

Reading note Theory of Change Sexual and Reproductive Health and Rights for submissions under the SRHR partnership fund

November 2019

Under the overarching Policy Framework Strengthening Civil Society, the subsidy instrument SRHR Partnership Fund is based on the general Theory of Change Strengthening Civil Society, and follows the same change processes, strategies and underlying assumptions. The Theory of Change in the field of sexual and reproductive health and rights (SRHR) below forms a thematic supplement to and interpretation of this general Theory of Change.

Alliances submitting an application must relate to the working method in the Theory of Change Strengthening Civil Society and give a thematic interpretation based on the Theory of Change SRHR. Civil society organisations play a crucial role in achieving the goals as described in the Theory of Change SRHR. Strengthening the capacity of these organisations and their networks is a prerequisite for – through processes of lobbying and advocacy – achieving structural changes and the universal realisation of SRHR.

The subsidy instrument SRHR Partnership Fund is guiding in the defined options with regard to the country selection and corresponding scores.

Theory of Change Sexual and Reproductive Health and Rights

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Why focus on SRHR?

Sexual and reproductive health and rights (SRHR) are essential for sustainable development because of their links to gender equality and women's wellbeing, their impact on maternal, newborn, child, and adolescent health, and their roles in shaping future economic development and environmental sustainability. Yet, in many parts of the world, sexual and reproductive health and rights (SRHR), are not universally protected, promoted and fulfilled because of weak political commitment, inadequate resources, persistent discrimination against women and girls, and an unwillingness to address issues related to sexuality openly and comprehensively. As a result, almost all of the 4.3 billion people of reproductive age worldwide will have inadequate sexual and reproductive health services over the course of their lives.

The many manifestations of this lack of SRHR include a high number of [unwanted \(teenage\) pregnancies](#), many [unsafe abortions](#), high [maternal mortality and morbidity](#), a continuation of the HIV-epidemic and large groups of girls undergoing [Female Genital Mutulation](#) and/or being [married](#) before [they are 18](#).

The autonomy and empowerment of women are essential, not only for their own health and wellbeing but also for those of their families and communities. Not being able to exercise ones SRHR reduces individuals and families' possibility to steer their own lives and to ensure full development of their own life and the life of their kids. Sexual and reproductive health are, in turn, fundamental for women's full participation in society. People who are ill and women who are frequently pregnant tend to be [less productive and less able to earn a living](#). High population growth rates place an undue stress on both [natural resources](#) and education and health systems. A young but uneducated population with limited economic prospects is also considered a risk for [stability](#). Investing in family planning can contribute to sustainable development and achieving a [demographic dividend](#).

SRHR are human rights. The [right to the highest attainable standard of health](#) includes gender equality in health, and [sexual and reproductive health](#). The essence of reproductive rights is freedom of choice. Human rights are universal, meaning that freedom from discrimination and violence applies to everyone, regardless gender or sexual orientation.

The context

The world has seen progress in SRHR the last two decades, but this progress has been uneven and overall insufficient. Still an estimated 25 million unsafe abortions take place every year. Each year in developing countries, more than 30 million women do not give birth in a health facility, more than 45 million have inadequate or no antenatal care, and over 200 million women want to avoid pregnancy but are not using modern contraceptive methods. In some regions in sub-Saharan Africa, particularly in the Sahel region, the population is still expected to triple.

We learn more and more on how to deliver [information](#) and [services](#) in such a way that gains for the target groups are maximised. [Performance-based financing](#) and other innovative financing mechanisms trigger delivery of services and increased donor alignment optimizes the use if existing funds and infrastructure. Innovative use of technologies such as ICT has opened up new ways of reaching poorly served people with the right information and services at the right time. There is growing recognition that young people, who now form the biggest youth cohort ever, hold the key to sustainable change. And we also learned that involvement of men in needed to advance the agenda on SRHR.

Despite all these promising developments, there continue to be serious bottlenecks:

- an increasingly vocal conservative opposition against core aspects of SRHR and subsequent politicisation of the topic, for instance with the re-instalment of the so-called Global Gag-rule,
- weak and fragmented health systems suffering from outbreaks such as Ebola or humanitarian crisis,

- insufficient investments by [governments](#), as SRHR is not a priority,
- insufficient and often fragmented financing by [donors](#),
- and reluctance in practice to take young people's needs seriously and cater to those needs.

Another bottleneck is that despite the fact that 50% of the new HIV infections are amongst key populations, continued criminalisation and stigmatisation of these groups (HIV+, sex workers, LGBTI, people who inject drugs) reduces their access to much needed services and care. Moreover, in 2020 70% of the people living with HIV will be living in middle income countries. These countries will receive less donor support but it is not certain that they will invest more in the health in general, let alone in the health needs of these specific groups.

Our mission and objectives

Our mission is to promote the **universal fulfillment of Sexual and Reproductive Health and Rights** and thus contribute to lower maternal and child mortality (SDG3.1 and 3.2), stopping the AIDS epidemic (SDG3.3) universal access to sexual and reproductive health (SDG3.7) and universal access to reproductive health and rights (SDG5.6). All actions should contribute to the overall SDG goals of ensuring healthy lives and promoting the well-being for all at all ages (SDG3) and achieving gender equality and empowerment of all women and girls (SDG5). The Ministry of Foreign Affairs (MFA) has identified four interrelated objectives that it considers necessary to achieve this goal.

1. There is a need for **greater freedom of choice for young people** about their sexuality. Information and education, including sexuality education, for both boys and girls, providing menstrual hygiene services at school, and promote meaningful youth participation in decision making are key to create a positive and supportive environment for sexuality, health and family planning.
2. There is a need to **increase demand and provision of acceptable and affordable reproductive health commodities** (including medicines) for women, young people, and key populations. To better address the specific needs of these groups, and ensure that products reach the last mile, innovation is needed.
3. **Reproductive and sexual healthcare and services should be available for all, including for women and men in crisis or in humanitarian situations, and should be of good quality.** Services should be comprehensive and include the provision of safe abortion and mental health and psychosocial support. HIV services should be available for all people at risk, regardless their sexual identity, gender or profession. Good quality care can only be achieved and sustained in post-aid situations if set up as part of a national health system, that provides opportunities for the private sector as well.
4. Finally, **retaining and strengthening sexual and reproductive rights, and ensuring compliance with these rights** is needed, also as prerequisite to achieve all these objectives. This includes fighting sexual harassment, gender based violence, child marriages and other discriminating and criminal practices

All of these objectives are part of the overall strategy of the MoFA to invest in prevention and to give people opportunities in order to avoid or mitigate conflict, poverty, inequality, climate change and irregular migration.

Assumptions

The following section describes the assumptions underlying these objectives and result areas.

Result area 1: Greater freedom of choice for young people about their sexuality

Young people face disproportionately large obstacles when it comes to their [SRHR](#). With the biggest cohort of young people ever, SRHR for all cannot be achieved without taking the needs and aspirations of young people seriously and without informing them on their possibilities and available choices. If young people are better informed about their options, and if this translates to change in attitude and behaviour, they may be better equipped to make healthy choices. If, at the same time services are provided that addresses specific needs, the number of unwanted pregnancies, the number of (unsafe) abortions and the number of STI's, including HIV, and maternal mortality will decline. This will also contribute to gender equality, justice and generational equality on the longer run.

In terms of achieving this outcome, we assume that:

- Adolescents and young people can only make healthy choices if they have (a) easy access to accurate information about sexuality that is in line with their needs and circumstances (b) are able to translate this to changes in attitude and behaviour, (c) have full access to SRH/HIV commodities and services with which they

can prevent unwanted pregnancies and STI's (results area 2) and (d) live in an enabling environment without legal barriers (e.g. age of consent) or implementation barriers (facilities, staff attitudes, availability of appropriate commodities)

- Good comprehensive sexuality education, also targeted at boys, will contribute to relations that are more respectful and thus reduce sexual violence.
- If young people are more involved in policy- and decision-making, as part of a more democratic system, their needs are more likely to be met. In addition, cultural (including religious) norms influence the extent to which young people's needs are taken seriously, but can be influenced through dialogue with opinion leaders.

Result area 2: Improved access to contraceptives and medicines

Sufficient access to the necessary products and commodities such as vaccines, contraception and medication, as well as an enabling environment to use these products, is a necessary condition for people, including young people mentioned in result area 1, to support their sexual and reproductive health. Availability and accessibility are determined by a host of factors: R&D and production of the right commodities, supply chain management, health financing systems (affordability, insurance), and priority given by government to SRH/HIV commodities. But it is also determined by quality of service delivery and demand side issues, such as legal issues, social, cultural and religious norms, stigma and discrimination (HIV, abortion.)

In terms of achieving this outcome, we assume that:

- People's needs vary according to age and their situation in life.
- Providing uninterrupted availability and accessibility of an appropriate mix of fit-for-purpose commodities (e.g. paediatric ART, condoms, emergency contraception etc.), are a prerequisite for achieving the outcome.
- Given existing limitations in availability and accessibility, innovation is still needed to ensure that the right products reach the right people, at the right time and for the right price.
- By addressing issues that hinder the demand for commodities (legal issues, social, cultural and religious norms, stigma and discrimination associated with e.g. HIV and abortion), the uptake of these commodities will increase.

Result area 3: Better quality public and private health care for SRH, including safe abortions

To fulfill SRH, quality service delivery of the full range of SRH/HIV services is needed. As SRH is part of the concept of Universal Health Coverage, the availability of services depend on a well-functioning health system.

In terms of achieving this outcome, we assume that:

- Prevention (including vaccination) and health promotion are cost-effective ways to increase SRH and should therefor always be part of health care systems.
- Quality SRHR address all [key aspects](#) of the right to the highest attainable standard of health
- In good health systems, governments spend sufficient domestic funding on public goods and play their role in standard setting, certification and quality control. Service delivery can best be organised in a context-appropriate mix of private and public providers, including CSOs, to make optimal use of local capacities.
- SRH care, including safe abortions, HIV/AIDS care and MHPSS is more efficient and effective when delivered as part of integrated service delivery ('continuum of care') that is attuned to the needs of diverse population groups. Key target groups and their needs are generally less well represented in national system. Inadequate attention to the needs of key target groups lead to critical service gaps and thus poorer results.
- In fragile contexts, including humanitarian emergencies, SRH services are largely insufficient. Moreover, people in humanitarian settings often suffer of a combination of physical and mental health issues. In order to improve mental health, resilience and prospects of people living in these settings, therefor the provision of life saving SRH services in those setting is a priority and should include psychosocial care.
- Politicization of SRHR as well as existing cultural barriers against elements of the SRHR agenda (e.g. abortion, adolescent sexual health), hamper effective integration of sexual and reproductive health services.
- End users are often insufficiently empowered to demand good quality services. Strengthening accountability has a positive impact on quality of service delivery and will contribute to a sustainable and resilient health care system that meets the demands of the users

Result area 4: More respect for the sexual and reproductive rights of groups who are currently denied these rights.

The universality of human rights necessitates a focus on specific groups that are facing extra challenges, be they (unmarried) young people, child brides, women who have abortions, injecting drug users, sex workers or LGBTIQ. There is significant and organised opposition against strengthening the rights of these groups. The denial of their SRHR however, has a disproportionately large effect on their health and the overall SDGs.

In terms of achieving this outcome, we assume that:

- A strong voice of civil society in the global South can increase accountability of government vis-à-vis their citizens.
- By supporting and empowering communities and networks of so-called key populations, they can effectively advocate for de-stigmatisation, de-criminalisation, and better service delivery.
- Organized opposition against sexual rights can be best countered by strengthening existing coalitions and networks, such as *She Decides*, as the impact of one individual donor is limited. Moreover, by linking global discussions to local realities, sexual rights can be better contextualized, making the case for change more convincing.
- Joint (and joined-up) investments by all stakeholders in ending child marriage, or fighting infringement of other sexual and reproductive rights, can propel a movement and create a multiplier effect.

Our approach to achieve the four objectives

SRHR is a complex and often-contentious issue, affected by many factors and actors at local, national, regional and international levels. Within that complex arena, MFA uses its political, human and financial capital in The Hague as well as its embassies and plays a number of different roles that we feel are all needed to contribute to solving the problems mentioned above. With our expertise, network, political capital, skills and available capital we can have added value as:

1. Funder
2. Partnership developer
3. Influencer and diplomat
4. Broker

Funder and partnership developer:

The Hague and embassies finance programs and form (strategic) partnerships with:

- Multilateral organizations and funds, including the Global Fund for Aids TB and Malaria, the Global Alliance for Vaccines, the World Health Organization, Global Financing Facility, UNAIDS and UNFPA. We have found evidence that because of their size (economies of scale), (geographic) reach and governance (participation and role of different constituencies) they can achieve results in a way that NL as an individual donor cannot. We also assume that we can exert enough influence on the course of these organizations and programs through our (indirect) membership in boards. The other types of programs mentioned here often generate the 'ammunition' for influence. Multilateral programmes should be complimentary and their work should always be put in the context of the overall goal to strengthening national sustainable and resilient health systems
- International and Dutch NGOs. We assume that NGOs can contribute to change in a way that government and international organizations cannot. They have a special role to play in innovation (developing new partnerships, interventions, methods), organizing and demanding accountability, advocacy, dialogue with opinion leaders, capacity building of and networking with local civil society organizations and reaching groups that are more difficult to reach. Therefore, strengthening civil society is a key objective.
- Target groups of the Dutch policies. We assume that involvement of the people whose rights and health we aim to strengthen is paramount to success of the efforts to do so. By empowering them directly or through civil society organizations, and by ensuring that national authorities, multilateral organizations and other stakeholders involve them in their policy development and implementation, these policies will become more effective.
- Knowledge institutes, private sector and networks. We believe that a solid evidence base can galvanize action. The impact of interventions can be greatly enhanced if they are based on or accompanied by operational research. We further assume that government funding plays an essential role in steering the R&D agenda in favor of accessibility and affordability of commodities that are important in low resource settings.

Influencer and Diplomat: MFA staff in The Hague, New York, Geneva and embassies are engaged in SRHR-diplomacy. We work on strengthening the international consensus (follow up of SDGs, resolutions in various councils and commissions) and the international human rights framework. We assume that progressive international agreements have the potential to set new standards and catalyze actions towards the fulfilment of SRHR. Being aware that the positions in international negotiations are not always convergent with the reality at country level, we assume that effectively linking advocacy efforts at these various levels, in close collaboration with civil society, is necessary to achieve progress. We further assume that if we reach out to non-likeminded countries in order to find common ground, we can achieve more progress than if we stay within like-minded groups.

Broker: We work on the above four result areas in several partner countries¹ and regional programs in partnership with governments, NGO's, multilateral organizations, opinion leaders, private sector and public-private partnerships. Over the coming years, further focus will be put on countries in West Africa and the Horn of Africa². The underlying assumption is that our presence at country level in a number of countries is necessary for generating impact in those countries. With our presence, we can influence the position of those countries vis-à-vis SRHR at national, regional and international level and provide feedback on the performance of international organizations and funds in the field. Finally, local presence can provide partners with experience and insights on (lack of) effects of work undertaken (evidence base and reality check).

Many stakeholders involved

To be able to fulfill these above-mentioned roles, we closely cooperate with, target or reach a number of stakeholders such as the ones mentioned below. Their different roles are summed here as well.

- *Governments (national and local) such as* policy makers, funders and implementers: quality control vis-à-vis private providers; negotiators in regional and international fora; duty to respect, protect and fulfil citizens' human rights.
- *Parliaments:* responsible for making laws and allocating budgets.
- *Judiciary and law enforcers:* interpreting law; meeting out justice; upholding the law.
- *Opinion leaders, including religious leaders (local and international):* media voices, prominent citizens (incl. first ladies) and religious leaders influence public opinion and social and cultural norms.
- *Southern civil society organizations (including community based organizations, local and national NGO's, networks):* 'ear on the ground, voice of the people', demanding accountability, advocating for improved policy and implementation – based on needs of people, innovation, litigation.
- *Faith-based organizations:* strong role in service delivery in many countries in the South, instrumental in facilitating or denying universal access to SRH.
- *Private sector:* Responsible for healthy workforce; R&D, production and delivery of commodities (medicines and equipment) and services (ICT); for-profit service delivery; CSR.
- *Regional organizations* such as AU, EU, OAS, regional UN commissions: involved in standard setting through negotiating, issuing and monitoring commitments. Can be powerful platforms for creating progressive consensus.
- *International networks of People living with HIV (PLHIV), networks of sex workers, people who inject drugs and sexual minorities*
- *UN and multilateral organizations, WB:* forum for forming international consensus in the form of hard and soft international human rights laws, standard-setting vis-à-vis concrete issues (e.g. [abortion guidelines](#), [CSE guidelines](#)), financing or implementation of programmes, knowledge function, lobby.
- *Global funds, programmes and partnerships:* design and implementation of programmes, with a varying range of specificity (vertical and more integrated programmes).
- *International NGO's:* innovation, accountability, service delivery, lobby and advocacy.
- *Academia and research organizations, also within UN organizations:* building the evidence base.
- *Non-governmental donors:* financing development initiatives; influencing discourse about development.

¹ Bangladesh, Yemen, Ethiopia, Mozambique, Burundi, Mali, Benin, Ghana; the Southern Africa Regional AIDS program, the Great Lakes regional program and the West Africa program

² Including Burkina Faso, Niger and Uganda

Focus on maximizing impact

Finally, we can maximize our impact if we

- Capitalize on its specific **added value**. We have a strong domestic track record in different SRHR areas as well as HIV prevention and harm reduction. We are considered an effective broker and bridge-builder between different constituencies, we are prepared to raise sensitive issues in national and international discussions and have a reputation as a flexible and reliable donor partner with significant resources at its disposal.
- **Interface** between programs, both within the SRHR program and with other MFA priorities such as programmes on WASH, nutrition, gender, governance and financing.
- **align** to national priorities and domestic investments, contributing to sustainable and resilient (domestic) health systems
- our investments of political, human and financial capital are well attuned and **complementary** to one another.