INTERWOVEN LIVES, THREADS OF HOPE

Ending inequalities in sexual and reproductive health and rights

UNFPA state of world population 2024

State of World Population report 2024

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Ensuring rights and choices for all

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A NOTE ON LANGUAGE
In this report, "Black" is capitalized when referring to groups or individuals in racial, ethnic or cultural terms. The term "Black" is often used to convey a shared sense of history and identity, while "white" is less commonly used this way. As the term "indigenous" can be used to refer generally to peoples of many cultures and traditions, the term is not capitalized in this report unless it is used to refer to a specific group or nation. This report also tends to refer to women and girls when discussing issues such as sexual violence and pregnancy; the data for these issues broadly come from surveys and studies that identify participants as women or girls. It is important to note that transgender men and non-binary people also experience pregnancy, and that gender-diverse people experience sexual violence and barriers to sexual and reproductive health care in disproportionate and unacceptable numbers.

A NOTE ON ART
For thousands of years, women and indigenous communities have used weaving and embroidery to blur the boundaries between art and function, practicality and beauty. Yet their work has long been dismissed as craft rather than fine art, and excluded from formal art institutions and markets. For this reason, women's movements and indigenous peoples have embraced this art form to draw attention to issues related to their exclusion, like gender-based violence, reproductive justice and systemic racism — and also to call for solidarity across communities. The artists and textile collectives featured in this report continue that tradition, expressing contemporary concerns with skills passed down by generations of women. Together, their art shows how each woman's rights, dignity and future are woven together with those of her sisters, daughters, mothers and friends.

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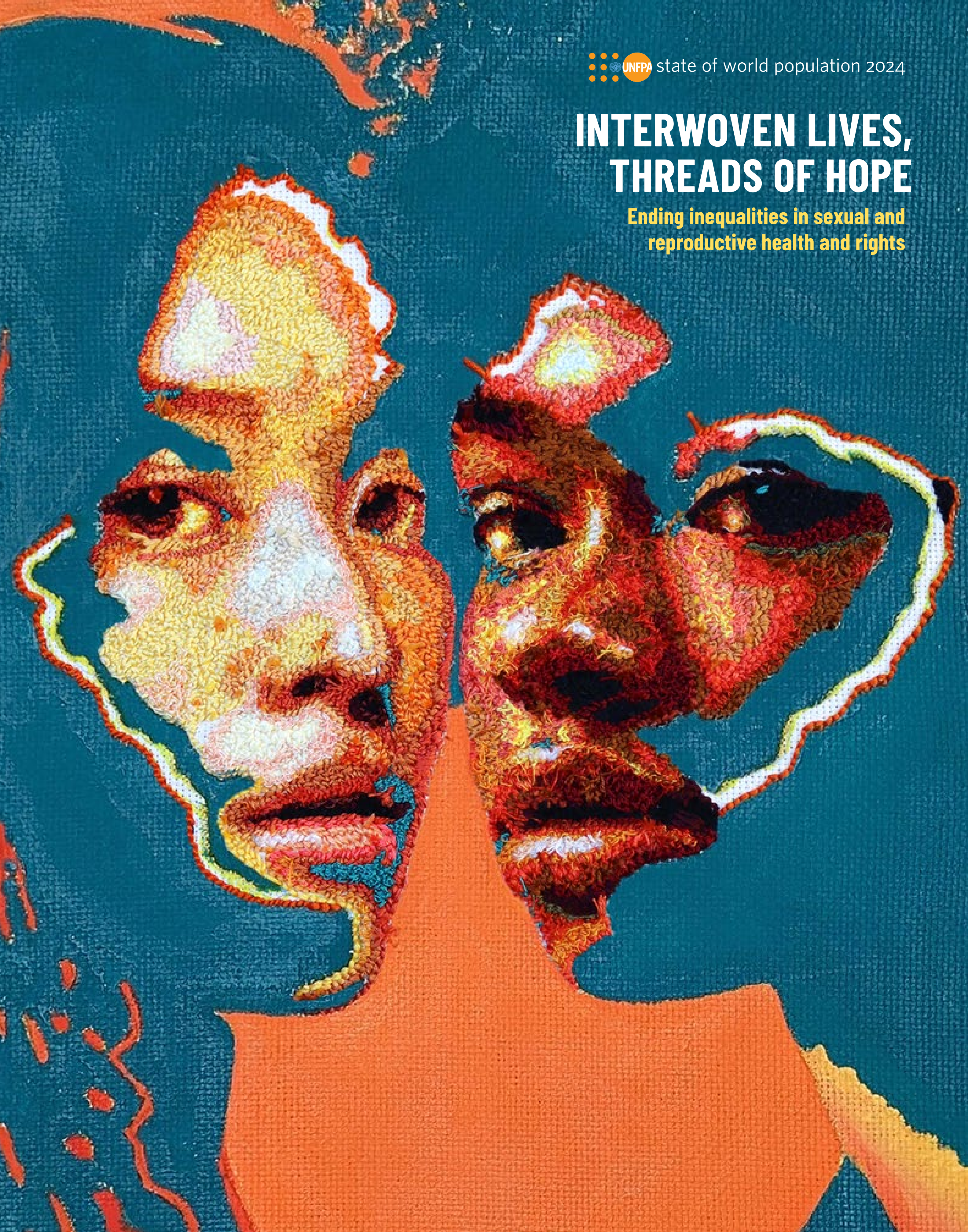

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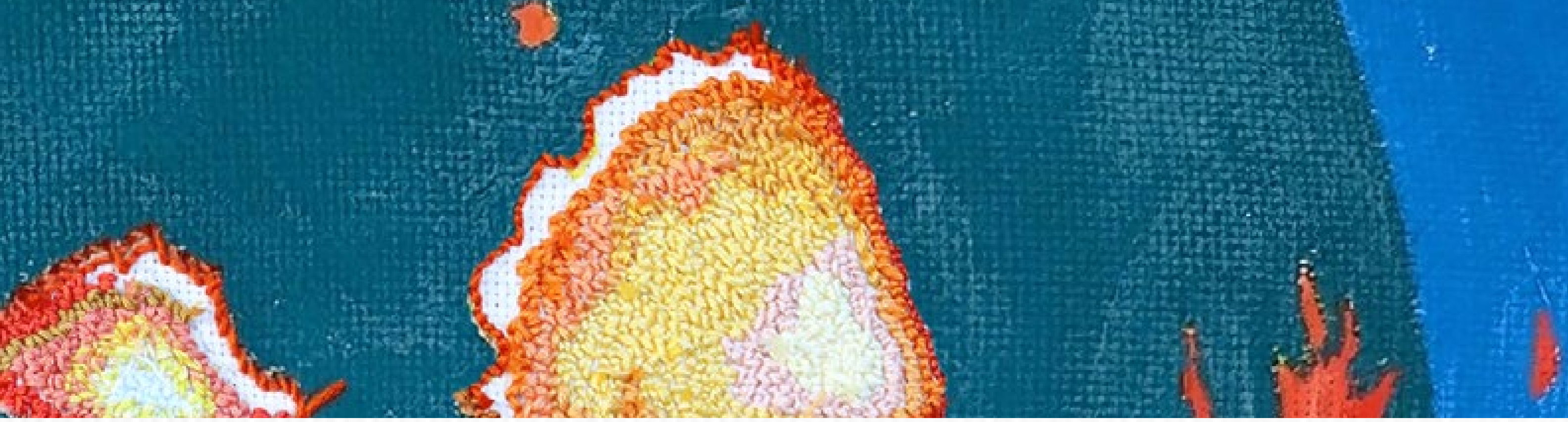
FOREWORD

Thirty years ago, governments around the world agreed that reproductive health and rights are foundation stones of global development – a groundbreaking consensus that paved the way for decades of progress. Since then, the global rate of unintended pregnancies has fallen by nearly 20 per cent globally. The number of women using modern contraceptive methods has doubled. Today at least 162 countries have adopted laws against domestic violence, and maternal deaths have decreased by 34 per cent since 2000.

Yet that progress has not been fast enough, nor far-reaching enough. Gender-based violence remains rampant in practically every country and community. There has been zero reduction in maternal mortality since 2016, and in an alarming number of countries the rates are rising. Nearly half of women still are unable to make decisions about their own bodies — unable to exercise their sexual and reproductive health and rights.

One important reason is inequality. New evidence in this report shows that although women across socioeconomic classes and ethnicities say barriers to health care have come down over time, the women most marginalized have experienced the least improvement. In other words, while the world has focused on serving the easiest to reach, we have neglected to confront the inequalities and disparities within our systems and societies, which has allowed gaps to widen into chasms.

Everywhere, people seeking essential sexual and reproductive health care are forced to navigate overlapping hurdles because of their gender, economic status, ethnicity, sexual orientation, disability and more. In the few places where data are collected, women of African descent are found to be more vulnerable to obstetric mistreatment and negative maternal health outcomes. Indigenous women are often denied culturally appropriate maternal health care, and their own childbirth practices may be criminalized, resulting in significantly higher risk of death in pregnancy and childbirth. Gender-unequal norms remain embedded in health-care infrastructure, including persistent underinvestment in the world's largely female midwifery workforce. Women and girls with disabilities face up to 10 times more gender-based violence



while also facing higher barriers to sexual and reproductive information and care. LGBTQIA+ people face serious health disparities in addition to – and as a result of – discrimination and stigma.

The path forward to fulfill the Cairo International Conference on Population and Development promise of universal sexual and reproductive health and rights is clear: To achieve it we must root out inequalities from our health systems and policies and focus as a priority on those women and young people who are most marginalized and excluded.

We need comprehensive, universal and inclusive health care grounded in human rights and evidence of what works. This work is vitally important, it is just, and it is possible. This report contains many examples of programmes and efforts that have expanded access to, and uptake of, quality care, usually with interventions tailored by and for those most in need. To accelerate success, we will require more and better data, disaggregated to understand exactly who is being left behind, and collected with their input and safety assured.

A diverse cross-section of people, from feminists to indigenous groups to climate and youth activists, are already pointing the way forward towards a fairer, shared future.

In the end, ensuring equitable progress will benefit all of society. That is important in its own right, and the dividends of achieving a more just and gender-equal world could also add trillions of dollars to the global economy.

The fabric of humanity is rich and beautiful, a tapestry composed of 8 billion threads and counting, each one of us unique. Our resilience comes not from any individual strand but emanates from the collective, interwoven whole. That is our strength, and it is how we will proceed and succeed — by working together.

Dr. Natalia Kanem
Executive Director
United Nations Population Fund

A work in PROGRESS

A safe birth. A choice of contraceptives. Protection from gender-based violence. More people than ever before have realized these essential, life-sustaining rights. But the number of people denied these rights has not yet reached zero – as it can and as it must.

Overall, people today live longer, healthier lives. Still, millions remain far behind on the trajectory of progress, trapped by multiple, compounding forms of marginalization and discrimination. In a world of tremendous wealth and proven solutions in sexual and reproductive health care, such disparity suggests a lack of will, not a shortfall of ideas or resources. This is important to keep in mind because it means that much faster progress in ending marginalization and discrimination is not just desirable but possible, starting right now.

In 2024, the world marks the thirtieth anniversary of the 1994 International Conference on Population and Development (ICPD) in Cairo. That conference produced a watershed global agreement putting people at the centre of development, one that committed to realizing better health, rights and choices for all. It affirmed a vision of human potential that has inspired significant progress ever since, echoed and amplified by the global 2030 Agenda for Sustainable Development agreed in 2015.

Yet the ICPD agenda remains only partially realized, for the most marginalized people most of all. Disparities cut through every society, depriving some human beings of fundamental sexual and reproductive health and rights. Differences in power and opportunity related to gender, race and ethnicity, among many other factors, both alone and in combination, still largely constrain people's choices and access. These dynamics manifest when a woman with a disability is refused sexual health information or when a girl in an impoverished village is married as a child. They arise when a pregnant woman or person from an ethnic minority encounters abusive practices that go unquestioned in health systems.

Moving faster to bring the promise of ICPD alive for people who have been pushed behind is one of the world's most urgent priorities. It's a priority because, for each individual, bodily autonomy – the power and agency to make choices over one's body and future, without violence or coercion (UNFPA, 2021) – depends on realizing sexual and reproductive health and rights. This determines the gains individuals can experience across their life course, in health but also in education, employment and political participation. In turn, peaceful, resilient and just societies depend on healthy and empowered people, without exclusions.

A strong foundation is in place to realize ICPD commitments for everyone. The world's understanding of how to dismantle remaining barriers and types of discrimination is greater than ever before. The international community has agreed for decades that people-centred development requires universal access to quality sexual and reproductive health care, and it is moving ever closer to the holistic goals of the reproductive justice movement (McGovern and others, 2022). This report argues that the thirtieth anniversary of the ICPD is an opportunity to pivot health and social systems towards providing services that empower all people, respect their diversity, uphold their dignity, and support them to realize their rights and bodily autonomy. It also calls for renewed

The opportunity to mobilize support for gender equality and reproductive rights is at hand.

commitments to unwind the disparities and inequities that still divide societies. These inequities create and reinforce systemic, structural barriers that chronically marginalize women and other groups in nearly every aspect of life, from labour markets to education to political participation. Now is the moment to take decisive action towards dismantling these barriers.

Political and social polarization, often linked to economic disparities, is driving insecurity around the world (United Nations, 2018), with reproductive rights issues – including comprehensive sexuality education, LGBTQIA+ rights, access to contraception, abortion and gender equality – increasingly caught in the crossfire (Kanem, 2023). Yet reducing inequalities in sexual and reproductive health and rights could help lessen economic disparities (UNFPA, 2017), thereby contributing to stability, preventing conflict (Nyård, 2018) and accelerating development. And in many ways, the opportunity to mobilize support for gender equality and reproductive rights is at hand: This year could herald the largest cumulative act of participatory democracy in history, with more than 50 countries holding major elections that will affect the fates of billions of people (Harbath, 2023; IFES, n.d.) – among them billions of women and girls, and countless marginalized communities.

Progress – but not for all

Since the ICPD, remarkable progress has been made in core areas of sexual and reproductive health, driven by social mobilization, leadership, partnership and the commitment of people from remote health service delivery points to the highest echelons of government, business and philanthropy. The relentless advocacy of civil society and grass-roots movements has been instrumental in securing these impressive gains (see timeline on pages 34–39).

Between 2000 and 2020, global maternal mortality declined by 34 per cent (WHO and others, 2023), a success story that can be credited largely to better access to skilled and emergency obstetric care. From 1990 to 2021, the number of women using modern contraception doubled (UN DESA, 2022). There has been a 19 per cent decline in the unintended pregnancy rate between 1990–1994 and 2015–2019 (Bearak and others, 2018). Births among girls aged 15 to 19 years have fallen by around one third since 2000 (UNFPA, 2023). HIV infection rates have dropped significantly. The number of new infections in 2021 was almost one third fewer than in 2010 (United Nations, 2023). The proportion of girls subjected to female genital mutilation has decreased significantly as well, due to shifting attitudes towards the practice (UNICEF, 2022).

As women's status has increased – evidenced, for example, by slow but steady gains in leadership roles (United Nations, 2023) – so has recognition of the importance of bodily autonomy as a human right (OHCHR, 2017). With the 2015 adoption of the Sustainable Development Goals (SDGs), the international community sought, through indicator 5.6.1, to measure women's ability to exercise bodily autonomy, a groundbreaking global affirmation that bodily autonomy is a human rights imperative. Governments around the world have also sought to protect women and girls through legislation: A historic 162 countries have passed laws against domestic violence (World Bank, n.d.). As a further advancement of bodily autonomy, the world is increasingly rejecting the criminalization of LGBTQIA+ sexuality. At the start of the AIDS pandemic, most countries criminalized same-sex sexuality, while today two thirds of countries do not – and this progress may be accelerating, with more countries eliminating punitive laws in 2022 than in any single year in the past 25 years (HIV Policy Lab and others, 2023).

Other hopeful signs come from new models of health care backed by sound evidence and recognition of human rights. These are reaching more people, and are more responsive to diverse contexts and human needs. For example, self-care models of health care have been endorsed by UNFPA, the World Health Organization (WHO) and other public health organizations, following rapid advancements in new technologies that enable users to promote and maintain their own health, and cope with illness and disability, without the direct intervention of a health worker. Such developments could greatly expand access to sexual and reproductive health (UNFPA, 2024). Also promising is the growing acknowledgement that health care delivered by skilled midwives – whose ancient profession has long been sidelined within modern medicine (see Chapter 2) – is both life-saving and cost-saving (UNFPA and others, 2021).

Gender equality is increasingly understood as one of the smartest development investments, generating enormous social and economic gains (UNFPA, 2023a), while the economic returns on investment in sexual and reproductive health are compelling too. According to a UNFPA calculation, spending an additional US$79 billion in low- and middle-income countries by 2030, for example, would avert 400 million unplanned pregnancies, save the lives of 1 million mothers and 4 million newborns, and generate $660 billion in economic benefits (UNFPA, 2022).

Yet with all that has been achieved, millions of people still see little difference in their daily lives and continue to struggle to realize their rights, largely because the roots of gender discrimination and other forms of marginalization run deep.

The latest data show that, in 69 countries, one quarter of women still cannot make their own health care decisions. One quarter cannot say no to sex with their husband or partner. Nearly 1 in 10 have no choice in using contraception (UNFPA, 2024a). But these data have yet to motivate significant improvements in women's bodily autonomy. Only about a third of countries even report these data. And for the first time, trend data on SDG indicator 5.6.1 are available for more than 30 countries, and while 19 countries have seen a positive trend in women's ability to exercise decision-making over their own sexual and reproductive health, 13 countries have seen a negative trend in this same measurement (UNFPA, n.d.).

Once promising progress in reducing preventable maternal deaths has largely stalled: Between 2016 and 2020, the global annual reduction in maternal deaths was effectively zero (WHO and others, 2023). That means around 800 women still die every day while giving birth, and nearly every one of those deaths is preventable. As Dr. Mahmoud Fathalla, former Director of the United Nations Special Programme on Human Reproduction, powerfully stated, "Mothers are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving" (Fathalla, 2012).

And maternal deaths are a telling microcosm of the inequalities that plague all aspects of sexual and reproductive health because of how blatant the disparities are – between countries and within them. The difference between living and dying can depend on where a woman gives birth, as the vast majority of maternal deaths, over 70 per cent, take place in sub-Saharan Africa, home to many of the world's least developed countries and most fragile health systems. A woman in this region who experiences pregnancy and childbirth complications is around 130 times more likely to die from them than a woman in Europe or North America. Inequities within regions and countries are also wide and deep. In Madagascar, for example, the richest women are five times more likely than the poorest to have skilled assistance when giving birth (UN Women and others, 2023); and across the Americas, people of African descent are more likely to experience obstetric mistreatment (UNFPA and others, 2023).

Inequities are also seen in access to modern contraceptives, including disparities based on race and ethnicity (Jackson and others, 2017), refugee and migration status

(Raben and van den Muijsenbergh, 2018), education, socioeconomic status, and rural versus urban location (Makumbi and others, 2023). And while gender-based violence is both pervasive and underreported, there are signs of inequities here, too – including disparities based on age (Decker and others, 2015) and sexuality (Evens and others, 2019), as well as racial, ethnic and gender-based disparities in years of life lost due to intimate partner violence (Graham and others, 2021).

Despite these inequalities – or perhaps because of them – too few countries are collecting data on sexual and reproductive health needs and barriers; fewer still are disaggregating these data by factors known to contribute to neglect, discrimination and marginalization, factors including culture, ethnicity, race, caste, language and religion, disability status, HIV/AIDS status, migration status, sexual orientation and gender identity.

At the same time, new challenges are arriving quickly in the digital realm. Health-care technologies are evolving rapidly and offer tremendous promise in improving information, easing bureaucracy and extending access to care. Yet millions of people remain stranded on the wrong side of a digital divide. Technologies such as artificial intelligence can replicate existing biases and discriminatory norms, potentially worsening inequalities. Some computer-assisted diagnostic systems, for instance, are shown to be more accurate for white men than people of other races and genders (Muro and Egbokhare, 2023). New research also highlights how technology offers a dangerous new avenue for gender-based exploitation and abuse (UNFPA, 2024b). Gender inequity can be

baked into the very design of technologies, with women underrepresented in training algorithm decisions. Gender-biased health technology can be especially problematic, leading to delayed or incorrect diagnoses and treatments. Women's representation in early phase clinical trials is as low as 22 per cent, and pregnant and breastfeeding women continue to be excluded from even postmarket stage clinical trials (Ravindran, 2020; Shields and Lyerly, 2013).

Pushing back – and pushing forward

The ICPD agenda was born from the commitment of people from all walks of life to come together and find solutions to common concerns about population and development, reflecting "major shifts in attitude among the world's people and their leaders in regard to reproductive health, family planning and population growth" (UNFPA, 1994). The powerful momentum it unleashed has since sustained and renewed progress on sexual and reproductive health and rights. Although no country can yet claim it has reached everyone, almost every country can celebrate significant advances. Many have committed to accelerating progress, recognizing it is integral to the 2030 Agenda for Sustainable Development and its 17 SDGs.

Multiple crises, however, including conflict, climate fallout and the COVID-19 pandemic, have put decades of gains at risk and threaten future progress. Further, a relentless, well-organized effort to push back against human rights and gender equality is under way. While opposition to sexual and reproductive health and rights is often rationalized in the name of tradition and cloaked in nostalgia, it contradicts long-agreed consensus and core human rights agreements, denies well-established scientific and medical knowledge, and contributes to political division and instability (Kanem, 2023; Guttmacher Institute, 2017).

Resistance to sexual and reproductive health and rights is resulting in greater marginalization for communities already left – or pushed – behind. Efforts to control fertility and restrict bodily autonomy disproportionately affect migrants, people with disabilities, and minority and indigenous communities, among many others. A lack of comprehensive sexuality education limits rights to information and education, and may be more likely to derail opportunities for young people with fewer resources to seek accurate answers to their questions. The stark denial of the rights of people with diverse sexual orientations and gender identities has escalated (El Chamaa, 2023). Amid the global trend towards decriminalizing LGBTQIA+ sexuality and identity, there has been an intensification of penalties within those countries that continue to criminalize LGBTQIA+ persons – including punishments as severe as the death penalty – despite clear evidence that criminalization not only increases HIV rates and leads to human rights violations, but also negatively impacts economies (HIV Policy Lab and others, 2023).

Regression and polarization leave societies less stable and trusting than they otherwise might be, and more prone to disinformation and falsehoods (Gupta and others, 2023; Osmundsen and others, 2021). To move forward, we can start with what we agree upon: that no woman should die while giving life; that every individual has the right to decide when, whether and with whom to start a family; that every person should be able to make choices about their bodies without violence or coercion; that when women and girls can chart their own destiny, they and their societies prosper. Further, as the ICPD implicitly acknowledges, the rights and well-being of any one person are inextricably linked to the rights and well-being of others. Where rights are at risk for one person, they are effectively at risk for us all (United Nations, 2020).

This principle was well understood by the feminist and other movements that came together with Member States to forge the ICPD agenda: In the lead-up to the September 1994 conference in Cairo, a broad cross-section of women came together from around the world. They mobilized to make sexual and reproductive health and rights a cornerstone of women's rights activism and central to poverty eradication, sustainable development and the realization of human rights as a whole (Corrêa and others, 2015). Nine months before the ICPD, women from 79 countries took part in a global preparatory conference in Rio de Janeiro, where they took a strong stand against coercive population policies and pointed to inherent structural inequities as the "underlying basis of increasing poverty and marginalization of women, environmental degradation, growing numbers of migrants and refugees, and the rise of fundamentalism everywhere" (Anon, 1994). Four months before the ICPD, a collective of Black feminists in the United States responded to international momentum by launching a call for reproductive justice – a concept that goes beyond access to reproductive health care to tackle multiple forms of economic, social, political and environmental injustice, all of which impact sexual and reproductive health and rights and must be addressed to yield holistic results for the most marginalized (Ross, 2017).

Today, a wide range of people's movements is reiterating these ideas in a renewed call for justice and development. Diverse constituencies, often led by marginalized peoples, are coalescing and linking concerns that are converging around the world, from the right to bodily autonomy to the desire for a liveable planet. Their shared reach is powerful and promising, with research suggesting that large-scale social change can take off as soon as about 25 per cent of people stand in favour of it (Sloane, 2018).

Many points of light include the increasing alignment of diverse grass-roots movements and civil society organizations with efforts to secure reproductive health and rights, and vice versa. Indigenous women are mobilizing to end the destruction of environmental resources, for example, because it threatens not just their culture and their sense of connection to the land but also their health and choices to bear children. Young activists are campaigning for climate justice with growing recognition that climate justice is also reproductive justice (McGovern and others, 2022). They have stressed that poor communities hardest hit by climate change are also those falsely blamed for worsening the crisis because of their high fertility rates – even as most greenhouse gas emissions still emerge from wealthier, lower-fertility countries.

In India, Dalit activists have argued for legal protections for women facing caste-based discrimination in workplaces and education. Many will otherwise remain too poor to support their families and give their children a dignified life, contributing to a cycle that perpetuates poor sexual and reproductive health. Almost half of Dalit women, for instance, receive no antenatal care, and high rates of gender-based violence are considered a means of oppression and control (McGovern and others, 2022).

Cases where women's rights have been largely obliterated, as in Afghanistan, have unified women's activists, human rights defenders, politicians and prominent jurists behind a move to define gender apartheid and make it a crime against humanity (Bahous, 2023; Nia, 2023).

The Green Wave movement sweeping across Latin America, which emerged from protests against shockingly high rates of femicide, has transformed activism as well as abortion laws in a region once known for some of the strictest limitations (Carpenter, 2019). As one activist said, "The cries of anger, pain, joy and sisterhood on the streets have certainly placed the feminist movement at the centre of public attention as a strong and necessary movement that is requesting radical changes in life as we know it" (Kharas and others, 2019).

Rollback as a response to progress

After decades of progress, there has also been a recent rollback in sexual and reproductive health and rights. Comprehensive sexuality education, once the subject of near-universal agreement, has been increasingly contested in international negotiations, for example (United Nations, 2023a). Advocacy organizations are reporting that abortion restrictions in one country are having a ripple effect in others (Fòs Feminista, 2023), with medical professionals increasingly uncertain about the legality of basic sexual and reproductive health services (Kanem, 2023).

But pushback can be a common response to progress. As the United Nations Office of the High Commissioner for Human Rights notes, "In several countries, the authorities have noted a dramatic spike in homophobic and transphobic violence in the immediate aftermath of high-profile legislative advances aimed at better protecting the rights of LGBT people. It is a phenomenon with historic parallels: past attempts to eradicate racial segregation and discrimination reportedly triggered a similar backlash directed at members of racial minorities" (OHCHR, n.d.). The challenge, therefore, is to sustain hope and momentum in the face of opposition.

FEATURE

When crises cut off health care, community members fill the gaps

Duha, a 28-year-old single mother, was already a refugee from the war in the Syrian Arab Republic, living in Türkiye's Hatay Province, when two powerful earthquakes struck in February 2023. The disaster forced her and her three young children from their former precarious housing and into a makeshift tent.

Duha became pregnant in the aftermath of the crisis, and suffered for months from a painful urinary tract infection; she says this is common among the earthquake survivors, given the unsanitary washing facilities. "The lack of clean water has led to many kinds of infections."

One of her biggest concerns was the scarce access to health care: Regulations under Turkish law allow registered Syrian refugees with temporary protection status to visit family and migrant health centres without paying. But in Hatay, near the epicentre of the quakes, many services were incapacitated, and others were at risk of buckling under the increased demand.

Fortunately, Duha was able to receive treatment from Dr. Eda Gülüm, a doctor working with HASUDER, the Turkish Association of Public Health Specialists, members of which have paid frequent visits to women and girls in the earthquake-affected areas.

Mobile units with HASUDER, supported by UNFPA, provide prenatal and postnatal consultations, as well as family planning advice and treatment for common conditions such as cystitis, vaginitis and urinary tract infections. They also deliver group information sessions on breast cancer awareness, personal hygiene, family planning and preventing sexually transmitted infections.

"We performed an abdominal examination and checked her vital signs," Dr. Gülüm says. "We also made sure she wouldn't miss her routine prenatal visits and gave her a 'maternity kit', which includes baby clothes, a blanket and toiletries."

Duha began organizing others to seek care. "Duha was fluent in Turkish and very eager to help the health staff communicate with more women, contacting doctors and gynaecologists whenever a woman in her neighbourhood needed them," Dr. Gülüm says.

Globally, the human right to health is articulated in many international agreements, but in displacement, conflict and other crisis settings, this right is often threatened or violated. Existing health systems can be compromised, patient populations may be uprooted and emergency responses may fail to prioritize sexual and reproductive health services – with consequences falling disproportionately on women and girls.

Dr. Gülüm and HASUDER are trying to bridge these gaps. Dr. Gülüm is fluent in Arabic and English as well as Turkish. Since August 2023, she has been serving quake-affected communities, typically seeing 10 to 30 women each day. When she's with the mobile unit, she can visit up to 80.

"The nearest hospital is about 20 minutes away by car," she explains. "With no public transport in the area, the mobile unit also supports patients in urgent need."

It's a situation 22-year-old Rama (name changed), from the Syrian Arab Republic, faced. She has also been living in a tent since the earthquake. She reached out to HASUDER when she discovered she had miscarried early in her pregnancy, putting her at risk of life-threatening sepsis. The mobile team helped her gain access to a public hospital where she was treated. A few days later, she called the mobile team: "I just want to let you know I got through it," she said.

For those not intending to become pregnant, being displaced and losing access to basic health facilities also poses critical risks. "The most common conditions I see are sexually transmitted infections, urinary tract infections and unintended pregnancies," says Ceylan Güzey, a nurse and health trainer with the UNFPA-supported Youth Approaches to Health Association (Y-Peer Türkiye) in Hatay. "I also do training and awareness-raising on these, and on family planning."

Since May 2023, Ms. Güzey has been working chiefly with people displaced by the disaster; she explains that the team often discovers other underlying issues. While distributing maternity kits, for example, staff may identify untreated sexually transmitted infections, or violence or coercion.

Nurse Ceylan Güzey says there's been an increase in child and unintended pregnancies since the 2023 earthquakes, as well as reports of sexual abuse, coercion and trafficking. © UNFPA Türkiye

"We've seen child and unintended pregnancies rise since the crisis, as well as reports of sexual abuse, coercion and trafficking… there's been a very visible increase."

To address the prevalence of unintended pregnancies, Ms. Güzey is liaising with men much more than before. "I work mainly with women, but we've seen more couples asking for advice together – it's unusual, normally men don't want to go and ask for contraceptives."

Although the disruption in services is leading to harmful outcomes, Ms. Güzey has seen a surprising upside to bringing support directly to those displaced. "Before the earthquake, sexual and reproductive health work was more hidden, it was a kind of secret – now men are more understanding about these issues. They thought contraceptives were somehow against them, so it's become less of a threat."

The language of inequality

The language we use to address inequality matters. It is crucial that we avoid depicting any individual or community as powerless or peripheral. While there has been a tendency to describe entire groups as marginalized or oppressed, efforts are increasingly being made to name the specific conditions that can impede access to rights and choices. For these reasons, UNFPA has shifted from a focus on furthest-behind *groups* to furthest-behind *factors*. Some experts and organizations now refer to those "pushed behind" (Kharas and others, 2019) rather than "left behind", avoiding the implication that marginalization is the result of a community's own failures or inadequacies. Many use the phrases "leave no one behind" and "reach the furthest behind first"; both principles are central to the 2030 Agenda for Sustainable Development (UNFPA, 2021a). The report uses many of these terms, not to reflect a preference for one or another but to adhere to the source material and/or to bring research together into a cohesive and comprehensible text. The authors recognize that overall, the language of inequality is ever-changing. We must commit to listening to and learning from all members of our societies on a continuous basis.

This report uses the following terms with the following definitions:

Leave no one behind – from the 2030 Agenda for Sustainable Development (United Nations, 2015). Leaving no one behind represents the commitment of all United Nations Member States to eradicate poverty in all its forms, reduce inequalities, and end all types of discrimination and exclusion.

Left behind/pushed behind – individuals who, due to systemic inequalities, face barriers to accessing their rights and choices. Both "left behind" and "pushed behind" are used in this report.

Furthest behind – individuals who are the most excluded from access to their rights and choices. Those furthest behind often face intersecting disadvantages that combine to produce extreme hardship or ostracization. Importantly, this is context-specific; the circumstances that lead individuals to fall behind are determined by larger social, political and cultural factors, which can differ substantially from one place to another.

Equality – the state of being equal, particularly in value, status, rights or treatment under the law.

Equity – fairness; the term "equity" is often used to highlight that an equal distribution of resources or opportunities can still result in unjust or unfair outcomes because of existing privileges and disadvantages.

Inequality – the state of lacking equality, particularly in status, rights or treatment under the law.

Inequity – the state of lacking equity.

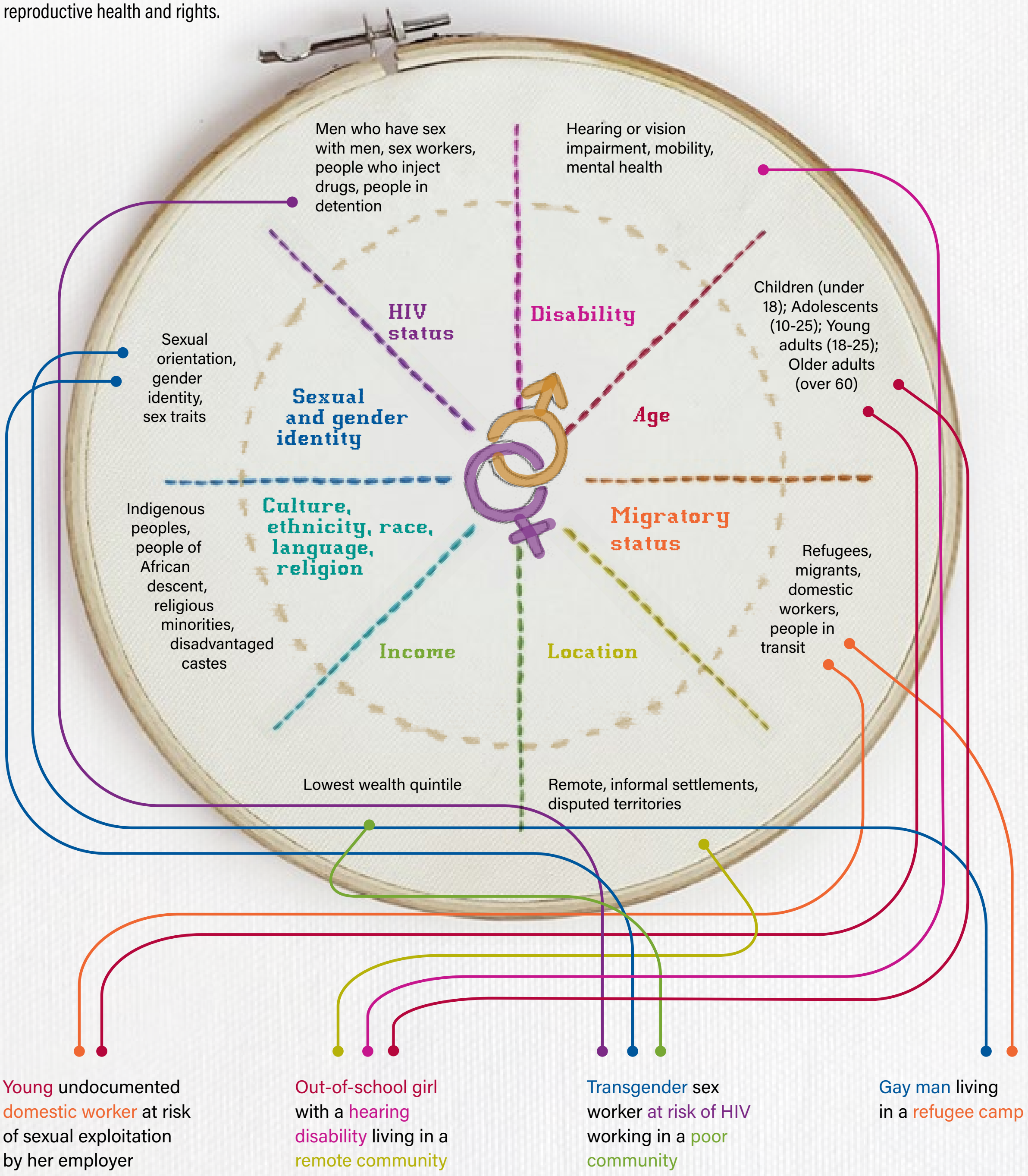
Marginalized – a person or group treated as insignificant, lesser or peripheral by virtue of their identity. A person can be marginalized because of their sexual identity, race, ethnic identity, religious identity, class, caste, level of education or economic status, or disability, among other things.

Vulnerable – susceptible to exploitation, abuse or other forms of harm; this term is widely used but can be problematic if the factors that lead to vulnerability, such as denial of opportunities or barriers to services, are not acknowledged.

FIGURE 1

Factors, in addition to gender, that push people behind

Many factors interact with gender to marginalize people and communities. These include, but are not limited to, ethnicity, race, caste, language, religion, disability status, HIV/AIDS status, migration status, sexual orientation and gender identity. Gender (in the centre of the illustration) and these marginalizing factors (the middle ring) can find many different forms of expression (examples given in the outer ring). In the real world, individuals may experience many overlapping identities and circumstances (bottom of the illustration) that negatively impact their sexual and reproductive health and rights.



Source: Adapted from UNFPA, 2021a.

We know more than ever about the levers of change

If some people are still pushed behind, there is scope – and hope – for rapid progress based on global agreements to achieve equity, notably a core theme of the 2030 Agenda (United Nations System Chief Executives Board for Coordination, 2017). Among the reasons for optimism is research showing that improvements in reproductive and maternal health coverage have advanced faster among the poorest populations in recent years (Ghebreyesus and others, 2020), though progress has been uneven, with well-off groups continuing to maintain substantially higher levels of health coverage (Amouzou and others, 2020).

Also encouraging is the mounting body of knowledge about who remains pushed behind and why, and what to do about it. Poverty is increasingly seen as only one driver of inequalities. Progress also diverges significantly (Ghebreyesus and others, 2020) when considering other factors that create barriers to services, lead to poorer health outcomes or otherwise limit fulfilment of sexual and reproductive health and rights. These factors include gender as well as age; culture, ethnicity, race, language and religion; disability status; HIV/AIDS status; location of residence; migration, asylum and displacement status; and sexual orientation and gender identity. This list is not exhaustive – and even among people who share a disadvantage, complex and diverse circumstances can abrogate their right to sexual and reproductive health in varying ways (UNFPA, 2021a). In all cases, a core human rights principle remains: Wherever and however discrimination, bias, vulnerability and inequality arise, they always warrant corrective action.

Since 1994, major international agreements have clearly defined responsibilities and obligations to close disparities in sexual and reproductive health and rights. They have codified the rights of people with disabilities and of indigenous peoples, adding to existing conventions on women's rights and the elimination of racial discrimination. Forward-looking regional agreements include the Montevideo Consensus on Population and Development, with its commitment to promote and protect sexual and reproductive health and rights as essential to social justice and sustainable development. The groundbreaking Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, better known as the Maputo Protocol, has led to the removal of abortion restrictions in over half a dozen countries, including colonial-era prohibitions linked directly to high levels of maternal mortality (see page 60 on colonial history) (McGovern and others, 2022).

Understanding and agreeing to redress the factors that push people and communities behind can propel new choices – and with the right choices, the race to reach all people can begin, at the pace and scale required. Many levers of change are well known and well demonstrated. These start with redressing the power imbalances embedded in societies, laws, economies and health care, because it will be difficult if not impossible to achieve inclusion in systems that remain intrinsically discriminatory. A deliberate rebalancing of gendered power relations is required on all levels, for instance, from families to parliaments, alongside efforts

Humanitarian crises drive marginalization

Humanitarian emergencies disproportionately affect women and girls, persons with disabilities, indigenous persons, persons with diverse gender identity and sexual orientation, older persons and adolescents. Pre-existing gender inequalities and discrimination against marginalized groups are exacerbated during crises. Gender-based violence also spikes, yet the prevention, mitigation and response to gender-based violence remains one of the most underfunded and least prioritized humanitarian sectors (OCHA, n.d.). Insufficient funding in a crisis increases vulnerabilities for those at risk: Survivors can be left without access to vital care, for instance, and cuts to food aid and other assistance are closely linked with increases in gender-based violence. In Chad, when two new refugee sites could not be established, many displaced women and girls were left living in an overcrowded camp with insufficient protection from violence (OCHA, 2023).

Meagre resources also limit health-care access for people in hard-to-reach areas. In Ethiopia, this meant mobile health teams could reach only 36 per cent of targeted people, with many remote communities going underserved. And in Afghanistan, around 170 static and mobile health facilities had to be discontinued, limiting primary health care for 1 million people, including pregnant women, children and persons with disabilities (OCHA, 2023).

However vulnerability is only half the story. Local women and women-led organizations on the frontline of emergencies are key actors in ensuring the needs of marginalized communities are met. Their full, equal and meaningful participation must be ensured and their leadership strengthened. While these organizations continue to be underfunded and underrepresented, progress is taking place. In 2023, 10 humanitarian country teams had at least one local women-led organization as a member. In Yemen, the humanitarian country team included two local women-led organizations and a local organization for persons with disabilities. Thirteen of 19 advisory boards for country-based pooled funds, which allocate funding to humanitarian actors, had representation of at least one local women-led organization. These are promising steps, but many more are needed.

This text was contributed by the United Nations Office for the Coordination of Humanitarian Affairs.

FEATURE

Women garment workers organize against gender-based violence

"Garment workers can raise their voices against workplace violence without the threat of retribution," says Thivya Rakini.

This represents a sea change for thousands of the garment industry's predominantly young female workforce, explains Ms. Rakini, president of the Tamil Nadu Textile and Common Labour Union (TTCU). With over 2,000 mills employing 280,000 workers, Tamil Nadu is India's largest producer of cotton yarn, supplying both domestic and international markets, including well-known fashion brands. Most of these employees are young women, while management and supervisors are mostly male. This uneven power dynamic is exacerbated by the garment workers' caste and migrant status, and by corporate efforts to avoid accountability for wrongdoing.

Existing unions were reluctant to address issues such as gender-based violence and harassment. "In Tamil Nadu, the garment industry is dominated by male-led trade unions, and the management and senior leadership are also men. Women's issues never really had space," says Nadita Shivakumar, an adviser with the TTCU. "What women workers wanted was for the labour movement to ensure gender-related issues are part of the core agenda; it's not just about wages."

"The workforce is 80 per cent women, 60 per cent of whom are from the Dalit community" – a marginalized caste in India, explains Ms. Rakini. "But the management and line leaders are men of the upper castes. It is not easy for them to listen when a Dalit worker says, 'You are doing this wrong.' That is something they find really hard."

Frustrated, women garment workers made the decision to begin organizing themselves, and the TTCU was born. It is one of the first women-led labour unions in Tamil Nadu, and it is also Dalit-led. Membership grew quickly; it now represents more than 11,000 workers. Trust between its leadership and members enabled the union to act decisively when tragedy struck: In January 2021, Jeyasre Kathiravel, a Dalit woman and member of the TTCU, was murdered by her supervisor at a Dindigul garment mill owned by Eastman Exports, following months of sexual harassment. Her death marked a breaking point; her colleagues wanted not just justice for Kathiravel but systemic change to protect all women garment workers.

"What was different in Jeyasre's case was that this was a village where the TTCU had a very strong union presence," says Ms. Shivakumar. "The women had been in the union for a very long time. Jeyasre's mother was in the union, and Jeyasre was in the union. So because it was such a village and such circumstances, there was strong solidarity and the general tendency to fall back to self-blame was not there[...] It was like whatever happens, we don't care, we're going to fight. It was that 'Me Too' moment, you know, for factory workers."

Their grief and frustration fuelled a global campaign, "Justice for Jeyasre". It culminated in the April 2022 signing of the Dindigul

Agreement to Eliminate Gender-Based Violence and Harassment, a historic deal that enshrines multiple layers of protection in the workplace through a set of supply chain agreements with a system of checks and balances intended to ensure accountability for gender-based violence and harassment at all levels. If management does not adhere to the stipulations of the agreement, brand signatories are legally required to impose business consequences on Eastman Exports to ensure compliance. Signatories include the supplier, the TTCU and the union's allies, including the Asia Floor Wage Alliance and the Global Labor Justice – International Labor Rights Forum. The agreement was also signed by international fashion brands that purchase garments from the factories, including the H&M Group and Gap Inc.

Today, Ms. Shivakumar explains, "There are women leaders in each production line acting as shop floor monitors. They have a lot of power to raise issues and they will not face retaliation."

And the impacts extend beyond the workplace, too. Many garment workers in Tamil Nadu are domestic migrants who stay in factory-arranged hostels and use factory-arranged buses; both were sites of exploitation. "Drivers harass women, saying 'If you give me a sexual favour, even if you come late I'll wait for five minutes,'" says Ms. Shivakumar. Business owners used to shrug off any responsibility. "They used to say, 'These are contracted services. It's not our responsibility.'"

Members of the TTCU celebrate the signing of the Dindigul Agreement. © TTCU

The Dindigul Agreement addresses this. "We've tried to cover not just the workplaces but buses that transport workers and hostels, because a lot of the issues happen on buses… Now we've got monitors on the buses."

One year on, the results of the agreement have exceeded the expectations even of its founders. Ninety-eight per cent of total grievances have been resolved (Asia Floor Wage Alliance and others, 2023), including 100 per cent of complaints related to gender-based violence and harassment. Over 2,000 workers have received training on identifying and preventing abuse, including senior management, support staff and external contractors. The agreement has also had positive results for the manufacturer. In September 2022, the Dindigul garment factory was removed from a list of manufacturers banned by the United States for suspicion of forced labour; the Dindigul Agreement was credited in the decision.

"In one year, we have made the workers understand that we are for them," says Ms. Rakini. "But now the top management also understands that we are not for the workers alone, just protesting against management. We are also for the business."

Now, the TTCU is negotiating for these protections to be expanded to other suppliers – but it is determined that each new agreement must be tailored to the needs of the workers it covers. "Wherever it goes, the agreement should speak to the local issues of women workers. That's the lesson that we learned," says Ms. Shivakumar. "Now what we need is to expand the agreement to more places so that these protections are available in every factory and this becomes the norm. That's what we need to do."

to extend and improve the quality of services and to shift norms and behaviours (George and others, 2020; Herten-Crabb and Davies, 2020). Concepts such as sexual and reproductive justice have been developed to acknowledge and act on the multiple drivers of discrimination and inequity, including through a deliberate call for people themselves to define what equity looks like and requires (McGovern and others, 2022).

Examples of how structural shifts can happen include the decline in child marriage in South Asia, which has emerged through more education for girls as well as changes in economies that opened options for women's employment (Herten-Crabb and Davies, 2020).

A recent pledge to end child marriage by four countries that are home to one fifth of all child brides drew on emerging evidence of an integrated package of solutions that comprise gender-responsive social assistance, inclusive labour-market policies and universal secondary school education, among others (Indira and others, 2023).

Much better data have been collected since the ICPD, helping to steer new programmes and investments. In 1994, we knew little about the scale of maternal mortality, for example; data were often unreliable or uncollected. Today, the figures are largely in place on an aggregate level. Further, population and health

data collected by international institutions and national governments are now commonly disaggregated by sex, income, location and age. Data are increasing rapidly on disability. More now remains to be done to capture a full picture of all forms of marginalization. Data on ethnicity, race, language, religion, indigeneity, migration status and LGBTQIA+ identity remain scarce. More is possible, with the right commitments, including through the continued harnessing of new technologies.

There is a nascent but growing understanding of how health services can help dismantle discrimination and structural barriers for those who have been pushed behind. Midwives have shown promise in both providing services and empowering women in marginalized communities. Growing evidence indicates that sex-positive sexual health interventions can reduce stigma; draw marginalized people to use services, including for sexually transmitted infections and HIV; and increase contraceptive use (Ford and others, 2022; Zaneva and others, 2022; Starrs and others, 2018). Women's self-help groups in poor communities have demonstrated merit in providing both information on health care and microfinance to respond to economic needs, resulting in significant improvements in antenatal care and family planning indicators. A critical component of these groups is that women members determine, on a local level, the terms on which they operate – a lesson that should be applied broadly, ensuring participation in decision-making over one's future is the norm, not the exception.

Population and health data collected by international institutions and national governments are now commonly disaggregated by sex, income, location and age.

Our past, our present, our future

No one wants a world where half of all pregnancies are unintended, where women are battered in their homes or die from preventable causes in childbirth. We all want a future where girls and women know they can complete their schooling, pursue decent jobs, start families if they wish to do so and become part of and contribute meaningfully to a healthy, thriving society. This is people-centred development – robust, just and resilient to crisis.

Original research in this report (page 28) will highlight how barriers to health-care access have fallen more quickly for women who are more socioeconomically privileged and for those belonging to ethnic groups that already had fewer barriers to care. This research also shows that disparities within countries are greater than disparities across countries – implicating every society in the perpetuation of these injustices and calling for redress at levels both low and high.

Chapter 2 of the report highlights why this is so. Despite 30 years of consensus about the emancipatory power of sexual and reproductive health, the systems that deliver this health care remain contaminated by deep legacies of gender inequality, racial discrimination and misinformation. Yet the process of exposing these injustices offers opportunities to develop systems and practices rooted in the common dignity of *all* people.

The third chapter explores the world's data revolution – sparked in some ways by the ICPD itself, which called for disaggregating data to identify where, and for whom, unmet sexual and reproductive health needs are most dire. This directive has gone largely unfulfilled. If the world is to achieve universal sexual and reproductive health and rights, the data element of the ICPD cannot continue to go overlooked.

Chapter 4 highlights the societal, health and productivity gains that still need to be made and the investments that can take gains to scale. The case for contraception is by now incontrovertible. Economists and advocates, and women themselves, have established that human capital development is greatly accelerated when individuals are able to plan their families. But investments in contraception alone are insufficient. This chapter elaborates on the benefits unleashed by reproductive autonomy more broadly.

The final chapter looks ahead, using analyses from a consortium of experts and thought leaders across the fields of demography, climate change, health and technology, to anticipate some of the greatest challenges to both the ICPD agenda and the world more generally. This chapter shows that, even amid the looming storm clouds of populism, disinformation, climate catastrophe and large-scale displacement, universal and inclusive sexual and reproductive health care and rights will remain as crucial, or indeed become more crucial, to securing a sustainable and rights-based future for all.

Each chapter begins with a reflection on the past 30 years of progress, a critical reminder that, despite current and imminent challenges, the broader trajectory is towards the fulfilment of human rights and gender equality. The chapters then aim to establish a basis of shared understanding about the importance of addressing discrimination before pointing to paths forward.

The struggle for health is a struggle for equality and bodily autonomy (Ghebreyesus and others, 2020), for justice and for people-centred development. It should lift people and societies up, not push them behind, through choices that all people deserve to have about their bodies and their lives. To do this, we must grapple with complexity.

We will have to move beyond measuring human experience in broad averages that obscure the experiences of marginalized groups. And we will have to advance beyond a zero-sum accounting, where some people always win and others always lose. We can look to the geometry of weaving as inspiration for an alternative vision of human potential. In weaving – which is inherent to cultures and communities everywhere – the strength of any single thread is vastly multiplied by braiding. Similarly, the education, autonomy, health and potential of every individual is tenuous alone but vastly strengthened when woven together with the rights, health and well-being of others. Indeed, 30 years ago, the ICPD Programme of Action affirmed by consensus that sexual and reproductive health and reproductive rights are enmeshed with, and inseparable from, the broader aims of sustainable development. This is both a new and an ancient way of understanding our world, in which diverse strands come together in a holistic tapestry, in which every life adds to the fabric of our collective humanity, beautifying and fortifying the whole.

The Boruca are an indigenous people living in Costa Rica. They collect seeds, flowers, tree bark, sea snails and other items from the natural world to create the dyes for their fabric, but first ask permission from Mother Nature to ensure that their practices and traditions remain sustainable. © Christian Moon/UNFPA Costa Rica

»»»»» IN FOCUS

Self-reported problems in accessing health care, over time, by socioeconomic status and ethnicity

Recent years have brought a proliferation of ways to track and measure progress towards the global expansion of accessible and affordable health care (WHO and others, 2023). Notably, the reporting for SDG target 3.8.1, coverage of essential health services, gives critical insight into the percentage of individuals receiving essential care, the number of health facilities and personnel per capita, and other internationally comparable measures. Yet, as this report shows, it is also important to let people speak for themselves. The original analysis elaborated here highlights how change in health-care access has been experienced by women from different socioeconomic and ethnic backgrounds, as they themselves report.

In 69 countries around the world, Demographic and Health Surveys have done precisely that. The surveys ask women to report on whether they have serious problems in accessing health care for themselves when they are sick. Among a larger list of various types of problems, there are four specific issues that have been asked across all country contexts, namely, whether women have a serious problem: (1) with the distance to a health facility; (2) with getting money needed for treatment; (3) with not wanting to go alone; or (4) with getting permission to go. In only 25 of the 69 countries – about one third of the total – have the questions been asked in more than one survey while also identifying a woman's ethnicity. This data set offers an opportunity to examine women's self-reported problems accessing health care, looking both across time, by socioeconomic factors (wealth quintile, level of schooling and urban or rural residence) *and* by ethnicity. Together, these 25 countries represent about one third of the global female population, and identify nearly 300 different ethnic groups.

It is worth emphasizing that these self-reported answers to health-access questions are very different from measures of universal health coverage (WHO and others, 2023a), and, importantly, the levels and trends of both can sometimes be in conflict with one another. Demographic and Health Surveys are among a variety of studies and surveys being used to evaluate health access, which can together bring nuance to this important topic.

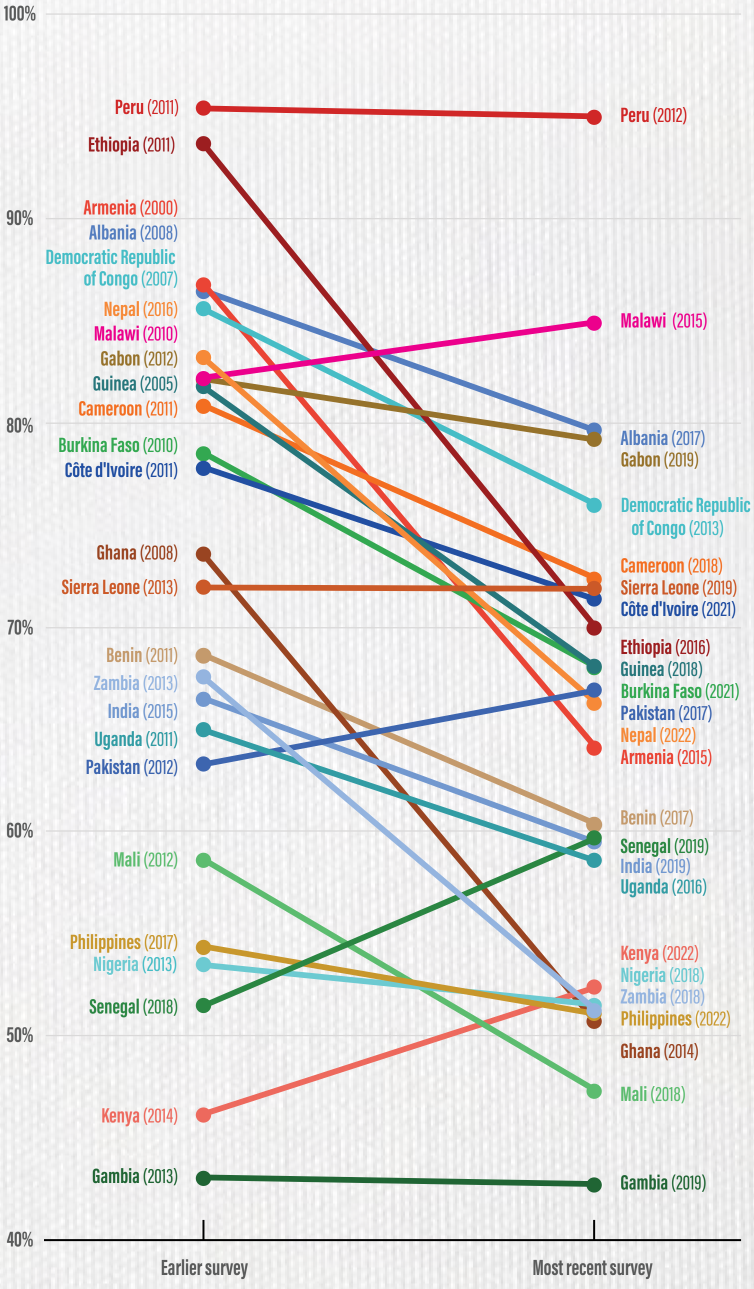
Overall improvement, unequal pace

The findings show a promising overall trend of reduction in problems accessing health care. According to the most recent surveys (which took place between 2012 and 2022, depending on the country), 61 per cent of women reported one or more serious problems in accessing health care for themselves when they were sick – improvement over the first survey period (2000–2018), when 67 per cent of women reported serious problems accessing health care.

Nevertheless, the analysis also finds considerable inequalities across countries. For example, in the most recent survey period, 43 per cent of women in Gambia had serious problems obtaining health care while 95 per cent of women in Peru did. And while most countries have seen women report improved access between the first and second surveys, a handful of countries saw little change (Gabon, Gambia, Malawi, Nigeria, Peru and Sierra Leone) or showed evidence

FIGURE 2

Proportion of women with serious problems in accessing health care for themselves when they are sick, by country



Source: Demographic Health Survey

Note: There is an overall positive trend of reduction in problems accessing health care. (For the case of Malawi, which shows little change over time, the margins of error are large enough to make this uncertain.)

of regression (Kenya, Pakistan and Senegal).

Furthermore, inequalities within countries are often greater than the difference across countries. That is, the differences that appear across socioeconomic groups and ethnicities within the same country usually exceed the gap seen in the averages between countries (i.e., Gambia compared to Peru). For example, in 2017 in Albania, 91 per cent of Roma women with the most marginalized socioeconomic status – urban women with no education and in the poorest wealth quintile – had serious problems in accessing health care while only 5 per cent of ethnic Albanian women from the most privileged socioeconomic status – rural women with higher education and in the richest wealth quintile – had serious problems. Likewise, while 18 per cent of urban Senoufo women with higher education and in the richest wealth quintile had serious problems in accessing health care in Burkina Faso in 2021, 95 per cent of rural Touareg/Bella women with no education and in the poorest wealth quintile did so.

Wealth, education, residence contribute to widening gaps

Women with the *most* marginalized socioeconomic status, who started out in the first survey with a higher prevalence of serious problems accessing health care, saw the least change over time on average. Those with the *least* marginalized socioeconomic status, who reported the lowest prevalence of serious problems with access, generally saw the most improvement over time, a finding highly reminiscent of other health research revealing similar patterns of inverse equity (Victora and others, 2018). These socioeconomic designations – which look at wealth, education and residence – are all country-specific, with some countries seeing more advantage among rural residents and others seeing more advantage among urban residents, for example, (see technical note 154).

On average, the *most* marginalized socioeconomic groups saw a 5 percentage point decline in the proportion of women with serious problems in health-care access between the earlier and later surveys. By contrast, in the *least* socioeconomically marginalized group, the proportion of women with serious problems in health care access declined by 8 percentage points.

Ethnicity plays a persistent role in inequality

Health disparities occur across a broad range of dimensions, including ethnicity. This research looked at how ethnic groups fared over time in access to health care; groups with higher proportions of women experiencing serious problems were considered to be more marginalized, and those with lower proportions facing access problems were considered less marginalized. Ethnicity-based differences persist even after accounting for different levels of education, wealth and urban/rural residence. In plain language, women with the same levels of education, wealth and place of residence, but different ethnicities, often report vastly different realities when it comes to accessing health care. Across all countries, 43 per cent of women from their country's most disadvantaged socioeconomic profile and least marginalized ethnicity faced serious problems accessing health care; for women from their country's most disadvantaged socioeconomic profile and most marginalized ethnicity this percentage was 83 – a 40 percentage point span among women who shared the same socioeconomic challenges and only differed by their ethnicity.

Furthermore, despite most countries seeing overall improvements in access, more than half of countries analysed saw ethnic disparities widen between the two survey periods. In the 14 countries with a widening ethnic gap, the earlier surveys showed a 41 percentage point gap between socioeconomically disadvantaged women from the most versus the least marginalized ethnic groups, while in the more recent surveys, the gap increased to 48 percentage points.

The trends among all the ethnic groups identified across the 25 countries are diverse, but the overarching tendency is clear: Ethnic disparities in self-reported problems accessing health care exist in almost every country and society where data are disaggregated for ethnicity. That is, when we listen to women's own reports about problems accessing health care when they are sick – using surveys representing one third of the female population of the planet – we see that ethnic disparities in health-care access are pervasive and, in a number of cases, widening.

Narrowing the gap is possible

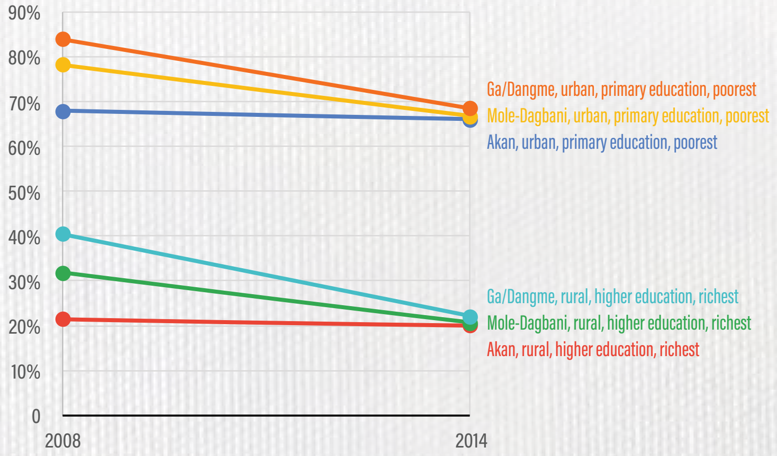
However, there is some good news. Ethnic differences are not extreme everywhere, and there are promising signs that narrowing the gap is possible. In Guinea, the poorest rural Guerzé women with no education saw the highest proportion with health-care access problems of any ethnic group, 96 per cent, in the earlier survey, but by the most recent survey the proportion with serious problems had declined to 72 per cent – better than rural women from all other ethnic groups with similar levels of poverty and schooling. In the earlier Nigerian survey, among the poorest rural women with no education, 87 per cent of Ekoi women reported serious problems in health-care access. By the most recent survey, that proportion had fallen to 64 per cent, nearly the same as poor rural Hausa women, the ethnic group reporting the best access. (Still, these improvements were not shared universally among all ethnic groups within these countries.)

One particular bright spot was Ghana, where there was only a

3 percentage point difference in the proportion of Akan women with the most marginalized socioeconomic profile facing serious problems in accessing health care compared with Ga and Dangme women, whereas in the earlier survey it was a 16 percentage point difference. In fact, inequality across several other ethnic and socioeconomic groups in Ghana also diminished between the earlier and later surveys, a sign of not just improved access to health care but also improved equity.

FIGURE 3

Ghana. Proportion of women with one or more serious problems accessing health care: socioeconomic extremes, by ethnicity



Source: UNFPA

Note: Only two ethnic groups (Ga/Dangme and Mole-Dagbani) were found to experience changes in health-care access different from the largest ethnic group (the Akan). For both of these groups, women reported health-care access improved over time, erasing gaps seen in the earlier survey.

Why was Ghana so successful in closing equity gaps compared to other countries? One possible explanation relates to the expansion of access to health care in Ghana over the period covered by these surveys, including the introduction of a free maternal health-care policy and the continued roll-out of a national health insurance scheme (Aikins and Koram, 2017; Blanchet and others, 2012). Many other countries have also adopted national health insurance schemes, but in Ghana equity seems to have been a deliberate tenet of health-care access efforts – not just in how initiatives were designed but also in the prioritization of evidence-driven evaluation and reform (Phillips and others, 2020). For example, where other countries with national health insurance schemes might rely heavily on private out-of-pocket expenditures, Ghana dramatically increased the portion of health financing from public funds (Odeyemi and Nixon, 2013).

Insisting upon progress for all

Overall, the analysis from these 25 countries offers important lessons to all nations and communities. Namely, global progress in improving access to health care has been uneven and, by many measures, those who are furthest behind remain among the last to be reached.

Additionally, ethnic disparities are not limited to certain countries but rather are identifiable everywhere adequate ethnicity data are collected. Highlighting the existence of ethnic and socioeconomic disparities in health-care access should therefore not be regarded as an accusation of bias or an appeal to politics. Rather, ethnic and socioeconomic disparities are seemingly universal – while progress towards eliminating these disparities is not. But progress *is* possible. And it starts by giving people the opportunity to identify their experience of inequality in the first place.

UNRAVELLING INEQUALITY

The ICPD Programme of Action emerged in the aftermath of the Cold War, a time of upheaval and uncertainty. That year, 1994, saw both the end of apartheid in South Africa, which held its first multiracial democratic election in April, and the eruption of genocide in Rwanda that same month. Sweden legalized civil unions between same-sex partners – making it the third country ever to do so – as the global rate of new HIV infections was reaching its highest-ever peak (UNAIDS, n.d.). The promise of collective action, and the perils of failing to take such action, could not have been more prominent in the minds of ICPD attendees in Cairo.

And indeed a central achievement of the ICPD, the paradigm shift in the world's understanding of population and development issues, did result from the collective efforts of the Member States and grass-roots movements. The Programme of

International women's and feminist movements spearheaded the inclusion of women's rights in global development agendas, starting before the ICPD in 1994 and accelerating progress thereafter. This timeline illustrates how the ICPD **brought together the population and development agenda and feminist movements** to consolidate support for sexual and reproductive health and rights globally.

FIRST WORLD POPULATION CONFERENCE, ROME

This largely academic conference focused on demography in developing countries; conversations at the time were dominated by fears over population growth and resource scarcity.

1954

THIRD WORLD POPULATION CONFERENCE, BUCHAREST

Following a decade of economic growth, population came to be seen as less of a 'problem'. Governments here agreed on the need for a new paradigm around population and development.

1974

Feminist researchers used human rights frameworks to carve a role for themselves.

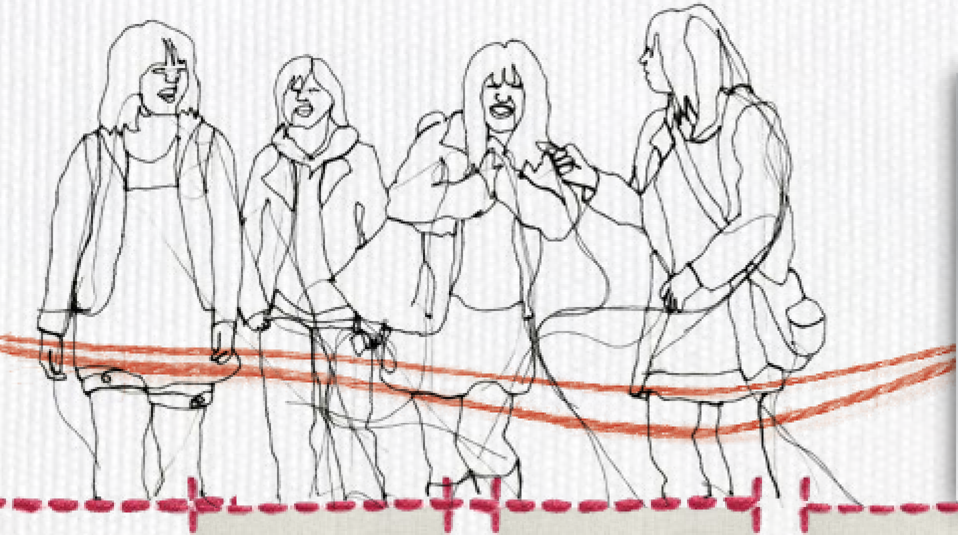
1975

THE UNITED NATIONS DECADE FOR WOMEN BEGINS

International women's movements were growing and mobilizing around social, economic and political issues.

Action introduced the concepts of reproductive health and reproductive rights – both terms already in use by the women's movement and public health advocates – to the broader international community (Berro Pizzarossa, 2018), and situated these within "human rights that are already recognized in national laws, international human rights documents and other consensus documents" (UNFPA, 1994). By invoking the wisdom of grass-roots advocates and drawing on the existing human right to health, the Programme of Action was able to secure, by consensus, recognition that States and health systems are obligated to uphold the sexual and reproductive health and reproductive rights and well-being of all people.

This role for health systems as an enabler of human rights – not only the right to the highest attainable standard of health but a suite of other rights – was



1976

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

(CEDAW) was drafted and approved by the Commission on the Status of Women.

1977

FIRST INTERNATIONAL WOMEN AND HEALTH MEETING (IWHM), ROME

The international women's health movement emerged.

1979

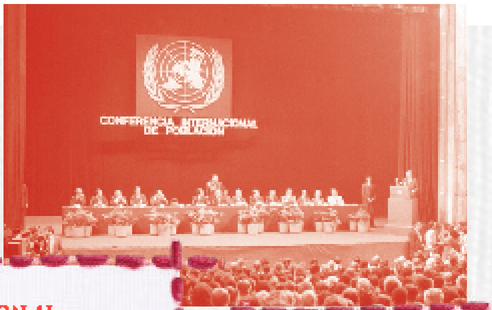
CEDAW ADOPTED BY THE GENERAL ASSEMBLY

1981

THIRD INTERNATIONAL WOMEN AND HEALTH MEETING, GENEVA

Activists from the Global North and Global South united on reproductive rights and access to health care.

by this point well understood, but in the contested arena of sexual and reproductive health this recognition was groundbreaking. The Programme of Action even achieved agreement on the hotly disputed issue of abortion, determining that “in circumstances where abortion is not against the law, such abortion should be safe” and that “in all cases, women should have access to quality services for the management of complications arising from abortion”. The final text showed that a woman’s “health and personal development are crucially dependent on the quality of the services she is offered, and the choices available”, as then-UNFPA Executive Director Nafis Sadik described the following year in Beijing, at the Fourth World Conference on Women, highlighting the role of health systems, doctors, contraception and information in “liberating women from a system of values which insists that reproduction is their only function”.



1984

INTERNATIONAL CONFERENCE ON POPULATION, MEXICO

Here discussions broadened to include both technical and political demands.

FOURTH INTERNATIONAL WOMEN AND HEALTH MEETING, AMSTERDAM

The term ‘reproductive rights’ was officially embraced by the international women’s health movement.

1990

Preparatory committees and the ICPD Secretariat at UNFPA began working towards the 1994 ICPD in Cairo.

Simultaneously, women’s organizations and networks mobilized to influence the existing population agenda.

1992

WOMEN’S DECLARATION ON POPULATION POLICIES

Signed by 2,539 individuals and organizations from over 110 countries, calling for population discussions to reorient around reproductive health and rights.

And in the 30 years since the Cairo conference, health systems, education systems and governments – and the civil society groups that hold them accountable – have delivered. When laws are assessed by whether they sufficiently guarantee full and equal access to sexual and reproductive health care, information and education — including maternity care, abortion, contraception, comprehensive sexuality education, HPV vaccination, and HIV testing, counselling and treatment — 76 per cent of such laws are found to be in place across 115 countries, as measured in SDG indicator 5.6.2 (UNFPA, 2024a). Additionally, since 1994, abortion rights have been recognized for millions of people worldwide, as more than 60 countries have revised their abortion laws to remove restrictions (Center for Reproductive Rights, n.d.), compared to just four that have rolled back the legality of abortion.

INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (ICPD), CAIRO

This was a rare opportunity for political agreement among governments, held at a unique time in global politics: amid the end of the Cold War, on the heels of the Oslo Accords, and as views on population issues shifted at the highest levels. NGO representation was unmatched, with 4,000 representatives from over 1,500 civil society organizations from 113 countries. Representatives of the women's movement were also part of national delegations, advocating for their realities and rights to be included in the ICPD Programme of Action.

1994

PREPARATORY CONFERENCE, RIO DE JANEIRO

Hundreds of women released a statement outlining principles and conditions needed to ensure a woman-centred, rights-focused approach to population.

1995

FOURTH WORLD CONFERENCE ON WOMEN, BEIJING

This culminated in the Beijing Declaration and Platform for Action and is recognized alongside the 1994 Cairo conference as a seminal moment in the international women's movement.

1999

ICPD+5

Youth movements were engaged to help advance the ICPD agenda among a new generation.

The ICPD also called for youth to have access to, and participate in the development of, "information, education and communication activities and services concerning reproductive and sexual health" – acknowledgement that this information would help to empower current and future generations to fulfil their potential. Since then, international standards have been developed and today two thirds of reporting countries state 76 per cent or more of their schools provide some form of sexuality education (UNESCO and others, 2021). Assisted reproductive technologies have become almost ubiquitous, enabling more people to realize their fertility aspirations and expanding opportunities for more diverse families.

But much more remains to be done.

Bodily autonomy is a reality for too few women globally. Today, just over half

2000

The Millennium Declaration was adopted by the United Nations General Assembly, followed by the Millennium Development Goals. But civil society called for amendments: The initial goal on improving maternal health, for example, did not contain any targets on reproductive health.

2005

MDGS + 5

Advocates succeeded in having universal access to reproductive health included in the Millennium Development Goals.

2014

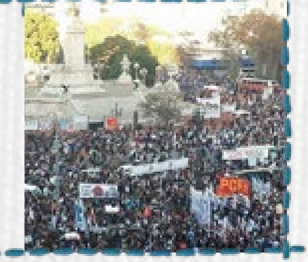
ICPD+20

Once more, experts, feminists, youth, NGOs and governments mobilized around the ICPD agenda, resulting in a bold Framework of Actions for the Follow-up to the ICPD Programme of Action Beyond 2014. The ICPD was also re-endorsed at the United Nations General Assembly Special Session on the ICPD.

2015

The 2030 Agenda for Sustainable Development was adopted, leading to the Sustainable Development Goals. Thanks to advocacy, Goal 3 on health and Goal 5 on gender equality both included targets on sexual and reproductive health and rights.

The #NiUnaMenos movement calling for an end to femicide emerged in Argentina, uniting women's groups across Latin America and ultimately leading to the Green Wave.



(56 per cent) of the world's women were able to make their own informed decisions about sex and reproduction. This means the freedom to make choices about health care and the use of contraceptives as well as to say no to sex with a husband or partner, information collected in countries' reporting for SDG indicator 5.6.1 (UNFPA, 2024a). And while data are limited (explored further in Chapter 3), a growing body of evidence indicates that bodily autonomy and reproductive health are more frequently, and more severely, undermined among those facing one or more forms of oppression, such as those enduring ethnic or racial discrimination, persecution over HIV status or disability, or discrimination over their sexual orientation or gender identity. There is increasing recognition that the capacity to determine one's reproductive future – including access to modern contraception, safe abortion where legal, prenatal medical care and childcare – is unequally distributed across race, sexual

2017

The SheDecides movement was launched in support of reproductive health and rights. The #MeToo movement also erupted, reviving a 2006 campaign, in response to millions of women decrying sexual abuse and harassment.

2019

NAIROBI SUMMIT ON ICPD25

Civil society, youth leaders and government representatives turned out in force for sexual and reproductive health and rights. The Summit resulted in nearly 1,300 commitments and the forward-looking Nairobi Statement.

2021

GENERATION EQUALITY

Due to the global COVID-19 pandemic, the review took place a year late. The Generation Equality Forums saw an emboldened international women's movement and reignited support from governments and partners; this included an action coalition dedicated to bodily autonomy and sexual and reproductive health and rights.

2024

ICPD30

The thirtieth anniversary of the groundbreaking Cairo conference. Feminist and reproductive rights movements have grown in numbers and in strength and many gains have been made – but our work is far from over. New organizations and members have mobilized, including on intersectional issues such as caste, disability, indigeneity, sexual orientation and gender identity. These are creating space for multiple voices and stakeholders, and social media is drawing more people, and perspectives, to the cause.

The strength of the international women's movement lies in our ability to imagine and re-imagine, to build and rebuild, to preserve and persevere, to bring in new generations, new constituencies, new ways of thinking and organizing. Until the battle to emancipate our bodies, our voices, and ourselves is won, we will persist.

This text was contributed by the Asian-Pacific Resource & Research Centre for Women (ARROW).

orientation, gender identity, sex characteristics, class and socioeconomic status.

In fact, the world is only just beginning to grapple with the legacy of multiple forms of discrimination in medicine and health systems. As this legacy is unearthed, questions are being asked about the people who have been marginalized, the mechanisms of that marginalization and the persistence of its consequences. Experts are drawing attention to the structures that perpetuate discrimination, sometimes invisibly – a contrast to earlier efforts that tended to focus on individual behaviours (OHCHR, 2021). As a result, discrimination is increasingly being identified through unequal outcomes rather than requiring proof that these outcomes were motivated by individual animus.

The human right to sexual and reproductive health

Sexual and reproductive health and rights are now widely understood, and acknowledged in a number of human rights frameworks (Organization of African Unity, 1981; OHCHR, 1966), to be grounded in the right to life, to dignity, to education and information, to equality before the law and to non-discrimination; the right to decide on the number and spacing of children; the right to privacy; the right to health; the right to freedom of opinion and expression; the right to consent to marriage and to equality in marriage; and the right to be free from gender-based violence, harmful practices, torture and ill treatment, as well as the right to an effective remedy for violations of fundamental rights.

It is also well accepted (OHCHR, 2019; UNFPA, 2019; Shalev, 1998) that the key principles that shape human rights – especially non-discrimination, equality and privacy, the right to information, as well as the integrity, autonomy, dignity and well-being of individuals, particularly in relation to sexual and reproductive health and rights – are integral to the realization of the right to health.

This reckoning has been most prominent in justice systems. The Ni Una Menos movement in Latin America, for example, highlighted the passivity of authorities in cases of femicide and other forms of gender-based violence. The Black Lives Matter movement brought attention to the disproportionate experience of police violence among Black people globally (OHCHR, 2023). Other sectors have been affected as well: Within education, the Rhodes Must Fall protest movement drew attention to inequities in higher education, first in South Africa and then internationally (Knudsen and Andersen, 2019).

This kind of reckoning is just as relevant for health systems, a fact deeply underscored during the COVID-19 pandemic. In many parts of the world, pandemic emergency measures were not in conformity with human rights law (OHCHR, 2020). Already marginalized populations experienced higher rates of COVID-19 pandemic-related illness and death and greater disruptions of other health services, including for sexual and reproductive health (WHO, 2020). Contemporary discourse around gender, social and racial justice movements might suggest these issues are controversial or political, but it is a mistake to see this process only through the lens of politics. We can recognize that the history of reproductive health includes regrettable tragedies and missteps without diminishing the many advances that have been made in science and technology. Rather, it allows us to learn from the past, creating opportunities for knowledge and progress – for all people.

Health systems must be enablers of human rights

Reproductive health systems have not always been health- and rights-affirming. At least not for all women. "A major shortcoming in reproductive health care within the health-care system was the philosophy with which services were provided," experts have commented. "Women were considered as means in the process of reproduction, and as targets in the process of fertility control. Services were not provided to women as ends in themselves. Women benefited from the process, but were not at its centre. They were objects, and not subjects" (Cook and others, 2003).

Systems and structures to control sexuality, especially (but not exclusively) the sexuality of women, have been universal, permeating all societies around the globe. The bodies of women, girls and gender-diverse people were often subject to discrimination, harmful practices, control, exploitation, violence and oppression – human rights violations that historically have been abetted by health systems (OHCHR, 2021a). And these issues are all too persistent today. Many obstacles continue to stand between individuals and their enjoyment of sexual and reproductive health and rights, operating at different levels: in clinical care, at the level of health systems and in the context of the underlying determinants of health. And they operate differently for those experiencing different forms of marginalization.

Health workers are, today, among those best placed to identify the transformative value of sexual and reproductive health and rights, as they see first-hand how family planning, protection from violence, safety from disease and access to maternal health care result in healthier and better-educated families and communities. Many contemporary reproductive health workers embrace their role in upholding the rights of their patients (and the topic of patients' rights is, in fact, a staple in the education of health professionals globally [Rostami-Moez and others, 2021; Karakuş and others, 2015; Lewkonia, 2011]). Through the provision of contraception, information and care, reproductive health practitioners often stand on the front lines of individuals' efforts to secure bodily autonomy (see feature on page 16) (Kalra and others, 2021). Yet they can be subjected to abuse for doing so. New research shows that, "as [sexual and reproductive health and rights] workers seek to fulfil the human rights of others, their own human rights are put at risk", as they face "ostracization and harassment in the workplace", "verbal threats and physical violence" and hostilities in their personal lives (Boydell and others, 2023).

The following sections illustrate how sex discrimination, racial and ethnic discrimination, and misinformation continue to impact health services and information today, making the case that both human rights and public health require reconciliation with this history. In order for health workers to become enablers of human rights, the health systems that employ them – which have historically been so complicit in exploitation and abuse, and which today leave many sexual and reproductive health workers

Health workers as champions of bodily autonomy

A reciprocal relationship exists between the receipt of dignified, quality sexual and reproductive health care and the experience of economic, social and personal empowerment. Health workers, in particular, observe directly how reproductive autonomy – the ability to choose whether, when and with whom to have sex or become pregnant, the ability to live free of violence and preventable sexually transmitted infections, etc. – enables individuals to pursue their education, delay or start their family, build their career and/or contribute to their community. And they see first-hand how empowered individuals – those able to pursue education, careers and/or families – are better able to access reproductive health services. The virtuous cycle is an uncontested truth for those who witness it. "We teach them to expect respect," says Víctor Cazorla, a male midwife working in the Andes mountains of Peru, who sensitizes his mostly indigenous patients about their rights (UNFPA, 2021). "Nobody has a right to touch their bodies: not me, not their aunts, not their fathers, not their mothers, not staff, not police, nobody."

vulnerable to mistreatment – can and should be reformed to realize their original and more noble purpose, for individuals, health professionals and society as a whole: healing.

The legacy of sex discrimination in reproductive health care

Understanding the legacy of sexism within sexual and reproductive health care can actually help to identify solutions – including cost-effective and readily achievable solutions – to persistent problems.

One important example is the history of childbirth care, which, for centuries, was largely considered the domain of women. Women midwives managed childbirth while physicians, a profession restricted to men, generally avoided it. Childbirth was long considered a female mystery, and women alone had special knowledge and understanding of it, including the use of herbs as drugs. Over time, male doctors did begin to assist birthing women, initially only in complicated and high-risk deliveries (Litoff, 1982).

Eventually, doctors and other male-dominated institutions assumed authority over midwives. In precolonial Indonesia, for example, women relied on traditional midwives, or birth attendants, known as *dukun,* who provided contraception, delivery care and abortion. When Indonesia became a colony in the 1800s, authorities sought to replace *dukun* with midwives trained under the male leadership of the Dutch medical service (Adnani and others, 2023). Around the same time, male physicians in India proposed the provision of formal training to traditional midwives known as *dai*, efforts that ultimately led to *dai* being replaced by trained midwives and doctors working under the medical establishment (Samanta, 2016).

Midwives were also brought under the jurisdiction of male leaders in Europe in the 16th and 17th Centuries, when they were licensed by male-dominated church authorities and, in some cases, compelled to serve as expert witnesses in cases of “infanticide, contested virginity, abortion and sterility” (Sprecher and Karras, 2011). It was during this period that “accoucheurs” (male midwives) became fashionable in France, creating competition with the so-called “natural practising” female midwives and popularizing the use of instruments such as forceps. The gender and status of men established their authority in the field despite having little or no practical experience (Martucci, 2017). At the time, men training to be doctors were largely influenced by writings about birth, written by practitioners who may never have seen labour or birth (Hobby, 1999), rather than practical knowledge (Thomas, 2016).

The emerging “science of nature” gave rise to a view of medicine as being objective, part of a universal system of knowledge, one from which female midwives were largely excluded (Shiva, 1996). Unlike male doctors, they were neither educated nor involved in the investigative and experimental scientific methods. By the 18th Century, the medical profession mostly consisted of men, and midwives were accused of using ancient, dangerous and outdated practices. Research on colonial-era South Africa, for example, shows that the real-world experience and knowledge of midwives – especially Black midwives – was largely omitted from the historical record (Deacon, 1998). Men's contributions to the field, by contrast, were better documented, enabling male-dominated views of childbirth to prevail. New birthing theories likened the body to a machine and childbirth to a mechanical process, a view that further alienated midwives as practitioners, since women were seen as lacking the knowledge and ability to understand the mechanisms of birth (Murphy-Lawless, 1998). Birthing bodies were increasingly viewed as uncontrollable, uncontained, unbounded, unruly, leaky and wayward (Carter, 2010). In 1915, Dr. Joseph DeLee, author of the most important obstetric textbook of that period, described childbirth as a pathological process that damaged both mothers and babies. "If the profession (obstetrics) would realize that parturition viewed with modern eyes is no longer a normal function… the midwife would be impossible even of mention," he wrote (DeLee, 1915). Dr. DeLee would later propose interventions, including routine use of sedatives, ether, episiotomies and forceps – all of which are now known to be harmful when used routinely – to save women from the "evils" natural to labour (Leavitt, 1988).

The sidelining of midwives within obstetric medicine was a global phenomenon, but today the consequences are most severe in low- and middle-income countries. WHO has identified Africa and South-east Asia as the regions with proportionally fewest countries recognizing midwifery as a distinct profession. Midwifery educators in these regions persistently report lacking access to toilet facilities, and in French-speaking West Africa, three quarters of midwifery educators lack access to clean water at least some of the time. Furthermore, WHO's Africa region accounts for 56 per cent of the global shortage in health professionals dedicated to providing sexual, reproductive, maternal, newborn and adolescent health care (UNFPA and others, 2021).

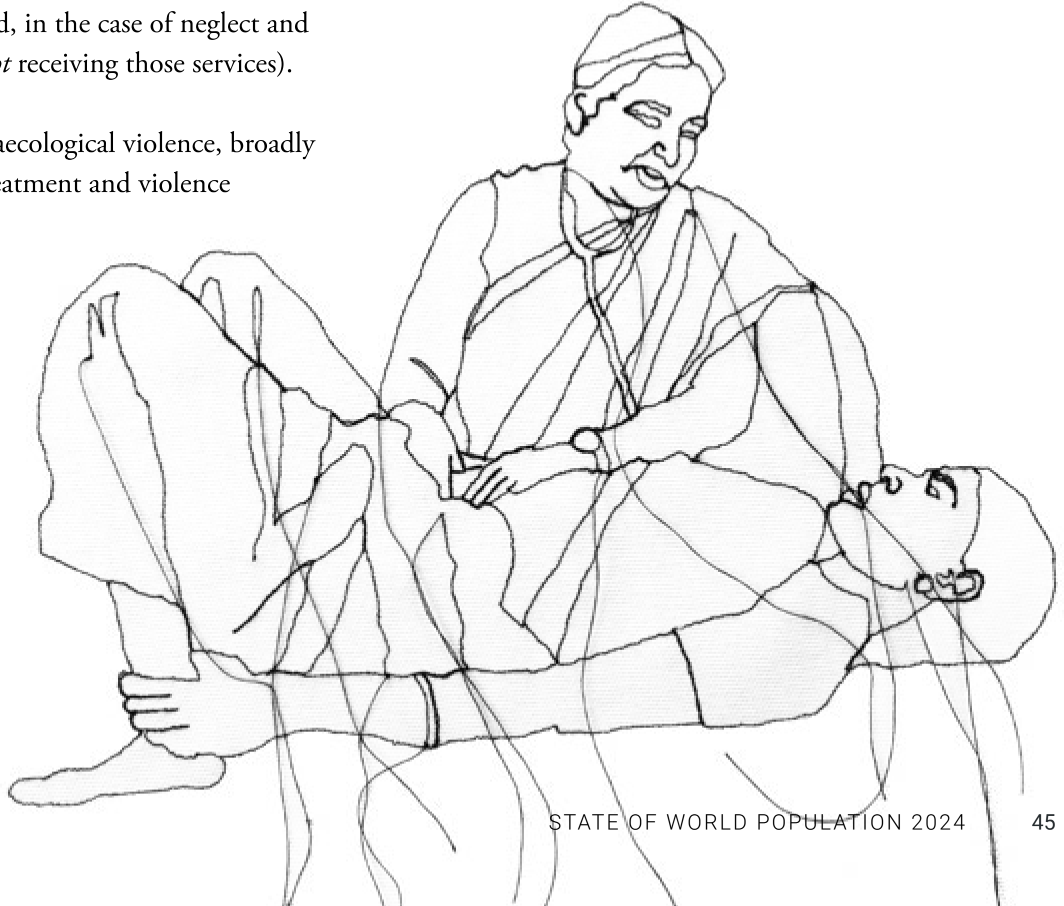
And although midwifery today is widely understood to be a modern, regulated, technical profession well integrated into the health-care infrastructure, it remains predominantly female in most places. Research shows the midwifery workforce suffers under serious occupational segregation, gender pay gaps, lack of leadership opportunities and multiple forms of discrimination and harassment, including sexual harassment (UNFPA and others, 2021). A 2019 WHO report found the gender pay gap in health care was larger than that in other sectors, with female health workers earning, on average, 28 per cent less than male health workers – and an 11 per cent gender pay gap persisted among nurses and midwives even after adjusting for occupational segregation (Boniol and others, 2019).

The undervaluing of midwifery "results in restriction of choices and job opportunities for midwives and reinforces unequal power structures within society", including a lack of professional autonomy (UNFPA and others, 2021), which midwives themselves identify as a barrier to providing high-quality care (International Confederation of Midwives and others, 2016). The 2021 State of the World's Midwifery report noted that, in low- and middle-income countries, many midwives struggle or fail to be reimbursed by government insurance programmes, leaving them to absorb financial losses or prioritize care for more affluent patients.

Yet researchers have long noted that investments in midwifery training and care would yield significant dividends for maternal and neonatal health, with lower costs and better outcomes than more medicalized models of care (UNFPA and others, 2021). A 2021 *Lancet Global Health* study, supported by UNFPA, found that substantially increasing coverage of midwife-delivered interventions could avert 41 per cent of maternal deaths, 39 per cent of neonatal deaths and 26 per cent of stillbirths – equalling 2.2 million deaths averted annually by 2035, and most of them in low- and middle-income countries (Nove and others, 2021).

In view of the historical marginalization of women within obstetrics and midwifery, it is worth examining the role of gender discrimination in the world's continued underinvestment in midwifery. It is also worth examining the consequences of these gendered hierarchies in medicine, which affect not only health practitioners but also the people receiving health services (and, in the case of neglect and exclusion, those *not* receiving those services).

Obstetric and gynaecological violence, broadly described as mistreatment and violence experienced during reproductive health care, including during childbirth, is a matter of growing concern to the international community (OHCHR, 2019a). The concept is expansive, including verbal and physical abuse – examples are mockery, threats, punching, kicking, gagging and physical restraint (Downe and others, 2023) – as well as over-intervention such as medically unnecessary episiotomy, lack of informed consent, denial of pain relief (UNFPA, 2019a) and forced sterilization. Research highlights that these forms of mistreatment tend to occur in "contexts where providers, primarily midwives, feel unsupported or even victimized within their professional hierarchies" (Schaaf and others, 2023). Mistreatment in reproductive health settings contributes significantly to maternal mortality and creates barriers to health services for marginalized women and girls (UNFPA and others, 2023).



FEATURE

Safe, culturally sensitive, empowering childbirth for Colombia's Afrodescendent women

More than two decades ago, 18-year-old Shirley Maturana Obregón visited a hospital in Chocó, in Colombia's Pacific region, seeking care for a case of gastritis. Despite the fact that she was nine months pregnant at the time, Ms. Maturana Obregón never considered staying on and giving birth there.

"It wasn't the environment I wanted," Ms. Maturana Obregón tells UNFPA. "I wanted my mum to be there, and what I heard [at the hospital] was that I was going to be alone."

So she returned home and soon went into labour. Her mother and sisters were there to support her throughout the delivery – as was a *partera*, a traditional birth attendant and practitioner of knowledge ancestral to Colombia's Afrodescendent community. "It was beautiful and unforgettable," she says.

For Ms. Maturana Obregón, the decision to give birth with a *partera* reflected her personal and cultural priorities. But home births also often reflect a lack of other options. Chocó's population – of which 80 per cent identifies as Afrodescendent – is disproportionately poor and remains largely disconnected from Colombia's formal health-care system. Getting to a doctor can require travel across hazardous, conflict-affected terrain, or can simply cost too much.

The consequences of not delivering safely can be deadly, particularly for Afrodescendent women and girls. In Colombia, they are at more than double the risk of dying due to pregnancy and childbirth than their non-Afrodescendent counterparts. Yet in seeking to improve maternal health outcomes, the Colombian health system has sometimes alienated *parteras* and the cultural values they represent.

Parteras have been derided as witches and herbalists, or portrayed as unhygienic and unprofessional. Historically, Colombian laws required anyone attending childbirth to be officially licensed by a medical institution, rules that led to the erasure of the work *parteras* do, isolating them from the medical establishment. Yet along Colombia's Pacific coast, *parteras* are often the only health provider on hand. In one town in Chocó in 2021, national statistics show every birth was supported by a traditional birth attendant (DANE and UNFPA, 2023).

"Doctors treat us like everything [we do] is filthy," says *partera* Francisca Córdoba, better known as Pacha Pasmo. "As I have told several doctors, you may have five years of experience, but you do not have the experience I have – I started attending births before you were born."

But a new initiative is knitting health workers and *parteras* more closely together. In 2020, the Partera Vital project was launched, aiming to validate *parteras'* often invisible work in providing culturally affirming care to pregnant and post-partum women, while also providing *parteras* with tools and skills to deliver their services safely to their communities and in conjunction with the formal medical system.

UNFPA's Partera Vital project seeks to empower traditional birth attendants like Shirley Maturana Obregón (left) and Pacha Pasmo (right) to support pregnant women across Chocó, Colombia. © UNFPA Colombia/Sara Chavarriaga

Through Partera Vital, Colombia's national statistics agency worked together with UNFPA and local *parteras* associations to amend rules barring traditional birth attendants from registering newborns. *Parteras* received a mobile app allowing them to register births in the national birth registry; they also came together for training sessions aimed at improving risk identification during pregnancy and childbirth.

The project was first rolled out to 30 traditional birth attendants in Chocó. The *parteras* also received scales for weighing newborns, safe delivery kits containing items like clean sheets and gloves, and blood pressure monitors, which can help them identify life-threatening pregnancy complications. "If a *partera* sees that a pregnant woman's blood pressure is high, they run to refer her," Ms. Pacha says.

The project's impact was immediately clear during the COVID-19 pandemic in 2020, when statistics showed 34 per cent of births in Chocó were supported by *parteras* – nearly 50 per cent more than had been recorded in the previous year. *Parteras* petitioned the Government to be recognized as essential workers amid the crisis, a change that led to *parteras* receiving resources and equipment to care for their communities. Most recently, UNESCO, the United Nations Educational, Scientific and Cultural Organization, designated midwifery in Colombia and other countries an integral part of humanity's intangible cultural heritage.

Partera Vital's introduction to Chocó has also corresponded with a major health advancement in the region: reduced maternal deaths. "We don't know yet to what extent the empowerment of *parteras* has contributed to the national efforts to reduce maternal mortality in Chocó, but in 2023, maternal deaths dropped by nearly 40 per cent," says UNFPA Colombia sexual and reproductive health adviser Jose Luis Wilches Gutiérrez.

Since delivering with a *partera*, Ms. Maturana Obregón has become one. "The people we serve – they want to experience having their children with a *partera*, because the *partera* puts her in the position she wants to give birth in," she says. "We are there, making those women's dreams come true."

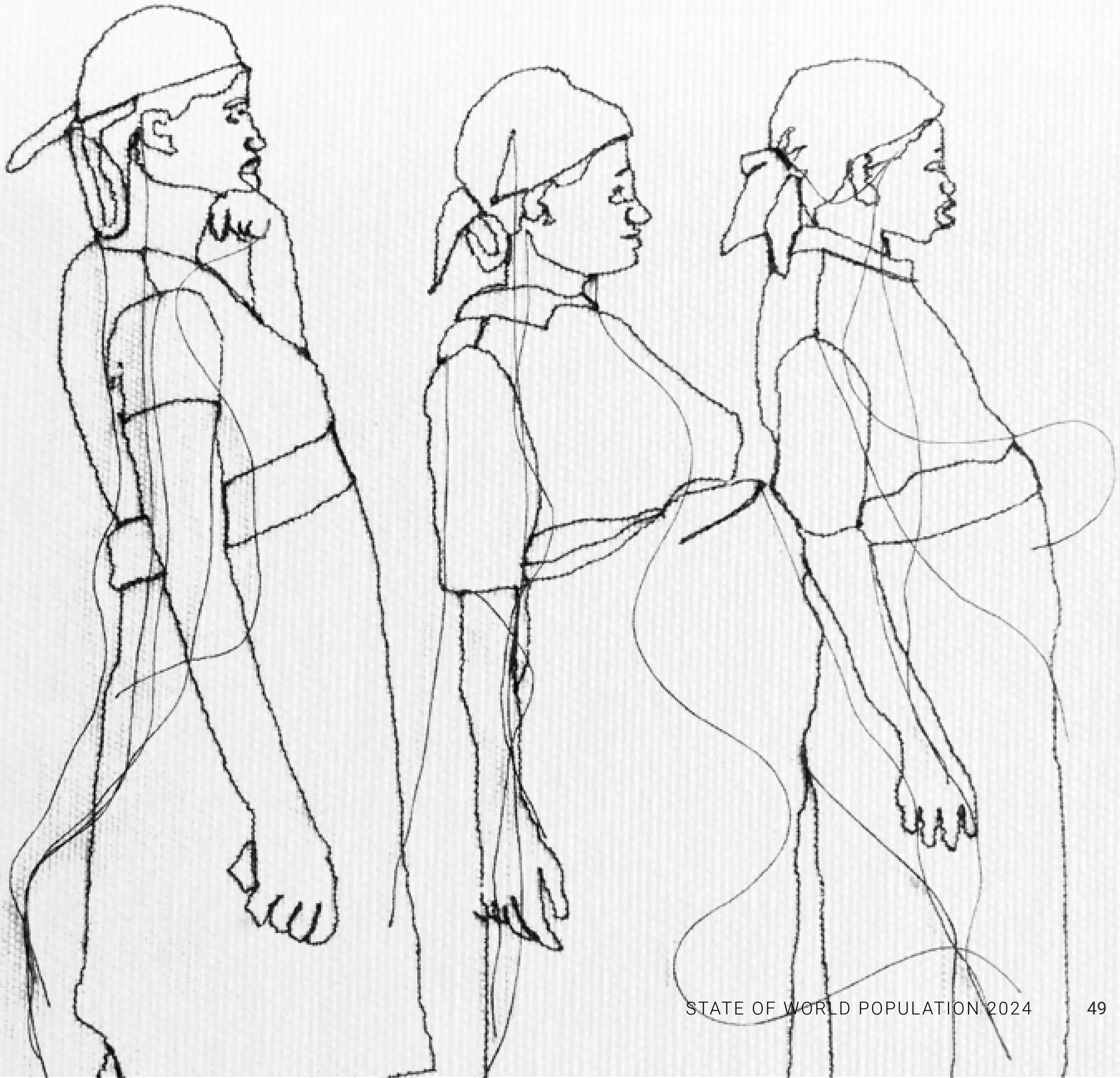
The legacy of ethnic and racial discrimination

One of the consequences of the COVID-19 pandemic has been a renewed awareness of the racial disparities that continue to persist within health systems, and a growing effort to understand these disparities within the context of historical inequities. While many conversations around racial inequity have been contentious, the advancement of equity and justice in health are in many cases yielding valuable and evidence-based solutions to these issues. In short, understanding the legacy of racial discrimination, and also the role of colonialism in exporting racial hierarchies, is revealing the many possibilities that exist for achieving equity and justice within medicine.

Historically, many governments have seen reproduction primarily in instrumental terms. Childbearing has been promoted when it is deemed valuable for economic or political objectives (Juan Bautista Alberdi of Argentina famously said, "To govern is to populate"), and it has been discouraged (often selectively, among groups considered "inferior") when deemed undesirable. During colonial regimes, and especially in the transatlantic slave trade, childbirth was seen both figuratively and literally as a form of asset production (UNFPA, 2023b). In Africa and the Caribbean in the early 20th Century, maternal health programmes were driven largely by a perceived shortage of labour needed to work on plantations and in export industries (De Barros, 2014; Thomas, 2003). Perspective shifted to promoting family planning in the mid-20th Century, as smaller families were seen as more conducive to national economic development and global security, and also as leaders and international organizations reacted to fears of an impending "population bomb" exploding in developing countries (UNFPA, 2023b; Bourbonnais, 2016; Solinger and Nakachi, 2016; Ahluwalia, 2008; Connelly, 2008; Klausen, 2004; Briggs, 2003; Hartmann, 1995). Notably, instrumentalist rhetoric around childbearing persists today, both in fears of "overpopulation" in a context of climate change, which can attribute environmental destruction to fertility rates among people in the Global South, and in fears of "underpopulation" when it comes to ageing societies (UNFPA, 2023b).

For these reasons, the field of reproductive health bears particularly deep scars from the world's racialized colonial history. Slavery institutionalized Black women's loss of bodily and reproductive autonomy and incentivized control over enslaved people's ability to reproduce (Johnson and others, 1999). For many Black women, reproduction was an area of control and exploitation, including rape, forced sterilization, medical experimentation and non-consented medical research and training. One of the most well-known examples is the case of J. Marion Sims, a gynaecologist who performed experimental surgeries on enslaved Black women without anaesthesia or their informed consent (Owens, 2017) – but in fact this was far from an isolated incident. Slave hospitals of the era primarily facilitated the production of biomedical knowledge about Blackness and normalized the idea that Black bodies were physiologically distinct, inferior and impervious to pain (Hogarth, 2017).

In this way, advances in obstetric and gynaecological medicine have contained an inherent contradiction for some of the most marginalized women and girls – these fields of medicine are comprised, on the one hand, of knowledge and technologies that can save lives and alleviate suffering, while on the other hand emerging from, and even perpetuating, significant harms. This duality played out, as well, in the advent of modern contraception, which was revolutionary for women's bodily and reproductive autonomy yet was also promoted as a tool for the application of eugenics theories. Modern fertility control was widely seen, including by its earliest proponents, as a means with which to curb the reproduction of "undesired" populations, particularly poor women, women with disabilities, Black women, women of marginalized ethnicities in the Global South, and indigenous people in the Global North (Ross and Solinger, 2017; Ginsburg and Rapp, 1995). The use of contraception as a tool



for reproductive control persisted for decades. In apartheid-era South Africa, for example, Black women were often subject to aggressive contraception programmes, which were carried out under the guise of population control (Klugman, 1993).

Black women living under South Africa's apartheid regime were also more likely to experience obstetric violence and mistreatment in the health-care system. Non-consented care and obstetric violence were particularly noted in public hospitals serving predominantly low-income communities, where multiple marginalizing factors – gender, poverty, race – coalesced. These populations endured lack of informed consent, lack of awareness of patients' rights, and lack of training for health-care providers on how to obtain informed consent and provide respectful care (Jewkes and others, 2015).

Subpar treatment of Black people and other disadvantaged persons within the medical field continues to this day (UNFPA and others, 2023). For example, international human rights bodies have repeatedly expressed concern about the persistent discrimination and human rights violations facing Roma women, particularly in reproductive health care (Committee on the Elimination of Racial Discrimination, 2017; Human Rights Committee, 2016; Committee on the Elimination of Discrimination against Women, 2015). A 2020 report by the European Roma Rights Centre on reproductive rights of Roma women found that numerous interviewees had been immobilized during childbirth, subjected to physical abuse and denied anaesthesia (ERRC, 2020). This legacy also persists in ongoing health disparities among Black and ethnic minority women in the United Kingdom (MBRRACE-UK, 2020) and United States (Hoyert, 2023), and among migrants and members of certain castes in India (Allard and others, 2022) and other South Asian countries (Kapilashrami and John, 2023).

But a positive development can be found in the increased attention, and growing body of evidence, on discrimination and harm in sexual and reproductive health settings (Downe and others, 2023). These findings note that discrimination is linked to the normalization of harm, and that it is often invisible to health practitioners, health systems and even patients themselves. "Where violence is an everyday, and even trivial, 'fact of life'... it becomes expected, invisible, and, therefore, structurally embedded," researchers note. Furthermore, efforts to reduce or eliminate violence are ineffective when discrimination and stigma are not addressed (Bohren and others, 2022), an observation that can also be seen as a call to action to root out bias in health-care spaces.

These findings can, and should, be applied in health systems writ large, where inequities in care are racialized or can be attributed to ethnicity, cultural differences, migration status or forms of marginalization. To address disrespectful and abusive treatment of women during childbirth, for instance, WHO has called for action – including research, human rights alignment and greater participation by women from affected communities – to be taken by governments, health-care providers, professional associations and educational institutions (WHO, 2015).

Forced sterilization – an ongoing violation

While quality sexual and reproductive health care contributes to – and is supported by – individual empowerment, the reverse is also true. Substandard or poorly tailored sexual and reproductive health care, denial of services and violations of reproductive rights can result in a cascade of harms across one's life, and disadvantages reciprocally contribute to vulnerability to substandard care, denial of care and rights violations. Perhaps nowhere is this more pronounced than in the case of coerced sterilization, one of the most extreme forms of control over a person's reproductive autonomy. By permanently denying women the right to have children, non-consensual sterilization enforces society's view that certain women do not deserve to be mothers. Black women, indigenous women, women from religious minorities, women living with a disability, institutionalized women, migrant women and impoverished women in rural settings have all been subjected to sterilization abuse (Roberts, 1991), both historically and today. In 2015, for example, a complaint was lodged with the Commission for Gender Equality on behalf of 48 South African women who had experienced forced or coerced sterilization in public hospitals. All were pregnant Black women, and most were HIV-positive. They described being coerced or forced to sign consent forms that allegedly permitted sterilization while they were in extreme pain or active labour. The Commission found that the complainants' rights to equality, freedom from discrimination, dignity, bodily integrity, freedom and security over their bodies, and the highest attainable standards of health, including sexual and reproductive health and rights, had been violated (Commission for Gender Equality, 2020). In another example, a 2022 report to the Human Rights Council highlighted that forced sterilization is a common practice around the globe (United Nations General Assembly, 2022).

Grass-roots activists raise visibility for missing and murdered indigenous women

Although Carolyn DeFord's mother disappeared in 1999, it wasn't until 2011 that she finally learned the term to describe the complicated grief she had felt since that day: ambiguous loss.

"You're stuck, and you can't move on, and there's the constant wonder," says Ms. DeFord, who is a member of the Puyallup Tribe in Washington State and board member of Missing and Murdered Indigenous Women USA (MMIWUSA). "I've imagined everything that could have happened to my mum, in every way, over and over again."

This lack of closure is experienced by thousands of indigenous people across the United States whose relatives are reported missing every year. The murder rate for Native American women living on reservations can be up to 10 times the national average (Urban Indian Health Institute, 2018), making murder the third leading cause of death for Native women. Though the statistics are stark, there are huge gaps in data, meaning that the numbers affected are likely underestimated. In 2016, the National Crime Information Center reported 5,712 cases of missing American Indian and Alaska Native women and girls; in the same year, the US Department of Justice recorded just 116 cases in its missing persons database.

Underreporting of cases, racial misclassification and poor relationships between law enforcement and Native communities all contribute to the lack of reliable data (Urban Indian Health Institute, 2018). A jurisdictional web exacerbates the problem. In 1978, the US Supreme Court ruled that tribal nations could no longer prosecute non-Natives who commit crimes against Native individuals on tribal lands. As a result, when an indigenous person is the victim of a violent crime, the Native or non-Native identities of the victim and perpetrator(s), the location of the crime either on or off the reservation, and the nature and severity of the act must all be established before it is even known which authorities should handle the case.

Many believe perpetrators have been able to take advantage of the confusion to target indigenous women and girls. "We need to be able to have jurisdiction over crimes committed on our land. We're nations within nations, sovereign nations within a nation, and we have the least ability to protect our people," Ms. DeFord says.

Families of missing persons and Native advocates say even when investigations are conducted, they are not afforded the rigour they deserve. "It feels like everybody's trying to pass the buck so that nobody has to get their hands dirty," says Ms. DeFord. "That's probably not the case, but it's what it feels like."

In 2013, the reauthorization of the Violence Against Women Act (VAWA) restored tribal criminal jurisdiction over non-Native individuals committing crimes of domestic violence on tribal lands. The most recent reauthorization, in 2022, expanded the list of crimes that could be prosecuted to include sexual violence, sex trafficking and stalking, among others. Luhui Whitebear, a professor of Indigenous Studies at Oregon State University and board member with MMIWUSA, says tribal nations now have access to a new range of tools to protect their communities from harm. Still, she says, legal reforms only go so far. “People think ‘Yes, we did it!’ But that’s not always the end of the story.”

Prof. Whitebear points out that the 2022 VAWA reauthorization doesn’t cover all tribal nations – only federally recognized ones. This means that nations like Prof. Whitebear’s own, the Coastal Band of the Chumash Nation, are not covered by the act. There is also the issue of resources, with tribes rarely having access to sufficient funding or training to conduct thorough investigations.

Grass-roots organizations like MMIWUSA are stepping in to help. Often, what families need most when a loved one goes missing are basic things – a plane ticket, feet on the ground to conduct a search, or money to hire a babysitter for children whose parent has disappeared. “I’m really thankful that there are people who are dedicating so much time to doing ground searches for people and creating missing fliers, because sometimes families have to choose, ‘Do I eat dinner, or do I look for my missing person? Because I don’t have support for a search.’ And so for organizations to be able to provide resources for those searches is critical,” says Prof. Whitebear.

Carolyn DeFord, whose mother disappeared in 1999, works with MMIWUSA to advocate for the rights and well-being of indigenous women and girls in the United States. Image courtesy of Carolyn DeFord

Another crucial step is ending stereotypes of indigenous people and communities. “De-normalizing that exploitation of people’s bodies and the view of us as disposable would help immensely,” Prof. Whitebear says. “I would say that what helps to end violence against indigenous women is viewing it as not just an indigenous issue. This is everyone’s issue.”

For Ms. DeFord, in the years since her mother disappeared, she has learned to take her grief and use it to help other families struggling for answers: “It’s been very healing to share my story, to be able to use my experience to help other people, like these other advocates are helping me,” she says. “Being able to do some of that footwork so that families can take care of themselves and be where they feel the most useful – that’s been helpful, really being able to feel like this horrible, traumatizing experience hasn’t been in vain. If I can use that to help other people, then it makes me feel like at least there’s a purpose.”

Local advocates are also helping to reshape laws. “Some of the first legislation in the country was passed here,” says Ms. DeFord, “and it was because of grass-roots voices, because of families going and testifying and sharing our stories and our frustrations and what we needed.”

The legacy of misinformation

Despite the progress seen within medical science and in international human rights agreements, falsehoods and assumptions remain widespread, permeating not only social norms and domestic laws but also health and education systems. As a result, these vestigial misconceptions continue to enact harm. Many of these misconceptions rely on an overly simple understanding of human sexual development. When sexual development, traits and identity are assumed to follow one standard pathway, natural variation in the human experience may seem wrong or disordered, and people who fail to conform to expectations may find themselves unserved or even harmed by policies and practices.

As one example, menarche – the onset of menstruation – was once widely believed to be a biologically incontrovertible sign of a girl's readiness for pregnancy. The ability to menstruate was assumed to indicate fertility and the ability to bear children. A girl's marriageability could be socially or legally determined by whether or not she had menstruated. As recently as the 1970s, one internationally used gynaecology textbook taught that menstruation was "the weeping of a disappointed uterus" (Jeffcoate, 1975), implying that menstruation signals the failure of a female body to become pregnant.

Perspectives about menarche have evolved over time, and contemporary views recognize a more comprehensive understanding of physical and emotional maturity. Today it is known that many early menstrual cycles are not accompanied by the release of an ovum, and therefore menarche does not necessarily signal that pregnancy is possible (Carlson and Shaw, 2019). Age of menarche also changes based on factors such as genetics, nutritional status and exposure to environmental pollutants (Forman and others, 2013), and mental and psychological maturity are now understood to take place years – even a decade – after the average age of menarche (Arain and others, 2013). Pregnancy and motherhood in early adolescence are now understood to pose life-threatening physiological and mental health risks.

Yet rather than teach that menarche is one factor among many in the process of developing fertility, it continues to be taught as signifying one's body is "prepared" for pregnancy. This oversimplification can be used to support incorrect beliefs, such as the notion that younger adolescents do not require education about menstruation or the presumption that pregnant adolescents are physiologically equipped for childbirth.

Another oversimplification involves gender essentialism – the outdated idea that men and women are distinct biologically, physiologically and in their innate capacities, and that these differences are unchangeable (Meyer and Gelman, 2016). Researchers across multiple disciplines have discredited this notion: "[E]vidence include[s] neuroscience findings that refute sexual dimorphism", i.e., the existence of two distinct and fixed categories, "suggesting that the tendency to view gender/sex as a meaningful, binary category is culturally determined and malleable" (Hyde and others, 2019).

The reality is much more complicated, for both sex and gender, terms that are often conflated but that carry different meanings. Sex, referring to the biological and physiological characteristics of females and males, such as chromosomes, hormones and reproductive organs, is often seen as falling into only two categories. Yet studies estimate that roughly 2 per cent of people actually have intersex variations (with some figures as high as 4 per cent [Jones, 2018]), meaning they have anatomy, chromosomes, hormones or other physical traits that do not fall perfectly within the male-female dichotomy. Gender, on the other hand, can be described as the socially constructed characteristics of women, men, girls and boys, and the process of conforming to these social expectations through norms, behaviours, roles and other means (WHO, n.d.). Gender, too, defies duality – communities from countries around the globe (including Argentina, Australia, Bangladesh, Canada, Fiji, India, Mexico, Nepal, New Zealand, Pakistan, the Philippines, Samoa, Thailand, Tonga and the United States) recognize identities that do not correspond with the male/female binary (OHCHR, 2023a).

When gender expectations are a moving target

While many people born with non-dimorphic sex traits are forced by legal, social and health systems to fit within the gender binary, those who *do* live within the gender binary often face scrutiny, stigma and exclusion for failing to embody those gender norms *enough*.

Elite South African runner Caster Semenya was both assigned female at birth and has continuously identified as female, but her femaleness has been repeatedly questioned by athletic competitors and institutions, a situation common to women and girl athletes perceived to be too masculine. Ms. Semenya was coerced into undertaking hormone treatments to “correct” her natural body. She continued to win races during hormone treatment, but felt tired, nauseous and as though, she said, “I had been running in a body that wasn’t my own” (Semenya, 2023). She has also been subjected to repeated invasive sex testing, a violation of a range of internationally protected fundamental rights. The human rights court of Europe recently ruled that her right to freedom from discrimination and private life had been violated (European Court of Human Rights, 2023), yet she remains barred from participating in athletic events by the World Athletics governing body (Reid and Worden, 2023). And she is just one of a number of world-class women runners (many from developing countries) who have been banned from competition, pressured into surgeries and/or subjected to genital examinations, all because their naturally occurring sex traits are considered unacceptable by athletics authorities (Longman, 2024).

There is nothing inherently political or ideological in acknowledging the existence of gender diversity, or in noting the prevalence of non-dimorphic sex traits. This complexity does *not* require eliminating the categories "men" and "women". Indeed, the global consensus on achieving gender equality *requires* that harms overwhelmingly associated with men and boys or with women and girls be identified as such. But harms overwhelmingly associated with people who do not conform to sex or gender binaries must also be identified accurately, or else these harms will persist – and they are significant. The Office of the High Commissioner for Human Rights notes that intersex people are subjected to infanticide; forced and coercive medical interventions; discrimination in education, sport, employment and other services; and lack of access to justice and legal recognition (OHCHR, n.d.a). People of diverse sexual orientations and gender expressions, including lesbian, gay, bisexual and transgender people, also face rampant discrimination and violence, including violence both legalized and enforced by States (OHCHR, n.d.b). The non-recognition of sexual diversity – such as denials that sexual diversity exists and refusal to collect data on sexual minorities – does not, and cannot, eliminate this brutality and exclusion.

Misinformation about anatomical differences based on race also remains deeply rooted in education systems, including medical education systems. For example, many contemporary midwifery and obstetrics textbooks continue to use the pelvic-shape classification proposed in 1938 by W.E. Caldwell and H.C. Moloy, doctors who believed certain pelvic shapes were "ultrahuman" – the perceived standard for human development – while others represented an "arrest in evolution from the ape form". Today, researchers note, "There is good evidence that the shape of the birth canal is highly variable and tends to differ both within and among human populations, and that using the gynaecoid shape as a model for all women is empirically unsupported, factually inaccurate and potentially dangerous, especially for women of non-European ancestry" (Betti, 2021).

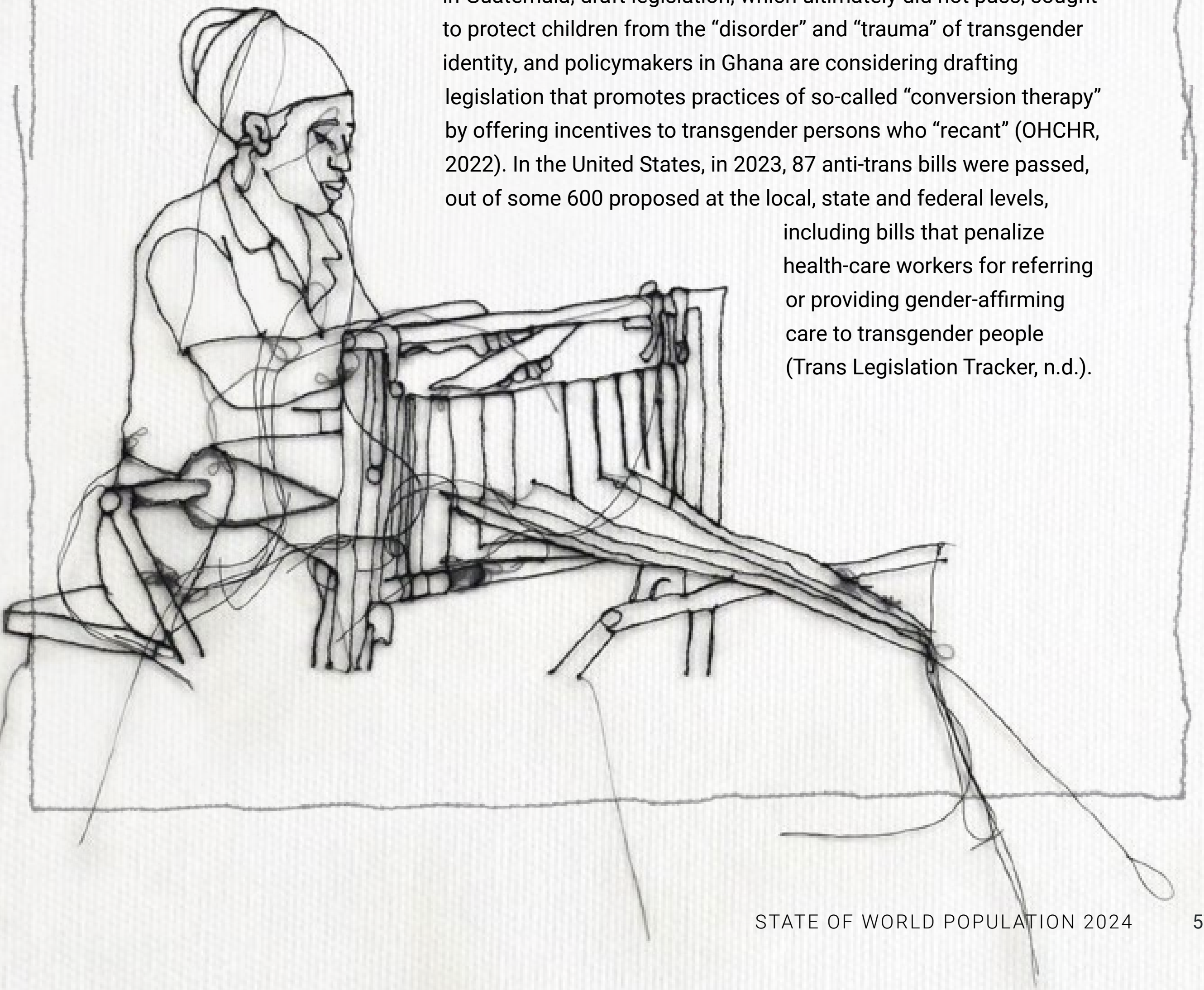
Similar misconceptions affect access to pain relief and other care. One study from 2016 in the United States found that about half of participating medical students and medical residents endorsed at least one false belief about biological differences between Black and white people, such as that Black people have less sensitive nerve endings, thicker skin or higher fertility (Hoffman and others, 2016).

As a final example, misconceptions about history are also pervasive, with ongoing consequences for access to services that should enable bodily autonomy and sexual and reproductive health. For instance, many popular narratives suggest that the advancement of sexual rights and abortion rights internationally are forms of Western influence (OHCHR, 2023a). In fact, a great deal of evidence points to colonial regimes enacting and enforcing homophobic norms and laws and restrictions on women's bodily autonomy (see spread on page 60). Often, these norms and laws remain in force after countries achieve independence from colonial control, even in cases where precolonial cultures were comparatively open to diversity in gender expression and sexual orientation.

New understandings embraced in health systems

Health experts now widely accept that menarche is not the defining marker of womanhood, and that racial assumptions about pain and pelvises can cause harm. Health systems are also increasingly recognizing diverse gender identities, sexual orientations and sex characteristics as being within the spectrum of normal human development. For example, over the past three decades, many traits of sexual minorities once believed to be pathological have been recategorized as non-pathological or otherwise removed from diagnostic codes. This is not simply an effort to better realize human rights; it is also a reflection of the “poor-quality evidence and social rationales that justified” these diagnoses to begin with (Carpenter, 2018). This move is also coherent with global efforts to improve public health overall through destigmatization (UNAIDS, 2021) and through growing awareness that health services must be tailored to populations that are far more diverse than previously acknowledged.

Still, some States are considering measures that entrench pathologization and intervene in rights-affirming health care. In 2021 in Guatemala, draft legislation, which ultimately did not pass, sought to protect children from the “disorder” and “trauma” of transgender identity, and policymakers in Ghana are considering drafting legislation that promotes practices of so-called “conversion therapy” by offering incentives to transgender persons who “recant” (OHCHR, 2022). In the United States, in 2023, 87 anti-trans bills were passed, out of some 600 proposed at the local, state and federal levels, including bills that penalize health-care workers for referring or providing gender-affirming care to transgender people (Trans Legislation Tracker, n.d.).



A bridge to a better future

Reconciling modern health systems with these legacies need not be painful or punitive. As the history of the ICPD shows, there is a globally agreed common agenda to secure gender equality and sexual and reproductive health and rights for all people. The benefits of this common agenda are felt individually, in human rights realized, higher standards of health attained and human potential expanded, and they are felt across communities, societies, nations and regions. To reach these agreed goals, a concerted and well-funded effort must be made, *not* to push down those who have already felt the gains of progress but to raise up those who have yet to access those gains.

It should not be controversial to note that many medical and societal advances have been enabled by a long history of health-system mistreatment, from the invention of tools like the Sims speculum to eugenics motives that ultimately played a role in expanding access to family planning. And it should not be controversial to recognize that the descendents of those who were mistreated continue to endure some of the most attenuated access to these services, technologies and rights.

Indeed, it is urgent that we learn from past mistakes. Reproductive health technologies continue to advance rapidly, creating opportunities both to benefit individuals and to perpetuate abuses (UNFPA, 2024b). Valuable diagnostic tools like prenatal testing are already commonly misused for gender-biased sex selection, for example. Users of powerful new digital technologies are already giving away access to deeply private data, often without knowing it. And on the horizon are artificial intelligence-boosted diagnostics, cytoplasmic transfers that could produce embryos with three parents, in-vitro gametogenesis that can produce sperm or egg cells from non-reproductive cells – innovations that could change the nature of reproduction, sex and family configuration – and many more advancements. The potential for serious harm, including issues of patient safety and privacy as well as "ethical and human rights concerns about the commodification of human reproduction", exists, as always, alongside significant positive gains (UNFPA, 2024). As much as these technologies could be used to mistreat or exclude marginalized groups, they can also be tools of inclusion and empowerment, for example by expanding quality sexual and reproductive health services to those who are currently beyond reach, and by enabling gender-diverse individuals and people excluded from infertility treatment services (Perritt and Eugene, 2022) to create the families of their choosing.

Movements around the world are helping us reconcile with the ills of the past, efforts that can – and should – inform our vision of the future. Global donors are targeting some of the most severely left-behind communities for investment in midwifery, gender equality and comprehensive sexuality education initiatives (see page 108). Increasing inclusivity in medicine and research is improving the quality of human knowledge. We have a much better understanding today of diversity in gender expression, how gender norms vary within and between countries and how complex and diverse sex traits are. We have a much better understanding of how women of colour, indigenous women and women in the Global South have been excluded from much of the progress seen in sexual and reproductive health and rights.

This report's analysis of barriers to health care, as reported by women themselves (page 28), finds that progress is indeed possible, and that while, in general, those groups of women who faced the highest prevalence of barriers to health care have experienced the least progress, they *did* experience progress. And in some countries, the strongest improvements in health-care access were among ethnic groups that had previously experienced the worst levels of self-reported barriers to care – heartening indications that progress can indeed be accelerated. And while much more evidence is needed to design policies and programmes that reach all people (see Chapter 3), the clarity of insight into inequity and, therefore, the possibility of achieving real justice has never been greater.

Bilums are tote bags used in Papua New Guinea. People use them as baby carriers – "bilum" translates to "womb" in the Tok Pisin language – and for transporting goods to market, as well as in the funeral ceremonies of prominent community members. In this way, bilums accompany many Papua New Guineans throughout life. This pattern, the skin pig design, represents the struggle of women to be seen, heard and respected. © UNFPA Papua New Guinea/PidginProductions

IN FOCUS

Decolonizing sexual and gender norms

In July 2023, the United Nations Secretary-General released a report drawing attention to the role of colonialism in perpetuating violence and discrimination against gender-diverse populations (OHCHR, 2023a). The report, by the Independent Expert on Protection from violence and discrimination based on sexual orientation and gender identity, drew from hundreds of meetings, visits and exchanges with State and non-State actors from around the world. The cumulative evidence found that specific strategies to exercise control over colonized persons – employed by diverse colonial powers – resulted in the stigmatization, criminalization and pathologization of same-sex attraction, transgender identities and other forms of diverse gender expression.

Precolonial diversity

From the Filipino indigenous community's *babaylan* spiritual protectors to *ogbanje* individuals in Nigeria, diversity in sexual orientations and gender identities has existed everywhere throughout recorded history. Individuals embodying gender-variant identities have been cherished and respected in many societies, such as the "two-spirit persons" in North America, the *bonju* in Europe, the *muxes* in Mexico, the *hijra* in India and Bangladesh, the *takatāpui* in New Zealand and the "sistergirls" of the Aboriginal and Torres Strait Islander peoples in Australia.

Indeed, the social meaning attached to sex characteristics is as varied as cultures around the world. Patriarchal and heteronormative social structures certainly existed in many precolonial societies, but there is also ample evidence of normalized gender variation in others. Some communities even had dedicated roles for people with diverse sex and gender characteristics, including positions as advisers, military commanders, royal court members, healers and keepers of traditional practices.

Colonial control strategies

While recent colonial projects did not invent gender-binary norms, they did result in the systematic imposition of a gender binary through laws and practices that affected colonized people over centuries of control. Colonial strategies included the conversion of colonized people to religious institutions, the criminalization of gender and sexual nonconformity and the enforcement of rigid social hierarchies.

Both religious and secular justifications were given for the moral codes enforced by colonial powers. Examples include "*pecado nefando*", or the crime of "nefarious sin", applied by Portuguese and Spanish inquisitorial courts; French laws criminalizing "lewd or unnatural acts", which were intended to inculcate colonized people with Christian morals; and British colonial laws punishing "gross indecency" between two men. Other laws included "sodomy", "buggery", "carnal knowledge against the order of nature", as well as offences such as "public indecency" and "encouraging debauchery". There were also "vagrancy laws" that did not directly restrict sexual or gender-divergent conduct, but which had a disproportionate impact on people living in poverty, gender and sexual minorities and persons with disabilities.

Notably, the same, or similar, laws were applied within the societies of colonial powers. Moments of "sex panic" or "moral panic" took place within European countries, for example, during which governments, medical authorities and the mainstream media identified groups who did not follow dominant "correct" sexual practices as deviants; the enforcement of these laws within colonies was linked to policymakers' perceptions – often based upon reports of explorers – that same-sex relations were pervasive across the colonized world (HRW, 2008).

While the law was a principal means of enforcement, it also formed the basis for complex systems of socialization that included policing, medicine, literature and education. Black sexuality, for example, was regarded as "rampant and insatiable, and thus in need of regulation" (Westman, 2023). Indeed, in colonial settings the ability to thrive was heavily dependent on a person's ability to assimilate to white, patriarchal and heteronormative customs.

Lasting impact

Colonial laws and norms have had an impact well beyond current and former colonies. In 1908, Thailand – which was never a European colony – adopted language from the Indian penal code to ban acts "against human nature". In some cases, colonial dynamics have influenced law and policy reform processes even in post-colonial settings. For example, Cameroon and Senegal, both former French colonies, criminalized same-sex relations after gaining independence in 1960.

Today, 64 countries still criminalize same-sex consensual acts, often referring explicitly to sexual intimacy between men; 41 countries criminalize sexual intimacy between women; and 20 countries explicitly criminalize and/or persecute transgender persons through laws targeting "cross-dressing", "impersonation" and "disguise". And although many of the world's anti-LGBTQIA+ legal frameworks originate from colonial legislation and social mores, today it is advocacy of the human rights of LGBTQIA+ persons that is often portrayed as colonial or as a Western agenda (OHCHR, 2023a).

One important step towards realizing the rights of all people, in all their diversities, is to reject the view that the Global West or North are archetypes of inevitable progress, while framing the Global South or East as backward. If anything, it is the persistence of colonial-era legal frameworks and social norms, inherited from the Global West and North, that continue to constrain the internationally agreed human rights of LGBTQIA+ persons, particularly those living in the Global South or East.

Further avenues for research

The above summary of the Independent Expert's report necessarily excludes the impact of colonial laws and norms on aspects of sexual and reproductive health beyond gender and sexual diversity. However, the findings raise important related questions about the legacy of colonialism on gender equality and sexual and reproductive health and rights.

For example, there is evidence that abortion was practised in many precolonial communities, but banned by colonial-era laws (OHCHR, 2021b; Malvern and Macleod, 2018). In fact, European colonial powers have been called "the most important sources" of laws restricting abortion; such laws were in place in almost every country in the world by the end of the 19th Century (Berer, 2017). Similarly, obscenity, vice and indecency laws – many dating from European colonial rule – were widely used to prohibit information about family planning from the start to the middle of the 20th Century (Stepan and Kellogg, 1974). These and other consequences of colonialism on women's reproductive health and rights merit further exploration, especially given the persistence of reproductive health and rights violations around the world.

This text was contributed by Victor Madrigal-Borloz, who from 2018 to 2023 served as the United Nations Independent Expert on Protection from violence and discrimination based on sexual orientation and gender identity.

COUNTING EVERY STITCH

The 1994 ICPD, and its resulting Programme of Action, not only represented a moment of remarkable consensus around the value of universal sexual and reproductive health and reproductive rights (Brown and others, 2019; Sen and others, 2019; Corrêa and others, 2015), it also represented a powerful call for better and more transparent data – a contribution to global standards that has seldom been recognized. In fact, an entire chapter of the Programme of Action, Chapter XII (UNFPA, 1994), is devoted to the need for "valid, reliable, timely, culturally relevant, internationally comparable data", including "gender and ethnicity-specific information". It also called for research into the views of less-empowered groups of people and those in different cultural settings.

This appeal for data took place at a time when little was actually known about men's and women's sexual and reproductive health or the realization of their rights. For example, reliable data – and in most cases *any* data – on maternal mortality for the vast majority of countries were non-existent in the 1990s (WHO and others, 2001). At the time of the ICPD, WHO's most recent maternal mortality estimates (already more than half a decade old) were rough given that many country-level data were thorny with non-representative samples and problems of under-recording (WHO, 1991). Even without a globally agreed maternal mortality estimate for 1990, the ICPD Programme of Action called for a cumulative 75 per cent reduction in maternal deaths between 1990 and 2015, and committed to narrowing maternal mortality disparities "within countries and between geographical regions, socio-economic and ethnic groups" (UNFPA, 1994).

These goals gave rise to a follow-up process that saw routine collaboration between population and health ministers, demographers, statisticians, epidemiologists and human rights experts, as well as the establishment of measurable health and rights indicators and subsequent collection of rigorous data to track progress towards achieving the goals of the Programme of Action (Snow and others, 2015; United Nations, 2014; UNFPA, 1998). Since 1994, the quality and quantity of maternal mortality data have vastly improved, as have the statistical methods used to estimate these data. By 2014, missing data had gone from being the norm to being the exception, even as the bar for what constitutes reliable data had been raised.

Thirty years after the ICPD, the world is at another inflection point, with a similar goal required, one which again recognizes vast and unacceptable unmet needs, even as we lack the data to precisely define the scope of the problem: the ambition to meet the sexual and reproductive health and rights of those individuals who have been left – and pushed – behind, not only by advances in health and the expansion of health infrastructure, but also by the data revolution itself.

This chapter explores most closely the issue of maternal mortality, for which numerous unanswered questions about levels and trends globally, regionally, nationally and subnationally remain, despite the steady advances in statistical prowess and data availability. But maternal death rates and ratios are only a starting point; beyond the issue of maternal mortality are many further, still unanswered, questions about the health and rights of women and girls who continue to see little of the progress experienced by their more privileged sisters.

A new inflection point

Part of the story, and one that has been apparent for some time, are the vast and – in many cases – growing inequalities in sexual and reproductive health and rights. An expanding body of evidence makes clear that some individuals are pushed to the margins of societies and health systems – those facing discrimination in health systems, those with language barriers in clinical settings, those stigmatized for their HIV status, or unreachable because they lack the privileges of citizenship, as only a few examples.

The available data strongly indicate these individuals are suffering and dying in far greater proportions than previously imagined (Khalil and others, 2023; Geller and others, 2018; Gon and others, 2018). Yet their deaths – and the morbidities and indignities that precede these deaths – are largely invisible (Creanga and others, 2014). Why? Deaths and injuries remain uncounted because of deficient data systems, infrequent surveys and other studies that are limited in scope or comparability. When their deaths and morbidities *are* counted, the underlying inequalities are often invisible because few efforts have been made to disaggregate data by the particularities of their exclusion. Their disproportionate experience of injury and death is absorbed into the vastness of statistical averages.

When this veil is lifted, we see gaping inequalities both between and within countries. One common public health explanation is the inverse equity hypothesis, in which new health interventions are most immediately adopted by wealthier populations that have the lowest levels of need (Victora and others, 2018).

Crying Women by Bayombe Endani, Democratic Republic of the Congo, 2010. Artwork contributed by the Advocacy Project, which helps marginalized communities use embroidery as a tool for therapy and advocacy.

Health advancements can therefore give rise to an initial increase in overall inequality – with inequality declining if and when those advancements become accessible to those with greater needs. Yet by some measures, inequalities both between and within countries are growing.

In 1990, for instance, a 15-year-old girl had on average a 1 in 12 chance of eventually dying from pregnancy or childbirth in the 10 per cent of countries with the highest risk, while a 15-year-old girl in the 10 per cent of countries with the lowest risk had a 1 in nearly 7,000 chance (see technical note). By 2020, girls in the countries with the highest risk had a 1 in 34 chance of dying, while girls in the countries with the lowest risk had a 1 in nearly 23,000 chance. This is a 2.8-fold change in the highest-risk countries, compared to a 3.3-fold change in the lowest-risk countries – a widening inequality. In other words, at the global extremes, progress was greater where maternal mortality was rarest and more limited where maternal mortality was highest.

Such inequalities between countries are often attributed to disparities in resources – but this explanation falters when looking at the inequalities that exist within countries. These intranational discrepancies make clear that persistent forms of discrimination and exclusion, not just limited resources, play a significant role in many of the global inequalities in sexual and reproductive health and rights that we see today (UNSDG, n.d.).

This is true both in countries where maternal mortality remains painfully high (Patel and others, 2018; Acharya and Patra, 2017) (see technical note on page 155) and also in high-income countries where maternal mortality is dramatically lower. Take the United States and the United Kingdom, for example – 2 of only 19 countries estimated to have a higher maternal mortality ratio in 2020 than in 1990. In both countries, the incidence of maternal death is multiple times higher for Black women than white women. The latest United Nations estimates, which differ slightly from each country's national estimates, indicate the United States had a maternal mortality ratio of 21 per 100,000 live births in 2020 (WHO and others, 2023). According to official national statistics in the United States, in 2021, Black women faced a mortality ratio more than double the national average (Hoyert, 2023). Maternal mortality risk is also higher than the national average for the country's Hispanic women (Hoyert, 2023).

Still, these trends in the United States are part of a broader increase in maternal mortality across the board – meaning it has been increasing for most groups of women in the country, including high, middle and low socioeconomic classes; women of all age groups; and women of all races (Hoyert, 2023; Singh, 2021) (see technical note on page 154). By contrast, in the United Kingdom, where the United Nations estimates maternal mortality stood at 9.8 deaths per 100,000 live births in 2020 (WHO and others, 2023), researchers have shown that the rising maternal mortality ratio is largely attributable to increased death rates among certain ethnic minorities and socioeconomic classes. The highest levels of maternal death, and highest increases, have been among Black women as well as women who are the most socioeconomically deprived (Knight and others, 2022).

It would be all too easy to dismiss these findings as stand-alone results from just two countries. Yet these are among a very small number of nations worldwide that even have data systems in place to identify such differences (Small and others, 2017) – meaning they are among some of the only places in the world where such disparities are being made visible. In fact, the United States' efforts to identify racial disadvantage in maternal mortality date back to the earliest WHO tabulations where it was the only country to have any type of racial or ethnic disaggregation (WHO, 1991). The United Kingdom has an impressive maternal mortality surveillance system, dating back to 1952 (making it the world's oldest), but it only started identifying ethnicity in 1995 (Small and others, 2017).

A UNFPA report released in 2023 examined, for the first time, indicators of maternal health among women and girls of African descent and those with other heritages across the small number of countries in the Americas where data make this possible. Only 4 of the 35 countries identify the race or ethnicity of the women who die in childbirth, and only 11 collect other maternal health data broken down by race (UNFPA and others, 2023). Canada, for example, joins the United States and United Kingdom as one of the few countries with worse maternal mortality ratios in 2020 than in 1990 (11 per 100,000 live births compared with 6.9) (WHO and others, 2023), but it does not collect racial data in maternal surveillance despite evidence of race-based barriers to access and utilization of maternal health care. It is therefore impossible to know whether increases in the country's maternal mortality over time have been universal or concentrated among select subpopulations (Dayo and others, 2022).

Where data do exist, they point squarely at persistent inequalities facing marginalized groups, not just among Black people and people of African descent but also among indigenous

people (Paradies, 2016). A 2018 paper by UNFPA, UNICEF and UN Women examined the limited data available on the maternal health of indigenous women and girls. Out of 80 countries examined, 16 had data, and across these 16 low- and middle-income countries (Belize, Costa Rica, Ethiopia, Gambia, Guyana, Indonesia, Kenya, Lao People's Democratic Republic, Mexico, Namibia, Nepal, Pakistan, Senegal, Sierra Leone, Suriname and Viet Nam), women from indigenous ethnic groups were significantly less likely to benefit from antenatal care, less likely to give birth under the care of a skilled birth attendant, more likely to give birth as an adolescent, and significantly more likely to die of causes related to pregnancy and childbirth (UNFPA and others, 2018). Research from other countries – looking at indigenous women in Australia (Australian Indigenous HealthInfoNet, n.d.), India (Government of India, Ministry of Health and Family Welfare, 2016), Guatemala (ENSMI, 2015), Panama and Russia (Anderson and others, 2016) – shows the same disparities.

Confronting the confounders

Evidence of racial inequities in health outcomes is often met with questions about possible confounding factors: Could these disparities be the result of levels of education? Income differences? What about employment factors or genetic predispositions towards ill health? The available research on indigenous women and women of African descent shows that, while these characteristics do matter for health outcomes, they do not explain all of the disparities observed, meaning some or many of these disparities are indeed linked to ethnicity (Australian Institute of Health and Welfare, 2023). "Maternal deaths persist regardless of income and education levels, with maternal deaths among African American college graduates still 1.6 times higher than among white women with less than a high school diploma," recent UNFPA analysis found, as just one example (UNFPA and others, 2023). Indeed, a growing body of research explores how chronic exposure to systemic injustice is linked to accelerated declines in physical health – often called weathering – that underpin many racial disparities in maternal health (Geronimus, 2023; Forde and others, 2019). The analysis in this report (page 28) also supports this point: While there are significant socioeconomic factors contributing to self-reported disparities in health-care access, there are *also* considerable ethnic differences in the proportion of women who have serious problems accessing care when sick, even controlling for wealth, income, and urban or rural residence.

Serious inequities are also apparent when considering persons with disabilities. Women with disabilities are up to 10 times more likely to experience gender-based violence, including sexual violence. And though young persons with disabilities are just as likely to be sexually active as their peers without disabilities, this population faces significant barriers to accessing sexual and reproductive health information and services, including lack of accommodating services and discriminatory attitudes among health-care providers (UNFPA, 2018). Yet data collection about the needs of this community is also hindered by the stigma attached to disability, and by the lack of agreed definitions when it comes to identifying persons with disabilities and measuring their needs.

These issues are particularly troublesome given that roughly 1 billion people, 15 per cent of the global population, are estimated to experience a disability within their lifetime. But important progress is taking place. In 2021, UNFPA found that the proportion of countries adopting standardized census questions from the international Washington Group on Disability Statistics "has increased from 33 per cent in 2018 to 73 per cent in 2020" (UNFPA, 2021b).

Similarly, sexual and gender minorities also face serious health disparities, not just in issues of access to and quality of health care, but in both psychological and physical health outcomes (Tabaac and others, 2020; Matsick and others, 2020; Caceres and others, 2019; Gibson and others, 2018; Müller, 2016), yet data remain limited. There are positive signs that data collection on sexual and gender minorities is expanding, but where data do exist, they remain largely the product of ad hoc efforts rather than arising from regular, standardized national data systems such as censuses or large-scale social surveys (European Commission, Directorate-General for Justice and Consumers, 2017). Furthermore, data collection is hindered not just by stigma but by the criminalization of same-sex sexual activity and transgender identity and expression in dozens of countries around the world (Human Dignity Trust, n.d.). Finally, compounding factors of exclusion, such as age, can create extreme marginalization. For instance, recent research points to how hostile laws and social attitudes – including taboos against teenage sexuality – mean that sexual and reproductive health services and information (including from LGBTQIA+ organizations) are all but completely closed off to sexual- and gender-minority adolescents in southern Africa (Müller and others, 2018).

FEATURE

Women with disabilities in Turkmenistan claim their rights

Years ago, at a gynaecologist's office in Ashgabat, Turkmenistan, Alia (name changed) and her husband were advised that it was "undesirable" for them to have a child because they were both blind. "How will you be able to take care of a child? How will you raise them, watch them?" she recalls being asked.

"They thought we wouldn't be able to cope at all and suggested having an abortion," Alia tells UNFPA. "But I disagreed. My mother is blind, too, and she raised all seven of us."

Alia's experience is tragically familiar among the one in five women globally living with a disability. Despite international agreements guaranteeing people the world over the freedom to make reproductive choices free from discrimination and coercion, women with disabilities often face a different reality, one in which prejudices drive health professionals, intimate partners and the public to question their capacity to make sexual and reproductive health decisions.

Research shows women and girls with disabilities are frequently confronted with discrimination around reproductive choices, barred from health services by accessibility issues and excluded from comprehensive sexuality education, especially in special education settings. And for some, that discrimination can even translate into forced sterilizations.

Like Alia, many have been judged as ill equipped for pregnancy and parenthood.

UNFPA research in 2021 found that many people with disabilities in Turkmenistan were not able to access sexual and reproductive health services and information. To meet their needs, UNFPA and the Society of the Blind and Deaf of Turkmenistan created sexual and reproductive health videos accompanied by sign language interpretation. The videos, available online and via flash drives, cover topics such as puberty, family planning and safe motherhood. Plans for a mobile app are in the works.

Women reported the resources taught them they could access contraceptives and pregnancy care free of charge. They also appreciated the materials' inclusion of contact information for different clinics and service providers. These steps and others are making the country a more inclusive and just place to be a pregnant woman living with a disability.

Still, Alia says more must be done: "It is necessary to increase the knowledge of medical staff so that we are accepted and treated like everyone else."

Meanwhile, she has embraced parenthood while living with a visual impairment, like her mother before her. "I knew I could do it," she says.

Adopting a lens of equality

One of the great developments to take place within the last 30 years has been an emerging consensus that factors like gender, race, ethnicity, disability status, sexual orientation and migration are not perks and penalties to be tallied with a simple score. Rather, they are dynamic factors at play within a complex web of advantages and disadvantages.

The last 15 years alone have seen a significant shift in the world's understanding of how structural and intersectional barriers are preventing certain people from realizing their health and rights. For example, where previous research might have focused solely on individual behaviours – such as delaying seeking treatment for an illness – that negatively affect health, researchers today more readily acknowledge that these behaviours are shaped by broader norms, systems and institutions, and also that multiple intersecting factors can intensify the challenges individuals face.

One groundbreaking study from 2009, for example, compares the health-seeking behaviours of poor women, non-poor women, poor men and non-poor men in India. The study reveals that traditional methodologies would mistakenly conclude that poor men and poor women are equally disadvantaged, while a methodology specifically designed to identify the compounding influence of intersecting factors of disadvantage reveals that poor men were actually better off than all women – both poor and non-poor women. In essence, both gender and class mattered for health outcomes, but, in this case at least, men were able to leverage their gender advantage to such a degree that even poor men were actually better off than non-poor women (Sen and Iyer, 2012; Sen and others, 2009).

The interplay between forms of advantage and forms of disadvantage greatly complicates the design of effective responses. A one-size-fits-all approach to policymaking simply does not work. The past 30 years have seen remarkable progress in part because policies and interventions have elevated the welfare of the people most easily reached, those with the least-complicated disadvantages, those best positioned to benefit. Reaching those who remain in need, those with intersecting vulnerabilities, will necessarily be harder and require more thoughtful interventions. To continue apace with current approaches creates the risks not only of inefficiency but also of waste and harm. Information circulated in languages that an intended target does not understand, campaigns that fail to account for cultural or religious requirements of intended users, or clinics inaccessible to people living with disabilities, as just a handful of examples, result in lost investments, continued exclusion and an erosion of trust between health providers and the populations they exist to serve.

But these findings are not cause for despair. This new lens for understanding is something to commend, even as it draws our attention to uncomfortable facts about privilege and prejudice. Through this lens, we see more clearly where efforts and resources are needed in order to achieve our global goals.

Inequalities between and within countries: the cases of India and Nigeria

For as long as measurements have existed, India and Nigeria have been the two countries with the largest absolute numbers of maternal deaths. Both in 1990 and in 2020, the countries together accounted for more than one third of all global maternal mortality. India started the journey with many more deaths, accounting for 26 per cent of all maternal deaths in 1990, compared to Nigeria, which accounted for 10 per cent. But by 2020, the countries had switched places, with Nigeria accounting for 29 per cent of all estimated global maternal deaths, while deaths in India had fallen considerably – accounting for 8 per cent of all worldwide maternal deaths (WHO, n.d.a).

While the pace of population growth plays a role in these trends (Nigeria's population more than doubled between 1990 and 2020, while India's grew by a factor of 1.6), the core issue is that maternal mortality ratios have declined steeply in India, but less so in Nigeria. India's success is often attributed to improved access to affordable, quality maternal health services (Exemplars in Global Health, 2023; Singh, 2018), as well as efforts to address the impact of gender discrimination on health outcomes. For example, one study found that policies designed to address gender equality – such as increasing the number of female physicians, increasing institutional support and respect for nurses, and promoting women's empowerment collectives — were associated with better health outcomes and increased health-care access for women (Hay and others, 2019). Another study points to how increases in the share of women in politics were linked to increased numbers of primary and community health centres, government dispensaries and hospitals (Heymann and others, 2019). Other effective programmes have promoted respectful care before, during and after delivery, and provided free antenatal care.

But this case study – of widening maternal health inequalities between two countries – becomes much more complicated when looking at inequities within these same countries. In both places, certain groups of women are receiving the care they need while others are not. Dramatic differences in maternal mortality are linked to locality in Nigeria, for example, with significantly higher death rates among women in urban slums and rural locales, and higher maternal death ratios in the north compared to the south (Babajide and others, 2021; Gulumbe and others, 2018; Anastasi and others, 2017). When related vulnerabilities, such as child marriage and skilled birth attendance, are examined by ethnicity, location and income, even more inequities are revealed (UN Women, 2018). India, too, continues to see dramatic inequities in maternal death risk. Recent research into India's 640 districts reveals that while nearly one third of districts have achieved the SDG goal of reducing maternal mortality ratio below 70 per 100,000 live births, 114 districts still have ratios of 210 or more deaths per 100,000 live births (Goli and others, 2022). The highest – 1,671 per 100,000 births – is seen in Tirap District of Arunachal Pradesh, a rural area with a high proportion of indigenous peoples. While disaggregating these figures by socioeconomic group, ethnicity, caste or religion is challenging, these factors clearly play a role in health outcomes. For example, despite the entitlement of all women to free maternal health care (Beckingham and others, 2022), women from the most disadvantaged castes and indigenous groups receive less antenatal, postnatal and obstetric care, or none at all (Raghavendra, 2020; Yadav and Jena, 2020; Saroha and others, 2008). A central lesson in these case studies is that all inequalities – including those across countries and within countries – require urgent attention, and that no one society or region has yet achieved the goals towards which we collectively aspire.

Acceleration needed

The most recent 2023 estimates, using the best available data and practices, hold that the global maternal mortality ratio, as of 2020, had changed little over the preceding five years – and was tragically far from the goal set in 1994 (UNFPA, 1994). Critics might suggest this means the 1994 goal was simply unachievable, but evidence from a handful of countries today indicates that maternal mortality ratios of 1 or 2 deaths per 100,000 births are indeed reachable (WHO and others, 2023). What does this mean for the state of maternal mortality today? Unfortunately, a real-time view of progress in reducing maternal death is currently impossible – not only because of limited data but also because official updates only happen several years after the fact. As a result, there is considerable uncertainty about the current state of progress, especially in the wake of the global COVID-19 pandemic. The most recent estimates contain data inclusive of only the first year of the pandemic, a time in which experts struggled to understand what proportion of total COVID-19 deaths were also indirect obstetric deaths (WHO and others, 2023). At present, the full scale of the effects of the pandemic on maternal outcomes remains unknown.

However, there *are* indications of distressing increases in maternal mortality ratios in parts of Europe, North America and Latin America and the Caribbean. These increases are substantial and widespread enough that they have offset declines elsewhere, leading to stagnation in global maternal mortality ratios since 2016. Without more recent data, it is not clear whether maternal deaths will rise further due to the impacts of the pandemic, or if the recent increases have abated (WHO and others, 2023).

Despite these mixed signals, there is hope in the progress that has been achieved. First, the total number of annual maternal deaths has fallen considerably since 1994 – encouraging given that the global population has grown dramatically from 5.7 billion in 1994 to 8.1 billion in 2024 (UN DESA, 2022a). And second, the data are themselves a sign of progress as well. With each iterative improvement in data collection and analysis, solutions present themselves – and sometimes in unlikely places.

For example, some estimates suggest that about one third of the total reduction in maternal mortality is attributable to declining fertility, with the greater uptake of contraception resulting in fewer pregnancies and safer spacing between pregnancies (Snow and others, 2015). Other research suggests that meeting the unmet need for contraception can avert more than half of maternal deaths simply because it will reduce pregnancies at old and young ages when risk is higher, increase the spacing between births and decrease the likelihood of unsafe abortions (Utomo and others, 2021; Chola and others, 2015; Ahmed and others, 2012). Meanwhile, the prevalence of unintended pregnancies and unmet need for contraception is plagued by inequalities across many factors, including age, socioeconomic status, race and ethnicity (Anik and others, 2022; Sully and others, 2020; Kim and others, 2016), pointing the world to the communities that need to be reached.

Decades of data also underline the role of unsafe abortion in contributing to maternal mortality. This link was known as far back as 1987, when the Safe Motherhood Conference highlighted a finding from a study in Ethiopia where more than half of maternal deaths in Addis

Measuring discrimination

With the Sustainable Development Goals, the international community has sought to measure the proportion of people who have reported experiencing discrimination or harassment in the previous 12 months, looking at forms of discrimination prohibited under international human rights law. These data reveal that almost one in six individuals have encountered discrimination within the past 12 months – and in certain settings, the number is as high as one in three. The global prevalence of discrimination is typically higher for women, and in certain societal contexts women report discrimination up to three times more often than men. Similarly, individuals with disabilities face discrimination nearly twice as frequently as those without disabilities, with ratios as high as 6 to 1 in certain contexts.

Forms of discrimination

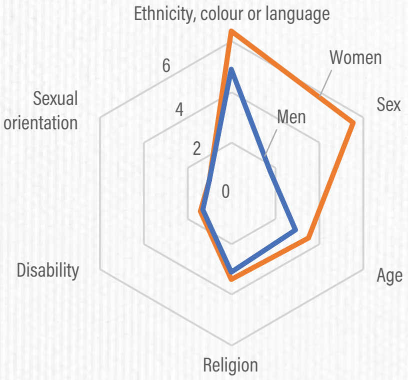
Racial discrimination*, rooted in factors such as ethnicity, colour or language, is the most common type of discrimination or harassment reported, with a median of 6 per cent of the global population reporting discrimination on these grounds within the past year. In extreme circumstances, this proportion can reach nearly 24 per cent.

Intersectional discrimination compounds the challenges faced by vulnerable groups, notably women and persons with disabilities, who report heightened discrimination based on their ethnic origins, skin colour and linguistic affiliations. In some national contexts, up to four times as many women or six times as many individuals with disabilities experience discrimination compared to men or individuals without disabilities.

Discrimination based on age and sex each affects a median of 4 per cent of the global population. In certain regions, discrimination based on sex impacts almost 19 per cent of the population, with significant disparities between men and women. For every man facing sex-based discrimination, four women are affected, and in specific country settings, this ratio can escalate to as high as 1 to 20.

FIGURE 4

Proportion of people experiencing discrimination, by selected grounds, 2015-2023 (percentage)



Source: UN Human Rights, 2024

Age-related discrimination exhibits the highest inter-country variation, with rates reaching slightly above 34 per cent in some places. Limited evidence suggests that younger populations report disproportionately more age discrimination.

Progress and room to improve

Since 2023, there has been a 25 per cent increase in the number of countries measuring discrimination – a significant achievement. Still, there is much room to improve: fewer than half of all nations systematically capture and report the voices of those marginalized by discrimination. Current data collection practices also lack the granularity necessary for comprehensive, disaggregated analysis of discrimination.

To address this challenge, the Praia Group is working to develop governance statistics, including statistics on non-discrimination and equality, and to promote a human rights-based approach to data.

This text was contributed by UN Human Rights.

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*The use of the term "race" here is consistent with international human rights treaties. It does not imply the acceptance of theories which attempt to determine the existence of separate human races.

Ababa were from infections following unsafe abortions (Cohen, 1987). Now, the association is well established: Unsafe abortion remains a leading cause of maternal death, accounting for an estimated 1 in 13 of all maternal deaths worldwide (Say and others, 2014). A growing body of evidence shows that legal restrictions do not lower the incidence of abortion and that legal access to safe abortion indeed reduces maternal mortality (Bearak and others, 2020; Latt and others, 2019; Haddad and Nour, 2009). Evidence also shows that restrictions in abortion access are likely to deepen existing inequalities in sexual and reproductive health and rights (Fuentes, 2023; Harned and Fuentes, 2023). The growing weight of these data may contribute to the fact that more than 60 countries have removed restrictions from their abortion laws in the last 30 years. Still, today, about one quarter of all women of reproductive age are living in places where abortion is fully prohibited or permitted only to save a woman's life or under specific circumstances such as pregnancy resulting from rape (Center for Reproductive Rights, n.d.).

Inclusive Data Charter

In 2018, UNFPA joined a global network of governments, businesses, philanthropists and non-governmental organizations in launching the Inclusive Data Charter, a commitment to improve the quality, quantity, financing and availability of inclusive and disaggregated data. The charter is guided by five principles (Inclusive Data Charter and Global Partnership for Sustainable Development Data, 2018):

All populations must be included in the data. We can only achieve the "leave no one behind" goal by empowering the furthest behind. This means ensuring their voices are heard and their experiences are represented through data and analytics.

All data should, wherever possible, be disaggregated in order to accurately describe all populations. Data should be disaggregated by sex, age, geographical location and disability status and, where possible, by income, race, ethnicity, migratory status and other relevant characteristics.

Data should be drawn from all available sources. High-quality, timely data from official and non-official sources should be accessible, and these should include new data sources, where consistent with internationally accepted statistical standards.

Those responsible for the collection of data and production of statistics must be accountable. The principles of transparency, confidentiality and privacy must be balanced to ensure personal data are not abused or misused, in accordance with national laws and the Fundamental Principles of Official Statistics (United Nations Statistics Division, 2014).

Human and technical capacity to collect, analyse and use disaggregated data must be improved, including through adequate and sustainable financing. Collecting and analysing disaggregated data requires specific skills and support.

FEATURE

African censuses strive to count everyone

After starting his career as a schoolteacher in the United Republic of Tanzania, Jonas Lubago went to his local bank to open an account but was refused. The reason: He was blind. The bank had a policy of requiring any person with blindness or vision impairment to bring a designated proxy to sign for even the most basic transactions. That was neither practical nor fair, says Mr. Lubago.

Becoming a schoolteacher was Mr. Lubago's second choice. He entered university with the intention of studying law, but his academic adviser discouraged him from trying because none of the required reading existed in braille. "He told me I would fail," Mr. Lubago says.

That was two decades ago. While the situation has improved over the years, people with disabilities in the United Republic of Tanzania still face an array of obstacles when they go about their daily lives or need public services, such as health care and education. A clinic may be right around the corner from the home of someone in a wheelchair, but if it is accessible only by stairs, or if the consultation rooms are too small to allow the door to close for privacy, or if the washrooms are not properly equipped, that service is out of reach. "And that's discrimination," says Mr. Lubago, who is today the secretary-general of the Tanzanian Federation of Disabled Peoples' Organizations.

In 2012, the country began identifying people with disabilities in its census. Still, the exercise did not count a wide range of disability categories nor did it consider severity. "There was a demand for better data – both from the disabled community and from the Government," says Principal Statistician and National Census Coordinator Seif Kuchengo.

The information gathered through the census is critically important. As a State Party to the Convention on the Rights of Persons with Disabilities, the United Republic of Tanzania committed to ensuring and promoting "the full realization of all human rights and fundamental freedoms for all persons with disabilities". Yet institutions require data in order to make services not only available, but also accessible.

Mr. Kuchengo says officials sought early involvement of representatives from the disability community in the design of the most recent census, including in the planning and in the training of enumerators. Mr. Lubago, who left his teaching job, joined forces with government offices to have the census adopt a more expansive and diverse set of internationally standardized disability questions. In all, about 400 people with disabilities and impairments were involved. Some 17 different categories of disability or impairment were included, and levels of severity could also be specified.

Preliminary findings from a 2022 national census show that about 11 per cent of the population has at least one type of physical or developmental disability or impairment, according to

Mr. Kuchengo. That level is about 2 percentage points higher than in 2012, but the increase is the result of the recent census's more comprehensive approach to counting people with disabilities. Mr. Lubago hopes that new census data will show just how large and important the disabilities community is, and result in persons with disabilities participating in local and national decision-making.

In addition to generating better data on persons with disabilities, the 2022 census also included an innovative and more complete count of nomads. Because these communities are constantly on the move in search of food, the government had to reach out to them well in advance to ensure they remained in one place while the census was under way. This meant making sure families had enough food to carry them through the two-day nationwide count.

Anastazia Gerald, a 23-year-old resident of Kahama, United Republic of Tanzania, is a trained Champion living with disability with the My Choice My Rights programme, funded by the Government of Finland. The programme aims to accelerate progress towards fulfillment of the rights of women and girls, particularly those with disabilities, and aims to contribute to ending gender-based violence, female genital mutilation and child marriage. Photo © UNFPA Tanzania/Ayubu Lulesu

The United Republic of Tanzania is not the only country generating better data on disabilities. Malawi's 2018 census, for example, also included albinism among its disability parameters. People with albinism experience multiple forms of discrimination and frequently face risk of violence or death. Since 2006, the United Nations Independent Expert on the enjoyment of human rights by persons with albinism received close to 800 reports from 28 countries of ritual attacks and witchcraft accusations against people with this genetically inherited lack of melanin in the hair, skin or eyes (OHCHR, n.d.c).

Deputy Director of Malawi's Demographic and Social Statistics Department Isaac Chirwa says, "Many people have problems walking around their communities or even going to school because they fear being attacked." Before the 2018 census, there were limited data about how many people with albinism there were or where they lived, Mr. Chirwa explains, and without this information, it was difficult for policymakers to take action to make it safe for people to go about their lives and enjoy their rights.

Data as a human right

Data are not just for governments, for policies or for budgets. Data are for all of us, everywhere, to support our efforts to understand, participate, make choices and assert rights. Yet in many ways a data lottery exists. The existence of the data we need depends upon where we live.

While some factors – like gender, wealth or income, geography and age – are routinely considered in surveys and analyses, disaggregation by ethnicity, race, language, religion or indigeneity remains quite rare. Disaggregated data showing access to services by HIV status, migration status or LGBTQIA+ identity are even rarer.

Disability was once rarely addressed, but the availability of data in this area is increasing rapidly. There are still gaps, however. For example, monitoring of visible disabilities is ahead of sensory disabilities, which are in turn ahead of mental and intellectual disabilities.

Furthermore, there are individuals that the United Nations and major regional systems almost never cover in data, such as people at risk of statelessness, internally displaced persons and prison populations. Sometimes their exclusion is made explicit (for example, a population survey might note that displaced people living in camps or people detained in prisons have been excluded), but most often, their exclusion remains invisible and unidentified.

Access to public information is a human right, well established under international law and many regional systems such as the African Union, the Council of Europe and the Organisation of American States (Article 19, 2012). It is considered an enabling right, one that allows other human rights to be fulfilled. Furthermore, the right to information is essential to upholding rights to equality and to life without discrimination. While some rights violations can be established through a single data point – the right to freedom from torture, for example, requires only one established case of torture to show the right has been breached – identifying systemic discrimination requires the collection and use of representative and disaggregated data. Without these data, it is impossible to determine whether laws, policies and programmes, however ostensibly neutral, result in discrimination.

This chapter's focus on the insufficiency of data on maternal mortality does not mean this is the sole need or focus. Rather it is one of many – too many – cases in which the absence of data means the perpetuation of terrible inequalities. For example, United Nations agreements have, since the 1990s, acknowledged the serious lack of data on gender-based violence, as well as of agreed measures of gender-based violence, making monitoring impossible. It was not until

Data are for all of us, everywhere, to support our efforts to understand, participate, make choices and assert rights.

Why are disaggregated data not collected?

Historically, many countries have claimed that certain population subgroups simply do not exist within their borders – and there may be good reasons for such claims, as stigma and discrimination often force people to hide their identities, making data collection extremely challenging. But there are other reasons that disaggregated data are not collected and published. Challenges include cost (Avendano and others, 2018) and capacity, as well as political sensitivity and risks (Backman and others, 2008).

Disaggregating data indeed comes with a cost. Achieving adequate sample sizes can be expensive, for example. A survey that supplies disaggregated data across many characteristics may be very large or have elements that are statistically less reliable. But there are ways to keep expenses down. For example, Multiple Indicator Cluster Surveys (MICS) are usually carried out for an entire country, but special surveys have been carried out exclusively among Roma communities in a range of European countries (e.g., North Macedonia and Serbia). Such special surveys can reveal stark inequities. For instance, a MICS in Kenya's Turkana County revealed that only about 26 per cent of Turkana women gave birth assisted by a skilled attendant while 84 per cent of women from other ethnic groups did so (Kenya National Bureau of Statistics, Population Studies and Research Institute and UNICEF, 2016).

It is also true that certain kinds of data collection can lead to abuse and misuse. For example, the tracking of Jewish and Roma communities facilitated genocide in many European countries during World War II, and as a result many of these countries avoid ethnic identification today (Al-Zubaidi, 2022). Similarly, following the genocide in Rwanda, the country has not identified ethnicity in its Demographic and Health Surveys, even though there are concerns about the persistent marginalization of populations of indigenous forest dwellers (Ndikubwimana and others, 2023; Collins and others, 2021). In recent years, the use of religion and ethnicity information on identity paperwork has been linked to discrimination. In response to these concerns, the Office of the High Commissioner on Human Rights has published a guidance note on a human rights-based approach to the collection and analysis of data (OHCHR, 2018), recommending that data be gathered with the active participation of disadvantaged groups, that it be disaggregated to allow for the understanding of differences between groups, that members of groups be allowed to self-identify, that data-collection processes be transparent, that those responsible be accountable, and that all data be confidential, with the privacy of individuals respected.

Finally, some governments and institutions avoid disaggregation because of fears that the data will create or exacerbate political and social tensions. They worry that data can be leveraged by political opponents or critics of the current authorities. However, avoiding collecting the data does not make the inequalities less apparent in the lives of those who are marginalized. In effect, this calculus places political advantage above the long-term development and inclusion of disadvantaged groups.

Not all risks will be present in all cases, and any risks and costs should be carefully weighed against the potential benefits in each case. Choosing to not collect data can reflect a lack of commitment to understanding and reaching the most marginalized and excluded, or can suggest that leaders are putting short-term political advantage above long-term development and inclusion. As the Minority Rights Group has asserted, “no data *is* data” (Thomas, 2023).

2013 that WHO first published global and regional estimates for intimate partner violence and non-partner sexual violence against women. At the time, 79 countries had data. By 2019, 153 countries had data (García-Moreno and Amin, 2019).

And in many cases, data still do not exist, or exist in early form. SDG target 5.6.1 tracks the proportion of women aged 15 to 49 years who make their own informed decisions regarding reproductive health care, contraceptive use and sexual relations. This indicator is hugely important – a first global attempt to measure and monitor bodily autonomy – but only about one third of countries have official SDG data. Analyses, based on data from 69 countries for 2007 to 2022, suggest that just over half (56 per cent) of married or in-union women aged 15 to 49 years make their own decisions regarding sexual and reproductive health and rights (UNFPA, 2024a). The existence of this indicator highlights growing recognition that restrictions on women's autonomy yield consequences for all of society (Menendez and others, 2023; UN Women, 2018). Yet more remains to be done, with experts calling for further measures to understand women's experience of reproductive agency more broadly.

Still, there has been tremendous progress over the past 30 years. The ICPD Programme of Action called for governments and institutions to "strengthen national data systems" (UNFPA, 1994), which are essential for producing the high-quality, disaggregated data required to identify and locate vulnerable groups, intervene to support their development, and track progress across relevant indicators each and every year. Since 1994, there have been remarkable transformations in population data systems – not least of which has been the digitization of the world's information. Data systems for censuses, surveys and civil registration and vital statistics, as well as routine health sector data, have accelerated the speed of data processing, broadened the types of data available and offered cost-cutting opportunities. Geospatial information and satellite imagery have brought invaluable possibilities for more granular targeting. Even so, underdevelopment and insufficient financing mean that many national data systems remain deficient (UNFPA, 2024c). Furthermore, while new data systems are on the horizon, and innovation within existing systems continues, protections must be put in place to guard against the risks to human rights found in the world's new digital and technological frontiers (UNFPA, 2024b).

Thirty years after its genesis, the ICPD Programme of Action endures as a compelling road map to a better world. The path to progress is neither predictable nor linear, and despite the crises and setbacks of the intervening decades, there is reason to hope. We can create a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. We can. We must. And together, we will.

›››››››› IN FOCUS

Who matters enough to measure? The case of adolescent mothers

There is an often unspoken assumption in policymaking and data collection that the things which matter are measured, and that those who are measured matter. As this report shows, that assumption does not bear out.

One powerful example can be found in the data collection around adolescent fertility (i.e., the fertility of girls and young women aged 10 to 14 and 15 to 19 years). Adolescent childbearing is widespread, with an estimated half a million births to girls between the ages of 10 and 14 years, and 12.8 million births to adolescents aged between 15 and 19 years taking place every year (UN DESA, 2022b). Early motherhood, particularly for the youngest adolescents, is "a form of gender-based violence. It is violence to force somebody to go through pregnancy or do something with her body that she doesn't want to do", says Carmen Barroso, co-chair of the Independent Accountability Panel appointed by the UN Secretary-General. Complications from pregnancy and childbirth are the leading cause of death among adolescent girls and affect social and economic outcomes for women, girls and their families. Yet in many countries, the policies and programmes needed to reduce early childbearing are based on incomplete data, which often lack disaggregation by single age and other important characteristics.

The good news is that more data have become available to provide insight into the scope and complexity of adolescent childbearing globally. This is particularly true following the 2030 Agenda for Sustainable Development, which called for reporting on adolescent birth rates as an indicator of progress towards achieving universal sexual and reproductive health care. Still, the basic criterion for reporting on this indicator, SDG 3.7.2, and also for estimating fertility rates and age-specific fertility in the United Nations World Population Prospects (UN DESA, 2022b), is the availability and quality of data from different sources – and there remain consequential gaps in our knowledge.

Unequal data quality across countries

Figure 5 shows an assessment of the availability of data on adolescent fertility worldwide since 2015, representing a wide range of sources of variable completeness and reliability. This assessment finds the most concerning lack of data – only sporadically available data or none at all – in 67 countries, home to 20 per cent of all girls aged 15 to 19 years. All 67 countries are in sub-Saharan Africa, Asia, the Caribbean and Oceania.

By contrast, the best available data are in Europe and North America and selected countries from other regions, representing 78 countries accounting for 16 per cent of girls and young women worldwide.

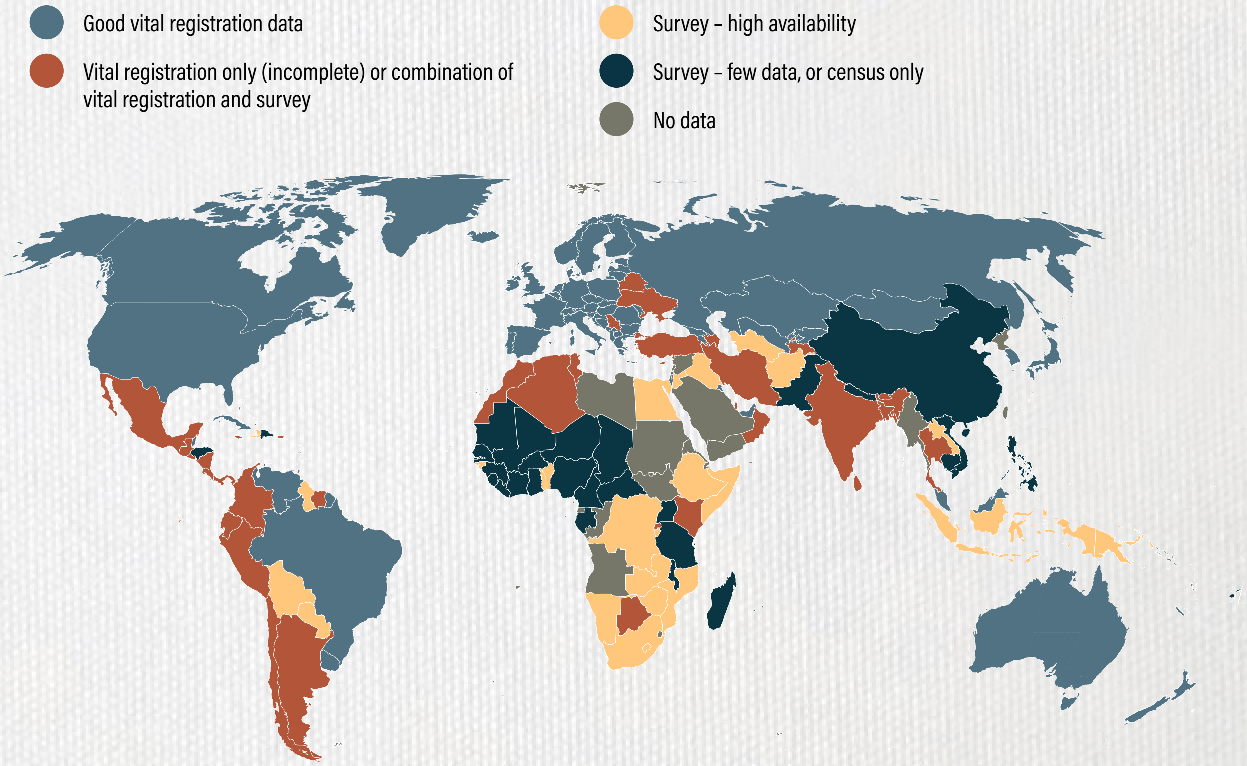
In very broad terms, the poorest data quality and availability are seen in regions where the information available suggests higher adolescent fertility rates, which in some countries is connected to high child marriage rates (Molitoris, 2023). By contrast, the best data quality and availability are, generally speaking, in countries with very low incidences of child marriage and adolescent pregnancy.

Unequal data quality within countries

Disparities in data quality exist not just across countries but within them as well. In Brazil – a country in a category (see Figure 6) considered to have the best estimates of births by age of mother – birth registration has consistently improved, increasing from about 80 per cent in the 1990s to over 96 per cent in recent decades (UNICEF, 2023; Hunter and Sugiyama, 2018). However, the lowest-income group registers around 88 per cent of its births,

FIGURE 5

Births per 1,000 girls aged 15 to 19 years, data available from 2015 onward



Source: UN DESA Population Division, 2024

Note: The Population Division of the United Nations Department of Economic and Social Affairs has established five categories of data availability. Group 1 countries have the best estimates of births by age of the mother, reported in civil registration and vital statistics (CRVS) systems, with complete coverage. Group 2 countries have data from incomplete birth registration from CRVS systems or a combination of incomplete registration data and data derived from nationally representative surveys, such as Demographic and Health Surveys or Multiple Indicator Cluster Surveys. Group 3 countries have heavily deficient CRVS data and use data from surveys as the main source of information. Group 4 consists of countries with only sporadically available survey and/or census data. Group 5 consists of countries with no data available on adolescent fertility since 2015.

while the highest-income group surpasses 98 per cent.

Figure 6 shows how, despite the challenges, continuous improvement has been seen in the quality of adolescent birth rate estimates.

In Bangladesh – a country with incomplete vital registration data – only 56 per cent of births were registered in 2019 (UNICEF, 2023) and estimates of adolescent birth rates need to be derived from other sources of data, such as nationally representative surveys. Figure 7 shows significant variation in adolescent birth estimates from 2000 to 2014. Still, there is notable alignment taking place over time.

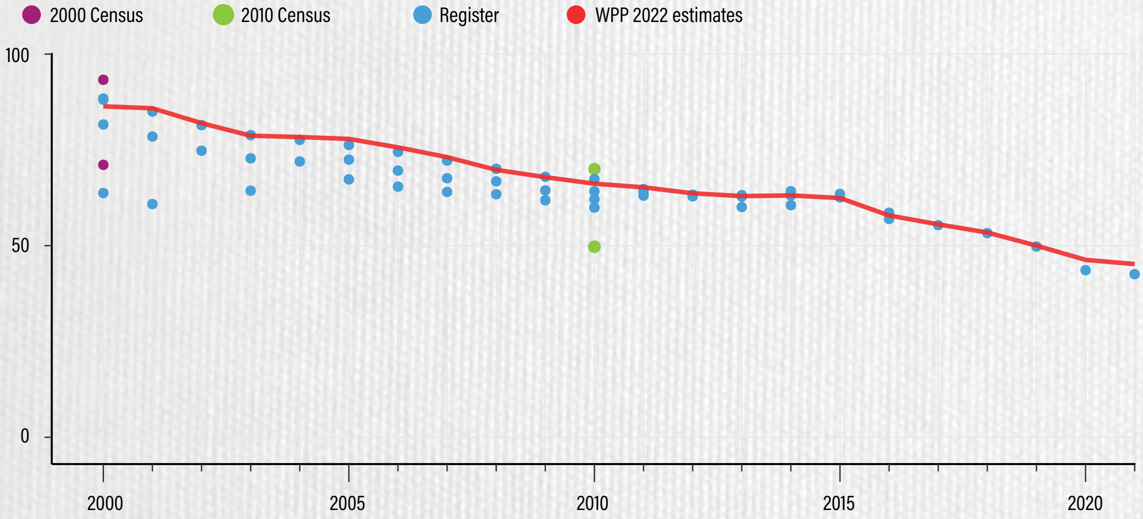
Better data, disaggregated data, still needed

Even in countries that fall into the category considered to have complete civil registration and vital statistics data, information about ethnicity or race is rarely available. These types of data are not routinely collected at birth registration and therefore must be complemented by sample surveys among selected subpopulations.

One such example is Slovakia, where no information on the ethnicity of the mother is collected when a child is registered. Data from surveys among the Roma population found that its teenage fertility rate has

FIGURE 6

Comparison of birth rates among girls aged 15 to 19 years from different sources for Brazil, 2000–2021



Source: UN DESA Population Division, 2024

Note: The red line represents the 2022 World Population Prospects (WPP) estimate of the birth rate among girls aged 15 to 19 years in Brazil for the last 20 years. The blue dots show the adolescent births identified in the civil registration and vital statistics system, and the pink and green dots show estimates from the 2000 and 2010 censuses. Multiple dots in the same colour in the same year show the wide range of values derived from the different sources, which narrow over time, indicating a general improvement in data quality.

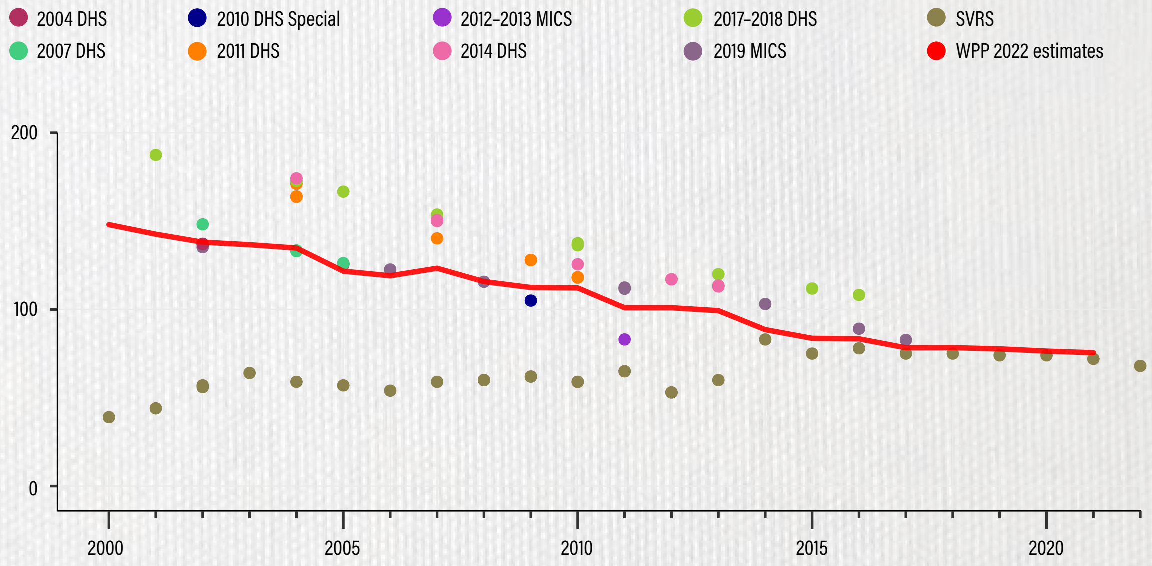
been consistently higher than that of the Slovak population as a whole. Comparing available survey data since 1996 with civil registration and vital statistics data on the entire Slovak population shows that adolescent fertility was, on average, more than seven times higher among the Roma than among the entire Slovak population. The most recent rates, from 2016 to 2018, show only slightly narrowed disparities, with adolescent birth rates for Roma girls still more than six times higher than for all Slovak adolescents (Nestorová Dická, 2021).

Overall, these findings show that the empirical knowledge base on adolescent fertility has improved greatly over the past decade. But they have also made clear that many countries and regions continue to lack the coherent and timely high-quality data necessary for the development of policies and programmes in support of adolescent girls, young mothers, their children and families. The findings also highlight the importance of collecting additional information – beyond the standard socioeconomic dimensions – relevant to each national context. Only then can meaningful and efficient solutions be designed to protect the health and rights of every girl.

This text was contributed by the Population Division of the United Nations Department of Economic and Social Affairs.

FIGURE 7

Comparison of birth rates among girls aged 15 to 19 years from different sources for Bangladesh, 2000–2021



Source: UN DESA Population Division, 2024

Note: The red line represents estimates of the birth rate among girls aged 15 to 19 years, derived from the 2022 World Population Prospects (WPP) and a wide range of sources, such as Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and sample registration systems. The dots, representing different data sources, show values from a wide range of sources that varied widely but narrowed over time (Kisambira and Schmid, 2021). Particularly noteworthy is that birth rates obtained from the sample vital registration system (SVRS) were notably lower compared to those from alternative sources until 2013.

WOMEN are the THREAD

A Chadian proverb holds that a woman is the thread that weaves and strengthens family ties in her household. By building peaceful families, women can in turn build peaceful societies.

In an ideal world, the advancement of women's reproductive rights and the promotion of equitable access to sexual and reproductive health and rights would be inherently motivated by the principles of human rights and social justice. But real-world sociopolitical contexts often demand quantifiable arguments on the short-term and long-term returns on investments in such programmes. Indeed, this was understood to be the case in 1994. Though the ICPD Programme of Action represented a monumental pivot away from population control policies and towards prioritizing the rights of all individuals, the economic rationale nevertheless remained critical for justifying investments in these rights.

In fact, the economic and social gains associated with sexual and reproductive health and reproductive rights were listed as the *first* objective of the ICPD Programme of Action: "Among these objectives and goals are: sustained economic growth in the context of sustainable development; education, especially for girls; gender equity and equality; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family planning and sexual health" (UNFPA, 1994).

This affirmation – that sexual and reproductive health and rights are necessary enablers for the large-scale emancipation of women and girls as empowered economic actors – has been borne out again and again in both the research and the accounting that has taken place in the past 30 years. Significant social and economic gains are unlocked at the individual, societal and national levels when sexual and reproductive health programmes receive investment.

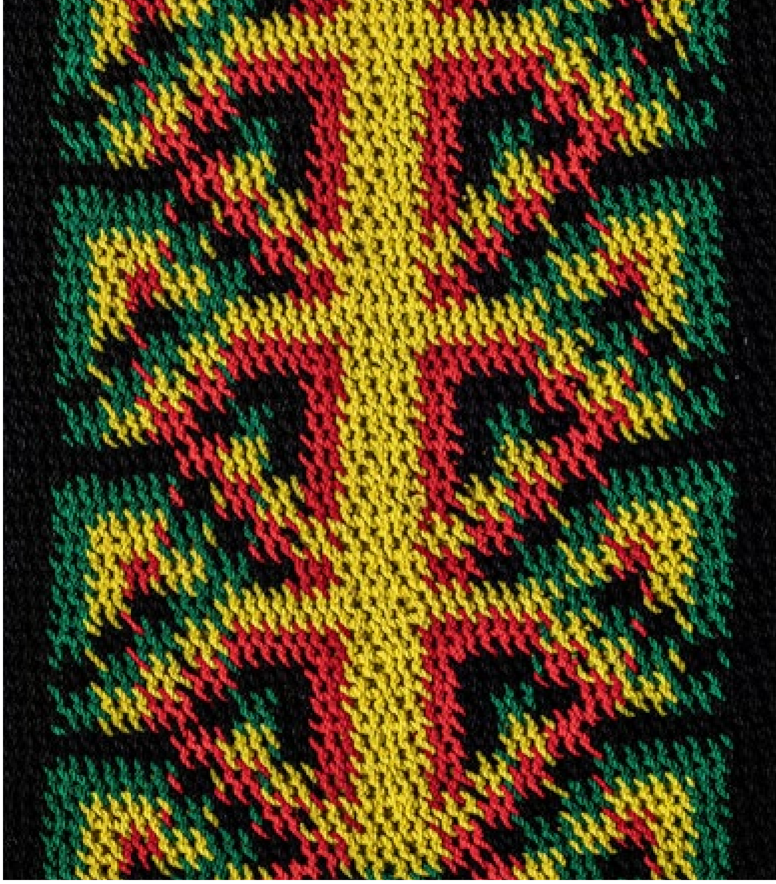
But there is even more of a case still to be made. Certainly, the costs associated with unintended pregnancy, maternal death and disability (UNFPA, 2022a), sexually transmitted infections (Owusu-Edusei and others, 2013) and gender inequality have been well studied (Wodon and de la Briere, 2018). What has been less well understood is the scale of economic *returns* that programmes advancing sexual and reproductive health and rights can yield. There have been many challenges to studying these returns on investment. For one, comprehensive sexual and reproductive health and rights refers to, and encompasses, a wide range of issues (Starrs and others, 2018): contraceptive services; access to safe abortion where legal; access to post-abortion care; maternal and newborn care; prevention and treatment of HIV and other

The economic and social gains associated with sexual and reproductive health and rights were listed as the *first* objective of the ICPD Programme of Action.

sexually transmitted infections; comprehensive sexuality education; prevention, counselling and treatment for gender-based violence; prevention, detection and management of reproductive cancers; information, counselling and services for subfertility and infertility; information, counselling and services for sexual health and well-being; and more.

An additional challenge to measuring return on investment is that investments in one area can result in cost savings in other programmes; investments in contraceptive care can reduce the need for abortion care and maternal health services, for example (Sully and others, 2020). An exceptionally large body of research would be necessary to fully understand returns on investments across all the components of sexual and reproductive health and rights. The situation is further complicated by the possibility that the cause-and-effect relationship between factors can work in both directions. For example, utilization of sexual and reproductive health and rights programmes can lead to economic empowerment of women, but empowerment can also lead to utilization of sexual and reproductive health and rights programmes.

Yet another challenge is measuring how much investment is being made in the first place. Investments across a variety of interventions can be seen as supporting sexual and reproductive health and rights, but there is no comprehensive accounting of the expenditures on these interventions. A look at official development assistance and private sector donations over the last three decades can offer some insights into investment trends. Reporting by the United Nations finds that, between 1990 and 1999, official and private contributions to population issues stayed below $2 billion per year, but that contributions markedly increased with the start of the Millennium Development Goals. Annual aid increased steadily from 2000 until 2011, when it reached $12.3 billion. Since 2011, contributions have vacillated between $9 billion and $13 billion per year, and aid spent on population issues declined as a percentage of overall global assistance. Notably, the great majority of this spending has gone to sexual and reproductive health, while population data collection and policy analysis has comprised a diminishing share of these expenditures (UN ECOSOC, 2024). Even so, these figures represent a limited view into overall global investments in sexual and reproductive health and other areas, since they exclude domestic spending.



The design of this bilum bag from Papua New Guinea is inspired by the shape of a woman's ovaries and fallopian tubes.
© Papua New Guinea

Still, there has been progress in calculating some returns on investment. In particular, there have been efforts to look at the costs and gains associated with investments in specific components of sexual and reproductive health and rights. In 2022, UNFPA, together with Avenir Health, Johns Hopkins University and others, released estimates of the returns from investing in ending unmet need for family planning and ending preventable maternal deaths (UNFPA, 2022). These UNFPA estimates found that spending an additional $79 billion to scale up coverage of 29 essential family planning and maternal health interventions by 2030 would yield $660 billion in economic benefits between 2022 and 2050. The spending was estimated to avert 400 million unplanned pregnancies, 1 million maternal deaths, 6 million stillbirths and 4 million newborn deaths, with overall economic benefits in the form of years of life gained, workforce participation, labour productivity and more (UNFPA, 2022).

The Guttmacher Institute similarly quantified the impacts of investing in sexual and reproductive health services, with a focus on more than 100 core interventions covering contraceptive services, maternal and newborn care, abortion services and treatment for the major curable sexually transmitted infections in low- and middle-income countries (Sully and others, 2020).These estimates take into account the fact that investments in some services can yield crossover benefits to other health outcomes. According to these estimates, providing this care would cost $68.8 billion annually, or $31.2 billion over current investments – an increase of only $4.80 per capita per year over current expenditures. In return, they projected unintended pregnancies would drop by 68 per cent, unsafe abortions would drop by 72 per cent and maternal deaths would drop by 62 per cent. In addition, newborn deaths would drop by 69 per cent, and new HIV infections among babies six weeks and younger would drop by 88 per cent.

The Guttmacher Institute also singled out the expenditures needed to satisfy all of the unmet need for modern contraception, and the costs would be modest: To get from current levels of contraceptive use to levels that would satisfy all of the unmet need for modern contraception in low- and middle-income countries, the cost would increase from $1.10 to $1.94 per capita. The short-term benefits of investments in contraceptive care would more than cover those costs: Every additional $1 spent on contraceptive services would reduce the cost of pregnancy-related and newborn care by $3. Each dollar above the current level spent on contraceptive services for adolescents, in particular, alongside recommended investments in pregnancy-related and newborn care, is estimated to reduce the cost of pregnancy-related and newborn care by $3.70.

While these, and other, methodologies have differed significantly – varying in their models, scope of estimation, timelines and baseline assumptions – the findings have consistently agreed that enormous value for money can be realized with increased investments in sexual and reproductive health.

People left behind by the estimates

The estimates clearly demonstrate that investments are most needed in the countries and regions that have been left behind by advancements in economic growth and development. Unmet need, for instance, is highest in low-income countries, where nearly half (46 per cent) of women who want to avoid a pregnancy are not using a modern method. Sub-Saharan Africa and southern Asia account for more than three quarters of the total increase in investment needed to provide the full package of reproductive health services, including contraception but also maternal health and disease prevention services, for all in need, according to the Guttmacher Institute. Many of the countries with the highest levels of unmet need are also among those with the largest proportion of women reporting they are unable to make their own choices about contraception, and among those with the highest fertility rates (Sully and others, 2020).

Unsurprisingly, but no less tragically, return-on-investment estimates are unable to factor in the costs and returns of reaching those most left behind *within* countries and communities. The factors that marginalize people and communities are so numerous and overlapping, and the barriers so towering, that sexual and reproductive health programmes must often be tailored and targeted. One systematic review of adolescent pregnancy found that, among other factors, "belonging to an ethnic and religious minority group also increased the risk" of becoming pregnant in adolescence, noting: "it is unlikely that strategies to reduce pregnancy among women aged less than 20 years will be effective" unless context-specific risks are addressed directly (Pradhan and others, 2015). In the best cases, messages and interventions could, or even should, be co-created with these communities to ensure accessibility and acceptability.

Such efforts could entail additional costs, or could represent lower-cost interventions – the data simply are not available to know. Yet there is often resistance to investing the resources needed to reach those who are furthest behind. This resistance can be attributed to the sparsity of actionable data, but bias, negligence and discrimination likely also play a role.

All of this helps to explain why evidence suggests the bulk of the gains seen over the past 30 years have primarily reached those who are, and were, well within reach of large-scale sexual and reproductive health programmes. As the inverse equity hypothesis holds (page 65), progress often comes at the cost of widening inequities for the most marginalized, at least initially. But continuing to reach only the "low-hanging fruit" is likely to further exacerbate these inequities and leave the ultimate goals of the ICPD agenda unfulfilled. Furthermore, while initial costs might be high, the tremendous levels of need among these left-behind individuals and communities could even mean that effective investments yield significantly greater returns than might be realized by programmes that target "low-hanging fruit".

The analysis in this chapter looks at the long-term social and, especially, economic benefits of investing in sexual and reproductive health and rights and women's reproductive agency. Because the returns on investment across the components

FEATURE

Syphilis highlights threat to health and human rights: stigma

Syphilis and other sexually transmitted infections are “secret diseases,” says Dr. Adel Botros, a specialist of dermatology and venereology in Egypt, recalling a phone call he received more than 10 years ago. A hospital reached out to report a case of congenital syphilis in a newborn. Dr. Botros rushed to the hospital and asked the father for permission to see the patient – no fee would be charged. Rather than agree, the father left the room; Dr. Botros never saw him again.

Stigma around sexually transmitted infections has long been used to divide communities and reinforce hierarchies – even as it drives people away from health services, perpetuating illness. Syphilis is perhaps the most notorious example of this, having been variously described as “the French disease”, “the Neapolitan disease”, “the Polish disease”, “the German disease”, “the Spanish disease” and “the Christian disease”, among many other names, typically by communities seeking to blame outsiders or enemies for the illness (Tampa and others, 2014).

Today, syphilis – a bacterial infection health officials long hoped would be eliminated by antibiotics – is on the rise around the world. Cases increased from 8.8 million in 1990 to 14 million in 2019, and incidence rose from 160 to 178 per 100,000 people over the same period (Tao and others, 2023).

Yet available data indicate that North Africa and the Middle East have bucked this trend. While rates of babies born with congenital syphilis have more than tripled in the United States since 2016, for instance, congenital syphilis incidence in Morocco has plunged (WHO, n.d.b). In 2022, the World Health Organization announced that Oman had eliminated mother-to-child transmission of the disease (WHO, 2022).

These data defy age-old stereotypes about syphilis in the Arab States region, a history that holds important lessons about disease, gender and power for the modern world, says Ellen Amster, a public health professor at McMaster University in Canada.

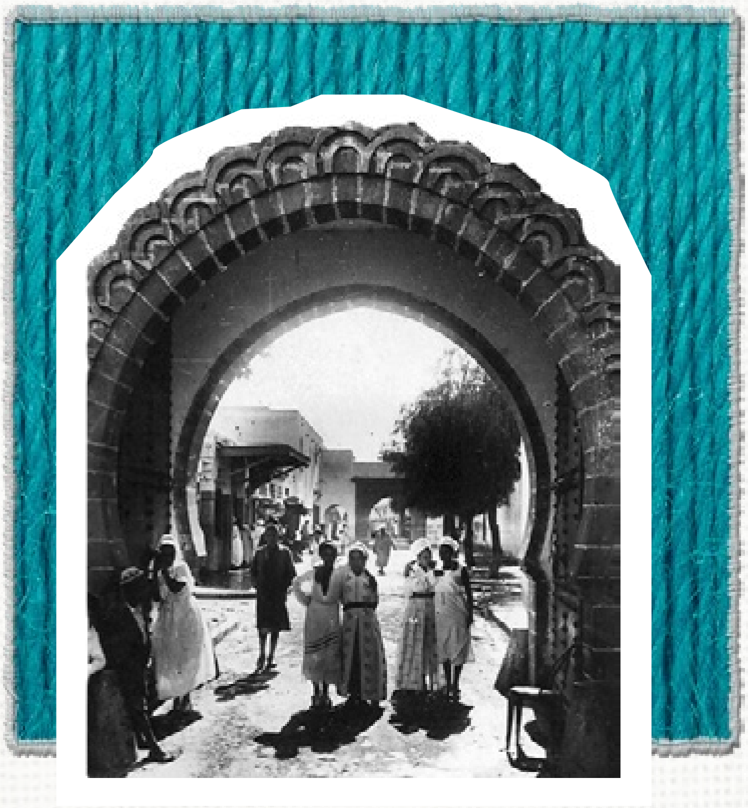
“Syphilis was really important in eugenics,” she explains. “Syphilis was considered one of these degenerate things that would destroy a population.” Western colonial authorities described Arabs as inherently vulnerable to it. They even invented a new term – “the degenerate and diseased ‘syphilitic Arab’” – to demonize and diminish Muslims and Arabs, Prof. Amster’s research has shown (Amster, 2016).

“Syphilis was tied to gender disempowerment, to shame around sexuality – which always becomes a gendered shame,” she tells UNFPA. “What the French did to protect their troops from these ‘syphilitic’ native women – in Morocco and throughout the empire – was to create closed brothels that were basically a prison for young women.”

Those efforts were driven by “claims throughout the [Moroccan] protectorate period that syphilis prevalence was like 80 per cent, 100 per cent," Prof. Amster notes, the result of false positive tests and misdiagnoses of tuberculosis, malaria and other diseases. "They found that when they actually tested women systematically, that syphilis prevalence was 0.5 per cent or less than one half of 1 per cent."

Modern society has yet to shake off the shame – and power dynamics – attached to contagious disease. In 2022, as global health authorities worked to contain the spread of Mpox (also known as monkeypox), they tried, simultaneously, to contain the stigma swirling around it. Reporting on Mpox "has used language and imagery, particularly portrayals of LGBTI and African people, that reinforce homophobic and racist stereotypes and exacerbate stigma", UNAIDS warned (UNAIDS, 2022). And illnesses need not be sexually transmitted to provoke intolerance; the COVID-19 pandemic saw waves of anti-Asian xenophobia unleashed around the world (HRW, 2020).

In designing programmes to address contagious disease, issues of power and prejudice must be closely considered. Despite the lessons of history, this remains true for syphilis as well, which is found to disproportionately affect men who have sex with men (WHO, n.d.c.). Communities affected by illness must be engaged, not stigmatized, experts say.



Bousibir was a walled-off brothel in Casablanca, created by colonial authorities as an STI-prevention measure. Historical photograph in public domain.

Even in the Arab States region, where comparatively low rates of syphilis are seen today, vigilance is required, both against the disease and against discrimination. In fact, says Dr. Botros in Egypt, the true incidence of sexually transmitted infections like syphilis cannot be known because fear and shame — once weaponized so effectively against the Arab world — persist even now.

"Sometimes we discover a case by coincidence," Dr. Botros says. "Some patients also don't come in unless they have no other way to get rid of the problem."

of sexual and reproductive health and rights are too vast to summarize, this chapter focuses on three essential elements: reproductive autonomy (represented here by contraceptive use among women who wish to avoid pregnancy, with the caveat that additional measurements are needed), preventing gender-based violence and providing comprehensive sexuality education. Each of these elements is known to increase people's ability to realize many other dimensions of sexual and reproductive health and rights. Finally, this chapter examines the returns on investments that are produced through the promotion of gender equality, which is a similarly critical enabler of many rights and choices. But in reflecting on the possible returns on investment that can be produced for each of these components, it is important to note that these investment estimates are blunt instruments looking at broad impacts over large populations. Effectively targeted programmes are likely to have different costs, and potentially much larger impacts in the form of human capital development, in communities that have so far remained beyond the reach of global progress.

The world is only beginning to measure reproductive agency.

The long-term value of reproductive autonomy

The world is only beginning to measure reproductive agency, a concept that is critically important yet not yet well defined. The Sustainable Development Goal indicators on bodily autonomy (5.6.1) and enabling environments (5.6.2) have been groundbreaking, exposing the vast numbers of people whose basic rights are insufficiently realized. Yet only 115 countries or territories provide data on 5.6.2, and only 69 provide data for 5.6.1, and these indicators are only a starting point. Much more information is needed to fully understand the state of women's reproductive agency.

Today, perhaps the best, though limited, measure available to estimate investment returns on reproductive autonomy is contraceptive use among women who wish to avoid pregnancy. This is because the scope and impact of unintended pregnancy has been well researched.

About half of pregnancies in low- and middle-income countries – 112 million annually – are unintended (Bearak and others, 2020). The majority, 77 per cent, are experienced by the 218 million women of reproductive age in low- and middle-income countries who want to avoid a pregnancy but are not using a modern method of contraception (Sully and others, 2020).

There are significant inequities within and between countries in the level of unsatisfied demand for contraception. Not only is unmet need highest in low-income countries, but disparities also exist by age group: Among women who want to avoid pregnancy, the proportion who have an unmet need for a modern method is much higher among adolescent women aged 15 to 19 years (43 per cent) than among all women of reproductive age (24 per cent) in low- and middle-income countries (Sully and others, 2020). Women from the wealthiest households, living in urban areas and with higher levels of education, also tend to experience lower levels of unmet need than their counterparts. As of 2015, about half of women in a union who want to avoid pregnancy and who are living in humanitarian crisis-affected countries are not using any form of contraception, modern or traditional – a rate much higher than the global average (Loaiza and Liang, 2016) (see technical note on page 155).

The Family Planning Impact Consortium – a collaboration between the Guttmacher Institute, African Institute for Development Policy, Harvard University, Institute for Disease Modeling and Avenir Health – recently reviewed evidence on the value of investing in family planning to enable women to reliably decide on the timing, spacing and number of their children (Family Planning Impact Consortium, 2023). The review highlighted that having control over these core elements of fertility allows women to attain a higher level of education and affords them a wider range of career choices than they would otherwise have. Family planning also enables women to advance further in their career paths. The benefits in terms of educational opportunities also yield a wide array of other benefits for girls and women: For example, they are more likely to access health care, and to understand their rights and have the self-confidence to act on them.

Higher levels of female education are also associated with women's higher earnings (Grown and others, 2005). Women with at least some primary education earn 14 to 19 per cent more than those with no education; women with secondary education make almost twice as much as women with no education; and women with tertiary education about three times as much as those with no education, according to data from up to 96 countries (Wodon and others, 2018).

Family planning also makes it possible for women who want to become mothers to determine, at least to some extent, the spacing between the births of their children and the total number of children they have – which enables women to plan time away from work. The costs of childbearing while in the workforce include lost earnings due to a temporary exit from the workforce and a reduction in work hours, which can both contribute to the atrophy of skills and act as disincentives for employers to invest in skills building, ultimately leading to compromised career trajectories (Adda and others, 2017).

Women's expectations regarding their ability to control their childbearing can also influence their choices at the beginning of their productive years. According to evidence from Europe, a substantial portion of the career and income costs of childbearing is determined by the career paths that women pursue when they are entering the workforce, based on expected fertility patterns (Adda and others, 2017). In Germany, it was estimated that occupational choices at the beginning of the career represent 19 per cent of the lost wages associated with having children.

There is a reciprocal relationship between contraception and education, in that more education can increase the knowledge and agency that women need to access and use contraception (Blackstone and others, 2017). In effect, contraceptive care unlocks a virtuous cycle of empowerment and opportunity for women. There are also multigenerational benefits to satisfying the demand for contraceptive services and thereby creating other opportunities for women: Women who participate in the workforce are more likely to expect the same for their daughters (UNFPA, 2023). This paves the way to more life choices for children, including the opportunity to delay marriage in order to complete their schooling and gain the long-term benefits that education confers in the forms of economic, social and personal empowerment.

It's not just individuals who benefit from girls' education. Employers are increasingly aware that supporting sexual and reproductive health and rights yields gains for their own bottom lines. Companies in Asia can use a return-on-investment tool developed by UNFPA to estimate the productivity benefits of supporting employee reproductive health, for example (UNFPA Asia and the Pacific, n.d.).

Countries benefit as well, because reproductive autonomy enhances women's contributions to the national economy. According to a modelling study in Kenya, Nigeria and Senegal, per capita income would increase by 31 to 65 per cent between 2005 and 2030 if all of the current unmet need for modern contraception were met in these countries (Bloom and others, 2014). In Kenya, if two thirds of the unmet need for modern contraception were met, the country would experience a 51 per cent per capita gross domestic product (GDP) increase by 2050, through effects on the relative size of the working-age population (see technical note on page 155). The relationship between women's ability to control their fertility and economic gains to individuals, families and societies has held up in several studies across a range of settings (Family Planning Impact Consortium, 2023).

The Family Planning Impact Consortium review also brings together evidence of the global returns on investments in family planning. For example, it has been estimated that a $1 investment in family planning would result in a $60 to $100 return, over time, in the form of economic growth (Kohler and Behrman, 2018). The World Bank estimates that, globally, the limited educational opportunities for girls cost $15 trillion to $30 trillion in lost lifetime productivity and earnings (Wodon and others, 2018). It has also been estimated that, globally, female labour-force participation decreases by 10 to 15 percentage points, or close to two years, with each additional child among women aged 25 to 39 years (Grepin and Klugman, 2013; Bloom and others, 2009).

It should be noted that, while most studies of the longer-term economic benefits of helping women control their fertility focus on satisfying unmet demand for contraception, no method of contraception is foolproof and, despite the persistence of restriction on abortions in many countries globally, some 6 in 10 unintended pregnancies are estimated to end in abortion every year (Bearak and others, 2020). Demand for abortion – safe or unsafe – is therefore unlikely to disappear.

Unsafe abortions are associated with a significant percentage of maternal deaths and widespread illness and disability. It is estimated that between 5 and 13 per cent of all maternal deaths worldwide, as well as widespread illness and disability, are attributed to unsafe abortions (Say and others, 2014). One estimated total cost of abortion-related care in low- and middle-income countries is $2.8 billion annually, which includes $1 billion for abortions (provided under both safe and unsafe conditions) and $1.7 billion for post-abortion care (Sully and others, 2020). It has been estimated that, if all abortions in low- and middle-income countries that are currently unsafe were provided safely, and if all needs for contraceptive and abortion-related care were met, the total cost of abortion-related care would decrease to $600 million.

The long-term value of ending gender-based violence

Securing the reproductive autonomy of all people will be impossible without securing freedom from gender-based violence, including intimate partner violence. Worldwide, more than one in four women aged 15 to 49 years who have been in a relationship report that they have been subjected to gender-based violence in the form of physical or sexual violence by an intimate partner in their lifetime, and 13 per cent have been subjected to physical or sexual intimate partner violence at some point in the prior year (WHO, 2021).

The prevalence of intimate partner violence is exceptionally high in southern Asia and sub-Saharan Africa, where 19 to 20 per cent of women are estimated to have experienced intimate partner violence in the past 12 months. According to a review of evidence from 46 countries, poorer and younger women and those living in rural areas tend to be particularly vulnerable to intimate partner violence (Coll and others, 2020). Violence against women is also typically higher among people who are forcibly displaced and those living in conflict-affected settings (Hadush and others, 2023; Horn and others, 2021; Delkhosh and others, 2019). The destabilizing effects of these conditions and the erosion of social networks and social protections contribute to the greater risk of intimate partner violence in these settings, where prevention and response efforts are also extremely challenging.

Disentangling the relationship between violence and lack of reproductive autonomy is challenging, not simply because sexual violence and coercion directly undermine bodily autonomy but also because reproductive coercion is itself a form of violence. Still, there are ways to understand some of the causal links, for example through studies of intimate partner violence and contraceptive use. Longitudinal studies have demonstrated that women who experience intimate partner violence are significantly less likely to subsequently use contraception, and they are especially unlikely to rely on partner-dependent methods such as condoms (Maxwell and others, 2015). Intimate partner violence has also been linked with increased incidence of unwanted pregnancies (WHO, 2013). Violence, then, is a driver of the individual and societal costs associated with loss of reproductive autonomy noted in the section above.

But violence also levies a considerable economic toll in the form of other adverse reproductive health outcomes, including sexually transmitted infections (Bacchus and others, 2018; WHO, 2013) and inadequate antenatal and skilled delivery care (Musa and others, 2019). Costs can be intergenerational, as women experiencing violence during pregnancy are more likely to have miscarriages, stillbirths and babies with low birth weight (Silverman and others, 2007; Boy and Salihu, 2004). Intimate partner violence and other forms of gender-based violence can also result in psychological trauma and stress, minor to severe physical injuries, and death (WHO, 2013). Women who experience non-partner sexual violence are also at greater risk of alcohol and drug abuse and mental health disorders. Health systems also bear significant direct costs related to treating survivors of violence.

There are also workforce, productivity and wage impacts. The erosion of women's autonomy brought on through gender-based violence compromises women's ability to make their own decisions, pursue an education and contribute fully in the labour force. Violence can result in reduced employment opportunities due to fear of harassment or violence; limited occupational choices, when women seek job options they perceive as safer or more acceptable by an abuser; lower productivity due to psychological distress and physical health consequences; and absences to deal with the aftermath of gender-based violence incidents (Vyas, 2013). A 2016 report offered a formula to help employers calculate the impact of gender-based violence on operating costs, including days lost, staff turnover and recruitment costs (Walker and Duvvury, 2016).

What is the overall bill? Tallies differ, but every finding is steep: The International Monetary Fund estimated that every 1 percentage point increase in the share of women subject to gender-based violence reduces economic activity by up to 8 per cent in sub-Saharan Africa – a decline attributed predominantly to a drop in female employment (Ouedraogo and Stenzel, 2021). Research in 2022 estimated a global cost of intimate partner violence at 5 per cent of worldwide GDP and nearly 15 per cent of GDP in sub-Saharan Africa (Yount and others, 2022). One review of evidence from 13 countries found the costs of violence against women to national economies ranged from 0.35 to 6.6 per cent of GDP (Ibrahim and others, 2018). The elimination of gender-based violence would not simply remove these costs, it would result in immediate and long-term benefits for individual productivity and earning potential with impacts cascading across generations.

Immediate economic gains can also be unlocked when women are helped to escape violent relationships. One small study of women in the United States found that civil legal aid services for survivors of intimate partner violence resulted in an average of $5,500 net income gains within one year of receiving assistance, a return of $2.41 in personal income for every $1 spent on legal assistance (Teufel and others, 2021). Women who received these services were also less likely to be in poverty one year later. Investing in the prevention of violence might yield similarly strong returns.

And the benefits persist across populations and generations. Strong evidence shows gender-based violence prevention interventions improve population health writ large (Ferrari and others, 2022; Musa and others, 2019; Bacchus and others, 2018). While some programmes are more expensive than others,

The economic case for inclusion

For reasons ranging from local circumstances to discriminatory norms, it can be more difficult and costly to reach the most marginalized people. At the same time, “one-size-fits-all” approaches can often be wasteful when applied to diverse groups; tailoring to women’s and girls’ language, religion, culture and contextual factors, such as conflicts and level of infrastructure, can avoid waste and make better use of available resources. Greater levels of need for sexual and reproductive health care to realize bodily autonomy and reduce marginalization can mean greater returns on investment and a stronger boost to development. Tailoring can also limit longer-term costs from the social fragmentation that arises from worsening inequities as services benefit some people but stop at the barriers to reaching others.

Normalizing exclusion also comes with serious costs, which are impossible to fully account for because exclusion renders people invisible. But one telling sign of these costs can be found in the economic gains unlocked when exclusionary laws, policies and norms are eliminated. This case was made recently in a report on the decriminalization of same-sex activity, which found both micro- and macroeconomic gains (HIV Policy Lab and others, 2023). At the individual level, the removal of homophobic laws was found to eliminate the labour and productivity costs of arrests, prosecutions and detentions, as well as the associated physical and psychological trauma. At a larger level, at least one study holds that homophobia costs the world $126 billion per year; improving the legal environment for LGBTQIA+ people, on the other hand, was associated with a $2,000 increase in GDP per capita (Badgett and others, 2019).

a variety of them have been found to be cost-effective, with effectiveness measured as programme costs per disability-adjusted life year averted through these interventions (Ferrari and others, 2022).

It is important to reflect on the importance of tailoring to the specific contexts of those in need.

The tailoring of interventions is particularly important for reaching marginalized populations, who experience gender-based violence differently due to intersecting factors such as ethnicity, gender identity, sexual orientation, disability and economic status. Adapting prevention efforts to address the root causes of gender-based violence within these communities can increase the chances of widespread and lasting impact (Capasso and others, 2022).

While tailoring is often assumed to be costly, there are some indications that responding to the needs of people with multiple intersecting vulnerabilities can increase effectiveness and therefore value for money. For instance, some community advocates caution that interventions to reduce gender-based violence can result in the mass allocation of resources to policing and incarceration without addressing the stigmas and inequalities that lead to women's vulnerability to violence in the first place. It can even result in the "unintended consequences of criminalization for women, which include not only arrest but also intervention by the child welfare system" (Goodmark, 2022), experts note (a phenomenon also known as the "abuse-to-prison pipeline" in which reporting violence to a disbelieving authority, running away from an abuser or being trafficked can all eventually lead to arrest). In these contexts, investments in community services, survivor support and educational interventions may produce more value for money.

It is also important to note that while studies have identified risk factors that increase vulnerability to intimate partner violence, a large proportion of survivors do not experience these risk factors, and that, in effect, "no safe group of women was identified" (Coll and others, 2021). Furthermore, men and boys also experience gender-based violence at rates believed to be seriously underreported (Wörman and others, 2021). So while interventions should be targeted to reduce intimate partner violence, these tailored approaches will not be sufficient in themselves. Population-wide laws, policies and social norms must also be enacted to support gender equality, which in turn supports reductions in violence and generates positive benefits for community welfare, as well as the mental and physical health of all people.

Long-term gains from comprehensive sexuality education

As is the case with ending gender-based violence, access to comprehensive sexuality education is a precondition to enabling reproductive autonomy for all (Starrs and others, 2018) – and to unlocking all the attendant social and economic benefits.

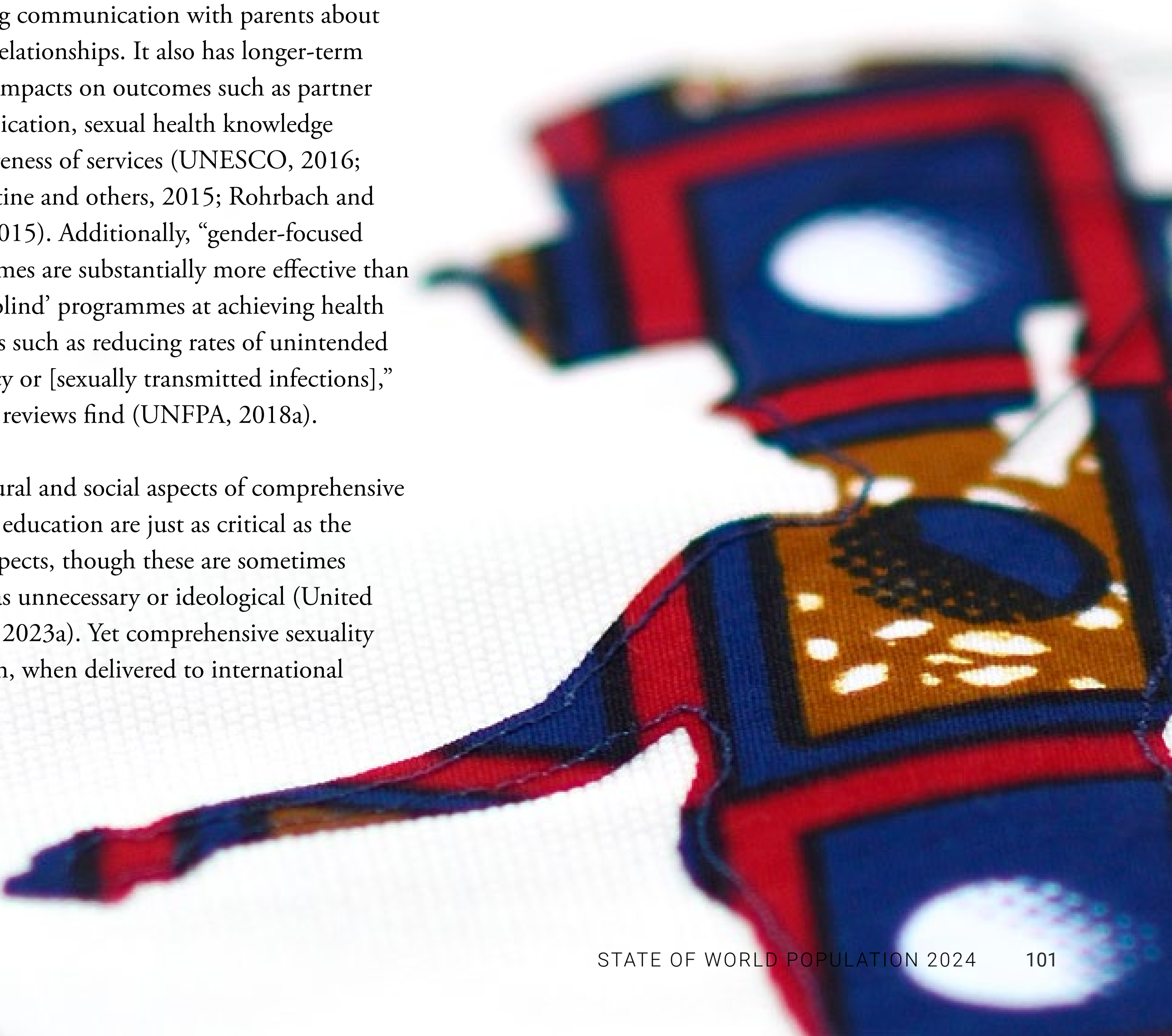
Comprehensive sexuality education equips people with the knowledge and skills they need to make informed, healthy and responsible choices related to their sexual and reproductive health throughout their lives. It covers a range of topics, including contraception, sexually transmitted infections, consent and healthy communication in relationships – with benefits spanning individual and public health, economic empowerment and physical and psychological well-being. Young people who are able to protect themselves from disease, prevent unintended pregnancies and prevent (or recognize and escape) violence are better able to pursue their education and participate and advance in the formal workforce.

While costs relative to impact have not been fully assessed, it has been demonstrated that comprehensive sexuality education is associated with delays in the age of first sexual intercourse, an increase in the utilization of contraceptive methods (Kirby, 2008), and a reduction in adolescent pregnancy rates (Aguirre and Carrión-

Yaguana, 2023; Kohler and others, 2008). Programmes that link comprehensive sexuality education with accessible, youth-friendly sexual and reproductive health services have been shown to be particularly impactful in reducing unintended pregnancy (Mbizvo and others, 2023). The returns on investment associated with these results have been elaborated in the reproductive autonomy section above (see "The long-term value of reproductive autonomy" on page 94).

The integration of internationally agreed human rights and gender equality standards into comprehensive sexuality education programmes has demonstrated short-term effectiveness in increasing knowledge, improving attitudes, and increasing communication with parents about sex and relationships. It also has longer-term positive impacts on outcomes such as partner communication, sexual health knowledge and awareness of services (UNESCO, 2016; Constantine and others, 2015; Rohrbach and others, 2015). Additionally, "gender-focused programmes are substantially more effective than 'gender-blind' programmes at achieving health outcomes such as reducing rates of unintended pregnancy or [sexually transmitted infections]," evidence reviews find (UNFPA, 2018a).

The cultural and social aspects of comprehensive sexuality education are just as critical as the health aspects, though these are sometimes derided as unnecessary or ideological (United Nations, 2023a). Yet comprehensive sexuality education, when delivered to international standards (UNFPA, 2018a), is age appropriate, culturally relevant and context appropriate. In fact, adapting comprehensive sexuality curricula to local needs is an important element of effective programming, as is ensuring their acceptability to parents, families and local communities (including faith-based organizations). This point may be particularly relevant when it comes to marginalized communities. Education or curricula that do not respond to community needs will likely fail to mitigate harm and promote positive health outcomes. For example, some countries include messages about the risks associated with "sugar daddies", or older men who offer to pay girls' school fees or provide gifts in return for sexual activity, due to the prevalence of this form of



The Suffragette Handkerchief is embroidered with 66 signatures, all of women imprisoned for their part in the Women's Social and Political Union Suffragette demonstrations of March 1912 in London. Image courtesy of the Sussex Archaeological Society.

exploitation. Others may include more emphasis on normalizing menstruation due to prevailing menstruation-related taboos (UNFPA, 2018a).

The evidence base on the impacts of comprehensive sexuality education beyond health outcomes – for example on attitudes and skills related to sexuality among adolescents, the incidence of gender-based and intimate partner violence, and the prevalence of gender-equitable norms and strong, healthy relationships – is more limited (UNFPA, 2018a). Still, there is a growing consensus that sexuality education programmes that seek explicitly to empower girls and other marginalized young people to see themselves as equal members in their relationships are particularly effective at equipping them to protect their health and to engage as active participants in society (Haberland and Rogow, 2015). In fact, researchers proposed comprehensive sexuality education as one way to help address and alleviate the rise in gender-based violence in the COVID-19 pandemic (Rollston and others, 2020), which speaks to its broader potential as a means to influence norms and behaviours.

Unfortunately, the full impact of rights-based comprehensive sexuality education has yet to be realized, in part because educators often minimize aspects of the curriculum they are uncomfortable teaching (UNFPA, 2018a) and in part because the inclusion of gender and social norms is often insufficient. One review of national sexuality education programmes in 13 countries in Africa, for example, found that the weakest content was related to gender and social norms (UNESCO, 2016).

Longitudinal studies of the longer-term returns on investment are challenging because of this inconsistency in programme application, among other factors. But it is also the case that returns on investment greatly increase when comprehensive sexuality education is delivered at scale and sustained over time. Examples from a number of countries illustrate why: An analysis of school-based sexuality education programmes in six countries found programme costs ranged from $7 to $33 per student reached in countries with fully scaled-up programmes

(Estonia, Nigeria and the Netherlands), while those costs were $50 and $160 per student reached in countries where programmes were still in the pilot stages (Kenya and Indonesia, respectively) (Kivela and others, 2013). According to a separate costing study in Indonesia, by the time an in-school comprehensive sexuality education programme has been running for three years, the programme costs drop by 90 per cent (El Halabi and Annerstedt, 2021). Moreover, the biggest share of programme costs, teacher salaries, is already embedded in educational expenses; if these are excluded, the outlays for sexuality education programming are only about 25 per cent of the full costs of scaled-up programmes as estimated above (Kivela and others, 2013).

Experts note that cost savings and investment returns are likely even higher when the provision of comprehensive sexuality education is integrated into teacher-training programmes, as this demystifies the topic and enables effective delivery of the curricula for a growing workforce of educators. The investment also mitigates costs related to in-service teacher training (UNFPA, 2018a).

Finally, the costs and returns for providing comprehensive sexuality education to out-of-school learners are likely to be quite different compared with in-school delivery. Out-of-school learners are often the most vulnerable to misinformation, coercion and exploitation, but they are also often the hardest to reach. Noting that some 263 million youth were out of school as of 2018, UNFPA and partners have developed evidence-based guidance for out-of-school comprehensive sexuality education, offering recommendations for curricula that are age appropriate as well as tailored to the needs of specific groups of people (UNFPA, 2020), such as young people with disabilities; in humanitarian settings; who are lesbian, gay, bisexual or gender non-binary/nonconforming; living with HIV; using drugs; or selling sex.

Implementing programmes for out-of-school learners carries numerous challenges, including issues around the mobility of young people as well as the lack of resources available to tailor programmes to the needs of these varied groups (Australian Aid and UNFPA, 2023; Fijian Ministry of Health and Medical Services and others, 2023). These programmes require not only monetary investments but also the right people to design and carry them out. Even though the body of evidence on their impact is limited, comprehensive sexuality education programmes for out-of-school youth hold potential for substantial returns, considering the size of this population and the heightened vulnerabilities they face (Anderson and Pörtner, 2014). These programmes also have the potential to yield cost savings over time, particularly when accounting for the higher risks to sexual and reproductive health (Anderson and Pörtner, 2014), and health overall, associated with lower educational attainment.

Further research on the impacts and potential long-term cost savings of both in-school and out-of-school comprehensive sexuality education programmes, and on programmes targeting marginalized communities, is warranted.

FEATURE

Local leadership reaches girls most in need

Maïmouna Déné is all too familiar with beliefs and assumptions that undermine equality for women and girls in her community in Burkina Faso. Literacy and labour-force participation are lower for women than men, and gender-based violence and harmful practices are tragically commonplace. But Ms. Déné, 43, has insight into another form of discrimination, one that overlaps with gender: It is, as she says, the "ignorance, social burdens and myths" that affect people with albinism.

Around the world, people with albinism face stigma, exclusion and violence, and in the worst cases can be subject to trafficking, mutilation and murder. Many people with albinism have vision challenges that are not accommodated in school or work settings, leading to high rates of school discontinuation and poverty. The impact on girls with albinism is particularly striking: In Burkina Faso, one third of girls with albinism do not finish primary school (Ero and others, 2021).

The Sahel Women's Empowerment and Demographic Dividend Project (SWEDD) Project is bringing hundreds of millions of dollars of investment into gender equality initiatives throughout West and Central Africa. But to make the most impact, the programme is engaging closely with local leaders like Ms. Déné, who are able to identify the specific needs of girls and women and how those unique needs can best be addressed.

As the president of the Association of Albino Women of Burkina Faso, she became an ambassador for the "Stronger Together" campaign, a SWEDD Project initiative performing outreach in communities at a local level. Through these efforts, she has been able to secure social inclusion for young girls and women with albinism, in schools and through access to economic opportunities and health care, including sexual and reproductive health and information services. Her association has signed agreements with the health ministry, hospitals, NGOs and other civil society groups, and offers economic training to support young people with albinism and their families. Since it was established in 2008, some 450 women with albinism and the parents of people with albinism have benefited from this training, including 280 who have learned skills in soap making to gain financial independence and help support their families.

Her role as a community leader means she is able to provide support and guidance where it is most needed. That work is intended to help not only people living with albinism today but the next generation as well: "Albinism being a genetic phenomenon, I also fight for my children," she says.

Syrah Sy Savané, in Côte d'Ivoire, is also acutely aware of the needs within her community. But she is concerned with a very different group of vulnerable girls: those at risk of abduction, forced marriage and female genital mutilation.

Ms. Savané, 50, has seen the ill effects of these practices in her own family: "I was raised by my paternal grandmother in Diokoué, a village in the north-west of Côte d'Ivoire. All my aunts suffered early and forced marriage. I was entrusted to them when they were married, I kept them company and saw them very unhappy. I also lost a cousin after she was subjected to female genital mutilation."

Ms. Savané was fortunate to have an ally in the form of her father, who strongly opposed female genital mutilation. "My aunts wanted to have it done to me too, but my father, who was a teacher, always refused."

Her experience drove her to become a social worker, before assuming a post in the ministry for women, families and children where, as a child protection expert, she saw how girls were being pulled from school to be married off. The problem, it became clear, was much larger than reaching individual girls. "It was necessary to target not the students, but the parents, who were seeking marriage for their daughters, as well as community leaders and religious guides."

Maïmouna Déné is ensuring that girls with albinism in her community have the education, skills and empowerment they need. Image courtesy of Maïmouna Déné.

Today she is applying these lessons in her work with the SWEDD Project. The project plans were written by technicians working in the very communities they were trying to reach, she says. This has proved essential in meeting the specific needs of the girls and their families. Safe spaces, husbands' clubs and other interventions are making a real difference and, Ms. Savané says, "shining a light where young girls thought they had no rights".

Dividends of a gender-equal world

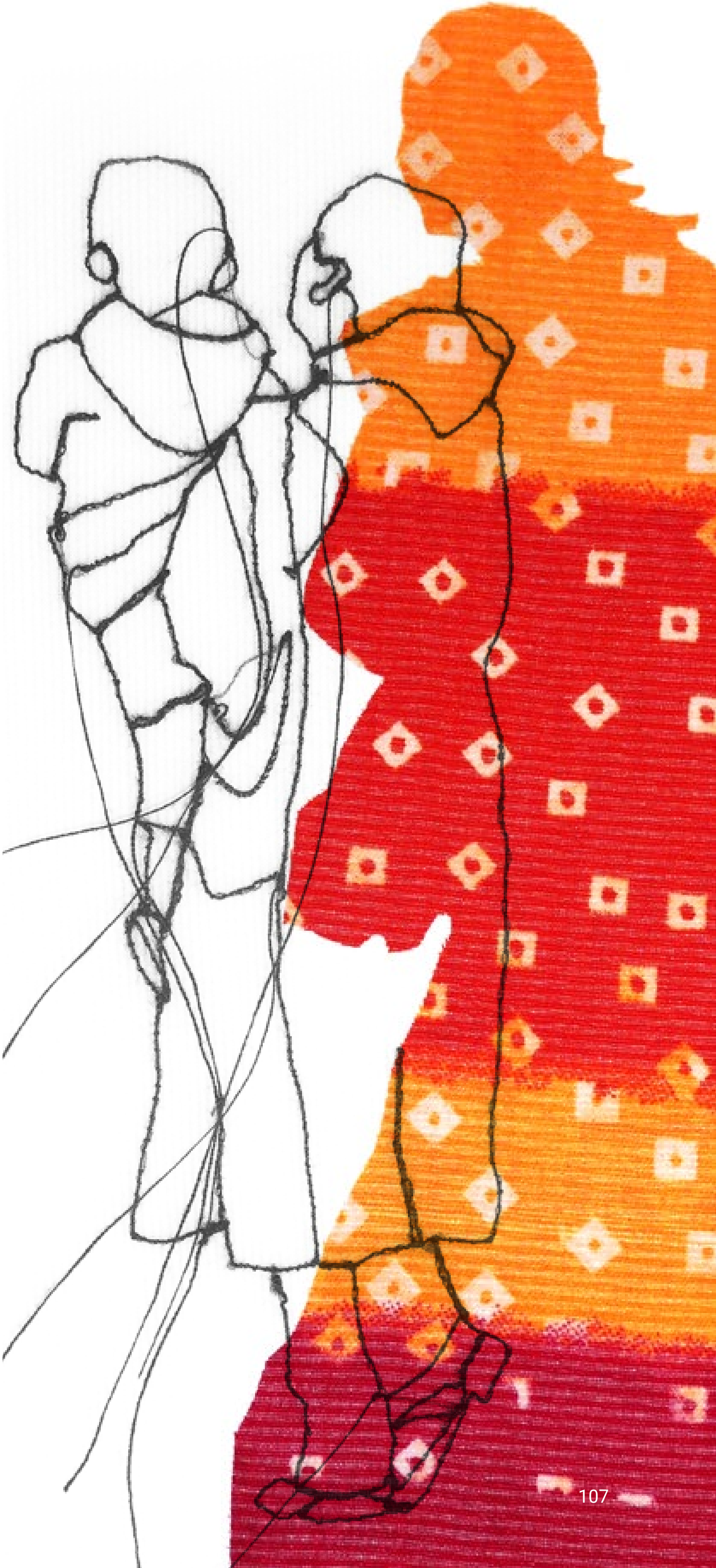
All of these elements of sexual and reproductive health – promoting individuals' rights and ability to decide whether and when to have children, ending gender-based violence and providing comprehensive sexuality education to international standards – are well rooted in human rights priorities, including the imperative to achieve gender equality. Gender equality and sexual and reproductive health have a powerful mutually reinforcing relationship. Progress on both fronts – advancing gender equality and sexual and reproductive health and rights – in tandem can be expected to maximize the social and economic benefits for societies as a whole.

Perhaps the most powerful illustration of this is the essential role of both sexual and reproductive health and rights and gender equality in the demographic dividend. When women use contraception to avoid unplanned births, the subsequent decline in fertility eventually leads to a smaller proportion of dependent children in the population relative to the size of the working-age population. This demographic shift can lead to what is commonly referred to as the demographic dividend: increased rates of productivity and economic growth. The concept of the demographic dividend was inspired by observations of economic growth following fertility decline in East Asian countries from the 1960s to the 1990s (Bloom and others, 2003).

But the demographic dividend does not automatically follow a fertility decline. In Asia, economic growth during the demographic transition was attributed, in part, to women's participation in the workforce (Bloom and others, 2009). Some evidence and policy analyses have concluded that the demographic dividend will not be replicated in the absence of some measure of gender equality alongside fertility declines (Marone, 2016). Indeed, fully one third of the economic growth experienced in Asia during the demographic dividend years has been attributed to improvements in women's empowerment and participation in the labour force alongside rapid fertility transition (Cardona and others, 2020).

In recognition of this, the United Nations and the World Bank Group launched the Sahel Women's Empowerment and Demographic Dividend (SWEDD) Project, a regional initiative to simultaneously reduce gender inequality and increase access to reproductive health services, in order to yield the benefits of a demographic dividend in the participating countries – those with some of the globally most left behind women and girls when considering indicators such as maternal mortality ratio, child marriage prevalence and adolescent birth rate.

The SWEDD Project is structured around three components: gender-transformative interventions that promote girls' and women's social and economic autonomy; programmes to strengthen reproductive, maternal, newborn, child and adolescent health and nutrition services, including by increasing the numbers of qualified health workers at the community level; and fostering regional and national commitments to gender equality and project implementation, as well as capacity for policymaking. Since it began in 2015, the project has reached nine countries (Benin,



Reaching those most globally left behind

The SWEDD Project targets girls most left behind by global progress, seeking to reach districts and communities affected by some of the world's highest rates of female genital mutilation, child marriage, unmet need for contraception, lower education attainment levels and poverty, as well as factors such as limited access to mass media or telephone (Camber, 2020). One important element of the SWEDD Project is life skills education (a culturally appropriate term for comprehensive sexuality education) provided through safe spaces located both in schools and within the community. The locations and constituents of the safe spaces are selected based on vulnerability criteria, ensuring the most disadvantaged adolescents and young women, including those out of school, are reached. The curricula are intended to enhance girls' knowledge and skills, with a specific focus on reproductive health, gender and human rights as well as financial capacity and economic empowerment – an acknowledgement of the deep connection between sexual and reproductive health and rights and human capital development. Importantly, the life skills curricula are developed through a participatory process designed to consider the sociocultural realities of each country, and are delivered by community mentors, ensuring the implementation is locally relevant.

The ability to tailor programming to local needs has been instrumental in the success of the work of Senami Mariette Atolou, a mentor at a safe space in Benin. Ms. Atolou experienced an adolescent pregnancy and subsequent abandonment; now 46, she is able to share insights from her life with girls facing similar challenges: "My relationship with young people, girls, allows me to guide them," she says.

As the SWEDD Project's name suggests, the investments are designed to unlock a demographic dividend, meaning economic and development results on a generational scale. The multifaceted initiative – which includes not only life skills but also midwifery training, efforts to end gender-based violence and improved access to contraceptive care and economic opportunities – is intended to create positive ripple effects that contribute to the broader transformation of societies in Sahelian countries. Measuring return on investment – which stands at around $850 million – will necessarily take time, but baseline data for all countries have been collected, enabling consistent and thorough monitoring of results.

And early results are promising. As of December 2023, the programme component aimed at empowering women and girls saw a 96 per cent school retention rate for adolescent girls in secondary schools receiving interventions, up from 75 per cent at baseline. In addition, 96 per cent of adolescent girls and women in life skills training clubs demonstrated good knowledge on the harms of child marriage and early pregnancy and on the benefits of birth spacing, compared to 74 per cent at baseline; and 21,087 cases of gender-based violence and harmful practice were referred to health, social, legal and security services, up from 5,415 at baseline. New users of modern contraceptives numbered around 903,000, up from 24,000 at baseline; and an estimated 8,790 maternal deaths, 2,422,000 unintended pregnancies and 830,000 unsafe abortions were averted (UNFPA, 2024d; UNFPA, n.d.a.).

Other outcomes, such as wide-reaching awareness campaigns and the establishment of a network of national observatories to monitor the implementation of public policies to support the demographic dividend, show promise that more change is on the horizon.

Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Guinea, Mali, Mauritania and Niger), and three more (Gambia, Senegal and Togo) have been approved for further expansion.

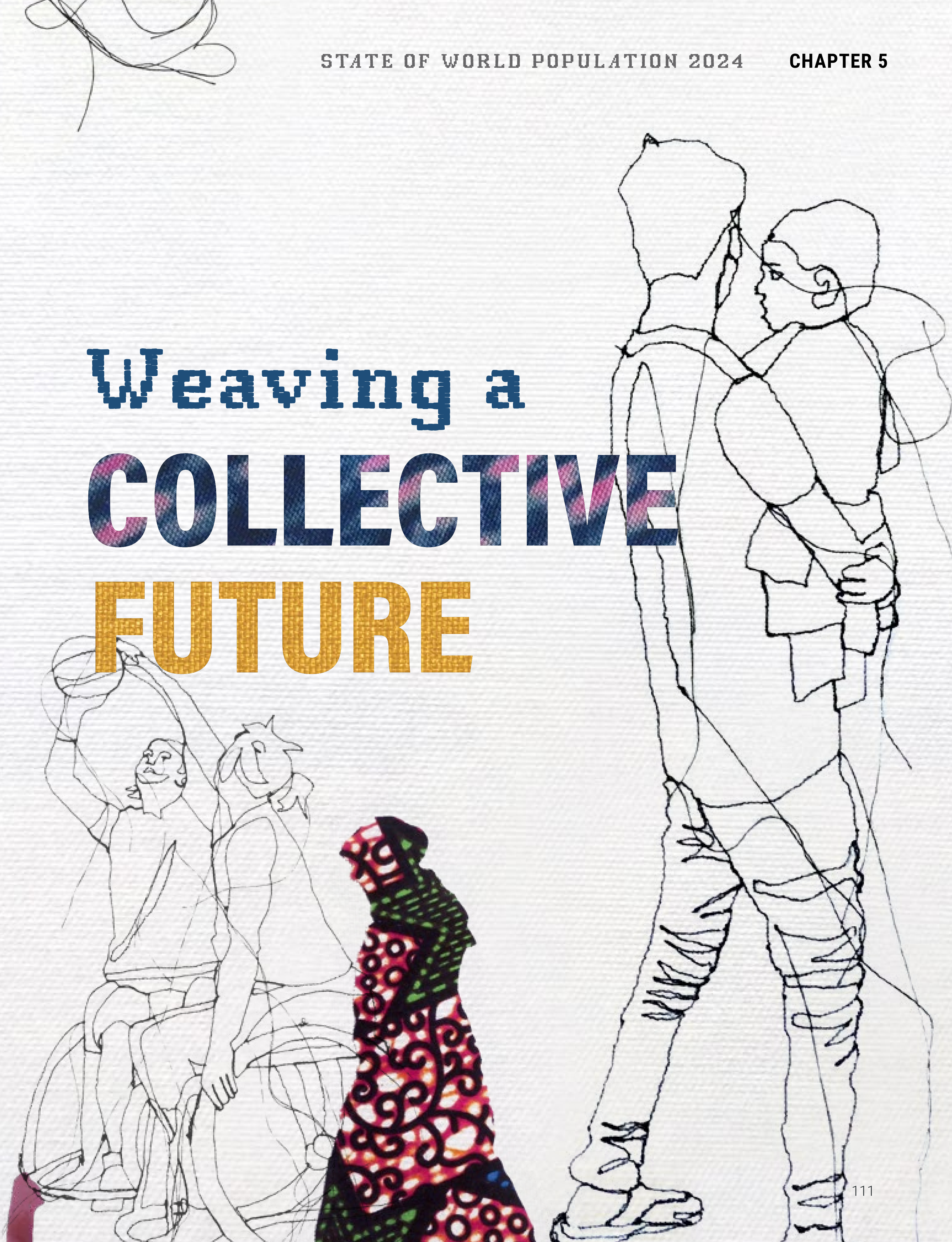
Key to this effort has been participation and partnership by civil society, women's organizations and other stakeholders in a holistic and integrated way. For example, more than 20,000 community and religious leaders have been engaged in promoting girls' education and adolescent sexual and reproductive health, and ending gender-based violence during the course of the programme (UNFPA, 2024d). The participation of community and faith leaders offers both a sign of local-level investment and also a strong indication that the programme is positively influencing social and gender norms at the ground level. The coordinated participation of stakeholders at all levels also enables the sharing of lessons across countries, opportunities for productive South-South cooperation and possibilities for the scaling-up of interventions.

Programmes like this can have powerful positive impacts on countries, and even on the national economy. It has been estimated that closing the global gender gap and advancing women's equality in the public, private and social sectors, even in the absence of further investments in sexual and reproductive health and rights programmes, could double the contribution of women to global GDP growth, and could add $12 trillion to global GDP in the course of 10 years (McKinsey Global Institute, 2015).

As the SWEDD Project's early achievements show, integrated action to empower women and girls through mutually reinforcing interventions can unleash a virtuous and sustainable cycle of human development – making the demographic dividend a reality for those not yet reached by the arc of progress, and lifting up the potential, rights and well-being of every girl. And these early results are just the beginning – the full impact will only be seen when the women and girls of today complete their educations, embark on their careers and plan the families of their choosing.

In all, the economic case for investing in programmes that advance reproductive autonomy and other aspects of sexual and reproductive health is strong – and the returns are even greater, perhaps synergistically increased, when these happen alongside improvements in gender equality. The world can and should work towards further strengthening the economic case for investing in programmes to serve the most marginalized, the most pushed behind. More data and analysis are needed to understand the full range of returns unlocked when we target investment towards those who need it most. But even with the evidence base we have now – coupled with common sense and a sense of what is right – the case is clear. The next step must be action.

Weaving a COLLECTIVE FUTURE



"If you have come here to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together." These were the words of Lilla Watson, an indigenous activist from Australia, at the 1985 United Nations Decade for Women Conference in Nairobi.

Today, perhaps more than ever, this notion is gaining momentum. Advocates, justice organizations and leaders are embracing a vision in which strengthening the rights and welfare of individuals reinforces those of the collective, and vice versa (see timeline on pages 34–39). It is increasingly clear that collective action offers the only path forward when it comes to many of the world's largest concerns, from climate change to increasing demographic diversity to the digital revolution. Collective efforts that reinforce individual rights are essential, too, when it comes to sexual and reproductive health. As this chapter elaborates, humanity will be ill equipped to address the challenges ahead unless we embrace an approach that is grounded in human rights as well as scientific and historical fact.

> "If you have come here to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together."
>
> – LILLA WATSON

Three decades of progress: a promising start

History shows us that solidarity works. The power of collective action – by individuals, advocates, civil society, institutions and Member States – should not be in doubt, but it is nonetheless worth reflecting on the power and promise of such efforts, which have shaped the past 30 years.

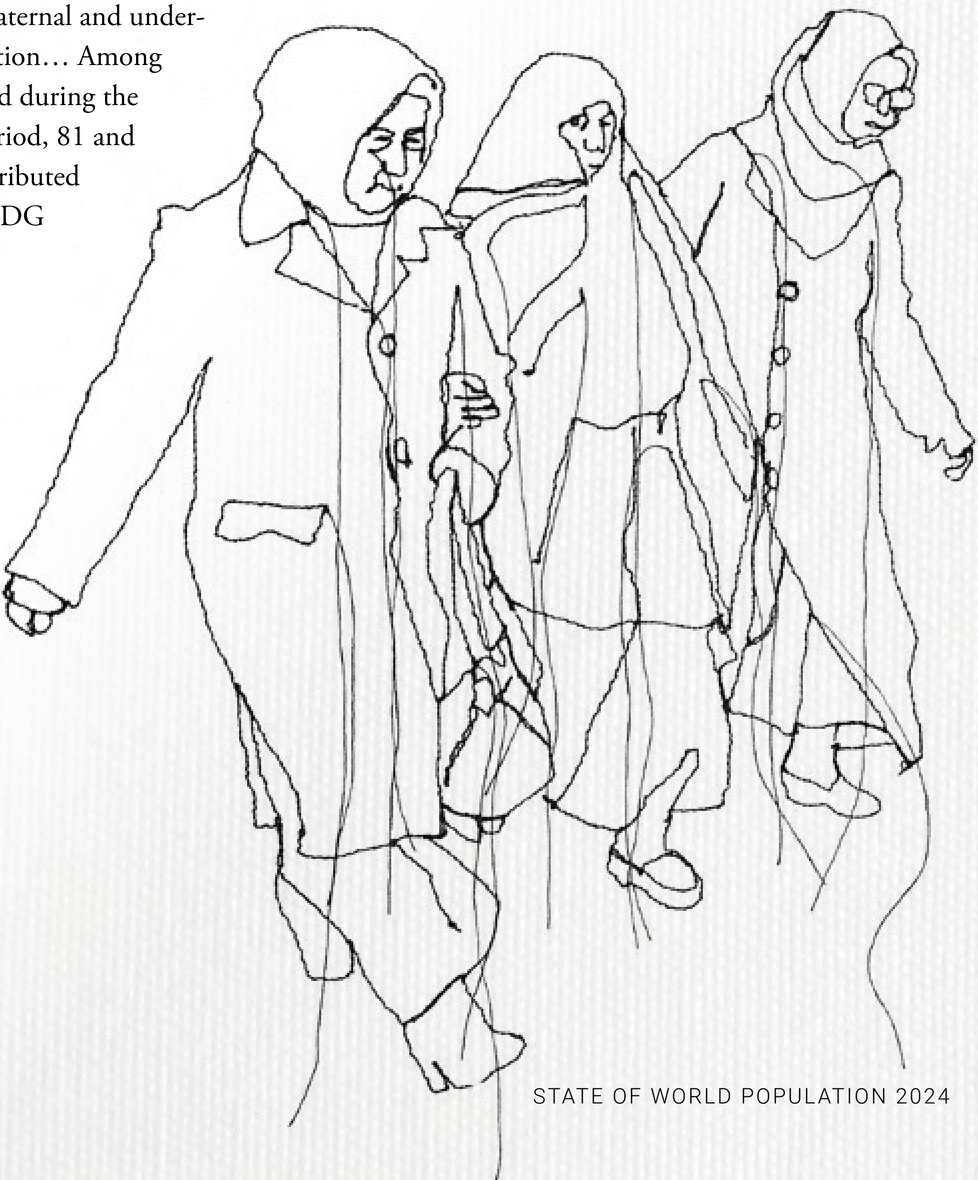
Indeed, since the ICPD, women's ability to use modern contraceptives has increased significantly: Between 1990 and 2022, the percentage of women married or in a union using modern contraceptive methods rose from 11.5 to 33.5 per cent. In middle-income countries, this percentage increased from 52.9 to 61 per cent (UN DESA, 2022c). In the period between 1990–1994 and 2015–2019, there has been a 19 per cent decline in the unintended pregnancy rate (Bearak and others, 2018), a major achievement in women's ability to exercise decision-making power over their bodies and futures. Relatedly, the global maternal mortality ratio fell by more than one third between 2000 and 2020 (WHO and others, 2023). Advances in medicine and health systems played a considerable role in both of these milestones. Contraceptive technology allows a wide choice of safe, reliable methods. Skilled health workers, available essential medicines and quality reproductive health services provided to international standards can also be credited for these gains in maternal survival.

It is no coincidence that this progress followed the watershed consensus reached at the ICPD in Cairo. The underlying agreement of the ICPD –

that sexual and reproductive health and rights are inextricable from broader sustainable development and, therefore, the welfare of all people – was carried forward in many of the international, regional and global initiatives undertaken since 1994.

One important example is the Millennium Development Goals (MDGs), globally agreed goals promoted between 2000 and 2015, that saw significant improvements in human health and well-being. The contribution of global solidarity and investment to achieving those results has been much debated, but recent research finds Africa experienced "a significant increase in progress for both maternal and under-five mortality reduction… Among the progress achieved during the MDG campaign period, 81 and 68 per cent were attributed to the worldwide MDG campaign for the maternal and under-five mortality reduction" (Cha, 2017). The researchers call for more attention to be paid to these positive results, noting "dominant pessimism about the sub-Saharan African countries, which showed the best performance among all the regions, can overshadow their substantial achievement".

A similar point must be made about the present day. Last year, 2023, marked the midpoint of global efforts to achieve the SDGs, which build upon the MDGs. Progress in achieving the SDGs has been greatly hampered by the COVID-19 pandemic as well as the grievous



impacts of conflict, climate change, biodiversity loss and pollution. Despite these challenges, there have been signs of success, including on the targets linked to the ICPD agenda. For instance, the proportion of women in lower and single chambers of national legislatures grew by 4.2 percentage points between 2015 and 2023. The proportion of women whose need for modern family planning was satisfied increased modestly, from 76.5 to 77.6 per cent, even as the global population grew – and the proportionately largest increase was seen in sub-Saharan Africa, the area with the greatest need. The global adolescent birth rate fell even more significantly, from 47.2 births per 1,000 girls in 2015 to 41.3 in 2023 (UN DESA, 2023). These gains, made even amid the extraordinary disruptions of the pandemic, demonstrate that the SDGs are achievable – if we follow the evidence and reject the pessimism that all too easily overshadows progress.

Undeniably, the pace of progress must be accelerated. Success has stagnated on many counts, most notably in the failure to improve maternal mortality rates between 2016 and 2020 (WHO and others, 2023). Adolescent pregnancy rates remain high across the developing world, with nearly one in three young women aged 20 to 24 years having given birth in adolescence (UNFPA, 2024a). Global abortion rates have been steady for decades, with declines observed only in countries where it is broadly legal (here, the abortion rate fell from 46 per 1,000 women in 1990–1994 to 26 in 2015–2019) (Bearak and others, 2018). And for the first time ever, the world has trend data on women's ability to exercise bodily autonomy (as measured by SDG 5.6.1) from 32 countries. A forthcoming analysis of these data shows a positive trend in 19 countries and a negative trend in 13 (UNFPA, n.d.).

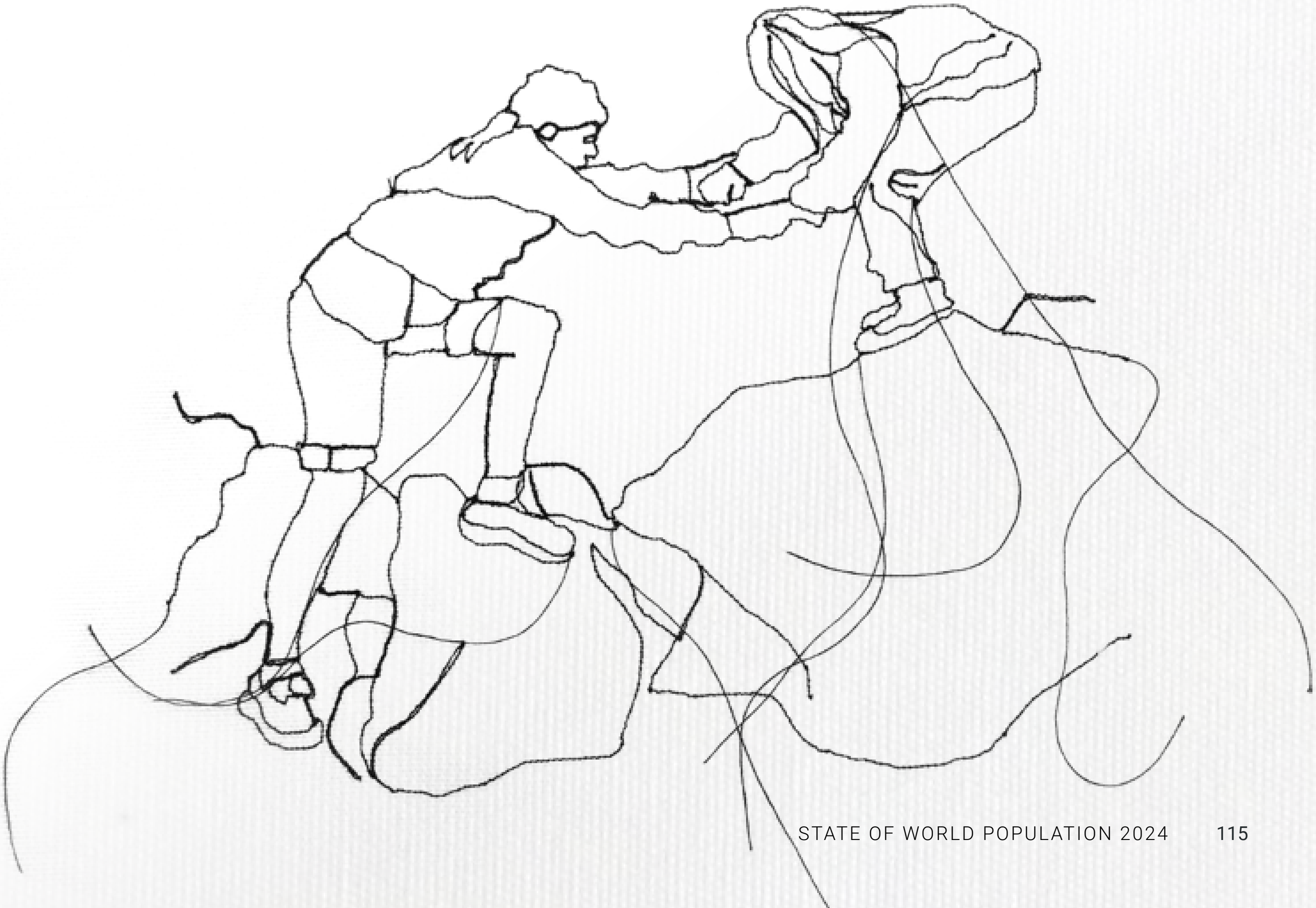
It must also be acknowledged that reversals in progress are taking place. Rates of gender-based violence skyrocketed in many countries during COVID-19 lockdowns, and new technologies are enabling this abuse to be perpetrated in virtual environments (University of Melbourne and UNFPA, 2023). And in some countries, the very heart of the ICPD – the consensus on reproductive health and gender equality – is being undermined, with backtracking often directed at the most vulnerable. In one country, migrants are denied health care (MTI-Hungary

Today, 2019); in another, enactment of restrictive abortion laws is expected to exacerbate health inequities for people with chronic health conditions, especially people from racial minorities (Hassan and others, 2023). In yet another, a military takeover means that women have largely been confined to their homes and denied education and employment (United Nations, 2023b). Elsewhere, discriminatory laws have been expanded to call for the death penalty for LGBTQIA+ persons (United Nations, 2023c).

But we cannot allow these obstacles to derail our demonstrated trajectory of progress. As this report notes, the world is at an inflection point, a moment where the weight of evidence points towards inclusive solutions even as the storm clouds of uncertainty, polarization and disinformation gather on the horizon.

A vision of the world to come

The changes of the past 30 years represent tectonic shifts in how the world works, in our health systems, political institutions and social norms, and in our expectations for our bodies, families and futures. These changes are only going to accelerate in the coming decades. At the end of 2023, UNFPA brought together a consortium of experts in human rights, sexual and reproductive health, demography, gender-based violence, technology and climate change, seeking to forecast the biggest challenges and opportunities for humanity looming just over the horizon. Many of the projections are disquieting – warranting not pessimism but vigilance.



The ongoing climate catastrophe is expected to greatly exacerbate global inequalities. Low-income populations who have contributed least to climate change are most likely to suffer from climate-related cyclones, droughts, flooding, heatwaves and other consequences. Additionally, climate change is expected to trigger increased national and international migration, which – as this report has highlighted – is a significant, and growing, cause of marginalization, with particularly deleterious impacts on sexual and reproductive health and rights. Crisis conditions and service disruptions are likely to place greatest stress on already marginalized groups, for example leading to greater incidence of gender-based violence and harmful practices like child marriage. Potential threats to reproductive health include greater difficulty conceiving, greater risks of miscarriage and risks to both maternal and newborn health (UNFPA, 2024e).

Demographic trends are also projected to greatly reshape the world as we know it, with many countries experiencing significant population ageing and others experiencing a boom in young people – a divergence likely to grow more extreme over time. While migration trends are difficult to predict, disparities in population growth rates, as well as uneven economic development and other factors, could potentially amplify the pace of global migration and related concerns over the health and rights of migrants. Anxiety over demographic changes, including the perceived threat of population decline and very low fertility in certain places, is leading some policymakers to push back against the values of the ICPD (UNFPA, 2024f).

The many successes that have been achieved in the area of sexual and reproductive health and rights could well be put in jeopardy as the world grapples with these and other megatrends. In anticipation of these changes, countries must reaffirm the basic principles of the ICPD to ensure that the rights and services guaranteed by the Programme of Action are available to everyone – including migrants and refugees.

Governments and societies can also address the rising challenges by harnessing new technologies. Such advances can, for example, go further towards ending the world's unmet need for contraception and address the growing issue of infertility. Health systems also require strengthening, and opportunities are emerging in the form of digital health records and identification, and increasing access to digital health tools (UNFPA, 2024). Such digital tools offer great potential but only if the digital divide – the gap between those who benefit from information technology and those who do not – is eliminated or greatly reduced. The downsides of the digital revolution, including the rise in disinformation campaigns, must also be addressed. Digital tools and information can be weaponized against vulnerable groups based on ethnicity, sexuality or gender. And technology-facilitated gender-based violence is taking a significant toll on the health, safety, and political and economic well-being of women and girls – and society as a whole (UNFPA, 2024b).

Finally, as Chapter 3 of this report emphasizes, advancing the ICPD Programme of Action and addressing emergent challenges require data systems that provide insight into demographic and social realities while enabling policymakers to anticipate the impact of megatrends. Since

1994, global data systems have grown stronger, but many national data ecosystems remain under-resourced. Without reliable data, none of the world's challenges can be confronted successfully. At the same time, we must face up to the growing risks related to data privacy and misuse that accompany rapid advancements in data technology. And, of course, data systems must generate and analyse disaggregated data so that existing inequalities can be addressed (UNFPA, 2024c). As this report has shown, the will and capacity of governments to collect and analyse these data will be essential to addressing the inequalities that hinder full achievement of the ICPD and SDG agendas.

The range of possible global futures, both positive and negative, is vast. Indeed, while global challenges are growing, so too is the unpredictability of their possible outcomes. In this time of uncertainty, one fact is inescapable: Our fates are interwoven. Amid the most intractable disputes and existential concerns, the only way forward is through collaboration, solidarity, shared values, narrowed inequities and the assurance of hope and dignity for all.

FEATURE

Sexual health of older adults emerging from the shadows

Some women arrived alone. Some came with friends. Some were as old as 70. All came for the Age of Love "café" at a community centre in Northampton, England, one Saturday afternoon in August 2023.

Inside, organizers played upbeat music while the women waited for the day's programme to begin. The curtains were drawn for privacy. Some women chatted with friends while others sat silently.

"At first, everyone was a little nervous, given that for the next three hours, the conversations would be about sex and health," says Audrey Tang, a psychologist, educator and co-organizer of the event. "But almost immediately, people started opening up – and having fun," Ms. Tang adds.

The event was one of a series in which older adults have an opportunity to learn in a "convivial and confidential" environment about sexual health and get answers to questions about their bodies and sexuality as they age, according to University of Sheffield psychology professor Sharron Hinchliff, who created the Age of Love series in 2019.

She says the events help fill the information void often encountered by older adults when they want to find out about matters such as menopause, erectile dysfunction, or the impacts of illness and medications on libidos.

"We keep hearing from older adults that there is no easy way to find trustworthy information," Prof. Hinchliff says. Part of the problem is that there's an assumption that older adults aren't sexual and therefore don't need information, she explains.

"But we know that many older adults are sexually active," she adds. Many others would like to be but are not: One study in the United Kingdom in 2019 found that about one in four men and one in six women between the ages of 55 and 74 have a health condition or take a medication affecting their sex lives (Erens and others, 2019). According to the Healthy Lifespan Institute at the University of Sheffield, the problem is even worse for the one in two people aged 65 or older living with two or more chronic diseases.

"There is a large unmet need" for information and services among the United Kingdom's older adults, Prof. Hinchliff says. And that need is likely to grow as people are living longer. Life expectancy in the country is about 80 years, and today about one in four people is aged 60 or older (UN DESA, 2022a).

Older adults tell Prof. Hinchliff their sexual health needs and concerns are often neglected or ignored by doctors because of their age. "This ranged from not being told when it was safe to resume sexual intercourse after a hysterectomy to being advised that painful sex was 'due to age' but without being offered any help or advice," Prof. Hinchliff says.

Anecdotal and scientific evidence show that the sexual rights of older adults are rarely met. In response, Prof. Hinchliff, along with University of Sheffield research associate Stephanie Ejegi-Memeh and Age-Friendly Sheffield learning officer Gilli Cliff, devised the United Kingdom's first Sexual Rights Charter for Older Adults, which aims "to ensure that people are treated with dignity and respect, and without discrimination, as they age when it comes to their sexuality".

Denying the sexual rights of older people can take many forms, ranging from being prevented from forming intimate relationships in care homes to being excluded from sexual health and education campaigns, including ones aimed at prevention and treatment of sexually transmitted infections.

In 2019, Age UK showed that between 2014 and 2018 new diagnoses of sexually transmitted infections fell by more than 7 per cent among men aged 20 to 24, yet they rose by nearly 14 per cent among men aged 45 to 64, and by 23 per cent among men and women aged 65 or older during that same period (Age UK, 2019). The trend reflects age-related inequalities in sexual health services and information in the United Kingdom, Prof. Hinchliff says.

Meanwhile, older adults are less likely than younger people to report sexual assault because of concerns about not being believed because they do not fit the "image of the rape victim", she says. And they may delay or avoid seeking help for sexual matters because they are painfully aware of the prevailing view that older people should not or do not have sex.

All these challenges are compounded for older adults who are gay, lesbian or transgender, are from racial or ethnic minorities, come from more conservative backgrounds or are from poorer households, Prof. Hinchliff says.

At the Age of Love café in Northampton, England, older adults can learn about sexual health in a safe and confidential environment. © Sharron Hinchliff

The Sexual Rights Charter is meant to help health-care providers, social workers, community groups, the volunteer workforce and policymakers better understand and respond to the needs of older adults. It is meant to "underpin" every initiative aimed at making Sheffield a great place for people to grow old.

"The idea for the Charter was born out of frustration" because many issues can be easily addressed by asking patients simple questions about, for example, how a medication might be affecting their sex lives, Prof. Hinchliff explains. The ideas within the charter are now being translated into action: With colleagues at the University of Sheffield, Prof. Hinchliff created AgeSexandYou.com, a website with straightforward information about sexual health and sexuality for older women and men.

In 2018, the World Health Organization welcomed Age-Friendly Sheffield, a partnership of organizations and individuals, into the global Age-friendly Cities and Communities network. As part of this network, Age-Friendly Sheffield is striving to create age-friendly physical and social environments. The café events are part of this effort. The first events were aimed at women, but one in December 2023, "Breaking the Silence," targeted men and focused on their mental health and well-being, including sexual well-being. "Men want to talk about these things as well," Prof. Hinchliff says, "but we often don't give them the chance or the right environment to do so."

The journey ahead

As this report acknowledges, there is no one-size-fits-all solution. But there are approaches, rooted in both ample evidence and international agreement, that can and will advance our shared goals. They include intensifying our already agreed-upon efforts to meet the needs of those most left behind, ensure inclusivity in decision-making and leadership, advance both comprehensiveness and universality in health care and increase access to quality, unbiased, medically accurate reproductive health knowledge for all.

Tailoring

The needs and perspectives of people who are subjected to the forces of marginalization must be proactively incorporated into sexual and reproductive health care and efforts to secure their reproductive rights. As WHO acknowledged in 2009, "although poverty and gender signficantly influence health and socioeconomic development, health professionals are not always adequately prepared to address such issues in their work" (WHO, 2009). The research summarized throughout this report highlights how poverty and gender are just two of many factors that overlap to contribute to many people's lack of access to and use of reproductive health care services and the realization of their reproductive rights. Addressing those gaps means looking at issues of inclusion, tailoring and targeting.

One concern is that tailoring to specific groups seems, on a superficial level, to contradict efforts to implement integrated models of care, wherein sexual and reproductive health information and care are provided through existing service delivery points. For example, integrating sexual and reproductive health services within HIV services has been shown to improve access, quality of care and health worker productivity, while also reducing stigma (Ford and others, 2021). But tailoring and integration need not be antonyms, and in fact they can be complementary. Complex care management programmes, for example, have been recommended to use the data and tools of existing health systems (including medical records analysis and patient classification systems) while also emphasizing the individual circumstances that impact service uptake and effectiveness, factors like precarious housing, transportation and social conditions (Williams and Fendrick, 2022). Tailored approaches, then, need not supplant integrated health systems.

Tailoring and targeted approaches can take many forms, but key to the effort is the meaningful participation of members of the affected community. These communities can, for example, identify approaches that are as simple as translation services or targeted outreach efforts, or they may call for more complex and expensive efforts, including specially designed or implemented stand-alone programmes. These latter programmes can provoke particular resistance, with some critics arguing that they actually reinforce stigma and exclusion by treating certain populations as the "other". Evidence, however, shows that the opposite can be true, with tailored programme designs actually granting people a space that ensures dignity and safety and reflects their specific needs, which may be different from others.

Perhaps the most salient example of this is the case of HIV, which disproportionately affects stigmatized communities, including sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs and people in prisons and other enclosed settings. In 2021, these populations and their sexual partners accounted for 70 per cent of new HIV infections, and each of these populations experienced inequitable access to safe, effective and quality HIV services. Furthermore, the resulting association between these groups and HIV transmission contributes to a cascade of further rights abuses, including discrimination, violence and criminalization (USAID, 2022). One study of successful HIV prevention and treatment programmes in Asia highlighted the importance of meaningfully engaging with key populations in services, research and programming, citing as an example the transgender-designed and -led "Tangerine" community health centre in Thailand (Yang and others, 2020). The availability of such community-led services has been shown to result in a much greater usage of HIV diagnostic and treatment programmes among targeted groups (Nugroh and others, 2017). A meta-analysis of HIV programmes for female sex workers in Africa, for instance, found that the key to reducing the transmission of HIV was consulting with the communities and targeting their specific needs in HIV prevention (Atuhaire and others, 2021).

Community inclusion, participation of the most left behind, bringing everyone to the table – these are lofty goals, but the obstacles are real and plentiful. One major barrier is the question of financial resources – a refrain that is likely to become even more frequent in constrained funding environments. But costs may not be the biggest barrier – indeed, Chapter 4 of this report highlights the extraordinary economic potential that can be unlocked when the sexual and reproductive health and rights of all people are realized. Instead, the attitudes, assumptions and divides that contribute to marginalization may actually be greater challenges to progress. From hostility towards LGBTQIA+ people, to poor (or even non-existent) communication with ethnic minorities, to neglect in implementing even simple measures that would improve service accessibility for disabled persons – the list of barriers is long, and while overcoming each of these examples would likely incur a cost, the arguably taller hurdle is in encouraging the normative and structural shifts that are required to effectively include marginalized people in the first place.

Meanwhile, failing to listen to, and tailor to, the needs of these groups can incur a significant cost – not only in the worsened health outcomes of marginalized groups but also in the form of expenses borne by health systems. For example, many indigenous women in northern Canada have historically preferred to give birth at home with a midwife or other female caregiver – a practice that was restricted by health authorities concerned about the safety of midwifery practices. As a result, at 36 weeks of gestation, pregnant women and adolescents in northern areas often had to be flown to urban facilities with advanced services, incurring significant costs. Today, midwifery is being reintroduced in the north, ensuring both modern obstetrical quality care and preservation of traditional birthing preferences. Women who give birth under the care of a midwife in Nunavut birthing centres, for example, report lower stress levels, greater involvement in decision-making and better psychosocial support compared to mothers who had to give birth in urban centres (Mikhail and others, 2021). The best-intentioned interventions, even those backed by abundant resources, do not, and cannot, achieve optimal results unless they involve the individuals and communities affected.

Inclusivity

Key to tailoring, as the previous several examples highlight, is inclusive participation of the communities affected. But inclusivity is critical beyond the work of targeting communities and populations, and, for several reasons, it bears consideration as a broader approach to sexual and reproductive health care.

Foremost among these reasons is that a community can appear collectively, to policymakers and programme designers, as a monolith when nothing could be further from the case. Indigenous populations in countries in every region of the world suffer from poorer health outcomes, for example (Akter and others, 2018). Yet these groups are extraordinarily diverse, both within and between countries. They often face intersecting forms of marginalization – including remote locations, poverty, challenges communicating in national languages, deprivation of education and discrimination often linked to historical traumas. Despite such similarities, each is unique, and the differences matter when it comes to health service uptake and acceptability.

Within a single indigenous group, socioeconomic differences can influence health outcomes, for example. In one study, indigenous women with more education were 11 times more likely to use maternal health services and 23 times more likely to access antenatal care services during pregnancy compared with those who had not been to school (Islam, 2017). Likewise, income status was a determinant of whether indigenous women accessed maternal health services, as was exposure to mass media and their relationship with health workers (Akter and others, 2018).

The needs of indigenous communities can be highly variable when it comes to sexual and reproductive health – a topic that is both sensitive and deeply rooted in cultural norms. Preferences for giving birth at home, with one's partner or with family members, can be powerfully influenced by culture. Preference for birthing positions can be cultural as well. Some Quechua indigenous women in Peru, for example, prefer vertical delivery using a rope suspended from a ceiling, a practice non-standard to medical practitioners in the country (Gabrysch and others, 2009). And, of course, indigeneity is simply one example of how inclusive design and community participation are essential in creating sexual and reproductive health system interventions – others' needs might vary based on migration status, caste, disability, age or other factors.

Even more powerful than community participation is community leadership. Programmes, funding mechanisms and other efforts to support community leadership are growing, as is endorsement of this approach at the highest levels. In the closing weeks of 2023, for example, UNAIDS called for increasing community leadership in disaggregated data collection and in the provision of services for HIV prevention, testing and treatment. This announcement drew particular attention to the need to reach transgender people, both with data-collection efforts and with HIV services tailored to needs as determined by transgender communities themselves. It was also notable for being the first time a Member State-led body adopted a consensus decision with references and commitments to transgender people (UNAIDS, 2023) – thereby affirming the necessity of engaging with, and directing funding towards, a community that remains among the most stigmatized and marginalized in the world.

The power of representation in decision-making is well elaborated in studies of leadership quotas for women, which show positive effects for gender equality broadly (O'Brien and Rickne, 2016). An example in Chapter 3 further illustrates the value of representation for health outcomes specifically: Increasing the numbers of female physicians and improving support and respect for nurses and midwives has been associated with improved health-care access and health outcomes for women (see page 72). Likewise, representation may be especially critical in the area of sexual and reproductive health, where stigma is a frequent barrier to care (Bohren and others, 2022).

More to the point, inclusion in decision-making means redressing power imbalances – imbalances that may be invisible even to those who wield power. Efforts to acknowledge and address inequities and increase inclusion are often met with counterclaims that they are discriminatory

Assuit is an ancient, intricate form of metal thread embroidery traditionally practiced by women in northern Egypt. The Tally Assuit Women's Collective (TAWC) is an intergenerational group of artisans dedicated to keeping the craft alive. The TAWC are a regular participant of the International Folk Art Market. © Tally Assuit Women's Collective

FEATURE

Ngäbe women spark a revolution in women's health and equality

"It's three hours walking," 25-year-old Eneida says, offering a casual description of the arduous mountain hike she had completed well into her ninth month of pregnancy to reach the maternity waiting facility, or *casa materna*.

Eneida lives in the remote Comarca Ngäbe Buglé, a region inhabited by the Ngäbe and Buglé indigenous groups, located high in the mountains of western Panama. There are only a few paved roads in the *comarca*, and they are pitted with holes. Some residents travel by horse. Most walk. Many pregnant women give birth at home for this reason. It is no coincidence that the *comarca* has the highest maternal death rate of any region in the country.

Eneida chose to wait out the final days of her pregnancy at the Casa Materna de San Félix, a maternity waiting home that provides food, health care and transport to safe delivery services. "I like it. This place is very nice," she says.

The maternity waiting home is only one of many sexual and reproductive health services introduced to the *comarca* thanks to the organized efforts of the Ngäbe Women's Association – a group that first convened 30 years ago with a very different goal. Back then, in the 1990s, the women of the community were seeking something else entirely: a market for their crafts.

"We began meeting and identifying our problems and our needs," says Gertrudis Sire, president of the Ngäbe Women's Association. It quickly became clear some of the biggest barriers to escaping poverty were not economic – they were reproductive. "The women in the community raised the problem that they had many children," Ms. Sire recalls. She explains that whenever a woman was unable to feed her children, she referred to the problem as "July", a reflection of how routine it was. "'I have a lot of July in my house,' people used to say. What is July? It was a way to identify the famine that was in the community. They said how can we avoid that situation? Have fewer children."

Other sexual and reproductive health needs also came to light. "We noticed that women were dying in their houses when giving birth. There was no plan to transport them because within the region there was no maternal and child hospital." The association approached the Ministry of Health and UNFPA, and together they established a network of health workers to provide care and raise awareness about maternal health, contraception and child nutrition. Ms. Sire says, "We gave talks on these topics, and they felt it, they lived it."

The mutually reinforcing relationship between gender equality, sexual and reproductive health, and economic empowerment was perhaps most notably recognized at the ICPD in 1994. But the experience of the Ngäbe Women's Association shows that this realization was also taking place in the most remote corners of the world, as women began to plan their families and invest in a better future for themselves and their communities. The Ngäbe Women's Association worked independently to unleash a virtuous cycle of reproductive autonomy, improved health and reduced poverty.

Eira Carrera, an intercultural interpreter at the José Domingo De Obaldía Maternal and Infant Hospital, began her career as a health promoter in the *comarca*. "That was in '96, '98," she recalls. "The topics we covered as health promoters were sexual and reproductive health, which involves sexually transmitted infections, Pap smears, everything related to sexual and reproductive health, family planning… domestic violence, even responsible fatherhood." The messages were better received among women than among men. While the women were generally eager to benefit from family planning – "because that was their need," Ms. Carrera says – men were less receptive. "Men did not want this resource."

There has been progress in the three decades since. Asked if Ngäbe women would say they make their own decisions about contraception, Ms. Carrerra says, "Out of 10 women, roughly 8 can say yes." But there is still a long way to go. The issue of machismo is greatly compounded by persistent ethnic discrimination facing the community. Not long ago, Ngäbe community members were expected to sit at the back of the bus when travelling outside the *comarca*. Even today, job opportunities are scarce, and many Ngäbe men survive as migrant labour for coffee plantations.

For women, this overlap between ethnic marginalization and gender inequality continues to be deadly. "The majority of maternal deaths are specifically because the husband has not been able to take his wife to get care," says Humberto Rodríguez, a nurse in charge of the Nole Duima District, describing deaths among women whose husbands were travelling when they went into labour. "The husband is not at home at that moment, and the decision is not hers."

Eira Carrera ensures Ngäbe women are heard and respected in the health system. She also teaches them about their rights. © UNFPA/Rebecca Zerzan

Ngäbe women used to be disempowered by health systems as well, Ms. Carrera says. "Doctors took the file, treated the woman and if she refused, the woman did not receive the care she needed or she received it in a forced, obligatory manner that would violate her rights… Today, that has totally changed." Ms. Carrera now interprets between the health staff, who speak Spanish, and the patients, who speak Ngäbe. She also trains hospital personnel to engage in a culturally sensitive way. Women treated with dignity and information will often consent to care, Ms. Carrera says. "If she does not accept, that is respected."

She wants women to understand bodily autonomy extends to their relationships, as well. "I give a talk here to mothers, saying you are not obliged to have sexual relations with your husband against your will. This is called sexual abuse," Ms. Carrera explains. "We still have to work a lot on that."

But these issues are not unique to the Ngäbe community, Ms. Sire emphasizes. "The problem is everywhere," she says. "There will always be this machismo thing… and discrimination will never end, because that is everywhere… But people like us in the Association, we have been trained by it. We already have an armour."

Eneida, the woman awaiting the birth of her third child, has such an armour – though she is open and smiling rather than defensive. Her armour is her confidence. Asked whether her partner would support her decision about family planning, there is no question: "Yes. Yes. I will be supported. Yes," Eneida says. "With whatever I want."

to those with institutional and historical advantages (Pierce, 2013). This adversarial framing of inclusivity is counterproductive – not only for the disadvantaged but often for society as a whole. After all, gender equality benefits not only women and girls but men and boys as well, on measures ranging from financial stability (Ozili, 2024) to better health and life satisfaction (Wells and others, 2024). The Lancet Commission on Peaceful Societies through Health Equity and Gender Equality notes that "improvements in health equity and gender equality [can] strengthen human capital, the inclusiveness of economies, social capital, and governance" (Lancet Commission on Peaceful Societies Through Health Equity and Gender Equality, 2023). Efforts to achieve equity through inclusion can also be expected to benefit society more broadly.

Comprehensive and universal

Building upon previous decades of research and agreement, the SDGs call for sexual and reproductive health services to be both comprehensive and universal. These are not novel concepts – but what is new, or newer, is growing optimism that both are readily achievable.

Comprehensiveness has been well elaborated by WHO in its guidance note on reproductive health, which defines a comprehensive package of reproductive health care as one including a wide range of services for contraception; antenatal, childbirth and postnatal care; safe abortion services and treatment of complications of unsafe abortion; prevention and treatment of HIV and other sexually transmitted infections; and services to address gender-based violence. In addition, health promotion is essential, including through provision of information and counselling for everyone on sexual health and well-being and, for young people, comprehensive sexuality education (WHO, 2023).

Universal health coverage, too, has been well articulated within the international community. SDG 3.8 calls for achieving "universal health coverage, 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" (UN DESA, 2023).

Still, both comprehensiveness and universality have been elusive, with persistent gaps in coverage negatively impacting the marginalized most of all. But where comprehensiveness or universality have been achieved, or nearly achieved, the contributions to equity have been notable. One report to the Human Rights Council, for instance, noted that universal health care is likely to have mitigated racial disparities in some countries (Human Rights Council, 2020). (In fact, one of the central aims of universal health coverage is equity in access.)

Further, significant progress has been seen in many countries, underlining how readily achievable this goal truly is. Peru, for example, experienced a decade of extraordinary growth in reproductive health coverage starting in 2007, when the country launched a results-based budget initiative that allocated funds to maternal and neonatal health and child nutrition (Huicho and others, 2018). The programme relied primarily on domestic expenditures, with development assistance as a minor component of the financial support, and the results included major reductions in under-five and neonatal mortality.

Advances are possible even if countries are unable to adopt a full package of universal and comprehensive sexual and reproductive health interventions at the same time. In 2020, for example, Zambia adopted a universal health coverage plan that includes contraceptive supplies and services – a plan that is universal if not yet comprehensive for all reproductive health services (PAI, 2020).

Importantly, universality must mean everyone. This may seem self-evident, but most countries persist in viewing universal health coverage as the goal of providing health care to all citizens. This excludes some of those most in need: undocumented migrants, temporary migrant workers, stateless persons and refugees, among others. As one study of the conundrum puts it, the world's health experts have "declared that 'all roads lead to universal health coverage' yet undocumented migrants do not travel those roads" (Onarheim and others, 2018). Considering that a mass movement of people across borders is possible in the coming years, this could lead to an ever-expanding population of people excluded from health care. In addition to supporting the fundamental human right to health, extending health care

In KwaZulu-Natal, South Africa, a yarn-bombed tree raises awareness for communities affected by HIV/AIDS.
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to all people within a country's borders can have public health and economic benefits. One study compared two high-income countries, Norway and the United States, that do not provide coverage for undocumented migrants, and one middle-income country, Thailand, which does; it concluded that Thailand's health approach is less "problematic" and more likely to achieve the SDG goal on universal health coverage (Onarheim and others, 2018). Other research suggests that providing health insurance for undocumented migrants could lead to lower health-care costs as a result of overall improvements in population health (Gostin, 2019).

And the issue of costs is, indeed, a central consideration for all countries. Today, developing countries are grappling with unprecedented levels of international debt, due to factors ranging from "the pandemic, a situation compounded by inflation, rising interest rates, trade tensions and constrained fiscal capacity" (UN DESA, 2023). Large interest payments are already affecting health-care spending in 48 developing countries that are home to 3.3 billion people. The average low-income country now spends 1.4 times more on net interest payments than on domestic health expenditures. High-income countries, by contrast, spend almost four times more on health care than on net interest payments (UNDP, 2023). There are, however, highly promising and innovative forms of health finance emerging that could bring quality, universal health coverage within reach, such as sovereign bonds tied to achieving specific health outcomes. Equally important is agreement (reinforced during the pandemic) that universal health coverage is both a moral and public health imperative. As the Managing Director of the International Monetary Fund Kristalina Georgieva said in December 2020, "One thing is clear: We will not go back to where we were. If we are to overcome the crisis and shape the recovery, we must move forward with a renewed sense of purpose and solidarity – with all people" (Georgieva, 2020).

Expanding accurate reproductive health knowledge

Empowering people to take charge of their own health through information and knowledge is as critically important as universal and comprehensive health care. This is especially true for marginalized groups, including young people. It will only become more important as technologies advance, countries' demographic profiles change and health systems evolve.

One of the main tools for expanding reproductive health knowledge is comprehensive sexuality education, the efficacy and benefits of which are elaborated in Chapter 4. In addition to generating individual and societal returns on investment in terms of health, education and productivity, comprehensive sexuality education can also strengthen the agency and capacity of marginalized youth. For example, research indicates quality, age-appropriate, rights-based comprehensive sexuality education can foster a young person's sense of power, autonomy and belief in their own equality, as it "seeks explicitly to empower young people – especially girls and other marginalized young people – to see themselves and others as equal members in their relationships, able to protect their own health, and as individuals capable of engaging as active participants in society" (Haberland and Rogow, 2015). In other words, effective comprehensive sexuality education can help young people reflect critically about inequalities, including gender inequality, leading to more equitable decisions and behaviours. Despite this, support for comprehensive sexuality education has faltered in recent years (United Nations, 2023a).

And comprehensive sexuality education is only one way to expand access to accurate, quality reproductive health knowledge. Another requires removing outdated, biased, inaccurate or overly simplified information from not only textbooks but also medical education curricula, health systems and reproductive health policies. As Chapter 2 highlights, misinformation, partial information and oversimplification have had adverse impacts on marginalized people throughout history and continue to do so today.

Failure to equip people – adolescents, health professionals, policymakers and everyone in between – with factual, unbiased information can only lead to societies that are ill equipped to address the concerns of the future. Global health systems are embracing self-care interventions as an increasingly critical tool "for every country and economic setting, as a critical path to reach universal health coverage, promote health, keep the world safe, and serve the vulnerable" (WHO, n.d.d). Self-care interventions are particularly critical for sexual and reproductive health, where barriers to services include not only access to health facilities but also stigma and patriarchal norms. But for those most left behind to effectively benefit from self-care, they require accurate health information (UNFPA, 2018a).

Expanding reproductive health knowledge also means investing in the development of inclusive health information and interventions. Health-care research continues to treat men, and especially men in high-income countries, as default patients and research subjects. Research and development funding for maternal health concerns fell by 15 per cent between 2018 and 2021, for example, a fact researchers attribute to the disproportionate concentration of these issues in low- and middle-income countries (Policy Cures Research, 2023). Women are estimated to spend 25 per cent more time in debilitating health than men, yet they remain underrepresented or inaccurately represented within medicine: "To understand basic female biology better, fundamentally new research tools should be developed (for example, animal models, computational models, patient avatars and humanized models) that better classify women's symptoms and manifestations of disease (as opposed to calling those 'atypical')," a recent paper asserts (World Economic Forum, 2024). Investments that close the women's health gap "would potentially boost the economy by at least $1 trillion annually by 2040".

Solutions will also be required to resolve questions over ethically thorny advances in reproductive medicine and digital tools that are both promising and also, at the same time, potential threats to privacy and safety. Humanity's ability to rise to these challenges is greatly undermined when we cannot agree on the facts of human development, reproduction, anatomy, sexuality and diversity. All people have the right to up-to-date, scientifically accurate, culturally sensitive, age-appropriate sexual and reproductive health knowledge – there should be nothing political or controversial about it.

Celebrate the gains, and commit to more

The evidence brought to light shows that the achievements since 1994 have been many but they must go further. Time and again, the world has seen that efforts to eliminate poor health outcomes and end preventable maternal deaths are simply not enough to overcome the barriers posed by inequality, discrimination, bias and stigma. Yet this fact offers us perhaps the best chance of achieving our agreed goals – those from both the ICPD and the 2030 Agenda – to realize the rights and choices of all people.

The recent past has been one of historic disruptions, disruptions that triggered calls for justice, inspired new thinking about systemic inequities, and mobilized advocacy around the world. Indeed, when we widen the lens, zooming out from the recent past to the last 30 years, we see far more reasons for hope than despair.

Lack of data, and especially disaggregated data, is an enormous hindrance, as detailed throughout this report – but the data we do have today, and the methods available to analyse them, are better than ever before. We must build on these gains. Milestone achievements – like SDG indicators 5.6.1 and 5.6.2, which stand as some of the world's first-ever measures of bodily autonomy and enabling legal environments – are just the first steps towards measuring and understanding the state of women's reproductive agency.

Systems must be reformed to eliminate embedded and invisible forms of discrimination, a process that is likely to cause debate and discontent – yet the process has already begun, with the Ni Una Menos and MeToo movements exposing gendered power imbalances and movements such as Rhodes Must Fall and Black Lives Matter highlighting racial inequities.

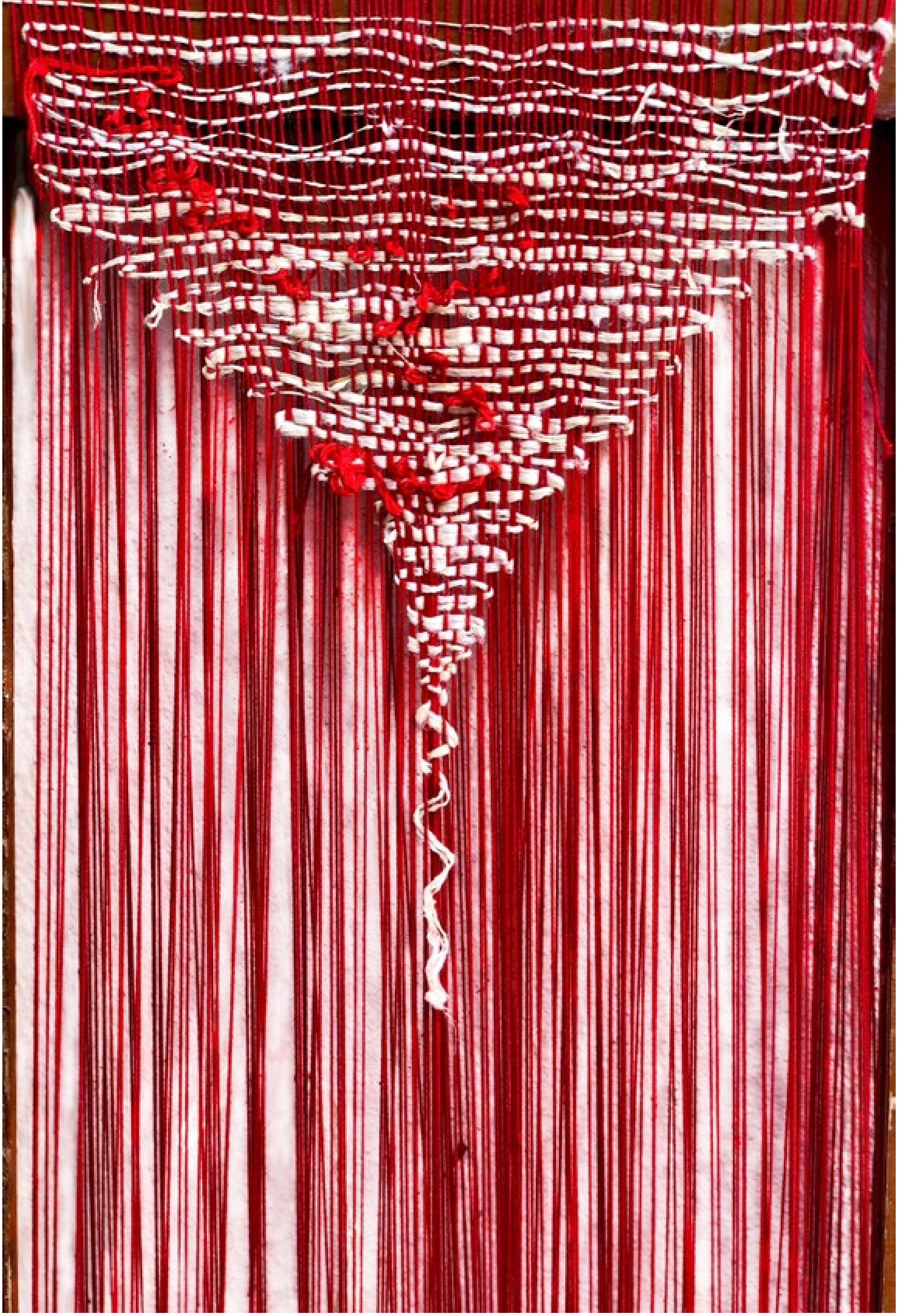
Political will is needed to direct more resources towards the sexual and reproductive health and rights of marginalized groups, seemingly a tall order in an increasingly polarized, politicized world – yet there are encouraging signs that policymakers are willing to address many of these issues head-on. In the 2023 voluntary national reviews (a process in which Member States voluntarily identify sustainable development priorities and efforts on the ground as part of the 2030 Agenda for Sustainable Development), all of the 39 participating Member States addressed groups affected by marginalizing factors such as gender and disability, people in rural or remote areas and ethnic minorities. Just under half, 49 per cent, addressed the needs of LGBTQIA+ persons (UNFPA, 2024g). While the reviews do not necessarily reflect on-the-ground change, they are a critical step towards transparency in States' policy positions and priorities (Fukuda-Parr and others, 2018). Strong advocacy, and follow-up, could therefore go a long way towards putting the sexual and reproductive health of marginalized people high on the development agenda.

The issue of power must also be addressed. Policies, attitudes and norms around the world perpetuate inequities at levels both high and low – but change is possible, and imminent. In fact, this year will represent a milestone for elections, with more than 2 billion voters set to go to the polls in more than 50 countries (World Economic Forum, 2023). Voting matters because, as this report highlights, representation does. This is why the world agreed to SDG 5.5.1, which measures the proportion of seats held by women in national parliaments and local governments. Voting can help lift up the voices of other vulnerable and marginalized people, as well.

And while elections and public advocacy are necessary tools for ending marginalization, it must also be acknowledged that these tools simply do not exist in too many countries. In these cases, international standards bodies such as those of the United Nations must speak up and emphasize that the adoption of the SDG targets and the many human rights instruments that reinforce them are obligations of all Member States, produced with the agreement of those very governments, that must be implemented.

Finally, the voices of the marginalized grow louder every day. Rather than respond with alarm, we can meet their appeals with openness and collaboration. Impatience with what we have yet to achieve is justifiable and can even be welcomed. It is a mark of progress that we can identify and grapple with the forces that continue to push people behind. There is progress, too, in the fact that our expectations of health, rights and fairness have shifted in the past three decades. The world has changed; standards are higher. So, too, is our ability to deliver.

In the end, achievement of the world's most lofty goals will mean little if we insist upon the simplest ways of tallying progress, with whole countries, communities and identities swallowed into a global average. We are capable of a more sophisticated vision, one that acknowledges the dignity and value of every individual, one which recognizes that assuring the rights of all people means securing the rights of each person. After all, the fabric of humanity is vast and beautiful, but it is only as strong as its most fragile thread.



Pankaja Sethi's artwork "The Flaming Womb" examines the gap between the symbolic attributes of womanhood and the role and conditions of women as dictated by a patriarchal society. The piece was included as part of the Fabric of Being exhibition curated by SEA Junction for the Nairobi Summit on ICPD25, in 2019. © Pankaja Sethi

Indicators

Sexual and reproductive health

	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Number of new HIV infections, all ages, per 1,000 uninfected population	Contraceptive prevalence rate, women aged 15–49, per cent				Unmet need for family planning, women aged 15–49, per cent		Proportion of demand satisfied with modern methods, all women aged 15–49	Laws and regulations that guarantee access to sexual and reproductive health care, information and education, per cent	Universal health coverage (UHC) service coverage index
						Any method		Modern method						
						All	Married or in union	All	Married or in union	All	Married or in union			
World and regional areas	2020	2020	2020	2022	2022	2024		2024		2024		2024	2022	2021
World	**223**	**202**	**255**	**86**	**0.17**	**50**	**65**	**46**	**59**	**9**	**11**	**78**	**76**	**68**
More developed regions	12	10	14	99	0.15	58	70	52	62	7	8	80	87	84
Less developed regions	244	221	279	81	0.17	49	65	45	59	9	11	77	72	64
Least developed countries	377	338	431	65	0.34	33	43	29	38	15	20	61	71	44
UNFPA regions														
Arab States	145	110	194	83	0.04	34	53	29	45	10	15	66	65	61
Asia and the Pacific	113	101	128	87	0.07	54	71	50	65	6	8	82	74	68
Eastern Europe and Central Asia	21	19	25	98	0.15	46	64	36	49	8	11	67	84	74
Latin America and the Caribbean	88	79	99	95	0.19	59	75	56	71	8	9	83	75	76
East and Southern Africa	360	313	441	70	0.83	36	45	33	42	15	20	65	72	46
West and Central Africa	750	625	986	61	0.30	21	23	18	20	17	22	47	70	40
Countries, territories, other areas	2020	2020	2020	2004–2022	2022	2024		2024		2024		2024	2022	2021
Afghanistan	620	406	1050	62	0.03	21	29	19	26	17	23	50	56	41
Albania	8	4	16	100	0.02	33	45	6	6	12	16	12	79	64
Algeria	78	41	164	99	0.05	35	60	30	52	7	11	72	–	74
Angola	222	148	330	50	0.44	17	18	16	17	26	35	37	62	37
Antigua and Barbuda	21	11	36	99	–	42	63	40	61	10	13	77	–	76
Argentina	45	38	53	99	0.09	59	71	57	68	10	11	83	92	79
Armenia	27	19	42	100	0.19	39	60	22	33	8	12	46	87	68
Aruba	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Australia	3	2	4	96	–	59	67	57	64	8	10	85	–	87
Austria	5	4	8	98	–	66	73	64	71	5	7	89	–	85
Azerbaijan	41	22	69	100	0.05	37	58	16	24	9	13	35	–	66
Bahamas	77	51	128	99	0.15	46	66	44	65	10	12	79	–	77
Bahrain	16	13	19	100	–	29	63	20	44	5	12	59	73	76
Bangladesh	123	89	174	59	0.01	52	64	45	56	9	11	74	–	52
Barbados	39	22	61	98	0.21	51	63	47	60	12	14	75	44	77
Belarus	1	1	2	100	0.11	54	63	47	53	11	11	72	83	79
Belgium	5	4	6	–	0.04	59	67	58	67	6	8	91	–	86
Belize	130	105	161	95	0.35	46	58	43	54	14	17	72	43	68
Benin	523	397	768	78	0.11	18	20	15	16	24	30	36	91	38
Bhutan	60	40	82	99	0.08	40	62	39	60	8	12	81	83	60
Bolivia (Plurinational State of)	161	103	272	81	0.16	49	68	37	51	11	15	61	94	65
Bosnia and Herzegovina	6	4	8	100	–	39	51	20	22	9	13	42	70	66
Botswana	186	151	230	100	1.92	59	70	58	70	8	10	87	64	55
Brazil	72	57	93	98	0.24	67	80	65	78	6	7	90	–	80
Brunei Darussalam	44	30	61	100	–	–	–	–	–	–	–	–	41	78
Bulgaria	7	5	10	95	0.03	66	81	52	60	5	6	73	62	73
Burkina Faso	264	169	394	96	0.08	30	34	29	33	19	23	60	81	40
Burundi	494	353	694	77	0.10	21	34	18	31	16	27	51	65	41
Cabo Verde	42	26	65	97	0.34	45	59	44	58	12	15	77	84	71
Cambodia	218	156	326	99	0.08	43	65	33	49	7	10	65	98	58
Cameroon	438	332	605	69	0.36	24	24	20	19	16	21	51	–	44

Sexual and reproductive health

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						Any method		Modern method						
						All	Married or in union	All	Married or in union	All	Married or in union			
Countries, territories, other areas	2020	2020	2020	2004–2022	2022	2024		2024		2024		2024	2022	2021
Canada	11	9	15	98	–	73	82	71	80	3	4	92	–	91
Central African Republic	835	407	1519	40	1.57	22	24	17	19	21	25	40	77	32
Chad	1063	772	1586	47	0.22	8	9	7	8	19	25	27	59	29
Chile	15	13	17	100	0.25	65	78	60	72	6	8	85	–	82
China	23	19	27	100	–	71	85	69	83	4	3	92	–	81
China, Hong Kong Special Administrative Region	–	–	–	–	–	49	71	46	68	8	9	81	–	–
China, Macao Special Administrative Region	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Colombia	75	65	86	99	0.16	65	82	61	77	5	6	87	96	80
Comoros	217	131	367	82	0.00	21	29	17	24	19	29	44	–	48
Congo	282	194	429	91	2.89	43	46	31	30	14	18	54	55	41
Costa Rica	22	18	26	99	0.14	57	74	56	72	9	10	84	84	81
Côte d'Ivoire	480	318	730	84	0.31	27	26	23	23	21	26	49	64	43
Croatia	5	3	7	100	0.02	50	71	36	47	5	8	65	98	80
Cuba	39	35	44	100	0.18	69	72	68	71	8	9	88	–	83
Curaçao	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Cyprus	68	47	99	99	–	–	–	–	–	–	–	–	72	81
Czechia	3	2	5	100	0.02	62	85	55	76	4	4	84	79	84
Democratic People's Republic of Korea	107	46	249	100	–	61	75	58	72	8	8	85	83	68
Democratic Republic of the Congo	547	377	907	85	0.13	27	31	17	17	20	25	36	–	42
Denmark	5	4	6	95	0.01	64	77	61	73	5	6	88	87	82
Djibouti	234	105	530	87	–	17	32	17	31	14	25	54	–	44
Dominica	–	–	–	100	–	46	64	44	62	10	13	78	–	49
Dominican Republic	107	87	133	99	0.37	55	68	53	66	10	13	82	–	77
Ecuador	66	52	86	99	0.11	59	80	54	73	7	6	82	92	77
Egypt	17	13	22	97	0.05	45	62	43	60	9	12	81	–	70
El Salvador	43	31	61	100	0.13	53	74	50	69	8	10	82	92	78
Equatorial Guinea	212	122	374	68	2.94	19	19	16	16	22	31	39	–	46
Eritrea	322	207	508	34	0.06	9	15	9	14	15	28	35	–	45
Estonia	5	3	9	100	0.10	58	71	50	60	5	7	78	98	79
Eswatini	240	147	417	88	4.10	53	69	52	68	9	12	84	98	56
Ethiopia	267	189	427	50	0.08	31	42	30	41	15	20	67	73	35
Fiji	38	28	55	100	0.33	35	51	30	44	12	16	65	–	58
Finland	8	6	13	100	–	79	82	74	77	3	4	91	98	86
France	8	6	10	98	0.09	66	78	64	76	4	4	91	–	85
French Guiana	–	–	–	–	–	–	–	–	–	–	–	–	–	–
French Polynesia	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Gabon	227	141	383	89	0.83	39	39	31	29	18	23	55	58	49
Gambia	458	333	620	84	0.60	15	21	14	20	16	24	46	–	46
Georgia	28	22	33	100	0.14	33	48	24	35	13	18	53	94	68
Germany	4	4	5	96	–	55	68	54	67	7	9	88	87	88
Ghana	263	180	376	79	0.53	27	36	24	32	19	26	52	66	48
Greece	8	5	12	100	0.08	53	75	39	52	5	7	68	72	77
Grenada	21	12	34	100	–	47	65	44	61	10	12	77	–	70

Sexual and reproductive health

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						Any method		Modern method						
						All	Married or in union	All	Married or in union	All	Married or in union			
Countries, territories, other areas	2020	2020	2020	2004–2022	2022	2024		2024		2024		2024	2022	2021
Guadeloupe	–	–	–	–	–	40	59	37	53	10	15	73	–	–
Guam	–	–	–	–	–	37	66	32	56	7	10	74	–	–
Guatemala	96	85	106	70	0.07	43	65	37	55	9	12	72	–	59
Guinea	553	404	808	55	0.43	15	15	14	14	18	23	43	79	40
Guinea-Bissau	725	475	1135	54	0.59	32	24	31	24	16	19	63	80	37
Guyana	112	83	144	98	0.62	30	39	29	38	20	28	57	87	76
Haiti	350	239	550	42	0.58	29	40	27	37	23	33	52	65	54
Honduras	72	58	91	94	0.05	51	73	47	67	8	10	80	80	64
Hungary	15	11	21	100	–	50	70	45	63	7	9	80	93	79
Iceland	3	1	4	97	0.04	–	–	–	–	–	–	–	–	89
India	103	93	110	89	0.05	51	68	45	60	6	9	78	74	63
Indonesia	173	121	271	95	0.09	44	63	42	60	8	11	82	77	55
Iran (Islamic Republic of)	22	14	32	99	0.03	58	82	47	66	3	4	77	63	74
Iraq	76	50	121	96	0.01	38	57	27	41	8	12	59	59	59
Ireland	5	4	7	100	–	65	70	63	66	6	9	89	–	83
Israel	3	2	4	–	–	41	73	32	56	5	8	69	–	85
Italy	5	4	6	100	0.04	60	67	49	52	6	9	75	–	84
Jamaica	99	80	122	100	0.50	44	73	42	70	9	9	79	76	74
Japan	4	3	6	100	–	47	53	41	42	12	17	69	85	83
Jordan	41	26	62	100	0.00	31	55	23	40	8	14	58	56	65
Kazakhstan	13	10	18	100	–	43	54	40	51	10	14	76	65	80
Kenya	530	382	750	70	0.46	49	65	47	63	11	14	78	48	53
Kiribati	76	33	146	92	–	24	32	20	27	17	23	49	–	48
Kuwait	7	5	11	100	–	36	60	30	50	8	13	68	–	78
Kyrgyzstan	50	37	70	100	0.11	29	43	28	40	12	17	68	73	69
Lao People's Democratic Republic	126	92	185	64	0.14	39	62	35	55	9	13	72	96	52
Latvia	18	14	25	100	0.19	59	72	52	62	6	8	81	70	75
Lebanon	21	18	24	98	–	33	62	25	47	7	12	63	–	73
Lesotho	566	385	876	87	3.03	52	67	51	67	9	13	84	–	53
Liberia	652	499	900	84	0.24	28	28	27	27	25	31	51	–	45
Libya	72	31	165	100	–	25	41	17	27	15	25	41	–	62
Lithuania	9	5	14	100	0.06	48	72	40	58	6	8	74	87	75
Luxembourg	6	4	12	100	0.06	–	–	–	–	–	–	–	–	83
Madagascar	392	311	517	46	0.30	42	53	38	47	13	14	69	–	35
Malawi	381	269	543	96	0.81	50	67	49	66	12	14	79	79	48
Malaysia	21	18	29	100	0.09	36	58	26	42	9	14	59	83	76
Maldives	57	40	83	100	0.01	18	24	14	19	22	29	36	93	61
Mali	440	335	581	67	0.28	19	21	19	21	21	24	47	–	41
Malta	3	2	5	100	0.09	61	79	50	63	4	5	76	–	85
Martinique	–	–	–	–	–	41	61	38	56	10	14	74	–	–
Mauritania	464	337	655	70	0.12	10	14	9	13	22	32	30	65	40
Mauritius	84	62	115	100	–	44	67	30	46	7	9	59	75	66
Mexico	59	46	74	97	0.16	55	74	53	71	9	10	82	86	75
Micronesia (Federated States of)	74	32	169	100	–	–	–	–	–	–	–	–	–	48

Sexual and reproductive health

	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Number of new HIV infections, all ages, per 1,000 uninfected population	Contraceptive prevalence rate, women aged 15–49, per cent				Unmet need for family planning, women aged 15–49, per cent		Proportion of demand satisfied with modern methods, all women aged 15–49	Laws and regulations that guarantee access to sexual and reproductive health care, information and education, per cent	Universal health coverage (UHC) service coverage index
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Countries, territories, other areas	2020	2020	2020	2004–2022	2022	2024		2024		2024		2024	2022	2021
Mongolia	39	28	55	99	0.01	42	58	38	53	12	15	71	–	65
Montenegro	6	3	11	99	0.02	23	27	16	17	15	21	43	52	72
Morocco	72	51	96	87	0.02	43	71	37	62	7	10	75	–	69
Mozambique	127	99	157	73	3.20	29	33	28	31	18	21	60	–	44
Myanmar	179	125	292	60	0.21	35	59	34	58	8	13	80	91	52
Namibia	215	154	335	88	2.39	53	62	53	61	10	14	84	88	63
Nepal	174	125	276	77	0.02	42	55	37	49	15	21	65	48	54
Netherlands (Kingdom of the)	4	3	6	–	–	63	72	61	70	5	7	89	100	85
New Caledonia	–	–	–	–	–	–	–	–	–	–	–	–	–	–
New Zealand	7	5	9	97	0.01	65	81	61	75	5	5	88	95	85
Nicaragua	78	54	109	94	0.08	59	82	57	79	6	6	88	75	70
Niger	441	305	655	44	0.06	12	15	12	14	16	20	41	–	35
Nigeria	1047	793	1565	51	–	18	21	14	16	15	19	43	–	38
North Macedonia	3	1	6	100	0.03	44	54	21	21	9	13	40	–	74
Norway	2	1	3	99	–	66	85	61	79	3	3	89	100	87
Oman	17	12	25	100	0.03	22	37	16	26	14	25	43	70	70
Pakistan	154	109	226	68	–	27	40	20	31	11	17	54	69	45
Panama	50	46	54	95	0.32	49	61	46	57	14	17	74	72	78
Papua New Guinea	192	126	293	56	0.65	28	39	24	33	17	24	52	–	30
Paraguay	71	60	82	92	–	60	73	56	68	8	8	83	76	72
Peru	69	59	80	95	0.17	51	77	40	58	5	6	71	85	71
Philippines	78	67	96	84	0.21	36	58	27	44	10	15	60	80	58
Poland	2	1	3	100	–	54	74	44	59	6	7	73	89	82
Portugal	12	8	18	99	0.06	59	74	51	63	5	7	79	95	88
Puerto Rico	34	25	54	–	–	51	82	47	74	7	5	81	–	–
Qatar	8	5	11	100	0.04	33	50	28	42	10	15	65	71	76
Republic of Korea	8	7	9	100	–	56	81	51	74	6	5	82	–	89
Republic of Moldova	12	9	17	100	0.34	49	59	40	47	12	15	65	–	71
Réunion	–	–	–	–	–	52	72	50	71	8	9	84	–	–
Romania	10	7	14	93	0.03	54	71	46	59	6	8	76	98	78
Russian Federation	14	9	20	100	–	49	68	42	58	7	9	75	70	79
Rwanda	259	184	383	94	0.24	40	67	37	61	9	12	76	82	49
Saint Kitts and Nevis	–	–	–	100	–	49	61	46	57	12	14	76	–	79
Saint Lucia	73	44	127	100	–	49	61	46	58	12	14	76	33	77
Saint Vincent and the Grenadines	62	40	92	99	–	51	67	49	64	10	12	80	81	69
Samoa	59	26	137	89	–	14	22	13	20	28	42	32	22	55
San Marino	–	–	–	–	–	–	–	–	–	–	–	–	–	77
Sao Tome and Principe	146	74	253	97	0.06	38	51	36	48	20	24	61	46	59
Saudi Arabia	16	11	22	95	0.04	21	33	18	27	15	24	49	–	74
Senegal	261	197	376	75	0.09	22	31	21	30	14	21	58	75	50
Serbia	10	8	14	100	0.02	49	59	29	29	7	11	51	99	72
Seychelles	3	3	4	100	–	–	–	–	–	–	–	–	–	75
Sierra Leone	443	344	587	87	0.44	28	27	28	26	19	24	58	65	41
Singapore	7	5	11	100	–	40	69	36	61	6	10	78	46	89

Sexual and reproductive health

	Maternal mortality ratio (MMR) (deaths per 100,000 live births)[a]	Range of MMR uncertainty (UI 80%), lower estimate[a]	Range of MMR uncertainty (UI 80%), upper estimate[a]	Births attended by skilled health personnel, per cent	Number of new HIV infections, all ages, per 1,000 uninfected population	Contraceptive prevalence rate, women aged 15–49, per cent				Unmet need for family planning, women aged 15–49, per cent		Proportion of demand satisfied with modern methods, all women aged 15–49	Laws and regulations that guarantee access to sexual and reproductive health care, information and education, per cent	Universal health coverage (UHC) service coverage index
						Any method		Modern method						
						All	Married or in union	All	Married or in union	All	Married or in union			
Countries, territories, other areas	2020	2020	2020	2004–2022	2022	2024		2024		2024		2024	2022	2021
Sint Maarten (Dutch part)	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Slovakia	5	3	6	98	0.02	55	79	47	67	5	6	79	86	82
Slovenia	5	3	7	100	–	52	79	44	67	4	5	79	–	84
Solomon Islands	122	75	197	86	–	24	33	20	27	13	18	54	–	47
Somalia	621	283	1184	32	–	8	10	2	2	17	26	9	–	27
South Africa	127	99	154	97	3.15	52	59	51	59	11	14	82	95	71
South Sudan	1223	746	2009	40	0.79	7	9	6	8	21	29	23	16	34
Spain	3	3	4	100	–	62	64	60	62	7	12	87	–	85
Sri Lanka	29	24	38	100	0.01	45	68	37	56	5	7	74	86	67
State of Palestine[1]	20	15	26	100	–	40	62	30	47	7	10	64	68	–
Sudan	270	174	420	78	0.09	12	17	11	16	17	27	37	57	44
Suriname	96	70	128	98	0.76	35	49	35	48	14	21	70	–	63
Sweden	5	3	6	–	–	59	71	56	68	6	8	87	100	85
Switzerland	7	5	11	–	–	73	73	68	68	4	7	89	94	86
Syrian Arab Republic	30	19	47	96	0.00	34	63	26	47	7	12	63	81	64
Tajikistan	17	9	31	95	0.10	25	34	23	31	16	21	57	–	67
Thailand	29	24	34	99	0.13	49	77	48	75	4	6	90	–	82
Timor-Leste	204	147	283	57	0.07	20	34	18	31	13	22	55	–	52
Togo	399	253	576	69	0.28	25	28	23	26	22	30	49	–	44
Tonga	126	55	289	98	–	20	34	17	29	14	25	50	–	57
Trinidad and Tobago	27	19	36	100	–	41	50	37	46	14	19	66	27	75
Tunisia	37	24	49	100	–	33	60	29	51	8	12	70	–	67
Türkiye	17	13	23	97	–	48	72	33	50	6	9	62	78	76
Turkmenistan	5	3	9	100	–	36	54	33	50	8	12	77	94	75
Turks and Caicos Islands	–	–	–	100	–	37	39	36	38	19	23	64	–	–
Tuvalu	–	–	–	100	–	20	27	18	24	20	28	46	–	52
Uganda	284	191	471	74	1.21	38	51	34	45	15	20	64	–	49
Ukraine	17	13	22	100	–	54	68	45	56	6	9	75	95	76
United Arab Emirates	9	5	17	99	–	38	53	31	42	12	16	62	–	82
United Kingdom of Great Britain and Northern Ireland	10	8	12	–	–	72	76	65	69	4	6	86	96	88
United Republic of Tanzania	238	174	381	64	0.54	38	47	34	42	15	19	64	–	43
United States of America	21	16	27	99	–	61	76	54	67	5	5	81	–	86
United States Virgin Islands	–	–	–	–	–	45	75	42	70	8	8	79	–	–
Uruguay	19	15	23	100	0.24	59	79	57	77	6	7	87	97	82
Uzbekistan	30	23	40	99	–	49	70	46	66	6	8	84	92	75
Vanuatu	94	43	211	89	–	38	49	33	42	15	19	62	–	47
Venezuela (Bolivarian Republic of)	259	191	381	99	–	56	76	53	72	8	9	83	–	75
Viet Nam	46	33	60	96	0.06	58	79	48	66	4	5	78	54	68
Western Sahara	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Yemen	183	120	271	45	0.03	29	46	21	34	14	22	51	65	42
Zambia	135	100	201	80	1.86	38	54	37	52	15	17	70	91	56
Zimbabwe	357	255	456	86	1.12	51	70	50	69	8	9	86	73	55

NOTES

– Data not available.

[a] The MMR has been rounded according to the following scheme: <100, rounded to nearest 1; 100-999, rounded to nearest 1; and ≥1000, rounded to nearest 10.

[1] On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine "non-member observer State status in the United Nations..."

DEFINITIONS OF THE INDICATORS

Maternal mortality ratio: Number of maternal deaths during a given time period per 100,000 live births during the same time period (SDG indicator 3.1.1).

Births attended by skilled health personnel: Percentage of births attended by skilled health personnel (doctor, nurse or midwife) (SDG indicator 3.1.2).

Number of new HIV infections, all ages, per 1,000 uninfected population: Number of new HIV infections per 1,000 person-years among the uninfected population (SDG indicator 3.3.1).

Contraceptive prevalence rate: Percentage of women aged 15 to 49 years who are currently using any method of contraception.

Contraceptive prevalence rate, modern method: Percentage of women aged 15 to 49 years who are currently using any modern method of contraception.

Unmet need for family planning: Percentage of women aged 15 to 49 years who want to stop or delay childbearing but are not using a method of contraception.

Proportion of demand satisfied with modern methods: Percentage of total demand for family planning among women aged 15 to 49 years that is satisfied by the use of modern contraception (SDG indicator 3.7.1).

Laws and regulations that guarantee access to sexual and reproductive health care, information and education: The extent to which countries have national laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (SDG indicator 5.6.2).

Universal health coverage (UHC) service coverage index: Average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population (SDG indicator 3.8.1).

MAIN DATA SOURCES

Maternal mortality ratio: United Nations Maternal Mortality Estimation Inter-agency Group (WHO, UNICEF, UNFPA, The World Bank and United Nations Population Division), 2023.

Births attended by skilled health personnel: Joint global database on skilled attendance at birth. UNICEF and WHO, 2023. Regional aggregates calculated by UNFPA based on data from the joint global database.

Number of new HIV infections, all ages, per 1,000 uninfected population: HIV Estimates. UNAIDS, 2023.

Contraceptive prevalence rate: United Nations Population Division, 2022.

Contraceptive prevalence rate, modern method: United Nations Population Division, 2022.

Unmet need for family planning: United Nations Population Division, 2022.

Proportion of demand satisfied with modern methods: United Nations Population Division, 2022.

Laws and regulations that guarantee access to sexual and reproductive health care, information and education: UNFPA, 2022.

Universal health coverage (UHC) service coverage index: WHO, 2023.

Tracking progress towards ICPD goals

Gender, rights and human capital

	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among women aged 15–49, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Decision-making on women's own health care, per cent	Decision-making on contraceptive use, per cent	Decision-making on sexual intercourse, per cent	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
World and regional areas	2024	2023	2022	2018	2007–2022	2007–2022	2007–2022	2007–2022	2020	2020	2020	2020
World	**41**	**19**	**–**	**13**	**56**	**75**	**89**	**76**	**85**	**1.00**	**67**	**1.01**
More developed regions	10	4	–	–	82	97	95	87	99	1.00	95	1.01
Less developed regions	45	22	–	–	56	75	89	75	83	1.00	63	1.01
Least developed countries	90	38	–	22	47	68	88	69	–	–	44	0.90
UNFPA regions												
Arab States	42	17	54	15	58	92	91	67	82	0.95	60	0.92
Asia and the Pacific	24	18	–	13	63	79	91	81	87	1.02	66	1.06
Eastern Europe and Central Asia	18	10	–	9	70	89	91	81	98	1.00	84	0.99
Latin America and the Caribbean	51	21	–	8	72	86	91	90	94	1.02	79	1.03
East and Southern Africa	92	30	–	24	48	76	88	67	–	–	–	–
West and Central Africa	101	33	18	15	26	44	80	55	61	0.97	41	0.87
Countries, territories, other areas	2000–2023	2006–2023	2004–2022	2018	2007–2022	2007–2022	2007–2022	2007–2022	2017–2023	2017–2023	2017–2023	2017–2023
Afghanistan	62	29	–	35	–	–	–	–	–	–	45	0.56
Albania	12	12	–	6	62	92	83	77	96	0.94	85	0.96
Algeria	11	4	–	–	–	–	–	–	97	0.99	83	1.11
Angola	163	30	–	25	39	75	74	62	–	–	–	–
Antigua and Barbuda	33	–	–	–	–	–	–	–	100	–	95	0.99
Argentina	28	16	–	5	–	–	–	–	99	–	96	1.10
Armenia	13	5	–	5	62	96	83	75	100	0.99	97	1.06
Aruba	13	–	–	–	–	–	–	–	–	–	–	–
Australia	7	–	–	3	–	–	–	–	98	1.01	94	1.05
Austria	4	–	–	4	–	–	–	–	98	1.00	89	1.00
Azerbaijan	37	11	–	5	–	–	–	–	87	0.99	80	0.96
Bahamas	26	–	–	–	–	–	–	–	86	0.99	63	1.01
Bahrain	9	–	–	–	87	93	92	79	97	1.00	98	0.98
Bangladesh	68	51	–	23	64	77	94	86	82	1.15	79	0.91
Barbados	48	29	–	–	–	–	–	–	99	1.00	93	1.01
Belarus	12	5	–	6	–	–	–	–	94	0.97	88	1.01
Belgium	4	0	–	5	–	–	–	–	99	1.00	99	1.00
Belize	51	34	–	8	–	–	–	–	94	0.99	71	1.11
Benin	84	28	9	15	32	52	66	58	55	0.91	31	0.78
Bhutan	10	26	–	9	–	–	–	–	85	1.15	67	1.15
Bolivia (Plurinational State of)	71	20	–	18	–	–	–	–	89	1.01	80	1.01
Bosnia and Herzegovina	10	4	–	3	–	–	–	–	94	0.97	79	1.03
Botswana	50	–	–	17	–	–	–	–	86	1.08	57	0.98
Brazil	43	26	–	7	–	–	–	–	96	1.01	89	1.05
Brunei Darussalam	9	–	–	–	–	–	–	–	99	1.01	68	1.06
Bulgaria	39	–	–	6	–	–	–	–	90	1.00	82	0.95
Burkina Faso	93	51	56	11	20	32	91	62	46	1.14	27	1.16
Burundi	58	19	–	22	40	72	88	60	59	1.06	42	1.17
Cabo Verde	40	8	–	11	–	–	–	–	83	0.99	74	1.07
Cambodia	48	18	–	9	80	92	93	91	95	1.09	57	1.12
Cameroon	105	30	1	22	35	55	74	67	53	0.93	35	0.86

Tracking progress towards ICPD goals

Gender, rights and human capital

Countries, territories, other areas	Adolescent birth rate per 1,000 girls aged 15–19 2000–2023	Child marriage by age 18, per cent 2006–2023	Female genital mutilation prevalence among women aged 15–49, per cent 2004–2022	Intimate partner violence, past 12 months, per cent 2018	Decision-making on sexual and reproductive health and reproductive rights, per cent 2007–2022	Decision-making on women's own health care, per cent 2007–2022	Decision-making on contraceptive use, per cent 2007–2022	Decision-making on sexual intercourse, per cent 2007–2022	Total net enrolment rate, lower secondary education, per cent 2017–2023	Gender parity index, total net enrolment rate, lower secondary education 2017–2023	Total net enrolment rate, upper secondary education, per cent 2017–2023	Gender parity index, total net enrolment rate, upper secondary education 2017–2023
Canada	5	–	–	3	–	–	–	–	100	–	87	0.98
Central African Republic	184	61	22	21	–	–	–	–	43	0.68	17	0.60
Chad	138	61	34	16	27	47	81	63	41	0.72	25	0.57
Chile	16	–	–	6	–	–	–	–	99	0.99	98	0.99
China	6	3	–	8	–	–	–	–	–	–	–	–
China, Hong Kong Special Administrative Region	1	–	–	3	–	–	–	–	99	0.97	94	0.99
China, Macao Special Administrative Region	0	–	–	–	–	–	–	–	90	0.97	82	1.06
Colombia	47	23	–	12	–	–	–	–	96	1.01	87	1.03
Comoros	74	21	–	8	21	47	71	47	87	1.02	52	1.07
Congo	111	27	–	–	27	41	87	71	70	0.94	58	0.92
Costa Rica	26	17	–	7	–	–	–	–	95	1.01	92	1.03
Côte d'Ivoire	96	26	37	16	25	43	82	67	43	1.01	45	0.92
Croatia	7	–	–	4	–	–	–	–	99	–	92	1.05
Cuba	47	29	–	5	–	–	–	–	92	1.00	83	1.05
Curaçao	18	–	–	–	–	–	–	–	99	–	88	1.02
Cyprus	6	–	–	3	–	–	–	–	100	–	96	1.00
Czechia	7	–	–	4	–	–	–	–	98	1.00	95	1.01
Democratic People's Republic of Korea	1	0	–	–	–	–	–	–	–	–	–	–
Democratic Republic of the Congo	109	29	–	36	31	47	85	74	–	–	–	–
Denmark	1	1	–	3	–	–	–	–	99	1.00	93	1.01
Djibouti	21	7	90	–	–	–	–	–	49	0.86	36	0.91
Dominica	50	–	–	–	–	–	–	–	81	0.95	77	0.92
Dominican Republic	77	32	–	10	77	88	92	93	89	1.01	68	1.09
Ecuador	52	22	–	8	87	100	92	95	99	1.02	80	1.02
Egypt	50	16	87	15	–	–	–	–	95	1.00	72	0.95
El Salvador	50	20	–	6	–	–	–	–	–	–	57	1.07
Equatorial Guinea	176	30	–	29	–	–	–	–	–	–	–	–
Eritrea	76	41	83	–	–	–	–	–	59	0.86	45	0.86
Estonia	6	–	–	4	–	–	–	–	98	1.00	94	1.01
Eswatini	87	2	–	18	49	72	89	74	–	–	–	–
Ethiopia	72	40	65	27	38	82	90	46	50	0.99	33	0.96
Fiji	31	4	–	23	62	86	84	77	89	0.81	73	1.13
Finland	3	0	–	8	–	–	–	–	98	1.00	96	1.01
France	6	–	–	5	–	–	–	–	100	1.00	96	1.01
French Guiana	58	–	–	–	–	–	–	–	–	–	–	–
French Polynesia	23	–	–	–	–	–	–	–	–	–	–	–
Gabon	100	13	–	22	48	60	90	86	64	1.03	53	1.05
Gambia	65	23	73	10	19	49	87	45	80	1.18	55	1.25
Georgia	22	14	–	3	82	95	98	88	99	–	99	1.01
Germany	6	–	–	–	–	–	–	–	99	1.01	89	0.98
Ghana	63	16	2	10	52	82	90	72	91	0.99	66	0.94
Greece	7	–	–	5	–	–	–	–	98	1.00	94	1.02

Tracking progress towards ICPD goals

Gender, rights and human capital

	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among women aged 15–49, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Decision-making on women's own health care, per cent	Decision-making on contraceptive use, per cent	Decision-making on sexual intercourse, per cent	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
Countries, territories, other areas	2000–2023	2006–2023	2004–2022	2018	2007–2022	2007–2022	2007–2022	2007–2022	2017–2023	2017–2023	2017–2023	2017–2023
Grenada	30	–	–	8	–	–	–	–	91	1.07	86	0.96
Guadeloupe	8	–	–	–	–	–	–	–	–	–	–	–
Guam	35	–	–	–	–	–	–	–	–	–	–	–
Guatemala	65	30	–	7	65	77	91	89	63	0.95	35	1.04
Guinea	128	47	95	21	15	41	76	40	47	0.78	27	0.67
Guinea-Bissau	84	26	52	–	–	–	–	–	–	–	–	–
Guyana	65	32	–	11	71	92	90	83	83	1.04	62	1.09
Haiti	55	15	–	12	57	76	93	79	–	–	–	–
Honduras	97	34	–	7	70	84	88	94	53	1.10	39	1.18
Hungary	19	–	–	6	–	–	–	–	95	1.00	87	1.01
Iceland	3	–	–	3	–	–	–	–	99	1.00	85	1.01
India	11	23	–	18	66	82	92	83	85	1.01	57	1.01
Indonesia	36	16	–	9	–	–	–	–	95	1.07	82	0.95
Iran (Islamic Republic of)	24	17	–	18	–	–	–	–	95	0.97	81	0.98
Iraq	70	28	7	–	–	–	–	–	–	–	–	–
Ireland	4	–	–	3	–	–	–	–	100	–	99	1.02
Israel	7	–	–	6	–	–	–	–	97	1.00	95	1.02
Italy	3	–	–	4	–	–	–	–	99	1.00	95	1.00
Jamaica	36	8	–	7	–	–	–	–	82	1.04	77	0.98
Japan	2	–	–	4	–	–	–	–	100	–	98	1.02
Jordan	17	10	–	14	58	92	91	67	74	0.98	62	1.05
Kazakhstan	20	7	–	6	–	–	–	–	98	1.00	70	1.08
Kenya	44	13	15	23	65	87	92	77	–	–	–	–
Kiribati	51	18	–	25	–	–	–	–	–	–	–	–
Kuwait	2	–	–	–	–	–	–	–	–	–	–	–
Kyrgyzstan	30	13	–	13	77	94	95	85	94	0.98	73	1.04
Lao People's Democratic Republic	83	33	–	8	–	–	–	–	66	1.01	46	0.93
Latvia	9	–	–	6	–	–	–	–	99	1.01	94	1.02
Lebanon	17	6	–	–	–	–	–	–	–	–	–	–
Lesotho	49	16	–	17	61	90	93	71	83	1.08	63	1.11
Liberia	131	25	32	27	59	79	84	82	60	1.02	61	1.03
Libya	11	–	–	–	–	–	–	–	–	–	–	–
Lithuania	6	0	–	5	–	–	–	–	100	–	99	1.02
Luxembourg	3	–	–	4	–	–	–	–	96	1.00	85	1.05
Madagascar	143	39	–	–	72	87	93	88	65	1.02	31	1.00
Malawi	136	38	–	17	45	68	91	69	76	0.99	30	0.62
Malaysia	6	–	–	–	–	–	–	–	89	1.03	67	1.10
Maldives	5	2	13	6	54	89	84	70	96	1.06	55	1.14
Mali	145	54	89	18	5	20	66	26	45	0.86	24	0.74
Malta	10	–	–	4	–	–	–	–	98	0.99	90	1.02
Martinique	9	–	–	–	–	–	–	–	–	–	–	–
Mauritania	90	37	64	–	25	63	79	44	67	1.04	38	1.04
Mauritius	20	–	–	–	–	–	–	–	95	1.01	77	1.10
Mexico	44	21	–	10	–	–	–	–	92	1.03	69	1.11

Gender, rights and human capital

	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among women aged 15–49, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Decision-making on women's own health care, per cent	Decision-making on contraceptive use, per cent	Decision-making on sexual intercourse, per cent	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
Countries, territories, other areas	2000–2023	2006–2023	2004–2022	2018	2007–2022	2007–2022	2007–2022	2007–2022	2017–2023	2017–2023	2017–2023	2017–2023
Micronesia (Federated States of)	33	–	–	21	–	–	–	–	83	1.03	62	1.08
Mongolia	21	12	–	12	63	85	84	80	96	1.02	88	1.07
Montenegro	9	6	–	4	–	–	–	–	98	0.98	87	1.02
Morocco	22	14	–	11	–	–	–	–	96	0.97	77	0.99
Mozambique	158	53	–	16	49	77	85	67	59	0.93	42	0.88
Myanmar	36	16	–	11	67	85	98	81	88	1.07	63	1.17
Namibia	64	7	–	16	71	91	83	93	100	1.00	88	0.95
Nepal	71	35	–	11	63	72	91	91	96	0.94	81	1.03
Netherlands	2	–	–	5	–	–	–	–	100	1.00	95	1.02
New Caledonia	11	–	–	–	–	–	–	–	–	–	–	–
New Zealand	11	–	–	4	–	–	–	–	98	1.00	95	1.01
Nicaragua	79	35	–	6	–	–	–	–	–	–	–	–
Niger	150	76	2	13	7	21	77	35	25	0.96	10	0.85
Nigeria	75	30	15	13	29	46	81	56	–	–	–	–
North Macedonia	14	8	–	4	88	98	99	90	–	–	–	–
Norway	1	0	–	4	–	–	–	–	100	1.00	95	1.01
Oman	6	4	–	–	–	–	–	–	86	1.01	76	0.99
Pakistan	41	18	–	16	31	52	85	55	72	0.82	51	0.84
Panama	62	26	–	8	79	94	89	95	88	1.02	57	1.08
Papua New Guinea	68	27	–	31	57	86	84	76	69	0.93	43	0.83
Paraguay	72	22	–	6	–	–	–	–	82	1.01	73	1.06
Peru	34	14	–	11	–	–	–	–	98	1.00	84	0.99
Philippines	47	9	–	6	82	95	91	92	89	1.05	82	1.10
Poland	6	–	–	3	–	–	–	–	97	1.00	96	1.01
Portugal	6	–	–	4	–	–	–	–	100	1.00	100	1.00
Puerto Rico	13	–	–	–	–	–	–	–	94	1.04	86	0.98
Qatar	5	4	–	–	–	–	–	–	98	1.00	90	0.99
Republic of Korea	0	–	–	8	–	–	–	–	100	1.00	96	0.99
Republic of Moldova	27	12	–	9	73	96	96	79	100	–	85	1.04
Réunion	15	–	–	–	–	–	–	–	–	–	–	–
Romania	34	7	–	7	–	–	–	–	89	0.99	77	1.02
Russian Federation	13	6	–	–	–	–	–	–	100	1.00	57	0.95
Rwanda	31	6	–	24	61	83	95	76	91	1.06	56	1.06
Saint Kitts and Nevis	74	–	–	–	–	–	–	–	–	–	95	–
Saint Lucia	24	24	–	–	–	–	–	–	87	1.09	76	1.02
Saint Vincent and the Grenadines	37	–	–	–	–	–	–	–	98	–	97	1.02
Samoa	55	7	–	18	–	–	–	–	100	1.00	77	1.15
San Marino	1	–	–	–	–	–	–	–	94	0.99	40	0.81
Sao Tome and Principe	86	28	–	18	46	69	78	79	–	–	–	–
Saudi Arabia	8	–	–	–	–	–	–	–	99	1.00	99	1.00
Senegal	67	31	25	12	6	27	81	18	38	1.18	19	1.20
Serbia	13	6	–	4	96	100	98	98	95	1.00	84	1.05
Seychelles	46	–	–	–	–	–	–	–	96	1.03	87	1.14
Sierra Leone	102	30	83	20	28	44	78	68	82	1.05	58	1.01

Gender, rights and human capital

	Adolescent birth rate per 1,000 girls aged 15–19	Child marriage by age 18, per cent	Female genital mutilation prevalence among women aged 15–49, per cent	Intimate partner violence, past 12 months, per cent	Decision-making on sexual and reproductive health and reproductive rights, per cent	Decision-making on women's own health care, per cent	Decision-making on contraceptive use, per cent	Decision-making on sexual intercourse, per cent	Total net enrolment rate, lower secondary education, per cent	Gender parity index, total net enrolment rate, lower secondary education	Total net enrolment rate, upper secondary education, per cent	Gender parity index, total net enrolment rate, upper secondary education
Countries, territories, other areas	2000–2023	2006–2023	2004–2022	2018	2007–2022	2007–2022	2007–2022	2007–2022	2017–2023	2017–2023	2017–2023	2017–2023
Singapore	3	0	–	2	–	–	–	–	100	1.00	99	1.00
Sint Maarten (Dutch part)	–	–	–	–	–	–	–	–	–	–	–	–
Slovakia	26	–	–	6	–	–	–	–	97	1.00	91	1.00
Slovenia	3	–	–	3	–	–	–	–	99	1.00	97	1.01
Solomon Islands	78	21	–	28	–	–	–	–	–	–	–	–
Somalia	116	45	99	–	–	–	–	–	–	–	–	–
South Africa	71	4	–	13	61	94	85	72	92	1.01	91	1.11
South Sudan	158	52	–	27	–	–	–	–	–	–	–	–
Spain	5	–	–	3	–	–	–	–	97	1.01	95	1.02
Sri Lanka	17	10	–	4	–	–	–	–	97	1.01	86	1.08
State of Palestine[1]	43	13	–	19	–	–	–	–	95	1.02	76	1.16
Sudan	87	34	87	17	–	–	–	–	70	0.96	51	1.07
Suriname	46	36	–	8	–	–	–	–	–	–	–	–
Sweden	2	–	–	6	–	–	–	–	100	1.00	97	1.00
Switzerland	1	–	–	2	–	–	–	–	100	1.00	92	0.99
Syrian Arab Republic	54	13	–	–	–	–	–	–	48	1.08	27	1.17
Tajikistan	42	9	–	14	27	47	79	54	–	–	–	–
Thailand	24	17	–	9	–	–	–	–	98	1.01	98	1.10
Timor-Leste	42	15	–	28	36	93	92	40	87	1.09	74	1.10
Togo	79	25	3	13	30	47	84	75	82	0.95	46	0.77
Tonga	30	10	–	17	–	–	–	–	99	1.08	82	1.19
Trinidad and Tobago	36	4	–	8	–	–	–	–	–	–	67	0.99
Tunisia	4	2	–	10	–	–	–	–	–	–	–	–
Türkiye	12	15	–	12	–	–	–	–	100	1.00	92	1.00
Turkmenistan	22	6	–	–	59	85	90	70	99	1.01	83	1.00
Turks and Caicos Islands	18	23	–	–	–	–	–	–	87	0.86	85	0.76
Tuvalu	44	2	–	20	–	–	–	–	93	1.06	56	1.25
Uganda	111	34	0	26	58	74	88	86	51	0.98	25	0.83
Ukraine	13	9	–	9	81	98	95	86	89	1.01	78	1.07
United Arab Emirates	3	–	–	–	–	–	–	–	–	–	73	1.36
United Kingdom of Great Britain and Northern Ireland	8	0	–	4	–	–	–	–	97	1.00	95	1.02
United Republic of Tanzania	112	29	8	24	50	74	85	68	49	1.07	16	0.86
United States of America	14	–	–	6	–	–	–	–	99	1.01	95	1.03
United States Virgin Islands	25	–	–	–	–	–	–	–	–	–	–	–
Uruguay	27	25	–	4	–	–	–	–	97	1.02	90	1.06
Uzbekistan	36	3	–	–	70	89	90	85	100	1.00	73	1.01
Vanuatu	81	21	–	29	–	–	–	–	95	0.95	75	1.06
Venezuela (Bolivarian Republic of)	76	–	–	9	–	–	–	–	83	1.03	72	1.12
Viet Nam	29	15	–	10	–	–	–	–	98	1.02	95	0.93
Western Sahara	–	–	–	–	–	–	–	–	–	–	–	–
Yemen	77	30	19	–	–	–	–	–	–	–	–	–
Zambia	135	29	–	28	47	81	87	64	–	–	–	–
Zimbabwe	87	34	–	18	60	87	93	72	77	–	37	–

Gender, rights and human capital

NOTES

– Data not available.

[1] On 29 November 2012, the United Nations General Assembly passed Resolution 67/19, which accorded Palestine “non-member observer State status in the United Nations...”

DEFINITIONS OF THE INDICATORS

Adolescent birth rate: Number of births per 1,000 adolescent girls aged 15 to 19 (SDG indicator 3.7.2).

Child marriage by age 18: Proportion of women aged 20 to 24 years who were married or in a union before age 18 (SDG indicator 5.3.1).

Female genital mutilation prevalence among women aged 15–49: Proportion of women aged 15 to 49 years who have undergone female genital mutilation (SDG indicator 5.3.2).

Intimate partner violence, past 12 months: Percentage of ever-partnered women and girls aged 15 to 49 years who have experienced physical and/or sexual partner violence in the previous 12 months (SDG indicator 5.2.1).

Decision-making on sexual and reproductive health and reproductive rights: Percentage of women aged 15 to 49 years who are married (or in a union), who make their own decisions on three areas – their health care, use of contraception, and sexual intercourse with their partners (SDG indicator 5.6.1).

Decision-making on women's own health care: Percentage of women aged 15 to 49 years who are married (or in a union), who make their own decisions on their health care (SDG indicator 5.6.1).

Decision-making on contraceptive use: Percentage of women aged 15 to 49 years who are married (or in a union), who make their own decisions on use of contraception (SDG indicator 5.6.1).

Decision-making on sexual intercourse: Percentage of women aged 15 to 49 years who are married (or in a union), who make their own decisions on sexual intercourse with their partners (SDG indicator 5.6.1).

Total net enrolment rate, lower secondary education: Total number of students of the official age group for lower secondary education who are enrolled in any level of education, expressed as a percentage of the corresponding population.

Gender parity index, total net enrolment rate, lower secondary education: Ratio of female to male values of total net enrolment rate for lower secondary education.

Total net enrolment rate, upper secondary education: Total number of students of the official age group for upper secondary education who are enrolled in any level of education, expressed as a percentage of the corresponding population.

Gender parity index, total net enrolment rate, upper secondary education: Ratio of female to male values of total net enrolment rate for upper secondary education.

MAIN DATA SOURCES

Adolescent birth rate: United Nations Population Division, 2024. Regional aggregates are from World Population Prospects 2022. United Nations Population Division, 2022.

Child marriage by age 18: UNICEF, 2024. Regional aggregates calculated by UNFPA based on data from UNICEF.

Female genital mutilation prevalence among women aged 15–49: UNICEF, 2024. Regional aggregates calculated by UNFPA based on data from UNICEF.

Intimate partner violence, past 12 months: Violence Against Women Inter-Agency Group on Estimation and Data (WHO, UN Women, UNICEF, United Nations Statistics Division, United Nations Office on Drugs and Crime, and UNFPA), 2021.

Decision-making on sexual and reproductive health and reproductive rights: UNFPA, 2024.

Decision-making on women's own health care: UNFPA, 2024.

Decision-making on contraceptive use: UNFPA, 2024.

Decision-making on sexual intercourse: UNFPA, 2024.

Total net enrolment rate, lower secondary education: UNESCO Institute for Statistics, 2024.

Gender parity index, total net enrolment rate, lower secondary education: UNESCO Institute for Statistics, 2024.

Total net enrolment rate, upper secondary education: UNESCO Institute for Statistics, 2024.

Gender parity index, total net enrolment rate, upper secondary education: UNESCO Institute for Statistics, 2024.

Demographic indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population, millions	Population annual doubling time, years	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2024	
World and regional areas	2024	2024	2024	2024	2024	2024	2024	2024	male	female
World	**8,119**	**77**	**25**	**16**	**24**	**65**	**10**	**2.3**	**71**	**76**
More developed regions	1,277	–	16	11	17	64	21	1.5	78	83
Less developed regions	6,842	66	26	17	25	65	8	2.4	70	75
Least developed countries	1,178	31	38	22	31	58	4	3.8	64	69
UNFPA regions										
Arab States	476	39	32	20	28	63	5	3.0	70	75
Asia and the Pacific	4,204	108	22	16	23	68	10	1.9	72	77
Eastern Europe and Central Asia	250	71	23	15	21	66	11	2.1	72	79
Latin America and the Caribbean	666	94	23	16	24	68	10	1.8	73	79
East and Southern Africa	688	28	40	23	32	56	3	4.1	62	67
West and Central Africa	516	28	42	23	33	55	3	4.8	57	59
Countries, territories, other areas	2024	2024	2024	2024	2024	2024	2024	2024	male	female
Afghanistan	43.4	26	43	24	34	55	2	4.3	62	68
Albania	2.8	–	16	12	18	66	18	1.4	78	82
Algeria	46.3	49	30	17	24	63	7	2.7	76	79
Angola	37.8	23	45	24	32	53	3	5.0	61	66
Antigua and Barbuda	0.1	127	18	13	20	71	12	1.6	77	82
Argentina	46.1	113	22	16	23	65	12	1.9	75	81
Armenia	2.8	–	20	13	19	65	14	1.6	71	80
Aruba[1]	0.1	–	15	13	19	67	18	1.2	74	80
Australia[2]	26.7	71	18	12	18	65	18	1.6	82	86
Austria	9.0	–	14	10	15	65	21	1.5	81	85
Azerbaijan[3]	10.5	–	22	16	22	70	8	1.6	71	77
Bahamas	0.4	111	18	14	23	72	10	1.4	71	78
Bahrain	1.5	79	20	13	18	76	4	1.8	80	82
Bangladesh	174.7	70	25	18	27	68	6	1.9	72	77
Barbados	0.3	–	16	12	19	66	17	1.6	76	80
Belarus	9.5	–	16	12	17	65	18	1.5	70	80
Belgium	11.7	–	16	12	17	63	20	1.6	81	85
Belize	0.4	50	27	18	28	68	5	2.0	72	78
Benin	14.1	26	42	23	31	55	3	4.7	60	63
Bhutan	0.8	111	21	17	26	73	7	1.4	71	75
Bolivia (Plurinational State of)	12.6	49	30	20	29	65	5	2.5	66	72
Bosnia and Herzegovina	3.2	–	15	10	16	66	19	1.3	76	80
Botswana	2.7	43	32	20	28	64	4	2.7	64	69
Brazil	217.6	127	20	14	21	70	11	1.6	73	79
Brunei Darussalam	0.5	97	21	15	22	72	7	1.7	73	77
Bulgaria	6.6	–	14	10	15	64	22	1.6	73	79
Burkina Faso	23.8	28	43	24	34	55	3	4.5	59	63
Burundi	13.6	26	44	26	34	53	3	4.8	61	65
Cabo Verde	0.6	72	25	18	26	69	6	1.9	73	81
Cambodia	17.1	68	28	19	27	65	6	2.3	69	74
Cameroon	29.4	27	42	23	32	56	3	4.2	61	64

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population, millions	Population annual doubling time, years	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2024	
Countries, territories, other areas	2024	2024	2024	2024	2024	2024	2024	2024	male	female
Canada	39.1	84	15	11	17	65	20	1.5	81	85
Central African Republic	5.9	23	48	26	37	50	3	5.7	54	58
Chad	18.8	23	47	24	33	51	2	6.0	52	56
Chile	19.7	–	18	12	19	68	14	1.5	79	84
China[4]	1,425.2	–	16	12	18	69	15	1.2	76	82
China, Hong Kong Special Administrative Region[5]	7.5	–	12	8	12	66	22	0.8	83	89
China, Macao Special Administrative Region[6]	0.7	55	15	8	13	71	14	1.2	83	88
Colombia	52.3	–	21	14	22	69	10	1.7	75	81
Comoros	0.9	39	37	21	30	58	4	3.8	63	68
Congo	6.2	31	40	24	32	57	3	4.0	62	65
Costa Rica	5.2	107	19	14	21	69	12	1.5	78	83
Côte d'Ivoire	29.6	28	41	24	33	57	2	4.2	59	62
Croatia	4.0	–	14	10	15	63	23	1.4	77	82
Cuba	11.2	–	15	11	17	68	16	1.5	76	81
Curaçao[1]	0.2	–	17	12	20	67	16	1.6	73	81
Cyprus[7]	1.3	107	16	10	16	69	16	1.3	80	84
Czechia	10.5	–	16	11	16	64	21	1.7	77	83
Democratic People's Republic of Korea	26.2	–	19	12	19	69	13	1.8	71	76
Democratic Republic of the Congo	105.6	21	46	23	32	51	3	6.0	59	63
Denmark[8]	5.9	–	16	11	17	63	21	1.7	80	84
Djibouti	1.2	50	30	19	29	66	5	2.7	62	67
Dominica	0.1	–	19	14	22	71	10	1.6	71	78
Dominican Republic	11.4	79	27	17	26	66	8	2.2	71	78
Ecuador	18.4	68	25	17	26	67	8	2.0	76	81
Egypt	114.5	44	32	20	28	63	5	2.8	70	75
El Salvador	6.4	–	25	17	27	67	9	1.8	69	78
Equatorial Guinea	1.8	30	38	22	29	59	3	4.0	61	64
Eritrea	3.8	37	38	25	35	58	4	3.6	67	71
Estonia	1.3	–	16	11	16	63	21	1.7	75	83
Eswatini	1.2	67	34	22	31	62	4	2.7	58	65
Ethiopia	129.7	28	39	23	32	58	3	3.9	64	70
Fiji	0.9	97	28	18	26	66	6	2.4	67	71
Finland[9]	5.5	–	15	11	17	61	24	1.4	80	85
France[10]	64.9	–	17	12	18	61	22	1.8	81	86
French Guiana[11]	0.3	29	32	18	27	62	6	3.4	75	81
French Polynesia[11]	0.3	88	20	15	22	69	11	1.7	82	86
Gabon	2.5	36	36	21	29	60	4	3.3	65	70
Gambia	2.8	29	42	24	34	55	2	4.4	63	66
Georgia[12]	3.7	–	21	13	19	64	15	2.0	69	79
Germany	83.3	–	14	9	14	63	23	1.5	80	85
Ghana	34.8	36	36	22	31	60	4	3.4	63	68
Greece	10.3	–	13	10	16	63	24	1.4	80	85
Grenada	0.1	129	24	15	22	66	11	2.0	73	79

Demographic indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population, millions	Population annual doubling time, years	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2024	
Countries, territories, other areas	2024	2024	2024	2024	2024	2024	2024	2024	male	female
Guadeloupe[11]	0.4	–	18	13	20	61	21	2.0	80	87
Guam[13]	0.2	105	26	17	25	62	13	2.5	75	82
Guatemala	18.4	46	31	21	31	64	5	2.3	71	77
Guinea	14.5	29	41	23	33	56	3	4.1	59	62
Guinea-Bissau	2.2	32	39	24	33	58	3	3.8	60	64
Guyana	0.8	101	28	18	27	65	7	2.3	66	73
Haiti	11.9	58	31	20	29	64	5	2.7	62	68
Honduras	10.8	45	29	19	29	66	5	2.3	71	76
Hungary	10.0	–	14	10	16	65	20	1.6	74	80
Iceland	0.4	111	18	13	19	66	16	1.7	82	85
India	1,441.7	77	24	17	26	68	7	2.0	71	74
Indonesia	279.8	87	25	17	25	68	7	2.1	69	73
Iran (Islamic Republic of)	89.8	101	23	15	21	69	8	1.7	75	80
Iraq	46.5	32	37	22	32	60	3	3.3	70	74
Ireland	5.1	111	19	14	20	65	16	1.8	81	85
Israel	9.3	47	28	17	24	60	12	2.9	82	85
Italy	58.7	–	12	9	14	63	25	1.3	82	86
Jamaica	2.8	–	19	15	23	73	8	1.3	70	75
Japan	122.6	–	11	9	13	58	30	1.3	82	88
Jordan	11.4	–	31	20	29	65	4	2.7	75	79
Kazakhstan	19.8	60	29	17	23	62	8	3.0	68	76
Kenya	56.2	35	37	23	33	60	3	3.2	62	67
Kiribati	0.1	42	36	21	29	60	4	3.2	66	70
Kuwait	4.3	78	19	14	19	75	6	2.0	79	83
Kyrgyzstan	6.8	46	34	20	27	61	5	2.9	68	76
Lao People's Democratic Republic	7.7	52	30	19	28	65	5	2.4	67	72
Latvia	1.8	–	15	11	15	62	23	1.6	72	80
Lebanon	5.2	–	27	20	27	62	11	2.0	78	82
Lesotho	2.4	64	34	21	30	62	4	2.9	52	58
Liberia	5.5	32	40	24	34	57	3	3.9	61	64
Libya	7.0	65	27	19	28	68	5	2.3	70	77
Lithuania	2.7	–	15	10	15	63	22	1.6	73	81
Luxembourg	0.7	69	16	11	16	69	16	1.4	81	85
Madagascar	31.1	29	38	22	32	58	3	3.7	65	70
Malawi	21.5	27	42	25	35	56	3	3.7	62	69
Malaysia[14]	34.7	67	22	15	23	70	8	1.8	74	79
Maldives	0.5	–	22	13	19	73	5	1.7	81	82
Mali	24.0	23	47	25	34	51	2	5.7	60	62
Malta	0.5	–	13	8	13	67	20	1.2	82	86
Martinique[11]	0.4	–	15	12	18	60	24	1.9	81	86
Mauritania	5.0	26	41	24	33	56	3	4.2	65	69
Mauritius[15]	1.3	–	16	12	20	70	14	1.4	73	79
Mexico	129.4	97	24	17	25	68	9	1.8	72	79
Micronesia (Federated States of)	0.1	74	30	20	30	64	7	2.6	68	76

Demographic indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population, millions	Population annual doubling time, years	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2024	
Countries, territories, other areas	2024	2024	2024	2024	2024	2024	2024	2024	male	female
Mongolia	3.5	53	32	18	25	63	5	2.7	69	78
Montenegro	0.6	–	18	12	18	65	17	1.7	75	81
Morocco	38.2	72	26	17	25	66	8	2.2	73	78
Mozambique	34.9	25	43	24	33	54	3	4.4	60	65
Myanmar	55.0	100	24	16	24	69	7	2.1	65	71
Namibia	2.6	41	36	21	30	60	4	3.2	60	68
Nepal	31.2	64	28	19	29	66	6	2.0	69	73
Netherlands[16]	17.7	–	15	11	17	64	21	1.6	81	84
New Caledonia[11]	0.3	70	22	15	22	67	12	2.0	78	85
New Zealand[17]	5.3	89	18	13	19	65	17	1.7	82	85
Nicaragua	7.1	52	29	19	28	65	6	2.2	72	78
Niger	28.2	18	49	24	33	49	2	6.6	63	65
Nigeria	229.2	29	42	23	33	55	3	5.0	54	55
North Macedonia	2.1	–	16	11	17	69	16	1.4	76	80
Norway[18]	5.5	95	16	12	18	65	19	1.5	82	85
Oman	4.7	48	27	15	21	70	3	2.5	78	81
Pakistan	245.2	36	36	22	32	60	4	3.3	65	70
Panama	4.5	53	26	17	24	65	9	2.3	76	82
Papua New Guinea	10.5	39	34	21	30	63	3	3.1	64	69
Paraguay	6.9	57	28	18	26	65	7	2.4	71	77
Peru	34.7	73	25	17	25	66	9	2.1	75	79
Philippines	119.1	47	30	19	28	65	6	2.7	70	74
Poland	40.2	–	15	10	16	66	19	1.5	75	82
Portugal	10.2	–	13	10	15	63	24	1.4	80	85
Puerto Rico[13]	3.3	–	13	10	17	63	24	1.3	76	84
Qatar	2.7	93	15	10	13	83	2	1.8	81	83
Republic of Korea	51.7	–	11	9	14	70	19	0.9	81	87
Republic of Moldova[19]	3.3	–	19	12	18	67	13	1.8	67	76
Réunion[11]	1.0	92	22	15	23	64	14	2.2	80	86
Romania	19.6	–	16	11	16	65	19	1.7	74	81
Russian Federation	144.0	–	17	12	17	66	17	1.5	70	79
Rwanda	14.4	31	38	23	32	59	3	3.6	65	70
Saint Kitts and Nevis	0.0	–	19	13	20	70	11	1.5	69	76
Saint Lucia	0.2	–	17	13	20	73	10	1.4	71	78
Saint Vincent and the Grenadines	0.1	–	21	15	22	67	11	1.8	71	77
Samoa	0.2	48	37	22	30	57	5	3.8	70	76
San Marino	0.03	–	12	10	16	67	21	1.2	82	85
Sao Tome and Principe	0.2	36	38	24	34	58	4	3.6	66	72
Saudi Arabia	37.5	50	25	16	23	71	3	2.3	77	80
Senegal	18.2	27	41	23	33	56	3	4.2	67	73
Serbia[20]	7.1	–	15	10	15	65	21	1.5	74	80
Seychelles	0.1	128	23	14	21	68	9	2.3	72	80
Sierra Leone	9.0	33	38	23	33	59	3	3.7	60	63
Singapore	6.1	112	12	8	13	71	17	1.1	82	87

Demographic indicators

	POPULATION	POPULATION CHANGE	POPULATION COMPOSITION					FERTILITY	LIFE EXPECTANCY	
	Total population, millions	Population annual doubling time, years	Population aged 0–14, per cent	Population aged 10–19, per cent	Population aged 10–24, per cent	Population aged 15–64, per cent	Population aged 65 and older, per cent	Total fertility rate, per woman	Life expectancy at birth, years, 2024	
Countries, territories, other areas	2024	2024	2024	2024	2024	2024	2024	2024	male	female
Sint Maarten (Dutch part)[1]	0.0	–	10	12	24	77	13	1.6	73	79
Slovakia	5.7	–	16	10	16	67	18	1.6	75	82
Slovenia	2.1	–	15	10	15	63	22	1.6	80	85
Solomon Islands	0.8	32	39	22	31	58	4	3.8	69	73
Somalia	18.7	23	47	24	33	51	3	6.0	56	60
South Africa	61.0	64	28	18	25	66	6	2.3	64	70
South Sudan	11.3	41	42	28	38	55	3	4.1	56	59
Spain[21]	47.5	–	13	10	16	66	21	1.3	82	87
Sri Lanka	21.9	–	22	16	23	66	12	1.9	73	81
State of Palestine[22]	5.5	30	38	22	32	58	4	3.3	74	78
Sudan	49.4	27	40	22	31	56	4	4.3	64	69
Suriname	0.6	79	26	17	26	66	8	2.3	70	76
Sweden	10.7	121	17	12	18	62	21	1.7	82	85
Switzerland	8.9	113	15	10	15	65	20	1.5	83	86
Syrian Arab Republic	24.3	15	28	23	35	67	5	2.6	69	76
Tajikistan	10.3	38	36	21	29	60	4	3.1	69	74
Thailand	71.9	–	15	11	17	68	17	1.3	76	84
Timor-Leste	1.4	50	34	22	33	61	5	2.9	68	71
Togo	9.3	31	39	23	32	57	3	4.1	61	63
Tonga	0.1	83	34	22	31	60	6	3.1	69	74
Trinidad and Tobago	1.5	–	18	13	19	69	12	1.6	72	78
Tunisia	12.6	84	24	15	22	66	10	2.0	74	80
Türkiye	86.3	137	23	15	22	68	9	1.9	76	82
Turkmenistan	6.6	57	31	18	26	64	6	2.6	66	73
Turks and Caicos Islands	0.0	87	17	11	16	73	11	1.6	73	79
Tuvalu	0.0	95	32	19	27	61	7	3.1	61	70
Uganda	49.9	26	44	25	35	54	2	4.2	62	66
Ukraine[23]	37.9	25	15	12	15	65	20	1.3	70	80
United Arab Emirates	9.6	90	15	9	14	83	2	1.4	79	83
United Kingdom of Great Britain and Northern Ireland[24]	68.0	–	17	12	18	63	20	1.6	81	84
United Republic of Tanzania[25]	69.4	24	43	23	33	54	3	4.5	66	70
United States of America[26]	341.8	132	17	13	19	65	18	1.7	77	82
United States Virgin Islands[13]	0.1	–	19	13	18	60	21	2.1	71	82
Uruguay	3.4	–	18	14	21	66	16	1.5	75	82
Uzbekistan	35.7	50	30	17	24	64	6	2.7	69	75
Vanuatu	0.3	30	39	22	31	58	4	3.6	69	73
Venezuela (Bolivarian Republic of)	29.4	37	26	19	28	65	9	2.1	69	77
Viet Nam	99.5	111	22	14	21	68	10	1.9	70	80
Western Sahara	0.6	38	24	15	22	70	6	2.2	70	74
Yemen	35.2	31	39	23	32	59	3	3.6	63	70
Zambia	21.1	26	42	24	34	56	2	4.1	61	66
Zimbabwe	17.0	33	40	24	34	57	3	3.3	59	65

NOTES

– Data not available.

[1] For statistical purposes, the data for Netherlands do not include this area.

[2] Including Christmas Island, Cocos (Keeling) Islands and Norfolk Island.

[3] Including Nagorno-Karabakh.

[4] For statistical purposes, the data for China do not include Hong Kong and Macao, Special Administrative Regions (SAR) of China, and Taiwan Province of China.

[5] As of 1 July 1997, Hong Kong became a Special Administrative Region (SAR) of China. For statistical purposes, the data for China do not include this area.

[6] As of 20 December 1999, Macao became a Special Administrative Region (SAR) of China. For statistical purposes, the data for China do not include this area.

[7] Refers to the whole country.

[8] For statistical purposes, the data for Denmark do not include Faroe Islands and Greenland.

[9] Including Åland Islands.

[10] For statistical purposes, the data for France do not include French Guiana, French Polynesia, Guadeloupe, Martinique, Mayotte, New Caledonia, Réunion, Saint Pierre and Miquelon, Saint Barthélemy, Saint Martin (French part), Wallis and Futuna Islands.

[11] For statistical purposes, the data for France do not include this area.

[12] Including Abkhazia and South Ossetia.

[13] For statistical purposes, the data for United States of America do not include this area.

[14] Including Sabah and Sarawak.

[15] Including Agalega, Rodrigues and Saint Brandon.

[16] For statistical purposes, the data for Netherlands do not include Aruba, Bonaire, Sint Eustatius and Saba, Curaçao, and Sint Maarten (Dutch part).

[17] For statistical purposes, the data for New Zealand do not include Cook Islands, Niue and Tokelau.

[18] Including Svalbard and Jan Mayen Islands.

[19] Including Transnistria.

[20] Including Kosovo.

[21] Including Canary Islands, Ceuta and Melilla.

[22] Including East Jerusalem.

[23] Refers to the territory of the country at the time of the 2001 census.

[24] Refers to the United Kingdom of Great Britain and Northern Ireland. For statistical purposes, the data for United Kingdom do not include Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Channel Islands, Falkland Islands (Malvinas), Gibraltar, Isle of Man, Montserrat, Saint Helena and Turks and Caicos Islands.

[25] Including Zanzibar.

[26] For statistical purposes, the data for United States of America do not include American Samoa, Guam, Northern Mariana Islands, Puerto Rico and United States Virgin Islands.

DEFINITIONS OF THE INDICATORS

Total population: Estimated size of national populations at midyear.

Population annual doubling time, years: The number of years required for the total population to double in size if the annual rate of population change would remain constant. It is calculated as ln(2)/r where r is the annual population growth rate. Doubling time is computed only for fast growing populations with growth rates exceeding 0.5 per cent.

Population aged 0–14, per cent: Proportion of the population between age 0 and age 14.

Population aged 10–19, per cent: Proportion of the population between age 10 and age 19.

Population aged 10–24, per cent: Proportion of the population between age 10 and age 24.

Population aged 15–64, per cent: Proportion of the population between age 15 and age 64.

Population aged 65 and older, per cent: Proportion of the population aged 65 and older.

Total fertility rate: Number of children who would be born per woman if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific fertility rates.

Life expectancy at birth: Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.

MAIN DATA SOURCES

Total population: World Population Prospects 2022. United Nations Population Division, 2022.

Population annual doubling time, years: World Population Prospects 2022. United Nations Population Division, 2022.

Population aged 0–14, per cent: UNFPA calculation based on data from World Population Prospects 2022. United Nations Population Division, 2022.

Population aged 10–19, per cent: UNFPA calculation based on data from World Population Prospects 2022. United Nations Population Division, 2022.

Population aged 10–24, per cent: UNFPA calculation based on data from World Population Prospects 2022. United Nations Population Division, 2022.

Population aged 15–64, per cent: UNFPA calculation based on data from World Population Prospects 2022. United Nations Population Division, 2022.

Population aged 65 and older, per cent: UNFPA calculation based on data from World Population Prospects 2022. United Nations Population Division, 2022.

Total fertility rate: World Population Prospects 2022. United Nations Population Division, 2022.

Life expectancy at birth: World Population Prospects 2022. United Nations Population Division, 2022.

Technical notes

The statistical tables in *State of World Population 2024* include indicators that track progress towards the goals of the Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development (ICPD), and the Sustainable Development Goals (SDGs) in the areas of maternal health, access to education, and reproductive and sexual health. In addition, these tables include a variety of demographic indicators. The statistical tables support UNFPA's focus on progress and results towards delivering a world where every pregnancy is wanted, every birth is safe, and every young person's potential is fulfilled.

Different national authorities and international organizations may employ different methodologies in gathering, extrapolating or analysing data. To facilitate the international comparability of data, UNFPA relies on the standard methodologies employed by the main sources of data. In some instances, therefore, the data in these tables differ from those generated by national authorities. Data presented in the tables are not comparable to the data in previous *State of the World Population* reports due to regional classifications updates, methodological updates, and revisions of time series data.

The statistical tables draw on nationally representative household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), United Nations organizations estimates, and inter-agency estimates. They also include the latest population estimates and projections from *World Population Prospects 2022*, and *Model-based Estimates and Projections of Family Planning Indicators 2022* (United Nations Department of Economic and Social Affairs, Population Division). Data are accompanied by definitions, sources and notes. The statistical tables in *State of World Population 2024* generally reflect information available as of March 2024.

Tracking progress towards ICPD goals

Sexual and reproductive health

Maternal mortality ratio. Source: United Nations Maternal Mortality Estimation Inter-agency Group (WHO, UNICEF, UNFPA, The World Bank and United Nations Population Division), 2023. This indicator presents the number of maternal deaths during a given time period per 100,000 live births during the same time period. Estimates and methodologies are reviewed regularly by the Maternal Mortality Estimation Inter-agency Group and other agencies and academic institutions and are revised where necessary, as part of the ongoing process of improving maternal mortality data. Estimates should not be compared with previous inter-agency estimates.

Births attended by skilled health personnel. Source: Joint global database on skilled attendance at birth. UNICEF and WHO, 2023. This is the percentage of deliveries attended by health personnel trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period; conducting deliveries on their own; and caring for newborns. Traditional birth attendants, even if they receive a short training course, are not included.

Number of new HIV infections, all ages, per 1,000 uninfected population. Source: HIV Estimates. UNAIDS, 2023. Number of new HIV infections per 1,000 person-years among the uninfected population (SDG indicator 3.3.1).

Contraceptive prevalence, any method and any modern method. Source: United Nations Population Division, 2022. Model-based estimates are based on data that are derived from sample survey reports. Survey data estimate the proportion of all women of reproductive age, and married women (including women in consensual unions), currently using, respectively, any method or modern methods of contraception. Modern methods of contraception include female and male sterilization, the intrauterine device (IUD), the implant, injectables, oral contraceptive pills, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge), lactational amenorrhea method (LAM), emergency contraception and other modern methods not reported separately (e.g., the contraceptive patch or vaginal ring).

Unmet need for family planning (any method). Source: United Nations Population Division, 2022. Model-based estimates are based on data that are derived from sample survey reports. Women who are using a traditional method of contraception are not considered as having an unmet need for family planning. All women or all married and in union women are assumed to be sexually active and at risk of pregnancy. The assumption of universal exposure to possible pregnancy among all women or all married or in union women may lead to lower estimates compared to the actual risks among the exposed. It might be possible, in particular at low levels of contraceptive prevalence, that when contraceptive prevalence increases, unmet need for family planning also increases. Both indicators, therefore, need to be interpreted together.

Proportion of demand satisfied, any modern method. Source: United Nations Population Division, 2022. Modern contraceptive prevalence divided by total demand for family planning. Total demand for family planning is the sum of contraceptive prevalence and unmet need for family planning.

Laws and regulations that guarantee access to sexual and reproductive health care, information and education, per cent. Source: UNFPA, 2022. The extent to which countries have national laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education (SDG indicator 5.6.2).

Universal health coverage (UHC) service coverage index. Source: WHO, 2023. Average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population (SDG indicator 3.8.1).

Gender, rights and human capital

Adolescent birth rate. Source: United Nations Population Division, 2024. Regional aggregates are from World Population Prospects 2022. United Nations Population Division, 2022. The adolescent birth rate represents the risk of childbearing among adolescent women 15 to 19 years of age. For civil registration, rates are subject to limitations which depend on the completeness of birth registration, the treatment of infants born alive but dead before registration or within the first 24 hours of life, the quality of the reported information relating to age of the mother, and the inclusion of births from previous periods. The population estimates may suffer from limitations connected to age misreporting and coverage. For survey and census data, both the numerator and denominator come from the same population. The main limitations concern age misreporting, birth omissions, misreporting the date of birth of the child, and sampling variability in the case of surveys.

Child marriage by age 18, per cent. Source: UNICEF, 2024. Proportion of women aged 20 to 24 years who were married or in a union before the age of 18 (SDG indicator 5.3.1).

Female genital mutilation prevalence among girls aged 15– 49, per cent. Source: UNICEF, 2024. Proportion of girls aged 15 to 49 years who have undergone female genital mutilation (SDG indicator 5.3.2).

Intimate partner violence, past 12 months, per cent. Source: Violence Against Women Inter-Agency Group on Estimation and Data (WHO, UN Women, UNICEF, United Nations Statistics Division, United Nations Office on Drugs and Crime and UNFPA), 2021. Percentage of ever-partnered women and girls aged 15 to 49 years who have experienced physical and/or sexual partner violence in the previous 12 months (SDG indicator 5.2.1).

Decision-making on sexual and reproductive health and reproductive rights, per cent. Source: UNFPA, 2024. Percentage of women aged 15 to 49 years who are married (or in a union), who make their own decisions on three areas — their health care, use of contraception, and sexual intercourse with their partners (SDG indicator 5.6.1).

Decision-making on women's own health care, per cent. Source: UNFPA, 2024. Percentage of women aged 15 to 49 years who are married (or in a union), who make their own decisions about their health care (SDG indicator 5.6.1).

Decision-making on contraceptive use, per cent. Source: UNFPA, 2024. Percentage of women aged 15 to 49 years who are married (or in a union), who make their own decision about use of contraception (SDG indicator 5.6.1).

Decision-making on sexual intercourse, per cent. Source: UNFPA, 2024. Percentage of women aged 15 to 49 years who are married (or in a union), who make their own decisions about sexual intercourse with their partners (SDG indicator 5.6.1).

Total net enrolment rate, lower secondary education, per cent. Source: UNESCO Institute for Statistics, 2024. Total number of students of the official age group for lower secondary education who are enrolled in any level of education, expressed as a percentage of the corresponding population.

Gender parity index, total net enrolment rate, lower secondary education. Source: UNESCO Institute for Statistics, 2024. Ratio of female to male values of total net enrolment rate for lower secondary education.

Total net enrolment rate, upper secondary education, per cent. Source: UNESCO Institute for Statistics, 2024. Total number of students of the official age group for upper secondary education who are enrolled in any level of education, expressed as a percentage of the corresponding population.

Gender parity index, total net enrolment rate, upper secondary education. Source: UNESCO Institute for Statistics, 2024. Ratio of female to male values of total net enrolment rate for upper secondary education.

Demographic indicators

Population

Total population, millions. Source: World Population Prospects 2022. United Nations Population Division, 2022. Estimated size of national populations at midyear.

Population change

Population annual doubling time, years. Source: World Population Prospects 2022. United Nations Population Division, 2022. The number of years required for the total population to double in size if the annual rate of population change would remain constant. It is calculated as ln(2)/r where r is the annual population growth rate. Doubling time is computed only for fast growing populations with growth rates exceeding 0.5 per cent.

Population composition

Population aged 0–14, per cent. Source: UNFPA calculation based on data from the United Nations Population Division, 2022. Proportion of the population between age 0 and age 14.

Population aged 10–19, per cent. Source: UNFPA calculation based on data from the United Nations Population Division, 2022. Proportion of the population between age 10 and age 19.

Population aged 10–24, per cent. Source: UNFPA calculation based on data from the United Nations Population Division, 2022. Proportion of the population between age 10 and age 24.

Population aged 15–64, per cent. Source: UNFPA calculation based on data from the United Nations Population Division, 2022. Proportion of the population between age 15 and age 64.

Population aged 65 and older, per cent. Source: UNFPA calculation based on data from the United Nations Population Division, 2022. Proportion of the population aged 65 years and older.

Fertility

Total fertility rate, per woman. Source: World Population Prospects 2022. United Nations Population Division, 2022. Number of children who would be born per woman if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific fertility rates.

Life expectancy

Life expectancy at birth, years. Source: World Population Prospects 2022. United Nations Population Division, 2022. Number of years newborn children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.

Regional classifications

UNFPA regional aggregates presented at the start of the statistical tables are calculated using data from countries and areas as classified below.

Arab States Region
Algeria; Djibouti; Egypt; Iraq; Jordan; Lebanon; Libya; Morocco; Oman; Palestine; Somalia; Sudan; Syrian Arab Republic; Tunisia; Yemen

Asia and the Pacific Region
Afghanistan; Bangladesh; Bhutan; Cambodia; China; Cook Islands; Fiji; India; Indonesia; Iran (Islamic Republic of); Kiribati; Korea, Democratic People's Republic of; Lao People's Democratic Republic; Malaysia; Maldives; Marshall Islands; Micronesia (Federated States of); Mongolia; Myanmar; Nauru; Nepal; Niue; Pakistan; Palau; Papua New Guinea; Philippines; Samoa; Solomon Islands; Sri Lanka; Thailand; Timor-Leste; Tokelau; Tonga; Tuvalu; Vanuatu; Viet Nam

Eastern Europe and Central Asia Region
Albania; Armenia; Azerbaijan; Belarus; Bosnia and Herzegovina; Georgia; Kazakhstan; Kyrgyzstan; North Macedonia; Republic of Moldova; Serbia; Tajikistan; Türkiye; Turkmenistan; Ukraine; Uzbekistan.

Latin America and the Caribbean Region
Anguilla; Antigua and Barbuda; Argentina; Aruba; Bahamas; Barbados; Belize; Bermuda; Bolivia (Plurinational State of); Brazil; British Virgin Islands; Cayman Islands; Chile; Colombia; Costa Rica; Cuba; Curaçao; Dominica; Dominican Republic; Ecuador; El Salvador; Grenada; Guatemala; Guyana; Haiti; Honduras; Jamaica; Mexico; Montserrat; Nicaragua; Panama; Paraguay; Peru; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Sint Maarten; Suriname; Trinidad and Tobago; Turks and Caicos Islands; Uruguay; Venezuela (Bolivarian Republic of)

East and Southern Africa Region
Angola; Botswana; Burundi; Comoros; Democratic Republic of the Congo; Eritrea; Eswatini; Ethiopia; Kenya; Lesotho; Madagascar; Malawi; Mauritius; Mozambique; Namibia; Rwanda; South Africa; South Sudan; Uganda; United Republic of Tanzania; Zambia; Zimbabwe

West and Central Africa Region
Benin; Burkina Faso; Cape Verde; Central African Republic; Chad; Côte d'Ivoire; Equatorial Guinea; Gabon; Gambia; Ghana; Guinea; Guinea-Bissau; Liberia; Mali; Mauritania; Niger; Nigeria; Republic of Cameroon; Republic of Congo; Sao Tome and Principe; Senegal; Sierra Leone; Togo

More developed regions are intended for statistical purposes and do not express a judgment about the stage reached by a particular country or area in the development process, comprising UNPD regions Europe, Northern America, Australia/New Zealand and Japan.

Less developed regions are intended for statistical purposes and do not express a judgment about the stage reached by a particular country or area in the development process, comprising all UNPD regions of Africa, Asia (except Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia.

The least developed countries, as defined by the United Nations General Assembly in its resolutions (59/209, 59/210, 60/33, 62/97, 64/L.55, 67/L.43, 64/295 and 68/18) included 46 countries (as of January 2022): 33 in Africa, 8 in Asia, 4 in Oceania and one in Latin America and the Caribbean – Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Djibouti, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Kiribati, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, South Sudan, Sudan, Timor-Leste, Togo, Tuvalu, Uganda, United Republic of Tanzania, Yemen and Zambia. These countries are also included in the less developed regions. Further information is available at https://www.un.org/en/conferences/least-developed-countries.

Note on In Focus: Self-reported problems in accessing health care, over time, by socioeconomic status and ethnicity (pp. 28–31)

About matching ethnic groups across surveys: This analysis included matching ethnic groups across the two surveys in each country and reconciling slight spelling differences or aggregating individual ethnic groups in one survey to the umbrella ethnic groups used in the other survey – based on the details provided in individual country reports' methodological appendices. Where matches were not possible, lone ethnic groups were reclassified to the pre-existing "other" category.

About socioeconomic variables: This analysis included wealth quintile, level of schooling and urban or rural residence. Wealth quintiles divide each country and survey's population into five groups based on a collection of information obtained in the household questionnaire related to wealth status. Schooling identifies whether a woman has no education, primary, secondary or higher education.

Methodology: Binary logistic regression models were used to estimate the proportion of women reporting serious problems in access to health care and to examine country-specific differences by ethnicity and socioeconomic status. The regression models take into account the DHS surveys' complex survey design and survey weights to produce valid standard error estimates. Where model testing indicated it provided a better fit, an interaction between survey year and ethnicity was included in the models, meaning that ethnicities had different rates of change over time. Otherwise, there was no interaction, meaning that ethnicities shared the same rate of change over time but different starting points. The analysis found ethnic differences in all countries, even after controlling for socioeconomic status. (In Armenia and Gabon, sample sizes were very small, meaning the differences seen could be due to statistical chance.) Multilevel models were used to examine higher-level patterns across all countries included in the analysis. This analysis found that, as a general trend, the most marginalized saw the least improvement in access while the least marginalized saw the most improvement. In the models, level 1 was the individual women, level 2 was represented by country-specific ethnic groups, and level 3 by the 25 different countries. To be more sensitive to the country-specific socioeconomic stratification, the multilevel models use an index variable for socioeconomic status instead of the categorical variables used in the binary logistic country-specific regressions. In the index variable, the socioeconomic profile (a given combination of wealth, education and residence) with the lowest predicted probability specific to each country takes the value of 1, and the profile with the highest predicted probability takes the value of 40. All intervening profiles take their corresponding value between 1 and 40 according to the ranking of their predicted probabilities in the country-specific regressions. Where the analysis refers to the proportion of women across all countries, these estimates were derived by weighting the country-level estimates by population size.

Note on highest and lowest maternal mortality risks, comparing 1990 to 2020 (p. 66)

In examining trends in maternal mortality from 1990 to 2020 throughout Chapter 3, the authors performed their own calculations based on data published alongside the most recent official maternal mortality statistics provided in the publication from WHO and others (2023a). The publication itself focuses on trends from 2000 to 2020, but accompanying data sets include estimates beginning in 1985. This means that the 1990 and 2020 estimates referred to in Chapter 3 compare estimates derived using the same methodology and input data. In comparing the 10 per cent of countries with the highest and lowest risk of women eventually dying from pregnancy or childbirth in 1990 and 2020, the averages were not weighted by population size.

Note on maternal mortality trend in the United States (p. 66)

While there are marked racial and ethnic inequalities in maternal death rates in the United States, maternal mortality figures in the country have been increasing across most groups of women. There is debate about how much of the increase is an artefact of changing definitions and surveillance; these questions cannot be answered without improved data systems such as systematic and standardized enquiries into all deaths across all states. Nevertheless, research does indicate the country's lack of universal access to health care plays a role (Braveman, 2023). Notably, a large share of maternal deaths in the country occur between six weeks and one year post-partum, many of them linked to mental health conditions (Trost and others, 2017). Unlike many high-income countries, the United States does not guarantee paid parental leave or home visits by health providers in the post-partum period (Tikkanen and others, 2020).

Note on unmet need for contraception in countries affected by humanitarian crises (p. 95)

The authors based this estimate on tabulations of data in Table 2.5 of the source, which provides data on the percentage of women with met and unmet need for contraception in countries affected by humanitarian crises in 2015. The percentages with met and unmet need were summed to compute the total percentage of women who want to avoid pregnancy in each country. The proportion of women wanting to avoid pregnancy who are not using any form of contraception was computed as the percentage with unmet need divided by the overall percentage with need. The unweighted average of the country estimates is 51 per cent.

Note on per capita income estimates from study in Kenya, Nigeria and Senegal (p. 96)

The authors calculated the per capita income estimates from Table 1 of the original source, which estimates the per capita gross domestic product (GDP) under different scenarios. According to the table, the GDP would be 3,480 international dollars if two thirds of the unmet need for modern contraception were met (the "moderate" scenario) and 2,310 international dollars in the baseline scenario.

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