Empowering young people towards happy and healthy lives

Rutgers Strategy

2017 — 2020

Rutgers

For sexual and reproductive health and rights

Introduction

Empowering young people towards happy and healthy lives is Rutgers' strategy for 2017-2020. Our aim is to contribute to improving Sexual and Reproductive Health and Rights by focusing on young people. Rutgers is a non-governmental organization that has been working for several decades to improve Sexual and Reproductive Health and Rights. The organization founded and based in the Netherlands implements programmes both nationally and internationally in more than 15 countries in Western Africa, Eastern Africa, Southern Asia and South-East Asia. In Pakistan, Indonesia and Uganda, Rutgers has country offices which operate within the corporate strategy but apply context-specific sets of programme implementation, research and advocacy.

Rutgers is named after Johannes Rutgers (1850-1924), an activist in SRHR, and general practitioner who provided contraceptives to the public when these were still illegal in The Netherlands. Rutgers has developed out of mergers between the Rutgers Foundation, NISSO and the World Population Foundation. The Rutgers Foundation was established in 1969 in The Netherlands and provided sexuality education, and sexual and reproductive health services through more than 60 health facilities to all people, no matter their age, marital status or sexual orientation. NISSO, founded in 1967, conducted research on the psychological and social aspects of sexuality. The Rutgers Foundation and NISSO merged in 1999 into the Rutgers Nisso Group. By 2011 this organization had merged with the World Population Foundation (established in 1987) that worked internationally on Sexual and Reproductive Health and Rights. Rutgers is a member of the International Planned Parenthood Federation.

Nowadays Rutgers combines the strengths of the organizations it stems from by focusing on three interlinked pillars in its work: programme implementation, research and advocacy. One of the main assets of the organization is the combination of work in the Netherlands and in other countries. This can be further developed to benefit the work needed to be done. Programme implementation focusses on access to and quality of comprehensive sexuality education, access to and quality of SRH service provision and creating acceptance and understanding for young people's sexuality. In doing so, Rutgers collaborates intensively with and provides support to professionals and local partner organizations. Research, carried out by Rutgers and its collaborating partners, is aimed at strengthening the evidence base of interventions, and development and measurement of sexual health indicators. Through its advocacy, Rutgers aims at policy development, adaptation and enforcement in The Netherlands, by local governments abroad and at international level. The work carried out by Rutgers is characterized by a positive and rights-based approach. The strength Rutgers is known for lies in developing effective, evidence-based approaches and interventions, dealing in a positive way with sexuality and sexual and reproductive rights within different cultural contexts. Due to recent developments, such as the introduction of the Sustainable Development Goals, adopted by the UN in September 2015, Rutgers aims to review its current strategy. The targets and indicators linked to these new SDGs will guide and shape our work as well as that of the larger SRHR community. It will also have an influence on the policy agenda and donor priorities in various countries. With a new strategy, Rutgers will reorient itself on these global dynamics and the continuously changing world that we are living in, reflect on the evidence-base that has been built up through our work in the past and set out the milestones for the future.

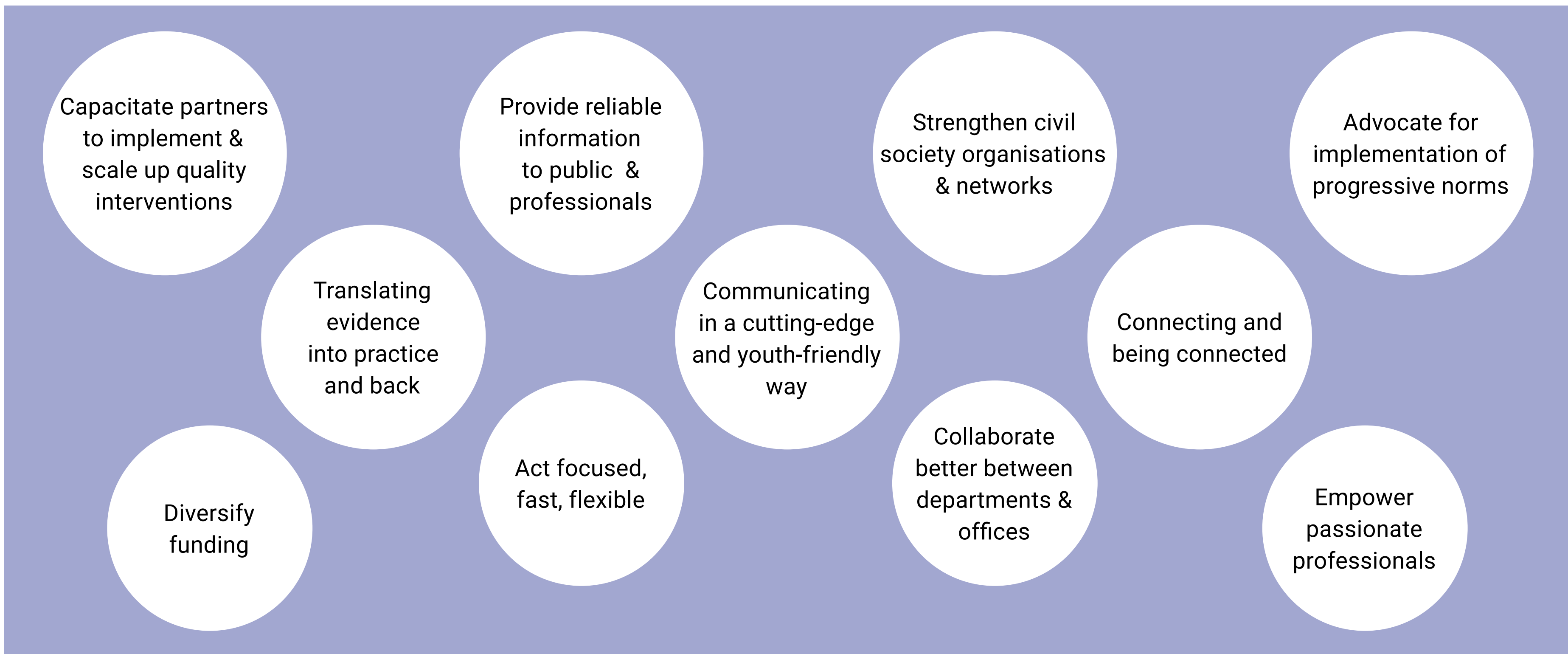
The Rutgers' strategy for 2017-2020 has been developed through extensive consultation, both internally with the staff at the Rutgers head office and the country offices, as well as externally with key donors, alliance members, research institutes and implementing partners.

Empowering young people towards happy and healthy lives

Vision statement — People are free to make sexual and reproductive choices, respecting the rights of others, in supportive societies.

More young people, in and out of school, receive comprehensive sexuality education	More people have access to improved, needs-based sexual and reproductive health information and services	Civil society is a leading actor in achieving sexual and reproductive health and rights in more countries	More governments provide greater support for sexual and reproductive rights

Our priorities
- Contraception
- Safe abortion
- Sexual violence
- Population dynamics



Our values
- Inclusive
- Gender equality
- Positive approach
- Activist
- Sustainable
- Openness
- Together

Urgency	Restrictive norms	Power dynamics

Mission statement — We empower people through education and improve access to information and services. We strengthen professionals, organisations and societies. We connect research, implementation and advocacy.

The strategy

The strategy map shows all the aspects that together form our focus for the coming years. It starts with the vision that reflects how we envisage our ideal world of tomorrow. At the bottom the mission is stated. The mission summarizes what Rutgers does in striving to reach its vision. The four outcomes presented under the vision clarify what is needed in order to make this vision a reality. These outcomes are changes in the world that many stakeholders are contributing to, including Rutgers. The eleven objectives in the centre of the map indicate the specific areas of focus in the day-to-day work of Rutgers: the deliverables, areas of excellence, areas to be strengthened in the organization and how this will be achieved. The drivers of our work are presented below the objectives. These form the basis of both our objectives and long-term outcomes. The drivers have been identified after analysing the facts and trends in the external environment. The set of values, presented at the right of the strategy map, shape our perspective during the implementation of our work. We also indicate a set of thematic priorities, topics within SRHR with specific focus in the coming years.

What drives our work

For many people, both in the Netherlands and abroad, experiencing their sexuality in a positive way is challenged by several factors. Looking at the current landscape of Sexual and Reproductive Health and Rights, a set of national and global developments can be identified which form the most relevant and urgent challenges that we foresee in the coming years. These challenges drive us to make strategic choices for realizing impact. These challenges can be clustered into three drivers that motivate our work.

Urgency

Global developments necessitate improvement of the sexual health of people worldwide and the fulfilment of their rights, specifically the SRHR of young people.

Urgency globally

The urgency to improve the sexual health and rights of people worldwide can be illustrated by the following facts and figures:

Today, the world population is growing by 1.18% per year, or approximately an additional 83 million people annually. The world population is projected to increase by more than one billion people within the next 15 years, reaching 8.5 billion in 2030, and to increase further to 9.7 billion in 2050. More than half of the global population growth between now and 2050 is expected to occur in Africa: 1.2 billion now, to 4.3 billion in 2100. Asia is projected to be the second largest contributor to future global population growth.[1] Furthermore, Africa is the youngest continent, with 60% of the population being below 30 years old. In addition, children under the age of 15 accounted for 41% of the African population in 2015. Because of this population growth, young people especially in Africa and Asia will more often face difficulties in the realms of higher education, employment, health and participation in decision-making processes.

Wars, persecution, and the effects of climate change have driven more people from their homes than at any other time.[2] Measured against the world's population of 7.4 billion people, one in every 113 people globally is now either an asylum seeker, internally displaced or a refugee.[3] These people are considered a vulnerable population due to their limited access to sexuality education and information, contraception and safe abortion. Sexual violence is a serious threat for people on the move.

The political climate is becoming more conservative and populistic. This tendency can be seen all over the world – in Europe, Africa, Asia and the USA. This affects the work we do in certain countries. And it will also more and more affect the donor community, given the shifts in politics in the USA and the UK. These countries are important donors and policy influencers in the international SRHR world. In recent years they had become relatively progressive forces. This is very likely going to change early in 2017.

Violence against women and girls is one of the most prevalent human rights violations in the world. Worldwide, an estimated one in three women will experience physical or sexual abuse in her lifetime. Sexual violence undermines the health, dignity, security and autonomy of the victims, yet it remains shrouded in a culture of silence. Apart from psychological problems such as depression, anxiety disorders and posttraumatic stress disorder, victims of violence can suffer sexual and reproductive health consequences, including forced and unwanted pregnancies, unsafe abortions, sexual dysfunctions, sexually transmitted infections including HIV, and even death.[4]

At least 222 million women in developing countries have an unmet need for contraception, meaning they want to avoid pregnancy but are not using modern contraceptives. Recent research reveals that insufficient progress has been made in meeting the demand for contraception in the developing world. In large parts of Sub-Saharan Africa, the unmet need for contraception has actually increased since 2008. Women with an unmet need for contraception are often not well informed about contraceptives which makes them decide not to use them.[5]

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[1] UNDP World Population Prospects: The 2015 Revision, Key Findings and Advance Tables.
[2] UNFPA. State of the World Population Report 2015: Shelter from the storm.
[3] UNHCR. Global Trends Report: World at War (2015).
[4] UNFPA. Via: http://www.unfpa.org/gender-based-violence.
[5] Sedgh G et al. (2016). Unmet need for contraception in developing countries: Examining women's reasons for not using a method. New York: Guttmacher Institute.

This limited use of contraceptives is illustrated by the fact that **four out of ten pregnancies are unintended and/or unplanned.** In 2012, 50% of all unintended/unplanned pregnancies ended in abortion. Due to restrictive abortion laws in most developing countries, safe abortion is not available, causing thousands of women in the developing world to lose their lives or become seriously injured every year as a result of unsafe clandestine abortions.[6]

Since the 1950s, the overall global trend has seen the easing of legal restrictions on abortion while at the same time anti-choice movements have focussed on adding legal barriers that impede access to legal abortion services.[7] The World Health Organization (WHO) recognizes that in countries with restrictive abortion laws, induced abortion rates are high, and most abortions are unsafe. Legal restrictions on abortion do not reduce the likelihood that women facing an unplanned pregnancy will seek abortion services. Instead, they jeopardize the lives and health of poor women especially who only have access to unsafe abortion.[8]

Conservative forces have worked to obstruct global recognition of sexual rights as human rights. At country level, the opposition to sexual rights is even stronger. For example, homosexuality remains illegal in 73 countries around the world. Most countries in the world have laws that set a minimum age for marriage, usually at age 18, but many countries provide exceptions upon parental consent or authorisation of the court, and customary or religious laws can set a lower minimum age for marriage.[10]

Hence, global developments challenge the sexual health and rights of the individual as well as hamper societies from becoming healthy, inclusive and prosperous.

Urgency in The Netherlands

Rutgers monitors the sexual health of people living in the Netherlands on a regular basis with large-scale studies among both adults and young people. These studies are important for revealing well-being, knowledge, attitudes, and behaviour about sexuality, and for identifying problems in the domain of sexuality.

From this research it became apparent that around 90% of both boys and girls use some form of contraception during first-time sex, and more than three quarters used contraception when having sexual intercourse with the last partner.[11] The use of contraception and condoms among young people is high compared to other western countries.[12] The number of teenage mothers (less than five per 1,000 girls under 20) and the number of abortions among adolescent girls (6.2 per 1,000 girls under 20) is among the lowest in the world. In general, young people feel confident and in control in sexual interactions.[14] Most adult men and women enjoy their sexuality and are satisfied with their sex lives. However, there are challenges to be met.

Sexuality education is mandatory in Dutch schools. **Every year 200,000 young people become sexually active in The Netherlands. They have to be prepared and need sexuality education;** therefore, teachers should be enabled to provide sexuality education. A recent study revealed that the quality of sexuality education at schools needs to be improved.[15] The need for comprehensive sexuality education is evident; the last representative study, for example, revealed:
• a lack of knowledge (e.g. 37% of boys and 29% of girls think that STIs can be prevented by washing oneself),
• unpreparedness for first-time sex (38% of boys and 31% of girls), which is a risk factor for pregnancy and STD, and inadequate communication about STD prevention (two thirds did not discuss this during first time sex),
• negative experiences, feelings and regret among girls (29% of girls and 16% of boys regret the first time),
• sexual problems among girls (e.g. 11% of girls suffer regularly/often from pain).

The prevalence of sexual harassment and sexual violence is comparable with international figures, which means that it is a serious problem in the Netherlands, as it is worldwide. Around 40% of Dutch women and 10% of Dutch men have at least once in their lifetime experienced some form of sexual harassment and 14% of women and almost 2% of men have had sexual intercourse against their will at least once. People with disabilities[16], homosexual men, bisexuals and transgenders[17] are at even higher risk. New forms of sexual harassment and violence arise that need to be addressed, such as sexting and grooming via internet.

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[6] Sedgh, G., Singh, S. & Hussain, R. (2014). Intended and unintended pregnancies worldwide in 2012 and recent trends. Studies in Family Planning, 45, 301–314.
[7] Finer, L. & Fine, J.B. (2013). American Journal of Public Health, 103: 4.
[8] WHO, Safe abortion: technical and policy guidance for health systems 23 (2012).
[9] International LGBTI association. June, 2016. Via: http://ilga.org/downloads/03_ILGA_WorldMap_ENGLISH_Overview_May2016.pdf.
[10] UN Department of Economic and Social Affairs-Population Division, Population Facts, 2011.
[11] Sources for the Dutch situation: Graaf, H. de, Kruijer, H., Acker, J. van & Meijer, S. (2012). Seks onder je 25e. Seksuele gezondheid van jongeren in Nederland anno 2012. Utrecht: Rutgers WPF/Amsterdam: SoaAidsNL. and Graaf, H. de (2012). Seksueel gedrag en seksuele beleving in Nederland. Tijdschrift voor Seksuologie, 36(2), 87-97.
[12] Gabhainn, S.N., Baban, A., Boyce, W., Godeau, E., & the HBSC Sexual Health Focus Group (2009). How well protected are sexually active 15-year olds? Cross-national patterns in condom and contraceptive pill use 2002–2006. International Journal of Public Health, 54, S209-S215.
[13] CBS; Landelijke Abortus Registratie 2014, Rutgers.
[14] De Graaf, H. et al. (2012). Seks onder je 25e. Seksuele gezondheid van jongeren in Nederland anno 2012. Utrecht: Rutgers WPF/Amsterdam: SoaAidsNL.
[15] Inspectie van het Onderwijs (2016). Omgaan met seksualiteit en seksuele diversiteit. Een beschrijving van het onderwijsaanbod van scholen. Den Haag: Ministerie van OCW.
[16] Van Berlo, W. van et al. (2011). Beperkt weerbaar. Een onderzoek naar seksueel geweld bij mensen met een lichamelijke, zintuiglijke of verstandelijke beperking. Utrecht: Rutgers WPF/Movisie.
[17] Rutgers WPF (2013). Wat maakt het verschil? Diversiteit in de seksuele gezondheid van LHBT's, een verkenning. Utrecht: RutgersWPF.

Women face more sexual problems than men: 27% of women vs 19% of men have a clinical sexual dysfunction. In addition, women enjoy sex much less than men (60% compared to 78% who indicate enjoying sex most of the time or always).

There are several groups in the Netherlands that need specific attention regarding sexual health because they are at greater risk of sexual problems, and their needs are often not adequately addressed. These groups include elderly people, (young) people from ethnic minorities, refugees, people with a chronic illness and those with an intellectual or physical disability.[16] These groups often lack adequate information about sexuality, sexual and reproductive rights, and policies in institutions. Professionals and teachers working with these underserved groups need specific knowledge and skills to deal with their sexual health issues.

Restrictive norms

Restrictive sexual and gender norms are preventing people from receiving the information and services they need to make safe and informed decisions and to fulfil their sexual and reproductive health and rights.

Global data reveals that there is a large difference in the extent to which people consider sexuality to be something secretive and shameful, that cannot be talked about. It was found that on average 46% of people across 40 nations saw sex between unmarried adults as morally unacceptable, with Pakistan as an outlier where 94% found this morally unacceptable. Most countries were more accepting towards the use of contraceptives, except for Pakistan, Nigeria and Ghana where half or more say that contraceptives are immoral.[19]

Data from the world values survey, conducted by the University of Michigan Institute for Social Research (ISR), indicate that Muslim and Western countries are worlds apart when it comes to a range of attitudes in relation to sexual liberalization and gender equality.[20]

Restrictive sexual and gender norms are motivated by religious, social and cultural views and beliefs, and have an impact on the sexuality of young people (who are not allowed to have sex before marriage), women, people with a non-heterosexual orientation, and people with different gender identities. The male heterosexual norm still very much prevails. Evidence is increasing that patriarchal gender norms not only have negative implications for women and children but also for men themselves.[21] As a consequence of these restrictive sexual and gender norms, many people worldwide are not acknowledged in their sexuality, and their sexual and reproductive rights are violated. In recent years, we have noticed polarization with, on the one hand, upcoming religious and cultural conservatism and, on the other hand, growth in progressive views.

This leads to increased disagreement, lack of understanding and polarization between conservative and progressive groups regarding SRHR issues.

Although the Netherlands has a reputation of tolerance and openness about sex, the double standard still exists among young people, meaning that boys have more sexual privileges than girls.[22] Furthermore, although tolerance regarding homosexuality is relatively high in the Netherlands[23], negative attitudes among young people towards homosexuality are quite common: 57% of boys and 31% of girls between 12 and 25 disapprove of two boys having sex, and 24% of boys and 30% of girls feel the same about two girls having sex.[24]

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[18] Gianotten, W., Meihuizen-De Regt, M., & Van Son-Schoones, N. (Red.) (2008), Seksualiteit bij ziekte en lichamelijke beperking. Assen: Van Gorcum; Leusink P. & Ramakers, M. (Red.) (2014), Seksuele gezondheid. Probleem georiënteerd denken en handelen. Assen: Van Gorcum.
[19] http://www.pewresearch.org/facttank/2014/04/15/whats-morally-acceptable-it-depends-on-where-in-the-world-you-live/
[20] http://ns.umich.edu/Releases/2003/Feb03/r022503.html
[21] WHO (2007). Engaging men and boys in changing gender-based inequity in health: evidence from programme interventions. Washington: World Health Organization.
[22] Emmerink, P., van Lankveld, J., van den Eijnden, R., ter Bogt, T. & Vanwesenbeeck, I. (submitted). Comparing explicit and implicit measures for the assessment of sexual double standard endorsement. The Journal of Sex Research.
[23] Kuyper, L. (2016). LHBT Monitor 2016. Opvattingen over en ervaringen van lesbische, homoseksuele, biseksuele en transgender personen. Den Haag: Sociaal en Cultureel Planbureau.
[24] De Graaf, H. et al. (2012). Seks onder je 25e. Seksuele gezondheid van jongeren in Nederland anno 2012. Utrecht: Rutgers WPF/Amsterdam: SoaAidsNL.

Power dynamics

The key influencers in the field of SRHR as well as their level of power are changing and becoming more interrelated to one another.

At several levels, changes in the existing power structures have been observed which have direct or indirect consequences for our work. Big shifts are taking place in the international development landscape that will impact future global health efforts.

Economic aspects

Since the adoption of the Millennium Development Goals in 2000, bilateral and multilateral official development assistance has increased and is still rising in terms of total US dollars (almost 10 billion US dollars in 2015 compared to 2014, although as percentage of gross national income this has flatlined at about 0.3%).[25] Evidence of the total corporate sector contribution for development aid is scattered. Corporate giving and funding by private foundations was estimated at 33 billion US dollars in 2014 compared to 137 billion US dollars of ODA in 2014.[26]

We see an increasing concentration of power in the hands of a few actors that go beyond national borders, for example, multinational corporations and philanthropic institutions that operate internationally. Furthermore, governments of developed countries are in some cases moving from funding northern development partners to funding implementing development actors in the South directly. This requires Northern development partners to develop new funding mechanisms.

There is a trend for economic theories becoming more important in public health and the global development aid sector; for example, the connection between aid and trade, the value for money approach and cost-effectiveness as well as results-based financing.

Collaboration

A shift is experienced from operating in isolation to multi-stakeholder approaches and more close collaboration between various types of players in the field of public health and development aid. Collaboration with district governmental staff, government health personnel, NGO clinic staff, ministries, international NGOs, donors, and multilateral institutions (UN agencies, World Bank) are more frequent than before and most of the time essential for realizing and sustaining impact. This intensive collaboration between stakeholders can furthermore be seen through public-private partnerships (e.g. the Global Fund) that are developed as well as work at national, regional and international level becoming more interlinked with one another.

Religious and political conservatism

A worrying shift in powers that we are faced with is increasing religious and political conservatism, populism and nationalism. We are confronted with a rise in conservative politics, the rebirth of nationalistic rhetoric and the promotion of a return to “traditional values”. The growing SRHR opposition is often supported (in terms of resources, know-how and finance) by anti-choice groups and seems to be part of a regional / global action.

For years opposition groups have been connected to religious groups. The involvement of young people has been a key strategy in the anti-choice movements. Recent strategies of opposition groups opposing SRHR actively mobilise parents and very young people (10-14 year olds).

Discrepancy between global commitment and national agenda

A challenge we are continuously facing are governments that publicly endorse global commitments but execute their own agenda at national level, sometimes contrary to international standards and agreements. This is especially visible in regard to human rights standards related to SRHR.[27] We also notice a shrinking space for civil society. Human rights organisations, pro-democracy actors and wider civil society movements in many countries are facing increased restrictions when trying to carry out their work. For example, in newer democracies or countries that undergo political transitions, there is a fear of civic activism and governments have little experience with regulating political protests or public debates. However, in democracies with longstanding traditions of supporting freedom of expression the space for civil society is also shrinking.

Online media

Online media provide many opportunities for communicating fast, easily and directly towards stakeholders and allow the voice of individuals/ smaller groups to be heard. Online media are changing the way messages are framed, using more images and infographics. We notice a tendency towards more emotional framing (i.e. storytelling, tweet messages, images through Instagram) compared to the use of evidence-based framing (i.e. scientific research): the world in 140 signs. However, with the rise of online media, new dangers emerge such as online sexual abuse.

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[25] The global picture of official development assistance, www.oecd.org.
[26] Development Initiatives (2014). Measuring private development assistance. Emerging trends and challenges, www.devinit.org.
[27] ASTRA Central and Eastern European Women’s Network for Sexual and Reproductive Rights and Health. Via: http://astra.org.pl.

Vision

People are free to make sexual and reproductive choices, respecting the rights of others, in supportive societies.

Mission

We empower people through education and improve access to information and services. We strengthen professionals, organizations and societies. We connect research, implementation and advocacy.

Outcomes

For our vision to become reality, we see a need, worldwide, for the achievement of the following four outcomes:

1. More young people, in and out of school, receive comprehensive sexuality education;
2. More people have access to improved, needs-based sexual and reproductive health information and services;
3. Civil society is a leading actor in achieving Sexual and Reproductive Health and Rights in more countries;
4. More governments provide greater support for sexual and reproductive rights.

The mission summarizes how Rutgers will contribute to achieve the four outcomes, and thus bring the realization of our envisaged ideal world a step closer. The core of our work is directed by the following objectives.

Objectives

What do we want to deliver?

Capacitate partners to implement and scale up quality interventions
We capacitate partners in implementing interventions; we ensure sustainability through scaling up strategies, by linking up with key actors such as governments; we design and implement quality interventions which are evidence-based, cost-effective and easy to adapt to a local context in order to be culturally sensitive.

Strengthen civil society organizations and networks
We capacitate civil society as a whole to fulfil their role as watchdog and implementer by training and skill building in SRHR aspects as well as fund raising, management, and communication; we strengthen networks by alliance-building mechanisms, (global) movement building and joint programming.

Provide reliable information to public and professionals
We develop context-appropriate SRHR content; we spread information through various channels, digital or in print, nationally and internationally, maintaining state-of-the-art knowledge, needs-based and evidence- and practice-based.

Advocate for adoption of progressive norms
We sensitize, raise awareness and convince stakeholders at community level as well as at national level on progressive norms around SRHR themes that include a human rights perspective and ensure freedom of choice while respecting the rights of others.

What do we want to be excellent at?

Translate evidence into practice and back
We collect insights through pilots, learn from academic research, monitor continuously; we conduct action research and evaluations of programmes. We translate the evidence into practice by adapting interventions and implementing strategies. We ensure that outcomes are applicable and available for professionals. The insights and work experience of professionals are reflected in our advocacy, implementation and research activities.

Communicate in a cutting-edge and youth-friendly way
We communicate effectively with our target audience in attractive needs-based ways. Our messages are clear cut and to the point and we are not afraid to speak out. Communication with young people takes place in a non-stigmatizing, non-judgmental way. Through meaningful youth participation we make sure that the voice of young people is heard.

Connect and being connected
We connect our national and international work. We connect partners in countries to support collaborations on SRHR. We make sure we are part of the global movements, relevant networks such as IPPF and influential alliances in order to make use of synergies and jointly achieve stronger outcomes. We stay connected in order to be well informed and to learn from our partners.

What do we want to strengthen in the organization?

Act focused, fast, flexible
Our focus is on what works best in order to realize long lasting impact on specific areas instead of serving all themes within SRHR. We move fast and flexible so that we can quickly act when new opportunities emerge. We develop easy adjustable interventions that can be modified based on new insights or evidence.

Collaborate between departments and offices
We can become so much stronger when connecting the work between national and international programmes, between all departments and between the four country offices. We connect departments at Rutgers by a better exchange of information between the domains of research, advocacy and implementation. We stimulate knowledge and information sharing, joint fund raising, sharing of contacts and we involve country offices when strategic discussions or decisions emerge at HQ and vice versa.

What are our resources?

Diversify funding
Rutgers currently carries out projects and programmes funded by public as well as private donors. The largest amount of funding is derived from public donors, leading to a need for diversifying funding. We aim to diversify our funding to various national and international donors.

Empower passionate professionals and country offices
The asset of Rutgers is its people - well trained and passionate staff. We aim to empower them in order to effectively and autonomously operate in their field of expertise and show creativity, commitment and entrepreneurship.
Country offices will follow an agreed, time-bound trajectory which leads towards substantial financial independency.

Thematic priorities

We have set thematic priorities, topics within SRHR that will receive our specific attention in the coming years. It is in these fields that we expect to have the greatest impact.

Our focus will be on contraception and safe abortion as important issues in the context of population dynamics, and the right of people to plan whether and when to have children. Sexual and gender based violence is a major problem worldwide that deserves our ongoing attention. These priorities also mean that we will mainstream several other topics in the work we do on sexuality education, advocacy, research and implementation:

- HIV and STIs
- Sexual diversity
- Child marriages
- Maternal health

Mainstreaming is crucial to be effective. And mainstreaming means inclusion and being explicit.

Values

In all our work, we commit to the following values:

Inclusive

We believe that all people, regardless of their sex, gender identity, sexual orientation, age, cultural background and socio-economic status, health status and disability have equal rights and access to regular services, education and information. This means we have a special responsibility to ensure the meaningful participation of young people and that those most deprived are focused on in our work.

Gender equality

We believe that gender equality is essential to realizing Sexual and Reproductive Health and Rights. Rutgers puts this into practice by, amongst others, using a gender transformative approach. This implies involving women, men and LGBTI people.

Positive approach

We believe that sexuality is a fundamental aspect of human life that refers to gender roles and identities, sexual orientation, intimacy and pleasure. Therefore, we communicate a positive approach by accepting sexuality as a normal and positive aspect of life, and enabling people to explore, experience and express their sexuality in healthy, positive, pleasurable and safe ways.

Activist

We believe we have to take responsibility to move agendas, to push boundaries and to be outspoken.

Sustainable

We believe that our actions contribute to a sustainable world and live beyond the end of a programme. We work to ensure that our programmes are integrated into the local context and build on local ownership.

Openness

We believe that being open and accountable about what we do, what we achieve and how we do it is essential for achieving impact. We share our knowledge and interventions.

Together

We believe that together we have better results and a greater impact than on our own. This means that we partner with other organizations, experts and networks on an equal footing; encourage participation of end users; and work collaboratively between disciplines. We partner with civil society, governments, academia, the private sector and other partners in order to achieve our objectives.

We focus on people under 30

In our national and international work, we prioritize youth and young adults under 30 years of age. Empowering them towards happy and healthy lives will help to achieve our vision: people are free to make sexual and reproductive choices, respecting the rights of others, in supportive societies. In the Netherlands, we monitor sexual and reproductive health for the entire population as well. If evidence suggests that other groups need attention, we will make a special case. We are also open to collaborate with others who focus on specific groups.

Making the strategy work

In order to make the strategy work and implement it into practice, Rutgers will define impact indicators that focus on our work. These will be finalized at the beginning of 2017. This strategy will be translated into work plans for each office per year. Through quarterly monitoring, we will check the implementation and will be able to adjust the work in order to achieve our objectives.

Rutgers

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