Paris	Head of Sahel Alliance Coordination Unit
BURCASO – Council of Community Development Organisations in Burkina Faso	National Coordinator
Delegation of the European Union in Burkina Faso	Assistant to the Head of Cooperation
	Programme Manager – Health
	Programme Manager EU Trust Fund
	Gender and CSO focal point
Embassy of Luxembourg	First Secretary
Enabel	Resident Representative
Equilibres & Populations	Innovation and Support Manager
	Advocacy Officer West Africa
Expertise France	EU Trust Fund Programme Manager
French Foreign Ministry, Paris	Project Officer
GIZ Burkina Faso	Technical Advisor Health
Global Fund Country Coordination Mechanism	Vice President
HELP (NGO)	Country Director
Italian Cooperation Office	EU Trust Fund Project Coordinator
Labo Citoyenneté	Programme Manager
Ministry of Health	Director of Population Policy
	Technical Counsellor - DGESS
Ministry of Youth	Programme Officer EU Trust Fund Project
Ministry of Finance	Head of Service IMEA – General Directorate for International Cooperation.
RAME Int. – CSO Platform	Director - Operations
SOS Jeunesse & Defis	Executive Director
UNFPA	Assistant Representative
USAID	Health Office Director

3.2 Ethiopia

Organisation	Position
AECID - Spanish technical cooperation office	Senior programme officer health
AMREF	RMNCH Programme manager
AU Youth division	Health and SRHR
	Senior Policy officer
	Skills development
	Youth Volunteer Corps Program Manager
CCRDA - CCM GFATM	Executive director
DFID	Senior Human Development Adviser
Embassy of Norway	Programme officer

Organisation	Position
Embassy of Sweden	Human Rights, Democracy and Gender Equality Counsellor
Embassy of the Netherlands	Senior Health & development expert
EU Delegation to Ethiopia	EU Trust Fund Manager
	EU Trust Fund Manager
	CSO Programme Manager
	Gender Programme Manager
	Health Programme Manager
EU Delegation to the AU	Health Programme Manager
	Gender Programme Manager
	Youth Programme Manager
IMPACT	Managing Director
Irish Aid	Deputy Head of Development
Italian Agency for Development cooperation	M&E Consultant
	Programme officer CSO
Save the Children	Senior Programme manager SRH
Talent Youth Association (TaYA)	Youth Engagement Coordinator
UNDP	DAG Secretariat
UNFPA	HIV Prevention and Adolescent and Youth development
UNICEF	C4D specialist
WHO	Program Management Officer Gender and HR
	Programme manager officer
	Child and Adolescent Heath
World Bank	PBS programme manager

3.3 Zambia

Organisation	Position
Abt Associates, Scaling up Family Planning in Zambia (SUFP II)	Senior FP Planning Advisor
	M&E advisor
African Directions	Program Manager
BAREFEET THEATRE	Programs Director
Centre for Reproductive Health and Education (CRHE)	Executive Director
DFID	Health Advisor
Embassy of Sweden/ SIDA	Counsellor Health and SRHR
EU Delegation to Zambia	Manager Health and Social Sector
	Programme Manager MDGi
Generation Alive	Programmes Manager
GIZ	Coordinator, Zambian-German Multi-sectoral HIV Programme
IPAS	Senior Adviser
Marie Stopes Zambia	Youth Advisor
Ministry of Health	Assistant Director for Adolescent Health
Ministry of Youth and Sport	Senior Youth Development Officer

National HIV/AIDS Council Zambia	Public-Private Sector Coordinator
Planned Parenthood Association Zambia (PPAZ)	Executive Director
	Programme Manager MGD initiative
UNAIDS	Advocacy, Communication and Resource Mobilization Officer
	Country Community Mobilization and Networking Advise
	PEPFAR/ Global Fund Implementation Advisor
	Social Mobilisation and Partnerships Advisor
	Strategic Information Adviser
UNESCO	Program officer – in-school implementation and M&E
UNFPA	Adolescent Sexual Reproductive Health and Youth Programme Specialist
UNICEF	HIV Specialist – Adolescents