SRHR is a broad concept, including and taking account of the whole population throughout the life-course. It is an area with importance for self-esteem, well-being and intimate relations, regardless of sex, gender identity/expression, sexual orientation, age, ethnicity, financial status and disability. The aim of the national response to SRHR in Sweden is to create societal and social preconditions to secure and improve SRHR. The starting point is the overall public health target to create societal prerequisites for good health on equal terms for the entire population (1) as well as the main principle of non-discrimination (2).

Globally the problem and consequences of inequalities between men and women are vast and even worse with regards to transgender people. The problem of inequalities is multifaceted; women die and suffer from sexual and reproductive ill-health as a consequence of: rising HIV and sexually transmitted infection (STI) cases; little or no sexuality education; lack of self-power over one’s own body or mind; high exposure to discrimination; and in many countries, lack of capacity or opportunities for women to have their own representation.

Sweden has a long tradition of addressing SRHR, partly based on the Swedish welfare model that promotes equal opportunities for all. Publicly funded universal health and childcare, as well as subsidized university education are part of its founding principles. This welfare model has generated a range of reforms and policies that have also been of importance for improved equity and gender equality and hence also affected SRHR in Sweden in a positive way.

Historically, SRHR has focused on the prevention of ill-health, including sexual ill-health, unwanted pregnancies, HIV and STIs and sexual violence. At the same time, there has been an awareness of the importance of the health promotional aspects of healthcare, for example, focusing on sexual health for young people by implementing youth friendly health services via youth clinics. A vital contribution in reducing the taboo of sexuality at large is that Sweden, since 1956 has an age appropriate compulsory sex and relationship education, starting from pre-school and throughout secondary school.

However, the perspective has changed during the years. It has progressed from being a narrow population-based development issue to a broader public health agenda, where sexual health is seen as a determinant for health and sexual health a prerequisite for reproductive health. Today’s SRHR efforts have a clear focus on equity, gender equality and human rights, including sexual rights (3). Ever since the world faced the HIV epidemic, the response to HIV raised awareness of the SRHR inequalities and its negative impact on sustainable and successful prevention.

In Sweden there has been and is a broad political consensus and continued support for HIV prevention. A state grant of 15 million Euro has been allocated to HIV prevention annually, a national strategy has been in place since the year 2006 and there has been a clear focus on co-operation between all national, regional and local levels of government. The HIV prevention strategy includes the perspectives of SRHR, for example, by advocating for minority groups, especially men who have sex with men, migrant groups and youths and young adults (4). Equally important as the link between HIV and SRHR is the link to Lesbian Gay Bisexual Transgender (LGBT) rights. In Sweden, a national strategy for equal rights and opportunities regardless of sexual orientation, gender identity or gender expression has been present since 2014. The continuous efforts for prevention of HIV and treatment to prevent progression to AIDS has led to an increased awareness of the living conditions of people living with HIV and the stigma and discrimination that comes with ignorance. The focus today must be on “leaving no-one behind”.

Since 2014 the government of Sweden has developed a focused, feminist political approach promoting equality policies and strategies such as the national gender mainstreaming of governmental agencies and universities (JIM), a national strategy for preventing men’s violence against women and other measures to integrate the wide governmental gender equality goals into the political agenda. This is in line with the ongoing work with Agenda 2030 that is currently being rolled out.

Interestingly enough, in Sweden, the government’s intention and priorities regarding SRHR have mainly been presented in official documents regarding Sweden’s foreign policy on the subject (3, 5, 6). In 2014 the government commissioned three governmental agencies to explore the need for and propose a national SRHR strategy, but it was not further investigated. However, in 2016 the Public Health Agency of Sweden became the national coordinator of SRHR. The agency is responsible for knowledge-building as well as for any monitoring and evaluation processes. In this role, the
agency will carry out the first population-based SRHR survey in Sweden during 2016-2019. Two earlier studies (1967 and 1996) have been carried out in Sweden, encompassing some parts of the SRHR arena, but focusing mainly on sexual behaviour (7, 8). The coming study will provide a baseline and a scientific basis for future prevention initiatives and work.

Current challenges to strengthening and assuring SRHR in Sweden are increasing socio-economic inequalities, segregation of groups and rural versus urban areas which increasingly affects availability and access to public services as well as information. With information today being largely available but also largely filtered through social networks, the challenge for governmental agencies, institutions, healthcare and civil society is to get through – and raise – the questions of sexual health, reproductive health and the rights to health. This is essential for a society where equity and equality are cornerstones, both in terms of monitoring and evaluation (to obtain information on and from risk groups) as well as in terms of promotion and prevention (delivering interventions and information to segments of society). Having this in mind, the Public Health Agency will within the next 5 years have built new knowledge and evidence for SRHR in Sweden, focusing on the structural and societal determinants of SRHR.

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References