INVESTING IN A HEALTHY FUTURE ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

PHOTO: JENN GARDELLA / SAVE THE CHILDREN

A desk study on ASRHR needs, promising practices and Norwegian ASRHR policies and funding.

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Abbreviations

ASRHR	Adolescents' Sexual and Reproductive Health and Rights
CEFM	Child, early and forced marriage.
CSE	Comprehensive Sexuality Education
CSW	Commission on the Status of Women
FGM/C	Female Genital Mutilation/Cutting
SRHR	Sexual and Reproductive Health and Rights
GFF	Global Financing Facility
HIV	Human Immunodeficiency Virus
HrP	WHO's Human Reproductive Programme
IAWG	Inter Agency Working Group on Reproductive Health in Crisis
ICPD	International Conference on Population and Development
MISP	Minimum Initial Service Package
ODA	Overseas Development Assistance
OECD/DAC	Organisation for Economic Co-operation and Development /Development Assistance Committee
PMNCH	Partnership for Maternal, Newborn, and Child Health
UNAIDS	United Nations Agency working on HIV/AIDS
UNFPA	United Nations Sexual and Reproductive Health Agency
WHO	World Health Organisation

Summary

Despite progress and increased global attention, adolescents represent a cohort that is often overlooked and fall outside of programmes addressing children and adults. Investments have been too scarce. In a climate with increased resistance towards Sexual and Reproductive Health and Rights, efforts to amplify adolescent voices, investments in gender transforming programming as well as increased political will is needed to secure continued improvement. Some best practices highlighted in research and by experts in the field indicate elements for successful programming:

- Ensure holistic approaches with targeted interventions.
- Build programming on: Creating demand providing supplies – creating an enabling environment.
- Education and health go hand in hand reinforcing positive outcomes.
- Gender transforming and positive approach to sexuality enable structural and lasting changes.
- Supportive laws and policies are a backbone to enable change.
- The 10-14 cohort need prioritisation in research and programming.
- Strong youth/adolescent-led organisations for meaningful participation.
- Active inclusion of people living with disability, sexual and gender minorities, and other minorities.

Globally, there has been an increased inclusion of youth and adolescents in strategies and programming. The same trend is reflected in Norway's policy documents, most clearly in the two latest action-plans for women's rights and equality. However, it is not possible to track if more funds have been invested in ASRHR in the same period of time. There is no tracking model for adolescent sexual and reproductive health and rights (ASRHR), neither in Norway nor globally.

For this report we have developed a proxy tracking model. We have identified an "ASRHR -pool" of SRHR projects that include the words children, youth or adolescent in the programme description used in Norad's database. We found an increase in the amount of funding for projects including ASRHR components, the "ASRHR-pool", from 2003, to 2013 and 2022. The increase is reflected both in actual funding and as a percentage of Norway's total official development assistance (ODA). This increased attention to ASRHR in project descriptions does not give evidence to increased funding spent on ASRHR. However, additional research should look into the reasons for the increase of the ASRHR-pool. Future research would benefit from analysing a combination of the global environment, Norway's focus in policies and within the bureaucracy, as well as implementing organisations. A considerable share of the ASRHR-pool funding is not included in the Norwegian SRHR-tracking model, and therefore not reflected as Norway's SRHR funding. Despite what looks to be an increased prioritisation and global attention, no funding commitment to ASRHR has been made by Norway.

To secure further progress and investment in the most formative period in life for the 1,28 billion adolescents globally, selected recommendations have emerged through this review:

- Increased funding for ASRHR is key to secure continued progress and achieve the SDGs. A funding commitment by Norway will clearly prioritise this goal.

- Inclusion of ASRHR in strategies and guidelines is likely to further boost the prioritisation.

- Developing a marker or a mechanism for tracking funding to ASRHR would increase transparency, accountability and can positively support prioritisation.

- Adolescents need to be part of planning, implementation, and evaluation. Engaging adolescent-led organisations and structures and including their participation in national, regional, and global decision-making and accountability processes enables meaningful participation.

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Introduction

In 1994, the International Conference on Population and Development in Cairo (ICPD) acknowledged the need for a rights-based approach to sexuality and reproduction. The ICPD Programme of Action[1] also underscored the importance of including youth in the planning, implementation and evaluation of interventions. The Beijing Declaration and Platform of Action already in 1995 acknowledged adolescents as a particular vulnerable group and recognised their need for sexual and reproductive rights, including access to information and services. Later, UNAIDS and the global efforts to curb the HIV epidemic was established and we have seen an increasing prioritising of youth in new and more substantial ways. The 2003 UNFPA State of World Population Report integrated adolescent as a definition for a particular vulnerable group of children and youth. The Global Partnership for Maternal, Newborn and Child Health (PMNCH) and the funding mechanism Global Financing Facility (GFF) have included adolescent as an explicit target group within their plans since 2015. This increased focus on adolescents, led to a Lancet Commission on adolescent health and wellbeing in 2016, bringing research and documentation of this diverse group's vulnerabilities, needs and potential to the foreground.

Sexual and reproductive health and rights

Sexual and reproductive health is a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in promoting self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right.[2]

In 2023 the global attention on adolescent SRHR culminated in the PMNCH led Global Forum for Adolescents. In the midst of increased global resistance towards gender equality, SRHR and equal rights, increased efforts are also prioritised by some actors.

This report will give an overview of some of the main trends within adolescent sexual and reproductive health and rights (ASRHR) globally, several examples of agreed promising practices for programming, before assessing commitments to ASRHR in Norwegian international development policies and funding. The report ends with recommendations to forward the ASRHR agenda within Norwegian development policy enabling increased efforts to meet the needs and human rights of the 10–19-year-olds.

Methodology

For this report, a body of research is assessed including global resources such as WHO/HrP, BMJ/PMNCH, Journal for Adolescent Health and UN agencies and reports by International non-government organisations (such as Save the Children, Plan International, International Planned Parenthood Foundation). The report also draws on interviews with technical experts from Norad, the UN as well as Norwegian and International non-governmental organisations. Norwegian development and human rights policies and documents were analysed for their inclusion of ASRHR.

The term adolescent covers the period 10-19 years, including a period of childhood and youth. The term is increasingly used in research and global initiatives. There is no equivalent term in Norwegian, nor is it a term defined within the OECD/DAC coding system for funding. The assessment of Norwegian policies and funding is therefore also inclusive of prioritisation of children and youth, and both adolescents and youth are used in the analysis according to the terminology used by the actor/organisation/document. By SRHR we refer to; SR health services, comprehensive sexuality education, contraceptives, safe abortion, child early and forced marriage, female genital mutilation/cutting, HIV, sexual and gender diversity and gender-based violence. These are ASRHR components.

A search for dedicated ODA funding towards ASRHR was done using the statistics available at the Norad webpage following the OECD/DAC coding.[3] Upon contacting Norad it was made clear that no defined method for tracking ASRHR exists, nor does the DAC system have any dedicated coding for adolescent, youth or most of the specific SRHR areas covered in this report.

Given the limitations for tracking ASRHR with the Norwegian SRHR tracking model, we have developed a methodology specifically for this report. We used a word-search of the agreement description of all development aid programmes. Descriptions show how implementing partners define the purpose of projects. We first searched for projects including the words; adolescent/youth/young/child/girl/boy to cover projects that are targeting the adolescent age group but are not using this terminology. We then searched within this sample for projects including the words; SRH/sexual/reproduct/cse/hiv/contracept/familyplanning/abortion/marriage/fgm/gbv/lgbt/disability. We also purposely checked the DAC 151/80 to ensure all projects on early, child and forced marriage were included. **We have named the total funding for these programmes the ASRHR-pool**. The funding to the ASRHR-pool does not specify the amount provided to ASRHR but gives an indication of the growth in funding to programmes including to a smaller or larger degree ASRHR components.

This method has limitations as the description may not be covering everything in the project and adolescent/youth might benefit from initiatives that are not described as targeting adolescent/youth. This methodology will thus not give a total picture of the funding but can show a trend of the prioritisation and awareness of ASRHR.

1. KEY ASRHR FIGURES

→ The world's **1.28 billion** adolescents reprxesent almost **16%** of the world's population.[4]

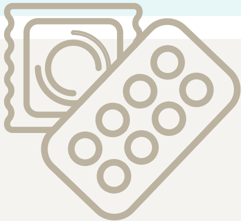
→ **50%** are aged 10-14 years and **85%** of these live in low- and middle-income countries.[5]

→ Children under 18 years old accounted for **52%** of the refugee population in 2017 —up from **41%** in 2009.[6]

→ **Complications from pregnancy** and childbirth are the leading cause of death for 15-19-year-old girls globally.[7]

→ About **60%** of sexually active adolescent women aged 15-19 have an unmet need for modern contraception.[8]

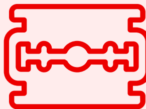
→ Annually about **5,5 million** unintended pregnancies among 15–19-year-old, end in abortion which is often unsafe.[9]

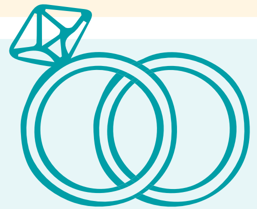


→ More than **130 countries**[13] have policies or legal frameworks related to **sexuality education.**

→ Over **200 million** women and girls alive today have experienced **FGM/C.**[11]

→ In 2023, **4.3 million** girls are at risk of **FGM/C.**[11]

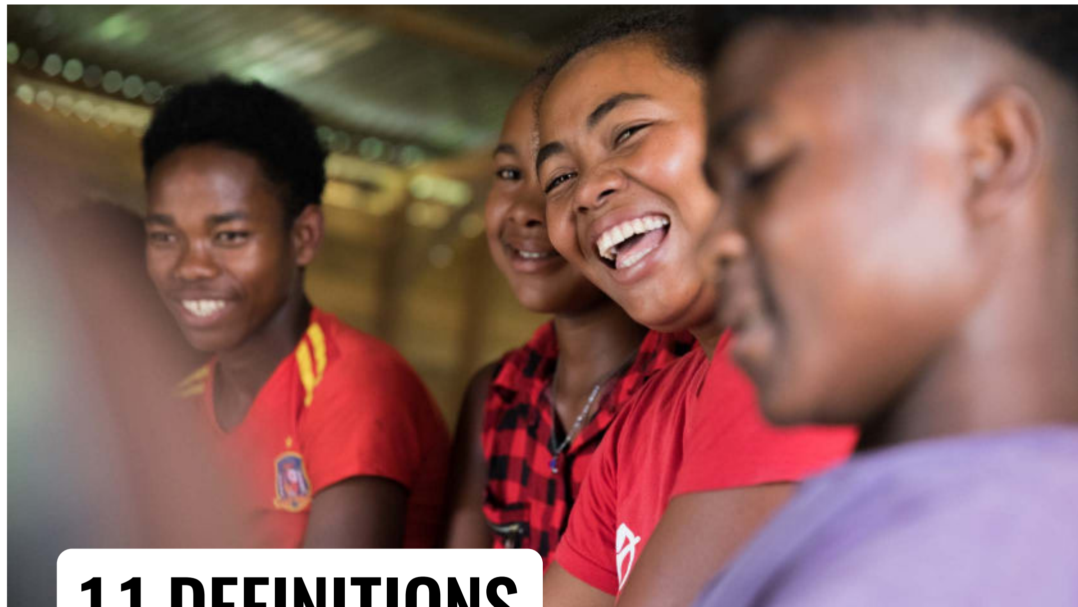




→ Globally **650 million girls** have been married as a child.[10]

→ Between **12–25%** of girls and **8–10%** of adolescent boys experience **sexual violence.**[12]

→ Girls with **disabilities** are ten times more likely to experience **genderbased violence** than those without disabilities.[12]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1.1 DEFINITIONS

Adolescents

Adolescence is the period between childhood and adulthood—beginning with puberty and transitioning from dependence on caregivers to self-sufficient adult members of society. United Nations (UN) defines this period as between 10 and 19 years of age. It's a period marked by changes to adolescent's physical, cognitive, behavioural, and psychosocial characteristics, a critical time for shaping behaviour and norms, including prevention of health problems and strengthening future resiliency of the next generation.[12, 14]

Child – adolescent - youth

There are several terms that overlap with "adolescence", including "children" (0-18years), "youth" (15-24years), and "young people" (10-24 years). While these terms are explicit, they are understood and applied in many different ways, depending on countries, cultures, and groups.[12]

Committee on the Rights of the Child (CRC)

Committee on the Rights of the Child (CRC) published in 2016 General Comment No. 20, on realising the rights of children during adolescence. It highlights states' obligations to recognize the special health and development needs and rights of adolescents and young people.

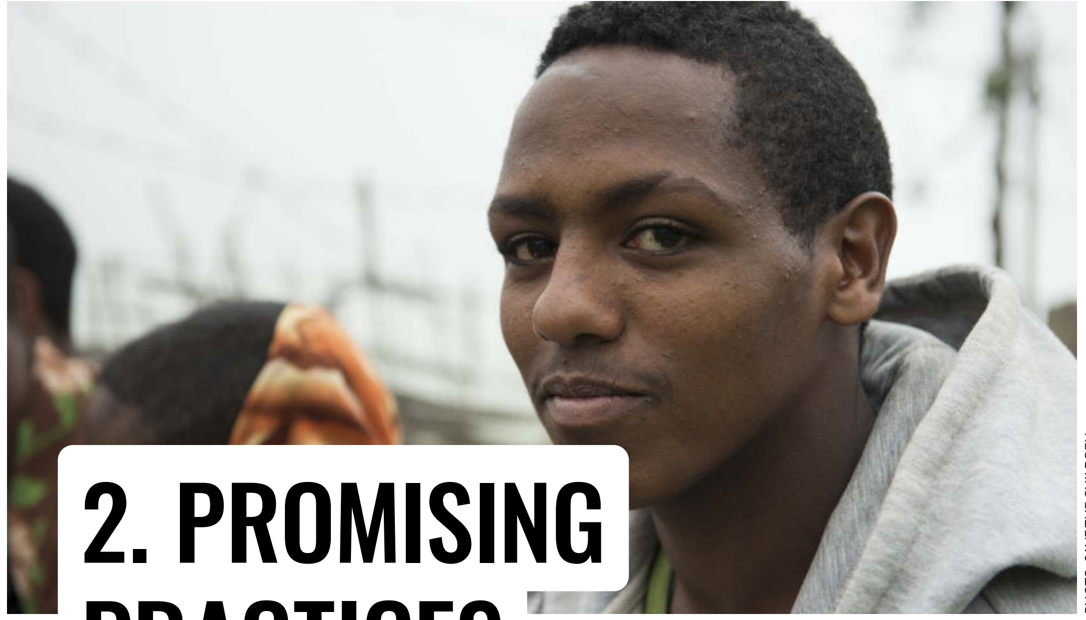

PHOTO: SAVE THE CHILDREN

2. PROMISING PRACTICES

There is a growing pool of research and documentation of interventions and approaches showing positive effects on adolescents' sexual and reproductive health and rights. Meanwhile there's also a need for more evidence to establish the direct link between interventions and success at scale, as well as data and approaches targeting the youngest cohort, 10-14, where less research is available.[15, 16, 17]

Humanitarian crises as well as the Covid-19 pandemic had severe adverse SRH and mental health outcomes for adolescents. Adolescents are often forced to take on adult roles in times of crisis. Covid-19 led to school-closures, reduced support network and access to health facilities, lack of contraception and safe abortion services as well as mental health distress, economic instability and increases in violence against children and adolescents.[18] Humanitarian crises and Covid-19 exacerbated adolescents' risk of child marriage and reinforced differences in well-being between married and un-married girls affected by forced displacement.[19]

Adolescents' vulnerabilities and needs are distinctly different from those of children and older youth and are often unaddressed.[20] Adolescents with a disability often experience an added vulnerability in terms of less access to services and information as well as higher risk of sexual exploitation. Adolescents with diverse sexual orientations and gender identities are often targeted for sexual violence crimes, and are at greater risk for poor mental health, violence, and HIV than their non-LGBTQ peers.[21] Societies with high levels of stigma and discrimination from family members, school, health providers, political and religious leaders, as well as a legal situation criminalising same-sex relations, exacerbates this situation. Research suggests that LGBTQ youth that either have family or other forms of support may experience less psychological distress, and that allies in schools is a factor to counter

homophobic behaviour.[22, 23] Advocating for legal reform, inclusive services and enabling supporting structures can support LGBT-adolescence well-being. Inclusive programming for LGBT-adolescents, adolescents living with disabilities as well as the youngest cohort is needed to leave no-one behind.

LGBT work in Vietnam

Save the Children's collaboration with FRI – Norwegian Association for Gender and Sexuality Diversity, targeting street children in Vietnam, is an example of how it is possible to start an LGBT-focused work for a non-LGBT organisation. Awareness raising of staff, acknowledging the needs of a vulnerable group in Vietnam, buy-in of Save the Children Vietnam, and collaboration with an LGBT-organisation ended up in a 10-year programme in Vietnam and an international strategy for the inclusion of sexual minorities at Save the Children International.

To better understand how programs can contribute to improved SRHR for adolescents, both research and experts refer to a holistic and multiple component system approach. This approach specifically looks into how to create demand, how to ensure supplies and how to develop an enabling environment. Some selected promising practices will be presented through this structure.

Demand – adolescents' agency

Building knowledge, awareness and understanding of sexuality, sexual health and human rights among adolescents creates a foundation for informed decision-making.

With increased investments in adolescent health in recent years, a growing emphasis has been placed on **adolescents' agency** as an important aspect of wellbeing.[16] Unicef is defining agency as the "personal ability to act and make free and informed choices to pursue a specific goal".[24] There are several factors both shaping, facilitating as well as limiting agency, such as individuals' belief in their capacities and self-worth, national policies and laws as well as dominant norms, unequal power relations and discrimination. To enable agency, programming needs to have a positive focus on adolescents' possibilities, belief in their independent voices and their capacity to drive change for their own wellbeing,[25] as well as gender transforming approaches to address root causes of inequalities and discrimination.

Meaningful youth participation and inclusion of adolescent, children and young people, in planning, implementation and evaluation of programmes is a clear recommendation by experts within the field. This was highlighted already at ICPD in 1994.

Adolescents' advocacy

At the GFF civil society network meeting in Accra, November 2022, the importance of CSO's/ Youth Led Organisation's participation was underscored. Their role in holding governments accountable to their commitments in terms of national health budgets, but also in terms of expenditures/disbursement of funds, and in terms of building capacity around transparency and access to the dedicated budgetary information.[26]

Youth-representative structures are increasingly in place at several levels of society, such as youth parliaments and committees. Youth representatives are a part of boards of global mechanisms, such as GFF, and youth leadership forums and movements are linked to global networks and conferences, such as PMNCH and Women Deliver, as well as other INGOs. Existing youth-led organisations and youth movements can be engaged for direct implementation as well as advocacy and policy work. In some contexts, additional structures need to be developed.

Experts and literature emphasize the importance of **funding youth led organisations** to enhance their reach and capacity to advocate for change. Adolescent engagement and leadership in **decision-making** can improve quality of care, programme effectiveness and outcomes. This is particularly important for marginalised and excluded groups, often overlooked due to factors such as sex/gender, identity, poverty, and abilities.[27] Strengthened agency to improve health has been shown to reduce incidents of unwanted sex and reduction in adolescent pregnancy.

Youth-led interventions

In Ghana, the Dutch NGO Rutgers have implemented **youth-led social accountability interventions** by providing training on SRHR and accountability for youth, a youth led exercise of rating clinics by scorecards and initiating dialogues between youth and health care providers on SRH service satisfaction. The intervention had several positive effects, such as: Youth became more vocal expressing their concerns, increased knowledge of SRHR and accountability, youth felt motivated to improve the situation for their fellow youth. Quality of services at the intervention-clinics also improved, such as increased non-judgemental attitudes and behaviour among health staff, as well as greater confidentiality and reduced waiting time.[28]

A growing body of research and documentation shows the **positive effects of Comprehensive Sexuality Education (CSE)** on adolescents' well-being. Both the 2016 Lancet Commission and UNESCO reports stated CSE as one of the well documented ASRHR interventions. CSE has a positive effect on health outcomes such as protection against unintended pregnancy and prevention of STIs, as well as behaviour, norms and improving self-esteem.

Studies are also suggesting that the inclusion of content on gender transforming approaches, power relations and human rights and the use of participatory methodologies are likely to be more effective. The importance of a positive approach to sexuality is also underscored by several actors in the field.[14, 29, 30, 31] High quality and impactful CSE is dependent on the **capacities of the teachers**. There is evidence that teachers are not sufficiently trained to comprehensively deliver CSE.[13] Research indicates that when schools implement LGBT supportive policies and practices, all students experience better health outcomes.[21]

Training teachers

In Zambia, a new teacher training model for sexuality education was developed in 2019, utilising teacher training colleges as education hubs. These hubs, which are also responsible for delivering pre-service teacher training, are considered 'centres of excellence.' Under this new training model, the colleges provide information to teachers through a five-day sexuality education training, which aims to impart skills acquisition, confidence and refined participatory methods.[13] The CSE curriculum was also revised in 2014 and CSE elements are now included in examinable subjects.[32]

According to UNESCO's global status report on CSE more than 130 countries have policies or legal frameworks related to sexuality education. These provisions are often not followed by guidance on curriculum, funding, or implementation, resulting in a lack of uniformity in implementation. More countries are reporting on including CSE components at secondary than primary level education and emerging evidence suggests that the curriculum is stronger for the older age groups.[13] This speaks to the continued need for an increased focus on the younger cohort (10-14 years). While

countries are taking steps in the right directions, more needs to be done on all levels; policies, curriculum, capacities of teachers and enabling environment to ensure quality education and access for all.

Combining comprehensive sexuality education with **access to school-based health services and modern contraception** can significantly reduce school dropout rates in areas where early pregnancy is prevalent. A comparison between data on years of education and adolescent fertility and mortality, suggests a strong association.[14] Each additional year of education is associated with fewer births and maternal mortality on average.

Using **technology** and taking advantage of the adolescent generation's online skills is an opportunity for increased well-being. There is evidence of some benefits of this approach, but so far, the research has mainly been in high-income countries.[14] In the context of the Covid-19 pandemic, access to mobile phones and other information and communications technology presented opportunities for many adolescents, particularly where connectivity rates are high. The development of using mobile phones (mHealth) and other digital interventions supports greater access to products, services, information, and learning. During Covid-19 several countries and actors successfully initiated digital and self-managed safe abortion services as well as digital CSE lessons. For the digital native present and future generation of adolescents this is a great opportunity. To ensure access for all adolescents to the technology, the solutions must be universally designed.

Supply – adolescents' access to SRH

Literature and evidence are clear on the need for a close link between creating demand and enabling access to supply, such as contraceptives, safe abortion, as well as broader sexual and reproductive and mental health services. Effective approaches should include a combination of health worker training; facility improvements geared toward welcoming adolescents and protecting their privacy; and information dissemination through schools, communities, and the media. Successful programs are those built with adolescent input, community buy-in and service elements that are locally appropriate.[8] To ensure access for all adolescents, services should be universally designed.

Adolescent-friendly health care

Research shows that adolescents across countries have similar views of what constitutes friendly and responsive health care, including patient-centredness, respect, coordination of care, appropriate provision of information, high-quality communication, involvement in decision-making, and ability to listen to their needs, as described in the **WHO adolescent-friendly framework:**

Equitable: All adolescents, not just certain groups, are able to obtain the health services they need.

Accessible: Adolescents are able to obtain the services that are provided.

Acceptable: Health services are provided in ways that meet the expectations of adolescent clients.

Appropriate: The health services that adolescents need are provided.

Effective: The right health services are provided in the right way and make a positive contribution to the health of adolescents.[33]

There is increased attention to improving access to and quality of care for pregnant and parenting adolescents, as adolescents appear

to receive a lower quality of both clinical care and interpersonal support than adult women do.[34] Evidence shows that adolescent friendly SRH services increases uptake. Stand-alone adolescent SRH services is not as effective, nor do they lead to increased uptake of contraceptives. An important condition for success is to ensure a good quality of provider training, as well as making changes to the facilities such as protecting privacy and physical access.[14] However, many barriers still exist, including restrictive legal frameworks, out-of-pocket costs, cultural and community attitudes and confidentiality breaches by the health care system. Enabling access to supply is also a comprehensive part of the global commitments to universal health coverage.

SRHR as part of UHC

Universal Health Coverage (UHC) is defined in target 3.8 of the Sustainable Development Goals: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. SRHR is part of UHC, as defined in the SDG target 3.7 and as an integral part of the right to the highest attainable standard of health.

Due to supportive policies, increased knowledge and awareness, and improved access to information and contraceptives (agency and supply),[35] there has been an overall decline in **adolescent birth rate** globally since the 1990s. However, variations between regions are big and the highest rate of adolescent birth rate is found in sub-Sahara Africa with 104 live births per 1000 girls. UNFPA estimated 1,4 million unintended pregnancies due to the Covid-19 pandemic, and country cases show increases in adolescent-pregnancies.[36] Studies have further shown that access to a contraceptive mix, delivered through women-centred services and structures is central to improving access and delaying early births and related morbidities and mortalities.[37]

Globally there has been a decrease in mortality due to unsafe **abortions** over the past 20 years. This is largely due to increased awareness of and access to medical abortion and self-care interventions.[38] Despite this, women and in particular adolescents around the world, are still prevented from accessing safe abortion services. Restrictive laws, regulatory barriers, poor availability of services, high costs and stigma as well as objections by providers are some restricting factors. Of the estimated 5,6 million abortions occurring each year among adolescents (15-19 years), 3,9 million are unsafe contributing to morbidity, mortality and lasting health problems.[8] Ensuring medication is available, adolescent friendly services is accessible and the legal environment is conducive will improve access to safe abortion options.

Enabling environment

Advancing gender equality helps catalyse change and improve health outcomes by addressing the underlying structural barriers to health.[39] **Time and long-term commitment over generations** is needed to see lasting changes in deeply entrenched structures of inequality.[16]

Interviews with experts underline the importance of an enabling environment. This is also stressed in UN guidelines. To achieve positive development for ASRHR, all parts of society need to work together for adolescents' access to education and health care. This means a shared understanding and commitment from government, traditional and religious leaders, community leaders, parents as well as adoles-

cents themselves. This requires programmes to incorporate broader information and awareness-raising efforts beyond the specific target group of each intervention.[14]

Programmes need to have **multiple components** that operates at all levels; individual, relational, community and state.[40] It includes strengthening the agency at the individual level, enable supportive relationships with parents and peers, initiatives to change social norms at community level and structural change through media campaigns at societal level. Interventions to improve parent-child communication on sexual health has shown some effect on safe-sex behaviours. Supportive l**aws, policies and global guidelines** are also important factors for enabling access to services and realising sexual and reproductive rights.

Studies and experiences emphasise the need for strategies and interventions that are enabling **gender transformative approaches** to tackle the normative and structural barriers of gender inequalities driving harmful practices[41] and SGBV, to strengthen equal rights for sexual minorities and to overall improve ASRHR. However, this thinking has yet to be mainstreamed in the ASRHR social norm change programming and vernacular.[42]

UNFPA estimates show COVID-19-related disruptions to programming could cause 2 million more cases of female genital mutilation to occur over the next decade unless concerted and accelerated action is taken.[43] Among **interventions to prevent FGM/C**, community mobilization and female empowerment strategies have the potential to raise awareness of the adverse health consequences of FGM/C and reduce its prevalence. The FGM/C abandonment should be seen as a continuum of phases linked to social, economic, religious and political elements, rather than a practice with a distinct start and end.[44] This speaks to the need for a holistic approach.

Reducing FGM/C through community work

The Tuti Island initiative in Sudan, is an example of using a community approach to abandon FGM/C in a whole community. The initiative did this through mobilising grandmothers, mothers and young girls that were already against the practice to speak out in the community. Then building a support network for young girls as well as discussion groups for the community. The work has been going on since 2006, and the FGM prevalence was reduced from 64% in 2009 to 12% in 2018.[45]

For humanitarian crises there is a need for direct programming targeting married girls in refugee and host communities. An estimated 2,3 million children lost a parent or a primary caregiver to COVID-related death within the first 18 months of the pandemic. We know from the HIV epidemic that such losses increase long-term risks of unsafe sex, STIs and HIV infection. This vulnerability must be considered when building support systems, inclusive health services, and planning for future epidemics.[37]

ASRHR in humanitarian crises

The ASRH toolkit developed by the Inter Agency Working-Group on Reproductive Health in Crisis is an example of a successful joint global effort to enhance adolescents sexual and reproductive health during humanitarian crisis. The toolkit not only involved adolescent participation in its development but also offers guidance on how to implement this approach during crises, alongside the provision of SRH services and education, while ensuring the adolescent-friendly implementation of MISP. Developing globally agreed standards and guidelines is a tool to enable implementation of less prioritised and sensitive areas.[12]

ASRHR under threat

Despite historical global commitments and positive development for ASRHR on national level, the current global climate sees increasing opposition to SRHR. The so-called anti-gender movements have proliferated internationally, fuelling growing resistance towards LGBTIQ+ rights and visibility, comprehensive sexuality education in schools, and a concern around marriage, fertility, and abortion. There are several organisations working to advance anti-gender ideology internationally, most of which are based in the United States.[46] ASRHR is often singled out as a particular area of concern by these organisations, attacking actors which are implementing adolescent SRH programming as well as stalling governments' initiatives and preventing the global normative agenda from progressing. We also see a trend of shrinking space for diverse voices and for civil society actors to work and advocate. This speaks to the urgency for continued and strengthened political, financial and social commitments to ASRHR.

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PHOTO: SUZANNE LEE / SAVE THE CHILDREN

3. NORWEGIAN POLICY AND FUNDING LANDSCAPE

For many years Norway has committed to SRHR in its long-term development aid and increasingly within its humanitarian support. Several strategies and policies[47] have over the past ten years guided Norwegian efforts within SRHR. The inclusion of adolescents and/or youth has increasingly become clearer, in line with global discussions and initiatives. This review of Norwegian policies and funding initiatives is showing some positive trends on policy and funding. It is however difficult to state a clear change since adolescent is not a term that is often used in the policies, rather the Norwegian equivalent of "youth" is used. The term "adolescent" is not a category in the reporting of financial funding within Norwegian development aid statistics.

Action plans for gender equality prioritising youth and adolescents

An increased inclusion of youth and adolescents can be seen when assessing the various Norwegian global development and humanitarian strategies, most clearly in the two latest action-plans for women's rights and equality. Even though the term "adolescents" is not used in these documents, we

interpret adolescents to be included in the term "youth". However, measures targeting the cohort 10-14 might be omitted, as they fall outside of the term "youth."

While the previous action-plan, *Frihet, makt og muligheter* 2016-2020, includes youth's access to sexual and reproductive health care services, the new action-plan in draft,[48] has included youth in a more profound way throughout the document. Youth are seen as both recipients of SRH services and participants in decision-making as well as playing an active role in developing, implementing, and evaluating programmes. The draft action-plan also includes a prioritisation of funding directed to youth led organisations, as well as an attempt of a youth accountability mechanism through bi-annual youth consultations at the Embassies. Depending on the final version, this Action Plan could become the most youth-inclusive policy by a Norwegian government so far. Additionally, an internal process in Norad is currently (Sept. 2023) ongoing, developing an evidence and priority document on further programming for adolescents.[49]

The new strategy on **people living with disability**, *Likestilling for alle 2022–2025*, includes a priority of initiatives to increase access to sexual and reproductive health services as well as sexuality education for girls with disabilities. The ASRHR funding review for this report, however, found few agreements mentioning SRHR for people with disabilities. This is an area seeming to lag behind within ASRHR funding.

Funding to ASRHR

At the Nairobi Summit in 2019, the ICPD+25, Norway committed to NOK 10,4 billion in funding for SRHR for the period 2020-2025. This was the last global funding commitment Norway has made in the SRHR sector. No specific ASRHR funding commitment has been made.

Nairobi commitments

Norway's commitment at Nairobi Summit 2019: "The Norwegian government is a staunch supporter of the ICPD Programme of Action, and of universal access to sexual and reproductive health and rights (SRHR). 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 commits to invest approximately NOK 10,4 billion in sexual and reproductive health and rights for the period 2020-2025."

Since 2015 Norway has been part of initiating and developing the new global funding mechanism, Global Financing Facility (GFF). The mechanism is mandated to support national health plans to scale up access to reproductive health care and nutrition for women, children, and adolescents. The mechanism has increasingly included SRHR and adolescents in their framework[50] and priorities as well as youth and civil society representation in their governance structure, as advocated for by civil society and some donor countries. In the interviews conducted for this review it was mentioned that youth was included already from the first country investment cases, but no tracking has been done to describe this. Today, Norway defines 26% of the GFF grants to support SRHR. How much of this is supporting adolescents is not defined.

Tracking model

Even though adolescents are mentioned in global strategies, among UN agencies, and has increasingly become a priority among donor governments, there is no common way of tracking the ODA funding directed towards ASRHR. Most donor governments report according to the OECD/DAC system where agreements are coded according to a few main categories.

No coding defines age-groups or other specific areas within SRHR, such as abortion, CSE or FGM/C. This makes it difficult to closely track funding for ASRHR. When asked, Norad informed that no tracking has been made of adolescents as a group or of ASRHR, and therefore no data or official model to collect the data exists.

Since 2013 Norway has used its own model for tracking the funding to SRHR. The model includes all projects coded with the DAC-code 130 – Population and Development, as well as a percentage of the core-support for selected UN agencies and global mechanisms, see table 1 below. This methodology does not give specific figures for adolescents, or any other age-group, nor does it include most projects on early, child and forced marriages, placed under DAC code 151/80, or humanitarian support to SGBV, DAC code 720. For the purpose of this report, we have used the same model to set the SRHR level for 2003.

The funding commitment at the Nairobi Summit 2019 was set to keep the same level of SRHR funding as in the year 2019, NOK 1 605 510 NOK. The increase of around 200 million NOK in 2022 reflects a recover of equally reduced funding in 2020 and 2021, compared to the 2019 level. The percentage of SRHR funding as part of the total ODA budget has decreased from 4,7% in 2003 to 3,6% in 2022. **Despite a political prioritisation of SRHR in policies, guidelines and global initiatives, this has not materialised in a continued or increased proportion of SRHR funding within Norwegian development aid**.

Given the limitations with the Norwegian SRHR tracking model we have developed a methodology specifically for this report. We did a sampling of

Year	2003	2013	2022
All agreements categorised as DAC130 – Population policies/programmes and reproductive health	278 853 445	924 502 000	612 521 000
100% of core support to UNAIDS	100 000 000	185 000 000	45 000 000
100% of core support to UNFPA	230 000 000	402 000 000	589 600 000
50% of core support to The Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM)	79 150 000	225 000 000	400 000 000
26% of Norways funding to the Global Financing Facility (GFF) (GFF was only established in 2015)			156 000 000
Total Norwegian ODA budget in NOK	14 500 000 000	32 800 000 000	49 600 000 000
SRHR as % of total ODA	4,7	5,3	3,6
Total SRHR	**688 003 445**	**1 736 502 000**	**1 803 121 000**

TABLE 1: **The Norwegian SRHR tracking model.**
All figures in the three tables are drawn from the Norad online database.

Year	2003	2013	2022
Total ASRHR-pool: Total funding by project where the agreement description includes elements of ASRHR, in NOK. The amount used for ASRHR is not specified.	58 380 553	550 091 952	943 369 797
Total Norwegian ODA budget in NOK	14 500 000 000	32 800 000 000	49 600 000 000
ASRHR-pool funding as % of total ODA	0,4%	1,7%	1,9%

TABLE 2: Financing to the ASRHR-pool.

funding to projects that includes ASRHR components, based on a word-search in the description of the project agreement in the Norad database.[51] We have named the total funding for these projects, the ASRHR-pool.[52] The funding to the ASRHR-pool does not specify the amount provided to ASRHR but gives an indication of the growth in funding to programmes including to a smaller or larger degree ASRHR components. We did this for the year 2003, 2013 and 2022 to reflect the development since the early days of adolescents being identified as an important target group globally. A limitation with this model is that the description of the project might not reflect the full content, and projects not mentioning adolescents/youth/child might still include these age-groups in their work. The project description is also not a clear indication of the extent to which adolescents are prioritised compared to other age groups.

Table 2 shows the figures of the ASRHR-pool. We see an increase from NOK 58 million in 2003, to NOK 550 million in 2013, and NOK 943 million in 2022. The ASRHR pool as a percentage of the total ODA has also increased, from 0,4% in 2003 to 1,7% in 2013 to 1,9% in 2022.

Table 3 shows the total ASRHR-pool compared to the funding marked as DAC 130. This is selected to compare with the Norwegian SRHR tracking model, as shown in Table 1. The percentage of funding including ASRHR components of the Norwegian SRHR tracking model has increased over the period. From 10% in 2003 to 30% in 2013 up to 65% in 2022. This reflects that an increasing proportion of the DAC130 coded funding is described as including elements of adolescence, child and youth. This could speak to both a stronger focus

Year	2003	2013	2022
ASRHR-pool: Total funding by project agreement description including elements of ASRHR, in NOK.	58 380 553	550 091 952	943 369 797
ASRHR-pool coded as DAC 130, in NOK.	29 051 870	279 907 811	399 734 777
% of the ASRHR-pool included in the Norwegian SRHR tracking model (DAC 130, Table 1, line 1)	10%	30%	65%

TABLE 3: The ASRHR-pool: Funding including ASRHR based on project agreement description.

on ASRHR by the agreement partners, as well as increased communication by Norway/Norad to partners on the inclusion of ASRHR. It also reflects the increased focus on adolescents and youth on the global scene.

On the other hand, a large proportion of the ASRHR-pool is not coded as DAC130, and therefore not included in the Norwegian SRHR tracking model. In 2022, almost 60% of the funding for projects including ASRHR elements were not included in the Norwegian SRHR model. This indicates that the current Norwegian SRHR tracking model is not a sufficient tool to track ASRHR related funding and could speak to the need for a more systematic way of marking ASRHR funding. For an area that is acknowledged by the donor-agencies as well as by the recipients and civil society as a priority area, it could be beneficial to have a joint understanding of the funding levels.

Three trends are of particular interest in this analysis:

1. **A positive trend of increased use of the term adolescent/youth/child over the period.** Projects that include ASRHR components in their project agreements constitutes a larger part of the funding in 2022 than in 2003. **In the same period, there is also an increase in the percentage of the total ODA that go towards ASRHR-pool projects.** This can indicate an increased focus on, and prioritisation of, adolescents and youth SRHR by the Norwegian government as well as by the project agreement partners. Funding for the ASRHR-pool projects as percentage of ODA has increased, while the general SRHR funding as percentage of ODA has decreased.
2. **An increase in funding for ASRHR-projects in the Norwegian SRHR tracking model.** This can indicate a prioritisation of ASRHR also within the SRHR funding.
3. **A large proportion of the funding for ASRHR-pool projects, are not included in the Norwegian SRHR model.** This means that the funding is not counted as SRHR by the Norwegian government.

UN agencies for ASRHR

UNFPA, as well as UNAIDS, are considered to be **the main UN agencies for ASRHR**. Norway has been a major donor to both for long. In the interviews, the global HIV initiatives were pointed to as a leading force for youth and youth participation. The HIV/AIDS programming were also early to include the more controversial areas, such as sex workers and men who have sex with men. HIV funding was an enabling factor for establishing organisations for sexual minorities and the LGBTI community. UNFPA indicates that just above 9% of their funding in 2022 went towards adolescents programming, up from 7% in 2014. Figures for UNAIDS have not been possible to retrieve.

Strategies, policies, and guidelines

As shown earlier, both global and Norwegian **strategies, policies and guidelines** have increasingly included adolescent (or youth) SRHR. Such changes can be attributed to both advocacy and pressure from civil society and youth led organisations as well as documented research, global initiatives and like-minded donors as well as engaged politicians. For policies to become effective both decision-makers and implementers must consciously change their ways of working. Within the field of SRHR this has happened in several ways.

In 2022 the revised SRHR guidelines on Sexual and Reproductive Health and Rights for Norwegian embassies[53] were launched by the Ministry of Foreign Affairs. Immediately after, several Norwegian Embassies granted funding

to local partners for SRHR programmes. Similarly, when the guidelines for human rights, sexual orientation and gender identity[54] were launched in 2013, selected Embassies was chosen to be focal-points and purposely engaged in and reported on the situation in their countries. Since then, more Norwegian Embassies have increasingly engaged and followed the recommendations in the guidelines. Guidelines as a tool for increased focus on a specific thematic area seems to be effective.

How implementing partners describe and categorise projects is likely to vary according to political and **technical priorities** of the donor, as it will influence the likeliness of a successful application appraisal. At the same time, what donors ask for, the implementing partners (civil society as well as global agencies) must respond to. This comes in addition to the push by civil society of the documented need "on the ground". Currently there is no official requirement to include ASRHR in the Norad funding application.

Each new government, and Minister, would like to put their "stamp" on the **political priorities** and will often re-direct funding to a specific area. Under the current Minister for Development, Food Security has been granted extra funding. At the same time, SRHR is defined as one of three priority areas (alongside food security and climate change) and is particularly promoted by State Secretary Bjørg Sandkjær through her speeches, participation in civil society seminars, as well as in the UN and global meetings. There is no equally clear political prioritisation of adolescents.

Meaningful involvement

Involvement of adolescents and youth in the planning, implementation and evaluation of initiatives as well as in decision-making structures is a recommendation highlighted both in the research and reports examined, and in conversations with technical experts. Norway has been funding youth delegates to UN-processes through the Norwegian Children and Youth Council (LNU) since 1971. The youth delegates are equal parts of the Norwegian delegations, included in discussions and asked to give speeches. From interviews attention was drawn to the prerequisite for the delegates to be selected by and within youth-led organisations to prevent tokenism and secure representativeness. Several politicians have participated as youth delegates, such as the current State Secretary to the Minister for Development, Bjørg Sandkjær, who attended the ICPD conference in Kairo 1994. She refers to it as a source of inspiration for her engagement. INGOs are also hosting delegations of youth from various countries to global conferences, such as Plan International's youth delegation to Women Deliver 2023. **Enabling participation at global decision-making forums is one way of supporting the inclusion of youth in advocacy and agenda-setting**.

At the beginning of this millennium **parliamentarians** has been mobilised for SRHR. In Norway, a parliamentary caucus on SRHR was set up by Sex og Politikk (IPPF Norway) which by 2023 has around 40 MPs as members from all the political parties. This group has not had a specific focus on adolescents and youth. Meetings with UN agencies, civil society partners from development cooperation as well as country-visits has been noted as a source of knowledge and inspiration to their work as MPs. Since 2018 there has been attempts to organise a similar group for youth parties by Sex og Politikk's youth organisation SNU. With a broad political consensus for SRHR among the political parties, ASRHR is already on the agenda and can easily be elevated.

PHOTO: YAGAZIE EMEZI / SAVE THE CHILDREN

4. RECOMMENDATIONS – ASRHR FOR THE FUTURE

This report has given a brief overview of the status and promising practices of ASRHR programming as well as the Norwegian policy and funding landscape. There is a trend of increased global, as well as Norwegian, attention to ASRHR. Research and practice reflect promising and documented practices for improved programming for ASRHR. Assessing the extent to which this is followed through in Norwegian investments is outside the scope of this report, and best practices are therefore presented separately. The global community of organisations, initiatives and researchers agree on the foundation ASRHR constitutes for inclusive and well-functioning communities and societies.

For ASRHR-programmes to be successful, this report has highlighted some promising practices to be included:

- Ensure holistic approaches with targeted interventions.
- Build programming on: Creating demand

providing supplies – creating an enabling environment.
- Education and health go hand in hand reinforcing positive outcomes.
- Gender transforming and positive approach to sexuality enable structural and lasting changes.
- Supportive laws and policies are a backbone to enable change.
- The 10-14 cohort need prioritisation in research and programming.
- Strong youth/adolescent-led organisations are foundational for meaningful participation.
- Active inclusion of people living with disability, sexual and gender minorities, and other minorities.

Despite progress and increased global attention, adolescents represent a cohort that is often overlooked and fall outside of programmes addressing children and adults. Investments have been too scarce. In a climate with increased resistance towards SRHR, efforts to amplify adolescent voices, investments in adolescent developed and gender transforming programming as well as increased political will is needed to secure continued improvement.

- **Global funding commitment for ASRHR – Money talks.** Increased funding for ASRHR is key to secure continued progress and achieve the SDGs. A funding commitment by Norway will give a clear priority of programming for adolescents as well as underpin continued advocacy efforts by Norway to uphold the sexual and reproductive rights of adolescents. Increased funding to ASRHR can also encourage other countries to do the same.

- **Strong inclusion of adolescents in policies and strategies – What is said and written matters.** Youth and adolescents have increasingly been included in Norwegian policy documents as well as dedicated funding to global ASRHR initiatives. This might have contributed to the increase of projects including ASRHR components. The Norwegian government's thematic guidelines, such as the LGBT and the SRHR guidelines, boosted the priority of these areas. Developing a similar guideline on ASRHR could facilitate a stronger engagement and implementation of policies. Such guidelines should be informed by the research identified in this report and developed in consultation with civil society organisations, especially including adolescent and youth organisations.

- **ASRHR tracking mechanisms – What is asked for by donors are reported on by recipients.** No model or mechanism for tracking ASRHR is currently available. This makes it difficult to know the level of investment and progress. A marker or a mechanism for tracking funding to ASRHR would increase transparency, accountability and can positively support prioritisation.

- **Meaningful participation – The adolescent view as a way of working.** To ensure effective and targeted programmes, evidence is clear that adolescents need to be part of planning, implementation, and evaluation. Avoiding tokenism can be achieved through engaging adolescent led organisations and structures and include their participation in national, regional and global decision-making and accountability processes.

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Redd Barna

SEX OG POLITIKK