Dialogue for change

Supporting material for policy dialogue on sexual and reproductive health and rights (SRHR)

Regeringskansliet

Content

Introduction 3
A comprehensive definition of SRHR 3
Sweden's overarching messages 6
Dialogue with civil society 8
Thematic Questions and Perspectives 11
Maternal mortality and morbidity 12
Access to safe abortion and post-abortion care 19
Comprehensive sexuality education (CSE) 24
Contraception 28
Sexually transmitted infections (STIs) and HIV 32
Sexual and gender-based violence 36
Infertility 41
Lesbian, gay, bisexual, transgender and intersex persons and persons with queer expressions and identities (LGBTIQ) and SRHR 44
Persons living with disabilities and SRHR 49
Young people and SRHR 53
Migrants and SRHR 58
Universal Health Coverage (UHC) and SRHR 60
COVID-19 and SRHR 62
Humanitarian settings and SRHR 64
The climate crisis and SRHR 66
Telemedicine, self-care and SRHR 68

Annex I: Conducting an effective dialogue 71
Annex II: Checklist for dialogue 74
Annex III: Definitions, terms and concepts 77
Annex IV: Policy frameworks, starting points and mandates 81
Annex V: SRHR actors 89
Annex VI: Useful links 94

Introduction

Sexual and reproductive health and rights (SRHR) are a fundamental component of gender equality, peace and security, human rights and democracy. SRHR impact individuals, societies and economies worldwide. Sweden has long been an important international actor on SRHR and SRHR are a cornerstone of Sweden's feminist foreign policy. Sweden is also a major – sometimes the largest – donor to UN organisations and other global institutions working with SRHR, including the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the Office of the High Commissioner for Human Rights (OHCHR), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

Dialogue with civil society, politicians, government agencies, religious and cultural leaders, among others, is an important tool in the work to promote SRHR. SRHR span across several different areas such as health, education, climate, water, sanitation and hygiene (WASH), democracy and human rights, peace and security, humanitarian settings and gender equality. Work on SRHR therefore requires a multi-sectoral approach. Staff at the Government Offices of Sweden, at the Swedish International Development Cooperation Agency (Sida) and at missions abroad, have a key role to play in integrating SRHR in dialogue with internal and external actors.

This material is an update to a previous version[1] and has been produced by the Government Offices of Sweden (the Ministry for Foreign Affairs), Sida and the Swedish Association for Sexuality Education (RFSU). Its aim is to serve as support for staff to conduct effective dialogue on SRHR in Sweden's international development cooperation work. It contains facts and suggested entry points for dialogue on a selection of fundamental interventions in the field of SRHR. The annexes also include definitions and terms, international frameworks and mandates, as well as links and references to important documents and actors that may be useful in this work.

A comprehensive definition of SRHR

The starting points, frameworks and mandates for work on SRHR are found in national steering documents and also in international frameworks and Sweden's commitments in relation to these. This normative basis forms the

[1] Government Offices of Sweden, *Dialogue for change. Supporting material for policy dialogue on sexual and reproductive health and rights*, (2010).

platform for central work on SRHR, namely operational implementation at country level. The most central international frameworks are described in more detail in Annex IV. These include the Cairo and Beijing Declarations, and the Programme of Action and Platform for Action, as well as their follow-up conferences which are important milestones in work for sexual and reproductive rights. Resolutions and conclusions adopted by the United Nations Commission on Population and Development (CPD), the United Nations Commission on the Status of Women (CSW) and the United Nations Human Rights Council (HRC) are also important in this respect.[2] All the Sustainable Development Goals in the 2030 Agenda can be linked to SRHR, but the clearest links are to good health and wellbeing (SDG 3), education (SDG 4), gender equality (SDG 5), clean water and sanitation (SDG 6) and reduced inequalities (SDG 10).

All people have the right to make decisions about their own body and to have access to healthcare that supports that right. When we analyse access to sexual and reproductive health (SRH) and examine violations of sexual and reproductive rights (SRR), it is clear that access to health is unevenly distributed and that the sexual and reproductive rights of certain groups are violated more frequently than those of others. It is therefore important, at the outset of any dialogue, to consider the specific context in a country, for a group or for an individual. It is also important to consider that a person will have many different interacting identities and expressions that create different opportunities to have their SRHR met. Multiple and intersecting forms of discrimination can for example exacerbate difficulties in having one's SRHR needs met.

SRHR cover both sexual and reproductive *health* and sexual and reproductive *rights*. Each aspect of SRHR is linked to other parts of SRHR, and sexual and reproductive rights are essential to ensuring sexual and reproductive health. In 2018, the Guttmacher-Lancet Commission (GLC) launched a comprehensive definition of SRHR that encompasses additional components compared to what has previously been included in international frameworks. The GLC definition places greater emphasis on the human rights perspective.[3]

---

[2] The United Nations Commission on Population and Development is tasked with evaluating the progress made in realising the Programmes of Action from the Cairo Conference on Population and Development and its follow-up conferences. The United Nations Commission on the Status of Women has overarching responsibility for evaluating the progress made in realising the Beijing Declaration and its Platform for Action, and its follow-up conferences.

[3] The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018). For a Swedish translation, also cited in this material, see the following summary published by the Public Health Agency of Sweden, *Sexuell och reproduktiv hälsa och rättigheter för alla: Sammanfattning av Guttmacher-Lancet-kommissionens slutrapport*, (2018).

Sweden works for universal SRHR based on this evidence-based and comprehensive definition of SRHR. The GLC's definition integrates the entire spectrum of individuals' SRHR needs and services, including those that are rarely recognised or raised in global discussions, such as sexual wellbeing and personal self-determination.

Sexual and reproductive health

The GLC defines sexual and reproductive health as follows: "Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing."

Sexual and reproductive rights

According to the GLC, sexual rights encompass a number of different human rights that guarantee people the right to decide over their bodies and their sexuality free from discrimination, coercion and violence.[4] The GLC states that the achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

[4] For further reading, see for example Starrs and Anderson, *Definitions and debates: sexual health and sexual rights*, Brown Journal of World Affairs, (2016), pp. 14-17., IPPF, *Sexual Rights: An IPPF Declaration*, (2008) and The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2645.

The GLC recommends a number of fundamental SRHR services in line with this broad definition of SRHR. These encompass generally accepted aspects of sexual and reproductive health, as well as initiatives essential for a comprehensive approach to SRHR. The GLC recommends that countries gradually expand access to the proposed services at the pace that resources and political circumstances allow, prioritising the needs of marginalised population groups. The identity of these groups will vary depending on the situation and an analysis should be conducted to identify those most marginalised in each specific context.

The essential sexual and reproductive health services recommended by the GLC include:

- comprehensive sexuality education;
- counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods;
- antenatal, childbirth and postnatal care, including emergency obstetric and newborn care;
- safe abortion services and treatment of complications of unsafe abortion;
- prevention and treatment of HIV and other sexually transmitted infections;
- prevention, detection, immediate services and referrals for cases of sexual and gender-based violence;
- prevention, detection and management of reproductive cancers, especially cervical cancer;
- information, counselling and services for subfertility and infertility;
- information, counselling and services for sexual health and wellbeing.

Sweden's overarching messages

Unmet SRHR needs have far-reaching consequences for public health and for social and economic development. Unwanted pregnancies, complications of pregnancy and childbirth, unsafe abortions, sexual and gender-based violence including child marriage and female genital mutilation (FGM), and sexually transmitted infections (STIs), including HIV, threaten people's wellbeing. Women, girls, LGBTIQ persons, young people, persons living with disabilities and migrants are particularly marginalised. A person's ability to get their SRHR needs met may also differ depending on further context-specific circumstances, such as socioeconomic factors and geographical location.

Fulfilling SRHR is essential to achieving social justice and the national, regional and global commitments for sustainable development and peace.

Sexual and reproductive health is an essential part of people's physical, psychological and social wellbeing throughout their lives. People's needs for SRHR are unique and may differ at different times in their lives. Therefore, it is important that dialogue and work in regard to SRHR incorporates a lifecycle perspective. Some SRHR needs, that can arise at different ages or for certain groups, may be more stigmatised than others, such as needs arising for persons living with disabilities, young people or older people, because their sexuality may in itself be stigmatised.

SRHR are also essential in public health work. Broad-based health promotion and prevention help to strengthen the individual's opportunity to enjoy their rights, and to attain good sexual and reproductive health and thus, improved overall public health.

The achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights. Despite significant progress on SRHR, there are counter-reactions that risk halting or reversing important progress on SRHR. References to traditional values, culture, freedom of religion, the nuclear family or the sovereignty of the state are often attempts to undermine SRHR commitments in international negotiations. SRHR also risk being deprioritised in the light of other political issues and financial commitments, despite SRHR constituting an important component of many human rights. Attempts to separate sexual and reproductive health (SRH) and reproductive rights (RR) from sexual rights (SR) undermine the comprehensive definition of SRHR laid down by the GLC. Sweden has an important role to play in working to ensure that sexual rights are not excluded from the SRHR framework and that support for SRHR, both political and financial, remains in place.

Social norms affect all aspects of SRHR and limit people's freedom to express their sexuality. It is therefore important to include a feminist and intersectional power analysis when engaging in dialogue on SRHR. Such a power analysis can reveal the complex ways in which power is organised and operates in a given society and specific context. A feminist approach to dialogue draws attention to the way in which a binary view of sex influences stereotypical assumptions about masculinity and femininity. An intersectional analysis focuses on structural and political inequalities and draws attention to the limitations of situational analyses that solely focus on one ground of

discrimination such as sex, socioeconomic status, sexuality or nationality. An intersectional analysis identifies how several power structures and grounds for discrimination can work together and reinforce each other. Ultimately, an intersectional analysis seeks to highlight marginalised groups whose experiences are often rendered invisible.

Dialogue with civil society

If SRHR policies and programmes are to be effective, rights-based and sustainable in the long term, dialogue with the stakeholders concerned is essential. Among these stakeholders, civil society organisations and actors are important[5]. There is a broad spectrum of civil society organisations and networks working to achieve SRHR. They range from large national and international non-governmental organisations, religious and traditional actors and organisations, to local associations and movements. Some of these are only active at local or national level, while others are also active at regional and global level. Civil society organisations working on SRHR are often not only important advocates when States fail to support SRHR, but also healthcare providers. If we are to mobilise broader alliances and work successfully for SRHR, differences between civil society organisations must be taken into account. Awareness of structures within SRHR movements is also important for promoting inclusion, visibility and participation of under-represented groups. Since there are civil society organisations that work actively to counter SRHR, one must have a good understanding of the civil society organisations with which dialogue is conducted.

As it is estimated that more than 80 percent of the global population identifies with a religious faith[6], dialogue with religious actors and organisations in civil society is important in order to promote SRHR. There is great diversity in constellations among religious actors and organisations. Like civil society actors in general, religious actors and organisations may have varying attitudes towards SRHR, from actively working for SRHR to actively countering SRHR. Working with like-minded religious actors and organisations can offer many advantages, including their possible far-reaching trust among target groups and local populations, and in many cases, they constitute an authoritative voice on norms and rules. This means that their message on SRHR can have a great impact. Religious actors and organisations can also own and run schools, hospitals and healthcare training. They might also reach

[5] In this material, "civil society" is defined as the sphere in society that differs from profit-driven commercial organisations, private life and the politically and legally governed activities of the public sector.
[6] UNFPA, *Annual report of the Executive Director of UNFPA 2019 annual session of the Executive Board*, (2019), p. 2.

people in informal settings which is crucial if the intended recipients of a programme or policy do not attend school. *The UN Interagency Task Force on Religion and Sustainable Development (UN IATF-R)* has been operating at UN level since 2010 and forms a platform for sharing knowledge, capacity building, guidance and supervision regarding engagement with religious actors and organisations in civil society. UNFPA has systematically engaged in and conducted dialogue with religious actors and organisations on SRHR.[7]

As work on SRHR spans a number of different thematic areas, questions and sectors, parallel efforts of different actors can take place in various settings and it remains important to coordinate these. Including civil society actors is key in order to identify challenges and solutions.[8] To determine which groups need to be included in dialogue, an analysis needs to be conducted of whose rights are being violated and who lacks access to SRHR. For example, one should ensure that those invited are not solely women's organisations in the capital, and that lesbian and transgender persons are represented among the LGBTIQ organisations. Meaningful participation is also an essential element in ensuring a rights perspective and should be incorporated throughout the process of designing SRHR programmes and policy discussions.[9] Such participation increases ownership and ensures that policies and programmes better meet the needs of the people they are intended to serve. Civil society organisations are often an important partner in implementation efforts as they can ensure that actions reach target groups and that contacts is passed on reliably. Ongoing dialogue with civil society is therefore important and civil society organisations often provide useful information and expertise. To foster trust, it may sometimes be valuable to hold meetings under Chatham House Rules, whereby nothing that is said in the meeting may be spread further. Premises belonging to Swedish embassies may, for example, be used to hold meetings and conversations in a spirit of trust.

In many contexts, the scope and the opportunities for civil society to work openly and freely are limited.[10] In contact with civil society organisations that work with SRHR, one should bear in mind that progressive SRHR actors may be subjected to threats, harassment and discrimination as they often challenge

[7] *Ibid.* As an example, in 2020, UNFPA's country offices worked with religious actors and organisations as implementation partners in 27 countries in six regions. UN IATF-R, *2020 Annual Report of the united Nations Interagency Task Force on Religion and Sustainable Development*, (2021), p. 29.
[8] See also Sida, *Guiding Principles for Sida's Engagement with and Support to Civil Society*, (2019).
[9] Many of the UN's core conventions on human rights emphasise the importance of involving those concerned, and the UN Committee on Economic, Social and Cultural Rights has particularly underlined this with regard to the right to health. See General Comment 14 on the Right to the Highest Attainable Standard of Health, para 54.
[10] According to CIVICUS, civil society continues to work and act in an increasingly hostile environment.

norms and traditional values. In many cases, SRHR actors from civil society may be viewed as human rights defenders and working with issues such as abortion, comprehensive sexuality education (CSE) and LGBTIQ questions can expose them to risks. Closer collaboration and dialogue between SRHR movements and broader human rights movements can be of importance in this respect.

Thematic Questions and Perspectives

The sections below present some of the thematic questions that the Government of Sweden prioritises in its work on promoting SRHR. These are maternal mortality and morbidity, access to safe and legal abortion, comprehensive sexuality education (CSE), contraception, sexually transmitted infections (STIs) and HIV, as well as sexual and gender-based violence. The different thematic questions are closely linked in many ways, which means that a dialogue on one of the questions may create openings for discussion on other SRHR issues.

The following sections specifically address how dialogues can be conducted to include SRHR needs among young people, LGBTIQ persons, persons living with disabilities and migrants. Even when these groups are addressed specifically, it is important to bear in mind that they are not homogenous groups and consist of persons with diverse needs. For example, the group migrants contain women, men and non-binary people, as well as married and unmarried people.

Each section comprises a brief background drawing on Sweden's standpoints and underlying information in the form of facts and figures, as well as proposed openings for dialogue.

The final six sections address the links between SRHR and humanitarian settings, universal health coverage (UHC), the climate crisis, COVID-19 and telemedicine and self-care. These sections are intended to highlight key facts and perspectives in relation to SRHR.

The sections can be used separately or in combination. The order in which they are presented in this material does not reflect any internal prioritisation. Prevailing circumstances and the specific context in which dialogues take place will determine which question or questions should be prioritised. General recommendations on how to conduct an effective dialogue can be found in Annexes I and II.

Maternal mortality and morbidity

Why must Sweden work to improve antenatal care and reduce maternal mortality?

In many contexts, pregnancy and childbirth can constitute significant health risks. Due to inequalities and discrimination in healthcare settings and in access to quality healthcare, the poorest and most marginalised people run the greatest risk of becoming ill or dying in pregnancy, childbirth or immediately following childbirth.[11] Although maternal mortality is largely preventable[12], almost 300 000 women die every year due to complications in pregnancy and/or childbirth.[13] For every woman who dies, it is estimated that around 20 to 30 women suffer injury or infection.[14] Globally, complications related to pregnancy, childbirth and unsafe abortions are the most common cause of death for young women and girls aged 15–19.[15] The causes of high maternal mortality in the world include lack of access to contraception, adequate obstetric care (antenatal care, childbirth and postnatal care), as well as complications following unsafe abortions. Access to contraception, good quality antenatal care, CSE and safe abortions can reduce and prevent maternal mortality and morbidity.

Reducing maternal mortality is central in international development cooperation, and although the number of women dying every year due to complications related to pregnancy and childbirth has fallen across the globe, much remains to be done.[16] The Cairo and Beijing Declarations and their follow-up conferences have constantly emphasised the importance of the right to access healthcare that enables women to undergo safe pregnancy and childbirth. Target 3.1 of the 2030 Agenda seeks to reduce the global maternal mortality ratio to less than 70 per 100 000 live births, in part through universal access to reproductive health. Despite these priorities, according to UNFPA, an estimated USD 103.6 billion is still needed to prevent maternal mortality between 2020 and 2030.[17] There are also indications of increased maternal mortality since 2000 in countries that have suffered conflict (e.g. Afghanistan)

---

[11] See for example Bohren et al., *How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys*, The Lancet, vol. 394, (2019), pp. 1750–1763.
[12] UNFPA, *Costing the Three Transformative Results: The cost of the transformative results UNFPA is committed to achieving by 2030*, (2020), p. 12.
[13] *Ibid.*
[14] *Ibid.*
[15] *Ibid.*
[16] *Ibid* and WHO et al., *Trends in Maternal Mortality: 2000 to 2017*, (2019), p. 45.
[17] UNFPA, *Costing the Three Transformative Results: The cost of the transformative results UNFPA is committed to achieving by 2030*, (2020), p. 8. UNFPA estimates the cost of preventing maternal mortality in 120 prioritised countries between 2020 and 2030 as USD 115.5 billion.

and in some high-income countries (e.g. the USA).[18] Growing antibiotic resistance is also very concerning, as antibiotics play a central role in preventing and reducing maternal mortality.

Global initiatives to improve antenatal care are focused on preventing and reducing maternal mortality rather than on reducing and preventing maternal morbidity. Maternal morbidity encompasses a number of different diagnoses and up to 121 conditions, including obstetric fistulas, uterine prolapse, infertility and postnatal depression.[19] Exact data on maternal morbidity is lacking in global terms but research indicates that serious maternal morbidity is on the rise in the world and between 15 to 20 million women are affected each year.[20] The scale of maternal mortality has been described as "the tip of the iceberg", where maternal morbidity is the base.[21] It can therefore be misleading to estimate success in improved maternal health by solely looking at data on maternal mortality.

Openings for dialogue on action to reduce maternal mortality and morbidity

The human rights perspective

A dialogue which is anchored in human rights emphasises that maternal mortality and morbidity do not arise as unavoidable and one-off events but as a result of discriminatory legislation, norms and practices, a failure to establishing well-functioning health systems and a lack of accountability. Responsibility for maternal mortality and morbidity is thus not only a question of public health but is predominantly about fulfilling human rights. The UN Resolution on Preventable Maternal Mortality and Morbidity and Human Rights[22] has repeatedly emphasised that high levels of maternal mortality can

[18] The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2659.
[19] Chou et al. on behalf of the Maternal Morbidity Working Group, *Constructing maternal morbidity – towards a standard tool to measure and monitor maternal health beyond mortality*, BMC Pregnancy and Childbirth, (2016).
[20] Geller et al., *A global view of severe maternal morbidity: moving beyond maternal mortality*, Reproductive Health, vol. 15, (2018), pp. 31–32. and Koblinsky et al., *Maternal morbidity and disability and their consequences: neglected agenda in maternal health*, Journal of Health, Population and Nutrition, vol. 30, no. 2, (2012). The lack of data in itself speaks for the issue not having been afforded equal priority, but also points to challenges in the definition and collection of comparative data from different countries and contexts. According to the WHO's Maternal Morbidity Working Group, maternal morbidity has been defined as "any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on the woman's wellbeing". See Firoz et al., *Measuring maternal health: focus on maternal morbidity*, Bulletin of the World Health Organization, (2013), p. 795.
[21] Firoz et al., *Measuring maternal health: focus on maternal morbidity*, Bulletin of the World Health Organization, (2013), p. 794.
[22] The most recently adopted resolution was "Preventable maternal mortality and morbidity and human rights in humanitarian settings", A/HRC/RES/39/10, adopted by the Human Rights Council on 27 September 2018.

be prevented and that States have not done enough to eradicate maternal mortality and prevent injuries as a result of pregnancy and childbirth.[23]

The UN Committee on the Elimination of Discrimination against Women (the CEDAW Committee) has asserted that maternal mortality can constitute an infringement of a woman's right to life, health and non-discrimination.[24] The CEDAW Committee has also asserted that States have a responsibility to ensure that women have access to healthcare during pregnancy, as well as during and after childbirth. In the case of *Alyne v. Brazil,* the CEDAW Committee stated that under Article 2 (e) of the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), States also bear a responsibility for the actions of private healthcare actors.[25] In the case of *Alyne v. Brazil*, the CEDAW Committee further stated that in order to protect women's rights to life, health and non-discrimination, States are obliged to provide rapid access to good quality antenatal care for all, irrespective of ethnicity or socio-economic status.[26]

A disproportionately high incidence of maternal mortality takes place in rural areas and cases of maternal mortality increase when sex-based discrimination is present at the same time as other grounds for discrimination, such as geographical origin, socio-economic status, age and ethnicity. It is therefore important to apply an intersectional approach when addressing the topic and it has been recommended that States should adopt measures that improve the SRHR of marginalised groups.[27]

Dialogue on improved maternal health can also involve demonstrating the links between reduced poverty in different countries and improved maternal health and reduced maternal mortality. Up to 94 percent of all maternal mortality occurs in low and middle-income countries.[28] In 2017, the maternal mortality ratio in low-income countries was 462 per 100 000 births, compared to 11 per 100 000 births in high-income countries.[29] In this respect, regional frameworks for human rights can also be beneficial in the dialogue. Up to 86 percent of global maternal mortality occurs in sub-Saharan Africa and South Asia.[30] Due to high maternal mortality in sub-Saharan Africa, the revised

[23] *Ibid.*
[24] CEDAW Committee, *Alyne da Silva Pimentel v. Brazil*, CEDAW/C/49/D/17/2008 (2011), paras. 7.4 and 7.7.
[25] *Ibid,* para 7.5.
[26] *Ibid,* para 5.2.
[27] UN Committee on Economic, Social and Cultural Rights, *General Comment 22*, para. 30.
[28] WHO, *Maternal mortality*, (2019).
[29] *Ibid.*
[30] UNFPA, *Costing the Three Transformative Results: The cost of the transformative results UNFPA is committed to achieving by 2030,* (2020), p. 11.

Maputo Plan of Action 2016–2030 seeks to prevent maternal mortality by increasing contraceptive use, reducing the proportion of unsafe abortions, preventing child marriage and ensuring access to sexual and reproductive health for young people.[31]

At the same time, access to antenatal care *within* countries can be unequal due to for example poverty, religion, age or marital status.[32] In this regard, the CEDAW Committee has asserted the importance of providing free healthcare for women living in poverty during pregnancy, childbirth and during the period following childbirth.[33]

Increased access to and use of healthcare services alone will not be sufficient to improve maternal health. The quality of the healthcare a woman receives during pregnancy, childbirth and the postnatal period affect her health and the likelihood of her seeking healthcare in the future. Good quality antenatal care should be evidence-based, safe, patient-centred, effective, equitable and provided in a reasonable timeframe.[34] The right antenatal care must be offered at the right time and delivered in a way that respects, protects and promotes human rights.

One in four healthcare facilities around the world lacks a basic water supply.[35] Infections, in conjunction with poor hygiene in healthcare settings, has been estimated to be the cause of up to 11 percent of global maternal mortality.[36] To reduce and prevent maternal mortality and morbidity, the quality of healthcare must be improved and healthcare facilities must be able to provide patients with clean water and adequate hygiene.[37] Access to clean water is essential to providing safe antenatal care and childbirth. Integrated investments in water, sanitation and hygiene (WASH) and SRHR are therefore required where connections can be made between actions to achieve SDG

[31] African Union Commission, *Maputo Plan of Action 2016-2030 for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights,* (2016).
[32] The USA has one of the highest levels of maternal mortality among high-income countries and there are major differences between different groups in the country. See Guttmacher Institute, *Maternal Mortality Review Committees*, (2021).
[33] CEDAW Committee, *General recommendation No. 24: Article 12 of the Convention (women and health)*, (1999), para. 27.
[34] WHO, *Standards for improving quality of maternal and newborn care in health facilities*, (2016), p. 15.
[35] Say et al., *Global causes of maternal death: A WHO systematic analysis*, Lancet Global Health, (2014).
[36] *Ibid.*
[37] Kruk et al., *High-quality health systems in the Sustainable Development Goals era: time for a revolution*, The Lancet Global Health, (2018), and WHO and UNICEF, *Global Progress Report on WASH in healthcare facilities*, (2020), pp. 9-12.

3.1[38] to reduce the global maternal mortality ratio and SDG 6 related to clean water and sanitation.

Antenatal care adapted to individual needs is an important component in ensuring good quality maternal healthcare and crucial to upholding human rights. Across the world, many people are subjected to discriminatory and abusive treatment in antenatal care, with marginalised groups being particularly at risk. Abuse may arise at the individual level, between the patient and carer, and through systematic discrimination at health system level.[39] At global level, the *Respectful Maternity Care Charter: Universal Rights of Women and Newborns*[40] has been composed to emphasise the improvements needed in policies and programmes.

The UN's *Global Strategy for Women's, Children's and Adolescents' Health*[41] sets out guidance for accelerating work on women's, children's and adolescents' health to 2030. The strategy can provide additional support in dialogues on maternal mortality and morbidity in regard to the 2030 Agenda.

The public health perspective

To reduce maternal mortality and morbidity, it is important to highlight that pregnant persons and newborn babies must have access to comprehensive and continuous healthcare.[42] In the dialogue, attention should be directed to the benefits that can be gained from investing in efforts to strengthen continuity of care encompassing counselling, contraception, safe abortions, combating FGM, trained midwives and healthcare staff, as well as maternity and paediatric healthcare. To strengthen comprehensive healthcare measures, one should bear in mind that while healthcare models can look different in different countries, primary healthcare is often an important first contact point for patients. Key services such as maternity care and access to qualified healthcare staff have improved considerably over the past two decades, but across the entire healthcare chain, greater efforts are needed, for instance to improve postnatal care.[43] Enabling access to healthcare initiatives for all

[38] Target 3.1 reads: "By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births".
[39] Bowser and Hill have described seven categories of abuse in childbirth and in 2015, this categorisation was expanded further. The WHO issued a statement on the topic in 2014: *The prevention and elimination of disrespect and abuse during facility-based childbirth*.
[40] The White Ribbon Alliance and The Global Respectful Maternity Care Council, *The Respectful Maternity Care Charter: Universal Rights of Women and Newborns*.
[41] For more information see *The Global Strategy for Women's, Children's and Adolescents' Health* and *Every Woman, Every Child*.
[42] The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2659.
[43] *Ibid.*

people should be emphasised, especially those with specific care needs, such as women living with HIV[44], young people and other marginalised groups. Healthcare needs often look different at different points in life and initiatives should therefore be adapted to the different stages of a person's life.

Humanitarian settings

A large proportion of maternal mortality in the world is found in contexts characterised by disasters and crises. In humanitarian crises, there is often no access to contraception, safe abortion, antenatal care or emergency midwifery. The UN's Economic and Social Council has urged States to safeguard access to healthcare needed to prevent maternal mortality and morbidity in humanitarian settings.[45]

Guidance for working with maternal health from a rights-based perspective has been published in *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response* and the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. The international standard *Minimum Initial Service Package for Sexual and Reproductive Health (MISP)*, produced by the *Inter-Agency Working Group for Reproductive Health in Crisis (IAWG)*, sets out a minimum level of SRH measures required in humanitarian crisis situations.[46] UNFPA and international non-governmental organisations strive to ensure that MISP activities and additional SRH services are included in all phases of the humanitarian programme cycle, where combating maternal mortality and morbidity is a key objective.[47]

Cooperation with civil society

Civil society expertise in the local context is important in understanding social and cultural obstacles to improving maternal health and to gain insight into the specific needs of different groups. Their capacity to reach different target groups, and their potentially high trust, means that they can provide important contacts, information and data on what is needed to provide good quality antenatal care. At the global level, civil society is also represented, for example in the *Global Financing Facility for Women, Children and Adolescents (GFF)* and the *Partnership for Maternal, Newborn and Child Health (PMNCH)*. Examples of civil society working together with States and other actors are the *Global Respectful*

[44] *Ibid.* All pregnant women living with HIV should receive treatment to extend their lives and to prevent HIV infection in newborns. Routine HIV testing and counselling at the first visit to a healthcare facility is essential to achieving universal coverage for antiretroviral treatment.
[45] E/RES/2019/14, *Strengthening of the coordination of emergency humanitarian assistance of the United Nations*, para. 42.
[46] IAWG, *Minimum Initial Service Package for Sexual and Reproductive Health*, (2019).
[47] *Ibid,* Objective 4 of MISP.

Maternity Care Council (GRMCC) and the *Network for Improving Quality of Care for Maternal, Newborn and Child Health* who gather relevant information from different stakeholders.[48]

[48] *Network for Improving Quality of Care for Maternal, Newborn and Child Health*.

Access to safe abortion and post-abortion care

Why must Sweden pursue and actively defend access to safe and legal abortion?

Bodily autonomy and the ability to decide over one's own health, sexuality and childbirth, are central for every person's wellbeing and for upholding human rights. Forcing a person to go through an unwanted pregnancy is a violation of their right to freely decide whether and when to give birth. The ICPD Programme of Action clearly lays down that everyone is free to decide when to have children and how many children they want and that where abortion is legal, access to safe abortion care must be ensured.[49]

Prohibiting abortion does not lead to fewer abortions being carried out – it increases the number of unsafe abortions.[50] Working to ensure that women and girls gain access to legal and safe abortion is an important element in Sweden's feminist foreign policy and foreign aid.[51] Abortion is a very safe procedure when it is carried out in line with medical guidelines, but unsafe abortions are a serious threat to the health of women and girls. Unsafe abortions are mainly carried out when access to safe abortion is restricted, for example due to legislation, high financial costs, stigma, a poor health system, physical distances or threats of violence. Between 2015 and 2019, just over 73 million abortions were carried out in the world, and around 45 percent of these were unsafe.[52] Many women die from unsafe abortions or from their consequences. About 7 million women are admitted to hospital every year following unsafe abortions.[53] The annual cost of treating major complications from unsafe abortions is estimated at USD 553 million.[54]

Openings for dialogue on safe abortion and post-abortion care

The human rights perspective

The ICPD Programme of Action does not contain any general reference to the right to safe abortion. However, the Programme of Action states that abortion must be safe in countries where abortion is legal in one or more

---

[49] *Population and Development: Programme of Action Adopted at the International Conference on Population and Development, Cairo, Sept. 5–13*, 1994, New York: UN, 1995.
[50] Guttmacher Institute, *Abortion Worldwide: Uneven Progress and Unequal Access*, (2019). For more information and comparisons, see The Global Abortion Policies Database. An abortion is considered to be unsafe when it is either performed by a person who lacks the knowledge and skills required, or when an abortion is performed in an environment that does not meet minimum standards, or both.
[51] To read more about Sida's work on abortions, see *Health Brief: Safe Abortion*, (2021).
[52] WHO, *Preventing unsafe abortion*, (2020).
[53] WHO, *Preventing unsafe abortion*, (2020) and Sida, *Health Brief: Safe Abortion*, (2021).
[54] *Ibid.*

circumstances. The Programme of Action also states that women must have access to the services required to treat complications that may arise following abortion.[55] The Platform for Action from the Fourth World Conference on Women, held in Beijing in 1995, also urges States to re-examine legislation that penalises women who have abortions.[56] In global international negotiations, such as CSW, it has proved difficult to achieve consensus regarding abortion. Although abortion was included in CSW's final documents from 2014 and 2016[57], this has been more difficult in subsequent years.

Access to safe and legal abortion is important to combat discrimination against women and girls and to safeguard the right of women and girls to health and the enjoyment of other human rights. Committees that monitor the application of UN conventions found that when a woman's access to safe and legal abortion is limited, several of her human rights are threatened.[58] States have therefore been recommended to review and amend legislation to increase opportunities for women to gain access to free and safe abortion, and for women who undergo an illegal abortion not to risk legal sanctions, including imprisonment.[59] The United Nations Human Rights Committee and the Committee on Economic, Social and Cultural Rights (CESCR) have also made the link between unsafe and illegal abortion and the right to life and the right to health.[60] The UN's Special Rapporteur on the right to health has asserted that the right to health is also considered threatened when access to abortion is restricted and/or where abortion is unsafe.[61]

The African Union's regional framework *The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (known as the Maputo Protocol) sets out the obligation of African States to authorise legal and safe abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother, or the life of the mother or the foetus (Article 14 (2) (c)).[62]

---

[55] PoA 8.25.
[56] Para. 106 (k).
[57] CSW 58th Session 2014, p. 11 and CSW 60th Session 2016, p. 8.
[58] E.g. regarding the right health: L.C. v. Peru, CEDAW/C/50/D/22/2009, para. 8.15, and regarding the right to private life: Whelan v. Ireland, CCPR/C/119/D/2425/2-14, para. 7.8; Mellet v. Ireland, CCPR/C/116/D/2324/2013, para. 7.7; K.L. v. Peru, CCPR/C/85/D/1153/2003, para. 6.4; V.D.A. v. Argentina, CCPR/C/101/D/1608/2007, para. 9.3.
[59] This is also urged in the Beijing Platform for Action.
[60] UN Human Rights Committee, General comment No. 36 (2018) on Article 6, para 8: "although States parties may adopt measures designed to regulate voluntary terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant"; CESCR, General comment No. 22, paras. 10, 30, 34.
[61] UN Special Rapporteur on the right to health, A/66/254 (2011), paras. 21, 65.
[62] Read more at the African Commission on Human and Peoples' Rights.

A few countries in the world currently have a total ban on abortion. Some countries criminalise women who undergo an abortion. Before entering into dialogue, it is important to be aware of what the legislation looks like in a country, how it is complied with and whether or not the population is aware of the law.[63] It is easy to focus on the fact that abortion is illegal, but in most countries, abortion is legal provided that one or more criteria are fulfilled.[64] If it is considered too difficult to argue for a change in the law, another opening may be to open a dialogue about the criteria where abortion is in fact permitted. If, for example, abortion is permitted when the woman's health is endangered, one way forward may be to also include mental health in line with the WHO definition. Another opening is to examine the criminality of abortion if abortion is illegal. There may be greater consensus that women or people who perform abortions should not be viewed as criminal due to having undergone or performed an abortion. The decriminalisation of abortion can therefore be an initial aim for dialogue.

The public health perspective

The link between maternal mortality, maternal morbidity and unsafe abortion is an important opening for dialogue. Unsafe abortions are the cause of approximately 4.7 – 13.2 percent of maternal mortality worldwide. In high-income countries, approximately 30 women die per 100 000 unsafe abortions. This figure rises to 520 deaths per 100 000 unsafe abortions in sub-Saharan Africa.[65] Of the unsafe abortions that take place in the world, around 29 percent take place in Africa, accounting for 62 percent of all deaths worldwide that occur as a consequence of unsafe abortions.[66] Refusing women and girls safe abortion has extremely harmful consequences, as they instead may turn to life-threatening methods in attempting to bring on a spontaneous abortion or miscarriage. Women and girls may also be left injured for the rest of their lives following unsafe abortions. Making safe abortions accessible and legal is therefore an integral part in reducing maternal mortality and in improving public health.

Supporting women's access to safe abortion also lowers the overall cost of healthcare and is a step towards realising the right to health. Unsafe abortions are a major financial problem that often burdens the national and local health sector by taking up a large proportion of healthcare resources.[67] Costs arising

[63] An overview of abortion legislation worldwide is available from the Center for Reproductive Rights.
[64] *Ibid.*
[65] WHO, *Preventing unsafe abortion*, (2020).
[66] *Ibid.*
[67] Guttmacher Institute, *Abortion: Cost*.

as a result of unsafe abortions typically exceed the costs of providing safe abortions.[68]

Women living in poverty and young women and girls make up a large proportion of women who undergo unsafe abortions.[69] Oftentimes, women who are financially better off have the opportunity to seek an abortion, travel where necessary, lose their working income and pay for a safely performed abortion. This means that the consequences of unsafe abortions are largely suffered by already at-risk and marginalised groups, making abortion also a question of poverty and social justice. Demonstrating what the situation looks like in the country and specific context and who is affected can be an opening for dialogue.

The Global Gag Rule (GGR)

In 1984, then US President Ronald Reagan introduced the *Mexico City Policy*, also known as the *Global Gag Rule (GGR)*, by presidential decree. The policy states that foreign aid organisations are denied American health assistance if they work on abortion-related issues, even if the organisation's abortion-related activities are not financed by aid from the USA. Since 1984, subsequent Democratic presidents in the USA have abolished the policy, while Republican presidents have reintroduced it. Under President Donald Trump, the GGR was reintroduced and expanded in the policy *Protecting Life in Global Health Assistance*, from having affected financing for contraceptives to covering all health financing to aid organisations. Under the Trump administration, the policy caused a marked increase in unsafe abortions among the women directly affected by the policy, which means that the policy has failed to achieve its own goals of reducing the number of abortions.[70] The Biden-Harris administration has abolished the GGR, but it is likely that it will be reintroduced with a political change of power. Legislation, such as the proposed *Global Health, Empowerment and Rights Act (Global HER Act),* may limit and prevent opportunities for future American presidents to reintroduce the GGR.

The Helms Amendment

In 1973, shortly after the US Supreme Court had established that there is a constitutional right to abortion in the case of *Roe v. Wade*, the US Congress issued an addition to the *Foreign Assistance Act* restricting the use of American

[68] *Ibid.*
[69] WHO, *Preventing unsafe abortion*, (2020).
[70] Brook et al., *USA aid policy and induced abortion in sub-Saharan Africa: an analysis of the Mexico City Policy*, The Lancet Global Health, (2019).

aid for abortion. This addition, the *Helms Amendment*, prohibits American aid being used to offer abortion as a means of contraception. However, the ban has come to be extensively applied to mean an overarching prohibition on American aid being used to finance abortion in general,[71] including in cases where pregnancy is the result of rape or incest, or endangers the pregnant woman's health. Legislation, such as the proposed *Abortion Is Health Care Everywhere Act*, would enable American aid to be used, and states that it should be used, to finance the right to safe and legal abortion.

Cooperation with civil society

In many contexts, organisations or individuals working to increase opportunities for safe and legal abortion encounter resistance and become the objects of abuse and harassment from both state and non-state actors. In dialogue, attention should thus be paid to the security of civil society actors, especially where abortion laws are restrictive or in contexts where abortion is criminalised. The International Planned Parenthood Federation (IPPF) and the organisation Ipas can be important allies and their national offices may provide good support for conducting dialogues at country level. Religious actors and organisations in favour of abortion, such as Catholics for Choice, are often valuable allies and they can be consulted to gain contact with national and local religious actors that support abortion. It is imperative to build inclusive abortion movements where collaboration between sectors can be promoted and where change can take place at all levels. It is also important to coordinate efforts on abortion with the broader SRHR movement and with other civil society movements in order to obtain a long-term overview of the opposition. At global and regional level, Sida, together with a number of other actors, coordinates regular Global Safe Abortion Dialogues,[72] where measures to promote the right to safe and legal abortion are discussed.

[71] Guttmacher Institute, *The Case for ending the "Global Gag Rule" and the Helms Amendment*, (2021).
[72] *2021 Global Safe Abortion Dialogues: Key Highlights and Priorities*.

Comprehensive sexuality education (CSE)

Why must Sweden work for comprehensive sexuality education?

Comprehensive sexuality education (CSE) is an important component in ensuring that people can make informed choices in regard to sex and relationships, but also to counteract myths and incorrect assumptions about sexuality. Good sexuality education promotes public health by providing age-appropriate information tailored to the recipients and the context, as well as by encouraging discussions related to sex, consent and relationships for young people. Together with wider changes in society and in social norms, CSE is a cornerstone in the work to fulfil everyone's SRHR. Despite the importance of CSE for people's health and rights, the topic encounters resistance.[73]

The most important components of CSE are that it provides correct and accurate information about the body and sexuality, that it sheds light on and critically examines attitudes and social norms, that it develops skills such as critical thinking and how to communicate about sex and sexual situations, self-esteem and respect for others, and finally, that it encourages respect for oneself and a non-prejudiced and non-discriminatory attitude.[74] Discussions about emotions, love, relationships, consent, masturbation, sexual pleasure, gender equality, gender roles, sexual orientation and gender identity, as well as methods to protect oneself against unwanted pregnancy and STIs, support people with the necessary knowledge to make healthy choices and practice safer sex.[75] CSE also seeks to prevent sexual harassment, sexual violence, and discrimination against especially marginalised groups such as LGBTIQ persons or people living with HIV and AIDS.

Openings for dialogue on comprehensive sexuality education

The human rights perspective

Referring to global and regional frameworks can be a way of opening up for dialogue on CSE. The ICPD Programme of Action highlights universal access to sexuality education as a criterion for the enjoyment of sexual and reproductive rights and states that sexuality education must be provided in compulsory education and in other formal and non-formal education.[76] Sexuality education is

[73] UNESCO, *Facing the Facts: The case for Comprehensive Sexuality Education*, Policy Paper 39, (2019).
[74] UNESCO et al., *International technical guidance on sexuality education: an evidence-informed approach*, (2018).
[75] UNESCO, *Facing the Facts: The case for Comprehensive Sexuality Education*, Policy Paper 39, (2019).
[76] The Programme of Action of the UN's International Conference on Population and Development (ICPD), paras. 4.29, 7.37, 7.41, and 7.47.

also necessary to achieve several of the SDGs of the 2030 Agenda and is particularly emphasised in SDGs 5.6 and 3.7.

Some developments in outcome documents and intergovernmental negotiations at the CSW and CPD, indicate that references to CSE have become more hard-won at the global level.[77] At the same time, references to family and parental consent or influence over CSE for children and young people have been introduced in final documents, which risks limiting the access to CSE.

The UN's monitoring committees on human rights, CEDAW and the UN Convention on the Rights of the Child have linked access to sexuality education in schools to the right to life, health, education and information.[78] Regional frameworks can also be important instruments in the dialogue. *The Mexico City Declaration on Sex Education in Latin America and the Caribbean* is one such example. Other examples are the *Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health services for adolescents and young people in Eastern and Southern Africa* (the ESA Commitment) and the *Maputo Plan of Action* for the African region.[79] In Europe, the European Committee of Social Rights, the monitoring body for the European Social Charter, has developed arguments stating that sexuality education must be objective, based on scientific facts and contain correct information about contraception and other questions. CSE may not be discriminatory by excluding children from the education or reinforcing negative stereotypes and prejudices.[80]

The public health perspective

Curriculum-based, teacher-led, good quality CSE has proved to be one of the most effective tools in promoting the sexual and reproductive health of young people.[81] Most children attend school for a few years of life and this offers great potential for CSE to reach children as part of regular education. The sexuality education in schools should be provided early on so that it can reach as many young people as possible, including those who only attend school for a few years. In low-income countries, as many as 62 percent of the population may not attend

---

[77] Gilby et al., *Global health without sexual and reproductive health and rights? Analysis of United Nations documents and country statements, 2014–2019*, BMJ Global Health, (2021), p. 7.

[78] See E/C.12/1/Add.106, para. 53 and CCPR/C/79/Add.110, CEDAW/C/LTU/CO/4, para. 25; CEDAW/C/NGA/CO/6, para. 33; CRC/C/15/Add.137, para. 48; CRC/C/15/Add.144, para. 61; E/C.12/1/Add.57, para. 27; E/C.12/1/Add.62, para. 7; and E/C.12/1/Add.65, para. 31.

[79] *'The Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa'* (ESA) was adopted in 2013 and expired in 2020. At the end of 2021, decision-makers prolonged the ESA commitments and updated it with new goals and targets for 2022-2030. Also see *'The Maputu Plan of Action 2016-2030'* part 4: Improving Strategic communication for SRH&RR, for further commitments related to CSE.

[80] A/HRC/47/27 *The Law of Inclusion: Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity*, (2021), para. 54.

[81] UNESCO, *Emerging evidence, lessons and practice in comprehensive sexuality education: a global review*, (2015) and UNESCO, *Highlights: The journey towards comprehensive sexuality education*, (2021).

the equivalent of upper secondary education.[82] CSE also becomes more effective if it starts to be given before young people become sexually active.[83] Like all other education, good CSE is tailored to the age of the child or young person.

Knowledge about the body, sexuality and contraception gives young people an opportunity to take responsibility for their lives, wellbeing and their sexuality.[84] CSE is an effective route to greater knowledge, while not hastening the sexual debut of students who receive it.[85] One-sided campaigns, or sexuality education that urges young people to abstain from sex, do not show positive results.[86] Being able to reflect on and discuss these issues together is crucial for strengthening young people's knowledge and skills.

One opening for dialogue may also be talking about how information about sexuality can reach adults and out-of-school young people. A very large proportion of adults in the world has never received any sexuality education and many marginalised groups do not have access to the formal educational system.[87] CSE is therefore not merely a challenge in terms of improving the knowledge of teachers and incorporating it into formal school curricula, but also in terms of developing educational programmes that reach those outside the education system. Efforts to reach people outside the education system can focus on increasing the level of knowledge among the general population. Innovative solutions such as spreading CSE via social media and on the internet may be an additional opening for dialogue.[88] Collaboration with the national public sector can be important, for example through specific public awareness and healthcare initiatives.

[82] UNESCO, *Accountability in education: meeting our commitments*, (2017/18), p. 124.
[83] UNESCO, *Facing the Facts: The case for Comprehensive Sexuality Education*, Policy Paper 39, (2019), p. 2.
[84] For additional arguments, see Section 4 in UNESCO et al., *International technical guidance on sexuality education: an evidence-informed approach*, (2018), pp. 28-31
[85] *Ibid*, p. 84.
[86] See for example Fonner, *School Based Sex Education and HIV Prevention in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis*, (2014) and Underhill et al., *Sexual abstinence only programmes to prevent HIV infection in high income countries: systematic review*, (2007).
[87] Sida, *Brief: Comprehensive Sexuality Education*, (2016).
[88] *Ibid.*

Technical guidance on sexuality education
UNESCO, UNAIDS, UNFPA, UNICEF, UN Women and the WHO have jointly produced *International Technical Guidance on Sexuality Education - An evidence-informed approach (ITGSE),* aimed at providing material and guidelines for CSE in schools to achieve the SDGs. The guidance identifies factors for good sexuality education and describes how it can be set up, key concepts in sexuality education, learning goals for different age groups and the actors with whom it is important to conduct dialogue.[89]

Technical guidance on out-of-school CSE
UNESCO, UNAIDS, UNFPA, UNICEF and the WHO have additionally produced guidelines to supplement ITGSE and which provide guidance on how to develop sexuality education that is appropriate for different groups of children and young people who are out of school *International Technical and Programmatic Guidance on out-of-school Comprehensive Sexuality Education (CSE) - An evidence informed approach for non-formal, out-of-school programmes*.

Cooperation with civil society
Close dialogue with civil society actors, including religious actors and organisations that work with education is central to ensuring that CSE reaches everyone, including those people who do not have, or have not had, access to schools or formal educational systems. Civil society organisations may often be the actors responsible for implementing national curricula and they may have great influence on decision-makers at national and local level. For example, the International Planned Parenthood Federation (IPPF) has produced a simplified guide for how CSE in- and outside of schools can be implemented by civil society actors. This guide also contains advice on how different stakeholders can be encouraged to implement policies on CSE which may be of benefit in dialogue.[90]

Collaboration between civil society organisations and States that oppose CSE is often transnational, well-organised and found at the national, regional and global level. It is therefore highly important to strengthen the operations and safety of civil society actors, teachers and educators who work with CSE.

[89] UNESCO et al., *International technical guidance on sexuality education: an evidence-informed approach*, (2018), see especially pp. 86-88 for dialogue with different actors and p. 85 on religious leaders.
[90] IPPF, *Deliver + Enable Toolkit: Scaling up comprehensive sexuality education (CSE)*, (2017).

Contraception

Why must Sweden pursue the question of access to contraception?

Access to a full spectrum of modern contraceptives saves lives and is fundamental for people to be able to decide whether and when they wish to have children.[91] Across the globe, the growing use of modern contraceptives has led to a reduction in maternal mortality, improvements in socioeconomic conditions and higher school attendance for girls and women.[92] However, access to modern contraceptives in different parts of the world is not sufficient. Up to 218 million women of reproductive age (age 15-49) in low and middle-income countries seeking to avoid pregnancy lack access to modern contraception.[93] The number of people who use contraception differs in different regions of the world. In Europe, Latin America, the Caribbean and North America, contraceptive use is around 70 percent of women of reproductive age, but in Central and West Africa, only about 25 percent use modern contraceptives.[94] In many countries, legal, financial, political, social, cultural and other structural obstacles, prevent individuals from accessing and using modern contraceptives. UNFPA estimates that a further USD 59.9 billion is needed in investments between 2020 and 2030 to accommodate the unmet need for modern contraception worldwide.[95] While this may appear to be a large investment, it would be balanced by the net saving in overall costs that a lack of contraception would cause.[96]

Openings for dialogue on contraception

The human rights perspective

Access to contraception is a central component in the ICPD Programme of Action and several of the SDGs.[97] The importance of access to contraception can also be linked to people's right to health and the right to live a decent life, as set out in several of the UN's human rights conventions. CEDAW includes the right to decide freely and responsibly on the number and spacing of

---

[91] WHO/HRP, *Evidence Brief: Contraception*, (2019).
[92] *Ibid.*
[93] Guttmacher Institute, *Adding It Up: Investing in Sexual and Reproductive Health in Low- and Middle-Income Countries*, (2020).
[94] Department of Economic and Social Affairs, Population Division, *World Family Planning Highlights* (2017), p. 1.
[95] UNFPA, *Costing the Three Transformative Results: The cost of the transformative results UNFPA is committed to achieving by 2030*, (2020), p. 19.
[96] Guttmacher Institute, *Adding It Up: Investing in Sexual and Reproductive Health in Low- and Middle-Income Countries*, (2020).
[97] Under SDG 3, target 3.7, States must ensure universal access to sexual and reproductive health-care services, including family planning.

children and to have access to the information, education and means to enable people to exercise these rights (Article 16(1)(e)). The CEDAW Committee has emphasised that in order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sexuality education and family planning services.[98] The Committee has also urged States to provide family-planning and sexual and reproductive health information, and services within disaster preparedness and response programmes, including access to emergency contraception.[99]

The Committee on Economic, Social and Cultural Rights has emphasised that States have a responsibility to ensure that sufficient contraceptives are available and include a broad range of different contraceptive methods, including emergency contraceptive pills.[100] These must be accessible in both physical and financial terms, and in a non-discriminatory manner. They must also reach women in rural or remote areas and be culturally acceptable as well as scientifically and medically appropriate, up-to-date and of good quality.[101] Having access to a broad spectrum of contraceptives and patient-centred contraception counselling[102] is important to ensure that individual needs can be met, that the right to bodily autonomy and self-determination can be maintained, and that use is effective. For example, contraceptives are not merely used to prevent pregnancy but also for other medical reasons. A person's health situation, or need for a particular contraceptive, may also change. Information about a broad spectrum of contraception is therefore necessary.

As fear of side effects is a key reason for low take-up of contraception, counselling must provide correct information to counteract myths.[103] How contraceptive counselling can be optimised largely depends on the context. It is important to create a space in which people do not feel forced to use a specific contraceptive or become stigmatised for their individual choices. It must also be ensured that the person concerned does not feel that anyone else, such as a partner or family member, is exerting power and control over their

---

[98] CEDAW Committee, *General recommendation No. 21, Equality in marriage and family relations*, (1994), para. 22.
[99] CEDAW Committee, *General recommendation No. 37 (2018) on the gender-related dimensions of disaster risk reduction in the context of climate change*, para. 68 (d).
[100] Committee on Economic, Social and Cultural Rights, *General Comment No. 14 (2000) on the right to the highest attainable standard of health*, para. 12.
[101] *Ibid.*
[102] See for example Brandi et al., *The history of tiered-effectiveness contraceptive counseling and the importance of patient-centered family planning care*, AJOG (2019).
[103] Guttmacher Institute, *Fact Sheet: Reasons for Unmet need for Contraception in Developing Countries*, (2016).

use of contraception. In this respect, one initiative can be to conduct dialogue on the opportunity of increasing access to contraception through self-care and telemedicine (see the section on *telemedicine, self-care and SRHR* in this material). The Committee on Economic, Social and Cultural Rights has urged States to repeal third-party authorisation requirements where a parent or spouse has to approve access to and use of contraception.[104]

The public health perspective

Legal, political, social, cultural and other structural obstacles can prevent individuals from gaining access to contraceptives. These obstacles may include a ban on unmarried women accessing contraception or a requirement of parental consent for minors to obtain contraception.[105] Social norms and misinformation about aspects such as the effectiveness or the side effects of contraceptives, prevent people from accessing contraceptives and information about how they are used. Without access to contraception, people run a greater risk of not being able to decide if or when they want to become pregnant. An unwanted pregnancy can make it harder for a person to finish their education and this may in its turn result in difficulties finding work. Unemployment can further result in the dependency on others and increased risk of exposure to sexual violence and abuse. CSE, including information about contraception, that reaches young people, is therefore particularly important to decrease the risk of unwanted pregnancies.

In some contexts, there may be prejudices or assumptions on the part of healthcare staff that conflict with the individual's own wishes when choosing contraception. This is particularly relevant to bear in mind in contexts with a history of forced contraception or discrimination, e.g. for people living with HIV or persons living with disabilities, but also among unmarried women and girls.[106] For this reason, access to a full spectrum of modern contraceptives and information is key to enable all individuals to make informed choices and find the contraception that suits them best at that particular time. Access and information are also important to ensure continuity in the use of contraceptives.

Logistical barriers, such as difficulties travelling to healthcare facilities or stock running out in local clinics, are common reasons for women not using modern

[104] Committee on Economic, Social and Cultural Rights, *General Comment No. 22 (2016) on the right to sexual and reproductive health*, para. 41.
[105] The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2658.
[106] OHCHR, *Contraception and Family Planning*, (2020).

contraception.[107] Women living in poverty and women in rural areas often have less access to contraception, making it important to consider how their needs are best met. *UNFPA Supplies Partnership* can be a strategic partner with which to conduct dialogue in this respect.[108]

Cooperation with civil society

Different people have different contraceptive needs. Conducting dialogue with civil society organisations that also deliver SRH or run SRH clinics can foster a better understanding of how programmes need to be designed and implemented in a specific context.[109] To meet different needs, it is also important that correct and complete information about contraception can be provided during healthcare appointments, via telehealth and in educational settings. Dialogue with schools, religious actors and organisations may help ensure that information and knowledge about contraception is spread.

The former FP2020, now FP2030, brings Governments, civil society, multilateral organisations, donors, the private sector and the research community together to mobilise support for access to modern contraception. It can serve as a platform to consult for knowledge in preparation for dialogue.[110]

[107] UNFPA, *Overview: Family Planning*.
[108] UNFPA, *Supplies Partnership* (the third phase of the programme runs in 2021-2030).
[109] For examples of how civil society can be consulted on changed needs for contraception, see FP2030's example from the COVID-19 pandemic.
[110] Read more at: https://www.familyplanning2020.org/Building2030.

Sexually transmitted infections (STIs) and HIV

Why must Sweden work to combat sexually transmitted infections and HIV?

Sexually transmitted infections (STIs) have a major impact on sexual and reproductive health around the world. Every year, about 1.7 million more new HIV infections occur, and more than 350 million people are in need of treatment for the four treatable STIs: chlamydia, gonorrhoea, trichomoniasis and syphilis.[111] About 300 million women are infected with human papilloma virus (HPV), the foremost cause of cervical cancer, and an estimated 240 million people in the world are living with chronic hepatitis B.[112] This is despite the fact that HPV and hepatitis B can be prevented by vaccination.[113] In addition to the immediate effect of the infection, STIs can have serious long-term consequences, such as infertility.

Around 37.9 million people are currently living with HIV and AIDS and of these, 12.6 million people still do not have access to medicines. The majority of them live in low and middle-income countries.[114] HIV can be passed on from mother to child during pregnancy, at birth or during breastfeeding and today there are approximately 1.1 million children under the age of 10 living with HIV.[115] Untreated, HIV is the deadliest of the STIs but great progress has been made in the past decade. Today we know that in the vast majority of cases, treatment with antiviral drugs reduces the risk of infection to zero. Due to stigma and discrimination, however, many children and key groups at a higher risk of HIV infection are not benefitting from this progress.[116]

STIs other than HIV generally attract little attention despite the fact that they are major contributors to poor sexual and reproductive health.[117] A lack of knowledge, combined with social stigma, prevents many people from seeking

---

[111] Guttmacher-Lancet Commission, *Executive Summary: Accelerate Progress: Sexual and Reproductive Health and Rights for All*, (2018), p. 3.
[112] *Ibid.*
[113] The majority of new cases and deaths from cervical cancer occur in countries where coverage of HPV vaccination and cervical cancer screening is poor. The Guttmacher-Lancet Commission has particularly asserted the importance of cervical cancer prevention, setting out four interventions, along with information, education and counselling as being key to achieve this aim: (1) HPV vaccination for girls aged 9–13, (2) cervical screening, diagnosis and treatment of precancerous lesions, (3) treatment for invasive cervical cancer and (4) palliative care. The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2665.
[114] UNAIDS, *Global HIV & AIDS statistics — 2020 fact sheet*, (2020).
[115] UNICEF, *Global Snapshot 2019: Children, HIV and AIDS*, (2019).
[116] The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2654.
[117] *Ibid.*

healthcare and receiving counselling, testing and treatment.[118] Low condom use, asymptomatic infections and a shortage of simple, accessible tests for STIs, hinder interventions that would prevent, identify and treat infections. Furthermore, antimicrobial resistance (AMR) has increased in recent years, which has led to a need for the development of new drugs and treatment options.[119] AMR causes up to 700 000 deaths a year and is a serious threat to combating STIs.[120] A cross-sectional approach can be important, in which AMR is taken into account and emphasised in dialogues about SRHR and STIs.

Openings for dialogue on sexually transmitted infections and HIV

The human rights perspective

Several human rights come into play in discussions on HIV/AIDS and STIs. States need to ensure non-discrimination and access to medicine on equal terms, among other things.[121] Citing the right to life, the UN's Human Rights Committee has urged States to provide medicines for people living with HIV and AIDS. Under Article 12 (2) (c) of the International Covenant on Economic, Social and Cultural Rights, the prevention, treatment and control of epidemic diseases is necessary to safeguard the right to the highest attainable standard of physical and mental health.

One of the central principles of the 2030 Agenda is that no-one is to be left behind in the implementation of the SDGs. Specific mention is made of people living with HIV/AIDS.[122] In 2021, the UN Member States adopted an updated Political Declaration emphasising what needs to be done to hasten and increase access to treatment of HIV with the aim of eradicating AIDS by 2030 in line with target 3.3. of the 2030 Agenda.[123]

Stigma and discrimination against people suffering from STIs, and especially people living with HIV, is widespread. Although today's HIV medicines are so effective that those with well-managed HIV do not pass it on during sex, this is not very well known. Criminalisation of transmission of HIV occurs despite the knowledge that criminalisation is ineffective and discriminatory. This can make people too scared to get tested, increase distrust of healthcare

---

[118] *Ibid.*
[119] *Ibid,* p. 2656.
[120] Interagency Coordination Group on Antimicrobial Resistance, *No Time to Wait: Securing the Future from Drug-Resistant Infections,* (2019).
[121] OHCHR, *International Guidelines on HIV/AIDS and Human Rights*, (2002), para. 24.
[122] UNAIDS, *AIDS and the Sustainable Development Goals.*
[123] Political Declaration on HIV and AIDS: Ending Inequalities and getting on Track to End AIDS by 2030.

staff and even reduce access to treatment and research.[124] The UN's Special Rapporteur on the right to health has pointed out that the criminalisation of private, consensual sexual interaction between adults not only infringes on the right to health but also various other human rights, including the rights to privacy, equality and freedom from discrimination.[125] It is therefore of the utmost importance to integrate the rights and gender equality perspective to combat stigma and discrimination in interventions to prevent STIs and HIV.

The public health perspective

To prevent the spread of STIs and HIV, social norms and traditional gender roles must be challenged. It is key to involve men and boys in this work. Interventions to promote gender equality and women's rights are also important. Unequal gender roles often prevent young women from accessing prevention measures, information and healthcare related to STIs. This leads to young women accounting for a disproportionate number of new HIV infections in young people.[126] Norms about masculinity can also deter men from seeking healthcare, creating risks in the form of low levels of testing and untreated STIs.[127]

Starting out from a principle of non-discrimination can be an opening for dialogue. In some countries, the spread of STIs and HIV is concentrated in particular groups while it covers the general population more broadly in other countries. Men who have sex with men, women, men and transgender persons who sell sex, and people who inject drugs are often left outside interventions. This exacerbates the vulnerability and exclusion of these groups.[128] These groups must be covered by context-specific interventions and be given an opportunity to participate in the design of programmes. Since these groups are often discriminated against, it is important to conduct an analysis of whether access is a broader question of discrimination or an issue of ensuring that health measures are targeted towards specific groups. Many national HIV and AIDS prevention programmes do not mention LGBTIQ persons for example.

---

[124] The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2654.
[125] A/HRC/14/20 (2010), paras. 2, 51.
[126] In 2016, it was estimated that 2.4 million girls and young women in the world were living with HIV, amounting to 61 percent of all young people living with HIV. UNAIDS, 2017, AIDSinfo online database.
[127] Courtenay WH. *Constructions of masculinity and their influence on men's well-being: a theory of gender and health*, Soc Sci Med, (2000), pp. 1385–1401.
[128] The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2656.

The major global initiatives to halt the spread of HIV have not always included SRHR despite the obvious link between sexuality, gender equality, power and the spread of HIV. One example is when information about HIV is provided in sexuality education without explaining the use of condoms, and/or not talking about the ways in which HIV can be transmitted. An integrated approach is thus required, also in dialogues on the design of national health systems.

In the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Sweden and other actors have worked to ensure that SRHR organisations are considered. Following up on the implementation of this work at country and regional level provides an opening for dialogue for representatives of Sweden. It should also be established who benefits from the funds from major global initiatives and to demand that these also respect gender equality and human rights, and that organisations, programmes and projects working with the rights of LGBTIQ persons and young people also gain access to funding.

Cooperation with civil society

Dialogues should be conducted directly with people living with STIs and HIV so that programmes and policies are able to meet their needs. Organisations working on contraception which incorporate condom use, CSE, gender equality and a focus on women, young people and communities that are particularly at risk are also important. In many countries, dialogue and collaboration with progressive, pragmatic religious leaders can be helpful, for example in dialogue on girls' rights to education and violence against women. Furthermore, men should also be engaged in interventions to prevent the spread of STIs and HIV and to encourage sexual and reproductive health in general. It can also be useful to conduct dialogues with the civil society organisations that work with the Global Fund's Country Coordinating Mechanisms (CCM).

Sexual and gender-based violence

Why must Sweden pursue issues of sexual and gender-based violence?

The extent of violence against women, girls and LGBTIQ persons in the world is not only a violation of their human rights, but is also a public health concern and a serious obstacle to their SRHR being realised.[129] One in three women suffer violence by an intimate partner and around 29 percent of young women have already experienced this form of violence by the age of 19.[130] LGBTIQ persons also risk being subjected to violence and harassment to a considerably higher degree than the general population.[131]

Sexual violence can be described as violations and abuse with a sexual element. Among other things, it encompasses violence, sexual harassment, being prevented from using contraception and forced abortion. Gender-based violence should be interpreted extensively and refers to all types of harm committed against a person or group due to their sex, sexual orientation and/or gender identity.[132] Gender-based violence and violence against women are two terms that are often used synonymously as the majority of the documented gender-based violence concerns men's violence against women. Specific groups of women and girls, such as women living with disabilities, migrants and those living in humanitarian settings, are particularly at risk.[133] The term gender-based violence is, however, not solely limited to women and girls and interventions aimed at combatting sexual and gender-based violence should integrate an intersectional perspective, incorporating several grounds for discrimination.

Sexual and gender-based violence takes different forms and often springs from norms about gender roles, power, sexuality and relationships. Breaching these norms exposes people to a greater risk of violence. Sexual and gender-based violence may be perpetrated by anyone and can take many forms, from online verbal abuse to rape or murder. Harmful practices, which is an umbrella term incorporating child marriage, so-called "virginity checks", FGM and honour-related violence and oppression, are also forms of gender-based violence[134]. Sexual and gender-based violence may even be prescribed in national law or encouraged by social norms. For example, LGBTIQ persons risk suffering violence in the form of death penalty or imprisonment due to their sexual

---

[129] Heidari, *Gender-based violence: a barrier to sexual and reproductive health and rights*, (2016).
[130] WHO, *Violence Against Women*.
[131] A/HRC/35/36, *Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity*, (2017).
[132] A/HRC/47/27 *The Law of Inclusion: Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity*, (2021), paras. 29-30.
[133] A/HRC/20/5, *Thematic study on the issue of violence against women and girls and disability*, (2012), para. 22.
[134] Read more at OHCHR.

orientation or gender identity. Another example where the CEDAW Committee and the UN's Special Rapporteur on violence against women have expressed concerns, is the case where lesbians are raped to be "cured" of their sexual orientation.[135] Sexual and gender-based violence is often upheld by a culture of denial and silence – as was revealed by the global MeToo movement.

Sexual and gender-based violence has serious social and economic consequences and affects society as a whole, also in terms of safety.[136] Besides the physical and psychological damage that arises in conjunction with the violence itself, the violence also leads to poorer reproductive and mental health outcomes.[137] Gender-based violence also enhances the risk of unwanted pregnancies and STI infections, especially for women, girls and LGBTIQ persons.[138] In spite of this, effective preventive measures to counter sexual and gender-based violence have long been lacking. Important interventions include preventive measures in the form of education and programmes where social norms about gender roles, power, sexuality and relationships are analysed. Other interventions may provide support to health systems so that healthcare staff can be trained to identify those who have been subjected to sexual and gender-based violence. Additionally, interventions to raise awareness of sexual and gender-based violence in the judicial system, as well as sufficient funding and access to inclusive support facilities and safe places, are needed. To the extent possible, such support should be available in all contexts, including in humanitarian settings.

Openings for dialogue on sexual and gender-based violence

The human rights perspective

The ICPD Programme of Action affirms that States must take steps to eliminate violence against women but no broader reference is made to combating gender-based violence against LGBTIQ persons.[139] At the follow-up Nairobi Summit ICPD25 (2019), on the other hand, the final version of the Nairobi Statement specifically urged States to strive to prevent all forms of sexual and gender-based violence.[140] The Beijing Platform for Action similarly emphasises that women's rights include women's right to sexual and reproductive health free from force, discrimination and violence.[141] The follow-up Generation Equality Forum (2021),

---

[135] A/HRC/19/41, *Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity*, (2011), para. 29.
[136] OHCHR, *Violence Against Women*, (2020).
[137] *Ibid.*
[138] The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2654.
[139] International Conference on Population and Development, Programme of Action (1994), para. 4(4)(e) and Principle 4.
[140] Nairobi Statement on ICPD25: Accelerating the Promise, para 5.
[141] Fourth World Conference on Women, Platform for Action (1995), para. 96.

created a specific coalition for gender-based violence to accelerate the efforts of States.[142]

Violence is a form of discrimination and States have a responsibility to prevent, investigate and demand accountability for all acts of violence, especially against women and girls, by Governments and non-governmental actors. A number of different resolutions adopted by the Human Rights Council and the UN General Assembly have asserted that violence against women and girls must be prevented.[143] The CEDAW Committee has also urged States to combat violence against women in its General Recommendations Nos. 19 and 35. In dialogue, one should also cite regional conventions that condemn all forms of violence, such as the Council of Europe Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention).

Harmful traditions and customs, such as FGM, forced marriage and child marriage, restrict the rights of girls and women to decide over their own bodies, sexuality and relationships.[144] The UN defines these acts as gender-based violence and they cannot be excused on the basis of culture or religion.[145] Under the 2030 Agenda, States are to eliminate forced marriage and FGM and eradicate violence against and exploitation of women and girls.[146] SDG 16 in the 2030 Agenda on peaceful and inclusive societies is yet another opening for dialogue. SDG 16 specifically outlines that States must reduce all forms of violence and violence-related death everywhere and promote the rule of law and ensure equal access to justice for all.[147]

The public health perspective

Staff in the judicial or healthcare system who are not trained on the topic of sexual and gender-based violence constitute a challenge. For example, sexual and gender-based violence may be perceived as a "private" matter and is thus not afforded sufficiently high priority by public services. Fostering a culture of accountability is important in healthcare, police operations and the judicial system. National policy and legislation are sometimes implemented at slow pace at local level, and initiatives geared towards the judicial system and the healthcare sector at local level can accelerate this process.

---

142 Action Coalitions GLOBAL ACCELERATION PLAN EXECUTIVE SUMMARY, (2021).
143 See for example Resolutions 64/137 and 65/187 of the UN General Assembly, and Resolution 14/12 of the Human Rights Council. See also reports by the United Nations Special Rapporteur on violence against women, its causes and consequences.
144 OHCHR, *Harmful Practices*, (2020).
145 *Ibid.*
146 Target 5.3.
147 Targets 16.1 and 16.3.

It is important to bear in mind the risk of survivors suffering additional violence when they seek help. People who have survived or are living with ongoing sexual and gender-based violence need access to knowledgeable and aware healthcare staff. Healthcare staff who ask the right questions, provide tailored counselling and treatment, document injuries and illness, protect the patient's confidentiality and who are also able to refer the person to additional support and help, save lives and increase the likelihood of the perpetrator being held accountable.

People in positions of authority may exploit their position by demanding sexual services. This has come to be known as "sextortion". Sextortion is both a form of corruption and sexual and gender-based violence. It is difficult to combat because it often falls between the cracks of legislation, policy and practice. One way of drawing attention to sextortion is to link the agendas on anti-corruption and sexual and gender-based violence.[148]

Despite the existence of proven effective programmes of preventive measures,[149] progress has been slow in many countries.[150] One entry point for dialogue can be to underscore the importance of countering harmful social norms that relate to male authority, female obedience and discrimination against LGBTIQ persons. Examples of measures that counter such norms include creating opportunities for women to gain access to positions of leadership in politics, business and peace processes. Increasing the influence of survivors in programmes implemented to tackle sexual and gender-based violence is also crucial.

Sexual and gender-based violence in conflict and post-conflict situations

Sexual and gender-based violence increases in conflict and post-conflict situations and women, girls and LGBTIQ persons are particularly at risk. In many cases, rape and other sexual violence is used as a deliberate strategy against the enemy.[151] In war and conflict situations, the opposing parties often use sexual violence to destroy the social fabric of the local community. There are also large gaps in healthcare and judicial systems for survivors of sexual violence in conflict and post-conflict situations.[152] Dialogues in this respect can draw on the importance of accountability, where sexual violence in conflict situations can be considered as a war crime or a crime against humanity.[153]

UN Security Council Resolution No. 1325 on women, peace and security and its subsequent resolutions, can serve as starting points for dialogue on combating

---

[148] Elden et al., *Sextortion: corruption and gender-based violence*, EBA 06, (2020).
[149] E.g. interventions to change social norms, see The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2654.
[150] *Ibid.*
[151] OHCHR, *Women's human rights and gender-related concerns in situations of conflict and instability*.
[152] *Ibid.*
[153] Article 7 (g) and Article 8 (xxii) Rome Statute of the International Criminal Court.

sexual violence in conflict and to underscore women's rights in crisis, conflict and post-conflict situations. Campaigns headed by the UN Special Rapporteur on sexual violence in conflict can also be used to initiate dialogue. Multi-sectoral approaches and interventions are needed and within the women, peace and security agenda, it is especially important that survivors of sexual violence gain access to SRHR.

Cooperation with civil society

Local civil society organisations and networks, such as organisations providing shelters, legal advice and medical treatment have a wealth of information about the needs and interventions required. Cooperation between local government agencies and civil society can lead to a better understanding of, and response to, the SRHR needs of different target groups. Research, data collection, legislation, resources and expert healthcare personnel are important in this regard. In certain contexts, civil society organisations can gain greater trust among marginalised women, girls and LGBTIQ persons than government institutions. To have an impact, interventions should be planned and implemented jointly with civil society organisations.

Infertility

Why must Sweden pursue questions of infertility?

Infertility[154], or the inability to become pregnant, is an area that has repeatedly been left out in discussions or priorities concerning SRHR. As many as 180 million couples worldwide are potentially affected by infertility.[155] The causes of infertility are often closely linked to unmet SRHR needs, such as unsafe abortions, complications of pregnancy, involuntary sterilisation and untreated STIs. In contexts where a woman's identity and social position is largely defined by her role as a parent and her ability to have children, infertility can have severe consequences. Women are often blamed and have to bear the guilt when a couple are unable to have children.[156] Fears about infertility, as a side effect of contraceptive use, can also risk deterring people from using contraception.[157]

An absence of political will, combined with the high costs of assisted reproduction technologies has resulted in extensive differences in access to fertility treatment between countries.[158] Information and education about infertility and fertility treatment also remain inaccessible for many people. However, success stories in reproductive medicine are rapidly on the rise, and these have responded to many infertility challenges. Solutions have varied from the simplest methods of enhancing general knowledge about fertility, to more advanced scientific innovations. However, much more can be done to raise awareness of, and prevent, infertility. There is a need to explore cost-effective solutions to make access to new fertility technologies fairer across the world.[159] A comprehensive approach to promoting SRHR should reflect the reality which many people face during their reproductive lifetime, namely seeking to avoid both pregnancy and infertility.[160]

---

[154] For a definition, see WHO, *Sexual and Reproductive Health: Multiple Definitions of Infertility*, (2016).
[155] Due to the strong focus in SRHR programmes on preventing unwanted pregnancy, we currently know little about the scope of infertility. Current estimates of infertility vary from 48.5 million couples to 186 million individuals worldwide. This broad spectrum of estimates emphasises the lack of reliable data on infertility. The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2664.
[156] The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), s. 2664.
[157] *Ibid.*
[158] *Ibid.*
[159] *Ibid.*
[160] Gipson et al., *Infertility: a continually neglected component of sexual and reproductive health and rights*, (2020).

Openings for dialogue on infertility

The human rights perspective

The lack of interventions to prevent and treat infertility, and a failure to recognise infertility as part of SRHR, affect individuals' enjoyment of their human rights.[161] Treatment of infertility is covered by the definition of reproductive healthcare under the ICPD Programme of Action and the definition of reproductive rights supports people both wishing to and not wishing to become pregnant.

Infertility is also part of the right to health, stated in Article 12 of the International Covenant on Economic, Social and Cultural Rights. The Committee on Economic, Social and Cultural Rights has urged States to provide information on fertility treatment and to take action to ensure universal access to diagnoses of infertility and treatment.[162]

The public health perspective

Research has shown that infertility is associated with mental illness and intimate partner violence, as well as stigma and economic difficulties.[163] Although all people can suffer from infertility, women are often blamed.[164] When developing solutions for infertility, broader structural discrimination and gender stereotypes must be taken into account. One opening for dialogue about infertility can thus be non-discrimination.

Fundamental interventions such as counselling, medical investigations and information about infertility and treatment options are often lacking on the ground. Advanced treatment of infertility requires a highly qualified workforce and expensive equipment, which is still a challenge in some countries and almost non-existent in many low-income countries.[165] Assisted reproduction technology is seldom included in primary healthcare and is, as a general rule, not covered by insurance. Starting points for dialogue on infertility can be to raise awareness of the issue, reduce stigma surrounding infertility and ensure that evidence-based information is available.

---

[161] Davis and Khosla, *Infertility and Human Rights: A Jurisprudential Survey*, Columbia Journal of Gender and Law, Northeastern University School of Law Research Paper No. 381, (2020).
[162] ESC Committee, *General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, (2016), paras 18, 40, 45.
[163] See Dyer et al., *Psychological distress among women suffering from couple infertility in South Africa: a quantitative assessment*, Human Reproduction (2005), Stellar et al., *A systematic review and narrative report of the relationship between infertility, subfertility, and intimate partner violence*, International Journal of Gynecology & Obstetrics (2016) and Dyer and Patel, *The economic impact of infertility on women in developing countries—a systematic review*, Facts Views Vis ObGyn, (2012).
[164] *Ibid.*
[165] The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018) pp. 2663-2664.

Cooperation with civil society

As infertility is associated with great shame in some contexts, it is important to conduct dialogue with civil society organisations to gather information and data on how different target groups are affected. Since the causes of infertility are often closely linked to unmet SRHR needs, cooperation with civil society organisations is key to increase knowledge about infertility in other SRHR interventions, such as those on CSE.

Lesbian, gay, bisexual, transgender and intersex persons and persons with queer expressions and identities (LGBTIQ) and SRHR

Why must Sweden work to ensure that LGBTIQ persons are able to enjoy their rights?

Societal norms and rules based on a binary social construct, consisting of heterosexual men and women, limit people's right to live free from discrimination on the grounds of their sexual orientation, gender identity, gender expression and sexual characteristics.[166] In a world characterised by a binary view of gender and stereotypical assumptions about masculinity and femininity, those who identify as women, girls and LGBTIQ persons have less social, political and economic power than heterosexual (older) men. Attempts to break this power structure often encounter powerful resistance in the form of violence, threats and harassment, which is a major obstacle to gender equality.

How the maintenance of a strict binary view of gender is expressed varies in different contexts and over time. For example, same-sex relationships or transgender identities may have been long accepted in local norms or belief systems, even if many people do not identify in a way that strictly matches "LGBTIQ". Some examples of this are *two-spirit persons* (North America), *muxes* (Mexico), *hijra* (India and Bangladesh), *kathoey* (Thailand), *bakla* (the Philippines), *travestis* (Argentina and Brazil), *fa'afafine* (Samoa) and *leiti* (Tonga).[167] In other words, LGBTIQ persons are a heterogenous group with diverse and individual needs that differ depending on their unique situations. The occurrence of discrimination and violence can differ considerably between and within countries based on factors such as the person's income, ethnicity, sex and gender identity.

In many parts of the world, LGBTIQ persons are subjected to violations of their human rights, including by means of discrimination, persecution, marginalisation and violence. Discrimination, stigmatisation and criminalisation mean that LGBTIQ persons are denied the right to fully enjoy their human rights, including the right to the highest attainable standard of physical and mental health. Healthcare available for LGBTIQ persons may

[166] The umbrella term "Sexual Orientation, Gender Identity, Expression and Sex Characteristics" (SOGIESC), is translated into Swedish as *sexuell läggning, könsidentitet, könsuttryck och könskarakteristika*, where sex characteristics refers to people who are intersex. The term SOGIESC is sometimes used instead of the term LGBTIQ. The term SOGIESC describes the grounds for discrimination and not specific categories.
[167] A/HRC/47/27 *The Law of Inclusion: Report of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity*, (2021), para 9.

also be poor quality, for example if healthcare professionals do not have sufficient knowledge or are judgmental.[168] A lack of data renders LGBTIQ persons invisible and as a result, SRHR policies and programmes may fail to meet the SRHR needs that exist.

Opposition to LGBTIQ persons' enjoyment of their human rights has intensified in many places as nationalistic and anti-SRHR actors have grown.

Openings for dialogue on LGBTIQ persons' enjoyment of rights

The human rights perspective

Sexual orientation and gender identity are covered by the principle of non-discrimination in the central human rights conventions. Although the ICPD Programme of Action does not make specific reference to LGBTIQ persons, discrimination due to sexual orientation or gender identity contradicts the fundamental principle of the equal value and rights of all people. According to the UN Special Rapporteur on the right to health, discrimination against LGBTIQ persons has far-reaching health-related impacts as it also prevents the people affected from accessing other economic, social and cultural rights.[169] Discrimination that infringes the right of every individual to enjoy the highest attainable standard of physical and mental health, including choice of sexual orientation, gender identity or other statis, is not permitted. Non-discrimination regarding the right to sexual and reproductive health covers everyone, including LGBTIQ persons.

The Human Rights Council has adopted several resolutions on human rights, sexual orientation and gender identity since 2011.[170] The first resolution, adopted in 2011, paved the way for the first official UN report on the subject, presenting how LGBTIQ persons suffer systematic violence and discrimination in all regions of the world.[171] In 2016, the Human Rights Council adopted a resolution to appoint an Independent Expert against

[168] Graham et al., *The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding*, Washington, DC: The Institute of Medicine, (2011).
[169] A/HRC/14/20, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, (2010), para. 6.
[170] A/HRC/RES/17/19 (2011) on Human rights, sexual orientation and gender identity.
[171] A/HRC/RES/32/2 (2016) on Protection against violence and discrimination based on sexual orientation and gender identity, para. 3.

violence and discrimination on the basis of sexual orientation and gender identity.[172] The Independent Expert's mandate was renewed in 2019.[173]

In several countries, same-sex sexual acts are criminalised and may even be punishable by death. Many of these laws were imposed by former colonial powers and still have the support of certain movements.[174] Generally, these laws only pay attention to men and women and in many cases, it is unclear how they might affect transgender persons. Laws that criminalise same-sex sexual acts and relationships or gender expression, such as "cross-dressing", infringe human rights, including the rights to a private life and freedom from discrimination.[175] These laws also cause stigma and prevent access to healthcare.

Transgender and intersex persons may face particular difficulties in terms of healthcare. Forced sterilisation of transgender persons and interventions on children to make their genitalia "match" a particular sex can occur. Transgender persons may also be denied healthcare when identification documents do not match their gender expression or identity. There is often a lack of resources and expertise to provide gender-affirming treatment and the lack of healthcare risks abandoning transgender persons to self-medication.

In countries where there is good legal protection, the dialogue can emphasise the importance of ensuring compliance with the law and and that different institutions in society do not discriminate against LGBTIQ persons. Being prepared to counter factual errors will make dialogue easier.

The public health perspective

Data collection to assess the SRHR needs of LGBTIQ persons should be expanded and improved. Terminology, categories and definitions often differ in different countries, making it difficult to compare data. Local contexts with specific cultural codes and practices also differ and under-reporting due to stigma impacts the quality of the collected data. One entry point for dialogue can be to assess how existing surveys can be improved, if different data collection methods can be reviewed and if standardised questions about sexual

---

[172] Read more about the UN Special Rapporteur on violence and discrimination based on sexual orientation and gender identity.

[173] A/HRC/41/L.10/Rev.1, *Mandate of the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity*, (2019), para. 2.

[174] Kaoma, *Colonizing African Values - How the U.S. Christian Right is Transforming Sexual Politics in Africa* Political Research Associates, (2012).

[175] A/ HRC/32/32, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, (2016), para.113 (e), A/HRC/35/23, *Special Rapporteur on extrajudicial, summary or arbitrary executions*, (2017), para.110 och A/72/172, *Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity*, (2017) para. 31.

orientation and gender identity can be included in population surveys. However, to prevent exposing LGBTIQ persons to threats, these surveys should be anonymous.

Increasing the knowledge of healthcare professionals and researchers about the different needs of LGBTIQ persons, emphasising that individuals have diverse healthcare needs, is important.[176] National medical guidelines are often necessary to ensure that the healthcare meets the sexual and reproductive health needs of LGBTIQ persons. One opening for dialogue may be to provide information about global medical guidelines that are available for healthcare professionals and encourage the development of national guidelines.

Due to the risk of stigma, discrimination and negative treatment, LGBTIQ persons often risk suffering high levels of stress. From a public health perspective, this is often termed minority stress.

Questions about sexual orientation, gender identity, gender expression and sex characteristics are seldom included in gender equality interventions. In some cases, this risks rendering important questions or groups of people invisible. Dialogues can draw attention to the fact that questions about gender equality from a public health perspective should not only target challenges related to social norms and structures related to heterosexual relationships between women and men.

Cooperation with civil society

LGBTIQ persons have the right to organise and make their voices heard. Despite this, legislation is sometimes used to make the work of LGBTIQ organisations more difficult by prohibiting organisation or financing in specific cases, e.g. citing national security concerns. Diplomacy and dialogue at different levels regarding the opportunity to amend legislation and provide support to human rights defenders are of the utmost importance. Global civil society actors working for LGBTIQ persons' enjoyment of human rights, including religious actors and organisations such as the Global Interfaith Network for People of all Sexes, Sexual Orientations, Gender Identities and Expressions (GIN-SSOGIE)[177], can be good allies and may be able to provide links to national actors.

[176] Blondeel et al., *Evidence and knowledge gaps on the disease burden in sexual and gender minorities: a review of systematic reviews*, Int J Equity Health, (2016).
[177] GIN-SSOGIE.

In countries where homosexuality is criminalised or not socially acceptable, LGBTIQ persons may be exposed to risks when coming out or being exposed by others. People working with these issues may also risk being subjected to threats and harassment and therefore, it is important to exercise caution when working with civil society actors.

Persons living with disabilities and SRHR

Why must Sweden pursue questions about persons living with disabilities and their sexual and reproductive health and rights?

People have diverse physical and mental abilities and each individual's abilities will differ at different times in their life. People's need for SRHR can change in line with their capacity and it is important that policies and programmes meet these needs. People may be treated differently based on their disability as social norms and societal structures often support and favour a certain type of norm in terms of capacity and function. Since the majority of the structures in society, including health systems, are built and designed according to a norm in terms of capacity and function that does not include everyone, persons living with disabilities run a higher risk of encountering discriminatory norms and practices that limit their bodily autonomy. Persons living with disabilities also have a higher risk of unwanted pregnancy, being infected with STIs and HIV, being subjected to sexual and gender-based violence, being forced to take a certain kind of contraception and being subjected to medical interventions such as abortion and forced sterilisation.[178] Insufficient and inaccessible SRHR information and a shortage of adapted and targeted resources put persons living with disabilities at risk.[179] Stigma and stereotypes related to the sexuality of persons living with disabilities are also a major obstacle to their full enjoyment of SRHR. These stereotypes include asexualisation of persons living with disabilities, which may be expressed in a lack of representation in CSE material, not being asked about sexuality at meetings with healthcare professionals or being assumed not to be interested in sex and relationships.[180] Persons living with disabilities are therefore significantly at risk of being denied access to their SRHR.[181]

Openings for dialogue on persons living with disabilities and SRHR

The human rights perspective

In line with the principle of non-discrimination set out in several international conventions, States have an obligation to provide persons living with disabilities with SRH services without discriminating. The principle of non-discrimination, which involves an obligation to safeguard the rights laid down by the respective convention without discrimination, is found in the UN Convention on the Rights

---

[178] A/72/133, *Report of the Special Rapporteur on the rights of persons with disabilities: Sexual and reproductive health and rights of girls and young women with disabilities*, para. 3.
[179] The United Nations Population Fund has highlighted the fact that the vulnerabilities of people living with disabilities have been heightened during the COVID-19 pandemic.
[180] RFSU and Funktionsrätt Sverige, *Vill du ligga med mig då? En Kartläggning om sexuell hälsa hos personer med funktionsnedsättning och kronisk sjukdom*, (2021), p. 13.
[181] Addlakha et al., *Disability and sexuality: claiming sexual and reproductive rights, Reproductive Health Matters*, (2017).

of Persons with Disabilities (CRPD), the Convention on the Rights of the Child, the Convention on Civil and Political Rights, the Convention on Economic, Social and Cultural Rights and CEDAW. CRPD states that the right of self-determination for persons living with disabilities is central in what concerns their SRHR.[182] The Convention prohibits harmful and discriminatory practices in all questions concerning marriage, family, parenthood and relationships, including the right to retain one's fertility and to decide the number of children.[183] The Convention also urges States to prohibit all forms of exploitation, violence and abuse[184], and promote access to good quality sexual and reproductive healthcare.[185] These rights are crucial as persons living with disabilities commonly do not have their SRHR needs met. In many cases, stereotypes about persons living with disabilities not being capable of making their own decisions about their sexuality and reproduction live on, and is expressed in policies and programmes focusing on the prevention of pregnancy. The same reasoning has led to sterilisation and abortion being forced upon persons living with disabilities.[186]

Since the Cairo Declaration and its Programme of Action were adopted, there has been an increased focus on the need for SRHR for persons living with disabilities but more remains to be achieved. In line with the principle of the 2030 Agenda framework that no-one is to be left behind, particular attention is to be paid to persons living with disabilities when implementing the SDGs.

The public health perspective

According to the WHO, more than 15 percent of the world's population has one or more forms of disability.[187] About one in five women have a disability and between 180 and 220 million of them are young women.[188] Studies underscore that there are extensive unmet SRHR needs for persons living with disabilities.[189] Data and information about context-specific needs and experiences, as well as evidence regarding how obstacles to the inclusion of persons living with disabilities in SRHR programmes can be removed, are limited.[190] Persons living with disabilities often lack access to SRH services for various reasons, such as physical barriers, distance and travel time to healthcare or educational settings,

[182] Articles 12 and 25. For further reading on sexuality and people living with disabilities within the remit of negotiations at UN level, see, for example Shaaf, *Negotiating sexuality in the convention on the rights of persons with disabilities*, (2011).
[183] Article 23.
[184] Article 16.
[185] Article 25.
[186] Mallik, *Women with Disabilities: Parenting and Reproduction,* Arrow For Change, (2017).
[187] WHO, *World report on disability*, (2001).
[188] UNFPA, *Key Messages for The Path to Equality for Women and Young Persons With Disabilities,* (2020).
[189] Hunt et al., *The sexual and reproductive rights and benefit derived from sexual and reproductive health services of people with physical disabilities in South Africa: beliefs of non-disabled people*, Reproductive Health Matters, (2017).
[190] Devine et al., *"Freedom to go where I want": improving access to sexual and reproductive health for women with disabilities in the Philippines*, Reproductive Health Matters, (2017).

stigma, discrimination and a lack of knowledge amongst healthcare professionals, a lack of adapted communication (e.g. available information in braille or sign language interpreters), and insufficient insurance and financing.[191] Persons living with disabilities are not a homogenous group and the needs and challenges in relation to their SRHR differ. The need for specific interventions varies, for example, depending on whether the person has physical or mental disabilities, or both. Persons living with disabilities can also suffer from multiple and intersecting forms of discrimination. For instance, a person with a disability may find it difficult to assert or exercise their sexual orientation as LGBTIQ if they are dependent on parents or carers who deny, or refuse to accept, their sexual orientation. Therefore, it is necessary to analyse SRHR interventions and conduct dialogue with an intersectional perspective so that programmes, policies and health systems are adapted to a broad spectrum of different SRHR needs.

Ensuring that universal health coverage includes SRHR and is also accessible to persons living with disabilities is important to safeguarding public health. Educating healthcare professionals and other healthcare actors is key to combat stereotypes about persons living with disabilities. It is also important to ensure that CSE and SRHR information is accessible and adapted to the needs of persons living with disabilities.

Cooperation with civil society

Organisations that are led by, and work with and for, persons living with disabilities are important actors with which to conduct dialogue. Global organisations and networks can often help to identify national and local actors. Some organisations are focused on a specific form of disability while others focus on the issue from a broader perspective. Therefore, dialogue with a broad spectrum of organisations in the relevant country or context can be benefical. The organisations may have a varying focus on SRHR but it can also be important to conduct dialogue with those who are not working directly with SRHR. "Nothing about us without us" is a core principle and actors and movements for persons living with disabilities must be involved and consulted to create solutions.

Practical measures to make dialogues and consultations with civil society actors accessible and inclusive, both physically and virtually, are vital. This can require specific resources and allowing plenty of time as existing structures or working methods may not be very inclusive. Before regional and international negotiations and meetings, dialogues should be arranged well in advance to obtain views and proposals regarding priorities. Close cooperation with civil society actors ensures

[191] Promoting sexual and reproductive health for persons with disabilities WHO/UNFPA guidance note.

that Sweden's measures, proposals and main messages become more effective, inclusive and sustainable in the long run.

Young people and SRHR

Why must Sweden pursue questions of young people's sexual and reproductive health and rights?

About half of the world's population is under 25 and in several low and middle-income countries, the proportion of young people amounts to between 50 and 60 percent of the population.[192] Half of these young people live in poverty or extreme poverty.[193] A record-sized generation of young people are at a stage of their lives in which they are shaping their life, planning for the future, starting to stand on their own feet and becoming sexually active. Young people's SRHR needs are diverse and interventions and programmes must be tailored to these different needs. Important aspects of work to meet the needs of young people consist of ensuring that SRH services are characterised by respect, non-discrimination and confidentiality, and are accessible and affordable.[194]

Young people have the right to participate in decisions that affect their lives. It is essential that young people can access knowledge and information about sexuality to enable them to make informed decisions about their bodies, relationships and lives. Ensuring young people's SRHR is imperative for their possibility to participate in society.

The consequences of not investing in young people's sexual and reproductive health are severe. Pregnancy and childbirth are the most common cause of death among teenage girls, who are also over-represented in cases of injury in childbirth, unsafe abortions and injuries from unsafe abortions.[195] When a girl has a baby, she is often forced to drop out of school. Failure to complete education due to discrimination and abuse of young people is a major loss to society.[196] In the same way that girls and boys have different opportunities to make decisions about their own body and sexuality, the situation differs for young people depending on whether they are married or unmarried, live in an urban or rural area, their level of education and that of their parents, sexual orientation and gender identity, ethnicity and several other factors.

---

[192] UNFPA, *Youth participation and Leadership*, (2020).
[193] *Ibid* and UNFPA, The Power of 1.8 Billion, (2014).
[194] Engel et al., *A Package of Sexual and Reproductive Health and Rights Interventions-What Does It Mean for Adolescents?*, J Adolesc Health, (2019) and Chandra-Mouli et al., *The Political, Research, Programmatic, and Social Responses to Adolescent Sexual and Reproductive Health and Rights in the 25 Years Since the International Conference on Population and Development*, J Adolesc Health, (2019).
[195] WHO, *Adolescent Pregnancy*, (2020).
[196] UNFPA, State of the World Population, The Power of 1.8 Billion, (2014).

In some countries there may be great resistance to young people making independent decisions about their sexuality and reproduction, and being sexually active outside socially recognised relationships. For example, in many contexts, leaders and decision makers advocate for sexual abstinence and fidelity in heterosexual marriage as the only option, especially for women. Therefore, they consider CSE and SRHR information, as well as access to condoms and contraception, as something that encourages deviation from their points of view.

Openings for dialogue on young people and SRHR

The human rights perspective

Children and young people up to the age of 18 are covered by the UN Convention on the Rights of the Child. Article 24 of the UN Convention on the Rights of the Child sets out the right of the child to the highest attainable standard of health and the right to healthcare and rehabilitation. One of the areas laid down in the UN Convention on the Rights of the Child concerns the obligation of States to strive to develop preventive healthcare, guidance for parents and family planning education and services (Article 24.2 (f)).

The Committee on the Rights of the Child monitors States' compliance with the Convention and interprets its content. In a comment on the health and development of young people,[197] the Committee on the Rights of the Child makes it clear that young people must not be discriminated against in enjoying their rights due to their sexual orientation, gender identity/gender expression or their health status (including HIV and AIDS), and that the minimum age for sexual self-determination and medical treatment without parental consent should be enshrined in law. It is recommended that the minimum age for marriage should be 18. Similarly, the Committee asserts that States – based on the principle of what is best for the child, the right to information and the right to health – must provide young people with information about sexuality and reproduction, including contraception, HIV prevention and how to avoid the transmission of other STIs. States are urged to allow young people themselves to play an active role in producing and disseminating information. Furthermore, States are recommended to develop programmes for access to sexual and reproductive healthcare, including contraception and safe abortion where this is legal (see the section on *access to safe abortion and post-abortion care* in this material). Research has shown that the best way to strengthen young people's knowledge about SRHR is through information and sexuality

[197] CRC/GC/2003/4, Committee on the Rights of the Child, *General comment No. 4, Adolescent health and development in the context of the Convention on the Rights of the Child*, (2003).

education which is comprehensive, positive and includes a gender equality perspective.[198]

The ICPD Programme of Action contains several wordings that highlight the link between young people and SRHR. It asserts that young people are to be actively involved in the planning, implementation and evaluation of activities and services concerning reproductive and sexual health (PoA 6.15). It further lays down, among other things, that States shall work to ensure that young people's access to services and information is not restricted and that Governments are to protect and promote the rights of adolescents to reproductive health education, information and care (PoA 7.45–46).

The Beijing Platform for Action[199] urges Governments to meet the educational and service needs of adolescents to enable them to deal with their sexuality in a positive and responsible way. It also includes a requirement to remove all barriers to accessing formal education for pregnant adolescents and young mothers, and support the provision of childcare and other support services where necessary.[200] Young women must themselves be given the opportunity to determine when and whether they are ready to marry or have children.

Several of the SDGs of the 2030 Agenda come into play in relation to young people's SRHR. In this respect it is also important to shed light on links and synergies between the SDGs that concern SRHR and the right to water and sanitation. The lack of access to water and hygiene products, including menstruation protection in schools, can impact the attendance of young people, especially women and girls, and hinder the fulfilment of their SRHR.

The public health perspective

Young people are a heterogenous group with different needs that are constantly evolving depending on their personal circumstances. In many contexts, young people have limited opportunities to grow and develop their full potential and factors such as poverty, insecurity and restrictive social norms and legislation, exacerbate their risk of health problems. Young people need protection from harmful factors but also significant support and encouragement to make their own, independent decisions. Parents and other family members, as well as religious and traditional leaders, often influence young people's SRHR. However, they are often unprepared and unwilling to

[198] UNESCO et al., *International technical guidance on sexuality education: an evidence-informed approach*, (2018).
[199] Beijing Platform for Action 108 (k).
[200] Beijing Platform for Action 83 (s).

address questions about puberty, sexuality and reproduction. Therefore, one initiative can be to engage them on questions concerning SRHR. Since the actions of family members can sometimes lead to violations of young people's SRHR, it is imperative to ensure that there are SRHR initiatives in place that reach young people when they are still dependent on other family members. This can, for example, be achieved through CSE or through ensuring access to evidence-based SRHR information on the internet, self-care interventions related to SRHR and through mHealth/e-health initiatives. Healthcare professionals must also understand the needs of young people, e.g. the need for respect and confidentiality and that services are accessible and affordable.

Postponing marriage and childbirth to later in life increases the opportunities of girls and young women to have power over their lives, education, work and enjoy a healthy life in line with their wishes. In a context of poverty, early marriage and early childbirth (within marriage) can often be perceived as the only way for a girl to attain a better social and economic status in life. However, evidence clearly demonstrates that early marriage and early pregnancy contributes to greater suffering, ill-health and continued poverty – also at the societal level.[201] Being persuaded or forced to marry as a child brings a heightened risk of violence, including sexual violence.[202] Teenage pregnancies and motherhood contribute towards reproducing poverty at a societal level when girls and young women are excluded from education and the labour market.[203] Information about SRHR, access to contraception and healthcare, support and awareness of sexual and gender-based violence are essential elements in preventing such developments.[204]

Cooperation with civil society

It is vital to include young people and civil society organisations that are led by young people and work with young people's SRHR. CSW has emphasised the importance of making space for movements run by young people and of giving young people the opportunity to participate in decision making at all levels.[205] Young people are not a homogenous group and their SRHR needs differ depending on their contexts and individual circumstances. To enable young people to make their voices heard, to be listened to and to be included

[201] WHO 2020.
[202] Girls Not Brides (GNB), *About Child Marriage*, (2021).
[203] WHO 2020.
[204] WHO, *Preventing Early Pregnancy and Poor Reproductive Outcomes*, (2011) and WHO et al., *Global Accelerated Action for the Health of Adolescents (AA-HA!)*, (2017).
[205] E/CN.6/2021/L.3, Commission on the Status of Women, *Women's full and effective participation and decision-making in public life, as well as the elimination of violence, for achieving gender equality and the empowerment of all women and girls*, (2021), op (i).

in decision-making, they must be able to participate in a meaningful way.[206] There is a risk that young people will only be asked to participate in dialogue at a late stage once messages and priorities have already been decided, whereby their participation risks merely being symbolic. Meaningful participation means that young people have the right to decide on important questions concerning their SRHR at all stages of designing programmes.

[206] The term "meaningful youth participation (MYP)" is often used in this context. See for example CHOICE for Youth & Sexuality's publication on MYP.

Migrants and SRHR

Why must Sweden work to ensure that migrants are able to enjoy their sexual and reproductive health and rights?

About 270 million people are currently living in a country that is not their country of origin.[207] A number of different factors drive people to migrate, such as socioeconomic factors, climate change, conflict and political instability. Refugees and internal refugees (internally displaced persons, IDPs) only make up a small percentage of all migrants but tend to be the people who are in the greatest need for support and assistance.[208] The group migrants also encompasses people who are particularly at risk such as children, women, LGBTIQ persons, persons living with disabilities, ethnic minorities, stateless persons and migrants without residence permits ("undocumented migrants"). About half of all migrants are women and girls and the majority are of reproductive age.[209] Almost half of all women and girls who are refugees suffer violence and violations of their rights during their journey and many have not had access to healthcare.[210] Migrants are an at-risk group and their need for SRHR often risks being omitted from important international migration frameworks and intergovernmental commitments. The SRHR of migrants is therefore an important question to address.[211]

Openings for dialogue on migrants and SRHR

The human rights perspective

More women are migrating alone than ever before.[212] Women now make up almost half of the international migrant population and in some countries account for as much as 80 percent.[213] Female migrants often end up in low-status, low-paid and service jobs in the informal sectors of the economy, such as domestic labour.[214] This means that they are exposed to a higher risk of exploitation, violence and abuse. Female migrants are also notably at risk to sexual exploitation and STIs, including HIV, but have little access to healthcare or legal help.[215] Human rights, especially the right to health and the right not to suffer violence or discrimination, are therefore particularly

[207] IOM, *Migration Initiatives*, (2020)
[208] IOM, *World migration report 2020*, (2020), p. 37.
[209] *Ibid.*
[210] UNFPA, *A call to protect women and girls on the move*, (2018).
[211] For example, SRHR are not mentioned in *The Global Compact for Safe, Orderly and Regular Migration*.
[212] UNFPA, *Overview: Migration*.
[213] *Ibid.*
[214] *Ibid.*
[215] *Ibid.*

important for female migrants.[216] Migrants' needs for SRHR can also be acute as they may have waited a long time to gain access to healthcare and information.

The public health perspective

Access to healthcare is often limited for migrants due to language barriers, a lack of information and financial barriers. In a survey conducted by UNFPA, three-quarters of young women who had migrated or been refugees responded that they did not know where they could access SRHR services.[217] Some of these young women also stated that they avoided seeking healthcare due to experiences of discrimination and disrespectful treatment.[218] Dialogues about making SRHR information available in different languages can thus be important.

High financial costs in accessing healthcare constitute a major barrier and can vary considerably between and within countries, depending on the individual's legal status. Uncertainty about legal status can also delay access to healthcare.[219] SDG 3.8 of the 2030 Agenda on universal health coverage entails that everyone must be able to access public healthcare. This incorporates access to quality essential health-care services and access to safe, effective, qualitative and affordable essential medicines and vaccines for all.

Cooperation with civil society

Migrants who do not have a legal right to reside in a particular place at a certain time find it more difficult to organise in civil society. This can make it more difficult to reach out to migrants in the local context and to gain an understanding of their SRHR needs. Civil society organisations that work with and for migrants are important dialogue partners, especially those that provide healthcare to migrants. Confidentiality and rapid action can be crucial in dialogue. It can also be important to make different actors aware of migrants' SRHR needs and dialogues with civil society organisations working with these actors, such as doctors, social workers, psychologists and lawyers, are relevant stakeholders to reach out to.

[216] E/CN.9/2018/2, *Report of the Secretary-General: Sustainable cities, human mobility and international migration*, (2018), para 80.
[217] UNFPA, *A call to protect women and girls on the move*.
[218] *Ibid.*
[219] WHO, *Health evidence network synthesis report 45 Summary*, (2016).

Universal Health Coverage (UHC) and SRHR

Under the Sustainable Development Goals of the 2030 Agenda (SDG 3.8), the UN Member States have committed to ensure that everyone enjoys good quality universal health coverage (UHC).[220] Everyone must have access to such a service and people should not be pushed into poverty due to healthcare costs.[221] UHC includes the whole spectrum of important health and medical services. Despite this, around half of the world's population lack access to healthcare and around 100 million people are forced into poverty because their healthcare costs are far too high.[222] A strong healthcare system is central to UHC. Sexual and reproductive health (SRH) is part of UHC under the agreement in the Political Declaration on UHC adopted in 2019.[223] In the Political Declaration, Governments have committed to deliver the Essential Packages of Health Services (EPHS), including SRH services.[224]

Links between SRHR and UHC

Sexual and reproductive health has often been ignored in large-scale programmes and initiatives to encourage UHC. The Political Declaration on UHC from 2019 and subsequent commitments have created new tools to change this. One important way of ensuring SRHR within the remit of UHC is to ensure that SRHR are included when countries define their EPHS at the national level. Every country has its own approach where the ministries concerned may be the ministry of health, the ministry of finance and the ministry of education. One important element in dialogue on UHC can be to encourage coordination between different ministries, government agencies and sectors to secure the inclusion of SRHR.

Another entry point is to encourage the development of a strong national SRHR strategy as part of a national UHC strategy. Helping to widen the visibility and the scope of SRHR in national dialogues about UHC and highlighting success stories, challenges and best practice in SRHR can be another entry point for dialogue. Good quality healthcare is a key factor in the UHC agenda. SRHR programmes must be rights-based, non-stigmatising and non-discriminatory to increase access to SRH services. Eradicating obstacles to providing safe abortion can be an important means of increasing the quality of and access to SRHR. Access to high-quality, disaggregated data is also

[220] A/RES/74/2, *Political Declaration of the High-level Meeting on Universal Health Coverage "Universal health coverage: moving together to build a healthier world"*, (2019).
[221] UHC 2030.
[222] WHO, *UHC*.
[223] A/RES/74/2, *Political Declaration of the High-level Meeting on Universal Health Coverage "Universal health coverage: moving together to build a healthier world"*, (2019).
[224] *Ibid.*

important in order to make decisions about priorities within UHC. This can be underscored in dialogue.

Meaningful cooperation and participation of civil society can help to make sure that SRHR and gender equality are integrated within UHC. The participation of civil society organisations can help in successfully implementing SRHR initiatives that meet local needs. Civil society organisations have an opportunity to contribute with evidence and experiences from the local level and they can provide feedback on national strategies. Encouraging and enabling strategic meetings between civil society and decision makers, such as members of national parliaments or parliamentary committees, and connecting national and regional working groups that work with health questions and UHC, can be a good first step for dialogue and to help integrate SRHR and gender equality in UHC.

COVID-19 and SRHR

What epidemics and pandemics have in common is that they lead to negative consequences for the healthcare sector and for individuals' opportunities to benefit from the healthcare that exists. This has direct consequences for people's SRHR. During the Ebola epidemic in West Africa between 2014 and 2016, a significant decline was seen in access to antenatal care, while sexual and gender-based violence soared.[225] Maternal mortality also increased by 75 percent in this period.[226]

The COVID-19 pandemic has harvested millions of lives worldwide. People are hit hard by the virus itself but the indirect consequences – as was the case with Ebola – are also wide-ranging. This especially applies to SRHR. Overburdened healthcare, lockdowns, infringements of human rights and isolation have had far-reaching negative consequences, particularly for people who were vulnerable even before the pandemic.[227] We are already seeing studies and research that indicate that COVID-19 led to an increase in sexual and gender-based violence[228], child marriage[229], FGM,[230] unwanted pregnancies[231] and maternal mortality.[232] The increase in sexual and gender-based violence during the COVID-19 pandemic has come to be termed a "shadow pandemic" and the ongoing pandemic has made it more difficult for survivors of violence to report crimes.

Links between SRHR and COVID-19

As a consequence of closed borders, travel bans, restrictions on meetings, people being ordered to isolate and healthcare services being forced to make tough priorities, it becomes more difficult to access SRH care[233] and for groups discriminated against to meet and create safe spaces. UNFPA initially calculated that the pandemic would lead to millions of women not being able to access contraception and that the number of unplanned pregnancies would

[225] Foreign Policy, *The Ebola Rape Epidemic No One's Talking About*, (2016).
[226] The Lancet, *The cost of Ebola*, (2015).
[227] See for example *The effect of COVID-19 on maternal newborn and child health (MNCH) services in Bangladesh, Nigeria and South Africa: call for a contextualised pandemic response in LMICs*, (2021).
[228] The Report of the UN Secretary-General *Intensification of efforts to eliminate all forms of violence* against women and girls (2020), and examples from South Africa: *SOUTHERN AFRICA: TREATED LIKE FURNITURE* Amnesty International, (2021).
[229] UNICEF, *COVID-19 A threat to progress against child marriage*, (2021).
[230] The Lancet, *COVID-19 hindering progress against female genital mutilation* (2021) and The Orchid project *Impacts of COVID-19 on FGM*, (2021).
[231] UNFPA, *Impact of COVID-19 on Family Planning: What we know one year into the pandemic*, (2021).
[232] The Lancet, *Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study*, (2020).
[233] UNFPA, *Impact of COVID-19 on Family Planning: What we know one year into the pandemic*, (2021).

rise.[234] Increased poverty means that more people will not be able to afford the antenatal care or midwifery help they need. Another reason is that decision-makers siphon funds away from maternity care to initiatives to combat COVID-19, usually termed a "crowding out" effect.[235] Studies have also shown that COVID-19 in the second half of pregnancy increases the risk of early labour and thus also of complications.[236]

At a very early stage of the COVID-19 pandemic, an increase in sexual and gender-based violence was observed and the figure is assumed to be much higher due to the difficulties in reporting crime during a pandemic.[237] When increasing numbers of families are forced to stay at home together, men's violence against women, other forms of intimate partner violence, honour-related violence, as well as oppression and sexual violence against children, increases. Isolation enables control and violence within the domestic sphere. Girls, women and LGBTIQ persons are particularly at risk in such situations.[238]

Forecasts by UNFPA show that the effects of the pandemic on child marriage and FGM may be disastrous. In total, the COVID-19 pandemic is estimated to amount to an additional 13 million child marriages, which could otherwise have been prevented.[239] Schools are a protective mechanism against child marriage. But when schools are being closed and families' incomes are plummeting due to the pandemic, girls are paying a high price. The number of teenage pregnancies has increased during the pandemic and UNESCO fears that more than a million girls will never return to their school desks because they have been married off and are now mothers.[240]

---

[234] UNFPA, *New UNFPA projections predict calamitous impact on women's health as COVID-19 pandemic continues*, (2020).
[235] The Lancet, *COVID-19 has "devastating" effect on women and girls*, (2020).
[236] See for example Allotey et al., *Clinical manifestations, risk factors, and maternal and perinatal outcomes of coronavirus disease 2019 in pregnancy: living systematic review and meta-analysis*, BMJ, (2020).
[237] Center for Global Development, *COVID-19 and Violence against Women and Children: A Third Research Round Up for the 16 Days of Activism*, (2020).
[238] Human Rights Campaign Foundation, *LGBTQ INTIMATE PARTNER VIOLENCE AND COVID-19*, (2020).
[239] UNFPA, *State of the World Population Report 2021*, (2021).
[240] UNESCO, *Over 11 million girls may not go back to school after the COVID-19 crisis.*

Humanitarian settings and SRHR

As a general rule, the need for sexual and reproductive healthcare increases in humanitarian settings, while its availability decreases. Insufficient access to SRHR services during humanitarian crises has adverse impacts and may be life-threatening. Without access to sexual and reproductive healthcare, people risk suffering from infections, unwanted pregnancies and serious conditions that place their health at risk.[241] In humanitarian settings, women and girls run a greater risk of STIs, including HIV, unwanted pregnancy, maternal mortality and morbidity, sexual and gender-based violence[242], child marriage and human trafficking. Among other things, evidence shows that if the need for contraception were met, maternal mortality would fall by 29 percent in humanitarian settings.[243]

SRHR in humanitarian settings

The international standard *Minimum Initial Service Package for Sexual and Reproductive Health (MISP)*, produced by the *Inter-Agency Working Group for Reproductive Health in Crisis (IAWG)*, sets out a minimum level of SRH measures required in humanitarian crisis settings. UNFPA strives to ensure that MISP activities and additional SRH services are included in all phases of the humanitarian programme cycle, where combating maternal mortality and morbidity is a main objective.[244]

The need for SRHR must be taken into account in all humanitarian crises, especially where crises risk being long-term. Provision of services in humanitarian settings is often poor. Emergency obstetric and newborn care (EmONC) is insufficient, the use of emergency contraceptive pills and regular contraception is low, and diagnosis and treatment of STIs other than HIV are insufficient.[245] Access to safe abortion is rarely provided in humanitarian settings. The assumption that abortion is illegal in these contexts poses a major obstacle.[246] In most countries, there is a right to perform an abortion to save a woman's life and, in some cases, also to preserve her wellbeing and health. Another misconception that restricts access to abortion is the assumption that abortion is not needed, or that "abortion is too complicated to be provided in

[241] UNFPA, *A call to protect women and girls on the move*, (2018).
[242] IPPF, *IMAP Statement on sexual and reproductive health services in humanitarian settings*, (2018).
[243] Ahmed et al., *Maternal deaths averted by contraceptive use: an analysis of 172 countries*, The Lancet, (2012).
[244] Objective 4 of MISP.
[245] Casey et al., *Progress and gaps in reproductive health services in three humanitarian settings: mixed-methods case studies*, Conflict and Health, (2015).
[246] McGinn and Casey, *Why don't humanitarian organizations provide safe abortion services?*, Conflict and Health, (2016).

a crisis", which indicates the need for further information to increase access to these services.[247]

One particular challenge in SRHR work concerns the visibility of people who are not included in national statistics. For example, statistics are rarely gathered on migrants (documented or undocumented) and young people, resulting in little attention being paid to their situation and needs.[248] Young people, for example, are especially at risk in humanitarian settings. Their needs must therefore be emphasised in existing guidelines and policies.[249]

[247] The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2670.
[248] RFSU, *Sexuell och reproduktiv hälsa och rättigheter i framtiden*. Ramböll future analysis for RFSU, (2019), p. 37.
[249] See for example *Adolescent Sexual and Reproductive Health (ASRH) Toolkit for Humanitarian Settings: 2020 Edition*, IAWG.

The climate crisis and SRHR

The climate crisis refers to the changes that have taken place in global and regional climate patterns, mainly from the mid-20th century onwards. The climate change that have been observed from the 1950s to today can largely be attributed to higher levels of greenhouse gas emissions due to human activity. The years 2015-2019 were the five warmest years ever recorded and the effects of climate change are expected to increase through the rest of this decade. The extent of the impacts in the longer term, in the second half of the 21st century and thereafter, will depend on different factors, such as the extent to which greenhouse gas emissions can be reduced and whether nature reserves, biodiversity and ecosystems can be protected and restored in the decades to come.

The climate crisis interacts with discrimination and other injustices. Those who have contributed the least to the climate crisis are often those hit hardest by its effects, while also being those with the most limited access to resources to adapt.

Links between SRHR and the climate crisis

There is a growing interest in better understanding and documenting the links between the climate crisis and SRHR among researchers and among donors, Governments and civil society. Key questions concerns the impacts of the climate crisis on SRHR and – vice versa – how SRHR can contribute towards solutions to the climate crisis.

Effects of the climate crisis on SRHR

The effects of climate change will lead to more movement of people, where the poorest countries and the poorest people will be hit the hardest. Due to discriminatory gender norms and power structures, climate change will amount to additional consequences and risks for already marginalised groups, including groups of women and girls. LGBTIQ persons also risk being hit hard by the effects of climate change. The climate crisis will result in more conflict over land, long-term drought, long distances to sources of water, flooding and unpredictable weather, which affects women and girls as they are often responsible for the family's food and water supplies.[250] All human rights are under threat, especially the right to health and the right to food and water.

[250] RFSU, *Det är dags att koppla ihop genus och klimat*, (2020).

The lack of clean water, which can also be a direct consequence of climate change, means a considerable risk for SRHR infringements. Unhygienic birth environments, without clean water or functioning sanitation, increase the risk of infection and complications. A shortage of clean water and toilets also makes it more difficult for women and girls to manage their menstruation and forces many girls to stay at home instead of going to school. The climate crisis overlaps with humanitarian crises and migration, which in turn increase the risk of sexual and gender-based violence, child marriage and forced marriage. In humanitarian situations caused by climate change, access to SRH services and healthcare is prevented by issues such as clinics and roads being destroyed by flooding.

SRHR help to create more resilient societies

Inequalities and discrimination weaken individuals' opportunities and capacity to adapt to the climate crisis. Combatting gender inequality and discrimination is thus essential to increase resilience to the climate crisis in individuals and in communities. Strengthening SRHR is critical in order to achieve gender equality. Strengthening SRHR means improving the resilience of individuals and communities and their capacity to adapt to the climate crisis. SRHR should therefore be an important element of the measures that seek to increase resilience towards both the long-term effects of the climate crisis and its more immediate impacts. Sometimes arguments are put forward that are based on the assumption that reducing the number of births could be an answer to the climate crisis. This argument is not human rights-based and nor is it one that Sweden supports.

Telemedicine, self-care and SRHR

Healthcare is becoming increasingly accessible via digital channels, such as text messages, social media, apps, voice messages and telemedicine. Telemedicine also increases opportunities for self-care so that people can carry out treatments themselves or perform measures that would otherwise have been performed by healthcare staff. Telemedicine and e-healthcare are a way of meeting health needs around the world, especially for those with limited ability to visit healthcare facilities in person. In low and middle-income countries, 1.2 billion women currently own a smartphone.[251] At the same time, mobile technology, automation and artificial intelligence (AI) are becoming sufficiently developed to support the infrastructure needed to carry out much of the basic healthcare provision, as well as to provide educational and emotional support related to SRHR.

Self-care: The WHO defines self-care as: "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a healthcare providers".[252]

Telemedicine: The WHO defines telemedicine as "the delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities".[253]

eHealth: The term eHealth can be seen as an umbrella term that covers several technological services such as the use of electronic notes and electronic prescriptions, but also digital healthcare.

mHealth: The term is an abbreviation of "mobile health" used to describe the use of mobile units (mobile phones) in medicine and healthcare, e.g. in the form of apps.[254] The field of mHealth also includes the use of mobile phones to gather clinical health information/data and

[251] GSMA, *The mobile gender gap report 2020*, (2020), p. 21.
[252] WHO, *WHO Guideline on self-care interventions for health and well-being*, (2021).
[253] WHO, *Telemedicine* (2010), p. 9.
[254] Karolinska institutet, *Mhealth*.

to develop apps able to track diseases, provide public health information, offer training to healthcare staff and act as treatment support.

Femtech: Femtech is an abbreviation of "female technology" and is a term that describes electronic units, software, products and other technological services that relate to women's health. One example is software able to save information about a woman's menstrual cycle.

Links between SRHR, telemedicine and self-care

Different services related to SRHR, such as contraceptive counselling, medical abortions, as well as testing and treating STIs and screening for some forms of cancer, can now be offered via telemedicine in several places in the world. In some cases, telemedicine can replace healthcare that involves a face to face appointment with healthcare professionals, making it easier for people who, for example, live far away from the nearest hospital to access SRHR. Today, these technological solutions are mainly used to complement ordinary healthcare rather than completely replacing it.

Several digital platforms have emerged and these are rapidly developing services that offer medical abortions at home, where digital health appointments before the abortion can be made by phone or video call and with the abortion pills sent to the patient by mail. Being able to offer counselling on medical abortion via digital services when other opportunities are not available can lead to fewer unwanted pregnancies, fewer unsafe abortions and reduced maternal mortality and morbidity. Telemedicine has also long existed in contexts where abortion has not been legal but where pregnant women have been able to circumvent the law to obtain a medical abortion.[255] However, it is important to point out that telemedicine should not replace abortion in a clinic. Rather, it is a complement to safe abortions.

For many people, stigma is a barrier to seeking treatment and help linked to SRHR and also healthcare in general, e.g. for people living with HIV or AIDS, LGBTIQ persons and young people. Digital health services offer an opportunity to circumvent difficulties linked to stigma surrounding SRHR. Among other things, digital health services enable people to obtain health information in a neutral way without being judged or criticised by healthcare professionals. Since digital services are usually available round the clock and

[255] See for example Women on the Web.

are easily accessed from anywhere, people can seek information and care discreetly at any time and from a safe place.

Fertility and period tracking apps on a phone enable people to gain a greater understanding of their bodies, menstrual cycles, reproduction and fertility. Several large companies have increased their investments in digital health and especially in apps that monitor the menstrual cycle. New technologies also enable people to obtain information, knowledge and education via more channels. There are, for example, information services/apps and websites that provide information on SRHR. The right to education and sexuality education must be attained under the 2030 Agenda and technological solutions can help to achieve this aim. Despite the opportunities that telemedicine and new digital technologies offer, there are several logistical barriers to its implementation, including privacy issues and equal access to digital services and platforms. Telemedicine must also be ethically operated where users and their data can be protected from misuse and abuse, e.g. if a user submits sensitive information to a chatbot.

Annex I: Conducting an effective dialogue

Sweden, an important voice in the world

Dialogue is a central political tool in the process of promoting SRHR. It is about engagement based on relevant knowledge and forging formal and informal contacts with government agencies, civil society in Sweden and in the partner country, academic and other institutions and partners. It is also about understanding the specific cultural, social and political context in a country or a region so as to get Swedish messages and positions across in the most successful manner.

Sweden is a respected actor in the world and is considered to be a leader in a number of areas such as human rights, gender equality and SRHR. Representatives of Sweden are therefore expected to be well-informed, well-placed and well-prepared to conduct dialogue on these issues.

SRHR span a broad spectrum of dimensions and questions, some of which are harder to pursue than others. What they all have in common is that they involve people's rights to decide over their own bodies, sexuality and reproduction.

Context and openings for dialogue

Choosing an opening for dialogue on SRHR can have an important impact. Some SRHR issues are less called into question than others and can therefore be used as openings to talk about the issues that are more difficult.

Using the national situation and local examples on HIV and AIDS as a starting point for talking about young people's sexuality, sexuality education and the need for access to reproductive healthcare can be a good entry point. Gender-based violence can also be an opening for dialogue on questions about women's rights to decide over their own bodies, sexuality and reproduction.

Effective dialogue and success often arise because the participants have an opportunity to come together in a more informal context. Informal meetings and structures can thus be beneficial for dialogue, but one should be aware of which actors are included in the informal dialogue and which lack access to it, and the consequences this might have.

SRHR and gender equality are important questions in all sectors, especially in combatting poverty and other work that is vital for a country's development. Several of these questions have a given place in the health sector but if SRHR

are to be achieved, the questions must also be discussed within sectors such as education, democracy development, infrastructure, agriculture and the labour market. If SRHR are included in national action plans, it offers a good opening for producing strategies and indicators to attain the desired result.

Preparing for dialogue – questions to think about

- What does the national legislation look like and what are the conditions for change in terms of realpolitik on the ground? What do different political actors want?
- What are the most important and most central SRHR challenges in the country I am working in? What are the consequences for different groups in the country? Find out the statistics and other fact-based information as arguments and link them to a specific objective. Fact-based and statistical data on population questions can provide a scientific starting point for debate and negotiation. Also talk to different groups that provide different pictures of their perception of reality.
- What is the purpose of the Swedish intervention and what does this demand of the foreign mission or the home unit? Can data and information be obtained from colleagues at other foreign missions or from the country office of a UN body to strengthen the argument?
- What do we want to achieve/accomplish? Be as concrete as possible and avoid spanning too many issues at the same time.
- Which guidelines and steering documents are we following, e.g. international, regional or national commitments, including Swedish policy and positions?
- What obstacles might we encounter and how can we prepare to deal with them?
- What are the internationally agreed terms and language on SRHR and in which resolution or other steering document were they agreed?

Spot the opportunities

It takes time to change people's views and societal norms. Patience is key.

It is also important to work with like-minded actors and countries. Sweden cannot always work with the same actors on all issues or in all forums. There will be different partners in different contexts able to support pursuing important issues. Sweden is an active member of many multilateral organisations and has long collaborated with international non-governmental organisations that are important to work with on SRHR. Supporting and promoting dialogue between actors in various ways, e.g. between

Governments, members of parliament, multilateral organisations, civil society, and the business community is also crucial.

Sensitivity and awareness of the context

Sometimes, it is not possible to discuss SRHR questions in the same way, using the same terms and concepts that we are used to in Sweden. Advocating what is seen by others as an extreme and inflexible SRHR policy can lead to conflict, culminating in counter-productive polarisation and locked positions.

Using language adapted to the cultural context can avoid unnecessary controversy and instead invite constructive dialogue. This does not mean that Swedish positions on SRHR should be abandoned. The key is to communicate by choosing one's words carefully and "packaging" one's arguments well, based on factual knowledge and an understanding of the other party's arguments.

Annex II: Checklist for dialogue

On this page, there is a checklist of questions and policy areas to help in building arguments and knowledge and provide openings for a dialogue on SRHR. International and regional agreements and commitments are key starting points for dialogue. It is important to find out which international and regional agreements the country has ratified, any reservations, and what is included on SRHR in the country's national reporting to the monitoring committees of the human rights conventions, where applicable, and the conclusions and recommendations the committees have issued regarding these. Naturally, the reporting on human rights by Swedish embassies is also an important source of information.

Proposed overarching questions one should ask oneself in this area

- What does the national legislation or the national policy framework look like in the health field or other areas that affect SRHR? How do the country's global and regional commitments relate to its national implementation?
- How are questions handled that have a bearing on maternal health, women's access to safe abortion or young people's access to contraception?

National policy to monitor that incorporates SRHR

Human rights

- How are they met?
- For women, men, children and young people, LGBTIQ persons and persons living with disabilities?

The judicial system and legislation

- What is the situation like in terms of the rule of law?
- How is violence and other crimes against women prosecuted?
- Are there laws that regulate voluntary sexual activity between adults?
- What is the legislation like on abortion, use of contraception and maternal health?
- What legislation is there on children's rights, sexual crimes and the rights and conditions of LGBTIQ persons?
- What is the national age of majority and the legal age for sexual debut?
- In terms of people living with HIV/AIDS, are there laws that protect against discrimination and/or Infection Prevention and Control Legislation?

- Are people able to organise and make their voices heard? Who find it the most difficult to do so?

Gender equality

- What is the lowest age for marriage under the law? Do women have the right to divorce?
- Are there laws about men's responsibility for their children?
- Do women have the right to own land? Do women have the right to inherit?
- Are there laws on violence against women?

Education

- Is it compulsory to provide sexuality education in schools and if so, what does it contain? Which components are in line with UNESCO's guidelines on sexuality education?[256]
- Is it permitted to hand out condoms in schools or in other public places?
- What is the situation like for girls who become pregnant while attending school?
- Is there any form of regulation on discrimination in school, e.g. against LGBTIQ persons?

Health

- Do young people have access to contraception counselling and testing?
- Are there different types of contraception to choose from?
- What are the costs of sexual and reproductive healthcare?
- What does access to contraception such as condoms look like?

Social norms

- What norms contribute to people's rights being infringed or strengthened?
- What groups affect social norms for others?
- What can motivate people to break social norms that are harmful to others?

[256] https://www.unfpa.org/publications/international-technical-guidance-sexuality-education

Public opinion, the media and politics

- Are SRHR questions asked in the media?
- Which ministers raise these questions and in what way?
- Who defend/defends these issues in public?
- Who is/are opposed to these issues?
- What does support look like in Parliament?
- What does support look like among civil society actors and out in local communities among traditional and religious leaders?
- What is the attitude of different key actors at national, regional and local level?
- Which people have formal and informal power in society?
- What role is played by: Religious representatives? Local leaders? Traditional leaders? Parliament? The media? Women's organisations and networks? Certain individuals or groups of men or women? Rights defenders and other civil society associations?

Attitude of international actors

- What does support look like among EU Member States?
- What is the attitude of international actors such as the donor community?
- Which donors or multilateral actors are active in the health sector, the education sector, in the field of human rights, or other relevant sectors?
- What are their starting points?
- What are their questions for dialogue?
- How can we more effectively reinforce each other's dialogue?
- Are like-minded donors included in contexts where Sweden is not represented and, in such cases, can we influence them?

Annex III: Definitions, terms and concepts

The very term SRHR and the aspects it incorporates are often questioned to different extents and for different traditional, political or religious reasons. Below are some explanations of key concepts to serve as support when finding openings to approach the questions and bring them up in a dialogue.

To highlight sexuality that not only aims for reproduction, Sweden uses the terms "sexual" and "reproductive" health separately. When questions on people's sexuality are addressed in international contexts, debate often focuses on problems and negative effects. In many cases, the positive aspects of sexuality and those that improve quality of life are ignored. Instead, Sweden wants to emphasise that the goal of good sexual health is for people to have equal opportunities, rights and conditions to affirm their sexuality and decide over their own bodies.

Sexual and reproductive health

The Guttmacher-Lancet Commission (GLC) defines sexual and reproductive health as "a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing."

Sexual and reproductive rights

According to the GLC, sexual rights encompass a number of different human rights that guarantee people the right to decide over their bodies and their sexuality free from discrimination, coercion and violence.[257] The GLC states that achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;

[257] For further reading, see for example Starrs and Anderson, *Definitions and debates: sexual health and sexual rights*, Brown J World Aff (2016), pp. 14-17., IPPF, *Sexual Rights: An IPPF Declaration*, (2008), and The Lancet Commissions, *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*, (2018), p. 2645.

- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence.

Abortion

Safe and legal abortion is one of the most controversial questions. The UN's International Conference on Population and Development (ICPD) has stated that abortion is to be safe where it is legal. This is as far as international negotiations have come. Abortion is often mentioned in negotiation texts in combination with unsafe abortion and here as a question of health rather than a question of rights.

Abstinence

Some assert that sexual abstinence and fidelity in a heterosexual relationship is the best and only way of preventing HIV and unwanted pregnancy. However, for most people, abstinence is not a realistic option for a longer period of time or a lifetime.

Abstinence-only messages and campaigns have not shown positive results and cannot stop unwanted pregnancy or the spread of HIV. Most women and men will have sex sooner or later in their lives. Studies show that when people are given more information, their sexual debut takes place later in life and that people who receive CSE and access to contraception protect themselves better against STIs and unwanted pregnancy.

Couples, individuals and groups

It is an individual right to be able to access sexual and reproductive healthcare. In many societies, individuals are considered to be inseparable members of a group and a context, defined by specific social and cultural parameters. This means that people's sexuality and reproduction is considered a collective matter rather than a private one. Such a view underlies unmarried people, women and young people being denied the right to a sex life and the healthcare and services associated with it.

Culture

Culture covers collective values, knowledge, assumptions, customs and traditions created by people to understand and interpret the world around them and provide meaning to their existence. All people belong to and are shaped by a cultural sphere that affects their behaviour, norms and actions. Cultures affect how people think but this does not mean that people from the same culture all think alike. Cultural background is one of the most important identity markers for how people navigate the world. Cultures are in no way static and are in a state of constant flux. They affect and are affected by internal and external events and processes. Different cultures meet and interact, giving rise to changes in cultural patterns, traditions and values. These processes can be both enriching and frightening. Questioning one's own culture and what that culture consists of can lead to uncertainty and alienation.

References to culture and religion are often used as a starting point for limiting people's rights, especially their sexual and reproductive rights. Such arguments are often used to counteract gender equality and women's enjoyment of their human rights. Human rights are universal and all people, everywhere, are entitled to them.

Family/families

So far, there is no single definition of the family, although the term has been important and controversial for a long time. Traditionally, in a Western context, the family has been defined as the nuclear family – mother, father and children. Using expressions that Sweden advocates such as "families or various forms of the family, different types of families or other unions" is interpreted by some as meaning same-sex relationships, and are therefore not accepted. In many parts of the world, the composition of the family is much more complex than merely the nuclear family and one should therefore talk about families and different types of families, not just the family.

Family planning

Family planning is a term that might not appear controversial but, as with the discussion of the term "family" above, family planning can exclude those who do not belong to a traditional family. Family planning includes providing information, counselling, methods, services and means of planning the number of children one has and when one has them. Consequently, family planning as a term excludes people who are unmarried or who are not planning a family. It is important that everyone who needs reproductive health services is included and to integrate this with prevention of STIs, including

HIV. Thus, we prefer to talk about contraception/contraceptives and contraception counselling rather than family planning.

LGBTIQ, sexual orientation and same-sex relationships

In many countries, consensual acts between two people of the same sex are criminalised and it is illegal for two people of the same sex to form a family. This fundamentally has to do with the principle of non-discrimination and all people's equal value, human rights and opportunity to take responsibility for and decide over their own body, and together with others be able to contribute to shared democratic work and discussion without risking exposure to violence or discrimination.

Sexuality

Sexuality is an important aspect of people's lives and encompasses sex, desire, gender identity and gender roles, sexual orientation, pleasure, intimacy and conception. Sexuality is also closely linked to power and has been controlled in different ways and in all societies throughout history. Women's sexuality has been, and is still, often controlled by traditions and customs. Sexuality is much more than the sexual act. Sexuality is part of being human, but this does not mean it is something determined by nature. Sexuality is shaped and changed by religion, legislation and the historic, economic, social and cultural contexts in which people live.

SOGIESC

The umbrella term Sexual Orientation, Gender Identity, Expression and Sex Characteristics (SOGIESC), is translated into Swedish as *sexuell läggning, könsidentitet, könsuttryck och könskarakteristika*, where sex characteristics refers to people who are intersex. The term SOGIESC is sometimes used instead of the term LGBTIQ. The term SOGIESC describes the grounds for discrimination and not specific categories.

Annex IV: Policy frameworks, starting points and mandates

Global frameworks

Starting points and mandates for work on SRHR can be found in several national steering documents and in international frameworks and Sweden's commitments under these.

The 2030 Agenda and sexual and reproductive health and rights

The 2030 Agenda is a universal agenda incorporating the Sustainable Development Goals for creating economic, social and environmental sustainability the world over. The 2030 Agenda was adopted by the UN Member States on 25 September 2015 and consists of 17 Sustainable Development Goals (SDGs) which in turn comprise 169 targets and 230 global indicators. The intention of the 2030 Agenda is to solve the climate crisis and safeguard lasting protection for the planet and its natural resources while realising human rights by eradicating extreme poverty, reducing injustice and inequality and promoting peace and justice – at global and local level.[258]

The goals of the 2030 Agenda are interlinked and integrated with each other. Fulfilment of one goal makes it easier to achieve another. For example, if more people gain access to clean water and sanitation (SDG 6), this improves people's health (SDG 3), and improved health enables more children to attend school and gain an education (SDG 4), and education enables more people to find work which reduces poverty (SDG 1).[259]

"Leaving no one behind" is one of the overarching principles of the 2030 Agenda. It is both a prerequisite for and an objective of sustainable development and should run through all our work to achieve the 17 SDGs. The principle cannot be achieved without including all people, especially the most vulnerable and marginalised. The 2030 Agenda incorporates an opportunity to improve the lives, health and rights of LGBTIQ persons, a group that have historically suffered great stigma, discrimination and institutional exclusion. Research shows that the exclusion of LGBTIQ persons from development work has negative effects, also on the economy.

What does the 2030 Agenda have to do with SRHR?

All the SDGs of the 2030 Agenda can be linked to issues concerning SRHR. The clearest links are to good health and well-being (SDG 3), gender equality (SDG 5), clean water and sanitation (SDG 6) and reduced inequalities (SDG 10). However, naturally the first SDG, no poverty, also has to do with sexual and

[258] SDGs, 2023 Agenda.
[259] SDGs, Hur hänger Globala målen ihop med varandra?, (2017).

reproductive rights. Poverty incorporates economic poverty but also a lack of freedom, power, influence, health, education and physical safety. Women and girls are particularly vulnerable, as are transgender persons who often face discrimination in the labour market. The same is true of SDG 2, zero hunger, where there is to be a particular focus on food security for girls and boys, and adolescent girls and pregnant women, who run the greatest risk of starvation and malnutrition.

SDG 3: Good health and well-being

SDG 3 on good health and well-being contains targets that seek to, by 2030 at the latest, reduce the global maternal mortality ratio, end the spread of HIV/AIDS, ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and integrate reproductive health into national strategies and programmes. Through the UN, the countries of the world have determined that by 2030, all people in the world should have access to SRHR. The goal also includes promoting mental health and wellbeing. Under SDG 3, target 3.8 is to achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Around half of the world's population does not have access to UHC and around 100 million people are forced into poverty because they have to pay for healthcare.[260] All UN Member States have agreed to seek to achieve UHC by 2030 as part of the Sustainable Development Goals. UHC involves safeguarding access to high quality healthcare for all and ensuring that healthcare costs do not force people into poverty.

SDG 4: Quality education

SDG 4 on quality education concerns SRHR as many young girls and women miss school and education due to menstruation, pregnancy at a young age or due to complications following FGM. It is also known that if all the girls in the world were to be educated to upper secondary level, child mortality would halve. Access to clean water and toilets in school is vital to girls staying in education, especially in adolescence when they start to menstruate. More than half of the world's population is under the age of 25 and in low-income countries, this proportion is even higher. Reaching young people with information and knowledge on SRHR is crucial to them being able to decide over their own bodies and lives. Schools play a key role in improving sexuality education.

[260] WHO, UHC.

SDG 5: Gender equality

SDG 5 on gender equality includes targets that seek to end all forms of discrimination against all women and girls everywhere, eliminate all harmful practices, such as child marriage, early and forced marriage and FGM, and to eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation. SDG 5 also seeks to ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

SDG 6: Clean water and sanitation

SDG 6 addresses clean water and sanitation and stipulates that by 2030, we are to achieve universal and equitable access to safe and affordable drinking water for all, improve water quality, reduce the proportion of untreated wastewater and substantially increase recycling and safe reuse, implement integrated water resources management at all levels, expand international cooperation and capacity-building support to developing countries in water and sanitation-related activities and programmes, ensure access to sanitation, hygiene and toilets for all (specific attention should be paid to the needs of women and girls and people in vulnerable situations), increase water-use efficiency and address water scarcity, protect and restore water-related ecosystems and support and strengthen the participation of local communities in improving water and sanitation management.

SGD 10: Reduced inequalities

SDG 10 of the 2030 Agenda is about reducing inequality within and among countries by empowering and promoting the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status. SDG 10 also seeks to ensure equal opportunity and reduce the incidence of unequal outcomes, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard.

ICPD and Beijing

Reproductive health was defined as a human right for the first time at the International Conference on Population and Development (ICPD), in Cairo in 1994. The 179 countries participating in the conference adopted a Programme of Action (PoA) containing 243 recommendations centring on individuals' sexuality and reproduction.

The Cairo Declaration on Population and Development lays down that reproductive health concerns the relationships and sexual lives of all people. It covers the entire life cycle and is not limited to the fertile period of a person's life. The concept incorporates knowledge about sexuality and reproduction, protection against HIV and other STIs, access to contraception and healthcare during pregnancy and childbirth, and neonatal healthcare. Access to safe abortion is also ensured, but only where abortion is legal.

At the UN's Fourth World Conference on Women, in Beijing in 1995, 189 countries adopted the Beijing Platform for Action containing actions in twelve critical areas where women face discrimination. These include areas such as poverty, education, health, violence, power and human rights.

The Platform for Action sets out that women's SRHR are vital to ensuring their active participation in every aspect of society. However, 62 countries expressed reservations about various paragraphs of the document. Most reservations concerned women's sexual rights, the question of abortion and the rights of girls to inherit.

Both the Cairo and Beijing Declarations are important milestones in working for sexual and reproductive rights and have been given continued mandates to apply as platforms for action on SRHR. Follow-up conferences, most recently ICPD+25 and Beijing+25, follow up on the declarations and programmes of actions annually in CSW and CPD.

Human rights framework

The Universal Declaration of Human Rights was adopted in 1948. It lays down that all human beings are born free and equal in dignity and rights. A number of international instruments in this area have subsequently been adopted. These comprise both legally binding conventions and non-legally binding declarations and political declarations of intent. They include economic, social and cultural rights, as well as civil and political rights. The instruments include the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Convention on the Elimination of all Forms of Discrimination Against Women, the Convention on the Elimination of All Forms of Racial Discrimination and the Declaration on the Rights of Indigenous Peoples.

The UN's Convention Committees monitor the implementation of the respective Convention and provide interpretations in the form of General

Comments. These are important sources of guidance on the interpretation of the conventions, including on cases with a bearing on SRHR, where applicable, but they are not legally binding on the States Parties. Besides legally binding frameworks, there are also relevant decisions, recommendations and resolutions from international bodies at regional and international level.

Regional European frameworks

Council of Europe

At regional European level, SRHR are regulated under different frameworks issued by the EU and the Council of Europe. The European Convention on Human Rights and its practice implicitly protect SRHR under the right to respect for private and family life (Article 8), the right to freedom from torture or inhuman or degrading treatment (Article 3), the right to life (Article 2) and the prohibition of discrimination (Article 14). The European Court of Human Rights has issued a number of decisions in line with these rights that protect SRHR but Member States still have a large degree of leeway and discretion to rule on SRHR issues, such as same-sex marriage and abortion.

The Council of Europe Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention) strengthened legal protection for women and condemns all forms of violence, recognising that violence against women is a manifestation of historically unequal power relations between women and men. It recognises the structural nature of violence against women as gender-based violence. Gender-based violence includes acts that infringe women's SRHR such as forced sterilisation and forced abortion. The Istanbul Convention is particularly relevant to SRHR in the following areas:

- Parties are to ensure that forced abortion and forced sterilisation are criminalised under Article 39, the aim of which, according to the Council of Europe's Explanatory Report, is to emphasise the importance of respecting women's reproductive rights by allowing women to decide freely on the number and spacing of their children.[261]
- Article 38 of the Istanbul Convention lays down that FGM is a crime and the Explanatory Report states that "the drafters considered it important to establish female genital mutilation as a criminal offence in this Convention because this practice causes irreparable and lifelong damage and is usually performed without the consent of the victim."[262]

[261] CoE Explanatory Report, 2011, para. 206.
[262] CoE Explanatory Report, 2011, para. 198.

- Forced marriage is considered to be a crime under Article 37
- Non-consensual sexual acts (including rape) should be criminalised under Article 36.
- Under Article 20, Parties shall take the necessary legislative or other measures to ensure that victims have access to services facilitating their recovery from violence.

The European Union (EU)

Respect for human rights is one of the fundamental values of the EU. The Charter of Fundamental Rights of the European Union supplements and clarifies this principle. EU Member States are all bound by human rights conventions such as the European Convention on Human Rights, the UN Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. All EU Member States were also united behind the programmes of action from Cairo and Beijing.

Non-discrimination and equal treatment are fundamental principles of EU law. These principles are found in the Charter of Fundamental Rights of the European Union but Member States have significant discretion on some issues, such as national regulation of marriage and in the field of which forms of preventive and medical treatment must be available to the population. Directive 2004/113/EC ensures equal treatment between women and men in "the access to and supply of goods and services" but there is uncertainty as to the extent to which this applies to the provision of SRH goods and services. Directive 2011/24/EU on the application of patients' rights in cross-border healthcare states that patients must be given all the information they require to enable informed choice.

In May 2017 "the new European Consensus on Development" was adopted. Paragraph 34 contains references to SRHR that have come to form the basis of subsequent agreements in this area:

> "The EU remains committed to the promotion, protection and fulfilment of all human rights and to the full and effective implementation of the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development (ICPD) and the outcomes of their review conferences and remains committed to sexual and reproductive health and rights (SRHR), in this context. Having that in mind, the EU reaffirms its commitment to the promotion, protection and fulfilment of the right of every individual to have full control over, and decide freely and responsibly on matters related to their

sexuality and sexual and reproductive health, free from discrimination, coercion and violence. The EU further stresses the need for universal access to quality and affordable comprehensive sexual and reproductive health information, education, including comprehensive sexuality education, and health-care services."[263]

Swedish frameworks

Sweden's feminist foreign policy

In October 2014, Sweden was the first country in the world to launch a feminist foreign policy. This means that a gender equality perspective is to run through all foreign policy and that all parts of the Swedish Foreign Service are to strive to strengthen the Rights, Representation and Resources of all women and girls in the Reality in which they are living. Sweden's feminist foreign policy is structured around three Rs: Rights, Representation and Resources.[264]

- Rights: The Foreign Service will promote the full enjoyment of human rights by all women and girls, including by combating all forms of violence and discrimination that restrict their freedom of action.
- Representation: The Foreign Service will promote women's participation and influence in decision-making at all levels and in all areas, and seek dialogue with women representatives at all levels, including in civil society.
- Resources: The Foreign Service will work to ensure that resources are allocated to promote gender equality and equal opportunities for all women and girls to enjoy human rights. The Foreign Service will also promote targeted measures for different target groups.

The Swedish Foreign Service action plan for feminist foreign policy 2019–2022 sets out that the Foreign Service is to contribute to all women and girls' 1) full enjoyment of human rights, 2) freedom from physical, psychological and sexual violence, 3) participation in preventing and resolving conflicts, and post-conflict peacebuilding, 4) political participation and influence in all areas of society, 5) economic rights and empowerment and 6) sexual and reproductive health and rights (SRHR).

[263] European Consensus on Development – "our world, our dignity, our future" – English (signed version) 26.06.2017.
[264] Ministry for Foreign Affairs, *Handbook Sweden's feminist foreign policy*, (2019).

Strategy for Sweden's humanitarian aid provided through the Swedish Internal Development Cooperation Agency (SIDA)

The Strategy for Sweden's humanitarian aid provided through the Swedish International Development Cooperation Agency (SIDA) 2021–2025[265] specifically emphasises the importance of SRHR:

> "In the context of Sida's work to strengthen the agency of crisis-affected people, the inclusion of women and girls in consultations and decisions related to humanitarian action should be ensured. Insufficient access to sexual and reproductive health and rights (SRHR) services during humanitarian crises has serious adverse impacts and may – like the absence of other basic services such as food and water – be life-threatening for women and girls in particular. The need for SRHR will be taken into account in all humanitarian crises."

[265] Ministry for Foreign Affairs, *Strategi för Sveriges humanitära bistånd genom Styrelsen för internationellt utvecklingssamarbete (Sida) 2021–2025*, (2020).

Annex V: SRHR actors

Where to find relevant information about SRHR?

The Swedish Ministry for Foreign Affairs (MFA) and Sida have information available about Sweden's work with SRHR. Regarding countries with which Sweden works in different ways, the best and most up-to-date information about the SRHR situation and needs comes from local actors. There are also a number of national, regional and international organisations working with policy development, method development and advocacy that can be consulted for more information, additional arguments and networking. Information about a number of organisations and actors able to provide in-depth knowledge about SRHR in Sweden and globally, is presented below.

RFSU

The Swedish Association for Sexuality Education (RFSU) is a Swedish non-profit organisation that works with SRHR in Sweden and internationally. RFSU provides information and engages in advocacy with partners around the world.

www.rfsu.se

IPPF

The International Planned Parenthood Federation (IPPF) is an umbrella organisation for SRHR organisations around the world, with RFSU as the Swedish member (and co-founder). IPPF exists in about 150 countries and works on information, outreach, clinical activities, advocacy and counselling in SRHR. IPPF's head office is in London with regional offices in Nairobi (for Africa), Tunis (for the Arab world), Brussels (for Europe), a sub-office in Delhi (for South Asia), Kuala Lumpur (for East Asia, South-East Asia and Oceania) and Colombia and Trinidad (for America and the Caribbean).

www.ippf.org

Act Church of Sweden

Act Church of Sweden is the name of the Church of Sweden's international operations. Act Church of Sweden is part of the ACT Alliance comprising more than 150 churches and faith-based aid organisations worldwide. Act Church of Sweden works to ensure that everyone has access to sexuality education, maternal healthcare and contraceptive counselling.

www.svenskakyrkan.se/act/sexuella-rattigheter

Association for Women's Rights in Development (AWID)
The Association for Women's Rights in Development (AWID) develops and produces reports and material to strengthen policy and work for women's human rights in development.
www.awid.org

Asian-Pacific Resource & Research Centre for Women (ARROW)
The Asian-Pacific Resource & Research Centre for Women (ARROW) is a regional women's rights organisation with its head office in Kuala Lumpur, Malaysia. ARROW works for women's rights, with a specific focus on SRHR.
https://arrow.org.my

Catholics for Choice
Catholics for Choice is an American organisation working to influence legislation and attitudes on sexuality, contraception and abortion from a Catholic perspective. They exist in the USA, Europe and Latin America.
www.catholicsforchoice.org

Center for Reproductive Rights (CRR)
The Center for Reproductive Rights (CRR) is an organisation that uses the law to pursue reproductive rights as human rights and works to ensure that States protect, respect and fulfil their obligations on reproductive rights. CRR engages in advocacy and change work in Africa, Asia, Europe, Latin America and the Caribbean as well as in the USA.
www.reproductiverights.org

Fòs Feminista
Fòs Feminista is an alliance that works on SRHR for women, girls and gender-diverse people. Fòs Feminista works on policy development and capacity building and develops advocacy in different parts of the world. Fòs Feminista's work implements an intersectional and feminist perspective.
www.fosfeminista.org

Global Interfaith Network for People of all Sexes, Sexual Orientations, Gender Identities and Expressions (GIN-SSOGIE)
The Global Interfaith Network for People of all Sexes, Sexual Orientations, Gender Identities and Expressions (GIN-SSOGIE) is an umbrella organisation for religious leaders and organisations working for the SRHR of all, irrespective of sexual orientation, gender identity, gender expression or sex characteristics.
https://gin-ssogie.org/

Guttmacher Institute
The Guttmacher Institute is a research organisation which produces research reports on SRHR, young people and sexuality in the USA and in low and middle-income countries. This is a source of interesting information and research on sexuality education, contraception, abortion and teenage pregnancy.
www.guttmacher.org

International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA)
RFSL is a member of the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA), an umbrella organisation for LGBTIQ persons' rights in the world. ILGA has member organisations around the world and a number of regional offices.
www.ilga.org

Inter-Agency Working Group on Reproductive Health in Crises (IAWG)
The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) is a member-based network in which members and partners work together to produce guidelines, policy documents and statements on SRHR in humanitarian settings.
https://iawg.net/

IPAS
IPAS is an organisation working for women's sexual and reproductive rights, especially reducing abortion-related deaths and harm.
www.ipas.org

Marie Stopes International (MSI)
Marie Stopes International (MSI) is a non-profit organisation that works to improve SRHR. They are represented in 37 countries around the world and have a large number of clinics providing contraception counselling, safe abortions, maternity and paediatric healthcare and HIV testing and services. They also carry out policy and lobbying work at global and national level.
www.mariestopes.org

OutRight Action International
OutRight Action International is a lobbying organisation that works to draw attention to, and combat, discrimination against LGBTIQ persons the world over.
www.iglhrc.org

Population Action International (PAI)
Population Action International (PAI) is an American organisation that works worldwide to safeguard access to SRHR. PAI works on aid and policy development in SRHR and has focused on areas such as ensuring access to contraception, condoms and other healthcare equipment.
www.populationaction.org

Reproductive Health Supplies Coalition
The Reproductive Health Supplies Coalition is a network of governmental, private and non-profit organisations that aims to ensure that people in low and middle-income countries have access to contraception, condoms, healthcare equipment and medicines to safeguard reproductive health. The Reproductive Health Supplies Coalition carries out lobbying, capacity building, counselling and technical support around the world.
www.rhsupplies.org

RFSL
The Swedish Federation for Lesbian, Gay, Bisexual, Transgender, Queer and Intersex Rights (RFSL) is a nationwide Swedish organisation that has been working since 1950 for the rights of LGBTIQ persons through information, lobbying and change work in Sweden and internationally.
www.rfsl.se

Sexuality Information and Education Council of the United States (SIECUS)
The Sexuality Information and Education Council of the United States (SIECUS) is an American organisation working to spread information about sexuality and sexual and reproductive health. SIECUS works with education, lobbying and information to create support for CSE.
www.siecus.org

Women's Global Network for Reproductive Rights (WGNRR)
The Women's Global Network for Reproductive Rights (WGNRR) is a global network consisting of civil society organisations working to support and build movements for SRHR and justice.
https://wgnrr.org/

UN bodies that work with SRHR

UNFPA
The United Nations Population Fund works to follow up and implement the ICPD Programme of Action. It provides relevant documents relating to SRHR and facts and statistics, mainly on reproductive health, young people and maternal health.
www.unfpa.org

UNAIDS
UNAIDS works with HIV and AIDS and provides information about policy development in the field, facts, statistics as well as material and methodology development.
www.unaids.org

UNICEF
UNICEF works with children and young people and has a large number of statistics and facts about young people's living conditions, HIV and SRHR.
www.unicef.org

UN Women
UN Women's work includes following up and implementing the Beijing Platform for Action and its action plan, and its follow-up conferences. UN Women is also the UN body responsible for the annual sessions of the United Nations Commission on the Status of Women.
www.unwomen.org

WHO
The WHO works broadly on health and health promotion but also specifically on SRHR.
www.who.int

Annex VI: Useful links

SRHR and the link to human rights
OHCHR, Information Series On Sexual and Reproductive Health and Rights, 2020.
OHCHR and WHO, The Right to Health.

Support in language negotiations
UN Advocacy Tool, database of UN Resolutions on SRHR.
The Government of Switzerland's app and database of commitments concerning women's rights.

Statistics
The Guttmacher Institute.
UNFPA.
WHO.

Important documents and sources
ICPD Programme of Action.
Nairobi Summit Commitments on ICPD.
IPPF's Commitment Analysis Report.
IPPF's ICPD25 Commitments database.
Beijing Declaration and Platform for Action.
The Guttmacher-Lancet Commission, Accelerate progress—sexual and reproductive health and rights for all.