**Theory of Change SRHR portfolio**

1. Problem statement[[1]](#endnote-2):

Protecting sexual and reproductive health and rights (SRHR) are crucial for gender equality and sustainable development. While progress has been made in strengthening SRHR laws over the past decade, opposition and funding shortfalls have hindered advancements. Globally, women, girls, and marginalised groups disproportionately [[2]](#endnote-3)face gender based violence including harmful practices,[[3]](#endnote-4)HIV/STIs, unsafe abortions, and lack of access to information and healthcare. Sub-Saharan Africa has seen the least progress, with SRH issues causing two-thirds of illnesses among women and girls of reproductive age[[4]](#endnote-5), with a rise in teenage pregnacies. Addressing these gaps is essential for social justice and achievement of the sustainable development goals.

1. Overall objectives - What does Norad contribute to?[[5]](#endnote-6)

Norad advances relevant SDG goals and the ICPD PoA[[6]](#endnote-7) through its impact and outcome areas. Our approach is intersectional, rights-based, and aligned with the Guttmacher-Lancet Commission's SRHR definition. Norad’s entry point is that gender equality is a prerequisite to achieving the SDGs and a result of better SRHR.SRHR is therefore vital to progressing other portfolios like health, education, climate, ocean, and food. It is also a critical component in humanitarian and fragile contexts.

Our focus areas are comprehensive sexuality education, safe abortion, and contraception/family planning, often characterised as sensitive issues. Given the need for strong technical expertise, solid outreach to underserved groups nationally, the need to innovate rapidly to changing needs and strong advocacy in the face of continuous opposition to human rights and gender equality, Norad selects its partners strategically.

## Theory of change: How will interventions contribute to goal achievement**?**

Impact is defined as **universal access to comprehensive sexual and reproductive health and rights**.[[7]](#endnote-8) The outcome areas are:

1. Women, girls, adolescents, and young people claim rights to bodily autonomy and drive changes in social and gender norms, together with their families and communities.
2. Health and education systems provide knowledge about and access to comprehensive SRH services
3. Laws and policies ensuring SRHR promoted and adopted by national authorities

A fourth crosscutting outcome area necessary for the realisation of all outcomes is:

1. Supporting normative and operative processes of the UN globally and at country level. The Norwegian Ministry of Foreign Affairs is responsible for normative engagement, while Norad provides technical expertise and advice.

Access to sexual and reproductive health (SRH) services depends on the adoption and implementation of SRH rights. In turn, fulfilling these rights requires comprehensive, affordable, and accessible healthcare for all. The implementation of SRHR[[8]](#endnote-9) requires individuals to assert their rights, civil society to advocate for individuals, and governments to create and maintain enabling environments that respect, protect, and fulfil these rights. Law and policy reforms can improve access to SRH services, highlighting the interlinked nature of these outcomes. Evidence indicates that a combination of strategies positively impacts SRHR. The selected outcome areas align with evidence-based approaches that are recognised in the SRHR ecosystem, including Norad’s partners. These strategies increase universal access to SRHR and include:

1) *Empowering women, girls, and young people to claim their rights to bodily autonomy can drive change in social and gender norms within their families and communities.* When supported by civil society leadership and informed advocacy from local communities, including religious and traditional leaders, men, and boys, social gender norms can shift in favor of SRHR. Such changes can reduce stigma, increase knowledge, foster acceptance, and raise demand for SRH services, particularly among young people.

2) *Health and education systems provide knowledge about and access to comprehensive SRH services ix*. Improving the technical expertise and capacity of health facilities and providers enhances the uptake of SRH services among women, girls, and young people. Factors like age-appropriate, skillful, and sensitive CSE connected to health systems and youth-friendly services also increase uptake. Integrating SRHR into primary healthcare and universal health coverage models[[9]](#endnote-10) improves the provision of comprehensive health services and rights. Additionally, partnerships with the private sector and civil society are crucial for advocacy and service delivery

3) *Authorities promote and adopt laws and policies ensuring SRHR:* Enabling laws and policies, promoted and adopted by duty bearers improves the realisation of comprehensive SRHR. Holding duty bearers accountable requires establishing platforms, mechanisms, and rights-based advocacy, as well as supporting key actors. Collaboration with other sectors, such as education, water, sanitation, food, nutrition, law, and justice, is necessary to address the underlying determinants of SRHR. Sharing knowledge across outcomes, thematic areas, and partners supports the development of effective strategies for access and rights.

Learning and knowledge sharing that supports effective strategies for access and rights is important across the outcomes, thematic areas, and partners. [[10]](#endnote-11)

1. Norads’s thematic priorities[[11]](#endnote-12)

The selected thematic areas for Norad’s portfolio [[12]](#endnote-13) are based on political priorities and where Norway has an added value, a clear voice and commitment and a comparative advantage and aligned [to Norway’s action plan for women’s rights and gender equality](https://www.regjeringen.no/en/dokumenter/a-just-world-is-an-equal-world/id3007548/) .[[13]](#endnote-14) Norad’s added value to SRHR intends to improve access, progress on sexual rights, and mitigate pushback and polarisation. The thematic areas are:

* **Comprehensive Sexuality Education (CSE)**: CSE has received essential support from the Norad-backed CSE partnership forum. Despite robust opposition, there's a need to consolidate and increase support for CSE and its evidence base.
	+ **Comprehensive, safe, and legal abortion:** Access to safe and legal abortion care is crucial for bodily autonomy and saves lives. Norway has consistently protected the right to safe abortion and will continue investing significantly in this area.
	+ **Contraceptives and access to SRH services**: Attitudes and norms significantly impact family planning and contraception use, and high out-of-pocket costs for young people create barriers. Supporting preventive and innovative initiatives for and with young people is therefore a priority.
1. Geographical focus, strategic partnerships, and data

Norad’s SRHR portfolio will primarily[[14]](#endnote-15) focus on low-income countries with high needs, many in Sub-Saharan Africa. While national governments are responsible for health care, SRH is often neglected. Norad will supports actors working with youth and adolescents, marginalised groups, and key populations. We'll partner strategically in priority areas of CSE, safe abortion, and contraception to strengthen human rights. Additionally, Norad will support gender transformative initiatives, work on masculinities and men's and boys' involvement in SRHR, and promote quality, the continuous development of relevant knowledge, including disaggregated data.

End notes

1. Based on suggestions in “SRHR facts and strategies” by Joar Svanemyr /Hera written for Norad May 2022. [↑](#endnote-ref-2)
2. Marginalized groups include LGBTQIA+ persons and persons with disabilities. [↑](#endnote-ref-3)
3. child, early, and forced marriage and female genital mutilation [↑](#endnote-ref-4)
4. “Gender equality, poverty reduction and inclusive growth”, update to the Board presentation that will be used as background material for the discussion at an informal meeting of the Executive Directors of the Bank and IDA and the Boards of Directors of IFC and MIGA. [↑](#endnote-ref-5)
5. These are outside the circle in the figure below [↑](#endnote-ref-6)
6. ICPD POA = International conference on population and development, programme of action [↑](#endnote-ref-7)
7. **Essential sexual and reproductive health services must meet public health and human rights standards, including the “Availability, Accessibility, Acceptability, and Quality” framework of the right to health**.28

The services should include:

	1. accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;
	2. information, counselling, and care related to sexual function and satisfaction;
	3. prevention, detection, and management of sexual and gender-based violence and coercion;
	4. a choice of safe and effective contraceptive methods;
	5. safe and effective antenatal, childbirth, and postnatal care;
	6. safe and effective abortion services and care;
	7. prevention, management, and treatment of infertility;
	8. prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and prevention, detection, and treatment of reproductive cancers.The definition of SRHR reflects an emerging consensus on the services and interventions needed to address the sexual and reproductive health needs of all individuals. Additionally, it addresses issues, such as violence, stigma, and bodily autonomy, which profoundly affect individuals' psychological, emotional, and social wellbeing, and it addresses the needs and rights of previously neglected groups. As such, it offers a universal framework to guide governments, UN agencies, civil society, and others in designing policies, services, and programmes that address all aspects of SRHR effectively and equitably.

  [↑](#endnote-ref-8)
8. This references the Guttmacher-Lancet Commission's definition of SRHR as the basis of Norad’s definition throughout its work. [↑](#endnote-ref-9)
9. PHC= Public health care, UHC= Universal health care [↑](#endnote-ref-10)
10. . The thematic areas of SRHR that are not currently covered in the suggested portfolio are also essential themes for the realization of full bodily autonomy and SRHR and although not chosen by Norad for this portfolio our partners work integrated and cross thematically. [↑](#endnote-ref-11)
11. Partly based on suggestions in “SRHR facts and strategies” by Joar Svanemyr /Hera written for Norad May 2022 and the Hera report on “SRHR Portfolio review” written for Norad , 2021 [↑](#endnote-ref-12)
12. Other thematic areas may be considered at a later stage as experiences and portfolios are established. [↑](#endnote-ref-13)
13. Other thematic areas within SRHR (see the circle in the figure) are also essential for the fulfillment of bodily autonomy and althogu not in focus for this portfolio they are part of the comprehensive work of our partners [↑](#endnote-ref-14)
14. other countries will be included such as Norwegian partner countries and countries that are part of the work of our selected partners. [↑](#endnote-ref-15)