Norwegian Ministry
of Foreign Affairs

Guideline

Norwegian guidelines for sexual and reproductive health and rights

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1. SRHR – what it is and why it matters

What it is[1]

Reproductive health, reproductive rights, sexual health and sexual rights are closely intertwined. Viewed together, **sexual and reproductive health and rights (SRHR)** involve having the information and access to services needed to make informed choices about sexuality and reproduction, free of discrimination, coercion and violence.

Reproductive health:
- safe pregnancy and childbirth;
- safe, effective and affordable methods of contraception;
- safe abortion and post-abortion care;
- menstrual hygiene management;
- illnesses or disorders related to the reproductive systems, e.g. infertility.
- prevention and treatment of sexually transmitted infections (STIs), e.g. HIV and hepatitis.

Reproductive rights:
- access to information about reproduction and contraception;
- the right to make decisions about reproduction free of coercion, discrimination, and violence.

Sexual health entails a positive and respectful approach to sexuality and sexual relationships, including:
- safe sexual experiences without coercion, discrimination, or violence;
- respect for the sexual rights of all persons.

Sexual rights include the rights of all persons to:
- choose whether to be sexually active and engage in consensual sexual relations with a partner of their choice;
- choose whether, when and with whom to enter into marriage, with free and full consent;
- make free, informed, and voluntary decisions about their sexuality, sexual orientation and gender identity;
- have access to comprehensive, evidence-based sexuality education;
- have access to sexuality health care;
- have one's bodily autonomy respected.

Why it matters

Health and survival	Promoting and protecting sexual and reproductive health and rights is essential for achieving gender equality and preventing unnecessary death and suffering. It is a precondition for sustainable development and a key element in the global fight against extreme poverty. SRHR plays a crucial part in safeguarding individual rights, health and survival – and for promoting societal progress with economic development and social justice.
Human rights	
Sustainable development	The attack on girls' and women's rights to decide over their own body is often part of a broader attack on liberal values and free democracies. Protecting girls and women's rights, including SRHR, is important in itself, but also as part of the protection of our fundamental values more broadly.

50 % of all pregnancies are unintended. Of these, 60 % end in abortion. 45 % of all abortions are unsafe[2]

Only 57% of women are able to make their own decisions over their sexual and reproductive health[3]

For more reading, see the list of resources and key documents in Section 8. It provides links to treaties such as CEDAW, the Maputo, Protocol SDG monitoring data, statistics, regional SRHR agreements and more.

2. International normative framework

SRHR is grounded in the international human rights framework, starting with the Universal Declaration of Human Rights and elaborated in the International Covenant on Civil and Political Rights (which sets out the right to life), the International Covenant on Economic, Social and Cultural Rights (which sets out the right to the highest attainable standard of health) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Two UN conferences held in the 1990s, the International Conference on Population and Development in Cairo 1994 (ICPD) and the World Conference on Women in Beijing 1995, led to consensus on elements of sexual and reproductive health, and the labelling of relevant, already existing human rights as reproductive rights (RR), and laid the foundation for SRHR commitments and targets for years to come.

CEDAW affirms the reproductive rights of women.

CEDAW recognises the need to influence discriminatory norms, traditions and cultural expectations that shape gender roles.

CEDAW is ratified by 189 countries, making it legally binding for almost all countries Norway cooperates with.

While there is still no global consensus on the definition of the term ‘sexual rights’, the term is being used increasingly, including by Norway and like-minded countries.

More recently, the Sustainable Development Goals (SDGs) have been adopted as a universal call to action for social, economic, and environmental sustainability for all people by 2030. Sexual and reproductive health and reproductive rights are central parts of the SDGs, by referring to ICPD 1994 and Beijing 1995 and with multiple direct and indirect targets and references to gender equality, women’s empowerment and SRHR. In addition, other SDGs support the achievement of SRHR targets; for example, improving education in a population group is linked to higher SRHR status.

SRHR in the Sustainable Development Goals

- **SDG 3 Good Health and Well-being** contains targets on maternal health, newborn health, HIV, universal access to family planning information and services and universal health coverage without financial hardship
- **SDG 5 Gender Equality** contains targets to eliminate gender-based violence and harmful practices and to provide reproductive health and rights services
- Other SDGs contain targets that will help to close SRHR gaps, e.g. access to quality education **(SDG 4)** and women’s full participation in political life, public spheres and decision making bodies **(SDGs 5, 16, 17)**

The SDGs are a useful tool for measuring progress and holding governments to account. Governments across the world are allocating resources to meet the SDGs by 2030.

3. Norwegian policy and priorities

Norway promotes universal access to SRHR for all, including girls, LGBTIQ+ persons and marginalised groups. Both SRHR and gender equality are given high priority in Norway's foreign and development policy. See also related action plans on women's rights and gender equality, and on women, peace and security.

Norway is a committed SRHR champion globally, pushing to accelerate progress on SRHR while at the same time seeking to protect the results achieved so far.

- ***At the global level***, Norway works to consolidate support for and further strengthen the international normative framework for SRHR. Much of these efforts take place in the international arenas where SRHR norms and targets are shaped and decided – e.g. UN fora, SDG mechanisms and other high-level global forums. Alliance building, support to strategic actors and partnerships with governments as well as multilateral and civil society organisations are all crucial elements of this advocacy work.
- ***At the country level***, Norway works to promote access to relevant health services for all citizens, as well as respect for their sexual and reproductive rights. Bilateral dialogues with relevant actors, including the government as well as support to multilateral- and civil society organisations are central in these efforts. Bilateral engagement is also important to build key alliances necessary to protect and reinforce the international normative framework.

"Norway commits to protect and promote universal access to sexual and reproductive health and rights for all – including girls, youth, and marginalised groups, both politically and financially. [...] Norway will stand firm and defend established norms and universal rights. Norway commits to strengthen access to sexual and reproductive health services for the affected population in humanitarian response."

Excerpt from Norway's pledge at the Nairobi Summit 2019 (25th anniversary of ICPD Cairo). Norway reiterated its commitment at the Generation Equality Forum in Paris in July 2022.

Within this strong commitment to **protect and promote SRHR for all, including girls, youth, LGBTIQ+ persons and marginalised groups**, the Norwegian Government has pledged to work specifically for:

- **Everyone's right to decide over their own body**
  The right to decide over one's own body is essential to enabling people to live their lives in freedom and dignity. Norway will build new alliances and increase support for family planning, contraceptives, and safe abortion to safeguard this right. The role of men and boys is important in our efforts to promote gender equality and women's rights. This must not be overlooked.

- **Equality and non-discrimination in access to health services**
  Norway works to strengthen equality and non-discrimination in access to health services, with a focus on those left furthest behind, such as women, girls and young people living in extreme poverty or in rural areas, affected populations in humanitarian settings, LGBTIQ+ persons, people with disabilities, and other marginalised groups.
- **Elimination of gender-based violence and harmful practices**
  Gender-based violence and harmful practices are a violation of human rights and affects the health of women and girls and people of all genders and identities. It limits theiropportunities to pursue education, seek employment and participate in political life. Norway works to increase the opportunities available to women and girls to promote their right to self-determination, further their empowerment and eliminate gender-based violence in all its forms.

4. Opposition to SRHR

In recent years, we have seen a political backlash against women's rights in general, and sexual and reproductive health and rights in particular, including the rights of LGBTIQ+ persons. This makes SRHR a battleground where human rights agendas clash with deeply entrenched cultural beliefs, values, and traditions.

The controversies often revolve around:

- comprehensive sexuality education;
- SRH services for adolescents;
- reproductive rights, especially the rights of women and girls to make decisions over their own bodies and to have access to safe abortion;
- sexual and gender-based violence;
- contraception and HIV;
- sexual rights, including rights for people with diverse sexual orientations, gender identities and gender expressions.

Opposition to SRHR can be linked to various factors:

- Tradition, culture, or religion – such as the belief that SRHR undermines national religious or cultural values.
- Restrictive legislation, such as laws that require women or adolescents to have the consent of male family members to access health services, or laws that criminalise same-sex sexual relationships.
- Lack of political priority – lack of action in implementing policy changes or allocating sufficient resources for SRHR implementation, despite having made commitments to do so.

In international negotiations, socially conservative countries or groups may also use religious or cultural arguments to stop or even reverse SRHR progress. Sexual rights, which are understood to include rights for LGBTIQ+ people, comprehensive sexuality education and reproductive rights related to safe abortion, are particularly controversial and often get excluded from global consensus policies.

5. Arguments in support of SRHR

Key arguments in support of SRHR:

- **Bodily autonomy:** The right to make decisions about one's own body, sexuality and reproduction is essential to enabling people to live their lives in freedom and dignity.
- **Equality and inclusion:** Equal access, equal opportunities and non-discrimination are also universal human rights for everyone, regardless of age, gender, sexual orientation, socio-economic status, marital status or other factors.
- **Better, healthier lives:** Strengthening access to SRH services prevents unnecessary suffering and death caused by pregnancy, childbirth, unsafe abortions, and sexually transmitted infections.
- **Cost-saving:** Access to contraceptives reduces both unintended pregnancies and STIs, thus decreasing the expenditures needed for maternal, newborn and abortion care. The benefits of investing in SRHR by far exceed the costs.
- **Resilience and future generations:** Access to SRHR helps women and girls obtain an education and engage in paid employment, improving income and resilience for the entire household. This starts a positive spiral of multigenerational gains.
- **Economic progress and sustainable development:** A healthier population and greater empowerment of women and marginalised groups promotes economic growth and yields other benefits for society, helping to achieve other development goals – including climate change adaptation.

Investing in SRHR in low- and middle-income countries makes economic sense

Key figures for SRHR investments:[4]

- **USD 10.60 per capita annually:** The cost of covering all women's needs for contraceptives, pregnancy-related and newborn care, and STI treatment. This is USD 4.80 per capita more than the current level of spending.
- **Covering contraceptives needs is a net saving:** One additional dollar spent on meeting the unmet need for modern contraceptives saves nearly three dollars on pregnancy-related and newborn care.
- **Expanding access to contraceptives and safe abortion can decrease abortion costs by 78 %:** Total abortion care costs would decrease from the current USD 2.8 billion to USD 1.5 billion annually, and decrease further to USD 0.6 billion per year if safe abortion were made available.
- **Up to 9 times return on investment in GDP growth and other benefits:** A study in 74 low- and middle-income countries has shown that an additional investment of just USD 5 per capita per year in SRHR will generate social and economic benefits up to 9 times that amount, including higher productivity and GDP growth.
- **Multigenerational benefits:** Family planning programmes in low-resource areas are associated with fewer, but healthier and better educated children, together with improvements in women's health, earnings and paid employment.

Can financial investments alone solve SRHR gaps? No. Gender inequality, restrictive legislation and norms that give rise to stigma, discrimination and exclusion also reduce people's access to SRHR services despite investments. Efforts to improve SRHR are therefore often closely linked to efforts in other policy areas, such as education and the justice system, alongside health sector investments.

6. What can embassies do to promote SRHR?

Embassies have a range of tools and modalities for promoting and protecting SRHR for all:

- **Mapping of SRHR context and actors.** Mapping of the national SRHR context and actors builds on an understanding of relevant legislation, implementation gaps, the political landscape, media, and public discourse on women's rights, harmful practices, gender-based violence, abortion, LGBTIQ+, SRH in universal health coverage and the situation of human rights defenders working on these issues. Civil society organisations can often provide evidence and contacts. See list in Section 8.
- **Dialogue – bilateral and multilateral.** Promoting and protecting SRHR should be included in embassies' diplomatic dialogues. Dialogue can take place both with national government counterparts and with multilateral partners, such as the World Bank and United Nations entities. Multilateral processes – e.g. Universal Periodic Review of the UN Human Rights Council and reviews of compliance with CEDAW treaty obligations – may be useful sources of information in this regard. References to regional treaties like the African Union Maputo Protocol may also be utilized.
- **Direct support and financing.** Embassies can directly support initiatives that promote SRHR programmes within the country. This could mean financial or technical support to national institutions, and multilateral or civil society organisations. Financial support should be marked with 'OECD DAC 130' in PTA. Embassies may also consider providing support for key actors' participation in the celebration of international days.
- **Strengthening the enabling environment for SRHR.** Exerting evidence-based influence on the wider political landscape and key actors, often men, may also help to strengthen the enabling environment for SRHR, by for instance engaging with parliamentarians and governments on the shaping of policies; alliance building and cooperation with national civil society organisations or other actors with shared interests in promoting and protecting SRHR; enabling participation of under-served and marginalised groups in SRHR engagements.
- **Social media awareness raising.** Embassy websites and social media platforms offer good opportunities for sharing facts, evidence, Norwegian positions, as well as SRHR progress and gaps, with content adapted to the context.

- **Support for individual cases and human rights defenders:** In countries where key elements of SRHR are criminalised, support can be provided for individual cases and human rights defenders where this is viewed as constructive. Relevant cases could be arrest of sexual violence survivors, of women who have had illegal abortions, of people living with HIV or of LGBTIQ+ persons. Embassies can align their reactions with like-minded countries and consider actions such as presence at trials, formal protests to authorities or statements of support, often in consultation with national civil society organisations. It may also be relevant to provide support to organisations working to strengthen the protective environment for at-risk groups.

- **SRHR as central in health sector reforms:** Inclusion of a comprehensive SRH service package is a priority for Norway in efforts to encourage changes in the national health sector at country and local level, e.g. development of essential health benefit packages or progression towards universal health coverage. SRH services are often insufficiently prioritised or financed in national systems, and/or initial reforms do not adequately address critical SRHR gaps. Embassies may consider mapping available health system resources and analysing SRHR needs across all population groups to shed light on inequities and gaps. Mobilising stakeholders to help shape reform discourse, identify financing priorities, and design resource mobilisation strategies may also be constructive.

- **SRHR across policy arenas.** SRHR lens has relevance across most, if not all, policy arenas, and can more often be included in various dialogues with authorities and relevant institutions, for instance incorporating comprehensive sexuality education in education policies, setting gender-sensitive occupational health and safety measures in labour standards, countering indifference to hate crimes in police or justice systems, and national adaptation plan (NAP) processes that recognise the link from realisation of SRHR to climate change resilience.

Selected international days

- January 24 International Education Day
- February 6 International Day of Zero Tolerance for Female Genital Mutilation
- March 8 Women's Day
- April 7 World Health Day
- May 17 International Day Against Homophobia, Biphobia and Transphobia (IDAHOT)
- May 28 World Menstrual Hygiene Day
- July 11 World Population Day
- June 22 World Refugee Day
- August 12 International Youth Day
- September 4 World Sexual Health Day
- September 26 World Contraception Day
- September 28 Safe Abortion Day
- October 11 Girl Child Day
- November 25 Elimination of Violence Against Women Day
- December 1 World AIDS Day
- December 10 Human Rights Day

- **Specific attention to crisis and conflict situations:** During a crisis (whether a pandemic, a severe downturn, natural disaster, displacement or armed conflict), SRHR is often not prioritised and there is an increased risk of sexual and gender-based violence. Contraceptives become less available, and access to lifesaving maternal health care is limited. The physical and mental trauma caused by sexual and gender-based violence, and lack of access to SRHR services, often has lifelong consequences for women, girls, and marginalised groups. Sufficient resource allocation to SRHR is therefore critical and a gender equality priority (see thematic areas for more information).

7. SRHR thematic areas

Maternal health

Access to quality maternal health care is critical to ensure a healthy pregnancy and reduce adverse outcomes of childbirth. Globally maternal health coverage has improved considerably over the last 2–3 decades and maternal death rates have declined in most parts of the world.

800 women die every day from preventable causes related to pregnancy and childbirth. This is about one woman every two minutes.[5]

However, inequalities persist both between and within countries. Women and girls in rural areas or in conflict-affected areas remain at much higher risk, often due to lack of access to health services. At the current rate of progress, the SDG targets for maternal and newborn deaths are unlikely to be reached by 2030. In addition, maternal morbidity – i.e. diseases or injuries resulting from pregnancy, childbirth or abortion – affects the resilience and vulnerability to poverty of the entire household.

Contraception

***275 million women** who want to avoid pregnancy are not using a safe contraceptive method*[6]

***121 million** unintended pregnancies occur every year*[7]

Modern contraceptives allow women, girls and their partners to decide the number, spacing and timing of children, and some also prevent transmission of STIs. Having access to these contraceptives is both a public health issue and a human rights issue.

Access to affordable contraceptive methods is often not available. The need for information and freedom to make a choice may not be met. Violence, poverty and misconceptions contribute to unintended pregnancies and STIs, as do power imbalances and gender inequality in sexual relationships.

Safe abortion

Access to safe abortion involves not only the availability of a safe medical intervention to terminate pregnancy and/or post-abortion care, but also access to legal and financial resources, without risking criminal, legal or social sanctions. Having such access is fundamental to the ability of women or girls experiencing an unwanted pregnancy to exercise bodily autonomy.

***45% of** all abortions globally are unsafe*[8]

Many countries have highly restrictive abortion laws. This drives women and girls towards unsafe abortions, which is one of the leading causes of maternal death and morbidity. Even in countries that have formally liberalised abortion laws, women and girls may still be prevented from accessing abortions due to lack of investment, unavailability and stigma. Restrictive abortion laws are not associated with lower rates of abortion.

Sexual and gender-based violence

__1 in 3__ women experience sexual or physical violence in their lifetime[9]

GBV was termed __'the shadow pandemic'__ by the UN Secretary-General during COVID-19[10]

Gender-based violence (GBV) is a harmful act towards an individual based on their gender. Sexual violence, such as rape, sexual abuse and sexual harassment, is a significant aspect of GBV together with physical violence and psychological violence. Women and girls are disproportionately affected by GBV. Men and boys may also be subjected to GBV, especially if they are non-conforming in gender identities, gender expressions or sexual orientation.

GBV is rooted in negative gender norms and gendered social discrimination. It takes place in every country and context, although the threat of GBV is higher in contexts where violence is normalised and gender inequality is high. GBV is known to be underreported, with survivors being doubly affected by stigma and insufficient access to services and support systems.

People affected by humanitarian crises are at high risk of sexual and gender-based violence. In many conflicts, sexual violence and abuse is used as a method of warfare. Strengthening prevention, response and accountability for SGBV is a priority in Norway's humanitarian policy and operational partnerships.

Child, early and forced marriage

Almost 1/3 of women in developing countries had their first baby while they were still in their teens

__15 times faster__ rate of progress is needed to reach this SDG target by 2030[11]

Child marriage refers to any form of marriage or informal union between a child under the age of 18 and an adult or another child. Child, early and forced marriage is a form of gender-based violence and a human rights violation that deprives those involved of choice and autonomy over their lives and bodies. It mainly affects girls and young women who are forced to marry against their will or without their consent. Boys and young men are also subjected to child, early and forced marriage but this is much less common.

Child, early and forced marriage are associated with poverty, weak enforcement of legislation, social and traditional norms, and perceptions that girls and young women will be 'protected' by marriage. The prevalence of girl brides increases in times of crises. For adolescent girls and young women, marriage often leads to adolescent pregnancy, education dropout or exclusion, higher risk of HIV, and a greater lifelong risk of extreme poverty and intimate partner violence.

Female genital mutilation

***200 million** girls and women have been subjected to FGM*[12]

*Girls whose mothers have a primary education are **40% less likely** to be cut compared to those whose mothers have no education*[13]

Female genital mutilation (FGM) is an extreme human rights violation undertaken i.e. to curb sexual desire in women and girls, and secure possibilities of marriage. Over 200 million women and girls alive today have been cut, and numbers of FGM is increasing, a reflection of global population growth. It is typically practised on girls younger than 15 years of age and is associated with poverty and rigid sociocultural gender norms.

This harmful practice causes immediate life-threatening health risks from haemorrhages and infections, but also carries lifelong serious health consequences: increased risk of death and serious complications during child birth, severe pain, chronic urinary problems, and complications for mental and sexual well-being. The SDG target of eliminating the practice by 2030 is unlikely to be met due to uneven progress and insufficient rate of change.

LGBTIQ+

LGBTIQ+ encompasses a wide range of diverse sexual orientations, gender identities, gender expressions and sex characteristics, including lesbian, gay, bisexual, trans, intersex and queer persons.
Sociocultural norms often cause stigmatisation and discrimination of LGBTIQ+ persons, and engaging in same-sex relationships is still criminalised in many countries. This undermines the fundamental rights of LGBTIQ+ persons and often prevents access to SRHR. LGBTIQ+ includes many sub-groups that have different SRH needs.

Human rights apply to everyone regardless of their sexual orientation, gender identity, gender expression or sex characteristics.

*There is little official data on homophobic and transphobic violence, but it is known to be **widespread and brutal, and often committed with impunity***[14]

This general application is important, especially in socially conservative contexts where perceptions of 'gay rights' may dominate – there is no such thing as 'gay rights' or 'trans rights', only human rights that apply to everyone.

Comprehensive sexuality education

*In sub-Saharan Africa, **6 of 7 adolescents** aged 15–19 who are newly infected with HIV are girls*[15]

***Two out of three girls** in some countries have no idea of what is happening to them when they begin menstruating.*[16]

Comprehensive sexuality education (CSE) is accurate, evidence-based and age-appropriate teaching and learning about sexuality, reproduction, gender equality and rights. It aims to equip children and young people to make informed decisions about reproduction, sexuality and relationships. CSE can be delivered in schools or in non-formal, out-of-school settings. In many countries, CSE is under-resourced and insufficiently delivered, even when included in official policies. As a result, many children and adolescents do not have access to accurate information on sexual and reproductive health and rights and are unable to develop the necessary knowledge, attitudes, and values to make informed decisions about their lives. Opponents claim that CSE encourages sexual activity among children and youth, although evidence shows this is not the case.[17]

When delivered correctly, CSE is known to make sexual behaviours safer, resulting in a reduction of unintended pregnancies and STIs and HIV. It also plays a role in transforming rigid gender norms and addressing root causes of GBV. This is relevant in digital spaces as well, where women and girls are disproportionately affected by online grooming, cyberbullying, and exploitation.

HIV and STIs

Sexually transmitted infections (STIs) have an impact on sexual and reproductive health worldwide. Condoms are one of the most effective methods of protection against STIs, including HIV and cervical cancer. Much progress has been made in reducing HIV transmission and providing treatment. HIV and other STIs still remain a public health risk across the world, often compounded by policy and legal barriers that prevent people from accessing sexual and reproductive health and HIV services. Specific population groups are disproportionately affected by HIV, such as sex workers, men who have sex with men, transgender persons, prisoners, people who inject drugs, and adolescent girls and young women in sub-Saharan Africa.

***Half** of all new HIV infections are in sub-Saharan Africa1*[18]

***Every week 4 900 young women and girls** become infected with HIV*[19]

SRHR in humanitarian contexts and crisis

60% of preventable maternal deaths take place in areas of conflict, displacement or disaster[20]

Even though SRHR needs are critical in humanitarian emergencies and crises, health systems resources are often diverted away from sexual and reproductive health services. Access to maternal health services including abortion services, contraceptives, HIV prevention and medication, comprehensive sexuality education and services for GBV survivors is reduced. This has a severe impact on women, girls, marginalised groups and their communities, and feeds a negative spiral of vulnerability and poverty.

Recognising that women and girls are doubly affected by crisis and SRHR gaps, Norway strongly supports the common minimum standards for priority services in crisis and conflict situations. The Minimum Initial Service Package (MISP) offers clear benchmarks and thresholds for what to prioritise and when. The MISP is a useful tool for advocacy, as resource allocation decisions within the national health system are often affected by discriminatory gender norms that deprioritise SRHR needs. The MISP is also a key tool for enabling humanitarian actors to ensure the inclusion of SRHR services in humanitarian response.

Prevention of and response to sexual violence against children is part of the Children and Armed Conflict mandate. SRHR services adapted to children and youth are necessary. This can be included in conclusions agreed by the Security Council working groups leading to action plans for parties to conflict. The Women, Peace and Security agenda also focuses on SRHR-relevant efforts, including combating sexual and gender-based violence.

SRH integration in health systems

Status on goal of 1 billion additional people having UHC by 2023: Shortfall of 800-840 million, i.e. ***at most 20% of the goal is achieved***[21]

SRHR is not a stand-alone target nor should SRH services be provided in parallel systems. SRHR has a profound impact on the health and well-being of individuals, and many sexual and reproductive health needs overlap with other health needs. The integration of health services, including SRH services, improves access to and the efficiency of health systems, and enhances health outcomes for individuals. One example of this is providing contraceptive services as part of post-partum or post-abortion care. Women and children are in contact with the health services in connection with postnatal care, vaccination and early childhood development services. This provides an opportunity to optimise services and ensure integrated follow-up of the child and his/her carers. SRH services should be prioritised as a part of an integrated national health services package that is adequately funded and implemented effectively. It is furthermore important to secure and support that SRH products such as pregnancy tests, HIV tests, contraceptives and abortion pills are provided outside the health sector, through pharmacies and digital platforms.

SRH service delivery must also be integrated into wider national health sector reforms, strategies and initiatives, and in particular into countries' efforts to achieve universal health coverage (UHC). Given the significant inequalities in SRH outcomes far more than for almost all other health parameters, universal access is of utmost importance. UHC is a global priority to ensure that by 2030, all individuals will receive the health services they need without financial hardship, in keeping with the SDG target. However, at the current rate of progress this target is unlikely to be met, which will in turn affect other SDG targets that are closely linked to the health of the global population, including poverty eradication and economic development

8. Annex: Useful information sources & reference documents

This annex contains:

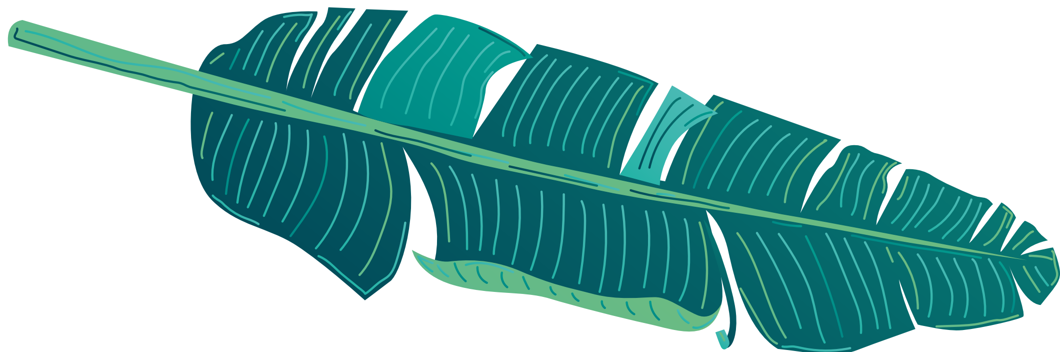
- International normative frameworks
- Regional consensus agreements
- Norwegian policies
- Global resources and guidelines
- Country-level statistics, data and information
- List of key actors with Norwegian funding
- End notes

International normative frameworks

UN Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), 1979	https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women
International Conference on Population and Development (ICDP) held in Cairo, 1994 – Programme of Action	https://www.unfpa.org/publications/international-conference-population-and-development-programme-action
Nairobi Statement, 2019 – 25th Anniversary of the Cairo Declaration	https://www.nairobisummiticpd.org/content/icpd25-commitments
World Conference on Women, 1995 - Beijing Declaration and Platform of Action	https://www.unwomen.org/en/digital-library/publications/2015/01/beijing-declaration
Yogyakarta Principles + 10 – the human rights principles applied to sexual orientation, gender identity and gender expression	https://yogyakartaprinciples.org/principles-en/

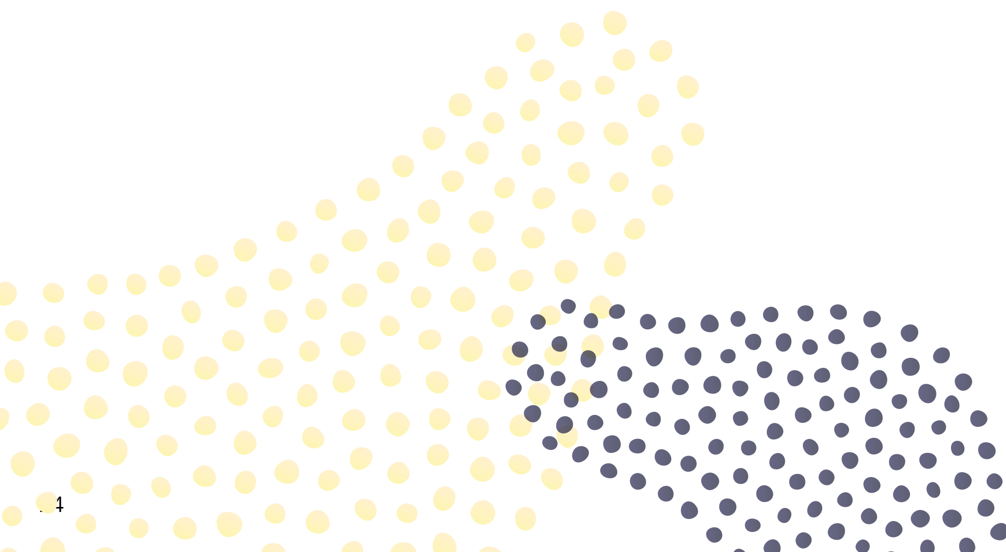
Regional consensus agreements

Africa	African Union's Maputo Protocol The Maputo Plan of Action 2016–2030 ESA ministerial commitment	https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-women-africa https://au.int/sites/default/files/documents/24099-poa_5-_revised_clean.pdf ESA Ministerial Commitment DT (youngpeopletoday.org)
Asia	Asia and Pacific Declaration on Population and Development, 2013	https://repository.unescap.org/handle/20.500.12870/829
Europe	WHO Regional Committee Action Plan for SRH: Towards achieving the 2030 agenda in Europe, 2016	https://www.euro.who.int/__data/assets/pdf_file/0003/322275/Action-plan-sexual-reproductive-health.pdf
Latin America and the Caribbean	The Montevideo Consensus on Population and Development in the Caribbean, 2013	https://www.unfpa.org/resources/montevideo-consensus-population-and-development



Global resources and guidelines

NORAD website – Norwegian Agency for Development Cooperation	https://www.norad.no/en/front/
WHO guidelines for sexual and reproductive health and the WHO abortion guidance of 2022	https://www.who.int/teams/sexual-and-reproductive-health-and-research-(srh)/guidelines Home - Abortion care guideline (srhr.org)
UNESCO international guidance on sexuality education	International technical guidance on sexuality education: an evidence-informed approach; overview - UNESCO Digital Library
UNFPA website	www.unfpa.org
UNAIDS website	www.unaids.org
UN Women website	www.unwomen.org/en
Guttmacher Institute's 'Adding It Up' initiative – needs, impacts and costs of investing in SRHR	www.guttmacher.org/report/adding-it-upinvesting-in-sexual-reproductive-health-2019
Regjeringen.no – 'Kvinners rettigheter og likestilling'	https://www.regjeringen.no/no/tema/utenrikssaker/fn/innsikt/likestilling/id439433/



Country-level statistics, data and information

Human rights, legislation and policies	
Universal Period Review (UPR) – Assessment of the human rights situation carried out by the UN Human Rights Council	https://www.ohchr.org/en/hr-bodies/upr/documentation
Database of references to sexual rights in UPR	https://www.uprdatabase.org/
WHO database on abortion policies by country	https://abortion-policies.srhr.org/
Health, gender and SDGs	
'Countdown to 2030' - Statistics on Reproductive, Maternal, Newborn, Child and Adolescent Health	https://www.countdown2030.org/landing_page
WHO World Health Statistics for SDG targets	https://www.who.int/data/gho/data/themes/world-health-statistics/
UN Women database on gender-related SDGs	https://data.unwomen.org/data-portal/sdg
UNFPA FGM Dashboard (17 countries only)	https://www.unfpa.org/data/dashboard/fgm
SRHR in Humanitarian settings	
UNOCHA Global Humanitarian Overview – global and country data, age & gender disaggregated, updated annually	https://gho.unocha.org/

SRH data in ongoing emergencies – from the Interagency Working Group on advancing SRHR in Emergencies (IAWG)	https://iawg.net/emergencies
Minimum Initial Service Package for SRH services in emergencies (MISP) – minimum standards for humanitarian response	https://iawg.net/resources/minimum-initial-service-package-advocacy-sheet#fnref:2

Key actors

Norwegian NGOs	International organisations
• Care Norge • Flyktninghjelpen • Fokus • Kirkens Nødhjelp • PLAN • Redd Barna • SAIH Studentenes og Akademikernes Internasjonale Hjelpefond • Sex og Politikk • SOS barnebyer • Strømmestiftelsen • Fri	• Guttmacher Institute • IPAS • IPPF • MSI Reproductive Choices • Robert Carr Fund • Safe Abortion Action Fund • The Global Fund to Fight AIDS, Tuberculosis and Malaria • UNAIDS • UNFPA • UN Women • WHO • UNESCO • OHCHR

End notes

[1] Definitions in this section are based on international consensus agreements, WHO publications, international human rights treaties and principles, as set out by the Guttmacher-Lancet Commission in 2018, available here: https://doi.org/10.1016/S0140-6736(18)30293-9

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[15] UNAIDS (2021): 'Fact sheet World Aids Day 2022'.

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