RFSU'S REPORT 2018, COVERING THE 2015-17 PERIOD

SEX IS POLITICS – WHERE IS THE MONEY?

A tracking of financial resources for sexual and reproductive health and rights within Swedish Development Assistance.

RFSU – FIGHTING FOR BODY RIGHTS SINCE 1933

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RFSU was founded in 1933 and is a non-profit, non-governmental organisation without party-political, trade union or religious affiliations. RFSU is convinced that sexuality has a central role to play, not only for individuals but also for society. For this reason, RFSU wants to contribute to increased knowledge and openness on sexuality issues. RFSU's vision is based on rights and freedoms. RFSU sees that the ability to make decisions about one's own body and sexuality is a human right. Being able to decide if, when, and with whom to have children is also a prerequisite for reducing poverty, and therefore increases the opportunity for a better life. The point of departure is the idea of that everyone should have the freedom to be oneself, to choose and to enjoy. RFSU wants to push for commitment and engagement around these three freedoms.

RFSU has been working at global level for over 50 years. It was one of the founders of IPPF in 1956, and is still an active Associate Member. For RFSU, IPPF is a valuable partner for networking, advocacy and exchange of information. IPPF brings together 152 Member Associations working in 172 countries.

As part of the global movement for SRHR, RFSU has partnered with organisations in low- and middle-income countries since the 1980s to change norms and improve policy and legislation that will strengthen the conditions for, and access to, SRHR. RFSU's advocacy has been focused on contributing to a stronger global normative framework for SRHR. In Sweden, RFSU runs a clinic to address concerns relating to sexual and reproductive physical and mental health, providing both treatment and counselling. The clinic also has a mandate to promote evidence-based knowledge and best practice. RFSU's domestic advocacy is focused on improving SRHR policies at national and municipality level.

RFSU has nineteen local branches spread across Sweden and around 3000 members. RFSU volunteers work locally with peer education and sexuality education in schools, arrange seminars, social activities, and advocacy towards local MPs and local media.

SUMMARY AND INTRODUCTION

Since 2004, Sexual and Reproductive Health and Rights (SRHR) have been spelled out as a priority in key development policies and strategies of the Swedish Government. In 2009, RFSU started publishing financial tracking reports in order to regularly look at government ODA spending on SRHR as one of many measurements of how the government fulfills its policy commitments on SRHR. This is RFSU's fifth report, tracking commitments and financial disbursements in 2015-2017, where the 2017 figures are preliminary estimates[1].

The past three years has been a time of new global policy commitments to SRHR. In 2015 world leaders committed to 17 new global goals for sustainable development (the SDGs), including specific targets on universal access to sexual and reproductive health and reproductive rights[3]. However, it has also been a period of intensified opposition to SRHR, culminating in the reinstatement of an expanded Global Gag Rule (GGR) in early 2017 and there are currently large funding gaps for SRHR in low- and middle-income countries. Without other alternative funding, the gap will widen. *Ensuring a continued strong voice for SRHR and equally strong funding has never been more critical. RFSU believes that Sweden has a particular and unique role to play in contributing to filling the enormous gap in funding to SRHR.*

In 2016, the Swedish Government spent around 2.7 billion of its aid budget on SRHR and the prognosis for 2017 is about the same [2]. This is an increase since 2014, when the Government spent 2.5 billion on SRHR (analysed in RFSU's previous tracking report). However, during the tracking period, *there has been no increase of the proportion of SRHR out of the overall ODA budget.*

The suggested increase in total ODA in 2019-20 is historically high[4]. Sweden is a world leading champion for SRHR and a country that other like-minded governments will look at and follow. The next two years offer an unprecedented opportunity to make significant financial priorities for SRHR. In light of the global crisis in funding to SRHR and Sweden's unique role as world champion in the matter, *RFSU recommends that the Swedish Government should use this opportunity to make strategic priorities and increased financial commitments to SRHR.*

AIM

One of the most important roles of civil society is to hold governments accountable. Since 2004, SRHR has been a political priority for the Swedish Government. At policy level, Sweden's voice is strong and its political support to SRHR has been steadily increasing.

With the financial tracking reports RFSU aims to regularly look at government ODA spending on SRHR as one of many measurements of how the government and the main implementing authority (Sida) translate policy into reality. Further, it is RFSU's intention that the report will serve as the base for constructive dialogue between Swedish stakeholders on the current crisis in funding to SRHR, and what efforts can be taken to contribute to its solutions.

With this year's report, RFSU also wants to highlight some acknowledged methodological difficulties related to global tracking of SRHR ODA funding. These challenges have implications for the extent to which different global and national estimations on funding to SRHR can be compared and analysed and for the extent to which governments and other actors can be held to account for their SRHR commitments.

WHAT IS SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)?

SRHR basically mean the right to decide over one's own body, sexuality and reproduction. It is about the rights to have and express your sexuality and decide freely with whom you want to have sex, irrespective of age, gender or sexuality - as long as that decision does not infringe on any other person's rights. SRHR also include the elimination of harmful social practices and discrimination, such as child and forced marriage, sexual and gender-based violence and the social control of young peoples' and women's bodies and sexuality. Sexual and reproductive rights are based on internationally agreed human rights that countries must respect, protect and fulfill.

GLOBAL MEASUREMENT CHALLENGES

In 1995 The International Conference on Population and Development (ICPD) and its Programme of Action (PoA) laid out new and groundbreaking goals for SRHR. The ICPD PoA states that the equal rights of women and girls and universal access to SRHR, are a necessary precondition for sustainable development. From 1997-2015 UNFPA, with the Netherlands Interdisciplinary Demographic Institute (NIDI), conducted annual calculations on global funding and actual cost for implementing ICPD PoA, or ”population activities”. A number of donors and actors, including the Swedish Government, have used this methodology as a way to calculate *global funding to sexual and reproductive health and rights*.

These calculations are based on four categories[6] that, in turn, are linked to a number of OECD/DAC[7] sector codes. To get the SRHR share, percentages are applied to funding reported to the OECD/DAC under certain sector codes and to selected multilateral organisations (for more information on NIDI methodology and OECD/DAC sector codes, see Annex I).

The results were presented annually in the *U.N. Secretary General Report on Financial Flows to the ICPD PoA*[8]. But concerns started to be raised about the validity and reliability of the calculations and there was no gathering of data in 2016-2017. Identified challenges include that with an integrated approach to development, it has become increasingly difficult to distinguish expenditures and to categorise them as, for example, *either* “reproductive health” *or* “family planning”[9] In 2016, the report recommended a revision of the methods, categories and data sources. In 2018, the report suggests that there should be only *one* broad category called Sexual and Reproductive Health under which related ODA funding is reported.[10][11]. This is to prevent the risk of overlap and misclassification.

The fact that no global SRHR tracking has been conducted for the past two years obviously limits the prospects for making comparisons with global trends and governments' funding to SRHR. Further, although RFSU recognises the challenges with the previous methodology, we believe that the suggested new methodology for following up on PoA/SRHR, also has significant limitations. The collapsing of categories will not be a support in tracking, understanding and comparing global and governmental funding to specific SRHR components, such as sexual rights, contraceptives, safe abortion and CSE. It is also questionable why the (previous) category *Social mitigation of HIV/AIDS* should be included in the future, broad SRH category. Further, the suggested methodology would include only those funding codes where 100 % of resources are classified as SRH, thus excluding all categories for which a share of the total had been included. In many cases, this will not give a fair picture of a government's total support to SRHR (also see Annex I).

While the methodology for tracking funding flows to SRHR is currently being revised, the tracking of Family Planning (FP) and Reproductive, Maternal, Newborn and Child Health (RMNCH) continues and is gaining attention through global initiatives such as The Partnership for Maternal, Newborn & Child Health (PMNCH) and Family Planning 2020 (FP2030)[12]. However, *neither of the methodologies can replace the PoA/SRHR tracking.*

Meanwhile, there is an ongoing process of developing a tracking system for funding of the SDGs[13]. The SDG targets and indicators are lacking explicit mention of certain SRHR components, including sexual rights, comprehensive sexuality education and safe abortion. By that, there will be no requirement to follow up and report on them. This means it will be difficult to identify funding gaps which in turn increases the risk of not being able to secure future financing to key SRHR components.

Global and comprehensive SRHR trackings are extremely important tools to ensure that SRHR policy commitments are matched with financial commitments and for drawing the attention of donors to SRHR. RFSU is concerned that no global tracking analysis is currently undertaken for the implementation of ICPD PoA/SRHR. RFSU is also concerned that the suggested future methodology for tracking funding to ICPD PoA and any future SDG tracking will not distinguish tracking of key aspects of SRHR such as sexual rights, CSE and safe abortion services.

GLOBAL FUNDING GAPS

In 2015 the world concluded the sustainable development goals with an agenda on how to reach sustainable development by 2030. The ambitious Agenda 2030 requires extensive funding[14] that goes far beyond the resources that were required for the MDGs and with increased competition between sectors.

An integral aspect of Agenda 2030 is the ICPD PoA. The ICPD PoA is specifically referred to in target 5.6 that *calls for universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the ICPD PoA and the Beijing Platform and the outcome documents of their review conferences*[15]. Thus, the Agenda 2030 and the ICPD PoA are global frameworks to which SRHR cost and funding can be measured[16].

At the ICPD conference, the international community agreed that two thirds of the global demand for what was defined as population assistance should be mobilised by the developing countries themselves and one third from the international community. During the Financing for Development Conference in Addis Ababa in July 2015, participating countries recommitted to achieve the target of 0.7 per cent of gross national income for ODA. This figure is spelled out in Agenda 2030.

As concluded in the previous section, UNFPA no longer makes annual calculations on global funding and actual cost for implementing ICPD PoA. The latest global tracking is from 2015. Between 2014 and 2015 aid to the health sector increased from 6.4 to 7.7 per cent of total ODA, whereas aid for population and reproductive health declined from 6 to 5.6 per cent[18].

One trend that remains steady over time is that the ODA to SRHR is dominated by aid for STIs which is largely a reflection of HIV/AIDS activities. Despite this, UNAIDS estimates that the 19.1 billion in total resources that was available to HIV in-country in activities is *still US$ 7.2 billion lower* than the resource needs estimated to be necessary by 2020 to be on track towards ending AIDS as a global public health threat by 2030[19].

The resources allocated to the implementation of the PoA and the SDGs must be as comprehensive as possible and go beyond foreign aid. This does not mean that ODA will be any less important but that it will not be enough. Today, the development[20] financing landscape is dynamic and constantly changing. Many countries are now able to mobilise more domestic resources for development[20]. However, many Least Developed Countries and fragile states remain heavily reliant on traditional donor aid[21] Further, ODA will be particularly important for areas where other forms of financing are less likely to be expected or not adequate - such as the more contested areas of SRHR.

Financing the ICPD PoA is pivotal to the fulfillment of Agenda 2030. As of today, the efforts to implement the ICPD agenda and the SDG target of ensuring universal access to reproductive health care and reproductive rights are not receiving adequate financing.

To further illustrate this the report now takes a closer at funding to three SRHR sub-areas: Contraceptives, safe abortion and LGBTI people's rights. These issues have for a long time been central to the work of the RFSU. RFSU has yet another priority area namely CSE. Currently there is unfortunately no way to follow up on global funding to CSE.

GLOBAL FIGURES ARE ESTIMATIONS

The global numbers and figures in this report – and especially those related to gaps and costs for specific SRHR components and services - are high level, aggregated data, where assumptions have been made in order to be able reach a conclusion. Cost estimations at country level will always be more accurate.

GAPS IN FUNDING TO CONTRACEPTIVES, SAFE ABORTION AND NON-DISCRIMINATION

In 2017 the global SRHR policy and funding landscape was dominated by the reinstallment of the Global Gag Rule (GGR) - and by its counter movement. Under President Trump, the GGR applies to nearly all health aid, an estimate of nearly $9 billion dollars in funding, compared to the $600 million when the GGR only regulated family planning under previous iterations of the GGR[22]. It has been estimated that GGR could potentially affect around $2.2 billion in global health funding[23]. Even as other donors have taken a strong stand in opposition to the GGR by offering both financial and moral support, their contributions cannot fill the large gap created by the GGR[24]. The approximately $ 450 (Euro 390) million so far pledged under the She Decides initiative covers a little over 20% of that "lost" funding. Marie Stopes International (MSI) estimates that without alternative funding between 2017 and 2020, the GGR could result in[25].

- **6.5 million unintended pregnancies**
- **2.2 million abortions**
- **2.1 million unsafe abortions**
- **21,700 maternal deaths.**

In addition, last year President Trump used the Kemp-Kasten[61] amendment to withhold funding from UNFPA that would have expected *$32 million* for 2017.

Costs and funding for contraceptives for all

Already before the GGR was reinstated, there were huge gaps in funding for SRHR and unless there are new sources of funding the gap will continue to widen[26]. 214 million women and girls (15-49) in developing regions who want to avoid pregnancy are not using a modern contraceptive. Disparities among countries in contraceptives follow economic lines where the proportion of women need for family planning is highest in low-income countries[27].

WHY INVEST IN CONTRACEPTIVES?

Increased investment in contraceptives would be dramatic and wide-ranging. If the unmet need for modern contraception were satisfied in developing regions, there would be approximately a 75% decline in

- **unintended pregnancies**
- **unplanned births**
- **induced abortions**

and there would be an estimated 76,000 fewer maternal deaths each year.

The estimated current annual cost of modern contraceptive services in developing regions, covering 671 million girls and women (15-49) who are currently using modern methods, is $6.3 billion[28]. Expanding and improving services to meet all girls' and women's needs for modern contraception in developing regions would cost $12.1 billion annually[29]. Compared with the current costs that is an additional *$6 billion annually*[30].

The UNFPA Supplies programme, the world's largest provider of donated contraceptives, has a funding gap of nearly *$700 million* from 2017-2020[31].

Adolescents' access to SRH services, including contraceptives, is often very restricted. When girls cannot decide over their bodies and pregnancies, they often have to leave school, get married and they continue facing additional and severe rights violations. To meet the contraceptive needs of the 23 million adolescents with unmet needs and for *all* adolescents to receive improved services, total costs would increase by *$548 million annually* The improvements would include changes to increase access by young people to accurate information and ensure health workers are trained to work with young people[33].

Whether we look at the $6 billion annually needed to cover contraceptives, or the $548 million needed to specifically meet the needs of adolescents, the difference between the cost of serving current users and the cost of meeting all needs for modern contraception is huge. The urgency and magnitude of the financing problem is alarming.

Costs and funding related to safe abortion

No matter what the level of availability and accessibility of modern contraceptives are, women and girls should always have access to safe and legal abortion. Provision of safe and legal abortion services is essential to fulfilling human rights and the global commitments to the SDGs, including universal access to sexual and reproductive health (target 5.6).

WHY INVEST IN SAFE ABORTION?

Worldwide, 45% of all abortions that occurred every year between 2010 and 2014 were unsafe. The vast majority of these unsafe abortions, or 97%, occurred in developing countries with the highest number occurring in Africa. The number of abortion-related deaths in 2014 ranged from 22,500 to 44,000[36]. Safe abortion is a major preventable cause of maternal death worldwide. Investing in safe abortion is investing in girls' and women's human rights. Investing in safe abortion is about saving lives.

In countries where induced abortion is legally restricted and/or otherwise unavailable, safe abortion has frequently become the privilege of the rich, while poor women and girls have little choice but to resort to unsafe alternatives.[37] Compared with older women, adolescents are more likely to seek abortions from untrained providers or to attempt to induce abortion themselves[38]. It is critical to work for abortion-friendly laws and policies and to invest in programmes aimed at changing harmful social norms around abortion. However, financial barriers (formal and informal fees, loss of salary, travel costs, etc.) are also hindering girls and women -especially the poorer and those living in rural areas- from accessing safe abortion[39].

In 2014, the estimated cost of abortion procedures in the developing world was $562 million. Of this amount, $271 million was for safe abortions and $291 million was for those obtained under unsafe conditions. If all abortions in developing regions that are currently unsafe were provided safely, the total cost of services for all abortions would be an estimated $833 million[40]. Increased provision of safe abortion services would nearly eliminate the cost of treating post-abortion complications[41].

Funding to LGBTIQ movements and non-discrimination

There are obvious challenges related to tracking ODA and other funding support to Lesbian, Gay, Bisexual, Trans and Queer (LGBTIQ) movements and non-discrimination based on Sexual orientation and gender identity (SOGI) in low- and middle-income countries. Comprehensive mappings of these types of funding streams are very few. There are no OECD/DAC codes for capturing SOGI work and no SDG indicator to follow up on. Further, initiatives aiming at combatting discrimination based on SOGI or providing services to LGBTIQ populations are often integrated into other programmes. Hence, ODA funding that aims at combatting discrimination based on SOGI or supporting LGBTIQ movements is often categorised as gender, health, human rights or HIV/Aids programmes.

However, some tendencies can be seen. Globally, it seems like funding for LGBTIQ programmes has been gaining momentum as (primarily) European, North American and Australian donors have become increasingly interested in issues related to SOGI[42]. Other Investments within the UN systems include the UNDP programme 'Being LGBT in Asia' (also supported by the Swedish Government and USAID) where objectives include seeking to achieve the mainstreaming of LGBT issues in existing development programming. The European Union currently supports a number of LGBT rights-related projects via its European Instrument for Democracy and Human Rights (EIDHR)[43].

In their latest tracking report the *LGBTI Funders*[44] reported that in 2013-2014, 68 foundations and government agencies awarded grants totalling US$ 79 million for "LGBTI issues in the international arena"[45]. However, most of the funding stayed in high-income countries (aimed at research, advocacy at the UN level, etc.). Only around US$ 20 million was *re-granted* to "support international LGBTI issues", including support to national or local CSOs in low- and middle-income countries. Sweden is ranked as the second largest donor (after the Netherlands) in supporting "LGBTI issues in the international arena"[46].

WHY INVEST IN LGBTIQ RELATED WORK?

All over the world, people are still being persecuted for their sexual orientation and gender identities and in almost 80 countries, same-sex relations are criminalised. In some of those countries, the sanction is the death penalty. Discrimination locks LGBTIQ people into a devastating cycle of exclusion and extreme poverty

Hence, Sweden is doing better than other governments and has been a pioneer in terms of integrating and highlighting LGBTIQ in its policy commitments. Sida was the first donor agency to launch an action plan for its work on sexual orientation and gender identity. Sweden has been tracking support to LGBTIQ since 2009.

The GGR is in different ways also impacting LGBTIQ communities and organisations that receive foreign aid, despite the fact the U.S government continues to prioritise SOGI issues. Many LGBTIQ-focused organisations receive funds from non-US sources for *integrated* SRHR services, including referrals to abortion. Or they closely collaborate with organisations that promote or provide abortion services. At the same time they have a budget from the US Aid to provide only a certain type of services. Under GGR, LGBTIQ organisations must now choose between losing their US funding or restricting their SRHR services and partnerships[47].

RFSU cannot draw any conclusions concerning the global level of funding or funding gaps to SOGI/LGBTIQ-related work in low- and middle-income countries. There seems to be increased interest among some donor countries to support this area of work, but there is also an acute and incalculable need to combat discrimination based on SOGI, including the need to support work of organisations led by LGBTIQ people.

SWEDISH SRHR POLICY COMMITMENTS

Since 2004, SRHR has been listed as a priority by the Swedish Government, either in itself or in the area of gender equality. This means that four consecutive governments have included SRHR as a main priority for development cooperation. With the current government the strong policy commitment has continued and even intensified.

In 2014 -as the first country in the world- Sweden pursued a feminist foreign policy. Sexual and reproductive health and rights features as one of six objectives. Since 2016, there has been an annual action plan for the policy. How the feminist commitments and plans are translated into financial priorities is, however, not always clear, as there is no budget attached either to the policy or to the the action plan. Key examples of results of the policy were recently reported on in the publication "Sweden's feminist foreign policy – examples from three years of implementation". The report concludes that Sweden has intensified its SRHR efforts to keep pace with the growing challenges.

In December 2016, the Swedish Government presented its 'Aid Policy Framework', which outlines the overall objectives and priorities of Swedish development cooperation. Among the eight are 2. Global gender equality and 7. Equal health. For the latter area, it is concluded that *Sweden will continue to defend all people's right to health with a particular focus on sexual and reproductive health and rights. Young people's needs and points of departure must be highlighted, as must respect for the rights of LGBTQ people*[48].

2017 was dominated by reinstatement of the GGR and by the counter movement, including the She Decides movement that Sweden co-initiated. *Sweden* also co-organised the first She Decides conference on 2 March 2017. Sweden committed about € 20 million. The initial pledges triggered broader political support and additional pledges have since been made by multiple country governments and foundations. The Swedish Government continues to politically support She Decides as a movement to mobilise support for SRHR.

In 2017, Sweden and six other EU member states[49] sent a letter to European Commissioner for International Cooperation and Development, in which they called upon the European Commission to allocate funding to SRHR in order to act upon EU's commitment to ICPD PoA and to address the gap left by GGR.

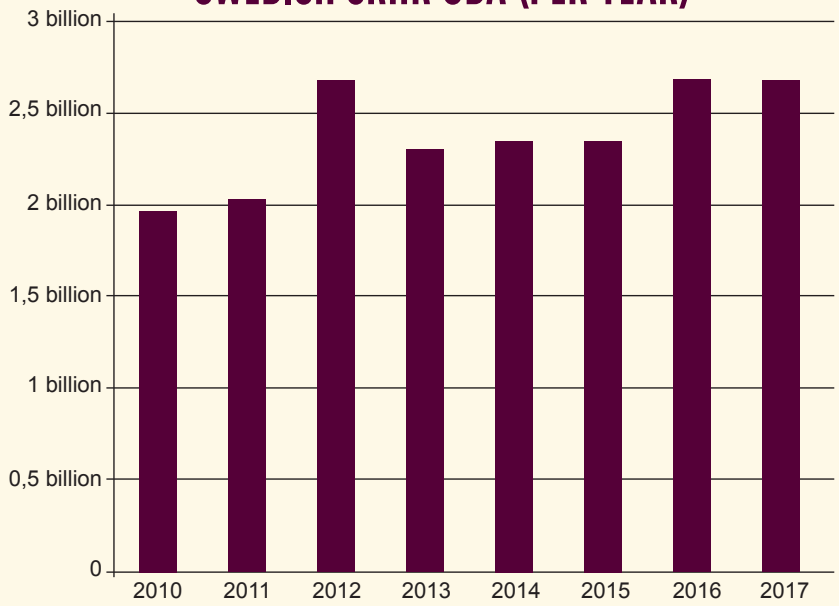
During this tracking report period (2015-2017), Sweden's voice on SRHR has been heard in the EU, UN and other international forums. At the 2016 World Humanitarian Summit, Sweden made a number of commitments, including to ensure universal access to sexual and reproductive health and reproductive rights for all women and adolescent girls in crisis settings[50].

The Swedish Government has increasingly emphasised the importance of SRHR in humanitarian settings and the Aid Policy Framework makes special mention of the nexus between development cooperation and humanitarian assistance. In 2017 Sweden launched a new strategy for humanitarian assistance (2017-2020) which states that gender equality should be systematically integrated into humanitarian activities. However, the strategy fails to mention SRHR and how to integrate it in a humanitarian response and there is currently no routines for tracking of SRHR within Swedish humanitarian aid.

SWEDISH DEVELOPMENT COOPERATION FUNDING TO SRHR

In 2016, the Swedish Government spent around 2.7 billion of its aid budget on SRHR and the prognosis for 2017 is about the same. This is a increase since 2014, when the Government spent 2.5 billion on SRHR (analysed in RFSU's previous tracking report).

SWEDISH SRHR ODA (PER YEAR)



The total figure of SRHR includes support for a number of sub-categories, including parts of the broader health sector and the education sector. The category "Reproductive health" includes, for example, support for contraceptives and abortion rights. For "Reproductive health" there is an increased support in 2015-2016 and the prognosis for 2017 reaches an all-time high of 843 million sek. The visible increase of support to work reported as "Reproductive health" is a signal that the Swedish Government has made contraceptives and abortion rights financial priorities. The steady increase of funding reported as "Reproductive health" have to some extent been at the expense of support to HIV and AIDS-related work. The prognosis for HIV/AIDS in 2017 is 91 million sek, the lowest level since RFSU 's tracking started. However, this tendency also has to do with the fact that HIV/AIDS work has become increasingly integrated with SRHR programs. And vice versa.

Sweden continues to be a strong supporter of multilateral organisations including extensive and increased core support to UNFPA, who monitor and review the implementation of the ICPD PoA. Sweden provided the largest core contribution to UNFPA in 2016[51]. For the earmarked multilateral, bilateral and CSO- support in 2017, key and large scale support include:

	Million sek
BILATERAL	
Zambia: Strengthening RMNCAH (2015-2019)	409
CSO support	
International Planned Parenthood Federation (2016-19)	160
Amplify Change	55
EARMARKED multilateral:	
UN SRHR/HIV programme, Sub-Sahara	100
WHO, the Human Reproduction Programme	40
SRHR and advocacy programme in Mozambique (2016-17)	35
Southern Africa, 6 countries; availability of contraceptives and safe abortion	25
UNESCO's global work on CSE	10

It can be concluded that Swedish policy commitments around safe abortion are accompanied by financial support, including 25 million sek in 2016 for a six-country programme in southern Africa aimed at decreasing the number of unwanted pregnancies and increasing the availability and accessibility of contraceptives and safe abortion.

Along with safe abortion, LGBTI rights is one of the most contested SRHR-related areas globally and also an SRHR focus area of the Swedish Government[52]. Sida's direct support to LGBTI work rose rather dramatically from 2013 to 2014, from 49 to 162 million SEK. Since then the support has decreased and the total figure for 2016 is 112 million sek. This can partly be explained by the fact that major payments to the ongoing *LGBTI Global Development Partnership* with USAID were made pre-2015. It should also be noted that these numbers only capture direct support. Other forms of funding for LGBTI work, for example through civil society support, is not captured.

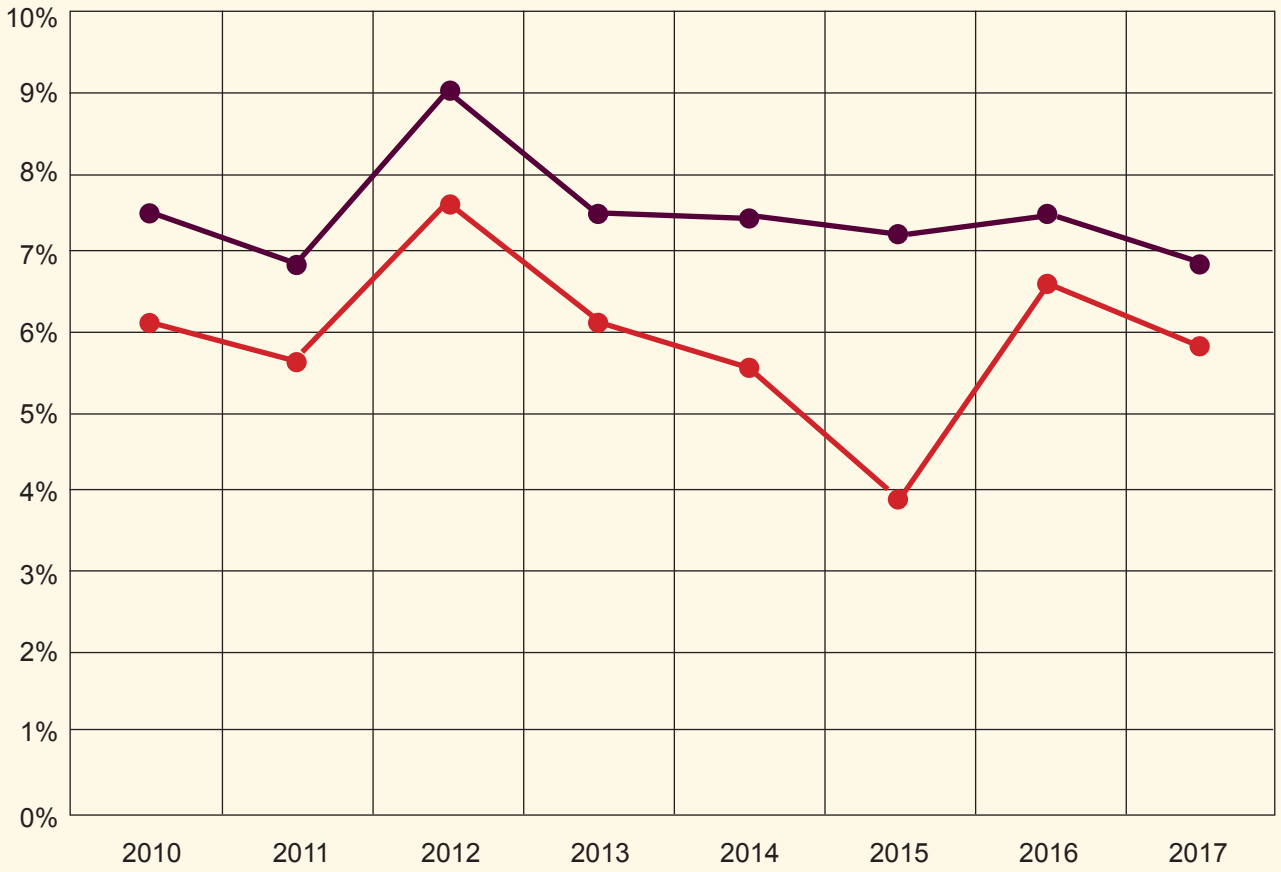
SRHR share of total ODA

As concluded, compared to 2014, Swedish funding in absolute figures for SRHR have increased and is now at the same level as in 2012. However, looking at SRHR figures as total share of ODA, not much has happened for the past 10 years. SRHR share of ODA, with the exception of 2012, stayed at around 6% in 2009-2014. In 2015, the number changes drastically and drops to 4%. However, this year should probably be seen as an exception, incomparable to other years because of an exceptionally high level of total ODA, that includes high in-country refugee costs and advanced payments to UN organisations as well as contributions to the Green Climate Fund. A moderate rise to 6.5% can be seen in 2016 and the prognosis for 2017 is 6.0%.

For the total ODA figure, RFSU uses the figure that Sweden reports as development assistance to OECD/DAC. The Ministry for Foreign Affairs (MFA) uses another total figure[53] when calculating (health and SRHR share of) total ODA, where in-country refugee costs are excluded from the total. Further, capital subscriptions and advance payments are adjusted for. RFSU chooses the former figure because we aim to measure political commitment in terms of financial priorities. Calculating refugee costs as ODA is a budget priority made by the Swedish Government. Not using OECD/DAC reported ODA as the basis for ODA -related calculations also makes multi-country comparisons of funding priorities more difficult.

Because of the different choice of overall figures the proportion of SRHR out of total ODA turns out differently in RFSU's calculations compared to MFA's. However, looking at the trends over time the conclusion remains the same. For the past eight years, there has been no increase of the proportion of SRHR out of the overall ODA budget (regardless of whether or not refugee costs, capital subscriptions and advance payments are adjusted for in total ODA).

SRHR FUNDING IN % OF TOTAL ODA



RED LINE= SRHR funding in % of total ODA. ODA as reported by the Swedish Government to OECD-DAC
PURPLE LINE= SRHR funding in % of total ODA when adjustments for in-country refugee costs, capital subscriptions and advance payments have been made (methodology used by the Ministry for Foreign Affairs (MFA). See Annex II.

CONCLUSIONS

The implementation of the SDGs ambitious and extensive agenda will require substantial amounts of funding. In light of the discussions around mobilising a range of resources in the support of SDGs, it becomes ever more important to make sure that ODA resources are targeted at areas for which other forms of financing are limited or inadequate - such as SRHR. The GGR is in place and even before its reinstatement, there were large funding gaps for SRHR services and supplies. Without other alternative funding, the gap will widen; leading to the violations of sexual and reproductive rights of millions of people.

Ensuring a continued strong voice for SRHR and equally strong funding has never been more critical.

RFSU believes that Sweden has a particular and unique role to play in contributing to filling the enormous gap in funding to SRHR. Sweden is a world leader in championing SRHR and a country that other like-minded governments will look at and follow. The pledges and political support that She Decides has triggered is proof of that. With its current and long-term commitment to the more sensitive SRHR areas, Sweden is uniquely placed to specifically support such areas, including CSE, LGBTIQ and safe abortion. This situation happens to coincide with a suggested increase in ODA (2019-20) that is historically high.

The coming two years offer an unprecedented opportunity to make significant financial priorities for SRHR.

RECOMMENDATIONS

• The Swedish policy engagements around SRHR have been steadily increasing, but for the past eight years there has been no increase of the proportion of SRHR out of the overall ODA. The budget forecast[54] indicates that Swedish ODA levels will increase with 2 billion sek a year in the coming 2 years. In light of the global crisis in funding to SRHR and Sweden's unique role as world champion in the matter, *the Swedish Government should use this opportunity to make strategic priorities and increase financial commitments to SRHR.*

• The extensive nature of the SDGs will lead to competition over funding between different sectors and a wide range of resources need to be mobilised to enable the implementation of Agenda 2030. *Sweden should make sure its ODA resources are targeted at SRHR, especially areas and groups for which other forms of financing may be absent or very limited.* Such areas include SDG target 5.6 as well as key areas of SRHR that are not mentioned at all in SDG targets and indicators, for example safe abortion, CSE and LGBTIQ persons rights.

• Although the new strategy for humanitarian assistance fails to mention SRHR, during the passed three years the Swedish Government has increasingly emphasised the importance of SRHR in humanitarian settings. But currently it is not possible to track Sweden's funds to SRHR in these contexts. Given Sweden's priorities and commitments in both areas – SRHR and Humanitarian aid – greater linkages should be made. *Tracking SRHR funding within humanitarian assistance would be an important starting point.*

• Sweden is in many cases one of the largest donors to the UN and other agencies. This status provides opportunities to influence budget and policy priorities of these agencies. *Sweden should use its influence that comes with being a credible and substantial donor to create more funding to safe abortion CSE and LGBTQI peoples rights within agencies* such as the WHO, UNFPA, UNESCO and the Global Fund.

• Sweden should safeguard *SRHR as a category for global financial tracking/accountability and explore what Sweden can do to address some of the dearth of data on SRHR funding* (both internationally and domestically). For instance, the SDG targets and indicators lack explicit mention of certain key components of SRHR, i.e. comprehensive sexuality education, sexual rights and safe abortion. Same goes for the suggested future methodology for following up ICPD PoA. This means that there will be no requirement to gather data, report and follow-up on these areas.

ANNEX

ANNEX I: UNFPA/NIDI METHODOLOGY FOR CALCULATING SRHR ODA - AND SUGGESTED CHANGES

From 1997-2015 UNFPA, together with the Netherlands Interdisciplinary Demographic Institute (NIDI), conducted annual calculations on global funding and actual cost for implementing ICPD PoA, *i.e global funding to sexual and reproductive health and rights*[55]. This methodology is under review and revision[56].

The calculations are based on 4 PoA categories[57] that, in turn, are linked to a number of OECD/DAC sector categories. In the OECD/DAC system ODA funding is reported under different sector categories. Some sectors are directly linked to areas that can be captured within the SRHR concept. These sectors are counted as 100% SRHR support. Moreover, there are different sectors for more general initiatives to support education and health. Because programmes in these areas may contain SRHR components, the NIDI has developed weights that indicate the proportion that can be attributed to SRHR.

OECD/DAC sector categories and label –	Share SRHR
13010 Population policy and administrative management	100
13020 Reproductive health care	100
13030 Family Planning	100
13040 STD control, including HIV/AIDS	100
13081 Personnel development for population and reproductive health	100
11220 Primary education	10
11230 Non-formal education	10
11240 Pre-school education	10
11320 Secondary education	10
12110 Health policy and administrative management	10
12220 Basic health care	25
12230 Basic health infrastructure	25
12240 Nutrition	75
12261 Health education	25
12281 Health personnel development	25
16064 Social mitigation of HIV/AIDS	100

The support to organisations that work exclusively with SRHR, (such as UNFPA), or HIV and AIDS, (such as UNAIDS), counts fully as SRHR assistance. For other organisations such as UNICEF and the World Bank, which only partly work with SRHR, NIDI has developed weights that indicate the SRHR proportion.

The proposed future estimates of resource allocations to SRHR include only categories/ funding codes above, for which 100 per cent of the resources are classified as SRHR and exclude all categories for which a weight of the total has been included.

Estimates of resource allocations to SRHR under the proposed future approach would, therefore, be lower, since the former estimates included shares of the other funding codes in the above table.

Further, it is proposed that all but one of the remaining components should be presented in one category called "Resources allocated for sexual and reproductive health" which includes the funding codes 13020, 13030, 13040, 13081, 16064[58].

ANNEX II: METHOD FOR CALCULATING SWEDISH ODA SUPPORT TO SRHR

To calculate its ODA SRHR support , the Swedish Government uses the NIDI methodology (see above). So does RFSU in this report. Both the Swedish Government and RFSU base the calculations on figures that come from the statistics that Sida and the Swedish Ministry for Foreign Affaires deliver to the OECD/DAC. The figures that RFSU adds when calculating Swedish ODA SRHR support is

a) funding that aims at strengthening lesbian, gay, bisexual and transgender (LGBT) rights. These are based on the information Sida has collected and provided to RFSU.

b) SRHR share of Swedish ODA that is reported under OECD/DAC Education categories (in line with NIDI metho

11220 Primary education	10
11230 Non-formal education	10
11240 Pre-school education	10
11320 Secondary education	10

Currently, neither RFSU nor the Swedish Government is calculating SRHR that is supported through other sectors, for example governance, democracy, human rights and gender equality. Better reporting mechanisms should be developed in order to track funding in these areas as well.

The key difference in methodology lies in the way the total ODA is calculated. For the total ODA figure, RFSU uses the figure that Sweden reports as development assistance to OECD/DAC. The Swedish Government uses another total figure[60] when calculating (health and SRHR share of) total ODA, where in-country refugee costs are excluded from the total and capital subscriptions and advance payments are adjusted for. RFSU chooses the former because we aim to measure political commitment in terms of financial priorities. It is a political choice to use funds in Sweden. Further, not using OECD/DAC reported ODA as a the basis for any ODA -related calculations, makes comparisons between governments very challenging

The 2017 figures and estimations in this report are *preliminary*. The total ODA figure for 2017 is the primilnarly figure that OECD/DAC published in April 2018. The 2017 figures per selected OECD/DAC categories and multilaterals are estimations from Sida and MFA (March 2017). The figures for LGBTI work and for MFA sector codes 12--- and 11320 are at this point not available. 2016 figures have been used.

	2 010	2 011	2 012	2 013	2 014	2015	2016	Prognosis 2017
Swedish International Development Cooperation Agency, Sida								
Reproductive health and rights								
13010 Population policy and administrative management	-	-	14 000 000	3 699 471	3 608 470	-	21 156 769	3 077 643
13020 Reproductive health care	243 119 482	180 059 660	671 529 143	445 832 853	501 108 721	601 530 802	746 394 959	827 442 433
13081 Personnel development for population and repr. health	286 233	31 362	-	-	-	-	-	-
Total Reproductive health and rights	***243 405 715***	***180 091 022***	***685 529 143***	***449 532 324***	***504 717 191***	***601 530 802***	***767 551 727***	***830 520 076***
LGBT								
LGBTI rights	35 223 535	44 502 695	35 846 102	48 866 000	161 711 000	123 991 856	112 145 551	112 145 551
Total LGBT	***35 223 535***	***44 502 695***	***35 846 102***	***48 866 000***	***161 711 000***	***123 991 856***	***112 145 551***	***112 145 551***
HIV/AIDS								
13040 STD control including HIV/AIDS	300 541 546	307 154 669	320 693 278	310 651 066	251 096 653	183 922 911	224 022 669	88 359 179
16064 Social mitigation of HIV/AIDS	143 587 505	112 580 153	85 729 833	70 943 770	55 920 773	29 779 462	25 987 105	3 093 523
Total HIV/AIDS	***444 129 051***	***419 734 822***	***406 423 111***	***381 594 836***	***307 017 426***	***213 702 373***	***250 009 775***	***91 452 702***
Health services								
12110 Health policy and administrative management (10%)	5 594 075	4 961 709	9 905 974	9 282 151	20 996 250	25 506 922	37 069 466	34 290 215
12220 Basic health care (25%)	56 956 267	83 134 530	103 338 567	111 026 406	73 707 636	37 729 910	57 386 492	116 497 853
12230 Basic health infrastructure (25%)	-	-	500 000	957 333	3 750 456	- 570	1 000 000	4 279 292
12240 Basic nutrition (75%)	4 935 416	4 350 000	5 708 619	25 581 783	15 565 813	17 775 000	22 127 573	37 035 172
12261 Health education (25%)	-	6 565 711	14 528 273	17 977 239	23 032 181	14 543 504	10 176 335	7 276 140
12281 Health personnel development (25%)	3 849 388	4 955 088	3 691 974	10 557 527	8 119 818	19 050 064	10 004 866	12 986 720
Total Health services	***71 335 147***	***103 967 038***	***137 673 407***	***175 382 439***	***145 172 155***	***114 604 831***	***137 764 732***	***212 365 391***
Education								
11220 Primary education (10%)	57 074 054	69 716 381	32 338 590	28 075 975	57 445 482	21 126 508	35 195 210	33 175 182
11230 Basic life skills for youth and adults (10%)	4 613 496	1 931 829	1 150 950	2 890 000	1 644 005	2 364 637	1 398 946	1 754 280
11240 Early childhood education (10%)	-	-	-	-	-	-	-	-
11320 Secondary education (10%)	759 587	250 000	-	28 200	-	-	-	-
Total Education	***62 447 137***	***71 898 209***	***33 489 540***	***30 994 175***	***59 089 488***	***23 491 144***	***36 594 157***	***34 929 461***
Total SRHR Sida	**856 540 584**	**820 193 786**	**1 298 961 303**	**1 086 369 775**	**1 177 707 259**	**1 077 321 006**	**1 304 065 942**	**1 281 413 181**
Total Development allocation (result) Sida	14 240 391 000	15 108 464 000	16 259 953 000	16 793 718 000	18 988 753 000	17 737 579 000	18 669 789 000	21 448 000 000
SRHR % of Sida's development allocation	6%	5%	8%	6%	6%	6%	7%	6%

Ministry for Foreign Affairs (MFA)								
Reproductive health and rights								
13020 Reproductive health care	-	-	-	-	40 000 000	-	-	-
13010 Population policy and administrative manag	3 950 000	3 000 000	1 000 000	7 568 981	12 000 000	-	1 000 000	-
UNFPA	427 114 750	445 500 000	445 500 000	427 800 000	485 000 000	485 000 000	504 000 000	575 000 000
UNICEF (**12,9%** 2013-)	37 680 000	64 320 000	64 320 000	59 933 400	70 950 000	67 725 000	132 225 000	95 976 000
UNDP (**7-7,5%** 2011-)	50 400 000	51 675 000	51 675 000	39 284 000	35 700 000	34 650 000	43 050 000	43 400 000
WHO (**7%** 2011 -)	2 474 233	1 759 598	1 797 740	1 687 219	1 560 580	1 995 350	1 817 550	2 002 000
WB (**1,3%**, 2013-)	46 771 670	24 961 800	26 066 040	28 210 650	25 781 990	20 758 530	25 328 810	21 091 200
UNIFEM/UN Women (**9%**)	2 340 000	4 500 000	4 500 000	11 268 000	6 300 000	6 300 000	9 900 000	12 600 000
Total Reproductive health and rights	***570 730 653***	***595 716 398***	***594 858 780***	***575 752 250***	***677 292 570***	***616 428 880***	***717 321 360***	***750 069 200***
13040 STD control including HIV/AIDS	-	-	-	-	-	-	-	-
16064 Social mitigation of HIV/AIDS	-	-	-	-	-	-	-	-
UNAIDS	266 000 000	266 000 000	266 000 000	244 720 000	230 000 000	200 000 000	250 000 000	*260 000 000*
The Global Fund (59% 2011, **54 %** 2012 -)	280 000 000	351 600 000	517 750 000	404 250 000	269 500 000	458 150 000	458 150 000	431 200 000
Total HIV/AIDS	***546 000 000***	***617 600 000***	***783 750 000***	***648 970 000***	***499 500 000***	***658 150 000***	***708 150 000***	***691 200 000***
Health services								
12110 Health policy and administrative management (10%)	-	500 000	950 000	500 000	100 000			-
12220 Basic health care (25%)	-	-	-	-	-			-
12261 Health education (25%)	-	-	1 250 000	-	131 440		84 115	84 115
Total Health services	-	*500 000*	*2 200 000*	*500 000*	*231 440*		*84 115*	*84 115*
Education								
11320 Secondary education (10%)	630 698	644 866	628 766	598 894	551 877	551 000	713 137	713 137
Total Education	*630 698*	*644 866*	*628 766*	*598 894*	*551 877*	*551 000*	*713 137*	*713 137*
Total SRHR MFA	***1 117 361 351***	***1 214 461 264***	***1 381 437 546***	***1 225 821 144***	***1 177 575 887***	***1 275 129 880***	***1 426 268 612***	***1 442 066 452***
Total SRHR MFA and Sida	**1 973 901 935**	**2 034 655 050**	**2 680 398 848**	**2 312 190 918**	**2 355 283 146**	**2 352 450 886**	**2 730 334 554**	**2 723 479 634**
Total Development assistance (result), as reported to OECD DAC	**32 651 000 000**	**36 360 000 000**	**35 468 000 000**	**37 954 000 000**	**42 686 000 000**	**59 780 000 000**	**41 700 698 237**	**47 116 000 000**
SRHR share (%) of total Development assistance (result)	**6%**	**6%**	**8%**	**6%**	**6%**	**4%**	**7%**	**6%**
Total Development assistance, MFA methodology (see Annex II)	**26 479 000 000**	**29 842 000 000**	**29 919 000 000**	**31 192 000 000**	**31 831 000 000**	**32 731 000 000**	**36 789 000 000**	**39 769 000 000**
SRHR share (%) of total Development assistance, MFA methodology	**7%**	**7%**	**9%**	**7%**	**7%**	**7%**	**7%**	**7%**

REFERENCES

[1]The figures and calculation for 2017 are preliminary as they are based on prognoses and not actual outcomes. See Appendix II on methodology
[2]Calculations based on; results and forecasts per selected OECD/DAC sector codes and relevant UN agencies (provided by Sida and the Ministry for Foreign Affairs, December 2017 and March 2018); Budgetpropositionen 2017 and 2018, utgiftsområde 7 Internationellt bistånd; Preliminary Swedish ODA figures 2017, reported by OECD/DAC April 2018
[3] Target 5.6
[4]Budgetpropositionen 2018
[6]1) Family planning services; 2) basic reproductive health service 3) sexually transmitted diseases/HIV/AIDS prevention and 4) basic research data and population and development policy analysis.
[7]The Organisation for Economic Co-operation and Development (OECD) Development Co-operation Directorate (DAC) .
[8]*Flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development*
[9]The three overlapping components are the first three in footnote [6]
[10]To be tracked alongside the (current) -fourth component: Population data and policy analysis.
[11]UN Secretary General Report; *Flow of financial resources for assisting in the further implementation of the Programme of Action of the International Conference on Population and Development*, 2018
[12]FP2030 is an outcome of the 2012 London Summit on Family Planning and is based on the principle that all women should have access to contraceptives, that is aligned with the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health
[13]This work is led by the OECD/DACs WP-STAT (Working Party of Development Finance Statistics), As a member of this group, Sweden is contributing to the work
[14]African Development Bank, Asian Development Bank, European Bank for Reconstruction and Development, European Investment Bank, Inter-American Development Bank, International Monetary Fund and World Bank, From Billions to Trillions: Transforming Development Finance Post - 2015 Financing for Development: Multilateral Development Finance (18 April 2015).
[15]General Assembly resolution 70/1, annex, para. 11.
[16]-Primarily SDG 3 and 5
[17]http://devinit.org/wp-content/uploads/2018/01/Final-ODA-data-2016.pdf
[18]UN Secretary General Report; Flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development, 2017
[19]http://www.unaids.org/en/topic/resources
[20]Financing the 2030 Agenda UNFPA 2018
[21]Financing the 2030 Agenda UNFPA 2018
[22]CHANGE_http://www.genderhealth.org/files/uploads/change/publications/CHANGE_global_gag_rule_fact_sheet.pdf
[23]Kaiser Family Foundation http://share-netinternational.org/wp-content/uploads/2017/12/new-report-from-the-Kaiser-Family-Foundation.pdf
[24]Guttmacher 2017: The Benefits of Investing in International Family Planning–and the Price of Slashing Funding Sneha Barot,Guttmacher Institute
[25]-MARIE STOPES INT'L, The Mexico City Policy: A World Without Choice (2017), available at https://www.mariestopes-us.org/wpcontent/uploads/2017/01/Mexico-City-Policy-A-World-Without-Choice.pdf.
[26]Adding It Up: Investing in Contraception and Maternal and Newborn Health, Guttmacher 2017
[27]Adding It Up: Investing in Contraception and Maternal and Newborn Health, Guttmacher 2017
[28]Including direct and indirect costs
[29]Including both direct and indirect costs
[30]Because the cost of preventing an unintended pregnancy through use of modern contraception is far lower than the cost of providing care for an unintended pregnancy, for each additional dollar spent on contraceptive services above the current level, the cost of pregnancy-related care would drop by $2.20 per person and year
[31]https://www.unfpa.org/sites/default/files/resource-pdf/FINAL_UNFPA_Backgrounder_web.pdf

[33]Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents Jacqueline E. Darroch,Vanessa Woog,Akinrinola BankoleandLori S. Ashford
[34]WHO Safe Abortion: Technical and Policy Guidance for Health Systems. 2nd edition). 2012, p32
[35]WHO and the Guttmacher Institute article in The Lancet. May 2017
[36]Induced Abortion Worldwide; Fact sheet 2017 Abortions
[37]WHO 2015 and La WHO and the Guttmacher Institute article in The Lancet. May 2017
[38]Adding it up 2016: Adolescents
[39]WHO Safe Abortion: Technical and Policy Guidance for Health Systems. 2nd edition). 2012
[40]Adding it up 2014: The Costs and Benefits of Investing in Sexual and Reproductive Health 2014
[41]Adding it up 2014: The Costs and Benefits of Investing in Sexual and Reproductive Health 2014
[42]Funds for NGOS
[43]BMZ report
[44]www.lgbtfunders.org
[45]Funding for the international arena encompasses all funding that crosses country and region boundaries.
[46]LGBT funders https://www.lgbtfunders.org/wp-content/uploads/2016/12/2013-2014_Global_Resources_Report_International.pdf
[47]The dilemma itself is described in an article by Human rights watch and we have heard additional details from an RFSU partner, who is facing exactly this dilemma https://www.hrw.org/news/2018/02/14/trumps-mexico-city-policy-or-global-gag-rule
[48]Aid Policy Framework - the direction of Swedish aid, p. 37
[49]Belgium, Denmark, Finland, The Netherlands, and Luxembourg
[50]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. https://www.agendaforhumanity.org/annual-report/6379 -
[51]Kaiser Family Foundation
[52]See Swedish Aid Policy Framework, for example, p. 34: In many places in the world, above all in poor parts, the sexual and reproductive health and rights of women -and LGBT persons are infringed upon. Improving this situation is a priority for Sweden. Other examples are to be found on p. 37 and p. 24
[53]Sveriges Hälsobistånd 2016 p.4 and p.,16
[54]Budgetpropositionen 2018, Utgiftsområde 7 p. 14
[55]Annually presented in the the Report of the Secretary-General on the flow of financial resources for assisting in the implementation of the PoA of the ICPD
[56]See Report of the Secretary-General on the flow of financial resources for assisting in the implementation of the PoA of the ICPD 2018 https://documents-dds-ny.un.org/doc/UNDOC/GEN/N18/030/19/PDF/N1803019.pdf?OpenElement
[57]-1) Family planning services; 2) basic reproductive health service 3) sexually transmitted diseases/HIV/AIDS prevention and 4) basic research data and population and development policy analysis.
[58]https://documents-dds-ny.un.org/doc/UNDOC/GEN/N18/030/19/PDF/N1803019.pdf?OpenElement
[59]Sveriges Hälsobistånd 2016 (2017)
[60]Sveriges Hälsobistånd 2016 p. 4 and 16
[61] The “Kemp-Kasten amandement”, first enacted by Congress in 1985, states that no U.S. funds may be made available to “any organization or program which, as determined by the president of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization.” Kemp-Kasten has been used to withhold funding from UNFPA in 16 of the past 33 fiscal years. While framed broadly, Kemp-Kasten was intended to restrict funding to UNFPA specifically, after concerns arose about China’s population control policies and UNFPA’s work in China. Evaluations by the U.S. government and others have found no evidence that UNFPA directly engages in coercive abortion or involuntary sterilization in China (Kaiser Family foundation, https://www.kff.org/)

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