From population issues to SRHR

– SWEDISH GLOBAL ENGAGEMENT IN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

REGERINGSKANSLIET

Government Offices of Sweden

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Foreword

Much has happen since the Programme of Action was adopted at the United Nations International Conference on Population and Development (ICPD) in Cairo in 1994. Women's health care is considerably more developed today and the risk of dying in childbirth is significantly lower. More women are surviving pregnancy and delivery, and more often it is women themselves who are determining the number of children they they will have. More women have access to maternal health care today and the life expectancy for both women and men has risen. So much has improved. Swedish assistance plays an invaluable part in strengthening women's rights and freedoms. But many challenges still need to be addressed.

On average, 800 women die every day due to complications in pregnancy and childbirth. Of these, approximately 200 are teenage girls. As many as 22 million unsafe abortions take place worldwide each year, often as a result of unwanted pregnancies. Being able to decide over their own bodies is far from self-evident for many women and girls and continues to be restricted.

Women's rights are by no means simply a question of poverty; rather they are influenced by many different factors. In Europe, the right to decide over one's own body may be limited by the perception of women's role in society. Resources for maternity care are often cut back in countries under economic crisis. In Sweden there are forces that want to restrict the statutory right to safe abortion, which has been in force since 1975.

The Ministry for Foreign Affairs has produced the publication *From population issues to SRHR – Sweden's global engagement in sexual and reproductive health and rights* for the International Parliamentarians' Conference on the Implementation of the ICPD Programme of Action (IPCI/ICPD), which will by hosted by Sweden on 23–25 April 2014. The aim of this work is to briefly describe Sweden's early engagement in population issues and how this has developed into today's sexual and reproductive health and rights (SRHR) initiatives, with a focus on gender equality and human rights. We hope that our experiences can inspire other countries to advance decisions that promote the development of SRHR.

This booklet, which is a summary of the much longer original work in Swedish, describes Sweden's engagement in SRHR from the 1950s, during the ICPD Conference in Cairo in September 1994, and in subsequent years. An important part of this journey has been a shift in focus from population issues to SRHR. In addition, the subject has developed from purely a public health issue to becoming a key part of gender equality efforts and the struggle for universal human

rights. Through documenting this work we can learn how to achieve success in our continued efforts to guarantee sexual and reproductive health and rights for all women, men and young people in the world.
I am very proud of the way in which Sweden has actively pursued and continues to pursue SRHR issues globally. I hope and believe that Sweden has helped improve the situation for thousands of women and men through this support.

My hope is that this booklet will be an inspiration to continue working towards a more gender-equal and equitable world. Strong engagement and commitment are still necessary.

Hillevi Engström
Minister for International Development Cooperation

Conflict and development – population issues in Swedish development assistance from 1958 to 1994

The start of Swedish development assistance

Issues related to sexuality and reproduction have long played an important role in the development of Swedish society. Midwives have been trained in Sweden since the early 1600s. In 1938 the ban on information about contraceptives was lifted, and in 1944 abortion was granted under certain conditions and homosexuality was decriminalised. Sexuality education in schools started in the early 1900s and became mandatory in 1955. The first youth clinic was opened in Falun in 1970, and in 1975 women gained the right to decide on abortion until the eighteenth week of pregnancy.

The more liberal view of sexuality that emerged in Sweden made it possible to speak more openly about sexuality and family planning. Sweden was therefore able to be a pacesetter in population issues and family planning as Swedish development assistance got under way in earnest. By the mid-1950s Sweden began raising population and family planning issues internationally. In a bold initiative Sweden raised the issue of female genital mutilation in the World Health Assembly, the governing body of the World Health Organisation (WHO). But resistance was solid. The resolution Sweden had presented was voted down by a crushing majority. Our neighbouring countries abstained from voting. The only vote in favour of the resolution was Sweden's own.

At a women's conference in New Delhi in 1955, representatives from former Ceylon contacted the Swedish delegates to discuss the possibility of development assistance for family planning. In 1958 Sweden began a development assistance initiative that was the first of its kind in the world. In 1961 a second family planning project was started in Pakistan.

Focus on population

In the early 1960s, two new revolutionary forms of contraception were introduced: the birth-control pill and the intrauterine device (IUD). This coincided

with the knowledge that the combination of declining child mortality and continuing high fertility in developing countries meant increasingly rapid population growth. The mortality rate in many developing countries fell as rapidly in 20 years as during the last 100 years in industrialised countries. The population in these countries rose by between 2.5 and 3 per cent per year, and alarm signals during the 1960s grew louder and louder.

Family planning, often referred to earlier as birth control, came to be seen by many, especially in the industrialised part of the world, as the most important way to reduce the rate of population growth, or even to save the world from a population explosion. US President Lyndon B. Johnson believed that an investment of USD 1 on family planning was worth more than USD 100 on 'development'. But there were also governments, particularly on the African continent, that wanted their populations to grow as rapidly as possible. For example, Tanzania, which in the early 1950s had a population equal in size to that of Sweden at around seven million, now has 48 million inhabitants, while Sweden's population amounts to nine million today.

Swedish population and family planning assistance from 1965 to 1975

These perspectives formed the backdrop as Swedish development assistance for family planning continued to increase. The Swedish Parliament (Riksdag) also decided that family planning should be exempted from the country concentration principle, which otherwise applied in bilateral assistance. Sweden supported family planning initiatives in over 30 countries in Africa, Asia and Latin America.

Half of this early family planning assistance was provided in the form of contraceptive services. For some time the Swedish International Development Cooperation Agency (Sida) was the world's largest buyer of condoms, and consequently was able to force prices down to benefit other countries as well. Swedish staff worked with family planning in Ceylon, Pakistan, Tunisia and eventually in Kenya as well. Sexuality education also became a component of the assistance.

The design of the development assistance provided reflected an overconfidence in technology – in this case, modern contraceptives. It was believed that simple access to contraceptives would lead to their use by those who were assumed to need them. But the new methods of family planning were clearly inadequate. Experts then recommended that 'motivators' had to be offered to encourage family planning. Information, education and communication (IEC) initiatives were developed. Sweden provided assistance with printing presses and paper, and supported the establishment of special units for information about family planning. Research was conducted on how to influence people's behaviour. Marketing experts were engaged. Consideration was given to which colours were most appealing, how images should be designed and which arguments would best sell the message.

This strategy failed in the same way as the earlier approach with its narrow focus on contraceptives. The technical solutions were not sufficiently adapted to people's situations and needs, and were clearly experienced as irrelevant by the vast majority. The fact that tens of millions of abortions were being performed every year, most of which were illegal and conducted under wretched conditions, did not automatically translate into a demand for family planning.

Many of the large Asian countries already had national family planning programmes in place at this time for demographic reasons. Not infrequently, it was the donors who pressured these countries into organising special 'vertical programmes'. Some even believed that health care was counterproductive for family planning, which should therefore be pursued separately and include the possibility of distributing not only condoms but also birth-control pills, just like any other product. There were also those who thought that health care, which led to reduced mortality rates, was less effective in development terms than 'pure' family planning, as it led to even more rapid population growth.

The pioneering Swedish work of the 1950s and 1960s – raising issues concerning population, family planning and sexuality in international bodies – was crowned with success in the late 1960s. In 1965 the UN, for the first time, gave technical assistance to family planning, and in 1968 the UN recognised the opportunity to decide the number and spacing of children as a basic human right. But it would still be another ten years before a woman's right to make such decisions on the same terms as a man was accepted. In 1966 Sweden was the first country to provide support to the International Planned Parenthood Federation (IPPF), founded in part by Elise Ottosen-Jensen in 1953, who was also the founder of RFSU, the National Swedish Association for Sexuality Education, which was one of the IPPF's member associations. Sweden was also the first to support the United Nations Population Fund (UNFPA) when it was founded in 1969. The World Health Organisation's Special Programme of Research, Development and Research Training in Human Reproduction (HRP) began its work in the early 1970s at the initiative of Sweden.

Turning point in the population debate

At the same time as reproduction and family planning issues were being placed on the international agenda, an increasing polarisation was taking place. On the one side were those who stressed population issues and the necessity of reducing population growth rates using family planning as the primary tool. On the opposite side were groups, often on the political left, who questioned both the existence of a population problem and whether organised family planning would have any impact.

From a rights perspective, there were two important aspects linked to family planning: the right of women to be free from coercion and undue influence, and

the right of access to safe and high-quality family planning services, including freedom of choice. Emerging feminist groups initially focused heavily on the right to prevent women from being subjected to coercive measures or influence. Above all, it was women in developing countries who claimed that it was not possible to have reproductive rights when society in general was characterised by economic, social and gender-related inequality. Their struggle accordingly also came to include women's liberation and independence. Common to these women's movements was the criticism of an attitude that viewed women as an instrument for limiting fertility and thus population growth. Instead they demanded policies that would make it possible for women to exert control over their own bodies and lives. This would require not only access to safe contraceptives, but also financial and social conditions that would make reproductive choices possible.

The World Population Conference in Bucharest in 1974 became somewhat of a turning point in the population debate. Developing countries protested against a one-sided focus on family planning and argued for assistance to advance socio-economic development and increased equality. The conference concluded with a declaration in which family planning was to be part of a general health and welfare policy: "Development is the best contraceptive."

But far-reaching changes took time to realise. The World Bank began to support family planning by the end of the 1960s. But it was not until 20 years later that the Bank began providing loans for health projects. And it was another ten years after that before these became a significant part of the Bank's lending programmes.

Development assistance to family planning as a population control measure is discontinued

The fragmentation of Swedish support between a large number of different recipient countries outside the sphere of programme countries declined over time. Meanwhile, assistance was increasing rapidly to IPPF and UNFPA, which were active in a large number of countries.

Family planning in the large Asian countries, generally divorced from health care, received development assistance from Sida in the 1970s for experiments using rewards and quantitative targets. But opposition grew between the separate family planning programmes and regular health care. Family planning benefited economically and staff-wise. Incentives – and in certain cases disincentives – were instituted, and quantitative targets were introduced for staff, who sometimes received bonus payments linked to the number of 'acceptors', as they were then referred to, of family planning.

In a number of Asian countries, family planning programmes were operated in isolation from general health care, which undermined confidence among the population. Studies showed that most people had knowledge of family planning

and many stated that they wanted to plan their families. But only a few did so.

Criticism increased in Sweden and within Sida of the perception of family planning as the primary instrument to reduce the rate of population growth. This development was hastened by the disastrous handling of family planning in India, where the Government in the mid-1970s implemented strict measures, including a forced sterilisation programme. Opposition was violent and brought the Government down. A lively media debate broke out in Sweden, and the criticism was so strong that in 1980 Sweden decided to stop supporting family planning in India.

Bangladesh had followed India's methods, particularly the sterilisation programme and the far-reaching system of incentives and disincentives. Typically, the focus was on the sterilisation of women – a significantly more extensive and risky operation than male sterilisation. In the early 1980s it was discovered that a number of women had died during the approximately 180 000 sterilisation operations already performed. The connection to women having been lured or forced to undergo sterilisation, and thereby subjected to the risk of harm or even death, was deemed unacceptable from an ethical perspective and led to the termination of Swedish support. This marked the end of the discussion on Swedish population assistance. After more than ten years of vacillation, Sweden had finally decided to let go of its old approach. The problem was that as yet there was no other alternative.

Fresh breezes

The 1978 primary health care conference in Alma Ata became a major milestone in the history of public health. It was here that the term primary health care (PHC) was launched and recognised internationally, and maternal and child health including family planning (MCH) was defined as one of the eight key elements of primary health care. The Alma Ata Declaration strongly supported family planning in primary health care, based on its significance for maternal and child health. The arguments for integrating family planning in health care were strengthened even further.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted in 1979 and became a platform for women's rights concerning sexuality and family planning. This is the only human rights convention that underscores the necessity of respecting women's reproductive health and rights to ensure a non-discriminatory society. The 1984 Conference on Population in Mexico City entailed a further shift in the perception of population issues. At the Conference, the implementation of family planning in maternal and child health care was emphasised more strongly than before. The role and importance of women was highlighted more clearly. The question of family planning as an individual human right and the ethical aspects of influence

on individuals also became more important. But at the same time, the Conference adopted a restrictive attitude towards abortions, which led to the Swedish delegation's public expression of regret that the Conference did not address the serious problems created by unsafe abortions.

By the mid-1980s, maternal health care was still largely in the shadow of child health. Huge progress was being made in the area of child health and survival. MCH in practice became a question of child health despite the knowledge that the differences between industrialised and developing countries regarding maternal health care were enormously greater than the differences regarding other health aspects. If the difference between countries with the highest and lowest levels of infant mortality was 1:20, the difference in maternal mortality was as much as 1:200.

In a now classic article published in *The Lancet* in 1985, authors Rosenfeld and Maine asked the question "Where is the M in MCH?" The article became the impetus for greater commitment to maternal health care issues, both globally and nationally. Two years later, in 1987, the Safe Motherhood Initiative was launched at a conference held in Nairobi. This primarily meant a stronger link between family planning and health care and the issue of the position of women.

These ideas, together with the emphasis on a woman's right to her own body and every person's right to reproductive health services led in 1992 to the coining of the term 'sexual and reproductive health', which included all these issues and accordingly came to stand for a holistic perspective.

Towards a new approach to development assistance

The conflicts surrounding family planning during the 1970s and 1980s had led to confusion and passivity within development assistance. Support to the family planning programmes in India and Bangladesh had been stopped. Swedish development assistance to family planning within the framework of health care was out of the question in these countries. African countries had accepted the principle of integrating family planning and health care in Swedish development assistance, but in practice this had no major impact. Maternal health care was often so deficient that it was unable to provide any kind of reasonable service.

A new policy for Swedish health aid was established in 1982, stipulating maternal and child health – including family planning – as one of three priority areas. Family planning was stated to have little effect for population policy purposes. It should instead serve the idea that "all couples and individuals have a basic right to decide freely and responsibly the number and spacing of their children" (paragraph 29 of the Declaration from the World Population Conference held in Bucharest in 1974). This meant that Swedish assistance should contribute to creating maternal and child health care that included family planning as a natural part of the service. This principle also meant that there should be a varied selection of

different contraceptive methods and that client reproductive choices must not be influenced by incentives to anyone other than the client her- or himself and must be free of coercion concerning irreversible methods such as sterilisation. Sweden simultaneously initiated funding to national maternal health care programmes and midwife training in countries such as Ethiopia and Angola.

The years leading up to the Cairo Conference

In 1990 Sweden drafted new guidelines, entitled 'Population and family planning: guidelines for development assistance'. Unlike previous guidelines, these were distinguished by their macro perspective, that is the link between global population growth and the environment, and the micro perspective, based on each woman's own situation. In other words, it was no longer a question of trying to resolve the world's population problem through measures directed at individual women.

The early 1990s saw the increasing influence of international and Swedish women's groups and non-governmental organisations (NGOs), and this impacted the aid debate in Sweden, particularly concerning the rights and role of women. In time it became clearer that the Swedish guidelines from 1990 needed to be rewritten to emphasise the gender perspective even more strongly, and to redefine the term family planning, which had traditionally excluded contraceptive services to those who were not married or considering starting a family. The point of departure was Sweden's experience in health care and work with young people, in much the same way as the early Swedish engagement in family planning – which was based on Swedish experience and the knowledge and evidence gathered from academics and practitioners around the world.

The new document, which was completed just before the Cairo Conference, was entitled 'Sexual and reproductive health: development cooperation to promote sexual and reproductive health – an action plan of the health division at Sida'. It focused on young people and women, access to contraceptives and safe abortions and the control of sexually transmitted infections, including HIV/AIDS, as well as capacity building and legislation.

The Cairo and Beijing conferences

Swedish preparations for the ICPD

The Swedish Government decided to make a major drive ahead of the Cairo Conference. Sweden's own history and experience from earlier aid initiatives formed the basis of continued support in the area of population and development, and women's health and rights. Sweden's experience would now be used to influence the international attitude towards these issues. But this required documentation that was carefully considered, well argued and factually based. Therefore, in 1991, three years before the UN International Conference on Population and Development (ICPD) was to take place, the Government appointed a national committee for the conference. The national committee represented broad knowledge on the matter and included members of the Riksdag, experts and NGOs. The national committee agreed early that Sweden would emphasise issues of sexuality, relationships and women's power over their own fertility at the Cairo Conference.

The committee drafted a position paper as background material for the negotiations and also ordered a number of written documents, including *Reproductive Health Revisted*, which was distributed in Cairo and at several pre-conference meetings in New York and Harare, for example. This book described Sweden's view of abortion, the important role midwives play in the prevention of unwanted pregnancies and sexually transmitted diseases, treatment for involuntary childlessness, sexuality-related information and young people's lives in Sweden at that time. The publication was factual and scientifically substantiated, yet at the same time it presented an appealing and sometimes challenging image for many countries. This was particularly true, for example, regarding the issue of adolescent sexuality and Sweden's view of sexuality education.

During the Cairo Conference, Sweden also distributed a publication about the perception of women in Sweden since the 1800s, as well as a book ordered from researchers at Harvard University entitled *Population Policies Reconsidered*, tens of thousands of copies of which were printed and which came to influence the approach to population issues which would distinguish the negotiations in Cairo. Sweden also supported a study that resulted in the publication *Human Rights in Population Policies*.

Sida participated in pre-conference meetings leading up to the Cairo Conference, which resulted in contacts with 'Women's Caucus', a large network of women's organisations that focused on achieving a new attitude towards population at the ICPD. Sida also financed some of this networking via the International Women's Health Coalition (IWHC), which had a leading role in the work.

As an additional part of the preparations, Sida and SAREC organised in 1993 a sub-regional conference in Harare with the countries of southern Africa. The conference helped focus on the individual and highlight the importance of women's rights and gender equality, issues that later became key to the Cairo Programme of Action. The parliamentarians from different countries that participated in this conference drafted a special 'Statement ahead of the ICPD', which advocated the legalisation of abortion, among other things.

International Conference on Population and Development (ICPD), Cairo, 1994

Gro Harlem Brundtland, Prime Minister of Norway at the time, opened the conference with a keynote address that essentially set the tone of the entire conference. She raised issues such as rights, health and resources, and adolescents' right to access education and basic reproductive health services, including family planning, as a universal human right for all. She emphasised that she could not understand how the term reproductive health care could possibly be interpreted as promoting abortions or qualifying abortion as a means of family planning. On the contrary, she stated, the global experience was that the number of abortions did not increase when abortion was legalised, but that abortion became safer for women.

Many people believed that it would be difficult to reach a consensus on issues that they had failed to agree on at the pre-conference meetings in New York. In particular, it seemed almost impossible to reach agreement on the issue of abortion. Resistance was political and religious, and the Vatican's support to the opposition carried considerable weight. There was great apprehension that it would not even be possible to agree on other health and rights issues that are particularly important to the health of women, children and adolescents.

But the outcome of the ICPD in Cairo instead became a turning point for how the world viewed population issues. From having been exclusively concerned with family planning, demographic trends and population control, the area was expanded to include sexual and reproductive health and reproductive rights, and other population-related issues such as migration and urbanisation.

Together with a number of other countries, the Nordic countries very determinedly pursued the right to safe and legal abortions. Sweden's focus was on women's conditions and rights – especially in the area of health – and adolescents' right to knowledge and power over their own sexuality and reproduction. Various arguments – everything from abortion as a right to the impossibility of speaking about safe abortions – were presented during the abortion debate. The drafting committee responsible for writing on the abortion issue remained deadlocked and therefore appointed a smaller group, which included representatives from the Nordic countries, to write a proposal. The outcome was a formulation establishing that abortion was a "public health issue" and that "in circumstances where

it is not against the law, abortion should be safe". The decision also meant that regardless of whether abortion was legal or not, women still had the right to the same aftercare.

The final document was adopted by consensus, although there were some reservations against certain parts from the Vatican and others. There was nothing in the document stating that abortion was a right, but no one had seriously expected this anyway. The outcome seemed inadequate from the Swedish perspective, but it was nevertheless experienced as a victory for women's rights. Reaching consensus on preventive measures against unwanted pregnancies and sexually transmitted infections, including HIV/AIDS, was also a step forward for the world's women. On the whole, the ICPD meant progress from the Swedish point of view, compared with previous world population conferences.

Several factors contributed to Sweden's impact on the outcome of the conference. In addition to the ambitious and extensive advocacy work pursued at the various pre-conference meetings within and outside the UN, Sweden collaborated extensively with IPPF and other international NGOs, both before and during the conference. But the Swedish delegation also felt that the long internal process of preparation and gaining support had made it possible for Sweden to pursue its objectives and have an impact on the negotiations. Sweden's political consensus, along with the Nordic cooperation in these issues, was also of great importance for how far the Swedish delegation could pursue certain SRHR issues in the negotiations. Specifically the issue of the right to abortion was a good example in which all political parties were united.

United Nations Fourth World Conference on Women in Beijing in 1995

Women's rights came even more clearly into focus during the Fourth World Conference on Women in Beijing in 1995, resulting in a greater highlighting and strengthening of SRHR issues as well. In an influential speech at the Conference, the then US First Lady Hillary Clinton recalled that "Women's rights are human rights" – the very wording used at the UN World Conference on Human Rights in Vienna in 1993 and found in the opening paragraphs of the Beijing Declaration and Platform for Action. The Conference also meant that SRHR was linked to a broad gender perspective that also stressed women's rights in issues of land ownership and property, inheritance, and political influence at all levels. The Beijing Platform for Action also established in paragraph 96 that "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence". Most importantly, women's sexual and reproductive rights were seen as fundamental to their participation in all parts of society. In the Beijing Platform for Action, States also undertook to combat violence against women and girls, both in times of peace

and war, and to protect and assist victims of violence. Moreover, it was established that references to culture, tradition and religion must never be used to disregard the rights of women.

Swedish actions following the Cairo and Beijing conferences

The period following the Cairo and Beijing conferences was very productive from the Swedish perspective. The national preparations had built up a knowledge base and critical mass. This, together with a political openness, enabled Sweden to tangibly contribute to the advancement of SRHR issues, both in terms of development cooperation and in other international contexts and negotiations. In 1999 Sweden assisted in drafting the resolution 'Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development' during a special session of the UN General Assembly. The resolution contained stronger language concerning adolescents, access to safe abortions where this was not against the law, and access to care following an unsafe abortion. Abortion was expressed as a right and as essential to achieving gender equality, and not as a method of family planning.

From words to action – Sweden's development assistance to SRHR after Cairo

Sweden's development assistance strategy for SRHR

The ICPD Conference in Cairo meant a complete reversal of thinking, from seeing population issues as caused by individuals' sexual behaviour to defining the problem as fundamentally a consequence of poverty, inequality and vulnerability. The term 'population issues' was thereafter used by Sweden exclusively for assistance related to demography and censuses, and to illustrate the consequences of continued population growth, for example within the debate on natural resources and urbanisation.

The Swedish action plan for sexual and reproductive health (SRH) from 1994 was considered to be well in line with the Programme of Action adopted in Cairo. It laid the foundation for work on a new aid strategy, 'Strategy for Development Cooperation – Sexual and Reproductive Health and Rights' (SRHR), which was launched in 1997. Sweden was early in including the element of 'rights', as the final R in SRHR. In Cairo, only the term SRH was used. 'Sexual rights' as a term was still controversial.

In addition to the self-evident aspects of maternal health care and care of newborns, counselling, services and access to contraceptives and measures against HIV/AIDS and other sexually transmitted infections, the strategy prioritised human rights and gender equality, safe abortions, adolescent health and measures to counter female genital mutilation, discrimination and sexual violence.

And then came HIV/AIDS...

From the mid-1980s the threat of AIDS became so immense that special new programmes were created to combat HIV and AIDS, internationally and nationally. Eventually it became clear that it was necessary to coordinate and integrate measures to combat HIV/AIDS and other sexually transmitted infections with measures to prevent unwanted pregnancies and make abortions safer.

During the initial chaotic period, Sweden chose to channel extra new resources for HIV/AIDS development assistance through international organisations, especially the World Health Organisation and the United Nations Development Programme. The first Swedish HIV/AIDS strategy, 'Investing for future genera-

tions', came in 1999. It advocated integrating HIV/AIDS issues in all development assistance sectors, and clearly distinguished between the causes of HIV infection and the effects of the AIDS epidemic. In 2002 Sida established an HIV/AIDS Secretariat and a regional HIV/AIDS team in southern Africa. The Ministry for Foreign Affairs established a position as AIDS Ambassador. These measures greatly strengthened Sweden's fight against HIV/AIDS.

At the end of the 1990s it became increasingly clear that HIV/AIDS would not disappear on its own and that Sweden and other aid donors needed to invest substantially more resources in order to tackle the problem. The Swedish reputation in the area of gender equality and SRHR provided Sweden with good opportunities to take forceful action.

June 2001 saw a huge breakthrough for international HIV/AIDS development assistance during the United Nations General Assembly Special Session on HIV/AIDS. Unlike in previous similar international negotiations, HIV/AIDS had made it easier to talk about sexuality and gender equality in relation to sexual health. It was clear that HIV was spreading fastest in Africa among heterosexuals, and that women were the most vulnerable as a result of both physiology and the prevailing gender-based power structure. But HIV/AIDS was also a huge issue for LGBT people and their organisations in both the North and South. The challenge during the negotiations was to have all countries agree on a resolution, including countries that did not even acknowledge the existence of people with another sexual orientation or gender identity. The final document stresses human rights for those living with HIV and for women and girls, as well as the need to eliminate all forms of discrimination.

The interdependence of SRHR and HIV/AIDS issues was seen early on as both a threat and an opportunity. The threat was that the availability of resources for HIV/AIDS initiatives was so great that SRHR aid would be overshadowed. The opportunity was the synergy effect. Many preventive measures to combat HIV/AIDS were identical to SRHR initiatives, such as education on sexuality and gender equality, prevention of sexually transmitted infections and distribution of condoms. Sweden pursued the issue of integrating SRHR initiatives in HIV/AIDS programmes in various contexts, not least through core support to UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and through a large regional programme in southern Africa.

New Swedish positions

In 2003 the Swedish Government adopted a new and broader development policy, 'Shared responsibility: Sweden's policy for global development'. Its dual approach – the perspective of poor people and the rights perspective – formed the foundation of a new SRHR policy and came to characterise Swedish SRHR aid. The world had changed since the SRHR strategy of 1997. New forms of aid had been

introduced under the Paris Declaration on Aid Effectiveness. Furthermore, US aid policy, in the form of the 'Global Gag Rule', had increased the need of financing for SRHR organisations that had lost their funding from the United States.

In 2006 the Government adopted 'Sweden's international policy for sexual and reproductive health and rights'. This new policy was based on the documents adopted in Cairo and Beijing, and on experiences of the SRHR strategy and of aid initiatives in the area. The foundation was the concept of the equal value of all people and the indivisibility of human rights. It was established that gender power analysis was a fundamental element of pursuing effective SRHR efforts. The SRHR policy specified 13 strategic areas, of which six dealt with gender roles, identities and human rights, four with reproductive health, two with sexual health and rights and one with capacity building. New areas included increased focus on LGBT people, and prostitution and human trafficking for sexual purposes. Several years later, in 2009, Sweden produced a new HIV/AIDS aid policy, 'The right to a future', and a 'Policy for gender equality and the rights and role of women in Swedish international development cooperation 2010–2015'.

Swedish development assistance

The Millennium Development Goals (MDGs) from the year 2000, particularly MDG 5 on improving maternal health, advanced SRHR aid. But it was only in 2006 – when reproductive health was introduced as target 5B as a result of strong advocacy by Sweden and others – that the entire SRH agenda from Cairo was secured. Political interest gradually grew and the lack of progress made in MDGs 4 and 5 eventually drew attention.

Early on Sweden gained the reputation of being a committed donor to SRHR concerns. The OECD-DAC peer review of Sweden in 1996 noted the fact that Sweden had stepped up its work in the field of reproductive health, and the review in 2000 identified Sweden as the "champion" of SRHR.

Swedish development assistance gradually changed after the turn of the millennium. The Paris Declaration on Aid Effectiveness from 2005 placed new demands on development assistance donors. For Sweden this meant a transition from direct funding of mainly specific, vertical programmes to a sector-wide approach in one country or to an entire organisation. This meant less potential to directly influence the use of Swedish funds, but opened the door to opportunities at country level, together with ministries and other donors, to exert influence in the field of SRHR in a larger context.

A large proportion of Swedish SRHR aid now goes to three international organisations whose activities are in line with Sweden's SRHR policies: IPPF, UNFPA and WHO. Sweden has also supported GFATM and UNAIDS since their inception. In addition, Sweden supports the Partnership for Maternal, Newborn & Child Health (PMNCH), and H4+, a partnership of six UN agencies.

A significant part of Swedish bilateral aid supports the development of health systems in a number of countries. All these country programmes include SRHR or HIV/AIDS components. Furthermore, Sweden supports global and regional programmes for the development of standards, knowledge, methods, capacity and advocacy at global and regional level, and international training programmes (ITPs) that aim to provide Swedish knowledge and skills through education and training. There are also SRHR components in Sweden's support for democracy and human rights initiatives through Swedish NGOs, and humanitarian assistance.

Maternal health care

Aid initiatives to counter maternal mortality are not controversial, unlike most other SRHR initiatives. But they have long been neglected as they are complicated, costly and dependent on functioning health systems at all levels, including qualified personnel and hospital care. Sweden's SRHR policy from 2006 is clear: all people must have access to reproductive health services and good maternity care, and all women must have power over decisions concerning their own health.

One of Sweden's comparative advantages as a development assistance actor in the field of SRHR is the Swedish experience of using midwives, who have been trained in Sweden since 1708 and who formed their own association in the 1880s. In the 1840s, the state of women's health in Sweden was at the same level as in many poor countries today. But following 50 years of reform efforts, the number of trained midwives rose, after which maternal mortality declined. Midwives are the personification of SRHR today, and not just in Sweden. Midwives are essential, with their broad sphere of responsibility and professional knowledge of reproduction and sexuality, and the rights associated with these. The role of the midwife as a reinforcement to education of other staff within maternity care has therefore become an important component of Sweden's maternal health care aid to countries such as Angola, Ethiopia, Nicaragua, India and Bangladesh. The African Midwives Research Network (AMRN), initiated in 1993, also received funding for many years.

As a result of assistance from Sida, the International Confederation of Midwives (ICM) was able to start national midwives associations in many poor countries. In 2006 ICM and Sida took an initiative to create the Global Midwifery Programme within the UNFPA, which falls under the umbrella of the Maternal Health Thematic Fund (MHTF), the aim of which is to make midwife training widely known and available in the poorest countries of the world.

Safe and legal abortions

Unsafe abortions are among the five most common causes of maternal mortality, particularly among girls and young women. Like most countries, Sweden once

had restrictive abortion legislation. But during the 1950s and 1960s, the perception of abortion gradually changed, and in 1975 this altered perception was confirmed in a new abortion law that entitled a woman to make her own decision on abortion up to the eighteenth week of pregnancy. This meant Sweden dared to emphasise the necessity of safe and legal abortions. Sweden's 2006 SRHR policy states that "women's lack of access to safe and legal abortions is an obstacle to their enjoyment of human rights... Sweden [therefore] supports efforts to make abortions available, safe and legal for all women".

Within country cooperation, state funding for abortion efforts has rarely been requested. However, menstrual regulation has been funded in Bangladesh since 1989 as a technique to provide abortions until the ninth week and is performed by several NGOs. In Kenya, development of the manual vacuum aspiration method was funded during the 1990s, providing a treatment for women who sought health care for serious complications following an unsafe, illegal abortion.
Sweden has found that the abortion issue is most effectively pursued through international organisations with technical credibility. One example is the funding of the World Bank's major report on the global abortion issue, which was written in 1993 by a Swedish gynaecologist. Another example is the financing of WHO's first abortion guidelines, *Safe abortion: technical and policy guidance for health systems*.

Global NGOs are important channels for support in the abortion issue. Ipas, founded in 1973, is one such organisation that has received Swedish core support since the early 1990s. Sweden is now the organisation's second-largest donor. Ipas focuses on ensuring access to safe abortions through funding the establishment of clinical services and staff training, and opinion formation at global level. Ipas was also a key actor in launching the African Union's Maputo Plan of Action (2006), a progressive policy that highlighted the issue of safe abortions. In this context it must also be mentioned that IPPF, which receives major funding from Sida, is one of the most important global actors in promoting safe abortions and preventing unsafe abortions.

Providing development assistance for safe abortions is politically sensitive. To combat the consequences of the Global Gag Rule in 2001, Sweden supported the formation of the global Safe Abortion Action Fund, the Global Abortion Meeting and several meetings within the International Consortium for Medical Abortion (ICMA). Support was also provided to Gynuity Health Projects and the Guttmacher Institute for research on medical abortions.

Access to contraceptives

Swedish SRHR policy states that access to information on and access to different methods of contraception, including condoms, is fundamental to enabling individuals to determine if and when they want to have children. Access to

high-quality contraceptive services, including freedom of choice, as playing a decisive role in women's health was somewhat lost in the controversies over the old form of population assistance and even after ICPD. The Vatican has also been consistently opposed to efforts involving modern methods of contraception.

But since ICPD, Sweden has financed major programmes that have included contraceptives as an important component, such as the substantial health sector funding in Bangladesh, Uganda, Zambia and previously in Kenya. Sweden is also one of the largest donors to IPPF, which in 2012 provided counselling to approximately 45 million young people and distributed 190 million condoms and 43 million other types of contraceptives. The issue of access to contraceptives and their use has once again come up on the global agenda, in part through the 2012 London Summit on Family Planning – FP2020. A global movement has started to ensure access to contraceptives for the 120 million women who today do not receive the help they require. A new type of support was established in 2013 when Sida, in cooperation with other donors and private foundations, entered into a partnership with the pharmaceuticals industry in an effort to significantly increase the use of two new long-acting contraceptives. A financial guarantee nowadays helps halve the price of these contraceptives and ensures they reach women in the poorest countries.

One example of Swedish partnership with the private sector in the HIV/AIDS area is the Universal Access to Female Condoms Joint Programme, run by several Dutch organisations, aimed at making different types of female condoms available that give women control and reduce their chances of becoming infected or pregnant.

Adolescents, SRHR and sexuality education

The view of adolescent sexuality and gender identity is primarily governed by prevailing values and cultural norms. These have implications for young people's scope and opportunities to express their sexuality, protect themselves from sexually transmitted diseases and avoid unwanted pregnancies. The Millennium Development Goal target 5B on reproductive health, adopted in 2006, became an indicator of 'adolescent birth rate', re-establishing for the first time since the ICPD a clear undertaking for the world's countries to target adolescents with their SRHR initiatives. Sweden has long supported initiatives for young people's right to decide over their own sexuality and to give them the opportunity to protect themselves against the risk of unwanted pregnancies or infection by HIV or other sexually transmitted diseases.

As early as the 1960s and 1970s, Sweden tried to support initiatives for sexuality education. But unfortunately this ambition was lost between sectors; the health care sector had difficulty reaching out to young people, and the education sector was difficult to engage. But from the 1980s Sweden became a pacesetter

by supporting NGOs' attempts to reach adolescent girls with sexuality education and through youth clinics. The demand for initiatives targeting adolescents, especially combined HIV/AIDS and sexuality education, increased with the rise of the HIV/AIDS epidemic. Sweden was able to support UNESCO in its production of 'International Technical Guidance on Sexual Education Curriculum' and provided extensive support to strengthen sexuality education in schools in eastern and southern Africa. Sida's support to and cooperation with NGOs, not least RFSU, also proved to be significant in pursuing difficult issues on SRHR, gender and power.

Gender equality and SRHR

Swedish gender equality strategies establish that gender equality between women and men is the foundation of effective work within the area of SRHR. This is also expressed in the action plans from Cairo and Beijing, and in Swedish SRHR and HIV/AIDS strategies. Sweden works with four areas of SRHR: support to women's networks, work with men and boys, efforts to combat violence against women and LGBTQ issues.

The role of men and boys

Since ICPD Sweden has sought to draw attention to the roles and responsibilities of men and boys in achieving gender equality, SRHR and HIV prevention. As these are typical dialogue and advocacy issues, Sweden has chosen to support networks and NGOs that disseminate information via publications and international meetings. As early as 1999 a meeting entitled 'Men's choices, men's voices: how can men gain from improved gender equality?' was arranged in Lusaka, Zambia. It focused on sexuality, fatherhood and male identity in a changing society.

There are men's networks for SRHR issues. One of the largest, MenEngage, has received Swedish funding for over a decade. It is a global umbrella organisation for 400 NGOs and many UN agencies working with men and boys to promote gender equality, prevent violence against women and sexual exploitation of children, and prevent the spread of HIV. The Swedish organisation, *Män för jämställdhet* (Men for Gender Equality), is part of this network. HIV/AIDS support has also been provided to their active African network, Sonke Gender Justice.

Gender-based violence

Gender-based violence is defined in Sweden as: "all injury and all suffering that a woman, girl, man or boy is subjected to that has a negative impact on the individual's physical, sexual or psychological health, development or identity. The cause of the violence is founded in gender-based, unequal power relations and gender-based discrimination." Moreover, gender-based violence is a crime against

human rights and a major risk factor in the spread of HIV and increased maternal mortality. Rape and other sexual violence is often used as a conscious tactic and weapon in war and conflicts. Many UN resolutions on women, peace and security have drawn attention to this, and Sweden's efforts in this area have increased significantly over the past decade. Sweden also assists the work of UN Action Against Sexual Violence in Conflict. In its disaster relief, Sweden has decided to only finance emergency aid plans that account for how issues of gender-based violence will be dealt with in the emergency action.

Right to their own bodies and sexuality

The final R in SRHR stands for sexual rights. This part of SRHR primarily concerns issues of rights, power and freedom from oppression, and the fact that all people have a right to their own sexuality as a fundamental element of human freedom. The term also implies recognising people's right to a different sexual orientation than the heterosexual one. The 2006 SRHR policy therefore highlighted the situation of homosexual, bisexual, transgender and queer people, and emphasised that Sweden must raise the level of knowledge and competence concerning sexual orientation and gender identities in its development assistance. Swedish support in the area of HIV is often focused on men who have sex with men (MSM), for example regionally in Africa through major funding to the International HIV/AIDS Alliance (IHAA), and in five African countries through the International Gay and Lesbian Human Rights Commission (IGLHRC).

Looking to the future

A number of international meetings during the last decade have involved complex negotiations on SRHR in both the UN General Assembly and in the UN Human Rights Council. These negotiations have included everything from rights of children and girls, forced marriage, young people, women in rural areas, women human rights defenders and family issues to trafficking, global health and the overall direction of the post-2015 agenda. Sweden's position in post-2015 negotiations raises SRHR as a priority issue within the framework of everyone's right to have access to health care services and in promoting gender equality, which also must become a goal in itself.

Sweden currently invests more money than ever on SRHR in its development assistance. In 2012, Sweden's support to SRHR (including HIV/AIDS) amounted to approximately EUR 300 million. Sweden is now the largest donor to UNFPA's core budget and third largest in its total support to UNFPA. Sweden is also very active on the boards of UNFPA, UNAIDS, UNICEF, GFATM, the World Bank and the GAVI Alliance to ensure that gender equality and rights perspectives underpin the work of these organisations. Sweden continues to defend SRHR in global negotiations and through its financial support.

In a speech at the UNGA Heads of State Meeting in New York in September 2013, Swedish Prime Minister Fredrik Reinfeldt focused on gender equality and SRHR. It was reported that at the press conference afterwards a journalist asked Mr Reinfeldt if he did not have any more important issue to raise than gender equality. This reaction to Mr Reinfeldt's speech once again proves that Sweden's leadership is still necessary in SRHR and gender equality issues.

Nordic cooperation on gender equality and SRHR has become increasingly important in recent years and now plays a key role in Sweden's UN-related negotiations. The policies, strategies and financing models of the five Nordic countries reflect common ideas and convictions that gender equality and SRHR are decisive for development. They agree on the importance of combating the tendency of conservative countries to narrow the broad field of SRHR to simply the issues of abortion or LGBTQ.

Closing comments

Sweden's current global engagement in SRHR, as noted above, is multifaceted, just like the term SRHR itself. The volume of initiatives within the uncontroversial areas of maternal health care, including the role of midwives, has grown considerably over the years. As well, Sweden has once again drawn attention to the glaring lack of contraceptives in poor countries and has begun to play a more active role in this area.

Initiatives in the controversial areas, which largely concern the issue of rights, have also grown and are examples of headwind issues that are difficult to integrate in major bilateral health funding or UN programmes. They include initiatives for safe and legal abortions, young people's sexual and reproductive health and rights, the role of men and boys, gender-based violence and everyone's right to express their sexual orientation.

The strong political support from the Government and Riksdag has resulted in the rapid advancement of both development assistance policy and assistance programmes in SRHR. It has also influenced the design of aid initiatives and once again put Sweden on the front line of many sensitive or controversial issues.

Every period has its challenges. A major task today is to defend the advances that have been made in past decades in the area of women's and men's sexual and reproductive health and rights, which continue to be threatened in many parts of the world. SRHR means recognising the equal value of all people and constitutes a tool against gender-stereotyped conceptions that limit people's lives, choices and rights. Poor women are particularly threatened today by restrictions of SRHR. This is why SRHR is a cornerstone in Sweden's initiatives in poverty reduction and the empowerment of women.

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