Logical framework and Activity matrix (annex E3d)

	Results chain	*Indicator*	*Baseline*	*Target*	*Source and mean of verification (MoV)*	*Assumptions*
Overall objective	(Contribute to) improved adolescents' sexual and reproductive health and rights (ASRHR) in the Great Lakes region (Burundi, DRC, Kenya, Rwanda, Tanzania and Zambia)	Adolescent fertility rate per 1,000 adolescents aged 15-19 years. (SDG Indicator 3.7.2)	Burundi: 54 (2019) DRC: 121 (2019) Kenya: 73 (2019) Rwanda: 39 (2019) Tanzania: 115 (2019) Zambia: 116 (2019)	.	World Bank	*Not applicable*
		Adolescent contraceptive prevalence rate per country (unmarried, aged 15-19)	Burundi: 38.5% (2016/17) DRC: 19.5% (2013/14) Kenya: 49.3% (2014) Rwanda: 11.6% (2014/15) Tanzania: 33.1% (2015/16) Zambia: 30.1% (2018)		DHS Burundi, DHS DRC, DHS Kenya, DHS Rwanda, DHS Tanzania, DHS Zambia	
		Adolescent contraceptive prevalence rate per country (married, aged 15-19)	Burundi: 21.2% (2016/17) DRC: 5.4% (2013/14) Kenya: 36.8% (2014) Rwanda: 32.8% (2014/15) Tanzania: 13.3% (2015/16) Zambia: 37.8 % (2018)		DHS Burundi, DHS DRC, DHS Kenya, DHS Rwanda, DHS Tanzania, DHS Zambia	
		Adolescent unmet need for family planning per country (unmarried, aged 15-19)	Burundi: 36.3% (2016/17) DRC: 48.2% (2013/14) Kenya: 43.9% (2014) Rwanda: 72.5% (2014/15) Tanzania: 42.4% (2015/16) Zambia: 58.8% (2018)		DHS Burundi, DHS DRC, DHS Kenya, DHS Rwanda, DHS Tanzania, DHS Zambia	
		Adolescent unmet need for family planning per country (married, aged 15-19)	Burundi: 14.6% (2016/17) DRC: 30.8% (2013/14) Kenya: 23.0% (2014) Rwanda: 3.6% (2014/15) Tanzania: 23.0% (2015/16) Zambia: 21.5% (2018)		DHS Burundi, DHS DRC, DHS Kenya, DHS Rwanda, DHS Tanzania, DHS Zambia	

	Results chain	*Indicator*	*Baseline*	*Target*	*Source & MoV*	*Assumptions*
Specific objective	Adolescents (especially girls) have increased access to ASRHR services and commodities due to their improved availability, accessibility, acceptability and quality, along with decreased socio-cultural-religious barriers	% of facilities in targeted locations having a core set of relevant essential SRH commodities available and affordable on a sustainable basis for adolescents (SDG 3.b.3). *Primary Level (PL), ≥3 modern contraceptives Secondary+Level (S+L), ≥5 modern contraceptives*	Burundi: 99.4%, 97.8% (2019) DRC: 77.6% PL, 91.2% S+L (2019) Kenya: 93.0% PL, 61.0% S+L (2018) Rwanda: 100% PL & S+L (2018) Tanzania: 84.1% PL, 96.7% S+L (2019) Zambia: 91.8% PL, 92.5% S+L (2018)			
		% of facilities offering specific adolescent-friendly SRH services	Burundi: 2% (2008) DRC: 17% (2018) Kenya: 46% (2018/19) Rwanda: 60% (2015) Tanzania: 63% (2019) Zambia: -			
		% increase of adolescents seeking services in health in project focus areas.	<no adequate data available, part of baseline assessment - 2022>			
		% of adolescents who believe the health facilities provide quality-assured ASRHR services and commodities that meet their needs	<no adequate data available, part of baseline assessment - 2022>			

	Results chain	*Indicator*	*Baseline*	*Target*	*Source& MoV*	*Assumptions*
Outcomes	Outcome 1: Duty-bearers adopt, develop, improve, and implement (sub) national and regional policies and budgets that advance ASRHR particularly for girls and other vulnerable adolescents	A. Number of (local/national/international) policies, regulations, administrative procedures and plans developed, improved or adopted	N/A			
		B. Number of additional ASRHR and FP budget lines established at the subnational level	0 in Congo Central, Kwilu, Mandera, Dodoma, Morogoro, Manyara			
		C. % and volume of additional funds allocated and disbursed at the national and subnational level	**National (x €1,000,000):** Burundi: 0.419 DRC: 0.403 Kenya:10 Rwanda: 6 Tanzania: 25 Zambia: 1.1 **Subnational:** Burundi: N/A Congo Central: 0 Kinshasa: 0 Kwilu: 0 Mandera: 0 Isiolo: 0 Marsabit: 0 Nyarungenge/ Gasabo/ Gatsibo/Nyagatare: €91,000 (on average) Dodoma: 0 Morogoro: 0 Manyara: 0			

	Outcome 2: Government officials ensure health service providers (public/private/faith sector) have quality assured ASRH services and commodities including Family Planning (FP) available, especially for adolescents	A. % of targeted government officials with increased capacity to hold health service providers to account	0 (2022)			
		B. % of targeted facilities regularly monitored by government officials or community systems	<no adequate data available, part of baseline assessment - 2022>			
		C. % of targeted public health facility staff that are intimately familiar with governmental ASRHR policies, standards and guidelines	<no adequate data available, part of baseline assessment - 2022>			
	Outcome 3: Decision-makers utilise inclusive multi-sector platforms to address ASRHR at the subnational, national, and regional level	A. % of different types of target groups (public sector, private sector, civil society sector, etc) that feel satisfied with their level of engagement within a multi-stakeholder space	<no adequate data available, part of baseline assessment - 2022>			
		B. Number of evidence-based recommendations developed by multi-stakeholder actors that advance access to ASRH commodities and services	0 (2022)			
	Outcome 4: Opinion leader have their voices amplified to position ASRHR in the public agenda, leveraging their different constituencies and communication channels, including social media, mass media and faith media	A. Number of opinion leaders that have amplified their voice to position ASRHR for the first time	0 (2022)			
		B. Number of actions undertaken by targeted opinion leaders that promote improved ASRHR	0 (2022)			

	Results chain	Indicator	Baseline	Target	Source& MoV	Assumptions
Outputs	Output 1.1. Civil Society Actors have increased capacity to lobby and advocate with formal and informal duty-bearers to advance ASRHR	A. % of CSOs who believe they have the skills and confidence to take action about ASRHR and engage with decision-makers and duty-bearers	<no adequate data available, part of baseline assessment - 2022>			
		B. # of new actions/engagements led by trained CS actors with formal and informal duty-bearers to advance ASRHR.	0 (2022)			
	Output 1.2. Policymakers and other duty-bearers have increased knowledge and awareness of ASRHR service and commodity barriers as well as the needs and wants particularly of girls and other vulnerable adolescents	A. Number of (public) statements made by (local/national) duty-bearers reflecting evidence-based issues put forward by adolescents, faith actors and CSOs	0 (2022)			
		B. Number of times (local/national) duty-bearers react upon the positions of SHARP-linked adolescents, CSOs and faith actors by adopting their argumentation, and/or react upon their positions by putting their advocacy issues on the agenda	0 (2022)			
	Output 1.3 Evidence-based policy recommendations and tracking systems have been developed that aid policymakers in strengthening evidence-based decision processes and policy and regulation development	A. Percentage of targeted stakeholder reporting using the advocacy and IEC materials and reports	0% (2022)			
		B. Number of IEC materials, policy materials and research reports developed and disseminated	0 (2022)			
	Output 2.1. Duty bearers, CSOs and health facilities have access to updated evidence on access to	A. Number of duty-bearers, CSOs and health facilities who have been introduced to research findings	0 (2022)			

	ASRH commodities for improved decision making	B. Number of duty-bearers, CSOs and health facilities who have used research findings in decision-making processes to advance access to ASRH commodities	0 (2022)			
	Output 2.2. Public/private/faith sector health facilities have improved policies and practices in place that improve ASRHR service and commodity availability for adolescents	A. Number of health facilities with new policies, regulations, standards, or legal frameworks to strengthen SRHC supply chain (incl. stock management, quantification, procurement, distribution or transport) improved or adopted	0 (2022)			
		B. Number of additional health facilities who have organised interfaces with clients for social accountability	0 (2022)			
	Output 3.1. Adolescents (esp. girls), CSOs and faith actors have increased representation in decision-making processes at the local, national and regional level that advance SRHR	A. Number of additional times the government, private sector, multi-lateral organisations, faith-based institutions or other CSOs at the national level and/or subnational level, including adolescents, CSOs and faith actors in the decision-making process related to their advocacy issue	0 (2022)			
		B. Number of targeted adolescents (esp. Girls), CSOs and faith actors that indicate having increased involvement in policy-making processes	0 (2022)			
	Output 3.2. At the regional level and within each target country, multi-sector platforms have been established/strengthened, that include adolescent organisations and FBOs	A. Number of multi-stakeholder meetings organised	0 (2022)			
		B. Number of functional multi-stakeholder platforms established or strengthened	0 (2022)			

	Output 4.1. Opinion leaders have strategic communication plans in place on ASRHR, to leverage social media, FM stations, press, community media, places of worship, congregational settings and other faith media.	A. Number of strategic communication plans rolled out by opinion leaders to advance ASRHR	0 (2022)			
		B. Number of positive mentions on ASRHR in different (social) media based on SHARP input	0 (2022)			
		C. Number of trained youth organisations raising awareness amongst adolescents on ASRHR based on SHARP input	0 (2022)			
	Output 4.2 Intra- and interfaith dialogues have led to improved understanding of faith leaders on ASRHR.	A. Number of faith leaders with improved understanding on ASRHR	0 (2022)			
		B. Percentage of targeted faith leaders that indicate they feel that the attainment of ASRHR is important	0 (2022)			

Activity Matrix

KEY Activities	***Assumptions***
Outcome 1: Duty-bearers adopt, develop, improve, and implement policies and budgets	
1.1.1 Assessment of CSO advocacy capacity by developing and administering an Organizational Capacity Assessment (OCA) tool	We assume that by offering needs-based workshops and assistance to CSOs (incl. adolescent and women-led) they will begin advocating to decision-makers
1.1.2 Provision of tailored training/workshops to civil society actors (including faith actors) active at the subnational, national and regional level (including the development of these training packages)	
1.1.3 Provision of technical assistance and/or coaching via (online) meetings to civil society actors (including faith actors) active at the subnational, national and regional level (including the development of these training packages)	
1.1.4 Participation in relevant local, regional and international fora to showcase programmatic results and share lessons learnt for upscaling and duplication purposes	
1.2.1 Organisation of roundtable meetings and workshops with policymakers and other duty-bearers (incl. NHRIs) to increase their knowledge and awareness of ASRH service and commodity barriers, needs and wants (particularly of girls and other vulnerable adolescents	We assume that we will be able to get the right policymakers and duty-bearers at the table and they are willing to talk and learn about ASRHR
1.2.2 Advocation to policymakers and other duty-bearers (incl. NHRIs) to increase their knowledge and awareness of ASRH service and commodity barriers, needs and wants (particularly of girls and other vulnerable adolescents. (one-on-one meetings)	
1.2.3 Provision of proactive and on-demand technical (online) assistance to decision makers and other duty bearers (such as NHRIs) when drafting briefings, technical documents, etc. where relevant in collaboration with other actors, such as other CSOs/NGOs.	
1.2.4 Amplifying regional commitments through media events (video, interviews, press briefings) to create public pressure.	
1.3.1 Track existing policies, regulations, budgets to inform strategic plans and the development of policy recommendations	We assume we will get ethical clearance and access to relevant people, facilities and data.
1.3.2 Development of evidence-based policy briefs to improve the accessibility of SRHC and services for adolescents in particular based on in-country research (see output 2.1)	

Outcome 2: Government officials ensure health service providers have ASRH services and commodities	
2.1.1 Conduct baseline and end-line research to measure the price, availability and affordability of ASRHR commodities and gaps in the supply chain to improve access to SRH commodities for adolescents	We assume we will get ethical clearance and that the political situation will be safe enough to undertake primary research in the field.
2.2.1 Provide technical assistance to (sub)national governments to enforce facility compliance with policies and practices to improve access to adolescents of SRHR commodities and services (financial contribution to government support supervision visits)	We assume that facilities have the means and willingness to engage with civil society and want to ensure that their services meet the needs of their clients.
2.2.2 Support (sub)national dissemination of existing policies and standards (financial contributions to dissemination events)	
2.2.3 Organise social accountability forums and activities to ensure client supervision of health facilities	
Outcome 3: Decision-makers use multi-sector platforms	
3.1.1 Develop regional / national advocacy plans	We assume that the targeted adolescents, CSOs and faith actors will and can adequately represent their community.
3.1.2 Internal assessment (power analysis) of existing decision- making platforms to drive their reform and set-up new multi- sector platforms (3.2)	
3.1.3 Conduct research by and with adolescents to measure their experienced barriers, needs and wants in relation to SRH commodities and services to help develop adolescent-driven policy-recommendations	
3.1.4 Amplification of adolescents, CSOs and faith actors' voices in national and regional decision-making processes by facilitating their engagement in (briefing) meetings, events and document (incl. policy) reviews	
3.2.1 Establish or strengthen multi-sectoral platforms (including Medicines Transparency Alliances - MeTA) in each country and in decentralised systems at the subnational level	We assume decision makers value the participation and contribution of adolescents, CSOs and faith actors so that their contributions at meetings do not serve to rubberstamp predetermined decisions
3.2.2 Organise and partake in multi-sector platform meetings (incl. TWG) at the (sub) national level bringing together the public sector, private sector and civil society actors to drive improved SRHC and services, particularly for adolescents	

3.2.3 Organise multi-sectoral events at the national and regional level bringing together the public sector, private sector and civil society actors to drive improved SRHC and services, particularly for adolescents	
3.2.4 Build and maintain national and regional advocacy coalitions (policy specific taskforces and committees) that help push for improved ASRH	
Outcome 4: Opinion leaders have amplified their voice to position ASRHR on the public agenda	
4.1.1 Participative design of communication campaign	Targeted opinion leaders are interested in engaging in the campaign and push for increased ASRHR, despite the sensitivity of (for example) FP for adolescents.
4.1.2 Disseminate messages, according to different channels	
4.1.3 Organise campaign events around media hooks (regionally coordinated, implemented at national level).	
4.1.4 Monitor and document campaign	
4.2.1 Map existing faith-based approaches to ASRHR	We assume that faith actors have a moral authority and therefore a significant influence on norm setting. Empowered with new insights and positive values faith actors will take actions that challenge existing public opinions towards ASRHR.
4.2.2 Organise workshops for faith organisations to facilitate positive engagement and understanding of ASRHR	
4.2.3 Organise intra- and interfaith dialogues to help improve understanding of ASRHR for faith leaders and their constituencies.	
4.2.4 Develop faith-based advocacy briefs on ASRHR	
Project Management, PMEAL and Communication	
5.1.1 Develop an M&E plan, including carrying out an M&E and (financial) reporting workshops	The design of the PMEAL framework is inclusive, gender-sensitive, focuses on both upwards and downwards ability and therefore is both attractive and easy to allow for participation by target groups and final beneficiaries.
5.1.2 Annual planning, review and exchange workshop to discuss progress made, synergising efforts and south-south learning	
5.1.3 External end-term evaluation of the programme results	
5.1.4 Implementation of M&E tools	